Better health for individuals

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What does health mean to individuals?

OUTCOMES

On completion of this chapter,
you will be able to:

- identify and examine why individuals give different meanings to health (P1)
- explain how a range of health behaviours affect an individual's health (P2)
- describe how an individual's health is determined by a range of factors (P3)
- use a range of sources to draw conclusions about health and physical activity concepts. (P16)

OVERVIEW

MEANINGS OF HEALTH
Definitions of health
Dimensions of health
Relative and dynamic nature of health

PERCEPTIONS OF HEALTH
Personal perceptions of health
Perceptions of the health of others
Implications of different perceptions of health
Perceptions of health as social constructs
Impact of the media, peers and family

HEALTH BEHAVIOURS OF YOUNG PEOPLE
The positive health status of young people
Protective behaviours and risk behaviours

This chapter provides an understanding of foundation concepts in preparation for the chapters that follow and for the HSC course. It examines the meaning of health, explores the interactions between the various dimensions of health and considers how health is a dynamic and relative concept.

We investigate how people's perceptions of health differ and analyse the degree to which these perceptions are socially constructed. In addition, we investigate the health behaviours of young people, challenge the accuracy of common perceptions of young people's health behaviours and consider the impact these behaviours could have on their current and future health.

MEANINGS OF HEALTH

Health is a topic of considerable interest to individuals, medical professionals, community and welfare groups, and all levels of government. The level of interest expressed in issues related to health is not surprising: it is the subject of extensive research, receives significant coverage in the media, is a major focus of government policies, and is an area of concern for many people seeking to improve their lifestyle and maximise their current and future health.

Health is considered one of the most important determinants of our quality of life and many people feel that they have some control over it. It is a valuable resource, but it is often taken for granted and not clearly understood.

Figure 1.1: Health is a topic of considerable interest to many people and organisations.

Definitions of health

People attribute different meanings to the term health. In order to understand issues related to health, it is firstly important to understand what is meant by the term health as it applies to individuals and the community.

INQUIRY What does health mean to me?

1. Using at least 15 words, complete the following unfinished sentences.
   (a) Good health to me means . . .
   (b) The signs of being healthy are . . .
   (c) To lead a healthy lifestyle you need to . . .

(d) The things I do that are good for my health …

(e) When I am healthy I feel …

(f) The unhealthy things I do include …

2. After completing this activity, write your own definition of what health means to you.

3. Discuss your answers as a class group. What do your answers tell you about your health beliefs and attitudes?

The concept of health is diverse and means different things to different people. This diversity can be recognised by considering the different meanings of health that have developed over time.

Early meanings of 'health'

In the past the term health was closely associated with how well a person's body functioned physically, and in particular with their capacity and ability to perform physical activity. Prior to World War II, health was viewed as the opposite of illness. If there was no evidence of disease or physical illness, we were considered healthy and any breakdown in the body system meant that it was not healthy. This view of health suggested that if you were ill, medicine, drugs and doctors were able to return you to a healthy state.

This early definition of health was recognised as being too narrow and one dimensional in its perception of what was involved in a person's health. Its failure to take into account an individual's mental, social or spiritual well-being meant that the definition had severe limitations. For example, a person may not be suffering from a physical illness, but may be experiencing depression or emotional stress. Without appropriate support and treatment this could develop into distress that significantly impacts on the person's everyday life and their overall level of health.

World Health Organization's definition of 'health'

In 1946, the World Health Organization (WHO) developed a definition of health that is still accepted today. Health was defined by the WHO as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. This definition gave greater recognition to a more holistic concept of health by recognising the whole person and focusing on more than the physical aspect of health and the absence of disease or illness.

However, the definition has limitations as it suggests that people cannot be considered truly healthy unless they have *complete* physical, mental or social well-being. Under this definition an individual who has a physical impairment, a mental health diagnosis or is socially isolated cannot be considered healthy. The fact that we all experience times when we are sick, sad or lonely means that according to this definition optimal health is virtually unachievable. A further weakness of this definition is that it fails to acknowledge that a person's state of health is always changing.

Dimensions of health

We now understand that a number of dimensions all play an important role in determining a person's state of health. These dimensions include a person's physical, mental, social and spiritual well-being. We also understand that a

Figure 1.2: Good health is much more than a physical state — it encompasses many dimensions.

person's level of health is the result of an interaction between these different dimensions and that a balance between all four dimensions is essential to produce general well-being and satisfaction.

Physical health

Physical health is the wellness of the body and the absence of chronic pain or discomfort.

Physical health refers to the state of the physical body, which includes
- the efficient functioning of the body organs
- our level of fitness

- nutritional status
- degree of energy
- body weight
- resistance to disease.

While our heredity and genetic makeup determine our physical potential, physical health is largely determined by lifestyle and behaviour. People who are physically healthy are generally free of chronic pain or discomfort.

Social health

Social health is our ability to interact with other people in an interdependent and cooperative way.

Social health refers to our interactions with other people (family, friends and others), as well as the social and communication skills and abilities we display. Good social health means we feel a sense of connection and belonging to various people, and to the wider community in which we live. We are able to interact effectively with people in an interdependent, appropriate and cooperative way. We can form and maintain positive relationships that provide us with a network of support and appropriately manage situations where relationships may break down.

Mental health

Mental or **emotional health** is a state of well-being where we can realise our abilities, cope with the normal stresses of life, work productively and make a contribution to the community.

Mental or **emotional health** refers to our state of emotional well-being. People who have good mental health generally possess a positive outlook and a sense of purpose and control over their lives. This enables them to realise their own abilities, cope with the everyday stresses of life, work productively and contribute effectively to the community. Factors that contribute to our mental health and the resilience needed to cope when faced with sad or difficult times include:

- our self-concept (the way we see ourselves), self-confidence and self-esteem (the way we feel about ourselves)
- our sense of connection or belonging to different significant groups such as family, peers or school
- our ability to appropriately express emotions such as love, anger and frustration
- our ability to think creatively and be flexible when making decisions and resolving problems
- our capacity to function productively within society without exhibiting personally and socially disruptive behaviour.

Spiritual health

Spiritual health relates to a sense of purpose and meaning in our life, and to feeling connected with others and society.

Spiritual health relates to feeling a sense of purpose and meaning in our life. Good spiritual health helps us to feel connected with others such as family members, peers, our community, to a religion or the environment. Ideals, values, morals and aspirations are factors that influence our spiritual health. Our level of spiritual health can be influenced by an awareness and understanding of ourselves. It can also relate to our ability to do things such as set realistic goals, appreciate the needs and feelings of others, and have ambitions and aspirations.

Our individual level of health is the result of a complex interaction between these four aspects and is continually changing. A breakdown in one aspect of health is likely to impact on the other aspects, while improvements in one area can enhance our overall sense of health and well-being in all areas. For example, if you are hospitalised after a cycling accident, as well as suffering

Physical
- bodily function
- nutritional status
- fitness
- resistance to disease

Emotional
- feelings and emotions
- adaptation
- decision-making skills

HEALTH

Social
- communication skills
- interpersonal relationships

Spiritual
- purpose
- meaning
- connectedness

Figure 1.3: Health is a result of interactions between all the dimensions of health.

physical injuries, you might feel angry about what happened, frustrated about being confined to bed and lonely because you are away from family and friends. Once you recover from these injuries and are discharged from hospital you will be able to resume school or work and socialise with others. This will help you overcome concerns about your injuries, and feel happier and less cut off from friends and family.

Dimensions of health

Recall a time in your life when one dimension of your health was poor; for example, when you had a virus. Consider how other dimensions of your health were also affected during this time. Draw a mind map or a flow chart to illustrate your ideas.

Relative and dynamic nature of health

Health is the result of a continually changing process. From a personal perspective it may be represented as a continuum, with optimum health or a positive state of well-being at one end and very poor health or being extremely unwell at the other end. Judging where we are along the health continuum at any point in time is highly subjective as people see health in different ways, have different perceptions about what is optimal or 'normal' and define the extremes of the continuum differently. Furthermore, when assessing their level of health people consider their past and current circumstances, as well as comparing themselves to others. For example, if we compare our physical health to that of an Olympic athlete we may not believe ourselves to be totally healthy.

The subjective judgements that people make about their level of health demonstrate the **relative nature** of health, with our health being relative to others and ourselves over time. For example:

The **relative nature** of health refers to how we judge our health compared to other people or other points of time in our life.

• someone with breast cancer who has a breast removed in a mastectomy may consider her health poor compared to how it was previously or compared
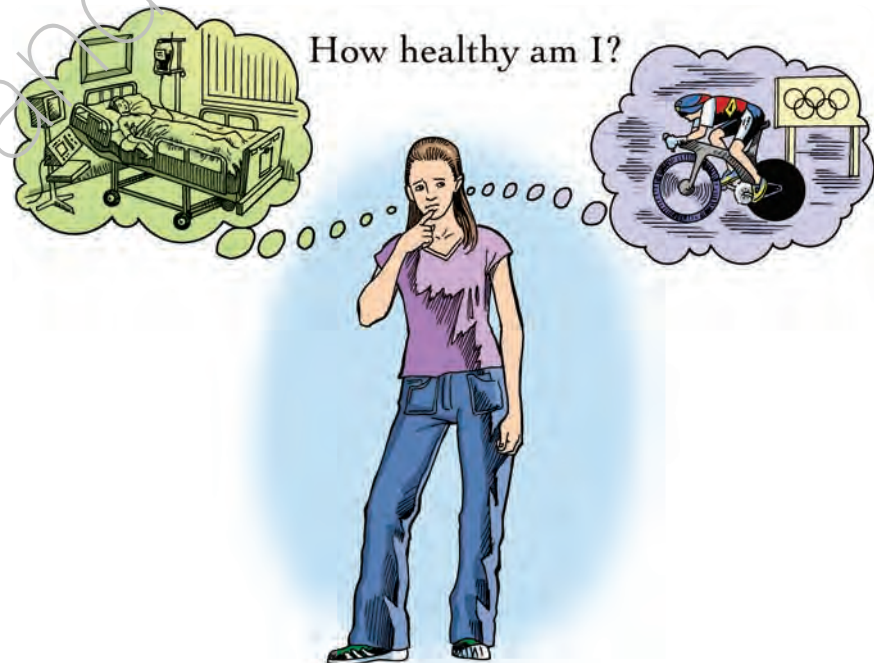

Figure 1.4: We perceive our health relative to the health of others. Our health may not be as good as that of an elite athlete, but it is better than that of a patient in hospital.

to others without cancer. However, she may consider her health good during her recovery compared to how it was while she was undergoing treatment.

- a person who has bipolar disorder may consider themselves well when they are taking prescribed medication, undergoing treatment, and are able to fulfil work and personal responsibilities, compared to how they felt prior to diagnosis and treatment
- people with a disability or chronic disease may describe themselves as healthy, especially on days when their disabilities seem less severe than usual
- we might consider ourselves very healthy, but believe we are very ill when we have influenza, which is a passing virus.

INQUIRY

Relative and dynamic nature of health

Read the case study 'Elsha's story' (page 11) and answer the following questions.

1. Explain how each of the following dimensions of Elsha's health were affected by different circumstances in her life and discuss the interactions that occurred between the various dimensions:
- physical health
- emotional health
- social health
- spiritual health.

2. Identify the events described by Elsha that have:
   (a) positively impacted on her health and well-being
   (b) negatively impacted on her health and well-being.

3. Draw a health continuum similar to the one shown below.

Poor	Fair	Good	Very good	Excellent

Use this continuum to rate Elsha's health at the following times in her life. Place each letter (a) to (e) at the relevant place on the continuum.
   (a) living on a property in a small country town
   (b) parents separating and moving house, so Elsha had to change schools
   (c) being diagnosed with depression
   (d) finding a clinician who Elsha was comfortable with and who she felt listened and understood
   (e) completing her diploma in counselling.

4. Explain the reasons for the ratings you have given Elsha's health at each of those points in time. What does this tell you about how a person's health changes over time?

5. As a class, discuss how this case study demonstrates the dynamic nature of health.

The case study demonstrates that health is relative to our own circumstances and that of others, and that our level of health is never static. Our health varies over time, fluctuating from minute to minute, day to day and year to year. Illness, accidents, personal experiences or environmental factors can move our level of health any number of times during our lives from very well to well, off-colour to ill, very unwell to critically ill and then back to full health. These continual changes in our state of health mean that health is **dynamic**.

The **dynamic** nature of health refers to the constant fluctuations that occur in our level of health.

Elsha's story

My life up until secondary school had been fairly uneventful in regards to traumatic events. Living in a country town on a property meant that we were fairly sheltered from the world around us.

When I got to secondary school my life as it had been changed rather drastically. My nanna passed away after a long battle with cancer. Later that year my parents separated as my Dad had an affair. My Mum and sister and I moved, and my sister and I moved schools. All of those events occurred in a very short period of time leaving me feeling overwhelmed and unable to cope and with so many mixed feelings.

My Mum noticed how down and fatigued I was and took me to our GP. It was then that I was diagnosed with depression. I was so confused as to what to feel. I was relieved to know why I had been feeling the way I had, but I was also scared that people would label me as crazy or different.

I went to several clinicians, whom I felt didn't really listen or understand where I was coming from. I eventually found one that I was comfortable with and was empathic to my thoughts and feelings. He helped me confront the hurt and anger I was experiencing, and taught me to think in a more positive manner, using affirmations when I felt really down. I would tell myself that despite feeling down, I had felt this way before and I got through it. I[t] was a matter of taking one step forward and three back but just reminding myself that I would survive.

The worst thing about having depression was the constant sadness I felt, sometimes for no particular reason at all, which left me feeling helpless and out of control. I experienced a lot of anxiety which led to panic attacks which made me feel like I was having a heart attack. My life was always on edge, like something was always behind me and I was running away from it always knowing it was eventually going to catch up with me and something terrible was going to happen.

Unfortunately I was unable to stay at school, and thus felt even more isolated and alone.

A major venture I have recently become involved with is launching the Dr Link campaign with other dedicated people, to help increase community awareness of depression. That will hopefully let other young people suffering from depression know they are not alone and that there is great help out there.

The community at large don't seem to know the difference between feeling sad — which of course is normal — and clinical depression, which we know isn't. This is because sadness only lasts minutes, hours or days. Depression seems to go on forever — like a pervasive and relentless sense of despair.

Since I have recovered I have completed a diploma in counselling in the hope of helping other young people overcome the battle with depression.

Source: www.reachout.com.au. ReachOut.com provides young people with the skills, tools and connections they need to make positive choices about their mental health and well-being.

APPLICATION

Conduct a polarised debate

Conduct a debate to explore the relative nature of health and the different interpretations that people have of the concept of good health. Some questions for debate are:

1. It is possible for a person who requires regular medication to be considered healthy.
2. You can be healthy without being physically active.
3. Elderly people cannot achieve the same level of health as young people.

A polarised debate is set up by dividing the class into two sides, one supporting the affirmative and the other side the negative. The debate begins with a comment from the affirmative and proceeds with a comment in turn from each side. If a comment reaffirms their side's position, the student remains on that side. If a student speaks against their side's position, they 'cross the floor' and move to the other side. The debate is concluded when there is no movement from either side or there are no further comments.

Evaluate the arguments presented by members of your class at the conclusion of the debate.

People's perceptions of health can be highly subjective. These differing perceptions have implications for the priority we give to taking action to maintain or improve our health and the type of action that is taken.

Perceptions of our health

Making judgements about your current state of health can be highly subjective. The way we judge our health may be different from the way a health professional or a professional athlete does. The meanings we give to health will most likely be based on what we have learned about health, along with our own experiences or on those of people we know. They will be reflected in our behaviour and may be different to the interpretation that others have.

Statistics such as the number of visits to a health professional, number and length of hospital admissions, or number of days absent from school or work due to illness can be used to provide some objective information about a person's physical health status. However, to determine a person's state of health more holistically — that is, their state of social, mental and spiritual well-being — some level of self-assessment is needed.

Perception refers to the way something is seen or viewed by an individual or group.

When making judgements about our level of health and well-being our **perceptions** are influenced by a range of factors, including:
- our personal interpretation of the term health
- our beliefs about our capacity to achieve good health
- our environment
- our health behaviours and lifestyle
- our past level of health
- the attitudes about health conveyed by family, peers and the media
- the value we place on the importance of striving for and maintaining a positive state of well-being.

These perceptions vary constantly throughout our lives. As we age, our definition of health changes to reflect our changing experiences, expectations and beliefs about what good health looks and feels like.

- Personal interpretation of health
- Our behaviours and lifestyle
- Environment
- Our past level of health
- Beliefs about our capacity to achieve good health
- Attitudes about health conveyed by peers, family and the media
- The value we place on the importance of being healthy

Figure 1.5: The way we perceive our health is influenced by a wide range of factors.

Table 1.1: Changes in the meaning of health during our life cycle

Period	Health
Childhood (birth to 11 years)	• generally take health for granted
Early adolescence (12–16 years)	• health seen as important to help establish and maintain a positive body image • health behaviours and values being formed
Late adolescence (17–24 years)	• majority enjoy good health and realise benefits of health-promoting behaviours, even if it is not a priority for them • more likely to have specific health concerns related to nutrition, drug use, injury, relationships, sexual health and mental health • develop intimate relationships • may engage in risk taking with a sense of impunity ('it won't happen to me' attitude)
Early adulthood (25–39 years)	• seen as a resource; realise the value of having all dimensions of health in balance in order to function effectively
Middle years of adulthood (40–59 years)	• preventative health behaviours and screening procedures become necessary as age increases
Senior years (from 60 years)	• good health seen as a precious resource • more likely to suffer from failing health due to ageing process

APPLICATION

How do perceptions of health change with age?

1. Divide the class into six groups. Each group is allocated a period within the life cycle (see table 1.1 for the six periods).
2. Using five questions devised by your group, interview 10 people whose age falls in the life cycle period allocated to your group; for example, 10 people aged between 17 and 24 years. The five questions you ask people should reveal the views these people have about health; for example:
   • What does the term health mean to them?
   • Why is health important to them?
   • What type of behaviours do they consider healthy?
3. As a group, summarise and report on your findings to the class. Compare your findings with the information in table 1.1.

APPLICATION

How healthy do others think I am?

1. Using a five-point scale (excellent, very good, good, fair, poor) rate your current level of health.
2. Write an explanation that clearly shows the reasons for your rating.
3. Choose four other people (including at least two adults) and ask them to rate your health using the same five-point scale, then ask them to explain the reasons for their rating. Record their comments.
4. Compare and contrast the perception you have of your own health and the perceptions of your health by others. Propose possible reasons for any differences that are found.
5. Discuss your findings with the class, highlighting similarities and differences.

Perceptions of the health of others

Just as our perception of our own level of health is influenced by a range of factors, so too are our judgements about the health status of others.

Our different ways of seeing and interpreting the living conditions, fitness levels and health behaviours of various groups significantly shape our notions of how healthy people in different circumstances are likely to be. We may hold stereotypical beliefs about particular groups in the community and this may limit our ideas about their likely health status.

Figure 1.6: Different interpretations of people's health and fitness influence the perceptions we have of other's health.

APPLICATION — How healthy do we think other people are?

1. Divide the class into small teams and allocate each team a card with the name of one of the following groups:

   Elderly people   Homeless people

   People with a physical disability   Parents

   Elite sports players   Aboriginal people

2. Each team then discusses where they believe their particular group of people is placed on the health continuum. Record ideas on butcher's paper about the reasons for the group's placement.

3. Use two sheets of A4 paper (one labelled excellent and the other labelled poor) to set up a health continuum on the floor of the classroom. Have a representative from each team place the card identifying their group on the continuum to show how healthy they perceived their group to be.

4. Allow all class members to view where various groups have been placed on the continuum. After several minutes invite students to pick up any card they believe should be placed elsewhere on the continuum and stand holding the card in the spot it was placed.
5. Facilitate a class discussion on where they feel the group could be placed and why they have different perceptions of the health status of the group.
6. As a class discuss the reasons that people's perceptions of health can be similar or different from others. Summarise the ideas generated by the discussion in a mind or bubble map.

Implications of different perceptions of health

People develop their own interpretation of what being healthy means and are likely to perceive their level of health and the health level of others differently. This has a number of implications for both the individual and society as a whole.

Implications at an individual level

On an individual level, people's perceptions of their health have a significant influence on their lifestyle choices and behaviours relating to health. For example, a person who regularly drinks large amounts of alcohol and recognises that this drinking behaviour is having a detrimental effect on their health is more likely to stop drinking, limit their alcohol intake or seek professional help than someone who does not believe their alcohol consumption is causing them harm. Similarly, a person who recognises that they are experiencing symptoms of depression is more likely to seek support or

Figure 1.7: Inaccurate perceptions of health can lead to behaviours that may harm our health.

undergo counselling than someone who is unfamiliar with the symptoms of depression, or disregards or dismisses these symptoms.

Being able to accurately assess our level of health assists us to be proactive about our health and take appropriate action to address health concerns. On the other hand an incorrect or distorted assessment of our health status, such as perceiving ourselves to be overweight when our weight fits within a healthy range, could lead to health behaviours that are likely to harm our overall health and well-being.

CASE STUDY

An individual's health behaviour

Kris is a year 11 student who sees herself as being fairly healthy. She is rarely absent from school, keeps up with her school work and is doing well in most of her subjects. However, she is often tired from the study she does. She sleeps in late most days and so doesn't always have time to have breakfast. Instead she buys a Mars bar and a can of Red Bull from the local shops on the way to school to keep herself going. She attends a lunchtime study group twice a week. On these days she misses lunch, so she stops at the local takeaway shop on her way home and grabs some hot chips and a soft drink to keep herself going.

While Kris was previously physically active — she played in a touch football competition one night a week, trained and played for the school soccer team and walked to school — her level of activity has dropped since she started year 11. Having her driver's licence has allowed her to drive to school most days to save time and her increased study demands have made her feel that there is not enough time for playing sport. Kris is not overly concerned about her lack of physical activity as she is not overweight and her clothes size has not changed. People often comment on how good she looks when she goes to the beach.

At weekends, Kris likes to relax and spend time with her partner and friends. She has been going out with her partner for two years. They are sexually active, but don't usually use a condom as Kris is on the Pill. They feel they can trust each other.

Kris often goes to parties on the weekend with her partner and a close group of girlfriends. Most of the group drink fairly heavily at these parties. When Kris is driving she has one or two drinks early in the night. She has trouble in passing up a cigarette or two when her friends are smoking. Even though she does smoke at these parties, Kris does not see her smoking having any effects on her health and she does not intend to keep smoking.

A **stereotype** is a simplified and fixed image, opinion or concept to which people may feel expected to conform.

Differing perceptions of health also have the potential to reinforce **stereotypes**. For example, a belief that being skinny or well tanned is healthy may encourage negative health behaviours such as skipping meals, excessive dieting, or sun baking. The perception that women's health and well-being could be endangered by competing in traditionally male sports such as rugby league

and boxing serves to reinforce notions of women being weak and delicate. This perception also limits the range of physical activities available to female athletes and restricts opportunities to test their capabilities.

Differing perceptions of health may also contribute to varying expectations of people's capabilities and levels of responsibility for managing their health. A perception that the elderly are frail, weak and unable to participate in strenuous activity may discourage older people from continuing to be active. Alternatively it may result in others taking control of aspects of elderly people's lives and thereby limiting their participation in everyday tasks that involve a degree of physical exertion. Likewise the belief that young people should be strong, fit and active may mean that those who are overweight are seen as solely responsible for their condition and any necessary action required to improve their health. The differing expectations that come with people's different perceptions of health are therefore likely to impact on the degree of support that individuals provide to others.

Implications at the policy level

At a societal level the perceptions of the health status of Australians held by various levels of government, health professionals, non-government organisations and other interest groups are likely to drive government policy, expenditure and action, and impact on the agenda set by various organisations. Statistics of ill health are often gathered to measure the health of individuals, communities and nations. These statistics show rates of **mortality**, **morbidity**, **life expectancy** and years of life lost to premature mortality, as well as causes of hospitalisation. The analysis of trends of illness and disease evident in these figures, known as epidemiology, has significant implications for health promotion and health care within Australia. It is used to identify areas of health that are emerging concerns, determine risk factors that contribute to ill health and target prevention or intervention strategies towards particular population groups or health issues. This determination of health priorities impacts significantly on the allocation of expenditure and the provision of resources and support by all levels of government.

Conflicting perceptions often arise about the areas of health that should be given highest priority, leading to competing demands for the finite resources allocated by the various levels of government. This can result in insufficient funding for particular health issues, inadequate or inappropriate support being provided to meet specific needs, or poor resourcing or a perception by certain groups that this has occurred. People who feel that funding and resources have been incorrectly allocated may feel resentful and disempowered. They may feel that resources have not been distributed equally.

Insufficient allocation of resources and limited budgets can also limit the number and range of strategies that can be implemented to address various health issues. Decisions need to be made about how to most effectively allocate money, meaning that opportunities to undertake research, instigate proactive approaches or commit to long-term projects may be restricted.

Perceptions of health as social constructs

We should now recognise that different people have different perceptions about what is meant by the concept of good health. So what is it that shapes our perceptions? Our views regarding what constitutes good health and who possesses it are largely influenced by the social, economic and cultural

Morbidity is the incidence or level of illness or sickness in a given population.

Mortality is the number of deaths in a given population from a particular cause and/or over a period of time.

Life expectancy is the average number of years of life remaining to a person at a particular age, based on current death rates.

A **social construct** is a concept that recognises that people have different views based on their social circumstances and ways of seeing, interpreting, interrelating and interacting with their environment.

conditions of our family and the society in which we live. This is referred to as our **social construct**.

A number of factors are likely to play a role in our social construct of health, including:

- socioeconomic status
- geographic location
- cultural background
- gender
- age
- level of education
- community values and expectations.
  All of these factors have an influence on:
- the expectations we form about our health potential
- the understanding we develop of what good health involves
- the ability we have to act on information and exert control over our own health
- the value we place on the importance of continually working to improve our health
- our choices about whether we use health products and services and how they are used
- how we respond to challenges to our health and well-being.

Socioeconomic status

Socioeconomic status is a measure of an individual's place in society, based on their income, education, employment and other economic factors such as house or car ownership.

Our **socioeconomic status** is linked to our level of income, education, employment and occupation. People from a lower socioeconomic background generally have poorer health outcomes than those who are well off. They live shorter lives, suffer more illnesses and have more risk factors for ill health present in their lives, such as smoking, drinking alcohol at harmful levels (males) and having high blood pressure (*Australia's health 2008*). They are also more likely to perceive their health as fair or poor and feel they have less control of their own destiny.

Social and economic disadvantage is closely linked with poorer levels of emotional health, which is characterised by:

- a loss of a sense of control, status or power
- higher levels of stress
- low self-esteem
- feelings of vulnerability, bitterness and resentment.

The differences in health status that are evident between people from different socioeconomic backgrounds are likely to lead to people from lower socioeconomic backgrounds having
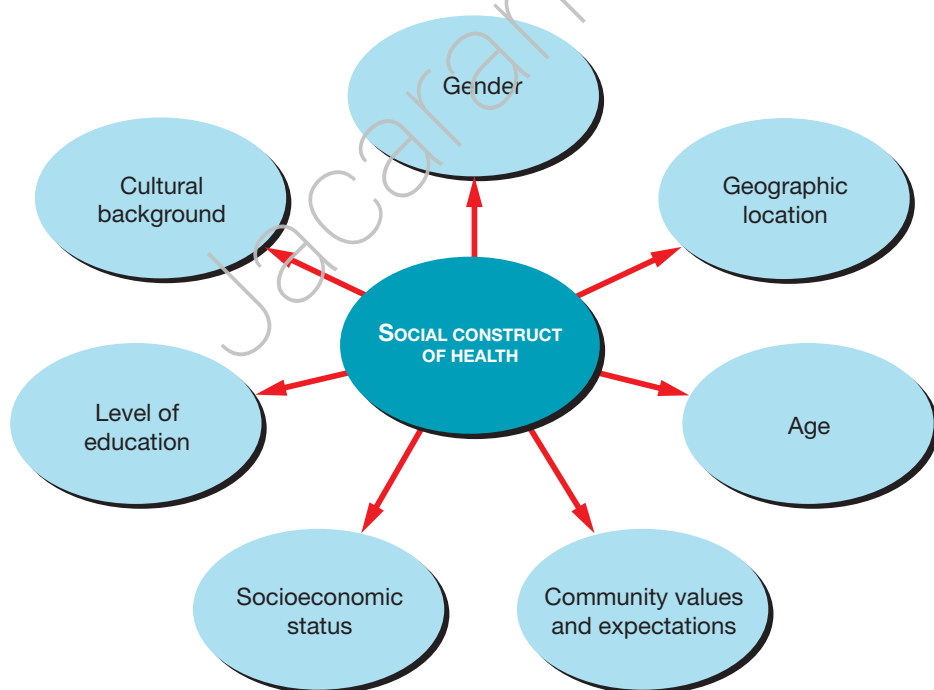

Figure 1.8: Numerous factors play a role in the social construct of health.

different expectations about their health potential. They have less money to invest in positive health behaviours, such as taking out fitness centre memberships, are exposed to more dangerous working and living environments, and have limited choices when accessing health care. Therefore it is likely that those from lower socioeconomic backgrounds will develop different meanings of health and well-being to people belonging to a higher socioeconomic group.

Geographic location

Location is also likely to play a role in the formation of people's definition of what it means to be healthy. Geographical areas can be broadly divided into urban, rural and remote. People from each area have varying social constructs for health and well-being. This is due to the unique features of these locations and the different social circumstances of the people who live there. In comparison to urban dwellers, people in rural and remote areas have relatively poor access to health services and recreational facilities, meaning they consult medical practitioners less often and may have restricted opportunity to participate in organised physical activity and receive social support. They are also exposed to harsher environments and are less exposed to health promotion and self-care messages. These differences are likely to affect the perceptions of health formed by people living in remote locations, as well as how they assess their current state of health.

Figure 1.9: The social construct of health for people in rural and remote areas is influenced by their relatively poor access to health and medical services, and the harsh environments in which many people live and work.

Cultural background

Population groups with similar ethnic backgrounds or cultural heritage (for example, Aboriginal people) may have vastly different explanations or meanings for health and well-being to other racial groups (for example, people from a European background). From an Aboriginal and Torres Strait Islander's perspective, health is a holistic concept, encompassing the social, emotional, spiritual and cultural well-being of an individual, together with their families and communities (*National Aboriginal and Torres Strait Islander health survey* 2000). Their emphasis on spiritual dimensions means that in traditional Indigenous communities traditional healers or 'clever people' may be consulted to help treat the sick.

People from different cultural backgrounds may also share beliefs, ideas and habits about behaviours relating to health that are learned and passed on by members of their culture. For example, in some cultures participation in physical activity, especially sport, may not be seen as a healthy pursuit for girls. This belief can restrict or prevent participation in physical activity opportunities by women. Differences in beliefs, values and attitudes about health that are learned and conveyed from one generation to another can see perceptions of health take on different meanings within some cultural groups.

Perceptions of health: effects of social setting and circumstances

Dan and Marco are both 16 years old and suffer from asthma. Their condition is under control if they follow their asthma management plan and avoid the triggers that have led to asthma attacks in the past, such as strenuous exercise and poor air quality.

• Dan lives in Palm Beach, Sydney, where his mother has a medical practice and his father teaches yoga. Dan attends the local high school and surfs or swims for an hour before doing homework and having dinner.

• Marco lives with his father and younger brother on a property in far west New South Wales. He rises at 5.00 am to help with farm work, does school work by correspondence, cooks dinner, then studies again before bed.

Describe:

(a) how each of the boys might perceive their own health

(b) the influences that might affect each boy's perceptions of their health.

The values and beliefs of the dominant culture act as a powerful influence on ideas constructed about health. Dominant cultures have greater social power and therefore more participation and influence in decision making among administrators, politicians and economists. Ultimately this affects the way health is seen in the broader community. The predominant view of health in Australia is derived from the majority middle-class, Anglo-Saxon urban population. According to this view, for example, a person's health is still primarily judged according to their state of physical health. Furthermore, the emphasis of health treatment should be on modern, scientific health care and mainstream medicine, which relies on drug treatment or surgery. However, traditional practitioners, naturopaths and other alternative practitioners (for example, acupuncturists) are being increasingly used and some methods adopted by mainstream medical practitioners as options or alternatives. **Alternative medicine** and practices are therefore gaining more respect from the dominant culture as people's values and attitudes change about what good health means and what is involved in achieving good health.

Perceiving health as a social construct allows us to consider the broad social and cultural factors that impact on an individual's behaviour. When we view health as a social construct it allows us to:
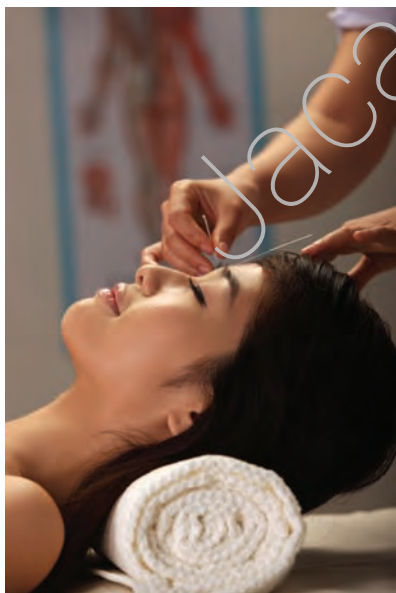
• explain why certain people choose to behave in particular ways

• understand how social norms are established in cultural subgroups

• realise how our concept of health can take on different meanings in particular social contexts.

Alternative medicine refers to various medical methods and practices that are not recognised as being conventional or traditional approaches to medicine.

Impact of the media, peers and family

The media, our peers and our family have a particularly significant impact on the perceptions we develop about health. These three groups exert a strong influence on the ideas that people form about what constitutes good health and the value they place upon various aspects of health.

Figure 1.10: The increasing acceptance of alternative medicine has influenced people's ideas about what is involved in good health.

The media

The media are a factor that impact on an individual's social construct of health. Some of the main forms of media include television, radio, magazines, movies, newspapers and the internet.

The media play a significant role in disseminating health-related information. For example, news stories on binge drinking, television advertisements about skin cancer or feature articles in magazines on obsessive compulsive disorder all seek to raise awareness and increase people's understanding of these health issues.

Stories in the media also influence people's perceptions through the depth of information they provide, the way this information is presented and the frequency of this presentation. A continued focus on a particular health issue can draw the public's attention to that particular topic, possibly at the expense of other areas of concern. It can also affect people's perception of the risk that they will experience a particular health problem, its likely severity and the future prevalence of this problem within the community. For example, media coverage relating to HIV/AIDS has contributed to a heightened knowledge and awareness of this particular virus in comparison to other sexually transmitted infections such as chlamydia or hepatitis B, which receive less coverage but are far more prevalent in the community.

APPLICATION

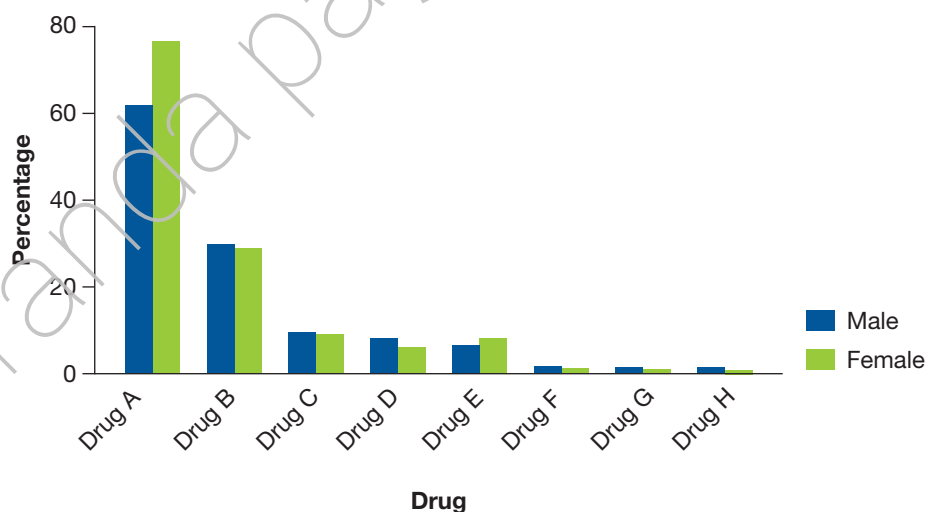## How can the media influence our perceptions of health?

Figure 1.11: Percentage of 12–17-year-old secondary students who indicated they had taken some type of drug in the last four weeks

1. The graph in figure 1.11 is taken from the National Drug Strategy's *Australian secondary students' use of tobacco, alcohol and over-the-counter and illicit substances in 2011* report. It shows the percentage of 12–17-year-old secondary students who indicated they had taken some type of drug in the last four weeks. Look at the percentages shown in each column and predict which drug relates to each letter A–H. (Answers are given on page 54.)

2. As a class, examine how closely your perceptions of drug use by young people matched the statistics gathered in the survey. Discuss reasons for any differences

that may have occurred. In this discussion highlight factors that influence our perceptions of drug use and determine the degree to which these perceptions are socially constructed.

P-PLATER MOUNTS FOOTPATH, INJURES TWO

UNLICENSED TEENAGER BANNED FROM DRIVING FOR THREE YEARS

DRUNK, DRUGGED, UNLICENSED: OUT OF CONTROL TEENS BLIGHT OUR ROADS

Cars confiscated from street racing hoons

CALL FOR URGENT REVIEW OF P-PLATERS AFTER TWO DEATHS

STUDY FINDS SPEED, DRUGS, ALCOHOL CAUSE MOST YOUNG DRIVER ACCIDENTS

Figure 1.12: Sustained media coverage of particular health issues can lead to increased public awareness and prompt government action.

The media are influential in shaping attitudes, values and behaviours relating to what good health looks like and means. Misleading messages in the media about health can contribute to misconceptions or distorted perceptions of health. For example, magazines, television, movies and other forms of media are full of images of tanned, attractive, slim women and men with athletic, muscular physiques. The constant portrayal of these body shapes as essential elements of good health has a significant effect on people's assessment of their level of health, while also exercising considerable influence on what they do in an effort to look this way.

Sustained media coverage of a particular health issue can lead to such attention and heightened public concern that it can influence government policy, priorities and health expenditure. For example, frequent front page stories about road crashes involving young people have been a critical factor in increasing community awareness and intensifying concerns about the over-representation of young people in accident statistics. Discussion provoked by this media coverage has contributed to the introduction of laws relating to zero blood alcohol levels, reduced engine capacity and passenger restrictions for learner and P-plate drivers, while also contributing to ongoing debate about further changes that could reduce the number of young people involved in crashes.

SNAPSHOT

An open letter to advertisers, media decision makers and teenagers

To whom it may concern,

My name is Stella Lycos, 16 years old. I have some issues of great concern to me that I would like to discuss with you.

My friends and I are currently being negatively affected by the advertising industry. Every day of every year images, slogans, brands and other forms of advertisement are being constantly thrown at us, preached to us, and marketed to us. In primary school we were briefly talked to about body image and self—esteem and how to prepare ourselves for high school and in turn, life. Sitting in that classroom I listened but I did not feel one bit concerned. I thought that self—esteem and body image was going to be about

as concerning and relevant as filling out tax return forms.

Now that I am in high school, I have begun to realise that the way women and girls are portrayed in media and advertising has a greater link with body image and self—esteem issues than I ever imagined. It's easy to think that you can choose what you listen to and see and just ignore what you wish. But when we are constantly bombarded with messages that are telling us that we are too fat, too thin, not toned enough, don't have the right clothes and should probably be out partying while keeping up good grades and becoming the thriving young women that we were meant to be; it's hard.

The Australian Psychological Society told the Senate Committee Inquiry into the sexualisation of children in 2008, 'the values implicit in sexualised images are that physical appearance and beauty are intrinsic to self- esteem and social worth, and that sexual attractiveness is a part of childhood experience . . . Girls learn to see and think of their bodies as objects of others' desire, to be looked at and evaluated for its appearance." I can say from personal experience that all these years of constant advertising images and messages about what girls and women look like are deeply affecting me and my peers. I am a human being, not an object to be used or altered to fit in to society. But sometimes it's hard to see my body for what it is and instead see it for what it's not. I know that it's not my own original thoughts telling me that I am not good enough; it's what has been taught to me. Feeling content and fulfilled in a nation that is riddled with graphic advertisements aimed at young people seems to no longer be an option.

At my school, bullying isn't tolerated. But my friends and I are getting bullied every day and for the most of it, it's not from other teenagers. We are getting bullied by media and advertisers. Being told over and over again that we are inadequate has serious damage on our minds, maybe even permanent damage. Teenagers are particularly vulnerable and influenced by advertisement. I am lucky to have a supportive down to earth family and a group of friends who don't care what I look like but I know and I promise you that I still find myself thinking negatively about myself and I know my friends do too. I simply cannot escape the idea that I am not adequate in today's society. No one wants to feel inadequate. So who is going to stand up against these big corporate bullies?

I have been learning about the way media and advertising are regulated, and I have been really disappointed in what I have found out. At the moment the rules which tell companies how they can advertise are inadequate and the system is weak. A voluntary code with no pre—checking of ads and a lack of ASB power to remove advertisements means that advertisers pretty much get away with doing whatever they like. It's not fair to expect me and my friends to stand up and defend our bodies and minds against these huge companies.

I for one can say from personal experience that all these images and messages have had a great effect on me and my peers. It is from these seeds of expectations that low self—esteem, mental illness and eating disorders can sprout.

When it comes to the internet and social media, things feel even worse. Companies are using social media to get their messages across to us 24/7. They bring the images and ideas which we are already exposed to everywhere, into our own homes, and often the images which come this way are much more explicit and intense than what we would be shown in a magazine, on TV or in an outdoor advertisement. I don't want a censored world full of rules and laws prohibiting us to speak freely or be individuals, but I do want a better environment for me and my friends to grow up in.

I'd like to ask you to speak up about these issues on behalf of me and others like me. We need the system to change and we need people like you to help bring about that change for us. I know that there have been other groups that have written reports into these issues but if you ever want to find out first-hand about what it's like to be a teenager in this media environment me and my friends would be more than happy to make ourselves available to talk to you.

Kind regards

Stella Lycos

Source: The Age, 21 July 2013

How significant is the media's influence on perceptions of health?

Read the snapshot 'An open letter to advertisers, media decision makers and teenagers' and then complete the following activities.

1. Summarise the main arguments expressed in the letter about the impact of the media on young people's perceptions about body image and body weight.
2. Discuss why the young person is concerned about the messages conveyed through the media about health.
3. Analyse the degree to which you feel a person's attitudes and ideas about body weight and body image are socially constructed.
4. The magazine *Indigo* was launched in 2007 by a group of women concerned about the unrealistic body images and stereotypes promoted in girls' and women's magazines. Its aim is to be the 'fun, body friendly alternative to other magazines on the market, without the airbrushed images, stick thin celebrities and sex articles' while tackling issues relevant to its 10–14-year-old female audience, such as 'puberty, bullying, self-esteem and body image, while keeping the feel of *Indigo* completely positive'.

eBook plus

(a) Use the ***Indigo*** weblink in your eBookPLUS to find out more about the techniques the magazine uses to convey positive health messages to young girls.
(b) Explain how the magazine might influence girls' perceptions of health.

Peers

The group with whom we associate at school and outside of school markedly influences our attitudes about health and the health behaviours we adopt. Along with our family, our peers are the group most likely to influence our ideas, promote certain behaviours and provide support in terms of our health.

When group members share similar ideas about what good health means and place comparable value on the importance of good health it is easier for the individual to behave in ways that will enhance their health and well-being. For example, when young people recognise that positive mental health is an important component of their general well-being, they are more likely to support individuals who are experiencing emotional difficulties and encourage them to talk openly about their feelings and seek support. However, when mental health problems are perceived as a sign of weakness, an attempt to get attention, or not a significant problem it becomes harder for the individual to recognise or acknowledge that they are experiencing difficulties or ask for help.

Figure 1.13: Young people's health attitudes and behaviours can be significantly influenced by peers.

Young people's behaviour can be significantly influenced by their peers. Social pressures, along with the desire to fit in, may contribute to decisions being made that are likely to negatively affect their health. For example, decisions to experiment with drugs such as tobacco and alcohol, take risks when driving, participate in sexual activity or spend time sunbaking are more likely to be made by young people when these behaviours are common among their peers. However, when a peer group recognises these behaviours are unhealthy and liable to cause significant immediate or future harm, they are likely to discourage others from engaging in these activities.

Family

Families have a significant influence in the lives of most young people. From our earliest years, our parents are our role models, so the ideas they communicate about what health means and the values they convey about the importance of good health have a strong effect on the perceptions that we develop. Their ideas relating to health also contribute significantly to their health behaviours and the efforts they make to promote behaviours that can positively impact on our own level of health, therefore further influencing the ideas that we form. For example, a belief that participation in sport and physical activity is important for good health is likely to see parents encourage their children to be active and support their involvement in regular physical activity. The values and attitudes instilled in us by our parents play an important part in the development of our own perceptions of health.

The living conditions of families, along with other socioeconomic factors such as income, education and employment, also have a bearing on our ideas about health. People living in **socioeconomic disadvantage** generally live shorter lives and suffer more illness and a lower quality of life than those who are well off. Poverty and unemployment can lead to stress, tension, conflict and a sense of hopelessness, all of which contribute further to poor health. The effect of living in situations where life expectancy is lower, sickness is experienced more frequently and expectations about health are poorer is likely to impact on the ideas young people develop about health and the level of control they believe they are able to exert over it. Poor economic circumstances can also limit the amount of money available to be spent on health-related expenses, therefore affecting the priority given to health and the importance with which it is viewed.

Living with a family member who is chronically unwell may also negatively impact on perceptions about health, particularly when a young person is required to take on the role of carer. The ongoing experience of living with someone who suffers poor health as a result of a physical disability, chronic health condition or mental illness has a significant influence on a person's ideas about what good health looks like. Furthermore, the stress and fatigue associated with the responsibility of caring for someone, along with possible social isolation, can have a detrimental impact on the judgements that carers might make about their own health and the expectations they have about being able to improve their health at some point in the future.

Socioeconomic disadvantage refers to significant limitations to opportunity that can be experienced as a result of factors relating to social and economic circumstances, such as lower education, poorer education, unemployment, limited access to services, inadequate housing or lack of social networks.

Figure 1.14: Families play an important role in our perceptions of health.

INQUIRY

Health as social constructs

Think about the following groups of people. For each group, explain what might influence the way they perceive health. Draw a mind map to summarise the influences for each group.

(a) People in rural and remote areas
(b) People from the lowest socioeconomic groups
(c) Refugees who have just been granted Australian citizenship
(d) Women
(e) Aboriginal and Torres Strait Islander peoples

The health of young people is a topic frequently discussed in the media. Stories often report increasing rates of obesity, escalating consumption of junk food, declining levels of physical activity in favour of television and computer-based activity, regular episodes of binge drinking, a rise in the use of illicit drugs such as ecstasy and ice, increased promiscuity, growing incidence of mental health problems and an over-representation in motor vehicle accidents. Such stories contribute to a perception that young people are in a poor state of health. How accurate are these perceptions? What has current research found about the health status of young Australians and their health-related behaviour?

The positive health status of young people

Research into the health status, health outcomes and factors influencing the health and well-being of young Australians has been regularly undertaken by the Australian Institute of Health and Welfare (AIHW). The findings of their most recent research have been published in a report titled *Young Australians: their health and well-being* 2011. According to this report the health of young Australians (defined in the report as those aged between 12 and 24 years of age) has continued to improve over time and the majority of young people are currently faring well in terms of their health and well-being. Evidence of this good state of health can be found in a decline in mortality in young people between 1987 and 2007, largely as a result of reductions in deaths caused by injury, suicide and transport accidents. Reductions in morbidity from **chronic** diseases such as asthma have also contributed to improvements in young people's health. Further evidence of the positive health status of young people was found in the decline in risk behaviours such as smoking and the use of illicit drugs, along with an increase in protective behaviours such as the regular use of contraception by sexually active young people. These positive behavioural changes have the potential to protect and improve the future health of young Australians.

Chronic means persisting over a long time, such as a long-term disease or illness.
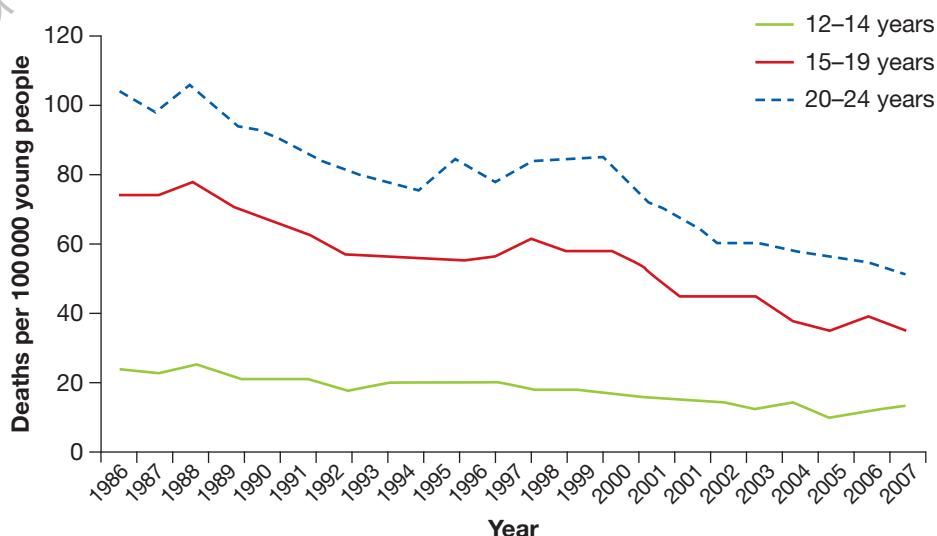
Figure 1.15: The continual decline in death rates for 12–24 year olds is evidence of the positive state of health experienced by most young people.
Source: Young Australians: their health and wellbeing 2011, chapter 6, figure 6.1, p. 21.

Analysing mortality rates of young people

1. Referring to information in the text on the previous page, propose reasons for the decline in mortality rates of young people over the last 20 years as shown in figure 1.15.
2. As a class, discuss strategies and initiatives that were implemented during this time that may have contributed to the fall in death rates.
3. Explain reasons for the significant difference in the death rates of the different age groups shown in the graph.

The findings of these statistics are substantiated by positive assessments by most young people of their own state of health. According to the *Australian Health Survey* 2011–12 (Australian Bureau of Statistics) around 64 per cent of Australians aged between 15 and 24 years old rated their own health as being either excellent or very good, with another 27.5 per cent assessing their health as good. These positive perceptions of their health, supported by the data showing the high level of health currently experienced by many young people in Australia, contrast markedly with some commonly held beliefs of adolescent health.

Table 1.2: Self assessed health status of young people aged 15–24 years, by sex and age group, 2011–12 (per cent)

Health status	15–17 years		18–24 years		15–24 years		
	Males	Females	Males	Females	Males	Females	Persons
Excellent or very good	71.8	68.6	62.2	53.9	67	61.3	64.2
Good	23.3	23.2	28.1	35.5	25.7	29.3	27.5
Fair or poor	4.9	8.3	9.7	10.6	7.3	9.4	8.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: Australian Health Survey: Updated results, 2011–2012, ABS

Survey of perceptions about young people's health

1. Survey four different people, including at least two adults, about their perceptions of young people's health status. Use the following questions and add your own questions to determine people's views. Record their responses and write a summary report of the four people's views.

   Survey questions:
   - Do you think that the health of young people is good? Explain reasons for your answer.
   - Do you think young males are as healthy as young females? Why/why not?
   - Name aspects of young people's health that you feel have improved in recent years.
   - Name aspects of young people's health that you feel have declined in recent years.

2. Use the **Young Australians: their health and well-being** weblink in your eBookPLUS.

   (a) Download the report profile *Young Australians: their health and well-being 2011* and read the summary of the report's key findings.
   (b) Compare the summary report of your own survey with the key findings from the report on the health and wellbeing of young Australians.

eBook*plus*

(c) Identify inaccuracies that people have about young people's health status and behaviours and use data from the report to challenge these inaccuracies.

3. Search recent newspapers and magazines for articles that you think give a negative impression of young people's health. Assess their accuracy and write responses that challenge negative perceptions.

Despite the generally positive picture painted of the health status of young people, the *Young Australians: their health and well-being* 2011 report did find particular groups of young people were not doing as well as others in terms of their health and well-being. Significant differences were evident in the health of young Indigenous Australians, young people in regional and remote areas and young people experiencing socioeconomic disadvantage compared to the general population. The perceptions of their own health that Indigenous young people and those living in areas of lowest socioeconomic status held also tended to be lower than those of other groups. The poorer levels of health experienced by these groups, coupled with their own negative perceptions of their health, are likely to contribute to poorer long-term health outcomes for these young people and a growing sense of disempowerment relating to their health and well-being. Without the implementation of specific intervention strategies to address these differences it is likely that in the future these inequities will continue to grow and widen.

INQUIRY Comparing the health of Indigenous and non-Indigenous young people

eBook plus

Use the **Young Australians: their health and well-being** weblink in your eBookPLUS to research differences in the health status of Indigenous and non-Indigenous Australians. (Look at Part VII, chapter 42.)

1. Create graphs to illustrate the differences evident in:
   (i)   death rates
   (ii) mental health
   (iii) injuries
   (iv) STIs
   (v)   tobacco use
   (vi) physical activity levels.
2. Write a report describing the current health status of Indigenous young people. Include in your report a discussion on the key factors that contribute to the differences evident between Indigenous and non-Indigenous young people.

Significant differences in all measures of health continue to be evident between Indigenous and non-Indigenous young people. Mortality rates are markedly different, with the report *Young Australians: their health and well-being* 2011 finding the death rate of young Aboriginal and Torres Strait Islander peoples in 2003–07 to be about 2.5 times higher than that of young non-Indigenous Australians. Life expectancy, which is commonly used as an objective general measure of a population's health, is much lower for Aboriginal and Torres Strait Islanders than the general population. Estimates predict that the young Indigenous people born in the period 2005–07 will live around 10–12 years less than the rest of the population. (67 years of age for an Indigenous male compared to 79 years for a non-Indigenous male and 73 years of age for an Indigenous female compared to 83 years for a non-Indigenous female). Aboriginal and Torres Strait Islander peoples are also more likely to experience chronic

illnesses and health problems that reduce their quality of life. They suffer higher rates of diabetes and mental and behavioural disorders requiring hospitalisation and are more likely to experience preventable health conditions that are uncommon within the general population such as rheumatic heart disease, skin infections and trachoma. They are also more likely to suffer ear disease that contributes to hearing loss and impairment. The report also found young Indigenous people were more likely to experience risk factors associated with poor health such as low levels of fruit and vegetable consumption, obesity, tobacco and illicit drug use, alcohol misuse physical inactivity, incarceration and lower levels of education achievement. For most Indigenous people these health disadvantages start at a young age and remain throughout their life, resulting in ongoing negative effects on their level of health. In addition to these objective measures, young Indigenous Australians aged 15–24 years were less likely than their non-Indigenous peers to perceive their health was excellent or very good.

Figure 1.16: Deaths among young people aged 15–24 among selected population groups 2005-2007
Source: AIHW Young Australians: their health and wellbeing 2011, AIHW, fig 6.3, p. 22.

Young Australians living in remote and very remote communities were identified as another group experiencing poorer levels of health in comparison to others.
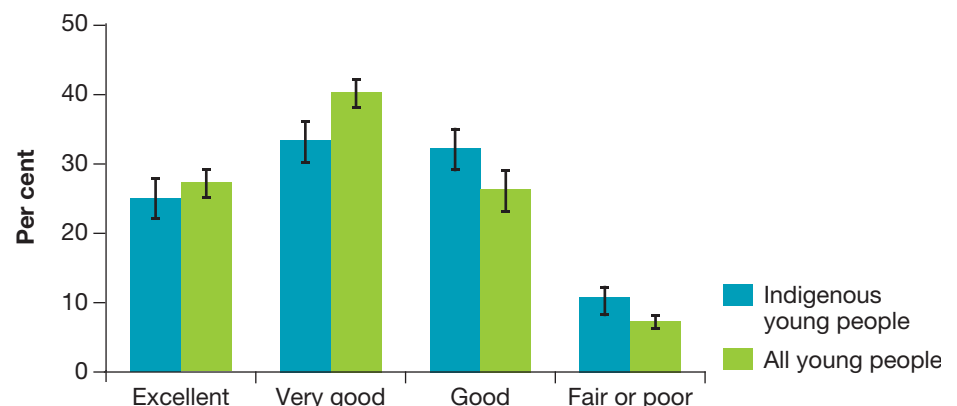
Figure 1.17: Self-assessed health status of Indigenous and non-Indigenous Australians aged 15-24 years, 2007-08
Source: Young Australians: their health and well-being 2011, AIHW, fig. 42.2, p. 179.

Young people in remote areas had significantly higher death rates, with mortality rates being 2.5 times higher in remote and very remote areas compared to major cities. Injuries, particularly those resulting from transport accidents and suicide, were the leading cause of this high mortality rate. These same injuries, along with assaults, were largely responsible for higher hospital admission rates among young people living in remote areas. Differences were also found in the likelihood of young people living in remote areas to engage in certain risky health behaviours, with fruit consumption and physical activity levels being lower and teenage birth rates higher than those in major cities.

The *Young Australians: their health and well-being* 2011 report also found that the health and well-being of young people differed significantly among young people of various socioeconomic groups. Young people from low socioeconomic groups were more likely to experience poor levels of health compared to others. Death rates in this group were nearly twice as high as the least disadvantaged areas. Injury rates were also higher among those living in areas with significant levels of disadvantage. They were more likely to be overweight and obese and also twice as likely to smoke as those in the highest socioeconomic areas.

In addition to identifying specific population groups who were not faring as well as others in terms of their health, the *Young Australians: their health and well-being* 2011 report also highlighted specific health conditions of concern for young people due to their continued or increasing prevalence, particularly for the above mentioned population groups. The report noted a significant increase in the incidence of insulin-dependent (Type 1) **diabetes mellitus** among young people, with a 41 per cent increase in new cases in a six-year period. Given the long-term health problems linked with poorly managed diabetes, such as increased risk of coronary heart disease, peripheral vascular disease, stroke, kidney failure, blindness and amputation of limbs, the rising incidence of diabetes represents an area of concern in relation to young people's future health.

The mental health status of young people is an area of ongoing concern, with **mental health disorders** continuing to be the greatest contributor to the burden of disease for young Australians Anxiety, depression and substance use disorders were the most common mental health problems experienced by young people. Nearly one in ten young people reported that they experience high or very high levels of distress, with females being twice as likely to report feeling high or very high levels of distress. These very high levels of psychological distress had a significant impact on young people's perception of their own health, with more than 19 per cent of those who reported feeling this way assessing their health as only fair and another six per cent judging it as poor, compared to five per cent of those who reported low psychological distress.

The report also highlighted injuries, particularly those sustained from motor vehicle accidents and intentional self-harm, as another area of ongoing concern in relation to young people's health due to the fact that they are largely preventable. While there has been a significant decline in the number of injury-related deaths, particularly among young males, the proportion of young people killed as a result of road accidents and suicide remains high. The report found injuries and poisoning continue to be the leading cause of ill health, hospitalisation and death among young people. Injuries were responsible for two-thirds of premature deaths by young people, particularly males, who were three times more likely to die as a result of an injury than

Diabetes mellitus is a chronic condition affecting the body's ability to take glucose from the bloodstream to use it for energy. Type 1 diabetes involves the body not being able to produce insulin or producing only minimal amounts.

Mental health disorders are a group of mental illnesses in which a person experiences disturbances of mood or thought that lead to difficulties functioning normally. These disorders include depression, anxiety disorders and schizophrenia.

females. Furthermore injuries leave many young people with serious disabilities and long-term conditions that significantly affect their future health and well-being, along with the health of others such as parents, who may need to resume a care-giving role due to the injuries sustained.

The fact that further improvements are still required in some areas of young people's health was also highlighted by the increasing rates of sexually transmitted infections, particularly **chlamydia**, with the number of notified cases of chlamydia increasing nearly fivefold. A decline was also found in the dental health of young people with a fall in the number of 12 year olds who were decay free.

The increasing prevalence of these health conditions has a significant impact on young people's quality of life and is likely to negatively affect their long-term health as well as their successful involvement in education, employment and the community in general.

Chlamydia is a sexually transmitted bacterial infection that can be passed on through unprotected sex and can cause infertility.

APPLICATION

Examining health issues of concern for young people

1. Research the prevalence of mental health disorders among young people. Use one of the following reports for your research (use the relevant weblinks for these in your eBookPLUS). Summarise your findings in note form.
   • *Young Australians: their health and well-being 2011*
   • *New South Wales school students' health behaviours survey 2011*
2. Suggest reasons why a significant number of young people are reporting that they experience high levels of distress.
3. Identify health risk behaviours that could be linked to mental health disorders. Predict possible health concerns that could arise as a result of these multiple health risk behaviours.
4. Discuss why injuries are the leading cause of ill health and death among young people.

eBook *plus*

Protective behaviours and risk behaviours

Adolescence is the time when young people begin to move from being dependent children to independent adults. Along the way they face a range of challenges and start to make decisions about particular health behaviours that play an important role in determining their immediate and longer term health. These health behaviours can be seen as being either **protective behaviours**, because they are likely to enhance good health (such as eating adequate amounts of fruit and vegetables), or **risk behaviours** because they have been found to contribute to the development of health problems or poorer levels of health (for example, smoking). The health and social behaviours that are adopted or reinforced during this time often continue into adulthood, so it is important to identify the prevalence of particular behaviours and analyse the trends that are apparent. Behaviours that are likely to have the biggest impact on a young person's current and future health include those related to:

Protective behaviours are those health behaviours that are likely to enhance a person's level of health.

Risk behaviours are those health behaviours that have been found to contribute to the development of health problems or poorer levels of health.

• physical activity
• eating habits
• substance use (including tobacco, alcohol and other drugs)
• sexual activity
• help-seeking behaviours

- social connectedness
- risk taking

INQUIRY

Protective behaviours and risk behaviours

Brainstorm your ideas for each of the following and draw two mind maps that summarise your ideas.

(a) Protective behaviours for health issues relevant to young people

(b) Risk behaviours for health issues relevant to young people

Compare your mind maps with those of other class members and discuss your findings.

Behaviours relating to physical activity

A certain level of physical activity is necessary to help achieve and maintain good levels of health. The recommendations outlined in *Australia's Physical Activity and Sedentary Behaviour Guidelines for Young People (13–17 years)* advise that adolescents should:

- partake in at least 60 minutes of moderate to vigorous physical activity every day
- limit the time they spend on the computer, watching television or playing video games to two hours (unless it is for educational purposes)
- engage in activities that strengthen muscles and bones at least three days a week.

Following these recommendations and participating daily in physical activity offers both immediate and long-term benefits to the health and well-being of young people. People who participate in less physical activity than recommended have a greater chance of suffering diseases, such as heart disease, stroke, **type 2 diabetes**, some forms of cancer, **osteoporosis**, back pain and depression that increase their risk of ill health and premature death.

The *NSW schools physical activity and nutrition survey (SPANS)* 2010 found that there had been a significant decline in the physical activity level of high school students, with the exception of year 10 girls. Less than two-thirds of surveyed students in years 8 and 10 met the recommended Australian physical activity guidelines during summer and this number dropped to just over 50 per cent during winter.

Osteoporosis is a musculoskeletal condition in which there is deterioration in the bone structure, leading to an increased risk of bone fracture.

Type 2 diabetes is the most common type of diabetes and is characterised by too little insulin being made or an inability to use insulin effectively.

Figure 1.18: Regular physical activity is a key protective behaviour for young people's health.
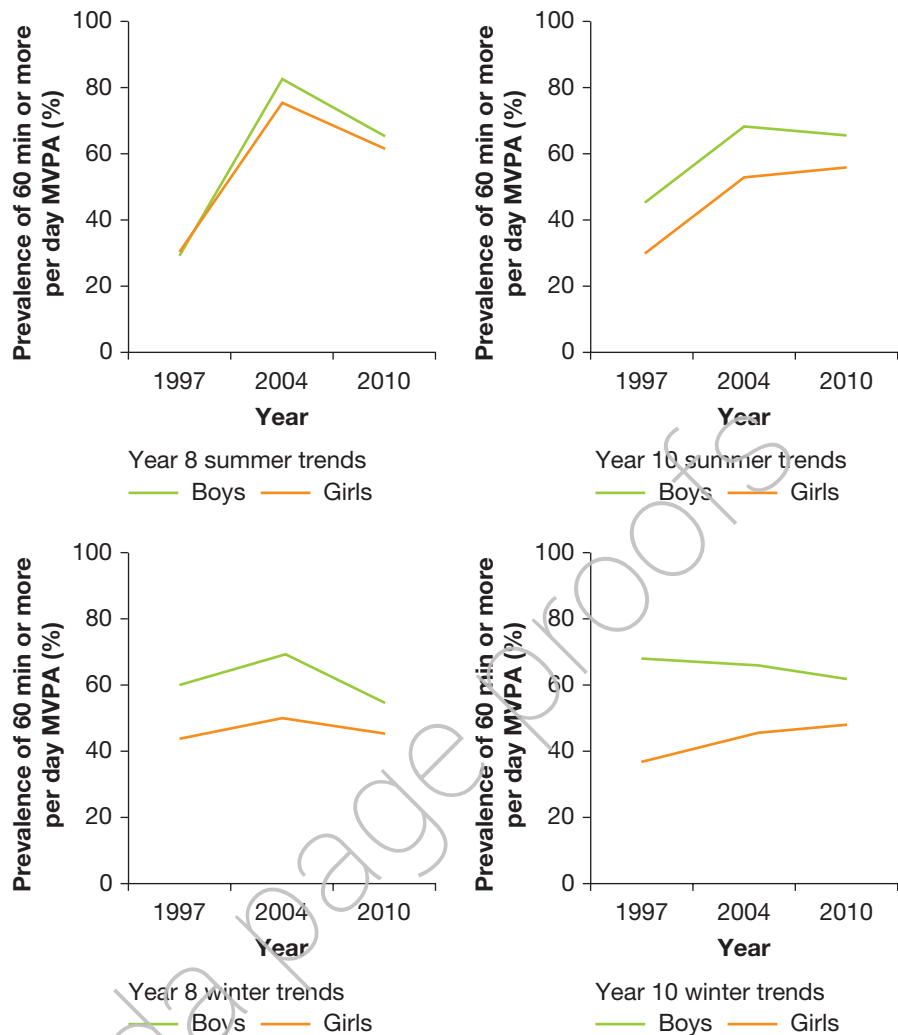
Figure 1.19: Trends in number of young people participating in moderate-to-vigorous physical activity each day
Source: NSW Schools Physical Activity and Nutrition Survey (SPANS) 2010, p. 133.

INQUIRY

Trends in relation to young people's participation in physical activity

eBook *plus*

1. Research trends in relation to physical activity patterns of young people reported in the *New South Wales schools physical activity and nutrition survey* (SPANS) 2010. Using the **NSW SPANS** weblink in your eBookPLUS, download and read section 8 (Physical activity among years 6, 8 and 10).

2. Share your findings with the class. Comment on whether these results surprised you and if so, why.

3. Discuss in groups whether these findings match commonly held perceptions about how physically active young people are.

Sedentary refers to a lack of regular physical activity and spending a lot of time sitting or resting.

Another finding of the SPANS research relating to physical activity was the significant proportion of young people who spent prolonged periods of time engaged in small screen recreation (SSR); that is watching television and DVDs, using computers for fun and playing e-games. According to the survey's findings, over 60 per cent of secondary school students exceeded the recommended guideline of two hours of SSR on weekdays, with this figure increasing to 80 per cent on weekends (see figure 1.20). Research has suggested that patterns of **sedentary** behaviour in childhood are likely to continue in
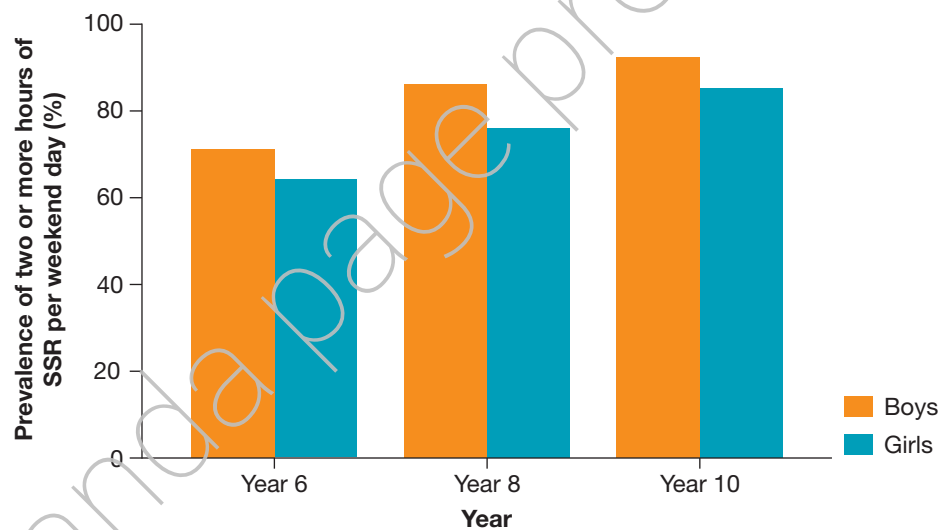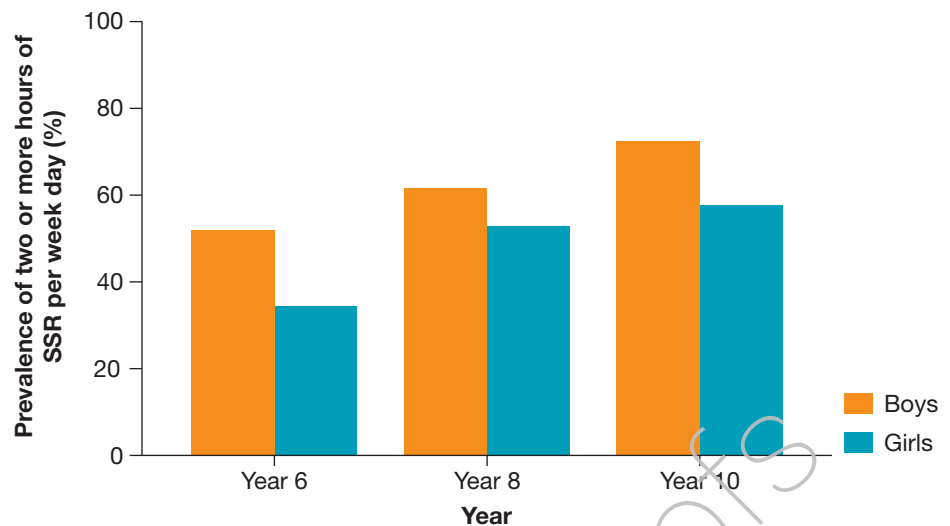
Figure 1.20: Percentage of male and female students in years 6, 8 and 10 engaging in more than two hours of small screen recreation (SSR) a day

Cardiovascular disease refers to disease that affects the heart or blood vessels.

Heart disease, also called cardiovascular disease, is the term used for diseases of the heart and blood vessels. Common heart diseases include coronary heart disease (diseases of the blood vessels supplying the heart muscle), cerebrovascular disease (diseases of the blood vessels supplying the brain) and peripheral arterial disease (diseases of the blood vessels supplying the arms and legs).

later life, thereby increasing risk of factors such as lower levels of fitness that contribute to **cardiovascular disease**.

Behaviours relating to healthy eating

The development of healthy patterns of eating helps to ensure an adequate intake of all nutrients essential for good health and protects against a range of chronic preventable diseases that are prevalent among Australians, including **heart disease**, type 2 diabetes, some cancers and obesity. Consuming plenty of fruit and vegetables each day is an important part of having a balanced, nutritious diet. The Australian Dietary Guidelines recommend that people aged 14-18 years consume 5–5½ servings of vegetables and 2 servings of fruits each day. Findings from the 2010 SPANS report on the dietary habits of high school students were positive in regards to their intake of fruit, with approximately 75 per cent of year 8 and 10 students reporting that they consumed two or more pieces of fruit daily. However the proportion of young people who satisfied the recommendations in relation to vegetable consumption was much lower,
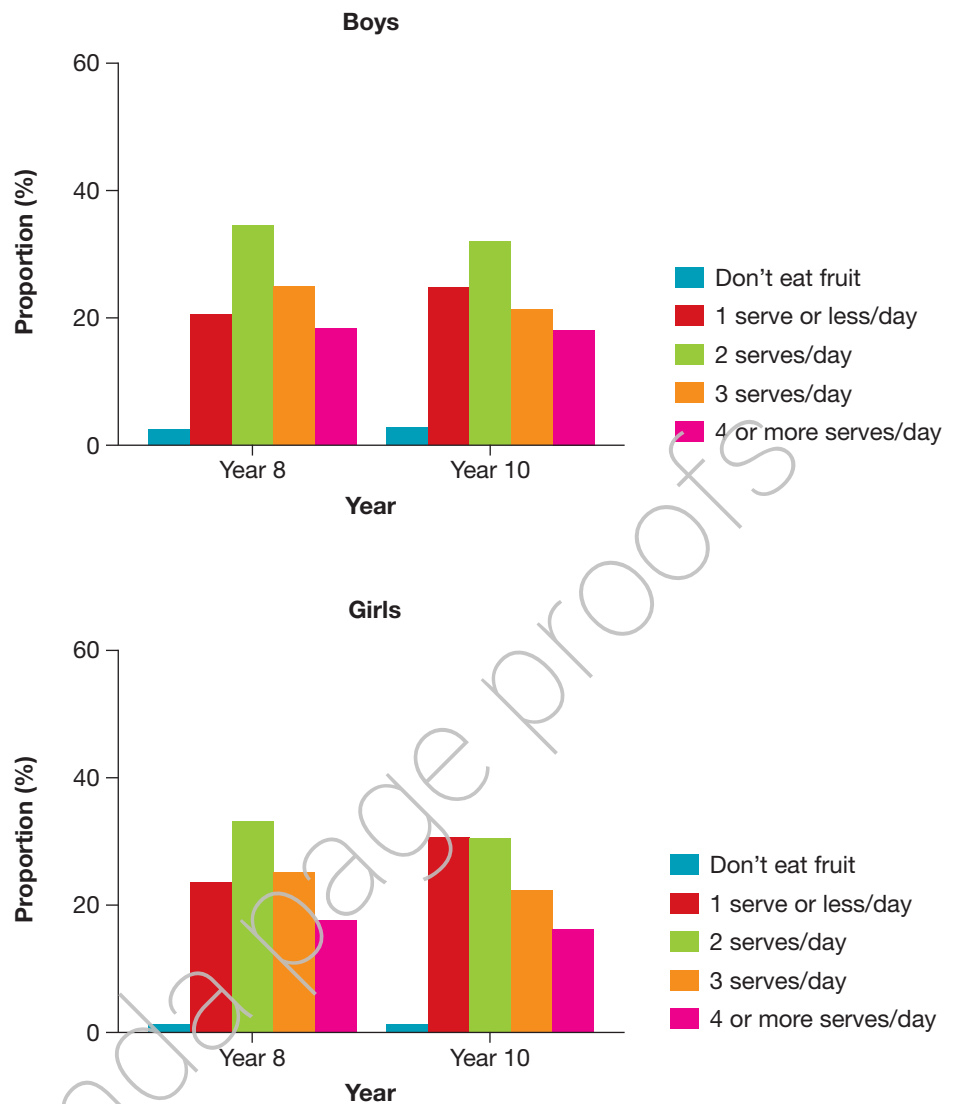
Boys

Girls

Figure 1.21: Usual consumption of fruit among year 8 and 10 students

with only eight per cent of high school students eating the recommended five serves of vegetables.

Reducing the intake of foods containing high levels of saturated fat, added salt and added sugar is another key component of healthy eating. Processed snack foods, take away meals, soft drinks and sports and energy drinks generally contain high amounts of saturated fats, salt and/or sugar, meaning their consumption should be limited so they are not eaten daily. According to the SPANS 2010 report a variety of 'extra' snack foods such as chips, biscuits, cakes, muesli bars, chocolate, ice cream and ice blocks were regularly consumed by students, with approximately one-third of surveyed students consuming them as often as three to six times a week. Nearly 10 per cent of students also reported consuming soft drinks on a daily basis.

The food choices made by young people are likely to be strongly influenced by a number of food behaviours such as skipping meals, eating dinner while watching television and consuming food and drinks purchased away from home. Research has identified the maintenance of healthy weight to be closely linked to the regular consumption of breakfast and not sitting down to dinner in front of the television.
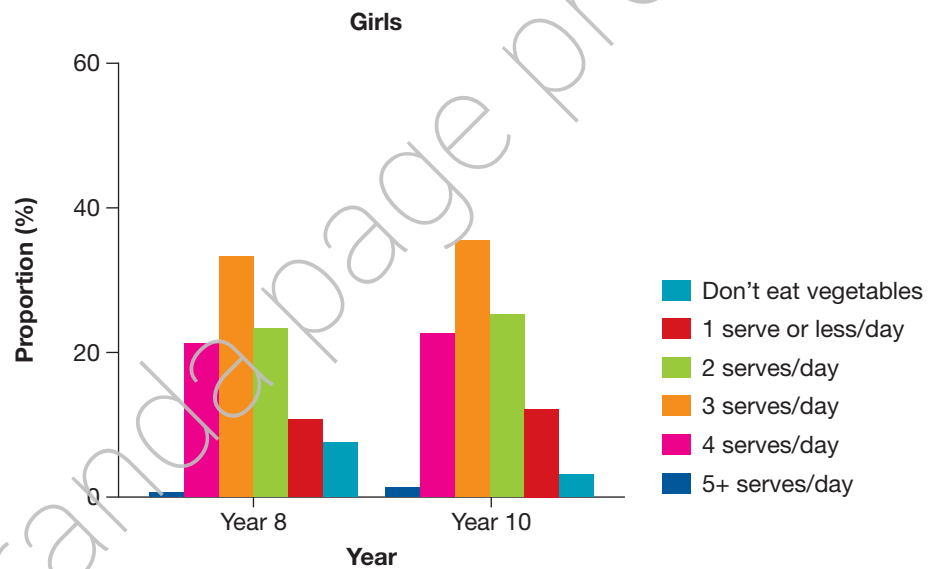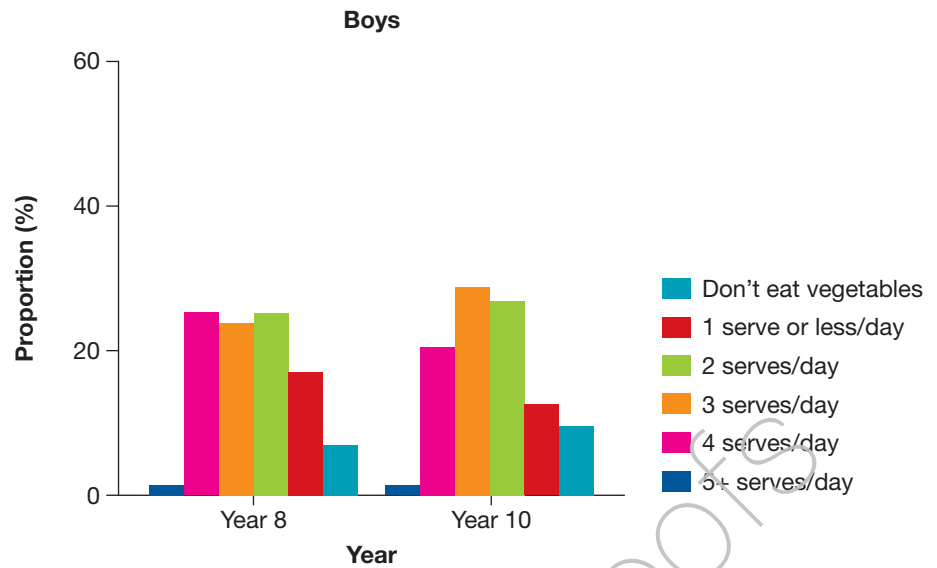
Boys

Girls

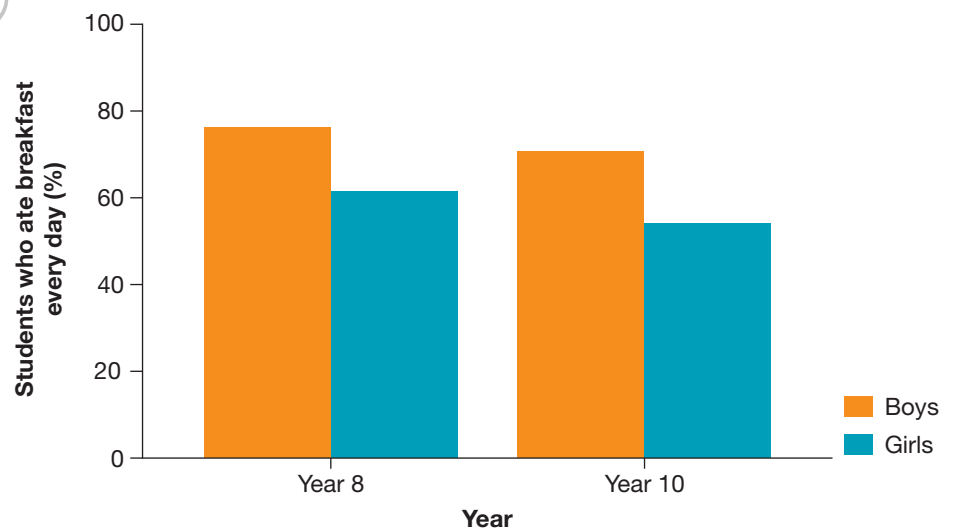**Figure 1.22:** Usual consumption of vegetables among year 8 to 10 students

Figure 1.23: Percentage of students who ate breakfast every day, by school year

Findings in the 2010 NSW SPANS report indicated that a significant proportion of young people, particularly girls, did not eat breakfast, with 70 per cent of boys and only 54 per cent of year 10 girls regularly consuming breakfast. The same survey found that approximately a quarter of students ate their dinner in front of the TV on most days.
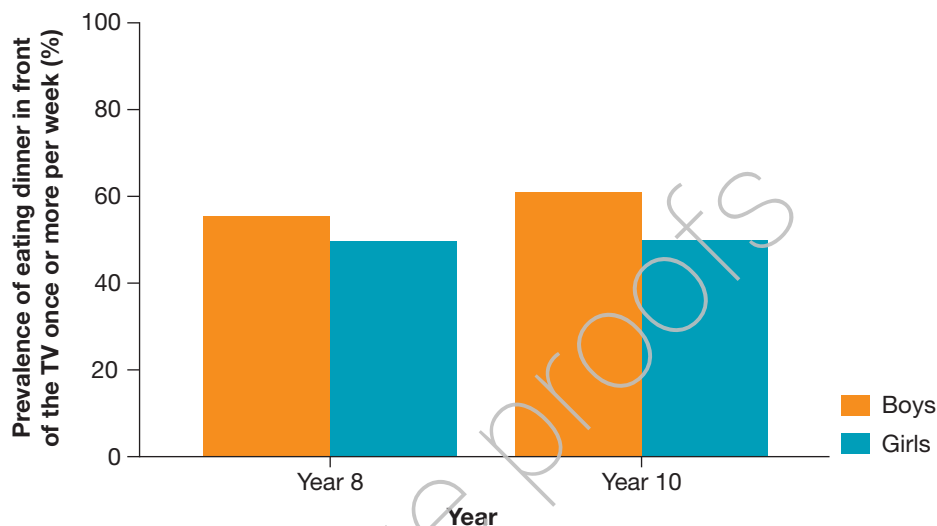

Figure 1.24: Percentage of students who ate dinner in front of TV at least once a week, by school year.

INQUIRY

Skipping meals

Examine figures 1.23 and 1.24 and answer the following questions.
1. Summarise the trends that are evident in relation to eating breakfast and eating dinner in front of the television.
2. Suggest possible reasons for the following findings.
    (c) Students were less likely to eat breakfast as they got older.
    (d) Boys were more likely to eat breakfast than girls.
    (e) Boys were more likely to eat dinner in front of the television than girls.
3. Research has suggested that skipping meals and eating in front of the TV are risk factors for becoming overweight or obese. Explain why these eating behaviours could be linked to this health problem.
4. Identify other health issues that could be linked to these two eating behaviours.

Behaviours relating to body weight

Problems associated with body weight, particularly being overweight and obese, contribute to a wide range of immediate and future health problems for young people. In the short term, being overweight or obese is likely to negatively affect a young person's social and emotional well-being, particularly their self-image and sense of confidence, while also increasing their risk of developing cardiovascular diseases and type 2 diabetes. Ongoing problems with excess weight further increase the likelihood that young people will develop these health conditions during adulthood, along with certain cancers, gallstones, disordered sleeping and osteoarthritis.

Body mass index (BMI) is the most common method of determining whether a person's weight fits into a healthy range. It is calculated by dividing their weight in kilograms by their height in metres squared.

Underweight is defined as a body mass index less than 18.5.

Overweight is defined as a body mass index of 25 or over.

Obese is defined as a body mass index of 30 or over.

Body image refers to the attitude or feelings we have about our body and the way we look or the way we think others see us. A person's body image can be positive or negative.

Data on the number of young people in Australia who are overweight and obese are generally based on measuring a person's **body mass index (BMI)**. BMI is determined by dividing a person's weight in kilograms by their height in square metres ($BMI = kg/m^2$). The resulting measurements are then used to classify people as **underweight**, an acceptable weight, **overweight** or **obese**.

Numerous studies have found a significant number of young people are overweight or obese. The 2010 SPANS survey found approximately 18 per cent of high-school-aged boys were overweight and six per cent were obese, while nearly 16 per cent of their female peers were overweight and four per cent were obese. While these figures represented reversal of the trends from previous SPANS surveys with no significant change in the number of females who were overweight or obese and a slight decrease among males, the prevalence of overweight and obesity among NSW secondary students remains high.

A lack of regular physical activity, participation in sedentary activities, poor dietary habits and the use of passive transport options are generally seen as the behaviours contributing significantly to the increasing risk of young people being overweight or obese. According to research, being overweight during childhood or adolescence is a health risk behaviour as it places a young person at greater risk of obesity during adulthood.

The *NSW school students health behaviours survey 2011* also used questions to ascertain how young people perceived their own body weight, then compared their responses with their calculated BMI. This comparison revealed significant differences in subjective and objective measures of body weight. Boys (14.9 per cent) were more likely than girls (5.1 per cent) to see themselves as too thin or about the right weight when they were found to be overweight. Girls were more likely to perceive themselves as overweight when their BMI was calculated as healthy or underweight (4.9 per cent males compared to 16.5 per cent females). These inaccurate perceptions of body weight can often be associated with poor **body image** and a sense of dissatisfaction with their physical appearance. Disordered eating habits such as skipping meals and limiting food intake, and other unhealthy behaviours such as smoking and excessive exercise can result from these negative perceptions. These types of behaviour place the immediate and long-term health and well-being of young people at risk.

INQUIRY

eBook plus

Health issues relating to body weight

1. Research the prevalence of and trends in relation to overweight and obesity among young people. Information can be obtained from chapter 4 of SPANS 2010. Use the **NSW SPANS** weblink in your eBookPLUS to download and read chapter 4 of the full report.

2. Explain health issues that young people who are overweight or obese could face:
   (f) during adolescence
   (g) during adulthood.

3. Discuss reasons why girls were more likely than boys to perceive themselves as overweight when they actually had a healthy body mass index (BMI).

4. Outline health issues that could arise from these inaccurate perceptions about body weight.

Behaviours relating to drug use

Adolescence is a time when young people may experiment with substances such as tobacco, alcohol and other illicit drugs. The use of all these drugs poses a risk to the health of young people, with their misuse likely to cause numerous immediate and long-term health problems for either themselves or the general community.

While rates of smoking in Australia have continued to decline, tobacco smoking remains the single most preventable cause of chronic ill health and death in Australia. It is a major risk factor for numerous cancers as well as cardiovascular disease, respiratory diseases such as bronchitis and emphysema, circulatory problems and pregnancy difficulties. Smoking is therefore a risk behaviour for young people because of the increased risk of developing these diseases later in life, as well as the likelihood of experiencing immediate health problems such as lower levels of fitness and higher rates of respiratory illnesses. Furthermore, the commencement of smoking at a young age increases the likelihood that a person will continue to smoke, smoke more heavily and have greater difficulty quitting.

Figure 1.25: Comparison of tobacco smoking status of 14–19-year-olds between 2001 and 2010 (*Source:* National Drug Strategy Household Survey 2010.)

The *National drug strategy household survey* found that in 2010 just under seven per cent of 14–19 year olds had smoked daily, with another 1.5 per cent smoking weekly. These reported rates indicate that smoking among young people has continued to decline in recent years (see figure 1.25). This reduction in the number of young people smoking suggests that the incidence of tobacco-related diseases is likely to decrease in the future.

INQUIRY Perceptions about tobacco smoking by young people

1. Survey at least 10 different people (including at least five adults) and ask them to predict the percentage of 14–19-year-olds who currently smoke every day. Record the responses.
2. Compare the responses with the information provided by the graph in figure 1.25.

3. Discuss the accuracy of people's perceptions about tobacco smoking by young people. Suggest possible reasons for the perceptions that people have formed.
4. Propose ways to challenge inaccurate perceptions that exist about the prevalence of tobacco smoking by young people.

Figure 1.26: Binge drinking by young people contributes to a wide range of alcohol-related risks and harms.

Binge drinking refers to the consumption of excessive amounts of alcohol in a short period of time. It commonly involves drinking to get drunk.

Drinking excessive amounts of alcohol is a major cause of ill health and death, particularly for young people. Consuming large amounts of alcohol in a short period of time can cause alcohol poisoning that can severely impair brain function, resulting in coma and even leading to death. **Binge drinking** also causes increased confidence, a lowering of inhibitions and the impairment of decision making and motor skills, all of which combine to increase risk-taking behaviour, particularly by young people. Statistics show that they are the population group at greatest risk of alcohol-related injuries and deaths, which most commonly result from road crashes, violence, sexual assaults, falls, drowning and suicide. Along with these physical harms, risky drinking behaviour is also responsible for a range of emotional and social harms likely to impact on young people's health and well-being, such as guilt, embarrassment, relationship conflict and legal problems. In the longer term, excessive drinking contributes to liver diseases such as cirrhosis, cardiovascular disease, diabetes and some forms of cancer.

Data from the 2010 *National drug strategy household survey* found that the proportion of teenagers who reported drinking weekly was around 18 per cent, while 35 per cent of 14-19 year olds stated that they had abstained from drinking. The number of non-drinkers represented a substantial increase from the previous survey in 2007 and suggested a positive trend in the drinking behaviours of young people. Among those who had consumed alcohol, around 14 per cent reported consuming an amount of alcohol at least weekly that placed them at risk of experiencing an alcohol-related injury. Young males were more likely than females to consume alcohol in quantities that placed them at risk and they tended to do this more frequently than females.

The *2011 Australian Secondary Student Alcohol and Other Drug Survey* found higher levels of alcohol consumption among teenagers, with 25 per cent of 14–17 year olds having drunk in the last week. However this figure also represented a fall from previous surveys. The survey also found that among

those 16–17-year-old students who had consumed alcohol in the past week, 45 per cent reported that they intended to get drunk most or every time they consumed alcohol. Only 26 per cent of all students reported having never consumed alcohol.
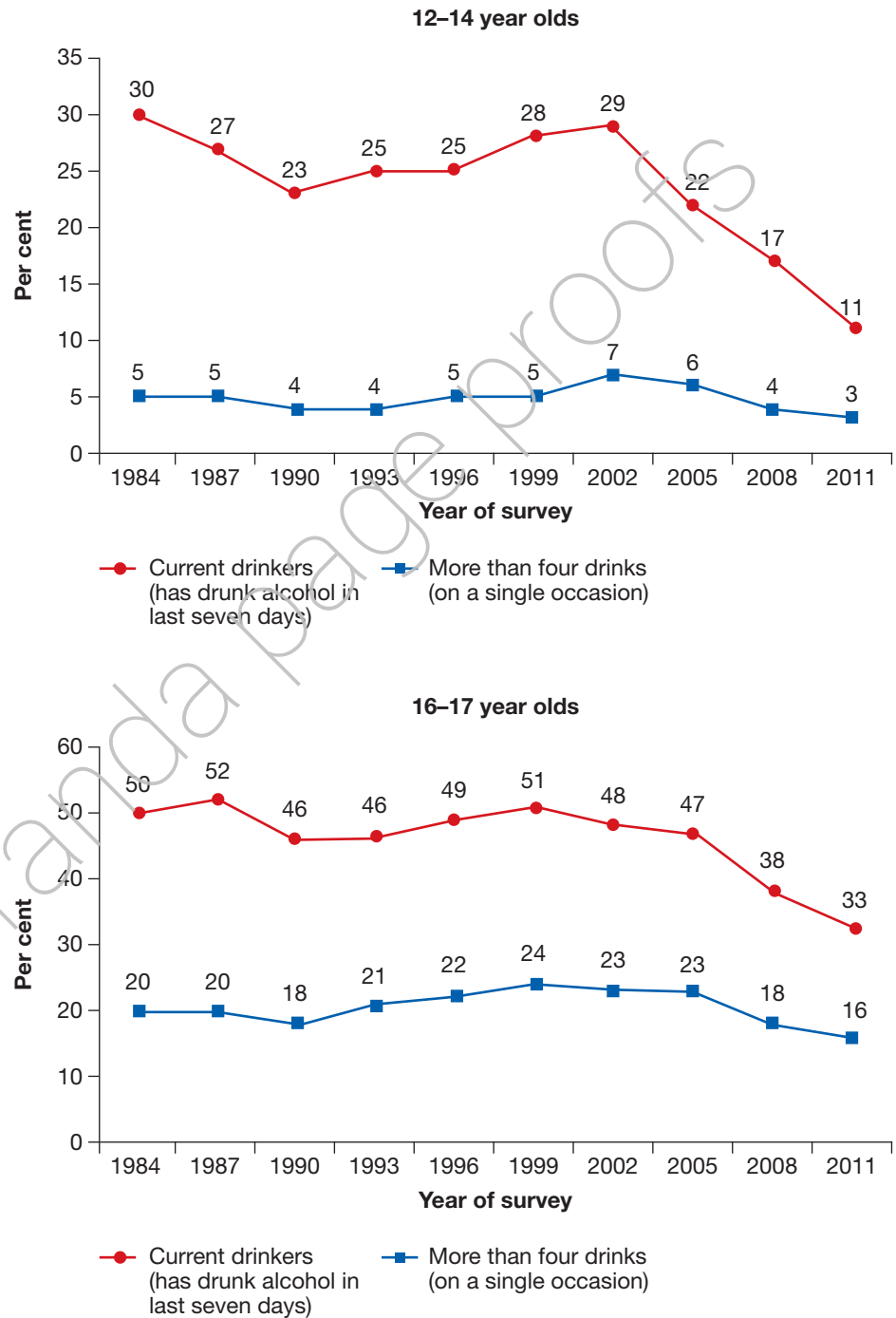

Figure 1.27: Trends in drinking behaviour by young people
Source: Australian secondary school students use of tobacco, alcohol, over-the-counter and illicit substances in 2011, Australian Government Department of Health and Ageing, fig 4.2 and table 4.3, pp. 52–3.

Alcohol consumption and young people

1. Examine the trends evident in figure 1.27 in the drinking behaviour of school-aged young people.
   (a) Analyse the trends evident in these graphs.
   (b) Propose reasons for the changes that are shown.

SNAPSHOT

A generation lost to the demon drink

By Richard Noone and Chelsea White

Children as young as 10 are seeking treatment for alcohol addiction, while five teens and young people die each week in incidents tied to binge drinking.

Recent studies have confirmed experts' fears that underage drinking is out of control.

One in five teenagers now regularly binge drinks by the time they turn 16, with the rate jumping to about 50 per cent by age 18.

A national survey of high school students has found parents have eclipsed friends and all other sources of supply for young people. One in three children aged 12 to 17 now turn to mum or dad to provide the rocket fuel they want to ignite a party.

Currently a legal loophole means parents who provide their children with alcohol escape any conviction or heavy fine.

Ben, 15, had his first alcoholic drink when he was in year 7.

'My mate bought a massive sports bottle with a little bit of Coke and the rest was Jim Beam from his mum,' he said yesterday.

Today Ben is often pressured by others to drink but is part of a Youth Off The Streets program that encourages him to stay away from bad influences.

Another program member Natalya — who started drinking at 13 — has ended up in hospital three times because of alcohol.

'You just drank until you got drunk really — you drink until you drop,' the 15-year-old said.

Ted Noffs Foundation CEO Wesley Noffs said his organisation was being approached to provide residential rehabilitation to minors as young as 10 and 11, while Odyssey House boss James Pitts said alcohol was blamed for a 33-year high in admissions.

'When I first started working in this industry 25 years ago I saw case files on 16-year-olds and I was sceptical you could even have a problem at that age,' Mr Noffs said. 'But 10- and 11-year-olds can really have serious drug and alcohol problems, we now know it's not just rhetoric. We are really not taking this problem seriously.'

A recent study done by Odyssey House, one of the country's biggest rehabilitation centres, found 90 per cent of residents named alcohol as their first drug of intoxication at age 12 or 13.

'These days young people are out there, they're not slinking around hiding. They are in your face, they're drinking in public places,' Mr Pitts said.

He said the short-term risks were obvious with about 264 people aged 15 to 24 dying every year in falls, crashes, fights and other alcohol-related incidents.

'The research indicates that the earlier people start to drink the greater likelihood they will develop problems later in life,' Mr Pitts said.

An Australian secondary school report last year found, while the overall number of students drinking was slightly down on previous years, those who did drink hit it harder and earlier.

A study by the National Centre for Education and Training on Addiction found so-called 'cool' parents, social networking, availability of supply and a shift in the traditional family structure fuelled a 'hedonistic culture' of alcohol abuse.

Paul Dillon studied change in attitudes and abuse in recent years in his role as director of Drug and Alcohol Research and Training Australia.

'For years when I was asked how and when to introduce alcohol to children, my response was "before someone else does and as early as you think appropriate",' Mr Dillon said. 'That message has changed dramatically.'

Source: The Daily Telegraph, 12 February 2011

Teen drinking falls but concern over risk takers

By Amy Corderoy

The number of schoolchildren drinking alcohol has fallen dramatically over the past 30 years, a large study of NSW students has found.

But experts say the message about the dangerous effects of alcohol on developing brains is not filtering through fast enough, with drinking still extremely common and many young people engaging in seriously risky behaviour.

McCusker Centre for Action on Alcohol and Youth head Mike Daube said a two-tiered drinking culture was developing.

'We have some positive indications about this generation in terms of alcohol and tobacco use, but we should be really worried by this two-tier split, these determined drinkers who are vomiting and drinking to get drunk,' he said.

Minister for Mental Health and Healthy Lifestyles Kevin Humphries said the survey of nearly 8000 NSW children from government, independent and Catholic schools showed just under half drank alcohol in the past year. This compared to nearly three-quarters of the students surveyed in 1984.

'When it comes to reducing the rate of teenage drinking, we are certainly heading in the right direction,' said Mr Humphries, who will launch the report on Wednesday.

'However, many of the statistics contained within this report are nothing short of alarming.'

Of those who drank in the past week, one in 10 drank more than 16 drinks in the one session. One-third of the students, aged between 12 and 17, who drank in the past year had drunk so much they vomited. One in five had got in a car with someone they thought had been drinking.

Michael Thorn, chief executive of the Foundation for Alcohol Research and Education, said it was very concerning that more than two-thirds of children had drunk alcohol, when the group was not meant to be drinking at all. 'The impacts of alcohol on young people, particularly on their developing brain and their future development of alcohol-use disorder, are significant,' he said. 'We know that young people who do consume alcohol are more likely to consume alcohol at risky levels.'

The report also shows that the eating patterns of secondary students in NSW appear to be improving, with increases in the proportion who eat enough fruit and vegetables and drops in soft drink consumption.

However, the majority still do not meet the recommended daily intake guidelines.

Chief health officer Kerry Chant said the level of students meeting the physical exercise guidelines — just over one in 10 — had remained stubbornly low.

'Physical activity is a problem across all age groups, and I think that's a reflection that there are a lot of drivers in society towards sedentary behaviour,' she said. 'It's going to take a lot of effort from everyone.'

Source: Sydney Morning Herald, 28 August 2013

APPLICATION   Drinking behaviour of young people

Read the two snapshot articles on patterns of drinking by young people and then complete the activities below.

1. Describe how the article 'A generation lost to the demon drink' portrays young people and their drinking behaviour. Compare this portrayal with the article 'Teen drinking falls but concern over risk takers' and note any significant differences.

2. Use current research to assess the accuracy of these depictions of young people's drinking behaviour.

Illicit drugs are drugs that are illegal to use, possess, produce or sell. The most commonly used illicit drugs include cannabis, ecstasy and amphetamines.

The use by young people of **illicit drugs** such as cannabis, amphetamines, ecstasy and heroin is another behaviour with obvious health risks. Serious injury and death can result from overdoses or the combination of excessive

consumption of illicit drugs and risk-taking behaviour by young people. Depending on the drug, the amount used, the frequency of use and the way it is consumed, other significant harms have also been linked with the use of these substances. In the case of cannabis, regular and heavy use has been associated with hallucinations, depression, anxiety, poor memory function, difficulties sleeping and respiratory disease. Similar psychological harms are also likely to result from the regular use of other illicit drugs. Furthermore, the use of illicit drugs can have detrimental effects on the emotional and social health of young people, particularly if they develop a dependence on the drug. Family conflict, relationship breakdown, loss of motivation, involvement in criminal behaviour, troubles with the police and disengagement from school can all result from the use of illicit drugs and cause harm to the overall well-being of young people.

Results from the 2010 *National drug strategy household survey* indicate that 25 per cent of those aged between 14 and 19 years had used an illicit drug at some time in their lives, with 4.9 per cent reporting they had used an illicit drug in the previous week. Cannabis was the most commonly used illicit drug, with nearly 16 per cent of teenagers reporting they had used cannabis in the last 12 months. As shown in table 1.3, rates of cannabis use had been steadily declining over the past 15 years, but in 2010 there was an increase in the number of young people who had used cannabis. Recent use of ecstasy, on the other hand, fell by nearly 50 per cent, with the drop in female use being particularly marked.

Table 1.3: Trends in rates of recent cannabis use by young people[a]

Gender	Year (percentage)			
	2001	2004	2007	2010
Males	26.6	18.4	13.1	15.9
Females	22.6	17.4	12.7	15.5

(a) Recent use = used in last 12 months

Source: Adapted from *2010 National Drug Strategy Household Survey report*, drug statistics series no. 25, table 6.1, p. 103.

Table 1.4: Trends in recent ecstasy use by young people[a]

Gender	Year (percentage)			
	2001	2004	2007	2010
Males	5.7	3.9	4.0	3.1
Females	4.3	4.7	6.0	2.5

(a) Recent use = use in last 12 months

Source: Adapted from *2010 National Drug Strategy Household Survey report*, AIHW, drug statistics series no. 25, table 7.1, p. 117.

INQUIRY

Trends in cannabis and ecstasy use by young people

1. Look at the information in tables 1.3 and 1.4 on cannabis and ecstasy use by young people and comment on what it shows. Does the pattern of cannabis and ecstasy use by young people surprise you? Why or why not?
2. Give reasons why rates of cannabis and ecstasy use by young people may have changed in recent years.

Trends in illicit drug use by young people

1. Use the internet to research the findings of the 2001, 2004, 2007 and 2010 national drug strategy household surveys in relation to the prevalence of use of *one* of the following drugs:
   (a) amphetamines
   (b) cocaine
   (c) heroin.
2. Investigate the percentage of young people who indicated they had used the drug in the previous 12 months.
3. Present your findings in a table similar to tables 1.3 and 1.4 and discuss possible reasons for the trends identified.

Behaviours relating to sexual activity

Figure 1.28: Young people who choose to be sexually active need to carefully consider the use of contraception to look after their own sexual health as well as their partner's sexual health.

A **dental dam** is a rectangular piece of latex that acts as a barrier between the mouth and genital area.

Adolescence is a time of heightened sexual awareness, an intensified interest in sexuality and emerging feelings of attraction towards others. At this time, some young people may choose to enter into close, intimate relationships and begin participating in sexual activity. Being sexually active can lead to a number of short-term harms and long-term consequences for the health and well-being of young people.

Engaging in unsafe sex increases the risk of contracting sexually transmitted infections (STIs), a number of which are increasing in prevalence in young people, notably chlamydia and gonorrhoea. Participating in unsafe sexual activity can also result in an unwanted or unplanned pregnancy. Studies have shown that teenage pregnancies are linked with a range of negative health and social outcomes that impact significantly on both young mothers and their babies. These include increased risk of premature birth, lower birth weight, difficulties finishing school and a lack of financial resources.

Experiences of unwanted sexual activity also lead to consequences that can last a lifetime. Along with the risk of physical harms such as STIs, pregnancy and injury, sexual assault can also result in the victim feeling a range of emotions including anger, shame, guilt, fear, mistrust, betrayal, loneliness and disempowerment. Left unresolved, these emotions can lead to poor mental and social health, which can then impact on other areas of health.

Young people who are sexually active need to look after their physical health by using protective behaviours that reduce or eliminate the possibility of an unwanted pregnancy and of being infected with an STI. These include participating in safer, non-penetrative sexual behaviours such as cuddling, kissing and mutual masturbation, and using a condom when participating in any form of penetrative sex. **Dental dams** can also be used when engaging in activities such as oral sex, which can also transmit STIs.

In terms of caring for their emotional health, it is important that young people endeavour to make sexual choices and develop strategies that will safeguard their reputation, minimise their chances of being used or exploited and prevent sexual assault.

The *Fourth National Survey of Australian Secondary Students and Sexual Health 2008* examined the sexual behaviour of young people. The survey examined the differing attitudes and behaviour of males and females in sexual relationships, such as their attitudes towards the use of contraception and their participation in sexual behaviour while under the influence of drugs. Results showed that the majority of young people in the surveyed groups (years 10 and 12 students) were sexually active in some way. The proportion of students who had engaged in sexual intercourse had increased since the previous survey in 2002, with 27 per cent of year 10 students and 56 per cent of year 12 reporting they had participated in sexual intercourse. A number reported having participated in oral sex (33 per cent of year 10 and 58 per cent of year 12). Around 45 per cent of sexually active students reported having more than one sexual partner in the past 12 months, and this number had increased significantly since the previous survey in 2002. There was a significant difference between the genders in the students' relationship to their last sexual partner, with young men being more likely to have sex with someone they had not met before than young women (21 per cent compared to 8 per cent). Participating in casual sexual encounters and having multiple partners are risk behaviours that increase the possibility of contracting an STI.

Table 1.5: Reported participation in sexual activity of years 10 and 12 students

		Year 10		Year 12		Total	
		2002	2008	2002	2008	2002	2008
Deep kissing	Males	75.9	69.4	84.3	85.8	79.4	75.9
	Females	77.2	71.1	86.6	90.9	81.2	80.1
	Total	76.6	70.5	85.6	89.2	80.4	78.6
Sexual touching	Males	63.5	55.2	74.1	71.3	67.9	61.6
	Females	59.6	55.8	74.9	80.6	66.1	67.0
	Total	61.3	55.6	74.6	77.6	66.9	65.1
Oral sex	Males	39.5	32.4	55.7	48.4	46.3	38.8
	Females	35.6	34.3	57.5	63.1	44.9	47.4
	Total	37.3	33.6	56.7	58.4	45.5	44.3
Sex without a condom	Males	11.1	14.1	28.7	30.0	28.7	20.4
	Females	12.2	18.1	35.5	46.2	22.1	31.0
	Total	11.7	16.6	32.6	41.1	20.5	27.3
Sex with a condom	Males	26.0	26.5	46.8	45.5	34.8	34.1
	Females	23.0	28.0	43.7	60.3	31.8	42.8
	Total	24.3	27.4	45	55.6	33.1	39.7

Source: A. Smith, P. Agius, A. Mitchell, C. Barrett & M. Pitts, *Fourth national survey of Australian secondary students and sexual health,* Australian Research Centre in Sex, Health & Society, La Trobe University, 2008, p. 26.

A significant number of young people reported being under the influence of drugs when they participated in sexual activity, with 25 per cent being

drunk or high the last time they had sex. Seventeen per cent of young people reported that being affected by drugs contributed to their involvement in an unwanted sexual experience.

The inconsistent use of contraception by sexually active young people is another behaviour that places their health at risk. The *Fourth National Survey of Australian Secondary Students and Sexual Health 2008* found that almost all sexually active students used some form of contraception during their last sexual encounter. 68 per cent of them used a condom during their most recent sexual encounter (a similar finding to the 2002 survey) and half of them used the contraceptive pill (an increase of 13 per cent from 2002). Being unprepared and not expecting sex (39 per cent), trusting a partner (31 per cent) and knowing a partner's sexual history (27 per cent) were the reasons most commonly given for not using a condom. While the survey found a decrease in the number of young people using the withdrawal method as a form of contraception, the finding that it is still practised by approximately 10 per cent of young people is concerning.

Table 1.6: Type of contraception used by years 10 and 12 students during their last sexual encounter

		Year 10		Year 12		Total	
		2002	2008	2002	2008	2002	2008
Condom	Males	75.1	78.6	68.7	68.9	71.4	73.2
	Females	69.2	73.7	51.1	60.6	58.6	65.1
	Total	71.9	75.4	59.0	62.8	64.4	67.6
The pill	Males	22.3	31.3	37.1	48.8	30.7	41.0
	Females	27.6	39.7	51.7	61.2	41.7	53.7
	Total	25.2	36.7	45.2	57.9	36.8	49.8
IUD	Males	0.7	3.5	0.9	0.0	0.8	1.6
	Females	0.0	1.7	0.1	1.2	0.0	1.3
	Total	0.3	2.3	0.5	0.8	0.4	1.4
Diaphragm	Males	1.3	1.1	0.8	0.0	1.0	0.5
	Females	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.6	0.4	0.4	0.0	0.5	0.2
The morning after pill	Males	7.0	4.9	3.0	3.5	4.7	4.1
	Females	1.8	4.0	4.5	11.9	3.4	9.1
	Total	4.2	4.3	3.9	9.6	3.9	7.6
Withdrawal	Males	8.4	10.7	10.0	3.2	9.3	6.6
	Females	8.6	13.9	17.5	9.1	13.8	10.8
	Total	8.5	12.8	14.2	7.5	11.8	9.5
Rhythm method	Males	0.7	2.5	0.8	0.0	0.8	1.1
	Females	0.0	0.1	2.9	0.3	1.7	0.2
	Total	0.3	1.0	2.0	0.2	1.3	0.5
Other	Males	2.3	2.0	1.7	3.3	1.9	2.7
	Females	2.1	2.5	1.5	3.6	1.7	3.2
	Total	2.2	2.3	1.6	3.5	1.8	3.1

(continued)

		Year 10		Year 12		Total	
		2002	**2008**	**2002**	**2008**	**2002**	**2008**
No contraception used	Males	13.2	0.4	5.5	0.0	8.8	0.2
	Females	11.6	0.4	8.6	0.1	9.9	0.2
	Total	12.3	0.4	7.3	0.1	9.4	0.2

INQUIRY

Human papillomavirus (HPV) is a common sexually transmitted infection in both males and females. While a majority of HPV infections clear within a year, a small proportion lead to abnormalities in the cells which can, over years, progress to cervical cancer.

Connectedness refers to the sense of belonging or attachment an individual feels towards people and places they are frequently in contact with.

Young people and sexual behaviour

1. Comment on the protective and risk behaviours evident in tables 1.5 and 1.6. Discuss health issues that could arise from these risk behaviours.
2. Identify other risk behaviours that increase the likelihood young people will experience harms to their health and well-being if they are sexually active.

Another behaviour that can protect the health of young women is being vaccinated against two high risk strains of **Human papillomaviruses (HPV)**, which cause 70 per cent of cervical cancers in women. A free national HPV vaccination program was introduced for 12–13 year old girls in 2007, with the program extended to include males in 2013. According to the *Fourth National Survey of Australian Secondary Students and Sexual Health 2008* a large majority of young women (86 per cent) reported that they had been vaccinated for cervical cancer.

Behaviours relating to establishing social networks and support

Having a strong sense of **connectedness** to family, peers, school and the community has been shown to positively affect the health and well-being of young people. Connectedness refers to the sense of belonging or attachment an individual feels towards people and places they are frequently in contact with. Research has shown connectedness to be a significant protective factor for good mental health, as it is crucial in establishing a positive sense of identity, enhancing **resilience**, creating a sense of purpose and forming networks that can provide support and advice. These social networks make people feel cared for, loved and valued. Supportive relationships can also encourage healthier behaviour patterns. Groups of young people who find it difficult to live in their community with their sense of identity

Figure 1.29: Developing a strong sense of connection to peers and other groups is an important protective behaviour.

Resilience is the capacity of individuals to deal with adversity and challenges in ways that make it possible for them to lead healthy and fulfilling lives.

intact or who feel they do not 'fit in', such as same-sex attracted youth or some ethnic groups, can experience feelings of loneliness, sadness and alienation. Young people who are unable to develop or maintain meaningful positive relationships can feel isolated, have limited avenues of support at times of need and experience higher rates of depression. Participating in peer activities such as sporting teams or church groups, regularly attending school and choosing to be involved in voluntary work are all examples of behaviours that can enhance young people's sense of belonging and help create social networks, thereby protecting their health and well-being.

The 2007 *National survey of mental health and wellbeing* reported that 95 per cent of young people had at least one family member in whom they could confide, indicating support was available for them when they experienced tough times. The 2010 *General social survey* also found 92 per cent of young people had at least one friend in whom they could confide. This strong social support is likely to have positive effects on young people's mental health and assist them to better cope with change and stressful events.

The Australian Bureau of Statistics 2010 *General social survey* found that a number of young people were actively participating in their communities by either involving themselves in a social group or undertaking some form of voluntary work. According to the study, nearly two-thirds of young people participated in a social group, with sport or physical recreation groups or religious organisations being those with which they were most frequently involved. A further 27 per cent of young people were involved in some form of volunteer work, most commonly for the same types of groups. Participation in social and volunteer activities helps to improve the physical, emotional and social health of young people as it assists to:
- develop a sense of connection
- increase self-confidence
- enhance personal skills such as problem solving and communication

Figure 1.30: Undertaking voluntary work can help young people establish a strong sense of connection to their community.

- provide opportunities for young people to meet others
- support young people to be active and enjoy themselves.

Behaviours relating to safety

Despite a steady decline in the number of fatal crashes in recent years, road crashes continue to be the leading cause of death and injury for young people. Statistics in the *Young Australians: their health and well-being* 2011 report showed that road traffic accidents continue to be the most common cause of injury related death in 15–24-year-olds (35 per cent). Particular concern has been expressed about the over-representation of young people in injury and trauma figures for motor vehicle accidents. Analysis of 2011 road crash statistics compiled by the NSW Transport Centre for Road Safety showed that 21 per cent of all drivers and motorcyclists involved in fatal crashes were young people aged 17–25 years, even though this group accounted for only 14 per cent of licence holders. While the reasons for the over-representation of young drivers in crash statistics are complex and interrelated, risk-taking behaviour by young people is a significant contributing factor.

Young drivers often put their health and the health of others at risk by speeding when driving. These dangers are compounded by their lack of experience at identifying potential traffic hazards and knowing how to react appropriately when these situations arise. Research has found speeding continues to be the major cause of fatalities and injuries in vehicle accidents for all age groups. In 2011, 30 per cent of the young male drivers involved in fatalities in New South Wales were speeding, In contrast only 5 per cent of speeding drivers who were involved in a fatal crash were females. Of all the crashes (fatal, injury or no injury) that occurred in 2011 where speed was involved, 73 per cent of the drivers were found to be males aged 17–25, compared to only 27 per cent young females.

Figure 1.31: Cyclists who wear helmets are decreasing their chance of head injury in the event of an accident.

Drinking alcohol and driving is another health risk behaviour common among young drivers. Consuming alcohol reduces a driver's coordination and decision-making skills, while increasing their confidence and decreasing their inhibitions. This combination of factors significantly impairs driving ability. In 2011 alcohol was a factor in 21 per cent of the fatalities that occurred in New South Wales involving drivers aged between 17 and 25 years, while a further 24 per cent of young drivers involved in crashes where injuries occurred had consumed alcohol.

Driving while fatigued also impairs a driver's skill. Research suggests that many young people do not get enough sleep and insufficient sleep is likely to interfere with their functioning when behind the wheel. Twenty-nine per cent of people aged between 17 and 25 years who were involved in fatalities during 2011 were fatigued at the time of the crash. Other behaviours such as talking on mobiles, listening to music or interacting with passengers can also distract young drivers and negatively affect their driving.

The sense that some young people have of being 'bulletproof' or invincible can lead them to discount the importance of using protective equipment. Wearing helmets when cycling, the use of safety equipment at work and wearing seatbelts are examples of health protective behaviours that can decrease the chance of injury and death in the event of an accident, or significantly reduce the severity of injuries that result from accidents.

Motor vehicle injuries and young people

1. Use the **Centre for Road Safety** weblink in your eBookPLUS to download the latest statistical statement on road crashes in NSW. Examine this data to investigate:

(a) fatality and injury rates for young drivers compared to the general population

(b) risk behaviours that contribute to crashes (for example, speed)

(c) gender differences in risky behaviour by young drivers.

2. Present your findings as a Prezi presentation.

Behaviours relating to accessing help

Having the knowledge, skills and services available to provide appropriate health information and quality support when needed is yet another protective behaviour associated with positive health. Education is important in the provision of accurate knowledge and increased awareness of health issues. Having a greater understanding of protective and risk behaviours in relation to health assists in decision making and provides young people with a sense of empowerment over their lives, both of which serve to protect their health and well-being. Furthermore, having health services available that are appropriate to the needs of young people and being able to access these services when required is crucial to the diagnosis and provision of early intervention.

Research has highlighted the importance of health education, with accurate knowledge and appropriate attitudes frequently associated with the adoption and maintenance of health protective behaviours.

Various studies have shown young people's knowledge of issues that are particularly relevant to their health can be inconsistent or poor. For example, the *National survey of Australian secondary students and sexual health* 2008 found young people's knowledge of specific sexually transmitted infected and their effects on health was poor, with less than half of students in the survey knowing that chlamydia, the most common STI in young people, could affect both men and women. A similar percentage were unaware that genital herpes had no cure, so once infected a person would always have the virus.

Studies have also shown a reluctance or inability among young people to access help when needed for particular health issues. The *National survey of mental health and well-being* 2007 identified a reluctance by young people to seek help when experiencing problems with their mental health. According to the survey, over 85 per cent of young males and nearly 70 per cent of young females with a mental health disorder did not use any services. This reluctance to use services was highest in people aged 16–24, making young people least likely of any age group to seek help.

Research has found the major barriers to seeking help were feelings of embarrassment and shame about being identified with a mental illness or seeking help about it, along with problems recognising the symptoms. Concerns about confidentiality and trust and a preference to manage the problem on their own were also found to be significant barriers to young people's ability to seek help.

The effect of multiple protective or risk behaviours

Research has shown that certain health behaviours are often associated with each other and that these behaviours increase the health risks that young people face. For example, the *Fourth National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health* 2008 found that one-quarter of all the young people surveyed were drunk or affected by illegal drugs the last time they were sexually active. The survey's finding that unwanted sex was most commonly associated with excessive drinking highlights the correlation between multiple risk factors and increasing risk of health harm.

The presence of multiple health risk behaviours increases the level of harm that young people are likely to experience, both in relation to their health and their overall social and emotional well-being. *Young Australians: their health and well-being* 2011 reported that young people in the juvenile justice system commonly engaged in health risk behaviours such as drug and alcohol use, smoking and unsafe sex practices. They therefore tended to experience higher rates of blood-borne viruses, sexually transmitted infections, mental illness, substance abuse issues and incidence of self harm. These findings highlight the negative health and social outcomes that can result from combined risk behaviours.

The combined interaction of health protective behaviours can contribute to reducing the health risks experienced by young people. Strong family cohesion has been linked with numerous other positive health behaviours that are likely to have significant immediate and long-term health benefits. For example, research has highlighted a range of positive health behaviours associated with families regularly eating meals together. These include a strong sense of family connection, higher intake of lean meat, fruit, vegetables and dairy foods, decreased consumption of high-fat and high-sugar foods, lower incidence of eating disorders, and a reduced likelihood of drug use. Findings such as this suggest that the more health protective behaviours present in a young person's life, the greater the benefit to their overall level of health.

SNAPSHOT

Young men in crisis: mental health study

By Clifford Fram

Young Australian men are in crisis, with half feeling stressed and nearly one in 10 having thoughts about suicide, according to new research.

Mental health experts are alarmed by the extent of the unhappiness, but they are optimistic about finding an appropriate internet-based method of helping the tech-savvy generation.

The research, which explores the impact of technology on mental health and wellbeing, shows distressed 16-to-25-year-old men are likely to find health information on the internet as many listen to music and play games online.

The results suggest the current mental health system is failing young men, say the organisers. They believe improved mental health will reduce the number of suicides, vehicle accidents and fights, which are the biggest killers of young men in Australia.

'For the last 20 years we have known our young men are not faring well,' says Young and Well Cooperative Research Centre CEO Associate Professor Jane Burns, whose organisation partnered with Movember and beyondblue for the study.

'Technology presents our best prospect yet,' she says. 'We must partner with young men to create services that are more relevant to them.' The research shows distressed young men are likely to use the internet late at night.

'We must make sure we provide the right type of service at the right time, and that includes being available after 11 o'clock at night.

'There is a real sense of young men having to go through a rite of passage and they will eventually grow out of it.

'But there is a group who end up being the drug, accident and suicide statistics that we are nervous and concerned about.

'There are also those whose issues are never addressed, who end up having issues with drugs and alcohol in their 40s, and who end up being suicide stats in our older generation.

'Let's work out what we need to do to ensure that when young men are in distress they know how to get support.

'That might not be going to speak to a professional. That may be getting support in an online space they are comfortable with.' Beyondblue CEO Kate Carnell says the research provides invaluable insight into the online habits of young men, particularly those who need support.

'This will pave the way for better engagement with at-risk young men.'

Source: The Australian, 22 July 2013

APPLICATION — Mental health—protection and risk

Read the snapshot 'Young men in crisis: mental health study' and then answer the questions below.

1. Analyse the various protective and risk behaviours that impact on the mental health of young men.
2. Outline the future health problems that researchers are concerned young men may face.
3. Explain why the interaction of various risk behaviours relating to mental health increases the potential harm to future health.

INQUIRY — Increasing or decreasing the risks faced

Choose a health issue relevant to young people; for example, sexually transmitted infections, injury or mental health problems. Discuss how risk behaviours or protective behaviours can interact to affect the level of risk young people face in relation to this health issue.

SUMMARY

- Health is diverse and means different things to different people.
- In the past health was defined as being free from disease or illness. However, the World Health Organization now defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.
- At an individual level, health depends on the interaction of four dimensions — physical, social, mental or emotional and spiritual aspects.
- Health is continually changing; that is, it is dynamic. Health is also relative, meaning that people consider their health in relation to the health of others and in relation to their own circumstances.
- People develop perceptions about their own state of health and the health of others. These perceptions are social constructs, meaning that how we see health is based on our own experiences and the social, economic and cultural conditions that we live in.

- The perceptions of health we develop affect our own personal health attitudes, beliefs and behaviours. They influence our expectations about people's ability to achieve good health. Government policy, priorities and expenditure are also influenced by perceptions of health.
- The media, peers and families all influence how health is perceived and the values, attitudes and beliefs we develop about the importance of health. They also influence our health knowledge, skills and behaviours.
- The health of most young Australians is generally good. However, young Indigenous Australians, young people living in regional and remote areas and young people who suffer socioeconomic disadvantage have poorer levels of health in comparison to their peers.
- The high incidence of mental health disorders, injuries and communicable diseases such as chlamydia and hepatitis C among young people are also areas of concern.
- The behaviours that young people adopt in relation to physical activity, healthy eating, substance use, sexual activity, help seeking, social connect-edness and risk taking are likely to have a protective or harmful effect on their current and future health.
- Health protective and health risk behaviours can interact to decrease or increase the level of risk that a young person is likely to face in relation to their current and future level of health.

QUESTIONS

Revision

1. Use examples to **discuss** how and why people's health is constantly changing. (P3) (5 marks)

2. **Outline** factors that have a significant influence on people's perception of their health. Provide examples to illustrate how the various factors can affect the perceptions people form. (P1) (4 marks)

3. **Compare** how two distinctly different social groups (e.g. young people and the elderly) are likely to perceive health. Discuss the possible implications these differing perceptions may have on their health behaviours. (P1) (6 marks)

4. Health is now seen as a social construct. **Explain** what this means, using examples to support this explanation. (P3) (5 marks)

5. **Outline** how the media can influence people's perceptions about health. (P1) (3 marks)

6. **Identify** measures of health that provide indicators of the positive health status of young people. (P16) (3 marks)

7. **Outline** areas of concern relating to the current health of young people and discuss reasons for these areas being identified as concerns. (P2) (5 marks)

8. Critically **analyse** how a range of risk and protective behaviours are likely to impact on young people's immediate and future health and wellbeing. (P2) (8 marks)

9. Using examples, **explain** why the interaction of multiple risk factors contributes to poorer levels of health. (P3) (4 marks)

Note: For an explanation of the key words used in the revision questions above, see Appendix 2, page XXX.

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Digital docs:

A summary quiz and revision test on this chapter's content are available in Microsoft Word format in your eBookPLUS.

Answers to Application questions, page 21:
A: painkillers; B: alcohol;
C: tobacco; D: cannabis;
E: inhalants;
F: amphetamines; G: ecstasy;
H: steroids.