TOPIC 1
What does health mean to individuals?

OVERVIEW
1.1 Meanings of health
1.2 Perceptions of health
1.3 Health behaviours of young people
1.4 Topic review

OUTCOMES
In this topic students will:
• 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)
This topic provides an understanding of foundation concepts in preparation for the topics 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.

1.1 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.

1.1.1 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.
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.

1.1.2 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 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 relates to the efficient functioning of the body and its systems, giving people the capacity to carry out everyday activities and be free from illness. It is the most visible dimension of health.

While our heredity and genetic makeup determine our physical potential, physical health is largely determined by lifestyle and behaviour.
Key lifestyle choices that affect our physical health include:
• participating in regular physical activity
• nutrition and diet
• the use of alcohol and drugs
• seeking medical care when needed
• having sufficient rest and sleep.

Social health
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 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 full potential, 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
• the range of coping and help-seeking skills we have developed
• our ability to think creatively and be flexible when making decisions and resolving problems
• biological factors, particularly a family history of mental health problems.

Spiritual health
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, culture or the environment. Beliefs, values, and the ethics we hold 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 dimensions and is continually changing. A breakdown in one dimension of health is likely to impact on the other dimensions, 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 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.
Inquiry

Dimensions of health

Recall a time in your life when one dimension of your health was poor; for example, when you experienced a relationship breakdown or loss. 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.

**FIGURE 1.3** Health is a result of interactions between all the dimensions of health.

1.1.3 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:

- 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 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 if their disability or disease has little impact on their ability to lead an active, productive life.
- we might consider ourselves very healthy, but believe we are very ill when we have influenza, which is a passing virus.

**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.

**Inquiry**

**Relative and dynamic nature of health**

Read the case study on Bradley and answer the following questions.

1. Describe how the various dimensions of Bradley’s health were affected by different circumstances in his life and discuss the possible interactions that occurred between the various dimensions:
   - physical health
   - emotional health
   - social health
   - spiritual health.

2. Identify the events described by Bradley that have:
   (a) positively impacted on his health and well-being
   (b) negatively impacted on his 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 Bradley’s health at the following times in his life. Place each letter (a) to (e) at the relevant place on the continuum.

- (a) after the loss of his friend in a car accident
- (b) after finding out his girlfriend cheated on him
- (c) after being diagnosed with depression
- (d) after seeing his GP and social worker on a regular basis
- (e) after delivering the formal presentation to his school.

4. Explain the reasons for the ratings you have given Bradley’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.

CASE STUDY

Bradley
By Bradley, 18

Depression can strike anyone at any time. Take me for example. I was a typical teenager at high school. I had good grades and got on well with people and I was a prefect.

Then, as fate would have it, I lost a dear friend of mine in a car accident. At that moment, my life went into a rapid downward spiral, but I forced myself to carry on. I refused to admit I had a problem or seek help. At the beginning, I bought into the stereotype that prefects were supposed to be perfect students.

As the time went by, my relationship with my then girlfriend became shaky, my grades began to fall and day to day life became a burden. Soon enough, I learnt that my then girlfriend had cheated on me with my then best mate. I then knew it was time to turn this thing around.

I began to think, my life is nowhere near as bad in comparison to some people. This little epiphany changed my view on my own situation. I made an appointment with the school social worker who referred me to a local GP who diagnosed me with depression. From there on I had a few appointments with the GP and I continued to speak with the school social worker on a twice a week basis. We used cognitive behavioural therapy and I began to conquer my dark passenger.

I knew there were people around school who felt similar to me or who were heading down the same dark road, so I decided I needed to address this issue. I arranged with my principal to allow me to make a formal presentation to the whole school. I stood up in front of the whole school and told them my story. It was the hardest thing I ever had to do. But looking back, I realise it was the best thing I could do.

The next day I was told that my speech has inspired one person to seek help. It may have been only one person who received my message, but that is one person I know I have helped. I could lie and say that the journey to recovery was simple, but it wasn’t. There were times I fell. But the thing is, you can never just lie down. Depression is a disease and you need to fight it with everything. Trust me, the journey may be tough but you will overcome the darkness.

My message is simple; there is always hope. I want people to know that it doesn’t matter who you are or where you come from, depression can strike anyone. Nobody is perfect. I hope my story is enough to show that anyone can suffer with depression. I urge anyone who feels even slightly like they may have depression to seek help. Better to have a false alarm than to leave it too late. Remember, you are not alone!


The case study on Bradley 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.
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.

1.2 Perceptions of health

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.

1.2.1 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.

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
- messages 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.
FIGURE 1.5 The way we perceive our health is influenced by a wide range of factors.

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

Application

How does health change over time?

1. Divide the class into seven groups. Each group is allocated a period within the life cycle (see table 1.1 for the seven periods).
2. Each group is to come up with at least two reasons for why health may improve or decline in the life cycle period they are allocated. These reasons should be accompanied by supporting examples. An example is provided in table 1.1.
3. Groups share their ideas with the class either via an online collaboration tool such as Google Drive or through a whole class discussion.

TABLE 1.1 Why health may improve or decline in the life cycle

<table>
<thead>
<tr>
<th>Period</th>
<th>Reasons health may improve</th>
<th>Reasons health may decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy and toddler years</td>
<td>A number of vaccinations to immunise against many common infectious diseases are given in the first years of life (e.g. whooping cough, diphtheria and polio).</td>
<td></td>
</tr>
<tr>
<td>(birth–3 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4–11 years)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 1.1 Why health may improve or decline in the life cycle (Continued)

<table>
<thead>
<tr>
<th>Period</th>
<th>Reasons health may improve</th>
<th>Reasons health may decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early adolescence (12–16 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Late adolescence (17–24 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early adulthood (25–39 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle years of adulthood (40–64 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior years (65 years onwards)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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 excluding infancy and toddler years).
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.

### 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. Ensure you refer to the various dimensions of health when explaining your rating, rather than just focusing on one or two.
3. On your continuum use a different symbol (e.g. an asterisk) to show how you would have rated your health 12 months ago. Write an explanation of why your rating has changed (if it has) or why you feel it has stayed the same.
4. 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.
5. 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.
6. Discuss your findings with the class, highlighting similarities and differences.
1.2.2 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 judg-
ements 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 others’ health.

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**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
   - Young people
   - People with a physical disability
   - Parents
   - Males
   - Elite sports players
   - Aboriginal people
   - Refugees

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.
1.2.3 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 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 a healthy weight when in reality our weight fits into the overweight category, could prevent us from recognising a need to make changes to our current lifestyle in order to improve our health.

Inquiry

An individual’s health behaviour

Read the case study on ‘An individual’s health behaviour’ and then complete the following.

1. Predict how Mel would define the concept of good health, giving reasons to support your prediction.

2. Using a continuum, indicate how the following people are likely to rate Mel’s current level of health. Underneath your continuum provide brief reasons for why you believe each person would have this perception of Mel’s level of health.
   (a) Mel
   (b) Her parents
   (c) Her friends
   (d) Her old swimming coach
   (e) Her doctor

3. Discuss the impact that Mel’s perception of health has upon her health choices and behaviours. Use examples to support your response.
CASE STUDY

An individual’s health behaviour

Mel is a year 12 student who considers herself to be relatively healthy. She consistently attends school and tries hard to keep up with her school work. She sometimes finds the amount of work challenging and gets really stressed before exams. This makes it hard for Mel to sleep, so she often feels tired, irritable and flat. Because she sleeps in late most days, Mel often does not have time to eat breakfast or pack lunch. She tends to grab a coffee on her way to school and buy something for lunch from the school canteen when she has money with her.

Mel used to be very active, training for swimming four mornings a week and playing in the school’s basketball team. However, she stopped these activities at the beginning of year 11 after getting a part-time job. She now works four-hour shifts on both Saturdays and Sundays in a local fast food store. Although gaining weight since she stopped swimming, Mel is not overly concerned about her lack of physical activity because she doesn’t think she is overweight and the photos she shares of herself on Instagram always get lots of likes.

At weekends Mel likes to relax and go to parties with her group of close friends. They occasionally have a really big night out, particularly during holiday breaks, and drink heavily. There have been a couple of times when Mel has called in sick to work due to being tired and hung-over. On a couple of occasions she has also hooked up with someone she just met at one of these parties, but is not worried about getting pregnant because she has been on the contraceptive pill for a couple of years.

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 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.

### 1.2.4 Perceptions of health as social constructs

We should now recognise that different people have different perceptions about what they believe good health means and what it involves. 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 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 these factors have an influence on the understanding we develop of what good health involves, the expectations we form about our health potential and the health-related choices we make. Perceiving health as a social construct also means that our understanding of health will continue to change over time.

**FIGURE 1.8** Numerous factors play a role in the social construct of health.

### Inquiry

To what extent are perceptions of health socially constructed?

- Read the snapshot ‘One in five school-aged children in NSW considered overweight or obese’ and then respond to the following questions to consider the degree to which perceptions of health are socially constructed.
- 1. Explain why people’s perceptions of what is considered a healthy weight have changed over time.
- 2. Describe the possible impact that this change in perception could have on people’s health behaviours in relation to eating and physical activity.
- 3. Outline two other ideas or perceptions of health that are socially constructed and describe factors that you feel have a major influence on people’s perceptions.
SNAPSHOT
One in five school-aged children in NSW considered overweight or obese, new research shows
By Sue Daniel and Antigone Anagnostellis

Australians need to reset their understanding of what is a normal weight, with more than one-in-five school-aged children in New South Wales now considered overweight or obese, health experts say.

New data indicates there is a disconnect within society about what is now considered a ‘normal’ weight, said Kerry Chant, chief health officer at NSW Health.

‘GPs have told us that sometimes it’s actually hard for them to raise healthy weight with families,’ Dr Chant said.

‘That’s partly because 70 per cent of parents of children who are overweight think their child is about the right weight, so the GPs said to us, we need some more help with some practical tools.’

New tools to address the growing childhood obesity epidemic have been launched including a website showing a healthy weight calculator and a video of a nutritionist giving a guided tour in a supermarket to highlight better food choices.

Dr Chant said new and clear ways have to be found to reach families.

‘As a society we’ve got fatter. So we’ve got over 50 per cent of adults are overweight or obese,’ she said.

‘And sadly one in five children are above a healthy weight in NSW, so you can imagine that the norms of healthy weight have actually changed.’

Obesity treatment must be equitable
Australian Medical Association spokesman Brad Frankum said the most insidious problem with the obesity crisis is that it is unevenly distributed.

‘Western Sydney and the Nepean Blue Mountains are in the top three metropolitan areas in Australia when it comes to overweight and obesity rates so we need to do everything we can to ensure that access to prevention and treatment is equitable,’ Professor Frankum said.

‘I don’t quote these figures to fat shame or judge people in the community where I work. We’re just talking about the most significant health issue that Australia is facing.’

Professor Frankum said it was important to normalise healthy eating early on, because research showed more than 80 per cent of children who were obese become obese adults.

‘There does seem to be an element of metabolic setting that happens in childhood that once you reach puberty — if you’re overweight, it does become harder to lose weight beyond that, so it is something to do with the way the body gets used to the nutrients that it gets.’

Dr Chant said the new tools would help parents to recognise when their children were overweight.

‘They may take it as a judgement, they may take it as blame, and so to better support general practice we need to develop tools to normalise and promote the conversation,’ she said.


Socioeconomic status
Our socioeconomic status is linked to our level of income, education, employment and occupation. Research has found that the higher a person’s socioeconomic status, the healthier they are likely to be. Those in the lowest socioeconomic groups are generally at greatest risk of poor health, suffer more illnesses and disability and have a lower life expectancy. They are more likely to engage in risky health behaviours such as smoking and being inactive and also rate aspects of their health, such as oral health, as fair or poor (Australia’s health 2016).

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 unfair treatment, 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 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.

**Inquiry**

**Perceptions of health as a social construct**

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 most days before doing homework and having dinner.
- Marco lives with his father and younger brother on a remote property in far west New South Wales. He rises at 5.00 am to help with farm work, completes his studies via distance education, cooks dinner, then studies again before bed.

1. Compare how each of the boys might perceive their own health. Give reasons for the similarities and differences discussed.
2. Use examples from the case study or other relevant examples to write an explanation of why perceptions of health are socially constructed.

**Cultural background**

Population groups from different ethnic backgrounds or cultural heritages (for example, Aboriginal and Torres Strait Islander peoples) may have vastly different explanations or meanings for health and well-being to groups from other racial backgrounds (for example, people from a European background). From the perspective of Aboriginal and Torres Strait Islander peoples, the meaning of health is much broader than the World Health
Organization’s definition provided in section 1.1.1. ‘Aboriginal health’ means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their community. It is a whole of life view and includes the cyclical concept of life—death—life (National Aboriginal Community Controlled Health Organisation, NACCHO). This emphasis on the health of the entire community makes it essential for health professionals and services to work in collaborative partnership with local Aboriginal communities to support the health of Aboriginal peoples.

People from different cultural backgrounds may also hold deep-seated beliefs and ideas related to health that are learned and passed on from one generation to the next. As a result, perceptions of health take on different meanings within some cultural groups. For example, in some cultures certain diseases or conditions, such as mental illnesses, are considered to be a sign of weakness or a personal failing rather than a diagnosed health concern. This can create significant stigma for those experiencing these diseases and contribute to feelings of shame or guilt, especially in cultures where the behaviour of an individual is felt to reflect on their family. Ideas about ‘healthy weight’ can also differ between cultural groups. What is considered overweight in one culture may be perceived as ‘strong’ in other cultures. According to the beliefs of people from these cultural groups, being a larger body size means they have an energy store to use in times of famine, leading to a perception that strong women are desirable and healthy.

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, naturapaths 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.
1.2.5 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.

The media

The media are a factor that impact an individual’s social construct of health. Some of the main forms of media include the internet, music, video games, movies, television, newspapers and magazines.

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.

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, passenger restrictions for learner and P-plate drivers and bans on their use of mobile phones while driving, 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.

If 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 firsthand 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: Open letter by Stella Lycos to advertisers, media decision makers and teenagers, Stella Lycos, The Age, 21 July 2013.
Application
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.

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.

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 alcohol and cannabis, 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.

Application
How can the media, peers and family influence our perceptions of health?

FIGURE 1.14 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 1.14 contains data from the National Drug Strategy’s Australian secondary school students’ use of tobacco, alcohol, and over-the-counter and illicit substances in 2014 report. It shows the percentage of 12–17-year-old male and female secondary students who reported that they had used some type of drug in the four weeks prior to the survey. Look at the percentages shown in each column and predict which of the following drugs relate to each letter A–H:

- Cannabis
- Analgesics
- Tobacco
- Alcohol
- Ecstasy
- Tranquilisers
- Inhalants
- Image enhancing drugs

2. As a class examine how closely your perceptions of drug use by young people matched the data reported in the survey. This can be found online, in section 6 of the report: ‘Use of over-the-counter and illicit substances among Australian secondary students’. Look at the data for use in the last month.

3. Discuss how your class’s perceptions of drug use by young people are likely to be influenced by the media, peers and family.

4. Consider how ideas about young people’s drug use are likely to affect perceptions of the health of young people who use drugs.

1.3 Health behaviours of young people

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 screen-based activities, 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?

1.3.1 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 is regularly undertaken by the Australian Institute of Health and Welfare (AIHW), with a report card on the health of Australians compiled every two years. According to the latest report, *Australia’s health 2016*, the health of young Australians 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 the positive health status of young people can be found in a continuing fall in the death rate among young people, largely as a result of a decrease in road-related fatalities. 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 (11 per cent of young people were daily smokers in 2013 compared to 21 per cent in 2001), rates of risky alcohol consumption (39 per cent of young people reported drinking at risky levels in 2013 compared to 49 per cent in 2001) and the use of illicit drugs (in 2013 one-quarter of young people reported using illicit drugs in the past 12 months compared to 33 per cent in 2001). At the same time research found a significant number of young people always (43 per cent) or sometimes (39 per cent) used condoms when having sexual intercourse, helping to manage their sexual health. These positive behavioural changes have the potential to protect and improve the future health of young Australians.
FIGURE 1.15 (a) The continual reduction in the death rate of young Australians is evidence of their positive health status. (b) An ongoing fall in the number of road-related deaths among young people has contributed significantly to a decline in death rates.

(a) Death rates among young people aged 15–24, by sex, 1997–2012

(b) Causes of injury deaths among all young people 2003–12


Inquiry
Analysing mortality rates of young people

Look at the two graphs in figure 1.15.

1. Propose reasons for the significant differences in the death rates of males and females that are evident in the graph.
2. As a class discuss strategies and initiatives that have been implemented in recent years that have contributed to the fall in injury related deaths.
The findings of these statistics are substantiated by positive assessments by most young people of their own state of health. According to the National Health Survey 2014–15 (Australian Bureau of Statistics) just under 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 27.7 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>
<thead>
<tr>
<th>TABLE 1.2</th>
<th>Self-assessed health status of young people aged 15–24 years, by sex and age group, 2014–15 (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health status</td>
<td>Males</td>
</tr>
<tr>
<td>Excellent or very good</td>
<td>64.1</td>
</tr>
<tr>
<td>Good</td>
<td>27.2</td>
</tr>
<tr>
<td>Fair or poor</td>
<td>8.8</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
</tr>
</tbody>
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SNAPSHOT
Junk food, alcohol and drugs fuelling health crisis in young adults
Young people refusing to eat fruit and vegetables and instead loading up on junk food are fuelling the state's obesity crisis.

More than one-third of 18- to 24-year-olds in NSW are knocking back dangerous amounts of alcohol and almost as many have used illicit drugs in the past year.

The worrying findings are contained in a new widespread report that reveals the true state of the health of NSW's young people, covering everything from sexuality to obesity.

The state government report shows young people's diets are feeding the obesity crisis with meals short on fruit and vegetables but rich in junk food and soft drinks leaving up to 37 per cent of them overweight or obese.

And nearly 22 per cent of young women and more than 12 per cent of young men are experiencing high or very high psychological distress.

Social demographer Mark McCrindle said the next generation of young people — dubbed Generation Alpha — will be plagued by obesity and mental health anguish.

‘Those high rates of mental health concerns will continue and we will see ongoing struggle for them with proper exercise and [the] challenge of sedentary lives will be exacerbated,’ Mr McCrindle said.

But he was confident rates of smoking and drinking among young people would continue to fall.

Source: Edited extract from The Daily Telegraph, 12 July 2017.

Application
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 Australia’s health 2016: Health of young Australians weblink in the Resources tab to read chapter 5.4 from the AIHW report.
   (a) Read the key findings on how young people are faring in terms of their health.
   (b) Compare the summary report of your own survey with the key findings from chapter 5.4 of the AIHW report.
3. Read the snapshot ‘Junk food, alcohol and drugs fuelling health crisis in young adults’. Describe the impression of young people’s health conveyed in the article.
4. Use the findings from chapter 5.4 of Australia’s health 2016 (question 2 above) to assess the accuracy of the article’s perception of the health of young Australians (question 3 above).
5. Outline common misconceptions that exist about young people’s health status and behaviours.

Despite the generally positive picture painted of the health status of young people, research has found that particular groups of young people are not doing as well as others in terms of their health and well-being. These groups include young Aboriginal and Torres Strait Islander people, young people in regional and remote areas and young people experiencing socioeconomic disadvantage. Significant differences in all measures of health are particularly evident between Indigenous and non-Indigenous young people and have been for some time. The AIHW found that death rates for young Aboriginal and Torres Strait Islander people were 2.5 times higher than all other young people (80 per 100 000 compared to 32 per 100 000) and the recent decline in the death rate was much less than that of non-Indigenous young people. They were three times more likely to die as a result of an injury, particularly road crashes, suicides and assaults; experienced higher rates of chronic diseases such as asthma; had a higher incidence of hearing problems; and were more likely to contract a sexually transmitted infection than other young Australians. The proportion of young Aboriginal and Torres Strait Islander people who reported experiencing high or very high levels of psychological distress was more than double that of other young Australians. Research has also found that young Indigenous people were more likely to experience risk factors associated with poor health such as low levels of fruit and vegetable consumption, obesity (1.5 times higher), tobacco use (more than twice as high), physical inactivity, incarceration and lower levels of literacy and numeracy (National Youth Information Framework (NYIF) indicators AIHW). For many young 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 Aboriginal and Torres Strait Islander people were less likely than other young people to perceive their health as excellent or very good and more likely to rate their health as poor (Aboriginal and Torres Strait Islander health performance framework 2017 report).
In addition to identifying specific population groups who were not faring as well as others in terms of their health, various reports have also highlighted specific health issues of concern for young people due to their continued or increasing prevalence, particularly for the above mentioned population groups. The mental health status of young people is one area of ongoing concern. While the 2013–14 Young Minds Matter Survey reported that the majority of young people have good mental health, mental health disorders continue to be the greatest contributor to the burden of disease for young Australians. Mental health problems and illnesses affect an individual’s thoughts, emotions and behaviour. This impact, coupled with the stigma attached to mental disorders, can contribute to isolation and discrimination, both of which negatively affect social well-being. According to this survey 14 per cent of young people aged between 12 and 17 years had experienced a mental disorder in the past 12 months, with this disorder having a severe impact on the daily lives of 23 per cent of these young people. Anxiety disorders were the most commonly diagnosed disorders experienced by young people (7 per cent), followed by attention deficit hyperactivity disorder (6.3 per cent) and then major depressive disorders (5 per cent). However, responses provided by young people themselves suggested that the prevalence of major depressive disorders is likely to be underestimated, with 7.7 per cent of adolescents providing information that showed they met the diagnostic criteria for a major depressive disorder. In addition, nearly one in five (19.9 per cent) young people surveyed reported experiencing high to very high levels of psychological distress, with these feelings being four times higher for those with a major depressive disorder.

Various health reports have also highlighted behaviours related to self-harm and suicide as another area of ongoing concern in relation to young people’s health. Statistics on the causes of death in 2016 showed suicide (or intentional self-harm) was the leading cause of death for 15–24-year-olds, accounting for 12.3 deaths per 100 000 (Australian Bureau of Statistics). Rates were significantly higher for males than females (18.3 deaths per 100 000 males compared to 6.3 deaths per 100 000 females). The Young Minds Matter Survey found that 11 per cent of young people aged 12–17 years had engaged in self-harming behaviour and one in 10 young people aged 16–17 years reported having suicidal thoughts; 4.7 per cent of females and 2.9 per cent of males in this age group also reported having made a suicide attempt in the past 12 months. Significant differences were found between genders, with rates of suicidal behaviour consistently higher...
in females. Rates of self-harm, suicide ideation and suicide attempts were also markedly higher among those who self-reported a major depressive disorder. These findings demonstrate that mental health continues to be a key issue of concern for young Australians that needs to be addressed by communities, families and all levels of government.

Road-related injuries are another area of ongoing concern in relation to the health of young people. While road safety statistics from the Australian government show that the number of road-related deaths involving 15–24-year-olds has fallen faster than other age groups in recent years, the number of young people killed or seriously injured as a result of vehicle accidents remains high and they continue to be over-represented in road crash data. This is particularly the case for males, who are three times more likely to die and twice as likely to be hospitalised as a result of a road crash. The injuries suffered as a result of road trauma 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 take on a caregiving 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, such as chlamydia, with the number of notified cases of chlamydia increasing in the last nine years (Australia’s health 2016, p. 211).

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.

**FIGURE 1.19** Although the annual number of road death crashes per 100 000 for those aged 15–24 decreased significantly between 2002 and 2012, it remains higher than for all other age groups except those 75 years or older.

**SNAPSHOT**

Nearly 1 in 4 teens meet criteria for ‘probable serious mental illness’: Mission Australia report

By Mazoe Ford

Nearly 1 in 4 Australian teenagers meet the criteria for having a ‘probable serious mental illness’, a joint report from Mission Australia and the Black Dog Institute has found.
The Five Year Mental Health Youth Report presented findings from the past five Mission Australia youth surveys, during which thousands of adolescents answered questions on several topics, including mental health.

The report found that there are more people in the 15-to-19 age category in psychological distress than there were five years ago.

It also found girls were ‘twice as likely as boys to meet the criteria for having a probable serious mental illness’, and almost a third of Aboriginal and Torres Strait Islander respondents met that criteria, compared with 22.2 per cent for non-Indigenous youth.

Mission Australia chief executive Catherine Yeomans said the results were ‘alarming’.

‘The effects of mental illness at such a young age can be debilitating and incredibly harmful to an individual’s quality of life, academic achievement, and social participation both in the short term and long term,’ Ms Yeomans said.

‘Their main concerns are coping with stress, school and study problems, coping with depression and anxiety, and body image.’

Black Dog Institute director Helen Christensen said because adolescence was a time of great change, teenagers needed lots of support.

‘I think [the report findings] are considerably disturbing, and I think it speaks to the fact that perhaps [Australia] is not doing enough for young people as they go through adolescence,’ Professor Christensen said.

‘You can get some people who experience something more serious than the usual angst that most people go through when they’re growing up, and because of vulnerability, past traumas, or a number of other factors they’re kind of propelled into a deeper and more frightening space.’

Bex Vandersluis, 19, had a difficult upbringing during which she was shuffled between relatives’ homes, guardians’ homes and youth refuges.

She was diagnosed with depression and anxiety as a child and then post-traumatic stress disorder and disassociation as a 15-year-old.

‘I don’t really know what it’s like now to live without depression and anxiety,’ Miss Vandersluis told ABC News.

‘To the world you look like you’re OK, you have a face full of make-up and a smile on your face, you don’t look like you’re sad, but inside you feel a bit dead.’

Despite various interruptions to her education, Miss Vandersluis graduated from high school and is now completing an art course.

She eventually wants to become a prosthetic make-up artist and an advocate for mental health organisations.

‘There’s no reason to be ashamed of feeling hurt, scared, angry, or frustrated over anything because everyone copes with things in different ways,’ she said.

‘If I can help one person by telling my story, that’s what I want to do.’

More young people turning to the internet for support

The report revealed that teenagers were increasingly turning to the internet to help them deal with their troubles.

‘This might signal that we have a way to go to reduce the stigma of mental health issues, [because] young people are not prepared to admit they have a problem, so they’re looking for the anonymity of researching on the internet to try and seek help,’ Ms Yeomans said.

‘What we need to make sure is that when young people go to the internet they actually can find evidence-based, self-help tools and ways to refer to help and get the support they need.’

Above that, Mission Australia and the Black Dog Institute are calling for specifically funded, mental health programs in all Australian high schools.

‘If we don’t do anything we should expect these results to just continue to increase, so we need more early intervention and prevention resources for young people,’ Ms Yeomans said.

Professor Christensen said ‘schools are the perfect place to start making changes’.

‘At the moment we have a mixed bag of different programs that are offered throughout schools, [but] we think there should be a much more evidence-based, strategic approach to reducing depression and anxiety,’ she added.

Miss Vandersluis agreed that schools ‘need more awareness of what mental illness looks like and how to help’.

‘If people know how to recognise it and what to do in those situations we can stop the old way of keeping mental health behind closed doors, like we should be ashamed to feel bad. We shouldn’t.’

Application
Examining key health issues of concern for young people

1. Undertake research on the prevalence of and trends in relation to:
   (a) mental health disorders among young people
   (b) behaviours in relation to mental health.
   Use at least two of the following resources for this research:
   • Read the above snapshot ‘Nearly 1 in 4 teens meet criteria for “probable serious mental illness”: Mission Australia report’.
   • Watch the video using the Young minds matter video weblink in the Resources tab.
   • Read the highlights of the survey using the Highlights: Mental health of children and adolescents weblink in the Resources tab.

2. Write a summary of your findings. Make sure it includes the following three headings:
   • Good news about the mental health and mental health behaviours of young Australians
   • Areas of concern about the mental health and mental health behaviours of young Australians
   • Groups of concern and reasons for this concern

3. Suggest reasons why a significant number of young people are reporting that they experience high levels of distress.

4. Outline the potential impact (both short and long term) of mental illness at a young age on:
   (a) quality of life
   (b) academic achievement
   (c) relationships and social participation.

5. Research the prevalence of and trends in relation to road injuries among young drivers by using the Young adult road safety — a statistical picture weblink in the Resources tab. Complete a summary similar to the one done in question 1. Make sure it includes the following three headings:
   • Good news about road injuries and deaths in relation to young Australians
   • Areas of concern about road injuries and deaths in relation to young Australians
   • Groups of concern and reasons for this concern

6. Propose reasons for the decline in road deaths and the increase in hospitalisations for road crash injuries evident in the graphs presented in the Young adult road safety — a statistical picture weblink in the Resources tab.

7. Discuss why injuries and mental health are two of the leading health issues faced by young people.

Resources

- Weblink: Young minds matter video
- Weblink: Highlights: Mental health of children and adolescents
- Weblink: Young adult road safety — a statistical picture

1.3.2 Protective behaviours and risk behaviours

Adolescence is a period of transition 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:

- 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

Health issues to consider could include:

- healthy eating habits/healthy body weight
- mental health
- sexual health
- drug use
- physical activity
- injuries
- road safety.

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:

- accumulate at least 60 minutes of moderate to vigorous intensity physical activity every day
- include a variety of aerobic activities in the physical activity they do, including some vigorous intensity activity
- limit the time they spend being entertained by electronic media (for example, television, seated electronic games and computer use) to no more than two hours a day
- look at breaking up long periods of sitting as often as possible
- 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 cardiovascular 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) 2015 measured and reported on a range of health behaviours relating to dietary patterns, eating habits, physical activity and fitness. Key findings relating to physical activity from SPANS 2015 include:

• 11.5 per cent of adolescents met the guideline of 60 minutes per day of moderate to vigorous physical activity and 88.5 per cent did not undertake the recommended amount of daily activity
• 59 per cent of adolescents were in the healthy fitness zone for cardiorespiratory fitness
• 35 per cent of adolescents were in the healthy fitness zone for muscular fitness
• 36 per cent of young people followed the recommendation for spending no more than two hours a day on screen time on weekdays. This fell to 17 per cent on weekends, when 83 per cent exceeded the recommendations.

**Inquiry**

**Trends in relation to young people’s participation in physical activity**

1. Use the **NSW SPANS summary report** weblink in the Resources tab to research the prevalence of and trends in the physical activity patterns of young people in NSW. Read the sections on physical activity and sedentary behaviour of secondary students.

2. Download a digital version of table 1.3 below using the **Summary table of health behaviours of young people** weblink in the Resources tab or draw up your own using the model provided. This table will be used for many of the inquiry activities in the following sections.

3. Record the findings of your research in a copy of table 1.3 to show the prevalence of and trends in various health behaviours of young people. Use the spaces provided to make notes on any variations found between different groups of young people (e.g. low and high SES groups).

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

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

### Resources

- **Weblink: NSW SPANS summary report**
- **Digital document: Summary table of health behaviours of young people (doc-26159)**

**TABLE 1.3** Summary of research about health behaviours of young people

<table>
<thead>
<tr>
<th>Health behaviours</th>
<th>Risk or protective</th>
<th>Prevalence</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATTERNS OF PHYSICAL ACTIVITY</td>
<td></td>
<td></td>
<td>(up, down, no change)</td>
</tr>
<tr>
<td>Percentage who did 60 minutes or more of moderate to vigorous physical activity every day</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Percentage in healthy fitness zone for cardiorespiratory endurance</td>
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<td></td>
<td></td>
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<tr>
<td>Percentage who did not meet recommendations on daily limits on screen time on weekday</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Percentage who did not meet recommendations on daily limits on screen time on weekends</td>
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<tr>
<td>Differences between groups of young people (e.g. from different cultural backgrounds, locations, socioeconomic status)</td>
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</tbody>
</table>

**HEALTHY EATING AND DIETARY BEHAVIOURS**

| | Male | Female | Trend |
| | | | (up, down, no change) |

**Percentage who met recommended daily vegetable intake**

(Continued)
### TABLE 1.3  
Summary of research about health behaviours of young people (Continued)

<table>
<thead>
<tr>
<th>Health behaviours</th>
<th>Risk or protective</th>
<th>Prevalence</th>
<th>Trend↑, ↓, – (up, down, no change)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage who met daily recommended fruit intake</td>
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<tr>
<td>Percentage eating snack foods such as cakes, muesli bars, and biscuits 3+ times a week</td>
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<td></td>
</tr>
<tr>
<td>Percentage who drank soft drink daily</td>
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<td></td>
<td></td>
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<tr>
<td>Percentage who ate breakfast every day</td>
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<td></td>
<td></td>
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<tr>
<td>Percentage who ate dinner in front of the TV five or more times a week</td>
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<tr>
<td>Percentage who ate a meal or snacks from a fast food outlet at least once a week</td>
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<tr>
<td>Differences between groups of young people (e.g. from different cultural backgrounds, locations, socioeconomic status)</td>
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</table>

#### WEIGHT STATUS

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Trend↑, ↓, – (up, down, no change)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage who were overweight or obese</td>
<td></td>
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<tr>
<td>Differences between groups of young people (e.g. from different cultural backgrounds, locations, socioeconomic status)</td>
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</tbody>
</table>

#### DRUG USE

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Trend↑, ↓, – (up, down, no change)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of 12–17-year-olds who had never smoked</td>
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<td></td>
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<tr>
<td>Percentage of 12–17-year-olds who smoked cigarettes in the last seven days</td>
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<tr>
<td>Percentage of 12–17-year-olds who smoked cigarettes in the last month</td>
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<tr>
<td>Percentage of 12–15-year-olds who drank alcohol in the last week</td>
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</table>

(Continued)
### TABLE 1.3 Summary of research about health behaviours of young people (Continued)

<table>
<thead>
<tr>
<th>Health behaviours</th>
<th>Risk or protective</th>
<th>Prevalence</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of 16–17-year-olds who drank alcohol in the last week</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Percentage of 12–15-year-olds who drank 5+ drinks in last week</td>
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<tr>
<td>Percentage of 16–17-year-olds who drank 5+ drinks in last week</td>
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<tr>
<td>Percentage of 12–17-year-olds who used cannabis in the last week</td>
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<tr>
<td>Percentage of 12–17-year-olds who used ecstasy in the last four months</td>
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<tr>
<td>Differences between groups of young people (e.g. from different cultural backgrounds, locations, socioeconomic status)</td>
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</tbody>
</table>

#### SEXUAL BEHAVIOUR

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Trend</th>
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</thead>
<tbody>
<tr>
<td>Percentage who are sexually active</td>
<td></td>
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<td></td>
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<tr>
<td>Percentage who use contraception when having intercourse</td>
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<tr>
<td>Percentage who had more than one sexual partner in last 12 months</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Percentage who were drunk or high when they last had sex</td>
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#### HELP — SEEKING AND SOCIAL SUPPORT

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage who spoke to family when unhappy, sad or depressed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage who spoke to friends when unhappy, sad or depressed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage who spoke to no one when unhappy, sad or depressed</td>
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<td></td>
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<tr>
<td>Percentage who participated in voluntary work</td>
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</table>
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 5–5 ½ servings of vegetables and 2 servings of fruits each day. Findings from the 2015 SPANS report on the dietary habits of high school students were positive in regards to their intake of fruit, with approximately 80 per cent of adolescents 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, with only 11 per cent of high school students eating more than 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 2015 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, although the number of students consuming snack foods such as ice cream, cakes, muesli bars and chocolate had declined since the last survey in 2010. 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.

Findings in the 2015 NSW SPANS report indicated that a significant proportion of young people, particularly girls, did not eat breakfast, with 65.5 per cent of boys and only 53.7 per cent of girls consuming breakfast every day. The same survey found that just over 20 per cent of high school students ate their dinner in front of the TV on most days.

**FIGURE 1.24** Usual daily consumption of vegetables among secondary students by (a) girls and (b) boys, 2015


**FIGURE 1.25** Prevalence of eating breakfast daily among secondary students, by year group and gender, 2015

Inquiry

Trends in relation to healthy eating by young people
1. Use the NSW SPANS summary report weblink in the Resources tab to research the prevalence of and trends in relation to healthy eating by secondary students. Read the sections on food consumption and dietary behaviours.
2. Continue to record the findings of your research in your copy of table 1.3 from page 35 to show the prevalence of and trends in various health behaviours of young people. Use the spaces provided to make notes on any variations found between different groups of young people (e.g. low and high SES groups).
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
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. 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.

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/m²). 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 2015 SPANS survey found approximately 56 per cent of adolescents were in the healthy weight range, with 6.6 per cent underweight, 21.7 per cent overweight and 5.8 per cent in the obese range. These figures represented an increase in the prevalence of overweight and obesity among NSW secondary students since the previous SPANS survey, particularly among people from low SES backgrounds and students from certain cultural backgrounds.

Inquiry

Health issues relating to body weight
1. Use the NSW SPANS summary report weblink in the Resources tab to research the prevalence of and trends in relation to healthy eating by secondary students. Read the section on weight status.
2. Continue to record the findings of your research in your copy of table 1.3 from page 35 to show the prevalence of and trends in various health behaviours of young people. Use the spaces provided to make notes on any variations found between different groups of young people (e.g. low and high SES groups).
3. Explain health issues that young people who are overweight or obese could face:
   (a) during adolescence
   (b) during adulthood.
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.

The National Drug Strategy household survey in 2016 found that 94.1 per cent of 14–19-year-olds had never smoked. The prevalence of smoking among young people has continued to decline in recent years, with only 3 per cent of 14–19-year-olds smoking daily and 1.4 per cent being occasional smokers (see figure 1.26). 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

Cigarette smoking by young people and perceptions about smoking

1. Research the prevalence of and trends in relation to cigarette smoking by young people. You can use the Australian secondary school students’ use of tobacco, alcohol, and over-the-counter and illicit substances in 2014 report weblink in the Resources tab to read about the prevalence of smoking among 12–17-year-olds and trends in cigarette smoking by students. (Look in section 3 of the report.)
2. Continue to record the findings of your research in your copy of table 1.3 from page 35 to show the prevalence of and trends in various health behaviours of young people. Use the spaces provided to make notes on any variations found between different groups of young people (e.g. low and high SES groups).
3. Survey at least 10 different people (including at least five adults) and ask them to predict the percentage of 12–17-year-olds who have smoked cigarettes in the last week. Record the responses.
4. Compare their responses with the data from the Australian secondary school students’ use of tobacco 2014 report.
5. Discuss the accuracy of people’s perceptions about tobacco smoking by young people. Compare the accuracy of adults’ and young people’s perceptions and note any differences found. Suggest possible reasons for the perceptions that people have formed.
6. Propose ways to challenge inaccurate perceptions that exist about the prevalence of tobacco smoking by young people.

Drinking excessive amounts of alcohol is a major cause of injuries, 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 2016 National Drug Strategy household survey found that the proportion of young people aged 12–17 years who had consumed no alcohol in the past 12 months had continued to increase in the past 12 years, with 82 per cent abstaining in 2016 compared to 54 per cent in 2004. On another positive note younger age groups were found to have reduced their consumption of alcohol at risky levels (drinking more than four standard drinks on a single occasion in the past month) from 2013 to 2016. Single occasion risky drinking by those aged 12–17 years fell from 8.7 per cent in 2013 to 5.4 per cent in 2016 while rates also fell for 18–24-year-olds from 47 per cent to 42 per cent. However, those aged 18–24 years continued to be the age group most likely to exceed single occasion risk guidelines, and people in their late teens and early 20s remain the age group most likely to consume alcohol at very high levels, with 15.3 per cent reporting they had drunk 11 or more drinks on a single occasion in the past month.
FIGURE 1.28 Trends in drinking behaviour by young people

(a) 12–15-year-olds
- Current drinkers (has drunk alcohol in past seven days)
- Five or more drinks (on a single occasion in past seven days)

(b) 16–17-year-olds
- Current drinkers (has drunk alcohol in past seven days)
- Five or more drinks (on a single occasion in past seven days)


The Australian secondary school students’ use of tobacco, alcohol, over-the-counter and illicit substances in 2014 report found a decline in the proportion of high-school-aged students who had consumed alcohol in the past week and who had consumed five or more drinks on one occasion. The report also noted a positive trend in the number of students who had never consumed alcohol, with this figure rising from 18 per cent in 2008 to 32 per cent in 2014.

Inquiry
Alcohol consumption and young people
1. Research the prevalence of and trends in relation to alcohol consumption by young people. Use the graphs provided in figure 1.28 and the Australian secondary school students’ use of tobacco, alcohol, and over-the-counter and illicit substances in 2014 report weblink in the Resources tab to read about the prevalence of and trends in relation to alcohol consumption among 12–17-year-olds. (Look in section 5 of the report.)
2. Continue to record the findings of your research in your copy of table 1.3 from page 35 to show the prevalence of and trends in various health behaviours of young people. Use the spaces provided to make notes on any variations found between different groups of young people (e.g. low and high SES groups).
SNAPSHOT

Don't believe the hype, teens are drinking less than they used to

By Michael Livingston, UNSW, and Amy Pennay, University of Melbourne

Ask your friends and colleagues about young Australians and alcohol and I bet they'll say something about a generation out of control or a binge-drinking epidemic.

The media regularly brings the worst outcomes of young people's drinking to our attention and points to a problematic drinking culture supposedly unique to young Australians. Little wonder people believe things have never been so bad.

The reality is startlingly different. Data recently released by the Australian Bureau of Statistics shows alcohol consumption in Australia has reached its lowest point since the early 1960s, having declined steadily since the mid-2000s. Survey data suggests this decline has been driven almost entirely by reductions in youth drinking.

According to the National Drug Strategy household survey, the proportion of 12- to 15-year-olds who reported any drinking in the past year halved, from 35 per cent in 2004 to 18 per cent in 2013. Over the same time, drinking by 16- to 17-year-olds fell sharply as well, from 81 per cent to 59 per cent.

In case you think there must be something wrong with this survey, results from the Australian secondary students alcohol and drug survey show similar trends. Between 2002 and 2011, drinking in the past week fell by more than half for 12- to 15-year-olds (from 29 per cent to 11 per cent) and nearly as sharply for 16–17-year-olds (48 per cent to 33 per cent).

Rates of heavy drinking have fallen as well. Teenagers in Australia are drinking less alcohol now than they have at any time since these surveys began in the early 1980s.

There is increasing evidence that these patterns are holding as this cohort of teenagers moves into young adulthood, with weekly risky drinking among 18- to 24-year-olds dropping from 32 per cent to 22 per cent between 2010 and 2013. Declines in drinking are occurring for boys and girls, across all socioeconomic groups and in regional and urban areas. The changes are not isolated in particular population sub-groups.

Remarkably, these trends seem to be part of a global shift. A recent paper identified significant declines in underage drinking in 20 of the 28 countries studied. In countries with similar drinking cultures to Australia such as the United Kingdom, Canada, and Sweden, teen drinking has halved.

Somewhat surprisingly, little attention has been paid to these trends or the reasons behind them. Based on Australian data, we can be reasonably confident that young people aren't shifting to illicit drugs instead of alcohol. Rates of cannabis and meth/amphetamine use have also declined in the past decade.

Similarly, it doesn't seem likely that major policy changes have caused the trends. The decline in youth drinking started well before the alcopops tax in 2008, and alcohol has become more widely available and promoted in recent years.

Attitudes to alcohol have clearly been shifting in Australia, with greater support for restrictive policies, more negative media coverage and increasing public concern. These attitude shifts may be driving the declines in youth drinking, although it is notable that drinking among Australians older than 30 remains unchanged.

It may be that decades of public education campaigns and school programs focusing on youth drinking have finally been effective, but the broader research literature suggests this is unlikely.

The global consistency of the trends suggests a broader shift in youth cultures might be driving change. One possibility is that the increase in the use of social media has altered the way young people interact, reducing the centrality of drinking in socialising. The impact of the internet and social media in young people's lives has increased enormously in recent years. But there is little research into how these changes have affected drinking.

Research has also shown that exercising, eating well and avoiding alcohol and other drugs are important lifestyle choices for many young people. An increasing focus on healthy living may be an important factor in declining youth drinking.

The declines in youth drinking may have been caused by a combination of all of these factors. Further research is crucial so that current trends can be supported through appropriate interventions.

The recent dramatic reduction in teenage drinking is good news for public health, and is a refreshing counter-argument to the way young Australians are often presented.

Source: The Conversation, 21 May 2015.
Application
Drinking behaviour of young people

Read the snapshot article ‘Don’t believe the hype, teens are drinking less than they used to’ and then complete the following.

1. The article suggests that most people believe teenage drinking is ‘out of control or a binge-drinking epidemic’. Do you agree that this is the commonly held perception of young Australians and alcohol? Give reasons to support your opinion.

2. Discuss the role of the media in the perceptions people form of youth drinking.

3. What reasons are proposed for the decline in drinking by teens? Do you feel there are other factors that have contributed to the fall in teen drinking?

4. Consider why it is important for people to have more accurate perceptions of youth drinking.

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 2016 National Drug Strategy household survey indicate that 22.2 per cent of those aged between 14 and 19 years had used an illicit drug at some time in their lives, with 4 per cent reporting they had used an illicit drug in the previous week. As shown in table 1.4 the use of illicit drugs by young people has gradually declined in recent years, although the prevalence of drug use continues to be higher among males than among females. Cannabis was the most commonly used illicit drug, with just over 12 per cent of teenagers reporting they had used cannabis in the last 12 months.

<table>
<thead>
<tr>
<th>TABLE 1.4</th>
<th>Trends in rates of recent illicit drug use by young people (a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year (percentage)</td>
</tr>
<tr>
<td>Males</td>
<td></td>
</tr>
<tr>
<td>12–17</td>
<td>11.1</td>
</tr>
<tr>
<td>18–24</td>
<td>36.1</td>
</tr>
<tr>
<td>Females</td>
<td></td>
</tr>
<tr>
<td>12–17</td>
<td>12.8</td>
</tr>
<tr>
<td>18–24</td>
<td>29.0</td>
</tr>
</tbody>
</table>

(a) Recent use = used in last 12 months

Source: Data extracted from Australian Institute of Health and Welfare, National Drug Strategy household survey 2016, data table, chapter 5 Illicit use of drugs, table 5.5.
Inquiry

Trends in cannabis and ecstasy use by young people

1. Research the prevalence of and trends in relation to the use of cannabis and ecstasy by young people. Use the Australian secondary school students' use of tobacco, alcohol, and over-the-counter and illicit substances in 2014 report weblink in the Resources tab to download and read about the prevalence of and trends in relation to cannabis use (section 6.3) and ecstasy use by 12–17-year-olds (section 6.10).

2. Continue to record the findings of your research in your copy of table 1.3 from page 35 to show the prevalence of and trends in various health behaviours of young people. Use the spaces provided to make notes on any variations found between different groups of young people (e.g., low and high SES groups).

Behaviours relating to sexual activity

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 Fifth national survey of Australian secondary students and sexual health 2013 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 (69 per cent). The proportion of students who had engaged in sexual intercourse had decreased since the previous survey in 2008, with 23 per cent of year 10 students and 50 per cent of year 12 reporting they had participated in sexual intercourse. Over a third of those surveyed had either given or received oral sex. Around 39 per cent of sexually active students reported having more than one sexual partner in the past 12 months, with this number representing a fall of 6 per cent since the previous survey in 2008. 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 (14 per cent compared to 4 per cent). Participating in casual sexual encounters and having multiple partners are risk behaviours that increase the possibility of contracting an STI.

A number of young people reported being under the influence of drugs when they participated in sexual activity, with 17 per cent being drunk or high the last time they had sex. A significant number of young people who reported having sex when they did not want to stated that being drunk was the reason for their unwanted sex (49 per cent), with a further 20 per cent indicating they were too high.

The inconsistent use of contraception by sexually active young people is another behaviour that places their health at risk. The Fifth national survey of Australian secondary students and sexual health 2013 found that most sexually active students used some form of contraception during their last sexual encounter, with 87 per cent indicating they had used some contraceptive method. However, the use of condoms had fallen since the last survey in 2008 (58 per cent in 2013 compared to 68 per cent in 2008), as had the use of the contraceptive pill (39 per cent compared to 50 per cent). Of particular concern was the increasing number of young people using the withdrawal method as a form of contraception. The finding that over 15 per cent used the withdrawal method represented an increase of nearly 6 per cent from the 2008 survey. Knowing a partner’s sexual history (32 per cent), trusting a partner (31 per cent), and not liking condoms (30 per cent) were the most common reasons given for not using a condom at the last sexual encounter, along with other types of contraception (such as the pill) being used instead of a condom.

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 Fifth national survey of Australian secondary students and sexual health 2013 only 52 per cent of young women reported having been vaccinated against HPV, with nearly 32 per cent unsure. Among males only 10 per cent indicated they had been vaccinated, with the majority (53 per cent) uncertain.

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 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 Australian Bureau of Statistics 2014 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, while 42 per cent of 15–17-year-olds indicated they had participated in some form of voluntary activity in the past 12 months. 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
- 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 a leading cause of death and injury for young people. Australia’s health 2016 showed that transport accidents were the main cause of hospitalisations for young males and the third most common reason for females being admitted. As reported earlier in this topic, young drivers continue to be over-represented in road crash statistics despite a decline in the number of deaths. The reasons for the disproportionate number of young drivers in crash data are complex and interrelated. They include:
• a lack of experience  
• limited ability and judgement  
• underestimation of risks  
• deliberate risk-taking behaviours such as speeding  
• use of alcohol and drugs  
• frequently travelling at times of higher risk such as late at night and in the early hours of the morning.

In 2016 New South Wales drivers aged 17–25 years were the group most likely to be speeding when involved in any type of crashes (fatal, serious injury, minor injury). Male drivers in this age group were three times more likely to be speeding than females of the same age in crashes that led to injuries and over four times more likely when the crash resulted in death. Fatigue was another key contributing factor for crashes involving drivers aged 21–25 years, with the number of males significantly higher than females, particularly in fatal crashes.

**SNAPSHOT**  
**Young driver crashes: the myths and facts**  
By Teresa Senserrick, UNSW

Many Australians will recognise young driver crashes as a serious problem. However, few might realise that crashes are the leading cause of death and acquired disability of young Australians, during the otherwise healthiest stage of life (rivalled only by suicide in late adolescence).  
Youth aged 17–25 comprise 13 per cent of the Australian population, but 22 per cent of the annual road toll.  
They are more likely to go to hospital due to a crash than any other age group.  
While the statistics are confronting, the myths surrounding them are affronting. Having trained in developmental psychology, I was surprised to hear comments within the road safety community such as: they just think they’re invincible, there is nothing you can do about it, and their brains aren’t developed properly — following advances in brain imaging research.

**The ‘youth factor’ in crashes**  
The truth is that newly licensed drivers of any age have the highest risk of crashing in the months following the (very safe) learner period. They are novices of a very complex skill and, as with any complex skill, they make mistakes. Factor in that most new drivers are young and it follows that young people have more crashes.

Why then is this not readily accepted?

A ‘youth factor’ contributes to the high crash risk. The increased risk for young new drivers is higher than for older new drivers. However, it is questionable whether this is due to intentional or unintentional risks.

In all age groups a proportion of drivers intentionally break road rules; speeding is probably the most widely accepted example. Young drivers are no exception and are more likely to speed and break other such rules than other age groups. Yet this still relates only to a minority.

Developmental factors, however, apply to all youth and particularly contribute to unintentional risks. During childhood, changes in the brain start to occur that strengthen neural connections. They allow quicker and more efficient travel of nerve impulses, as cognitive abilities become more localised to certain brain areas.

It is during middle adolescence — when new licensed driving typically begins — that this process reaches the frontal lobe of the brain. This area is associated with functions such as controlling impulses, overriding emotions and anticipating consequences — all extremely important for ensuring safe driving. This process continues into the early 20s.

Sleep needs also increase at this time, to around nine hours. The hormone that helps bring on sleep is released later at night, around 11pm. With lifestyles typically demanding earlier bed times and rise times, these changes result in youth being prone to fatigue. This is reflected in their over-representation in fatigue and fall-asleep crashes.

Adolescence is also a time of important social shifts, including decreased dependence on parents and greater standing of peers. For reasons such as social outings and casual work, young people drive more at night than adults, which is a higher crash risk time for all drivers. Therefore youth are more likely to be in a crash simply by when they choose to drive.

Adolescent brains are therefore developing ‘properly’ and in important ways, including changes that facilitate leaving home and moving into the adult workforce. Yes this results in intentional ‘pushing the limits’ for some. However, for all, everyday factors such as hazards and distractions are not as easy to perceive and manage compared to older drivers.

What then can we do?
Moving towards safer roads
Calls for mandatory driver training are common. However, traditional programs fail to focus on these key factors. Often they target advanced vehicle handling skills in imminent crash scenarios, which, contrary to expectations, are shown to increase crashes. Such complex skills cannot be mastered in a day. Nor can they be applied effectively without practice, yet these skills might be needed months later.

Such approaches increase young drivers’ judgement of their skills beyond their actual ability. This results in more rather than less risk being accepted when driving.

Alternatively, licensing conditions for new drivers — including restrictions on night driving and peer passengers — serve to reduce exposure to high-risk conditions. Contrary to some beliefs, they do not punish all for the sake of the intentionally risky few, but rather address inexperience and developmental limitations. They have proven to be the single most successful initiative in reducing youth crash casualties.

With increased cries of ‘the nanny state’ and a current federal inquiry into restrictions on ‘personal choices’, it is timely to increase general understanding of the young driver problem (rather than the problem young driver). Through this, we should support initiatives that protect youth during an important stage of development while they learn an also important but complex life skill.

Source: The Conversation, 1 December 2015.

Inquiry
Challenging perceptions about driving behaviour of young people
Read the snapshot ‘Young driver crashes: the myths and facts’ and then complete the following.

1. What reasons are typically put forward by the road safety community for young driver crashes?
2. The author argues that the ‘youth factor’ needs to be considered when investigating why new drivers are more likely to be involved in crashes.
   (a) Define the term youth factor.
   (b) Outline the youth factors that contribute to risk behaviours by young drivers.
3. Explain why the author feels it is important to challenge the perception that road crashes involving young people are due to intentional rather than unintentional risks.

Behaviours relating to acquiring knowledge and accessing help
Health literacy skills provide individuals with the ability to access, understand and use health information and services. Developing these skills will enable young people to research health-related information and organisations and critically assess this information and services when making decisions that can promote and protect their health. This not only enhances their understanding of protective and risk behaviours, but also provides young people with a sense of empowerment over 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 accurate knowledge and appropriate attitudes with the adoption and maintenance of health protective behaviours. The Young Minds Matter Survey found that 18 per cent of young people reported they had used services for information on mental health issues, self-help strategies, chat rooms and personal support and counselling for emotional and behavioural problems. These services included telephone counselling services, such as Kids Helpline, online services such as Reachout and eheadspe, and face-to-face health services.

However, various studies have shown gaps in young people’s knowledge of issues relevant to their health. For example, the Fifth national survey of Australian secondary students and sexual health 2013 found young people’s knowledge of specific sexually transmitted infections, other than HIV, and their effects on health was generally poor, with just over half of students in the survey (60 per cent) knowing that chlamydia, the most common STI in young people, could affect both men and women. Less than half (46 per cent) were unaware that genital herpes had no cure, so once infected a person would always have the virus. The Report on the
second Australian child and adolescent survey of mental health and wellbeing found that a key barrier to help seeking by young people with depression was being unsure if they had a problem.

Research has also found that young people can find it difficult or be reluctant to seek help when needed. The NSW school students health behaviours survey 2014 found that approximately 42 per cent of young people spoke to no one when they were unhappy, depressed, stressed or under pressure. This figure rose to 50 per cent when they were in some form of trouble because of their behaviour. Males were far less likely to seek help when psychologically distressed, with females seeking advice more readily, particularly from friends. The Young Minds Matter Survey also found a reluctance among young people, particularly males, to seek help with 52 per cent of 13–17-year-old males indicating they had received informal support for emotional or behavioural problems, while 48 per cent said they had not. These findings highlight that a significant number of adolescents find it difficult to seek help and support.

![FIGURE 1.33 Person secondary school students aged 12-17 years, NSW, spoke to about psychological distress (a) 2014, (b) 2011 and (c) 2008](image-url)
The report found that a number of barriers prevented young people who reported having a major depressive disorder from seeking help. The most common barriers were being worried about what others might think or not wanting to talk to a stranger (62.9 per cent), believing the problem would get better by itself (61.7 per cent) and preferring to work out the problem themselves or with the help of family and friends (57.1 per cent).

**Inquiry**

Understanding the help-seeking behaviours of young people

1. Look at the three graphs in figure 1.33 and use them to understand the prevalence of help-seeking behaviours by young people.

2. Record the findings in your copy of table 1.3 from page 35 to show the prevalence of and trends in various health behaviours of young people.

**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, a study on risk and protective factors for depression (Cairns et al.) found alcohol consumption, drug use, unhealthy diet and negative coping strategies to be risk behaviours associated with depression, while a healthy body weight and nutritious diet and good sleep patterns served as protective behaviours that reduced the risk of depression.

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. The 2015 Young
people in custody health survey reported that the prevalence of a range of health risk behaviours was significantly higher among those in juvenile detention, including higher rates of unsafe sexual practices, smoking, problematic alcohol consumption and illicit drug use. This group therefore tended to be much more likely to experience poorer health, with higher rates of sexually transmitted infections, assault injuries, suicidal behaviour and mental disorders than other young people. 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.

**Application**

**Behaviours that interact to increase or decrease young people’s health risks**

1. Divide the class into groups of 3–4. Each group is allocated one of the following health issues relevant to young people:
   - sexually transmitted infections
   - mental health problems
   - self-harm/suicide
   - road-related injuries
   - overweight or obesity.

2. Each group is to identify behaviours that can interact to:
   a. increase the risk of experiencing their allocated health issue
   b. decrease the risk of experiencing their allocated health issue.

3. Each group is to discuss how these behaviours interact to protect or jeopardise the health of young people.

4. Each group is to present its ideas to the class.

**Weblink:** NSW school students health behaviours survey 2008, 2011, 2014

**1.4 Topic review**

**1.4.1 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 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 connectedness 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.

1.4.2 Questions

Revision
1. Use examples to discuss how and why people’s health is constantly changing. (P3) (5 marks)
2. Describe 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 well-being. (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 400.
1.4.3 Key terms

**alternative medicine** refers to various medical methods and practices that are not recognised as being conventional or traditional approaches to medicine. *p. 20*

**binge drinking** refers to the consumption of excessive amounts of alcohol in a short period of time. It commonly involves drinking to get drunk. *p. 42*

**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. *p. 40*

**cardiovascular disease** refers to disease that affects the heart or blood vessels. *p. 34*

**chlamydia** is a sexually transmitted bacterial infection that can be passed on through unprotected sex and can cause infertility. *p. 30*

**chronic** means persisting over a long time, such as a long-term disease or illness. *p. 25*

**connectedness** refers to the sense of belonging or attachment an individual feels towards people and places they are frequently in contact with. *p. 47*

**dental dam** a rectangular piece of latex that acts as a barrier between the mouth and genital area. *p. 46*

**dynamic** nature of health refers to the constant fluctuations that occur in our level of health. *p. 10*

**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). *p. 38*

**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. *p. 47*

**illicit drugs** are drugs that are illegal to use, possess, produce or sell. The most commonly used illicit drugs include cannabis, ecstasy and amphetamines. *p. 45*

**life expectancy** is the average number of years of life remaining to a person at a particular age, based on current death rates. *p. 16*

**mental or emotional health** is a state of well-being where we can realise our full potential, cope with the normal stresses of life, work productively and make a contribution to the community. *p. 7*

**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. *p. 29*

**morbidity** is the incidence or level of illness or sickness in a given population. *p. 16*

**mortality** is the number of deaths in a given population from a particular cause and/or over a period of time. *p. 16*

**obese** is defined as a body mass index of 30 or over. *p. 40*

**osteoporosis** is a musculoskeletal condition in which there is deterioration in the bone structure, leading to an increased risk of bone fracture. *p. 34*

**overweight** is defined as a body mass index of 25 or over. *p. 40*

**perception** refers to the way something is seen or viewed by an individual or group. *p. 11*

**physical health** is the wellness of the body and the absence of chronic pain or discomfort. *p. 6*

**protective behaviours** are those health behaviours that are likely to enhance a person’s level of health. *p. 32*

**relative nature** of health refers to how we judge our health compared to other people or other points of time in our life. *p. 9*

**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. *p. 47*
risk behaviours are those health behaviours that have been found to contribute to the development of health problems or poorer levels of health. p. 32
sedentary refers to a lack of regular physical activity and spending a lot of time sitting or resting. p. 40
social construct 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. p. 17
social health is our ability to interact with other people in an interdependent and cooperative way. p. 7
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. p. 24
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. p. 18
spiritual health relates to a sense of purpose and meaning in our life, and to feeling connected with others and society. p. 7
stereotype is a simplified and fixed image, opinion or concept to which people may feel expected to conform. p. 16
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. p. 34
underweight is defined as a body mass index less than 18.5. p. 40