2. Physical and emotional health

Summary

> The majority of young Victorians (aged 15–24) rate their health positively. However, young Indigenous Australians give less positive health ratings.

> Immunisation coverage in secondary schools is lower than recommended levels. The notification rate of vaccine preventable illnesses in young people (aged 12–24) has declined (between 2000 and 2006). Rates in 20–24 year olds are consistently higher than in younger people.

> Asthma rates are higher in Victorian than in Australian young people (aged 12–17). Asthma hospitalisation rates are decreasing (in young people aged 10–24) and are lower in Indigenous young people.

> Cancer was the sixth overall lead cause of disease burden among 15–24 year olds in 2003. However, Victoria has a lower rate of cancer diagnosis than Australia.

> Melanoma is the most common form of cancer in young people aged 12–24, although the incidence is decreasing.

> The proportion of Victorian young people (aged 12) with dental decay is increasing. Indigenous young people (aged 12–16) have higher rates of decay.

> The evidence suggests that nearly one-third of young people are overweight or obese. Further data is needed to confirm whether the proportion of young people who are overweight or obese is increasing.

> National and state survey data show that males engage in higher levels of physical activity than females and that the level of physical activity declines with age for both genders. Only 22.9 per cent of young Victorians (aged 11–13) meet recommended physical activity levels.

> Information on the prevalence of eating disorders in Victoria is limited. However, a recent Victorian survey found that around 10 per cent of young women (who did not have a diagnosed eating disorder) reported that they experienced at least two symptoms associated with anorexia or bulimia at some point between adolescence and young adulthood.

> Less than a third of Victorian 12–18 year olds and less than a half of 19–24 year olds, meet recommendations for fruit consumption. Nearly 60 per cent of 12–18 year olds, and less than 10 per cent of 19–24 year olds meet recommendations for vegetable consumption.

> Birth rates among young women aged under 24 have remained fairly stable and Victoria has the second lowest rate nationally. Rates of young motherhood are higher among Indigenous women.

> The most common sexually transmitted infection (STI) is chlamydia. Rates are increasing nationally, but are lower in Victoria than Australia.

> A Victorian school-based survey shows that the proportion of young people (aged 12–17) who smoke cigarettes is declining. Nearly a quarter of 18–24 year olds in the Victorian Population Health Survey (VPHS) are current smokers. Smoking rates are higher among Indigenous young people.

> While most young people drink alcohol at responsible levels, trend data suggest there have been recent increases in the proportions of young people who drink at levels that risk short-term harm. Rates of alcohol-related hospital admissions have also increased in young people (aged 15–24). Thirty per cent of males (aged 22–24) admit to driving while under the influence of alcohol.

> Rates of illicit drug use among young people are very low, with the exception of cannabis. The use of cannabis is declining. Cannabis and alcohol are the most common drugs for which young Victorians seek treatment.

> The proportion of young Victorians (aged 18–24) experiencing high to very high levels of psychological distress has declined from 20.2 per cent in 2001 to 14.8 per cent in 2006. Survey data suggest that depressive symptoms are present in just under a third of young Victorians in Years 6 and 8 (HNSS).

> Young women account for the majority of self-harm injury hospitalisations. Suicide rates have declined steadily since 1990.

> Young people (aged under 25) in Victoria account for higher levels of community mental health care service contacts and residential mental health care than young people nationally.
Future Directions outcome areas

- Young people choose healthy lifestyles in communities that are inclusive and welcoming of their diversity

Lead measure:

- The health of young people will improve

The Outcomes Framework

- Adequate nutrition
- Free from preventable disease
- Healthy teeth and gums
- Safe from environmental hazards
- Healthy weight
- Optimal physical health
- Adequate exercise and physical activity
- Positive behaviour and mental health
- Healthy teenage lifestyle
- Healthy adult lifestyle
- Positive family functioning
- Adequate supports for vulnerable teenagers

A Human Rights Framework

- Health and wellbeing is a fundamental human right for all, and the rights of young people to enjoy the highest attainable standards of health are laid down in the UN Convention on the Rights of the Child

Most young Australians enjoy very good health and there have been enormous improvements in young people’s health over the past 20 years. However, the evidence shows that some groups, including young Indigenous people, young people from more socioeconomically disadvantaged backgrounds and young people from rural and regional areas, are not faring so well on a range of health measures (AIHW 2007).

The health of young people is affected by a wide range of individual, familial, neighbourhood, environmental, and socioeconomic factors, such as education, employment and income (AIHW 2005, 2007). Health-related behaviours that young people engage in during their adolescence and early adulthood can be important influences on both current and future health outcomes into adult life.

This report adopts the broad World Health Organisation (WHO) understanding of health as ‘a state of complete physical, mental and social wellbeing’. This kind of understanding reflects the complexity of factors that impact on health as well as some of the key themes that emerge in young people’s own accounts of what it means to be healthy. It also suggests that health is best understood as a continuum from poor to optimal health and that policy efforts in this area should focus on maximising good health as well as preventing ill health.

This chapter focuses on the health of young Victorians, looking at young people’s own perceptions of their health and at evidence relating to a range of health conditions. It also examines young people’s lifestyles and health-related behaviour. Other key factors that impact on health, such as socioeconomic status (SES) and housing, are covered in the next chapter.

For example, research suggests that young people link their sense of health and overall wellbeing with the quality of their social and emotional environments: with their family and friendship networks (see Department of Human Services 2006a).
2.1 Young people’s assessment of their health

It is encouraging, overall, that the majority of young Victorians rate their health positively. In Victoria, 68.8 per cent of young males (aged 15–24) and 71.6 per cent of females rate their health as either ‘excellent’ or ‘very good’. These health ratings of young Victorians are broadly similar to those of young people nationally, although young Victorian females are a little less likely (than young Australian females) to rate their health as ‘excellent’ (see figure 2.1).

Figure 2.1: Self-rated health status of young people aged 15–24 in Victoria, 2004–05

Indigenous young people

The National Aboriginal and Torres Strait Islander Health Survey (2004–05) shows that young Indigenous Australians are less likely (than non-Indigenous young Australians) to give positive ratings to their health (data cited in AIHW 2007). In 2004–05, 59 per cent of Indigenous young people (aged 15–24) rated their health as ‘excellent’ to ‘very good’, compared with 70 per cent of non-Indigenous young people. Young Indigenous people were also more likely (than non-Indigenous young people) to rate their health as ‘fair’ or ‘poor’.

Trends in self-reported health

There are increases, between 2001 and 2004, in the proportion of Indigenous and non-Indigenous young people with positive health ratings (excellent to very good). However, the differential, or percentage gap, between the ratings of Indigenous and non-Indigenous young people has not lessened over time (see table 2.1).

Table 2.1: Self-assessed health status of Indigenous Australians and all young Australians aged 15–24, 2004–05

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent to very good</td>
<td>54.0</td>
<td>64.0</td>
<td>59.0</td>
<td>70.0</td>
</tr>
<tr>
<td>Good</td>
<td>33.0</td>
<td>26.0</td>
<td>32.0</td>
<td>24.0</td>
</tr>
<tr>
<td>Fair or poor</td>
<td>13.0</td>
<td>9.0</td>
<td>9.0</td>
<td>7.0</td>
</tr>
</tbody>
</table>

Source: ABS 2006, National Health Survey 2004-05
2.2 Physical health

Immunisation and vaccine preventable illnesses

Notification of vaccine-preventable illnesses

There were 535 notifications of vaccine-preventable disease among young people aged 12–24 in Victoria in 2006 (representing a rate of 59.3 per 100,000 population in this age group).

The rate of notification of vaccine-preventable diseases in young people (aged 12–24) has declined overall (from 2000 to 2006). However, in 2005 rates of notification for hepatitis B increased among females. The rate of notifications among 20–24 year olds is consistently higher than the rate among 12–14 and 15–19 year olds.

Immunisation coverage

Vaccination plays a key role in reducing many bacterial and viral diseases. Evidence suggests that a minimum of 90 per cent coverage is required to interrupt the transmission of disease (AIHW 2005). Department of Human Services data show that coverage is lower than this for all the NHMRC recommended immunisations in secondary schools.

In 2006, 70 per cent of Victorian Year 7 students had completed immunisation against hepatitis B. The proportion of students with completed immunisation has varied from 71 to 78 per cent in the previous five years. A total of 72 per cent of Year 7 students in Victoria in 2006 were immunised against varicella (chicken pox).

The proportion of Year 10 students completing immunisation against diphtheria and tetanus has been fairly stable (from 2001 to 2006), at between 76 and 78 per cent (78 per cent in 2006).

Cancer

Although cancer among young people is relatively uncommon, this was the sixth overall lead cause of disease burden among 15–24 year olds in 2003 (with the leading cause being mental disorders). Death rates from cancer have decreased between 1995 and 2004. However, improvements in cancer outcomes for young people have been less marked than for children and older adults (AIHW 2007).

Melanoma, Hodgkin’s disease and cancer of the testis are the most frequently occurring cancers among young people. Victoria has a lower rate of cancer diagnosis than Australia, particularly among young people aged 20–24 (see figure 2.2).

Figure 2.2: Rates of cancer diagnosis per 100,000 young people in Victoria and Australia, 2001

Source: The Victorian Cancer Council Epidemiology Centre (data available on request) and AIHW and Australian Association of Cancer Registries 2004

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18 Varicella (or chicken pox) immunisation began in 2006 in Victoria for non-immune young people. Of all Year 7 students, 27 per cent were immunised. However, 45 per cent of eligible students had already been immunised against varicella or were considered immune following a varicella history of varicella. A total of 72 per cent of Year 7 students in Victoria in 2006 were therefore immunised against varicella.

19 Year 10 students were offered booster vaccinations against diphtheria and tetanus until 2003. This was replaced, in 2004, by the adult/adolescent booster dTpa (diphtheria tetanus acellular pertussis) vaccine. The proportion of students who have completed immunisation dTpa (78 per cent) includes students who have been immunised outside school (as well as those immunised in school).

20 When young people are compared with the general population.
Diabetes

Diabetes mellitus is a disease group characterised by high levels of glucose in the blood resulting from defects in insulin secretion, insulin action or both (WHO 1999). Diabetes is a serious chronic disease that can lead to a variety of major complications that are responsible for a loss of working ability, shortened life expectancy and a reduced quality of life.

Type 1 diabetes usually arises in childhood and lasts throughout life and is caused by an autoimmune disorder, resulting in destruction of the pancreatic cells that produce insulin. Treatment requires a daily injection of insulin (AIHW 2005). The cause of type 1 diabetes is unknown but it is believed exposure to environmental factors, toxins or viruses may contribute to this disease. An inherited component is also suspected, although a large number of cases occur with no family history. Race and ethnicity are also important factors which can contribute to this disease (AIHW 2002).

Type 2 diabetes is caused by reduced insulin production or the inability of the body to use insulin properly. Type 2 diabetes results from a combination of genetic, environmental and behavioural risk factors. This disease demonstrates a strong relationship with family history, although the genetic basis for this remains unknown. Race, ethnicity and age are also associated with an increased risk of developing type 2 diabetes. Other risk factors include overweight, obesity, physical inactivity, impaired glucose tolerance and poor nutrition. The risk factors for type 2 diabetes can be largely modifiable with a change in lifestyle including increased physical activity and modification of diet (AIHW 2002).

Victorian data on type 1 and type 2 diabetes mellitus are limited. However, the National Diabetes Register has shown that there was an incidence rate of new cases of type 1 diabetes in 15-25 year olds in Victoria of 15.2 per 100,000 people between 1999 and 2005. There is also evidence that the incidence of type 2 diabetes is increasing in younger people as 720 new cases of type 2 diabetes have been diagnosed between 1999 and 2005 in 15-25 year olds in Australia (Catanzanti et al. 2007).

Asthma

Asthma is one of the most common chronic diseases of young Australians. Its underlying causes are not fully understood. However, factors such as genetic traits, age and sex, diet and lifestyle may increase the risk of developing asthma. Females are more commonly affected than males.

The prevalence of asthma increased nationally during the 1980s and early to mid 1990s. However, recent evidence suggests that this trend has evened out in adults and may have reversed in children (AIHW Australian Centre for Asthma Monitoring 2005, cited in AIHW 2007).

Victorian data, for 18–24 year olds, point to a declining trend between 2001 and 2004 with rates falling from 19 per cent in 2001 to 11.8 per cent in 2004. However, there are increases in the proportion of young people with asthma in 2005 and 2006.

The proportion of young adults (aged 18–24) with current asthma is similar in Victoria to Australia (13.6 per cent of Victorian young adults have current asthma, compared with 12.9 per cent in Australia).

However, the proportion of young people (aged 12–17) with current asthma is higher in Victoria than nationally (15.2 per cent of Victorian 12–17 year olds compared with 12.3 per cent in Australia) (see table 2.2).

Table 2.2: Percentage of young people with current asthma

<table>
<thead>
<tr>
<th></th>
<th>Victoria</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12-17 years (%)</td>
<td>18-24 years (%)</td>
<td>12-17 years (%)</td>
<td>18-24 years (%)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>15.6</td>
<td>12.4</td>
<td>11.9</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>14.9</td>
<td>14.8</td>
<td>12.7</td>
<td>15.1</td>
<td></td>
</tr>
<tr>
<td>Persons</td>
<td>15.2</td>
<td>13.6</td>
<td>12.3</td>
<td>12.9</td>
<td></td>
</tr>
</tbody>
</table>

Source: ABS National Health Survey 2004–05. ABS data available on request

Complications from diabetes can arise quickly or develop over a number of years. Short-term complications include diabetic ketoacidosis, which is the result of a severe lack of insulin and low blood glucose (hypoglycaemia), and may lead to a coma and death within a short period (AIHW 2006). Diabetes can also result in a range of long-term complications. High blood sugar levels are known to damage important body organs and people with diabetes are more prone to heart disease, stroke, blindness, neurological problems and premature death (AIHW 2005).
Hospitalisation

Table 2.3 shows the top five diagnoses for hospital admissions for young people in Victoria in 2005–06. For young males (aged 10–14), the most common reasons for hospital admission are appendicitis, forearm fractures and asthma. For young girls they are tonsillitis, abdominal pain and appendicitis. In the older age groups the most common reasons for admission for males are dialysis, chemotherapy and schizophrenia, while for females it is abortions, tonsillitis and pregnancy-related issues.

Table 2.3: Top five diagnoses for hospital admissions for males and females in each age group, Victoria, 2005–06

<table>
<thead>
<tr>
<th>Gender and age</th>
<th>Diagnosis</th>
<th>Number of admissions</th>
<th>Rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male 10-14</td>
<td>Appendicitis</td>
<td>321</td>
<td>187.1</td>
</tr>
<tr>
<td></td>
<td>Bone fractures (forearm)</td>
<td>281</td>
<td>163.8</td>
</tr>
<tr>
<td></td>
<td>Asthma, unspecified</td>
<td>212</td>
<td>123.6</td>
</tr>
<tr>
<td></td>
<td>Tonsillitis</td>
<td>208</td>
<td>121.2</td>
</tr>
<tr>
<td></td>
<td>Bone fractures (elbow and forearm)</td>
<td>189</td>
<td>110.2</td>
</tr>
<tr>
<td>Male 15-19</td>
<td>Dialysis</td>
<td>617</td>
<td>360.6</td>
</tr>
<tr>
<td></td>
<td>Chemotherapy</td>
<td>297</td>
<td>173.6</td>
</tr>
<tr>
<td></td>
<td>Appendicitis</td>
<td>281</td>
<td>164.2</td>
</tr>
<tr>
<td></td>
<td>Follow-up care for fractures</td>
<td>239</td>
<td>139.7</td>
</tr>
<tr>
<td></td>
<td>Impacted teeth</td>
<td>238</td>
<td>139.1</td>
</tr>
<tr>
<td>Male 20-24</td>
<td>Dialysis</td>
<td>741</td>
<td>408.8</td>
</tr>
<tr>
<td></td>
<td>Chemotherapy</td>
<td>385</td>
<td>212.4</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia</td>
<td>363</td>
<td>200.3</td>
</tr>
<tr>
<td></td>
<td>Gastroenteritis and colitis</td>
<td>287</td>
<td>158.3</td>
</tr>
<tr>
<td></td>
<td>Appendicitis</td>
<td>252</td>
<td>139.0</td>
</tr>
<tr>
<td>Female 10-14</td>
<td>Tonsillitis</td>
<td>386</td>
<td>236.5</td>
</tr>
<tr>
<td></td>
<td>Unspecified abdominal pain</td>
<td>263</td>
<td>161.2</td>
</tr>
<tr>
<td></td>
<td>Appendicitis</td>
<td>247</td>
<td>151.3</td>
</tr>
<tr>
<td></td>
<td>Lower abdominal pain</td>
<td>180</td>
<td>110.3</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
<td>169</td>
<td>103.6</td>
</tr>
<tr>
<td>Female 15-19</td>
<td>Medical abortion</td>
<td>816</td>
<td>496.4</td>
</tr>
<tr>
<td></td>
<td>Tonsillitis</td>
<td>524</td>
<td>318.8</td>
</tr>
<tr>
<td></td>
<td>Impacted teeth</td>
<td>417</td>
<td>253.7</td>
</tr>
<tr>
<td></td>
<td>Abdominal pain</td>
<td>405</td>
<td>246.4</td>
</tr>
<tr>
<td></td>
<td>Paracetamol related overdose</td>
<td>342</td>
<td>208.1</td>
</tr>
<tr>
<td>Female 20-24</td>
<td>Medical abortion</td>
<td>1122</td>
<td>638.8</td>
</tr>
<tr>
<td></td>
<td>Other conditions complicating pregnancy</td>
<td>863</td>
<td>491.3</td>
</tr>
<tr>
<td></td>
<td>Dialysis</td>
<td>804</td>
<td>457.7</td>
</tr>
<tr>
<td></td>
<td>Child birth related complications</td>
<td>777</td>
<td>442.4</td>
</tr>
<tr>
<td></td>
<td>Child birth</td>
<td>683</td>
<td>388.9</td>
</tr>
</tbody>
</table>

Sources: Department of Human Services, Victorian Admitted Episodes Dataset (VAED) and ABS, Estimated Resident Population at 30 June 2005, ABS data available on request
Rates of hospital admission for Indigenous young people

Indigenous young people (aged 15–24) have higher rates of hospital admission than non-Indigenous young people. For young males (aged 10–14) the rate of hospital admission is 82 per 1000 for Indigenous males and 68 per 1000 for non-Indigenous males. For the older group of males aged 15–24 the rate of hospital admission is 131 per 1000 for Indigenous males and 99 per 1000 for non-Aboriginal males.

For young females (aged 10–14) the rate of hospital admission is similar for Indigenous females (53 per 1000) and non-Indigenous females (56 per 1000). However, in the older age group of females (aged 15–24) the rate of hospital admission is much higher for Indigenous females (372 per 1000) compared with 166 per 1000 for non-Indigenous females. The higher rates in Indigenous (than non-Indigenous) females are due to pregnancy-related admissions (Victorian Admitted Episodes Dataset (VAED) 2005–06 data, reported in Department of Human Services 2007a).

Trends in asthma hospitalisation

Asthma hospitalisation rates may reflect changes in the prevalence or severity of asthma, or in asthma management practices and hospital admission criteria (AIHW 2007).

Asthma hospitalisation rates in the total population of 10–24 year olds, in Victoria, have decreased between 2001–02 and 2005–06. Rates are lower among Indigenous than non-Indigenous young people (see figure 2.3). This finding is surprising given that asthma prevalence rates and asthma hospital separation rates are known to be higher among Indigenous young people nationally.

Figure 2.3: Hospital admissions for asthma per 100,000 young people aged 10–24 in Victoria

Source: Department of Human Services calculations based on Victorian Admitted Episodes Dataset, ABS 2004 (High Series) and ABS estimated resident population from 2001 to 2005, ABS data available on request

Note: The VAED counts admissions not individuals thus will include repeat admissions. The calculations used in this Figure use population estimates for the first year in the financial period, for example, 2004 estimates are used for the 2004-05 financial year, because population estimates are published one year in arrears.

There appears to be an increase in the rate of Indigenous young people hospital admissions from 2004-05 to 2005-06. However, these data should be treated with caution, as the numbers of Indigenous young people are small and this actually represents an increase from five to eight admissions. Furthermore, as the VAED counts admissions and not people, this increase could be due to one or two people being admitted more than once during the year.

Asthma hospitalisation rates are higher overall among females than males, and among 10–14 year olds than in young people aged 15–19 and 20–24. However, when the data are analysed by both age and by gender, this shows that admission rates are higher in males than females in the 10 to 14-year age group, and higher in females than males in the two older age groups.
2.3 Staying healthy and healthy lifestyles

Dental health

There are significant gaps in knowledge about the oral health status of young people (aged 12–24) (particularly for young people aged 15 and over) and a lack of Victorian-specific data.

The oral health of Australian adolescents (aged 12–14) compares very favourably with that of young people from other OECD countries (Armfield and Slade 2006, Office for National Statistics 1998, Slade et al. 2007, WHO 2007). It has improved over time owing to an increasing use of fluoride and to the School Dental Scheme Service. However, there has been a recent increase in the proportion of young people (aged 12–15) with tooth decay (AIHW 2007). This may be linked to changes in diet.

National data also suggest that oral health appears to worsen as children become young adults. Almost two thirds (64.1 per cent) of young adults (aged 15–24) have experienced some dental caries, compared with 36.7 per cent of 12 year olds. Untreated dental decay accounts for 25 per cent of the disease experience in 15–24 year olds and nearly one in five (18.5 per cent) have at least one tooth missing due to dental disease (Slade et al. 2007).

Victoria’s School Dental Service

In Victoria, Dental Health Services Victoria (DHSV) operates the School Dental Service which offers dental care to all primary school children and eligible adolescents in Years 7 and 8, in fixed and mobile dental clinics across the state.

In 2006–07 DHSV invested more than $61.9 million in purchasing dental services from 60 external agencies. These agencies are responsible for delivering the Community Dental Program through community-based dental clinics across the state. DHSV also aims to raise awareness of oral health issues among the broader Victorian community through health promotion programs and advocacy activities.

In 2006–07, more than 209,271 adults and 95,294 children from rural, regional and metropolitan Victoria received general and specialist care from DHSV. DHSV services are available to all Victorians who hold a pension, concession or healthcare card, and their dependants.

The national trend towards increasing proportions of adolescents with tooth decay appears to be reflected in Victoria (see figure 2.4). The figure shows a decrease in the percentage of Victorian children aged 12 attending school dental services who are decay free, from 64 per cent (in 2001) to 57.7 per cent (in 2005).

Figure 2.4: Percentage of children attending school dental services whose teeth are decay free at age 12 across Victoria

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage decay free</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>100</td>
</tr>
<tr>
<td>2002</td>
<td>90</td>
</tr>
<tr>
<td>2003</td>
<td>80</td>
</tr>
<tr>
<td>2004</td>
<td>70</td>
</tr>
<tr>
<td>2005</td>
<td>60</td>
</tr>
</tbody>
</table>

Source: Dental Health Services Clinical Analysis and Evaluation Unit, Dental Health Services Victoria

Surveillance and data collection has focused principally on primary school aged children through the School Dental Scheme Service.

The DMFT is a score that is commonly used to describe an individual’s, group or population’s dental caries experience. At any one time a person can have decayed (current untreated decay), filled or missing due to caries teeth. The sum of each of these i.e. number of decayed + number of filled + number of missing teeth, is the total (cumulative) dental caries experience to that point. The decayed component (the D) is the number of teeth that have decay but are at that time untreated. The D score could be the same or less than a total DMFT score. If it is less it does not indicate an individual’s total experience of decay.
Table 2.4 suggests that the prevalence of dental caries among young people is similar in Victoria to nationally. However, there are no Victorian data for the 15 to 24-year age group.

Table 2.4: Caries experience data for young people aged 12, 14 and 15-24

<table>
<thead>
<tr>
<th></th>
<th>12 year olds</th>
<th>14 year olds</th>
<th>15-24 year olds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DMFT</td>
<td>% DMFT=0</td>
<td>DMFT</td>
</tr>
<tr>
<td>Vic</td>
<td>0.93</td>
<td>59.1</td>
<td>1.54</td>
</tr>
<tr>
<td>Aust</td>
<td>0.83</td>
<td>63.3</td>
<td>1.29</td>
</tr>
</tbody>
</table>

Source: Armfield and Slade 2006; Slade et al. 2007

Indigenous young people

Indigenous young Victorians (aged 12–16) have a much lower rate of decay free or no decay experience than other young people in the same age group. The relationship also holds true when Aboriginal and Torres Strait Islander (ATSI) young people are compared with young people who would be considered as low SES (as defined by holding a Health Care Card (see figure 2.5). This suggests that the poorer dental health of Indigenous young people cannot be explained by SES.

Figure 2.5: Percentage of young people, 12–16 years of age, decay free or with no decay experience, (pooled data) 2003–05

Source: Dental Health Services Clinical Analysis and Evaluation Unit, Dental Health Services Victoria

Variations between subgroups in level of dental caries

Greater levels of dental caries are also seen in those young people who report only attending dental services for a problem, who leave school early and those who are eligible for public dental care (Roberts-Thomson & Do 2007). Urban youth have lower levels of reported extractions and more fillings and ‘scale and cleans’ than rural and remote youth (Slade et al. 2007). These findings may be linked to the lower usage of dental services among rural young people.

There are no Victorian, national (or international) data on the oral health of young people with special health care needs (SHCNs). There are also no reliable data on the oral health of migrant young people in Victoria.
Young people’s use of dental services

There are no Victorian data on young people’s views on the use of dental services or on their tooth-cleaning behaviour. While 63 per cent of young Australians attend the dentist at least once a year, there is a significant minority who could be considered outside the dental care system. These individuals are highly likely to be eligible for public dental services and attend only when a problem occurs (Spencer & Harford 2007).

Around a quarter (23 per cent) of young people report avoiding or delaying dental visits because of the cost. Problems completing a recommended course of care because of the cost are reported by 11.6 per cent, and a quarter of young people state they would have trouble paying a $100 dental bill (Slade et al. 2007).

Young people from rural and remote locations are less likely to report visiting a dentist within the past 12 months when compared with urban dwellers. In addition, rural and remote youth have a lower average frequency of attendance per year (2.06 and 1.81 per cent respectively) compared with their urban counterparts (2.61 per cent) (Slade et al. 2007).

Dental health and water fluoridation

School Dental Service data show that children living in fluoridated parts of Victoria have considerably less tooth decay than those living in non-fluoridated areas.

Prior to 2004, about 74 per cent of the Victorian population had a fluoridated drinking water supply, with most of these people living in metropolitan Melbourne. In 2007 the percentage has increased to approximately 77 per cent. Following community engagement programs over the past three years, the towns of Sale, Morwell, Moe, Warragul, Traralgon, Robinvale, Horsham and Wodonga were all fluoridated during 2006 and 2007. Wangaratta will follow in 2008.

Sun protection and damage

Australia has the highest incidence of skin cancer in the world. Skin cancer is one of the most preventable cancers, but is still the most common type of cancer in young people. There is also evidence to suggest that over-exposure to the sun as a child or teenager can significantly increase the risk of melanoma later in life.

Data for this section was sourced from The Cancer Council Victoria. It collected data from 4111 Victorian secondary school students aged 12–17 about their attitudes and sun protection behaviour.

While the majority of young people knew that most cancer is caused by ultraviolet radiation (UVR), more than a quarter believed (wrongly) that you only get skin cancer if you get burnt often (see table 2.5).

8 A routine dental visit is currently estimated to cost $150 (Slade et al. 2007).
9 Water fluoridation is the adjustment of the natural level of fluoride in drinking water to around 1 milligram per litre, the optimal level that helps to protect teeth against decay. As a public health measure it is one of the most effective as it allows everybody access to the benefits of fluoride regardless of age, gender or socioeconomic status. In non-fluoridated areas of Victoria, three times as many people per capita required a general anaesthetic in hospital for treatment of decay than in fluoridated areas.
10 While the incidence of melanoma among young people (aged 12–24) has been declining (AIHW 2007), there has been an increase in new cases in the total adult population. The skin cancer incidence projection for melanoma skin cancers for 2002 to 2011 is for a 23 per cent increase for women and a 28 per cent increase for men (AIHW, AACR & NCSG: Ian McDermid 2005, Cancer incidence projections, Australia 2002 to 2011. Canberra: Australian Institute of Health and Welfare [AIHW], Australasian Association of Cancer Registries [AACR] and the National Cancer Strategies Group [NCSG]).
11 2070 of the students were male and 2041 were female. The data were collected as part of the 2002 Australian Students Smoking, Alcohol and Drug Survey and were weighted to reflect age and sex distributions within the Victorian population.
12 Results add to more than 100 per cent as respondents could give multiple answers.
Table 2.5: Knowledge of the causes of skin cancer, young people aged 12–17, Victoria

<table>
<thead>
<tr>
<th>Knowledge about skin cancer</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>You only get skin cancer if you get burnt often</td>
<td>32.7</td>
<td>23.6</td>
<td>28.2</td>
</tr>
<tr>
<td>Most skin cancer is caused by UVR from the sun</td>
<td>91.1</td>
<td>89.9</td>
<td>90.5</td>
</tr>
</tbody>
</table>

Source: The Cancer Council, Victoria

More than three quarters of young people reported that they liked getting a tan, and females were more likely than males to report this (see table 2.6).

Table 2.6: Young people’s attitudes towards gaining a tan

<table>
<thead>
<tr>
<th>Do you like to get a tan?</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>26.4</td>
<td>18.1</td>
<td>22.3</td>
</tr>
<tr>
<td>Yes, a light tan</td>
<td>33.7</td>
<td>29.5</td>
<td>31.6</td>
</tr>
<tr>
<td>Yes, a moderate tan</td>
<td>30.9</td>
<td>37.3</td>
<td>34.1</td>
</tr>
<tr>
<td>Yes, a dark tan</td>
<td>6.7</td>
<td>11.9</td>
<td>9.3</td>
</tr>
<tr>
<td>Yes, a very dark tan</td>
<td>2.3</td>
<td>3.2</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Source: The Cancer Council, Victoria

**Sun protection**

The survey found that around half (48 per cent) of young people usually or always wear maximum protection (30+) sunscreen on a sunny day in summer. The rate of young people reporting usually or always wearing a hat on a sunny day in summer is 42.5 per cent. Smaller proportions of young people usually or always wear sunglasses (39 per cent), stay mainly in the shade on sunny days in summer (25 per cent) and wear clothes that cover most of their body (16 per cent).

**Experience of sunburn**

When asked whether they had been sunburnt over the past summer, 78.8 per cent of young people stated that they had and 21.2 per cent said they had not, with females slightly more likely to report sunburn than males. Of those who reported sunburn over the last summer, 33.9 per cent reported only getting sunburnt once, 33 per cent said two to three times and 12 per cent experienced sunburn four or more times. Nearly four in 10 (36.9 per cent) young people reported ever having had severe sunburn with blistering.

Skin cancer campaigns aim to emphasise to young people the ways of protecting themselves from harmful ultraviolet radiation: seeking shade, wearing appropriate protective clothing, broad-brimmed hats, wraparound sunglasses and applying a SPF 30+ sunscreen to exposed skin. These campaigns have had some impact on behaviour.

**The UV index**

The WHO Global Solar UV index is a number relating to how much solar UVR reaches the ground. The Bureau of Meteorology issues SunSmart UV (ultraviolet) alerts when the UV index is forecast to reach or exceed exposure category three (moderate), a level that can damage skin and lead to skin cancer. Figure 2.6 shows the average number of UV index days for Melbourne.

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63 Males were less likely to do so than females with 29 per cent of males reporting they never or rarely wear 30+ sunscreen.
64 The most common hat worn was a cap (40.4 per cent), followed by a wide-brimmed hat (15.3 per cent), narrow-brimmed hats (11.7 per cent) and sunvisors (5.6 per cent).
Solariums are artificial tanning beds that produce UV radiation up to five times stronger than the sun.\textsuperscript{45} \n
WHO recently completed a systematic review of biological and epidemiological studies on sunbed use.\textsuperscript{46} The review found a significantly increased risk of melanoma and squamous cell carcinoma among sunbed users. The increase in melanoma risk was associated with exposure to sunbeds before age 35.\textsuperscript{47} \n
Research in Australia and elsewhere shows that younger people, (particularly females) are more likely than older people to use solariums. Nearly one in 10 (9 per cent) of all Victorians aged 14–29 had used a solarium.\textsuperscript{48} Also, the 2004 National Sun Survey by The Cancer Council of Australia shows that 72 per cent of 18–24 year olds believe most of their friends would think a suntan is a good thing compared with just 45 per cent of 25–44 year olds.\textsuperscript{49} \n
Regulation of the solarium industry \n
In response to the increasing body of research on the harmful health effects of solarium use and community concern about the use of solariums, the Victorian Government recently announced the regulation of the solarium industry from 1 February 2008. Under these arrangements solarium businesses will be required to be licensed with the Department of Human Services.\textsuperscript{50} The regulations also make it illegal for anyone under the age of 16 to use a solarium and require 16 and 17 year olds to provide parental consent. \n
Outdoor air and water quality \n
Environmental health hazards, including pollution of air, land and water, can potentially impact on the health status of young people and the broader population. Global warming from climate change is also an emerging public health challenge. \n
Outdoor air quality: ozone and particles smaller than 10 micrometres \n
Ozone is found naturally, in low concentrations, in the air we breathe. If levels of outdoor ozone are high,\textsuperscript{51} this can result in an increase in asthma attacks and hospitalisations for heart and lung conditions. Over the past two decades Melbourne's air quality has typically met the ozone goals, and progressive improvements in vehicle emission standards have contributed to this.

\textsuperscript{45} Australian Standard (AS/NZ 2635: 2002) Solaria for Cosmetic Purposes. \n\textsuperscript{46} The International Agency for Research on Cancer Working Group on artificial ultraviolet light and skin cancer 2007, ‘The association of use of sunbeds with cutaneous malignant melanoma and other skin cancers: A systematic review’, International Journal of Cancer; 120: 1116-1122. \n\textsuperscript{47} The Cancer Council of Victoria provides information about the risks of using Solariums on the Better Health Channel website. \n\textsuperscript{48} See http://www.cancervic.org.au/media/media-releases. \n\textsuperscript{49} The Cancer Council of Australia www.cancervic.org.au. \n\textsuperscript{50} Solarium operators who fail to license their business face fines of nearly $1 million. The maximum penalty for a business that does not comply with its licence is $660,720. \n\textsuperscript{51} From late spring to early autumn, higher concentrations (i.e. summer smog) can occur when nitrogen dioxide and hydrocarbons react together in the presence of sunlight.
Particles smaller than 10 micrometres (or less than one-tenth the width of human hair) are called PM$_{10}$. If levels of outdoor PM$_{10}$ are high this can exacerbate existing heart and lung conditions. The major sources of particles in an urban environment are motor vehicles (particularly diesel-powered), industry and wood combustion for heating. In recent years, bushfire smoke and windblown dust have contributed significantly to high particle levels. In years not significantly affected by bushfire smoke or dust, Melbourne monitoring stations typically meet the goal.

The air objectives for ozone and PM$_{10}$ are:

<table>
<thead>
<tr>
<th>Air quality indicator</th>
<th>Air objectives</th>
<th>Goal (by 2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ozone</td>
<td>One-hour average of 100 ppb</td>
<td>No more than one day a year where the objectives are not met</td>
</tr>
<tr>
<td></td>
<td>Four-hour average of 80 ppb</td>
<td></td>
</tr>
<tr>
<td>PM$_{10}$ particles</td>
<td>One-day average of 50 µg/m$^3$</td>
<td>No more than five days a year where the objective is not met</td>
</tr>
</tbody>
</table>

**Drinking water**

Escherichia coli (E. coli) is a bacterium that can occur in water supplies as a result of human or animal faecal contamination and cause diarrhoeal illness. Drinking water authorities collect weekly E. coli measurements in all drinking water locations and report these to the Department of Human Services. The water quality standard for E. coli states that, ‘98 per cent of weekly samples should contain no E. coli per 100mL of drinking water over a 12-month period.’

From 2004 to 2005, 95.35 per cent (i.e. 451 out of 473) of water locations met the state’s E. coli water quality standard. From 2005 to 2006, this increased to 95.54 per cent (i.e. 471 out of 493) compliance. Localities that did not comply with the standard – in either year – were Clunes, Sea Lake, Corryong, Tawonga, Tawonga Ranch Road, Mount Baw Baw and Mount Buller.

**Recreational water**

Enterococci are a group of bacteria found in the gastrointestinal tract of warm-blooded animals. Enterococci levels are measured as an indicator of faecal contamination in marine waters.

During summer, when beaches are popular for swimming, EPA Victoria carries out weekly water sampling of Enterococci levels across 36 beaches in Port Phillip Bay. Over the 2006-07 summer period, the water quality at bay beaches was generally good during fine weather. Poor water quality was generally associated with rainfall.

**Healthy body weight**

Overweight and obesity account for a large proportion of the total global burden of disease and are now very serious public health problems in Australia. Childhood and adolescence are critical periods for the development of this condition, and obesity early in life is of particular concern because of the associated health consequences and its influence on young people’s psychosocial development. High levels of overweight and obesity are viewed as being linked to increasingly sedentary lifestyles and to changing dietary habits.

Once obesity develops it is difficult and costly to treat, and when treated, it can be very difficult for individuals to maintain a healthy body weight throughout their life. Overweight children are more likely (than lean children) to become overweight in adulthood, and studies have shown that about half of overweight adolescents and over one-third of overweight children remain obese as adults (Wang & Lobstein 2006, Lobstein et al. 2004).
Young people who are overweight and obese may also face difficulties in their day-to-day lives. For example, in the Victorian Government-funded study ‘It’s Your Move’ young people (aged 12–17) who were overweight or obese reported more difficulty in running and playing sport or doing exercise than those who were a healthy weight. They also reported experiencing some teasing and felt sad more often than those who were a healthy weight (Sanigorski AM, unpublished data).

While the significance of overweight and obesity for young people’s lives cannot be contested, it may be more helpful and less potentially stigmatising to place policy emphasis on the wider, more positive goal of attaining a healthy body weight. Many young people show considerable knowledge about the contribution of physical activity and diet to healthy weight. It is important to recognise that there are tremendous social pressures on young people to lose weight to fit in with desired body images and that these body images may bear little relationship to healthy body weight and may even contribute to the development of eating disorders.

While just over half of the Victorian students (aged 12–17) surveyed in the It’s Your Move study were either happy or very happy with their body weight and shape, it is concerning that 23 per cent of males and 44 per cent of females were actively trying to lose weight. The students who were trying to lose weight included 33 per cent of ‘healthy weight’ females and 11 per cent of ‘healthy weight’ males along with over 85 per cent of those who were overweight or obese (Sanigorski, unpublished data).

Recent data from the HNSS show that the desire to lose weight is also affecting the younger age group. Of a representative sample of Victorian young people in Years 6 and 8, 38.2 per cent were trying to lose weight. Nearly a quarter (24.2 per cent) of these students were of normal weight and among these (normal weight) students 17.8 per cent said that they would be either worried or really upset if they gained one or two kilograms in weight (Williams 2007).

Body image may also fail to reflect actual body weight in young people who are overweight and obese. While overweight and obese young people were more likely (than normal weight young people) to be trying to lose weight, many of the young people who were measured as overweight and obese did not appear to recognise their risk of weight-related problems. For example, more than 50 per cent of overweight students and more than 16 per cent of obese students described themselves as about the right weight and more than 65 per cent of obese students described themselves as slightly overweight (Williams 2007).

The 2004 inquiry into the development of body image

In 2006 the Minister for Youth Affairs, Jacinta Allan, launched the Teenagers Go for your life positive body image strategy, following a parliamentary inquiry into the development of body image among young people and the associated effects on their health and wellbeing.

The Positive body image strategy will promote a healthy body image among young people through new community education and training partnerships, community-based programs and partnerships with the media and fashion industries. Small grants of up to $5000 were distributed to 32 community-based organisations in June 2007. The ministerial-appointed Community Advisory Committee on Body Image, chaired by Nicole Livingstone OAM, has been convening regularly.

Prevalence and trends in overweight and obesity in Victorian young people

Figure 2.7 presents data on the proportions of young people who were measured as overweight or obese in 1995 (national data) and 2005 (Victorian data) together with self-report data from state and national surveys (2004 and 2004–05).

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55 Funded by the Victorian Government as part of ‘Go for your life’: an initiative that aims to promote healthy eating and increase levels of physical activity.
56 The majority of young people in the It’s Your Move study had good knowledge about behaviour (sedentary and dietary) that would promote weight gain and recognised that the foods available from their school canteens were not healthy (>90 per cent) (Sanigorski, unpublished data). Young people (aged 12–24) consulted in the development of Future Directions associated a healthy lifestyle with maintaining physical health through exercise and eating healthy foods.
57 In the HNSS girls were also more likely than boys to be trying to lose weight, although they were no more likely (than boys) to be overweight or obese.
The figure shows that the proportion of young people who are overweight or obese is high (close to one-third of all young people). However, it is not possible to comment on trends on the basis of these data. The trend (in measured weight) for young people (aged 12–18) appears as stable. However, the 1995 data are national but the 2005 data are from only one region in Victoria. Results from the current (2007) National Nutrition Survey should provide a better indication of the trends and highlight whether this is increasing, as is the case for younger children and for adults.

The findings from the state and national surveys (2004 and 2004–05) should also be treated with some caution as the use of self-reporting of height and weight introduces a large amount of underreporting bias, especially in females.

**Figure 2.7: Overweight and obesity in young people**

<table>
<thead>
<tr>
<th>Survey</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995 National Nutrition Survey</td>
<td>25%</td>
<td>16%</td>
</tr>
<tr>
<td>Measured (12-18 years)</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>2005 IYM (measured)</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>2004 VPHS (self reported)</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>18-24 years</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>2004-5 NHS (self reported)</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>15-17 years</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>2004-5 NHS (self reported)</td>
<td>35%</td>
<td>25%</td>
</tr>
<tr>
<td>18-24 years</td>
<td>40%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Sources:
- National Nutrition Survey (Magarey et al. 2001)
- It’s Your Move! Victorian adolescent obesity prevention project (Sanigorski, unpublished data)
- Victorian Population Health Survey 2004
- NHS – ABS National Health Survey 2004–05

More recent data from the Victorian HNSS show that nearly a quarter (23.7 per cent) of young people (in Years 6 and 8) were measured as being overweight and 7.4 per cent were measured as being obese. The prevalence of overweight and obesity was not significantly different for boys and girls (Williams 2007).

**The level and nature of physical activity of young people**

Young people who do not participate in regular (moderate to vigorous) physical activity are more likely to have health-related problems than those who are sufficiently active. Young people who are physically active are also more likely to continue this behaviour into their adult lives (Twisk 2001).

**Australia’s physical activity guidelines for 12-18 year olds recommend that young people should be engaging in at least 60 minutes of moderate to vigorous exercise per day (Commonwealth of Australia, Department of Health and Ageing 2004).**

The HNSS found that 22.9 per cent of young people (in Years 6 and 8) were physically active for a total of at least 60 minutes on seven days (over the past week), in line with recommended levels. However, physical activity decreased with age and twice as many boys than girls met recommended activity levels (30.7 per cent of boys, and 15.2 per cent of girls). Younger children and boys also reported enjoying physical activity more.

One way in which young people can get regular physical activity is through walking or cycling to and from school. However, there is a concerning trend in school travel with the proportion of trips to school by car dramatically increasing from 16 per cent in 1970 to approximately 70 per cent in 2003 (see figure 2.8). This trend has significant implications for young people’s physical activity levels and independent mobility as well as for congestion, road safety and local amenity.
The shift to car has largely come at the expense of walking. Initiatives such as the Department of Infrastructure’s TravelSmart Schools program, VicHealth’s Walking School Bus program, and Bicycle Victoria’s Ride2School program aim to encourage alternatives to getting to school by car.

The physical activity guidelines for 12-18 year olds also recommend that young people should not spend more than two hours a day surfing the net, watching TV or playing video games (Commonwealth of Australia, Department of Health and Ageing 2004).

The HNSS found that 40.3 per cent of the Victorian (Years 6 and 8) students surveyed reported watching two or more hours of television per day on school days, rising to 57.1 per cent at weekends (see table 2.7). In addition, 17.1 per cent of young people reported spending two or more hours on a computer or playing video games during the week, increasing to 30.6 per cent at weekends. Boys were significantly more likely (than girls) to spend time - at weekends - watching TV and playing computer/video games.

| Time spent watching TV and on computer or video games, 11–13 year olds, Victoria |
|------------------------------------------|-----------------|-----------------|---------------------|
| TV - school days (%) | TV - weekends (%) | Video/computer School days (%) | Video/computer Weekends (%) |
| None | 2.9 | 2.1 | 20.1 | 12.8 |
| Less than an hour | 17.4 | 11.3 | 35.7 | 26.4 |
| 1 to 2 hours | 39.5 | 29.3 | 27.1 | 30.3 |
| 2 to 4 hours | 28.6 | 33.7 | 11.7 | 18.5 |
| 4 to 6 hours | 8.6 | 15.6 | 3.0 | 7.3 |
| More than 6 hours | 3.1 | 7.8 | 2.4 | 4.8 |

Source: Williams 2007

The adult physical activity guidelines (covering 18-24 year olds) state that adults should engage in at least 30 minutes of moderate-intensity physical activity on most, preferably all, days (Commonwealth of Australia, Department of Health and Ageing 2003).
The 2004 VPHS found that 65 per cent of males and 58 per cent of females aged over 18 years had undertaken adequate amounts of physical activity (according to the national guidelines) in the previous week, and this proportion declined for both genders with age.

**Differences between subgroups in obesity or overweight and physical activity levels**

**Indigenous young people**

The ABS 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) found that for young people (aged 15–24) 31 per cent of males and 26 per cent of females were overweight or obese. These rates are higher than those in the non-Indigenous population, and a substantially larger proportion of the Indigenous (than non-Indigenous) youth was also classified as obese.

The HNSS (in Victoria) found that Indigenous students were more likely to be overweight, but not as likely to be obese as non-Indigenous students (38.2 per cent of Indigenous students were overweight and 2.5 per cent were obese, compared with 23.4 per cent of non-Indigenous who were overweight and 7.5 per cent who were obese) (Williams 2007).

The HNSS also found that Indigenous students were more likely to have been physically active for at least 60 minutes on seven days in the past week (37.4 per cent of Indigenous students, compared with 22.8 per cent of non-Indigenous).

**Children and young people from CALD backgrounds**

The HNSS found that Victorian students (in Years 6 and 8) who spoke a language other than English at home were less likely (than students who spoke English at home) to have been physically active for at least 60 minutes on seven days (17.9 per cent of those speaking another language, compared with 24.1 per cent of those speaking English). These students were also significantly more likely to be overweight or obese than those who only spoke English at home (see table 2.8).

**Children and young people affected by chronic disadvantage**

In Victoria, the HNSS shows that students from higher socioeconomic groups were more likely to have been physically active for 60 minutes or more on seven days in the past week (26.3 in the highest SEN compared with 22.6 per cent in the lowest).

The survey also shows that SES is significantly inversely related to the prevalence of overweight and obesity, with those in the lowest socioeconomic groups having significantly higher rates of overweight and obesity (see table 2.9).
Table 2.9: Socioeconomic quintile by weight category, young people in Years 6 and 8, Victoria

<table>
<thead>
<tr>
<th>SES Quintile</th>
<th>Normal Number (%)</th>
<th>Overweight Number (%)</th>
<th>Obese Number (%)</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>406 (61.3)</td>
<td>165 (24.9)</td>
<td>91 (13.7)</td>
<td>662</td>
</tr>
<tr>
<td>2</td>
<td>463 (67.0)</td>
<td>180 (26.0)</td>
<td>48 (7.0)</td>
<td>691</td>
</tr>
<tr>
<td>3</td>
<td>486 (69.3)</td>
<td>170 (24.2)</td>
<td>46 (6.5)</td>
<td>701</td>
</tr>
<tr>
<td>4</td>
<td>516 (73.7)</td>
<td>152 (21.7)</td>
<td>32 (4.6)</td>
<td>700</td>
</tr>
<tr>
<td>Highest</td>
<td>494 (72.8)</td>
<td>148 (21.8)</td>
<td>37 (5.4)</td>
<td>678</td>
</tr>
<tr>
<td>Total</td>
<td>2366 (68.9)</td>
<td>814 (23.7)</td>
<td>254 (7.4)</td>
<td>3433</td>
</tr>
</tbody>
</table>

Source: Williams 2007

A link between lower SES and overweight or obesity and between lower SES and sedentariness is found in some other studies, but not in all and caution should be used in interpreting the evidence in this area as some studies are based on self-report and others on measured data.

Are there any differences by geographical area?

HNSS data for the younger Victorians (in Years 6 and 8) show that there are no significant differences in either weight or physical activity levels between students in urban and in rural areas.

However, the 2003 VPHS shows that the proportion of overweight/obesity (among 18–24 year olds) is substantially higher in the rural Department of Human Services regions, although this was based on self-reported height and weight (see figure 2.9).

The VPHS 2003 also shows that there were more youth from the metropolitan (than the rural) Department of Human Services regions who were sufficiently physically active (mean proportion was 71 per cent versus 65 per cent, respectively).

The VPHS in 2004 found that for all adults aged over 18 years, there were similar proportions of males classified as overweight/obese across quintiles of the Index of Relative Socio-Economic Disadvantage (IRSED), however there was a greater proportion of overweight/obese females living in the most disadvantaged areas compared with those living in relatively higher SES areas (41.5 per cent versus 30.6 per cent). The NSW SPANS found no significant association between SES and prevalence of physical activity or overweight/obesity in secondary students, although there was some evidence of an inverse gradient of overweight/obesity prevalence across levels of SES (Booth et al. 2006). In the NHS, sedentary/low exercise level varied by several indicators of socioeconomic status (SEIFA index of disadvantage, education level, employment status and household income) for people aged over 18, with a higher proportion of people who were sedentary coming from lower SES.

Outside of Victoria, the NSW SPANS in secondary students found that rural students were more active than urban students but the prevalence of overweight/obesity was not different between rural and urban secondary students (Booth et al. 2006).

The highest and lowest proportions of youth (who were sufficiently active) were in the Lodden Mallee region (75.9 per cent) and Gippsland region (59.8 per cent), respectively. In seven of the eight Department of Human Services regions more males were sufficiently physically active than females.
The Victorian Government’s ‘Go for your life’ strategy

With overwhelming evidence supporting the social, health, economic and environmental benefits of healthy and active lifestyles, the Victorian Government is spearheading a whole-of-government and community approach aimed at building a healthy and more active Victoria.

In recognition of the importance of working to increase levels of physical activity and healthy eating and to address the rising prevalence of obesity and diabetes, the Government announced in the 2006 election that $132 million would be invested over four years to promote good health and wellbeing.

The Government recognises that action needs to occur at all levels of our community if the range of benefits available through increased levels of physical activity and healthy eating are captured. Similarly, multi-sectorial and multi-intervention approaches, which are responsive to the broad physical, social, economic and cultural environments, are required.

Within this context, a coordinated approach across government has been developed under ‘Go for your life’, to identify areas for collaborative investment, opportunities for building on existing activities and integrated stakeholder engagement.

‘Go for your life’ includes a significant investment in a range of community-based programs. Where possible, these programs build on existing community building activities and target socioeconomically disadvantaged and isolated areas. These programs will provide support at the community level to achieve sustained change.

Community ownership is an important aspect of the strategy, including the prioritisation of need and selection of activities/interventions. The aim will be to create a culture and commitment to local environments and services that support healthy lifestyles.

The Government also recognises the importance of engaging Victorians from culturally and linguistically diverse backgrounds (CALD) to take up healthier and more active lifestyles. It has funded tailored programs for high risk groups within this community.

In recognition of the importance of encouraging the commencement of healthy lifestyles at an early age, the Government announced that under the Go for your life – Healthy Start in Schools program, government primary schools would receive grants of up to $6,000 to install bicycle sheds, create cafe-style school canteens, establish kitchen gardens, and upgrade their playgrounds. This is in addition to the provision of free fruit once per week for all students in Prep to Year 2.
The most notable change in the diet of young Australians over recent decades has been the increased consumption of energy-dense food and drinks (processed foods and snacks that are high in fat and sugar). Young people today live in an environment that is characterised by abundant ‘obesogenic’ foods. Of particular concern are foods that are high in simple sugars, processed starch and fats. These foods are convenient and pleasant to eat and are heavily marketed.

Consumption of energy-dense foods and drinks
Young people (in Years 6 and 8) in the HNSS were asked about their consumption of biscuits, doughnuts, cakes, pies or chocolate; as well as their consumption of sweet drinks and takeaways.

The survey found that 29.5 per cent of young people consumed two or more serves of biscuits, doughnuts, cakes, pies or chocolate per day; and 32.6 per cent consumed two or more servings of sweet drinks. Just under a quarter of young people had takeaway less than once a month (24.2 per cent) and once a week (23.9 per cent) and a minority (4.2 per cent) had takeaway 2–3 times a week or most days (0.8 per cent).

Boys were more likely than girls to consume sweet drinks and takeaways. CALD students were less likely to report that they eat takeaway food, although more likely to report consuming sweet drinks.

Students in the higher socioeconomic group were significantly less likely than students in the other socioeconomic groups to report consuming: more than one sweet drink per day; and more than one biscuit, doughnut, cake, pie or chocolate per day (see tables 2.10 and 2.11).

Table 2.10: Responses to the question, ‘How many serves of the following foods do you usually have per day? Sweet drinks such as soft drinks, cordial, Big M, flavoured mineral water etc.’

<table>
<thead>
<tr>
<th></th>
<th>Lowest SES (%)</th>
<th>2 (%)</th>
<th>3 (%)</th>
<th>4 (%)</th>
<th>Highest SES (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>16.3</td>
<td>25.5</td>
<td>25.0</td>
<td>33.6</td>
<td>34.1</td>
<td>26.9</td>
</tr>
<tr>
<td>1</td>
<td>39.5</td>
<td>38.9</td>
<td>39.3</td>
<td>43.7</td>
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<td>7.7</td>
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<td>5.6</td>
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<td>4.9</td>
<td>3.2</td>
<td>2.2</td>
<td>4.0</td>
</tr>
<tr>
<td>5 or more</td>
<td>7.3</td>
<td>5.5</td>
<td>2.2</td>
<td>1.4</td>
<td>2.0</td>
<td>3.7</td>
</tr>
</tbody>
</table>

Source: Williams 2007
Table 2.11: Responses to the question, ‘How many serves of the following foods do you usually have per day? Biscuits, doughnuts, cakes, pies or chocolate’

<table>
<thead>
<tr>
<th></th>
<th>Lowest SES (%)</th>
<th>2 (%)</th>
<th>3 (%)</th>
<th>4 (%)</th>
<th>Highest SES (%)</th>
<th>Total (%)</th>
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<tr>
<td>5 or more</td>
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<td>4.3</td>
<td>2.0</td>
<td>2.0</td>
<td>1.4</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Source: Williams 2007

**Consumption of fruit and vegetables**

Adequate consumption of fruit and vegetables helps young people to maintain good health and reduces the risk of chronic diseases (AIHW 2007).

The Australian National Health and Medical Research Council (NHMRC) guidelines recommend that young people aged 12–18 eat three serves of vegetables and three serves of fruit per day (NHMRC 2003a).

Less than a third (27.1 per cent) of Victorian 12–18 year olds meet the NHMRC recommendations for fruit consumption, with females more likely to meet these than males. A much greater proportion (57.3 per cent) meet the recommendations for vegetable consumption, with little difference between females and males (ABS, NHS 2004–05. ABS data available on request). The levels of fruit consumption are lower than those reported for 11–13 year olds in the HNSS (35.5 per cent), suggesting that fruit consumption declines with age across the 11 to 18-year age group.

The NHMRC guidelines recommend that young people aged 19 and over eat two servings of fruit and five servings of vegetables (NHMRC 2003b).

Nearly half (45.6 per cent) of 19–24 year olds meet the recommendations for fruit consumption. Only 8.5 per cent meet the recommendations for vegetable consumption. Females are slightly more likely to meet recommended levels than males.

There are few notable differences between young Victorians and young people nationally, although Victorian males aged 12–18 are slightly more likely to meet the vegetable guidelines and Victorian males aged 19–24 are more likely to meet the guidelines for fruit (ABS, NHS 2004–05. ABS data available on request).

**Eating disorders**

Eating disorders are uncommonly seen before puberty, rise steeply in prevalence in the early teens, and rarely have an onset beyond the early twenties. They are much more common in females than males.64,65

The two most common eating disorders in young people are anorexia and bulimia nervosa. Bulimia is the more common of these, although both occur only rarely.

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64 Puberty marks a transition point in risk for the onset of eating disorders. Symptoms of eating disorder as well as a heightened sensitivity to body weight and shape rise steeply across pubertal stage in girls (Killen et al. 1992). Increases in body fat, associated with puberty, may contribute to body dissatisfaction and a greater use of dieting, a major risk factor for eating disorders in post-menarcheal females (Abraham & O’Dea 2001. Patton et al. 1999). There has also been recent speculation that rising rates of childhood obesity might lead to greater rates of eating disorders in early adolescence.

65 Eating disorders are a mental health disorder, with both physical and mental health elements. They are discussed here (and not with emotional and mental health below) because of the links between eating disorders and healthy body weight, nutrition and body image.
Anorexia nervosa is characterised by a refusal to maintain a minimum normal body weight; intense fear of gaining weight or becoming fat, even though underweight; distortion of body image with a perception of being fat even though very underweight; and a loss of normal menstrual periods.

Bulimia nervosa is characterised by a frequent loss of control of eating (bingeing); the use of extreme methods of weight control such as self-induced vomiting, laxatives, diuretics or compulsive exercising; and an extreme fear of becoming fat.

Other types of eating disorders that do not fit the criteria for diagnosis as anorexia nervosa or bulimia nervosa are called ‘partial syndromes’ or ‘eating disorders not otherwise specified’ (EDNOS). Most cases of partial syndrome remit spontaneously but ongoing psychiatric and social problems are common in this group.

What are the consequences of eating disorders?

Anorexia nervosa has arguably the highest mortality rate of any psychiatric disorder. The principal causes of death are suicide and the physical complications of weight loss. It is associated with reduced educational attainment and recurrent hospital admission. In Victoria, eating disorders are the fourth leading cause of disease burden in 15 to 34-year-old females.

Where anorexia occurs during puberty (or less commonly before puberty) it may have an irreversible effect on physical development (leading to growth stunting) and on the achievement of normal secondary sexual characteristics. Chronic anorexia has an impact on brain development that may be irreversible (Kingston et al. 1996). Anorexia can similarly have profound effects on bone mineral density, the early development of osteoporosis and the risk for pathological fractures (Zipfel et al. 2000).

Bulimia nervosa commonly has a chronic course. In a review of 88 studies, nearly 20 per cent continued to meet full criteria for bulimia nervosa five to 10 years after presentation (Keel & Mitchell 1997). A further 30 per cent of women experienced relapses into bulimic symptoms; risk of relapse appears to decline four years after presentation. Symptoms of partial syndromes in adolescence tend to improve, but higher rates of depressive and anxiety disorders are evident in young adulthood. Substance abuse is also common in this group and for those who had a partial syndrome of anorexia nervosa, a majority were still underweight in their mid twenties (Patton et al. 2007).

Prevalence of eating disorders

Adolescent dieting is the usual forerunner of an eating disorder (Patton et al. 1999) although most dieters do not go on to develop an eating disorder.69

Surveys in developed Western countries have generally found prevalence rates of around 0.5 per cent for anorexia nervosa and 1 per cent for bulimia nervosa in females aged 15–24. In contrast rates for ‘partial syndromes’ have been around 3 to 5 per cent (Johnson-Sabine et al. 1988, Rastam, Gillberg & Garton 1989).

Information on the prevalence of eating disorders in Victoria is limited. A recent longitudinal study of young Victorian women suggests that around 10 per cent of young women (who did not have a diagnosed eating disorder) reported that they experienced at least two symptoms associated with anorexia or bulimia at some point between adolescence and young adulthood (Patton et al. 2007).

69 Around 30 to 40 per cent of young Victorian women are on a restricting diet at any one time (Patton et al. 1997). Around one in five younger adolescent males diet but this figure falls to around one in 20 by the late teens. Most evidence also suggests that dieting has little effect on weight and may even increase risks for later becoming overweight (Hill 2004).
Mental health service development

Following the release in May 2007 of the Eating Disorders Service Mapping Project report, the Minister for Mental Health requested that the Department of Human Services and the Ministerial Advisory Committee on Mental Health establish a subcommittee to advise on improvements to address issues associated with eating disorder treatment in publicly funded health services.

The Service Mapping report identified the need for a more systematic approach to eating disorder service delivery in Victoria involving primary, acute and mental health services that deliver a hierarchy of accessible services supported by specialist expertise.

The Centre for Excellence in Eating Disorders was provided recurrent funding from 1 July 2007 to assist public mental health child and adolescent and adult services in meeting their responsibilities in assessing, treating and managing individuals presenting with moderate to severe forms of eating disorder.

Sexual health and health-related behaviour

The formation of a sexual identity is one of the major developmental tasks to be negotiated in the transition from child to adult (King & Chown 2004). Sexual identity refers to how people describe their sexuality, and is usually an expression of that person’s sexual orientation (Moore & Rosenthal 2006, Smith et al. 2003). However, research suggests that there are varying degrees of congruence between sexual identity, attraction and experience.67

Victorian young people’s identification of their sexual orientation

Among two representative samples of Victorian young people aged 16–25, around 98 per cent identified as heterosexual, while around 0.6 per cent identified as gay and 1.5 per cent as bisexual. An average of 90 per cent were only attracted to the opposite sex, 8 per cent were attracted to both sexes and around 0.4 per cent were only attracted to the same sex (Smith et al. 2007a&b).68

Respondents to a survey of same-sex-attracted young people aged 14–21 predominantly described their identity as homosexual or lesbian (62.2 per cent), while one-fifth (19.9 per cent) said that they were bisexual and 16.2 per cent preferred not to be labelled (Hiller et al. 2005). Among this group, 67.8 per cent were only attracted to their own sex, while 27.2 per cent were attracted to both sexes and 5 per cent were unsure.

In comparison, data taken from a 2006 survey of gay, lesbian, bisexual, transgender and intersex (GLBTI) young people aged 16–25, show that 77.1 per cent identified as gay or lesbian and 12.4 per cent as bisexual, while only a small number said they did not use a label (5.3 per cent) or were not sure (3.1 per cent) (Pitts et al. 2006). When asked about their sexual attraction, 41.3 per cent said they had only ever been attracted to the same sex, while 45.7 per cent were more often attracted to the same sex, 8.1 per cent were equally attracted to both sexes and 5 per cent were more often attracted to the opposite sex (Pitts et al. 2006).

Proportion of young people who have had sexual intercourse

In the Victorian HNSS, 4.1 per cent of 12 year olds and 5.4 per cent of 13 year olds reported they had had sex. The 2002 National Survey of Australian Secondary Students, HIV/AIDS and sexual health found that 26.4 per cent of Year 10 students and 44.2 per cent of Year 12 students reported having had sexual intercourse, giving an average figure of 34.4 per cent (Smith et al. 2002). Two-thirds of students surveyed (66.4 per cent) had not had sex.

67 Studies show that uncertainty over sexuality is common in adolescence, and that uncertainty gradually changes over time to either heterosexual or homosexual identification (Moore & Rosenthal 2006). This is important because young people’s sexual behaviour may not be congruent with their stated attractions or identity (Hiller et al. 2005). Same-sex-attracted young people need information about contraception and reproduction as much as heterosexual youth (Hiller et al. 2005).

68 Research with school students reveals a similar pattern of sexual attraction, with 93 per cent of students saying they were only attracted to the opposite sex, 4.6 per cent to both sexes and 0.6 per cent to the same sex, while 1.9 per cent said that they were not sure of their sexual attraction (Smith et al. 2002).
Two representative samples of young people aged 16–25 found that 76 per cent of respondents had experienced sexual intercourse (Rissel et al. 2003, Smith et al. 2007a&b). Among respondents to a national survey of same-sex-attracted young people aged 14–21, 67.6 per cent reported having experienced penetrative sex, while 27 per cent of 12–17 year olds from rural towns in Victoria, Tasmania and Queensland reported having had sexual intercourse (Hillier et al. 1996 2005).46

The median age of initiation of sexual intercourse taken from two representative samples of young people aged 16–25 was 17 years of age (Smith et al. 2007a&b).70 Data from same-sex-attracted young people aged 14–21 found that 11 per cent first had sex at 15, 13 per cent at 16, 12 per cent at 17 and 18 per cent were aged 18 and over (Hillier et al. 2005).

Use of contraception

Surveys have found that condoms are the most common form of contraception used, with between 56 per cent and 71 per cent of young people reporting condom use at their most recent sexual encounter (Hillier et al. 1996, 2005, Smith et al. 2002, de Visser et al. 2003).11

Looking at the use of contraceptive methods other than condoms, 37.4 per cent of school students reported using the oral contraceptive pill (at the most recent sexual encounter), 5 per cent the morning-after pill, 2.1 per cent the rhythm method, 1.3 per cent an intra-uterine device and 1.3 per cent a diaphragm, while 11.1 per cent did not use any method of contraception (Smith et al. 2002).

Sales of emergency contraception

The number of sales of emergency contraception in Victoria is not currently available. The available data show that between 28 per cent and 40 per cent of women aged 16–25 who had ever had sex had used emergency contraception, and of those who had ever used this form of contraception, 45 per cent had used it at least once in the past 12 months (Smith et al. 2007a). Additionally, 5.5 per cent of Years 10 and 12 students said they had used emergency contraception the last time they had sexual intercourse (Smith et al. 2002).

Rates and types of sexually transmitted infections in young people

Sexually transmitted infections (STIs) can have significant impacts on health and fertility. While the rate of STIs in Australia is relatively low, there has been a trend of increasing prevalence in the most common infections (studies cited in Pitman et al. 2003).

In Victoria there were 6712 young people aged 12–25 diagnosed with a sexually transmitted infection in 2006. The most common infection was chlamydia (93 per cent of all STI reports for young people), followed by gonorrhoea (6 per cent), and syphilis (1 per cent).12 Young people aged under 25 account for well over half of chlamydia cases in Victoria.73 Nevertheless, notification rates for chlamydia are lower in Victoria than nationally (see figure 2.10).
Cervical smears

Data from a range of sources suggest that approximately 30 per cent of young women have a cervical smear test every year (Victorian Cervical Cytology Registry 2005, Pitts et al. 2006). Of the young women surveyed for the Australian Longitudinal Study of Health and Relationships (ALSHR), 2.6 per cent had received a positive pap test in the past 12 months.

Young people and sexual health: Are there differences between metropolitan and rural areas?

The data for young Victorians aged 16–25 shows that there were few differences in sexual health behaviour between those living in major cities and those from rural/regional areas. However, studies suggest that young people in rural areas may experience particular access difficulties.

Young people’s perspectives on their sexuality and sexual relationships and behaviour

A survey of school students found that students generally expressed positive feelings about their last sexual encounter, with approximately half feeling ‘extremely’ happy, good or loved. However females, particularly those in Year 10 were less likely than males to report positive feelings after sex (Smith et al. 2002).

The majority of students (90 per cent) were confident or very confident that they could talk to their partner about using a condom. Most students (72 per cent) also felt they could confidently say no to sex, despite their partner wanting to have sex (Smith et al. 2002). However, the ALSHR found that a high number of young people, especially women, had experienced unwanted sex (Smith 2007).

The majority of same-sex-attracted young people surveyed in 2004 said that they felt either ‘great’, or ‘pretty good’ about their sexuality (76 per cent), while only 5 per cent reported feeling ‘pretty bad’ or ‘really bad’. A common finding was that young people who reported positive feelings (about their sexuality) had become clearer about their sexuality and felt more confident and comfortable in themselves (Hillier et al. 2005). In comparison, young people who reported negative feelings about their sexuality were unable to access positive ways of thinking about same sex attraction.

74 Figures for the youngest age group (aged 10–14) are not shown as they are extremely small.

75 Differences that clearly emerged were that those living in rural/regional areas were significantly less likely to have ever used emergency contraception (21.81 per cent versus 47.62 per cent), less likely to use a condom as the form of contraception (47.4 per cent versus 65.4 per cent) and less likely to have ever had a termination (1.4 per cent versus 12.5 per cent). There were few statistical differences between same sex attracted young people from rural areas and their peers. Young people from rural areas were found to feel less safe at social occasions than their peers, and were more likely to express concern about isolation and the safety of their situation (Hillier et al. 2005).

76 These national data show that 30 per cent of women and 18 per cent of men aged 16–19 and 18 per cent of women and 19.2 per cent of men aged 20–24 reported having ever had an unwanted sexual experience because they were too drunk or high at the time (Smith 2007). Among this same sample, 24 per cent of women aged 16–19 reported having ever been coerced into an unwanted sexual act.
Sexual health issues for key groups of young people

Same-sex-attracted young people
Same-sex-attracted young people report high levels of discrimination (38 per cent) and abuse (44 per cent) on the basis of their sexuality, with the majority experiencing this abuse at school. Young people experiencing homophobic abuse were more likely to self-harm, report an STI and use a range of legal and illegal drugs (Hillier et al. 2005). Same-sex-attracted young people from CALD backgrounds were found to have had similar experiences to the rest of the group; however, they were less likely to have disclosed their sexuality to parents and to have received support or information about safe sex from their parents (Hillier et al. 2005).

Homeless young people
Of a group of homeless young people aged 12–15 who were also injecting drug users, 98 per cent reported having engaged in sexual intercourse, and 80 per cent indicated they only sometimes or never used a condom. This figure for unprotected sexual intercourse is far higher than for other groups of young people, and suggests these young people are particularly at risk of pregnancy and STIs (Hillier et al. 1999).

CALD and refugee young people
Adolescents from refugee and CALD backgrounds face the challenge of dealing with the tasks of adolescence while growing up between two cultures (King & Chown 2004). There may be great variation in cultural values and norms regarding the central tasks of adolescence, such as developing a sense of identity and independence. In some cultures, young people are not considered independent until they marry. Sexual health and identity are closely linked and identity is a very sensitive issue for adolescents with a CALD background.

Data gaps
There is a dearth of information about the sexual health of young people with a disability and Indigenous young people. These areas need to be addressed by future research.

Births to young mothers
Motherhood in young people aged under 20 years is associated with an increased risk of poor social, economic and health outcomes, although it is important to recognise that not all teenage conceptions are unplanned or unwanted and many teenage parents – and children of teenage parents – report positive experiences (Quinlivan 2004).

Victoria has the second lowest rate of births to young mothers nationally (ABS 2005) and birth rates among young women have remained fairly stable from 2001 to 2005, with some suggestion of a decline (see figure 2.11).

Figure 2.11: Birth rates in Victoria by age of mother, 2001-05

Rates of young motherhood in Indigenous women are higher than in non-Indigenous women. In 2005, 20.6 per cent of Indigenous women giving birth in Victoria were aged under 20 years, compared with only 2.6 per cent of non-Indigenous women. The percentage of Indigenous women (under 20 years) giving birth has also increased since 1996 (Department of Human Services 2007b).
Barriers to young people's access to sexual health services

The majority of testing and treatment for STIs in Australia occurs in general practice (Commonwealth of Australia Department of Health and Ageing 2005). Research has identified the major barriers to young people accessing health services, particularly for STI testing, are concerns about confidentiality and trust, such as GPs disclosing information to parents or being identified by other patients or by other staff at the clinic (King & Chown 2004). A report on young women and sexual health found that some young women did not know where to go to obtain information about sexual health (Girls Incorporated 2001).

Other barriers include concerns about the attitude of the GP, for example that the GP will have a judgemental or unsympathetic attitude. Young people can also be intimidated by the appearance of the clinic and the attitude of staff. Cost may be a barrier to young people who do not understand the Medicare system, do not have their own Medicare card or are unable to pay for consultations in clinics that do not bulk bill.

Concerns about confidentiality and ‘being known’ are particularly important for young people living in rural areas, particularly for services that may be stigmatised such as sexual health or mental health services. Social visibility is higher in rural communities (Francis et al. 2006, Wilkinson 1991) and the lack of anonymity also means that any social stigma follows a young person in all aspects of community life (Bourke et al. 2004, Francis et al. 2006).

A study on young people from rural towns in Australia found that over half of students perceived that youth centres, sexual health clinics, family planning clinics and community health centres as difficult to access. While 60 per cent of female students indicated they would prefer to discuss personal sexual issues with a female doctor, 36 per cent thought that female doctors were difficult to access (Hillier et al. 1996).

Substance use among young people

In adolescence many young people begin experimenting with substances that can cause health problems, if misused. For the majority of young people, this experimentation does not develop into an ongoing pattern of addiction and risk-taking behaviour. However, for a minority, particularly those who engage in chronic or multiple substance abuse, there may be serious present and long-term health consequences (AIHW 2007, Pitman et al. 2003).

While the majority of young Victorians (in Years 6 and 8) who responded to the HNSS thought that substance use (in someone their age) was wrong and was harmful, the youngest students (among the sample) were, in general, significantly more likely to state that this was the case. For example, 93.9 per cent of 11 year olds and 69 per cent of 13 year olds said it would be ‘very wrong’ for someone of their age to smoke cigarettes, 90.3 per cent of 11 year olds thought that people were at ‘great risk’ of harming themselves if they used marijuana regularly, compared with 86.1 per cent of 13 year olds (Williams 2007).

In general, substance use was also less likely to be viewed as ‘cool’ by the youngest students, with 82.6 per cent of 11 year olds saying that there was ‘very little or no chance’ that they would be seen as cool if they began drinking alcoholic beverages regularly, compared with 51.9 per cent of 13 year olds; 84.4 per cent of 11 year olds said there was ‘very little or no chance’ they would be seen as cool if they smoked cigarettes, compared with 72.6 per cent of 13 year olds.

Although the majority of students thought that substance use in someone their age was wrong, they were less likely to think that it was wrong (for someone of their age) to drink alcohol, more likely to think that it was wrong to smoke cigarettes and most likely to think that it was wrong to use marijuana and other drugs.

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The youngest students were not significantly more likely than the older students to think that people risked harming themselves if they smoked one or more packs of cigarettes a day.

The HNSS also identified some differences in the views of boys and girls, with boys being more likely to think they would be seen as cool if they began drinking alcoholic beverages regularly, compared with 51.9 per cent of 13 year olds; 84.4 per cent of 11 year olds said there was ‘very little or no chance’ they would be seen as cool if they smoked cigarettes, compared with 72.6 per cent of 13 year olds.

Although the majority of students thought that substance use in someone their age was wrong, they were less likely to think that it was wrong (for someone of their age) to drink alcohol, more likely to think that it was wrong to smoke cigarettes and most likely to think that it was wrong to use marijuana and other drugs.
These findings reflect the relative ‘social acceptability’ of alcohol in society, in comparison with cigarette smoking and illegal drug use. It is interesting too, in light of this, that young people thought they would be more easily able to obtain alcohol than cigarettes and illegal drugs.\textsuperscript{80}

**Tobacco smoking**

Tobacco smoking is responsible for 19,000 deaths in Australia every year and is the single most preventable cause of chronic disease and premature death (AIHW 2007). The majority of smokers commence smoking as teenagers and the earlier the age of smoking initiation, the greater the likelihood of continued smoking into adulthood. The smoking behaviour of friends and family are key influences on whether young people smoke.\textsuperscript{81}

**Tobacco smoking among young people aged 12–17**

The Victorian Secondary School Students’ use of Licit and Illicit Substances 2005 survey (DHS 2006b) found that at 12 years of age, only 21 per cent of males and 10 per cent of females had ever smoked while by age 17, 56 per cent of males and 56 per cent of female students reported ever smoking.

Figure 2.12 shows there appears to be a declining trend in rates of current smoking, between 1984 and 2005, among young people aged 12–17. While females have been generally more likely to smoke than males, this pattern is also changing so that by 2005, there is little difference in smoking between females and males (aged 16–17) and no difference between females and males aged 12–15.

**Figure 2.12: Trends in current cigarette smokers aged 12–17 from 1984–2005**

Source: Victorian Secondary School Students’ use of Licit and Illicit Substances 2005

**Young people aged 18–24**

This decline in smoking is also evident in young people aged 18–24, particularly among young males. The Victorian Public Health Survey shows that the proportion of those identifying themselves as current smokers has declined from 44.2 per cent of males in 2001 to 23.9 per cent in 2006, and from 27.6 per cent of females in 2001 to 23.3 per cent in 2006.

Data from the National Aboriginal and Torres Strait Islander Health Survey (2004–05) show that rates of current smoking are nearly twice as high among Indigenous young people (see figure 2.13). Nearly 60 per cent (57.7 per cent) of Indigenous young people (aged 18–24) described themselves as current smokers, compared with just over 30 per cent (30.7 per cent) of non-Indigenous young people.

\textsuperscript{80} 27.7 per cent of young people reported that it would be ‘very easy’ or ‘sort of easy’ for them to obtain alcohol, compared with 20.8 per cent for cigarettes, 7.2 per cent for marijuana and 5.5 per cent for other illegal drugs.

\textsuperscript{81} Among young people surveyed for the 2005 Secondary School Students’ use of Licit and Illicit Substances, students were more likely to have never smoked a cigarette if neither of their parents were smokers, and for 12–15 year olds, when a parents smokes, bans on smoking in the home reduce the likelihood that the young person will smoke.
Figure 2.13: Smoking status of 18–24 year olds in Victoria by Indigenous status

Source: National Aboriginal and Torres Strait Islander Health Survey 2004–05

Teenage mothers and smoking

National data show that teenage mothers are much more likely to report smoking during pregnancy (42 per cent compared with 17 per cent for all women) (AIHW 2007).

Tobacco reform in Victoria

Legislation governing tobacco products and smoking in Victoria has been progressively implemented over many years.

These reforms have included:

- measures to address youth smoking such as increasing the penalties for selling cigarettes to a minor (November 2000)
- smoke-free dining laws (1 July 2001)
- smoke-free shopping centre laws (1 November 2001)
- smoking restrictions in licensed premises, gaming and bingo venues, and the casino (1 September 2002)
- restricting tobacco advertising and displays within tobacco retail outlets (1 July 2001 through to January 2002)
- banning smoking in most enclosed workplaces (1 March 2006)
- banning smoking, the promotion of tobacco products and the sale of tobacco products at underage ‘music/dance’ events (1 March 2006)
- banning smoking in covered areas of train station platforms, tram stops and bus stops (1 March 2006)
- banning ‘buzz marketing’ and non-branded tobacco advertising (1 March 2006)
- strengthening laws to enforce the ban on cigarette sales to young people (1 March 2006)
- banning smoking in enclosed licensed premises (1 July 2007).

Accompanied by mass media campaigns, these reforms have led to sustained declines in both adult and youth smoking rates in Victoria. In young people aged 18–24 (particularly among young males) smoking has declined significantly.
Alcohol
Excessive consumption of alcohol is a major risk factor for morbidity and mortality – and is associated with transport accidents, physical and sexual assault, drowning and suicide, together with a range of long-term health problems (AIHW 2007). As with smoking, young people are more likely to consume alcohol as they get older.\textsuperscript{22}

Alcohol consumption in young people aged 12-17
The Victorian Secondary School Students’ use of Licit and Illicit Substances survey (DHS 2006b) reported that 5 per cent of 12–15 year olds and 23 per cent of 16–17 year olds were drinking at levels that risked short-term harm in 2005 (see figure 2.14).\textsuperscript{82} The figure also shows that the percentage of 16–17 year olds who are drinking at levels that risk short-term harm has increased (from 15 per cent) since 1984.

Figure 2.14: Trends in the percentage of all students drinking at risk of short-term harm, among 12-15 year olds and 16-17 year olds, 1984-2005

\begin{center}
\begin{tabular}{|c|c|c|c|c|c|c|c|}
\hline
\hline
% 12–15 year olds & 3 & 3 & 3 & 4 & 4 & 6 & 5 & \\
% 16–17 year olds & 15 & 18 & 15 & 21 & 20 & 23 & 25 & 23 \\
\hline
\end{tabular}
\end{center}

Source: The Victorian Secondary School Students’ use of Licit and Illicit Substances 2005

Young people aged 16-24
The 2004 Victorian Youth Alcohol and Drug Survey found that 44 per cent of young people aged 16-24 considered themselves to be non-drinkers, occasional drinkers or light drinkers, while 51 per cent considered themselves social drinkers and 5 per cent considered themselves heavy or binge drinkers (Premier’s Drug Prevention Council 2005).

The survey identifies a slight increase (from 2002 to 2004) in drinking among young people aged 16-24 ‘at more extreme levels associated with potential for short-term harm’.\textsuperscript{84}

More recent data (on short-term risk from alcohol consumption) identifies that the prevalence of drinking alcohol at least weekly at ‘risky’ or ‘high-risk’ levels is greater among young people aged 18-24 than among other (adult) age groups (VPHS 2005).\textsuperscript{85} A higher proportion of males than females are drinking at least weekly at risky or high-risk levels. However, the VPHS also suggests that, from 2002 to 2005, there has been an increase in the proportion of females, and a decrease in the proportion of males, who are drinking (at least weekly) at risky and high-risk levels (see table 2.12).

\textsuperscript{22} In the Secondary School Students’ use of Licit and Illicit Substances survey 82 per cent of 12 year olds, 51 per cent of 14 year olds and 14 per cent of 17 year olds considered themselves to be non-drinkers.

\textsuperscript{23} Drinking at risk of short-term harm is defined for males as consuming more than six alcoholic drinks on any day in the past week, and for females as consuming more than four alcoholic drinks on any day in the past week. Students who reported consuming more than 20 alcoholic drinks on any day in the past week were excluded from the analysis.

\textsuperscript{24} More young people reported in 2004 (than in 2002) that during a 12-month period there was at least one instance of drinking until they couldn’t remember what happened (45 per cent of young people reported this in 2004 compared with 35 per cent in 2002). Thirty-six per cent of young people in 2004 reported consuming 20 or more standard drinks in one day at least once (in the past 12 months), compared with 31 per cent in 2003.

\textsuperscript{25} Population guidelines used in the VPHS state that males who drink up to six standard drinks and females who drink up to four standard drinks per drinking occasion are at low risk of alcohol-related harm in the short term. Males who drink 11 or more drinks and females who consume seven or more drinks are categorised as being high risk. Between these levels is classified as risky in the short term.
Table 2.12: Proportion of young people (18–24) drinking alcohol at least weekly at risky and high-risk levels, 2002–05 (percentages)

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>25.1</td>
<td>23.9</td>
<td>29.3</td>
<td>21.5</td>
</tr>
<tr>
<td>Females</td>
<td>14.6</td>
<td>13.4</td>
<td>16.2</td>
<td>17.1</td>
</tr>
</tbody>
</table>

Source: VPHS (2002–05)

**Alcohol-related hospital admissions**

The rate of alcohol-caused hospital admissions for young Victorians (aged 15–24) has also increased substantially in recent years. This increase has occurred in both males and females, with admissions in the oldest female age group (aged 20–24) increasing from a rate of 0.56 per 1000 people in 1998–99 to 1.34 per 1000 people in 2005–06 (see figure 2.15). This finding is of concern as it highlights an increase in the number of young Victorians drinking at extremely risky levels, to the point where they are being admitted to hospital.

**Figure 2.15: Rates of alcohol-caused hospital admissions (per 1000 people) by age and sex, Victoria, 1998–99 to 2005–06**

Source: VAED

**Young people’s behaviour while under the influence of alcohol**

Another area of concern is the proportion of young people (particularly young males) who report exhibiting undesirable behaviours while under the influence of alcohol during the past 12 months. As figure 2.16 shows, 16 per cent of males (aged 16-24) and 8 per cent of females admit to driving while affected by alcohol.

Of particular concern is the percentage of males who admit to driving while affected by alcohol (16 per cent aged 18–21 and 30 per cent aged 22–24).
Figure 2.16: Behaviour of Victorian young people aged 16–24 under the influence of alcohol

Source: Premier's Drug Prevention Council, Victorian Youth Alcohol and Drug Survey 2004

Measures to address alcohol misuse

- The Premier has established a Ministerial Taskforce, chaired by the Minister for Mental Health, Lisa Neville MP, to lead the development of a comprehensive whole of government strategy (Victorian Alcohol Action Plan - VAAP) to reduce alcohol related harm, especially teenage binge drinking.

- Currently the Victorian Government provides funding to a number of initiatives that address alcohol misuse in the community. These include:
  - Good Sports Program – an accreditation program that addresses alcohol use in amateur sporting clubs. It aims to assist sporting clubs manage alcohol responsibly via a step-by-step accreditation process and provides a basis of incentives for sporting clubs to develop alternative income streams not related to alcohol.
  - Drug education in primary and secondary schools. A range of drug education initiatives are in place including: guidelines on effective drug education programs; 18 Senior Program Officers based in regions to support schools through professional development and advice; and evidence-based resources including Get wise, Celebrating safety, Rethinking drinking and In tune.
  - Schoolies Week – a harm minimisation response to encourage young people to celebrate their graduation safely is coordinated across government by an interagency steering committee, which includes local government. Information for safer schoolies week celebrations is promoted on the Victorian government’s youthcentral website. The website is targeted at young people heading to end of school celebrations and provides information on the risks and effects of alcohol, and advice and strategies for drinking safely.
  - Alcohol and Workplace initiative – a website has been established to assist employers recognise alcohol issues in the workplace and to develop policies and practices to address alcohol-related concerns.

- The Victorian Government has also taken the lead on issues relating to alcohol advertising and currently provides the Chair and secretariat support to a national committee, the Monitoring of Alcohol Advertising Committee (MAAC), which monitors, in particular, the exposure of young people to alcohol advertising.
**Young drivers**

Despite a large reduction in Victoria’s road toll since 1989, the 18–25 age group remains vastly overrepresented in road trauma statistics. In their first year of driving, young Victorians are almost four times more likely to be involved in a fatal or serious injury crash than more experienced drivers.

While 18 to 25 year olds represented 14 per cent of licenced drivers, they accounted for 30 per cent of all drivers killed on Victoria’s roads and 25 per cent of claims (from hospitalised drivers) received by the Transport Accident Commission (TAC) in 2005.

A review of young drivers by the Australian Federal Office of Road Safety, now the Australian Transport Safety Bureau (ATSB), found them to be at greater risk on the roads for a variety of reasons including:

- lack of experience
- limited ability and judgement
- underestimation of risks
- deliberate risk-taking behaviour
- use of alcohol and drugs.

As part of a coordinated effort to reduce the incidence, severity and cost to the community of road crashes involving young people, the TAC developed a youth strategy aimed at pre-drivers, learner drivers and probationary drivers. The strategy includes the programs and initiatives of the TAC’s road safety partners: VicRoads, Victoria Police and the RACV.

Launched in March 1999, the HELP campaign aims to achieve long-term reductions in the youth road toll by:

- reducing deliberate risk-taking behaviour
- increasing learner driver experience
- providing a research platform to address young driver behaviour.

A new Graduated Licensing System is also being introduced in Victoria. From 1 July 2007 and from July 2008, new requirements for probationary license holders and young drivers aged up to 25 will be implemented.

Arrive Alive 2008–17 will introduce a range of new road safety measures which are aimed at achieving a 30 per cent reduction in Victoria’s overall road toll. Measures include a peer passenger restriction on first year probationary drivers. Based on research that shows that the fatal crash risk for P-plate drivers increases by four times when they carry two or more passengers, P-platers will no longer be able to carry more than one peer passenger between 16 and 21 years.

**Illicit drugs**

**Young people aged 12–17**

The Victorian Secondary School Students’ use of Licit and Illicit Substances survey (2005) shows that cannabis is the most commonly used illicit drug among young students aged 12–17 and use is higher among young males than females. While the percentage of young people who have ever used cannabis ranges from 3 per cent (of 12 year olds) to 33 per cent (of 17 year olds), rates of regular usage\(^\text{86}\) are very low (between 1 and 6 per cent). There has also been a significant decrease in the use of cannabis among young students between 1996 and 2005 (see figure 2.17).\(^\text{87}\)

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86 This is defined as having used cannabis 10 or more times in the past year.

87 The percentage of students viewing regular cannabis use as very dangerous has also increased significantly since 1996, including a significant increase between 2002 and 2005.
Young people aged 16-24
The Victorian Youth Alcohol and Drug Survey found that cannabis is also the most widely used illicit drug among young people aged 16-24, with 48 per cent of young people reporting having ever used cannabis. The survey also identifies a decline in the use of any illicit drugs, with the proportion of those who had ever used (defined as lifetime use) illicit drugs falling from 54 to 50 per cent between 2003 and 2004. The reported use of cannabis shows the most significant fall.

Use of other illicit drugs ranged from 18 per cent who had ever used ecstasy, to 15 per cent (ever using) amphetamines and 6 per cent cocaine.

Young people (aged 16-24) admit to engaging in similar behaviour under the influence of illicit drugs to those that they report engaging in under the influence of alcohol. The most common behaviour reported was driving with 26 per cent of males and 15 per cent of females reporting that they had engaged in this behaviour.

Treatment for drug and alcohol issues
During 2005–06, 8890 young people aged 12–25 (or one in 1000) accessed drug and alcohol treatment services in Victoria. Young people aged 12–25 made up 33 per cent of all Victorians who sought drug and alcohol treatment (while accounting for only 17.7 per cent of the population).

Males were much more likely than females to access drug and alcohol treatment and, in line with the pattern of drug and alcohol use, the likelihood of accessing drug and alcohol treatment increased with age.

Cannabis and alcohol were the most common primary drugs for which young people sought treatment, followed by heroin, amphetamines and ecstasy. Young people accessed a range of different types of treatment services, with the most common ‘course of treatment’ (COT) being for counselling, consultancy and continuity of care (32.4 per cent of COTs) and alcohol and drug outreach service (25.7 per cent).

Sharing of injecting equipment among young people
The Victorian Needle and Syringe Program is a major public health initiative to minimise the spread of blood-borne viruses among injecting users and to the wider community, using strategies designed to prevent the sharing of used needles or other injecting equipment. The proportion of young people (using this program) who report having shared injecting equipment declined markedly from 20.2 per cent in 2003–04 to 2.7 per cent in 2005–06 but has risen in 2006–07 to 4.6 per cent.

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**Figure 2.17: Percentage of students (aged 12-17) who have ever tried cannabis**

Source: Victorian Secondary School Students’ use of Licit and Illicit Substances 2005

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---

**Figure 2.17: Percentage of students (aged 12-17) who have ever tried cannabis**

Source: Victorian Secondary School Students’ use of Licit and Illicit Substances 2005
The prevalence and effects of parental substance use

A recent report by the Australian National Council on Drugs (ANCD) synthesises research on the impact of parental substance use on child outcomes. It suggests that there is good evidence that parental substance misuse is highly disruptive to family functioning. In particular the report notes that children of alcoholics have been found to be at elevated risk for negative outcomes including anxiety, depression, conduct disorder, aggression and behavioural problems (ANCD 2007).

The report estimates that 13.2 per cent of Australian children are at risk of exposure to binge drinking in the household by at least one adult with another 2.3 per cent of Australian children living in a household where there is at least one daily cannabis user (ANCD 2007).

The Victorian Public Health Survey finds that in 2006, 23.4 per cent of parents of children aged under 18 surveyed were categorised as risky drinkers, up from 21.7 per cent in 2005. A total of 13.3 per cent of parents stated that they occasionally have people smoking in their home (down from 13.5 in 2005), with an additional 12.2 per cent of parents stating that people are frequently smoking inside their home (down from 12.3 in 2005) (VPHS 2006).

Family and community risk factor

In families where parents are tolerant of their children’s alcohol or drug use children are more likely to become drug abusers and the risk is increased where adults involve children in their own drug or alcohol using behaviour (for example, by asking the child to light a cigarette). Also, in communities whose norms are favourable to substance use, and where substances are more easily obtained, young people have been shown to have higher rates of youth alcohol and drug use.

The HNSS found that a very small minority of young Victorians (0.6 per cent) were at risk from parental attitudes that were favourable to drug use. The study found that 3.4 per cent of young people were at risk from living in communities where the norms were favourable to substance use and 4.1 per cent were at risk from living in communities with a perceived availability of drugs. Indigenous young people and young people from lower socioeconomic groups were more likely to perceive that they had access to drugs (Williams 2007).

2.4 Emotional and mental health

Improving the mental health of young Victorians

In February 2006, the Council of Australian Governments (COAG) identified mental health as an issue of national importance. As part of Victoria’s contribution to the national mental health plan the Boston Consulting Group (BCG) prepared the report Improving mental health outcomes in Victoria.

The report highlights particular groups of people who tend to fall within the cracks of Commonwealth and state-funded parts of the mental health system, including:

• children with significant behavioural problems
• children at risk of mental illness through family environments
• youth with some level of mental disorder.

The authors argue that effective early intervention for children and youth could deliver significant social benefits including a reduction in suicide and crime rates.

The HNSS included a series of questions to measure whether these risk factors applied. Examples of questions include: ‘How wrong do your parents feel it would be for you to smoke cigarettes?’ (measuring parental attitudes that are favourable to drug use) ‘How wrong would most adults in your neighbourhood think it is for kids your age to drink alcohol?’ (measuring communities whose lores or norms are favourable to substance use) and ‘How easy would it be for you to get marijuana?’ (measuring perceived availability of drugs).

6 The HNSS included a series of questions to measure whether these risk factors applied. Examples of questions include: ‘How wrong do your parents feel it would be for you to smoke cigarettes?’ (measuring parental attitudes that are favourable to drug use) ‘How wrong would most adults in your neighbourhood think it is for kids your age to drink alcohol?’ (measuring communities whose lores or norms are favourable to substance use) and ‘How easy would it be for you to get marijuana?’ (measuring perceived availability of drugs).

6.3 per cent of young people from the lowest socioeconomic group, and 6.2 per cent of Indigenous young people were at risk from perceived availability of drugs, compared with 3.0 per cent in the highest socioeconomic group and 3.5 per cent in non-Indigenous young people.
Mental health is defined by WHO as ‘a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community’ (WHO 2001, cited in AIHW 2007).

Many of the indicators discussed elsewhere in this report are protective factors that may promote mental health and reduce the likelihood of mental health problems developing (e.g. ‘reported support from family and friends’, economic security and good physical health). This section looks principally at what is known about emotional, behavioural and mental health problems among young Victorians.

There are a number of definitional and methodological problems associated with measuring these problems as these are clearly subjective states that vary across cultures and subgroups of children and families. There are also difficulties in employing service-based data to estimate prevalence as many young people who are experiencing psychological difficulties may not come to the attention of mental health services.

A distinction is commonly made, however, between mental disorders and mental health problems. Mental disorders are defined by a set of symptoms that are typically associated with an impaired capacity to work, to engage with others and to deal well with the challenges of everyday life. The term mental health problem is commonly used to define a level of mental disorder of concern to health practitioners but one that does not necessarily meet all of the diagnostic criteria for a mental disorder.

Adult mental disorders most commonly manifest themselves in adolescence. Mental health problems and disorders can have a serious impact on the short and long-term wellbeing of young people – affecting their participation in education and the workforce, and relationships with families and friends. In some instances they can affect personality development and even lead to death as a result of suicide or drug overdose.

**Prevalence of mental health problems and disorders**

Data relating to the prevalence of mental health problems in young people in Australia (aged 12–17) is available from the child and adolescent component of the National Survey of Mental Health and Wellbeing 1998. The survey showed that 14 per cent of young people aged 12–17 years had a mental health problem, with approximately equal numbers having internalising or externalising problems (cited in AIHW 2003b).

Around 12 per cent of young people (aged 12–17) were assessed as having attention deficit hyperactivity disorder (ADHD), conduct disorder or depressive disorder, with ADHD the most prevalent at 8 per cent, followed by depressive disorder (4 per cent) and conduct disorder (3 per cent).

The 1997 National Survey of Health and Wellbeing identified that, among young people aged 18–24, 27 per cent of males and 26 per cent of females had a mental disorder. Substance use disorders were the most prevalent. One in 10 young people experienced anxiety disorders and depression and dysthymia (chronic mild depression) affected 3 per cent of males and 11 per cent of females (1997 National Survey of Health and Wellbeing, cited in AIHW 2007).

Victorian survey data on the prevalence of mental health problems among young people is limited, particularly for the 12 to 17-year age group. The sections below cover depressive symptoms in young people in Years 6 and 8; psychological distress (in young people aged 18–24); self-harm and suicide trends (in young people aged 12–24) and young people’s use of mental health services.

**Depressive symptoms in young Victorians: Years 6 and 8**

The HNSS used the Short Mood and Feelings Questionnaire (Angold et al. 1995) to ascertain the proportions of young people in Years 6 and 8 who were showing depressive symptoms. This 13-item scale is commonly used, both nationally and internationally, as a reliable tool for identifying and measuring the extent of depressive symptoms in children and adolescents.

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**Notes:**

98 The survey, based on parent self-report, examined internalising problems (such as anxiety or depression) and externalising problems (such as delinquency or overt aggression).

99 Anxiety disorders were not included in this survey.

100 It is important to note that the 1997 and 1998 surveys used different survey instruments. The findings from the two surveys are not comparable.

101 Examples of statements included in the scale are: ‘In the past two weeks, I felt miserable or unhappy’; ‘In the past two weeks I was a bad person’; ‘In the past two weeks, I felt like I was no good anymore’; ‘In the past two weeks, I didn’t enjoy anything at all’. Students are asked to respond to these statements as either ‘not true’ ‘sometimes true’ or ‘true’. A score of ‘0’ is given for ‘not true’ responses, of ‘1’ for ‘sometimes true’ responses and of ‘2’ for ‘true’ responses.
Just under a third of students in Years 6 and 8 (29.8 per cent) scored more than seven on the depression scale, indicating the presence of depressive symptoms of concern. Young people from the higher SES quintiles were less likely than those from lower quintiles to score more than seven on the scale (see table 2.13).

Table 2.13: Percentage of students scoring more than seven on the Angold depression scale by SES

<table>
<thead>
<tr>
<th></th>
<th>Lowest (%)</th>
<th>2(%)</th>
<th>3(%)</th>
<th>4(%)</th>
<th>Highest (%)</th>
<th>Total (%)</th>
</tr>
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<tr>
<td>Yes</td>
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<td>71.3</td>
<td>71.4</td>
<td>75.5</td>
<td>70.2</td>
</tr>
</tbody>
</table>

Source: Williams 2007

**Psychological distress**

Psychological distress refers to an individual’s overall level of psychological strain or pain as manifested in depression, anxiety and anger. The distress may be transient and short lived (relating, for example, to stressful life events) or it may be continuing, particularly among those who are experiencing mental health problems and disorders.

Figure 2.18 shows the levels of psychological distress of young people (aged 18–24) in Victoria, from 2001 to 2006, as measured using the Kessler 10 (K10) distress scale. There is a strong association between the K10 scale and current diagnoses of anxiety and affective disorders and a lesser, though significant, association with other mental disorder categories (Andrew & Slade 2001, cited in AIHW 2007).

The figure shows that the majority of young people experience only low to moderate distress. It also shows that the proportion of young people experiencing high to very high levels of distress has declined from 20.2 per cent in 2001 to 14.8 per cent in 2006.

Figure 2.18: Psychological distress as measured by the Kessler 10 (K10) score category, young people 18–24 years of age, Victoria, 2001–06

Source: VPHS 2006, Department of Human Services

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102 Angold recommends a score of more than seven as the cut-off point to indicate the presence of depressive symptoms of concern. A score of more than seven is not an indication of clinical depression but it does suggest that the young person is experiencing depressive symptoms that require attention and monitoring. In the 1999 survey Improving the Lives of Young Victorians, a cut-off point of more than 11 was used. This is more indicative of clinical depression. A total of 18.2 per cent of students from Years 7, 9 and 11 scored 11 or more in this survey.

103 The K10 distress scale is a questionnaire that asks about feelings such as nervousness, hopelessness, restlessness, depression and worthlessness (AIHW 2007).

104 These data can be compared with Australian data from the 2001 and 2004–05 National Health Surveys (cited in AIHW 2007). In 2001 the proportion of young Australians experiencing high to very high levels of distress was 16.45 per cent, less than the figure for Victoria of 20.2 per cent. In 2004–05 the Australian figures were 15.55 per cent. This is broadly similar to the Victorian figure of 16.5 per cent.
The VPHS also show that young women are much more likely than young men to report high or very high levels of psychological distress. For example, in 2005, 22.5 per cent of young women reported high or very high levels of distress, compared with 10.6 per cent of young men and in 2004, 24.8 per cent of young women reported high or very high levels of distress, compared with 8.6 per cent of young men.

It is of some interest that rates of high or very high psychological distress show a marked increase among females between 2003 and 2004, followed by a slight decline in 2005, with a fairly stable trend across the four-year period. In contrast to this, for males, there is a marked decline (in rates of high or very high psychological distress) between 2003 and 2004, and a suggestion of a declining trend over the four-year period (see Table 2.14).

Table 2.14: Percentage of young males and females in Victoria reporting high or very high levels of distress, 2002–05

<table>
<thead>
<tr>
<th></th>
<th>2002 (%)</th>
<th>2003 (%)</th>
<th>2004 (%)</th>
<th>2005 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>13.0</td>
<td>13.5</td>
<td>8.6</td>
<td>10.6</td>
</tr>
<tr>
<td>Females</td>
<td>22.8</td>
<td>18.1</td>
<td>24.8</td>
<td>22.5</td>
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The wellbeing and mental health of refugees and asylum-seekers

Refugees and asylum seekers have commonly experienced significant trauma and loss – experiences that may impact on their current and future mental health (Boese & Scutella 2006). Although analysis of some refugee groups does not show a higher prevalence of psychiatric disorders than for the general population (McKelvey et al. 2002), young people from migrant families have been shown to have more difficulties accessing mental health services (Boese & Scutella 2006).

The mental health and wellbeing of young people in residential care

Department of Human Services analysis of 2006 data suggest that children and young people in residential out-of-home care are more likely to have or be at risk of having behavioural and mental health problems than young people in the general population.

During April 2006, 342 young people in residential care in Victoria were assessed using the Strengths and Difficulties Questionnaire (SDQ). This is a reliable and widely used tool that measures emotional symptoms, conduct problems, hyperactivity and peer problems to derive a total difficulties score.

The Department’s analysis found that the mean (average) total difficulties score for the residential care group was 19.25. Sixty-five per cent had total difficulty scores of 17 or more. UK research identifies children with scores of 14 to 16 as ‘borderline’ and with scores of 17 or above as at ‘abnormal’ risk of having a diagnosable mental health disorder (Meltzer et al. 2000).

Children and young people in residential care were also assessed using the Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA), a mental health outcome assessment tool (comprising 13 scales) that is used by clinicians in the UK and Australia. A total of 59 per cent of the residential care group had scores of 13 or above (a score that is consistent with that of children and young people receiving a service from a child and adolescent mental health service). The mean HoNOSCA scores were greater for young people aged over 13 than for those under this age. SDQ scores were also higher in older children, although the difference in scores between older and younger children was smaller than in the HoNOSCA.

(Department of Human Services, unpublished data)
These findings illustrate the impact that their experiences of abuse and trauma have had on the mental health status and wellbeing of young people in State care, and the significant challenges we face in providing them with appropriate care. There is a clear need to further strengthen our service response to better meet the needs of these children, and this requires joint effort across numerous areas of Government. In Victoria, significant investment is occurring through services such as Take Two, which provides intensive support to children and young people displaying significant emotional and behavioural difficulties as a result of abuse, and the Therapeutic Foster Care program which seeks to provide care better able to meet the therapeutic needs of children. The Hurstbridge Farm Therapeutic Care service is another example of our focus on meeting therapeutic and mental health needs. The out-of-home care service system continues to strive to improve the quality of services, so that the care young people receive provides a therapeutic response which is able to address immediate needs and improve long term outcomes.

These issues will also be addressed in the new Mental Health Reform Strategy. A key thrust of this strategy is to resource better responses to mental health problems experienced by clients of other state funded service systems, with priority being given to vulnerable young people. This will involve stronger partnerships between specialist Child and Adolescent Mental Health Services and out-of-home care providers, training of workers in the residential care system in mental health issues, and new funding models that support more flexible, tailored mental health interventions.

Self-harm and suicides

There is a strong relationship between self-harm and suicide, and deliberate self-harm (defined as ranging from a failed suicide attempt to scratches on the wrist) is probably the best predictor of suicide. While suicide among young people is rare, particularly among those under 15, and suicide rates are declining, the number of young people who self-harm is not inconsiderable. Many who do self-harm will not come to the attention of hospitals, so the data presented below underestimates the actual prevalence rates.

Emergency department presentations

The number of young people presenting for self-harm at hospital emergency departments is recorded in table 2.15 for the years 2003–04 to 2006–07. The numbers have increased over this period from 2227 to 2503. However, as these data only relate to four years, further data will be needed to confirm if there is an increasing trend.

Table 2.15: Self-harm emergency hospital department presentations in young people aged 12–25, Victoria, 2003–04 to 2006–07

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<tr>
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<tbody>
<tr>
<td>Metropolitan</td>
<td>1602</td>
<td>1690</td>
<td>1783</td>
<td>1645</td>
</tr>
<tr>
<td>Rural/regional</td>
<td>603</td>
<td>686</td>
<td>705</td>
<td>791</td>
</tr>
<tr>
<td>#NA</td>
<td>72</td>
<td>55</td>
<td>56</td>
<td>67</td>
</tr>
<tr>
<td>Total</td>
<td>2227</td>
<td>2431</td>
<td>2544</td>
<td>2503</td>
</tr>
</tbody>
</table>

Source: VEMD data. Note: #NA refers to young people from interstate or overseas.

Analysis of data for 2004–05 shows that young females are much more likely than young males to present for self-harm (around two-thirds of females compared with one third of males). Young people aged 16–22 are the most likely to present, with the highest number of presentations (254) in 19 year olds.

Hospital admissions

There were 1549 hospital admissions for self-harm injury in 2006 (consistent with 1549 in 2005 and 1548 in 2004). In contrast to other causes of injury hospital admissions in this age group, most self-harm hospitalisations (in 2006) were female (72 per cent). The peak ages for self-harm admissions were ages 16 through to 21.\(^{107}\)

\(^{107}\) By far the most common mechanism of injury for self-harm hospitalisations was overdose of pharmaceuticals (75 per cent of self-harm hospitalisations), followed by cutting/piercing by a sharp object (16 per cent). There were another 418 hospital admissions for self-poisoning by pharmaceuticals and other and unspecified poisoning substances where the intent was undetermined.
Figure 2.19 shows the yearly trend in self-harm injury admission rates in Victoria for the 12-year period from 1995 to 2006. A young person is recorded as an admission (in hospital records) if the duration of their treatment lasts more than four hours. Where the young person is discharged from hospital in less than 24 hours, they are counted as a ‘same-day admission’.

There was little change in the self-harm hospitalisation rate over time if same-day admissions are excluded, but a non-significant upward trend in admission rates for self-harm injury if they are included. The significantly decreasing trend in the rate of male hospitalisations for self-harm injury between 1995 and 2006 is partly offset by the increasing trend in the female self-harm hospital admission rate over the same period.\(^{108,109,110,111}\)

**Government investment to enhance mental health care in emergency departments**

The government has invested significantly in this area, with over $5 million in additional funding over the past three years, to enhance mental health care in major emergency departments. This has improved both the quality and timeliness of mental health treatment in emergency departments, including those people who have presented as having self harmed or attempted suicide.

**Figure 2.19: Yearly trend in self-harm injury admission rates, young people aged 12-24, Victoria, 1995-2006**

![Graph showing yearly trend in self-harm injury admission rates](image)

Source: VAED 1995-2006

\(^{108}\) The self-harm injury and poisoning admission rate (excluding same-day admissions) was stable over the 12-year period from 901/100,000 in 1995 to 975/100,000 in 2006, representing an estimated annual change of 0.04 per cent (-1 per cent to 1.1 per cent) and an overall increase of 0.5 per cent (-1.1 per cent to 13.6 per cent).

\(^{109}\) The self-harm injury and poisoning admission rate (including same-day admissions) increased over the 12-year period from 1386/100,000 in 1995 to 1549/100,000 in 2006, representing an estimated annual increase of 0.8 per cent (-0.3 per cent to 1.8 per cent) and an overall increase of 9.4 per cent (-3.8 per cent to 24.2 per cent). This increase in rate was not significant.

\(^{110}\) The male self-harm injury and poisoning admission rate (excluding same-day admissions) decreased significantly over the 12-year period from 320/100,000 in 1995 to 265/100,000 in 2006, representing an estimated annual decrease of 2 per cent (-3.3 per cent to -0.8 per cent) and an overall reduction of 21.7 per cent (-32.9 per cent to -9.4 per cent).

\(^{111}\) The female self-harm intentional injury and poisoning admission rate (excluding same-day admissions) increased over the 12-year period from 581/100,000 in 1995 to 710/100,000 in 2006, representing an estimated annual increase of 1.1 per cent (-0.6 per cent to 2.8 per cent) and an overall increase of 13.7 per cent (-7.2 per cent to 38.7 per cent). This increase in rate was not significant.
Youth early psychosis services

Young people are more likely to develop psychosis during late adolescence or early adulthood. Psychotic symptoms are not always recognised or treated as they may be combined with, or masked by, other problems such as substance abuse. Research shows that the sooner psychosis is detected and treated, the greater the likelihood that the young person will recover and that long-term problems can be avoided or minimised.

Since 2003, the Victorian Government has been rolling out new early intervention services for young people who are experiencing, or at risk of, a first episode of psychosis. These youth early psychosis (YEP) services are an innovative, youth-focused subspecialty program within the adult area mental health service and have close links to child and adolescent mental health services, primary care services and other community services. Treatment is targeted at the particular stage of the illness, with lower caseloads making a more intensive case management approach possible. YEP services are resourced to ensure continuity of care by providing treatment and support over the crucial three-year period after psychotic symptoms first emerge, when relapse is most likely to occur.

In 2005–06, YEP services assisted more than 1200 young Victorians. Many of these also had drug and alcohol problems. Funding for YEP services has quadrupled since 2003–04 and totals $7.9 million in 2007–08. New YEP services were established in Ballarat, Box Hill and Warrnambool last year and YEP services are now being delivered from more than 25 sites across the state. The statewide rollout of the YEP program will be completed in 2007–08 with the establishment of four new services to cover the catchment areas of The Alfred, Austin Health, St Vincent’s Health and Melbourne Health’s Northern Area Mental Health Service.

A recent youth early psychosis status report, compiled by the Department of Human Services Mental Health Branch, found that YEP services deliver on their primary role of providing intensive case management for young people aged 16–25 with early psychosis. The care they deliver is guideline based and phase specific. In keeping with the YEP service focus on early intervention, a lower threshold for intake is in place and is supported by effective linkages with triage and CAT teams.

Staff working in youth early psychosis services have commented that the program embodies a recovery-oriented approach to clinical practice, adding that the opportunity to deliver significant preventive work with young people is a definite ‘hook’ for recruitment. Young people who have used a YEP service have described it as ‘helpful’, ‘caring’, ‘flexible’ and ‘supportive’. ‘The YEP has given me a better understanding of my illness and of my treatment’, commented one young woman in response to a recent survey. Another user liked the fact that the YEP service was outreach based and, in his case, delivered entirely in the family home. The most compelling praise probably came from a young person who felt the YEP service was ‘reassuring’ and ‘makes you feel you’re not alone’.

Suicides

The suicide rate has declined fairly steadily since 1990 (an estimated 4 per cent each year and by 50 per cent over the whole period) and in 2005 it was the lowest over this 16-year period. There were 57 suicides among 12–24 year olds in Victoria in 2005 (44 males and 13 females), compared with 67 in both 2004 and 2003. Most suicide cases in 2005 were young men aged between 15 and 24 years (n=44, 78 per cent) (ABS Death Unit Record File (ABS-DURF) 1990–2005).

Suicide and Indigenous young people

There are no reliable national or Victorian data on the prevalence of mental health problems in Indigenous young people. However, national data show that suicide and self-harm are more frequent in Indigenous communities than among other Australians. Evidence suggests that suicide and self-harm are most common among young men and are commonly associated with alcohol and substance use and often preceded by interpersonal conflicts (Steering Committee for the Review of Government Service Provision 2005).
Suicide in rural areas

In the late 1980s and early 1990s, suicide was the leading cause of death for 15 to 19-year-old rural males (Dudley et al. 1992, Hassan, 1995). Evidence suggested that suicide rates were higher in rural than urban males (Kelk 1995, Baume & Clinton 1997) and higher in smaller towns than larger rural centres (Kelk 1995). Rates have declined in recent years and there is considerable variation across rural areas, with some communities having higher rates and rates changing from year to year (Cantor & Slator 1997, Hassan 1995). Green (1997) argued that suicide rates are high for young, rural men who were homosexual, confused over sexual identity and aware of the impending marginalisation that can be associated with homosexuality.

Young people’s use of mental health services

Victorian Government-funded specialist mental health services for young people under 25 years are offered by child and adolescent mental health services (CAMHS), by youth specific services such as Orygen Youth Health, and through a specialist stream within adult mental health services that, in particular, targets youth early psychosis. These specialist services are part of a broad system of mental health care that includes targeted services such as Take Two and more universal services such as school support services, youth services, community health centres, general practitioners and private allied health practitioners.

Young people seeking help and advice for a mental health issue

Recent data from the VPHS and from Kids Help Line suggest that there are some recent increases in the numbers of young people who seek advice or help for a mental health issue. The VPHS shows a small rise in the proportion of young people (aged 18–24) who report seeking help for a mental health problem (from 8.9 per cent of young people in 2004 to 9.3 per cent in 2005 and 10.4 per cent in 2006). In their 2005 report on Victoria, Kids Help Line describes a more than twofold increase, over the past three years, in the proportion of calls from young people that relate to mental health issues (Kids Help Line and Boystown 2006b).

Young people’s use of community health care services

In 2004–05 young people (under 25 years) accounted for 28 per cent of all community mental health care service contacts in Victoria (and 25 per cent of all community mental health care service contacts in Australia) (see figure 2.20). Young Victorians (aged 15–24) made up a slightly smaller proportion of community mental health care service contacts, than young Australians of the same age. However, young Victorians (aged 15–24) made up a greater proportion of community mental health care service contacts, than young Australians of the same age.

Figure 2.20: Community mental health care service contacts by age, Victoria and Australia, 2004–05

Source: Mental Health Services in Australia 2004–05, AIHW (cat. no. HSE 47)

***Community mental health care refers to specialised mental health care provided by community mental health services and hospital-based ambulatory services, such as outpatient clinics that are government operated. Service contacts are defined as the provision of a clinically significant service by a specialised mental health service provider(s) for patient/client, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24-hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question (Mental Health Services in Australia 2004–05, AIHW).
Psychiatric hospitalisation rates

The rate of residential mental health care episodes is higher among young people (aged under 25) in Victoria than in Australia (see figure 2.21).

Figure 2.21: Episodes of residential mental health care by age, Victoria and Australia, 2004–05 (rate per 10,000 of population)

Source: Mental Health Services in Australia 2004-05, AIHW (cat. no. HSE 47)

**Kids Help Line and young people in Victoria**

Kids Help Line offers a free, confidential and anonymous, 24-hour telephone and online counselling service for young people, in Australia, aged between five and 25. The demand for Kids Help Line services in Victoria closely reflects the proportion of Victoria’s five to 25-year-old population (Kids Help Line and Boystown 2006a).

Kids Help Line carried out 10,395 telephone counselling services in 2005 in Victoria (Kids Help Line and Boystown 2006b). The vast majority (96 per cent) of these were with young people aged 10–25 (37.1 per cent aged 10-14; 53.4 per cent aged 15–18 and 5.6 per cent aged 19–25).

Family relationships accounted for the largest proportion (16.5 per cent) of ‘main problem’ area classifications (in all age groups), followed by relationships with friends and peers (15.3 per cent) and relationships with partners (9.5 per cent).

The proportion of ‘main problem calls’ relating to mental health (7.4 per cent) was similar to that for emotional or behavioural management issues (7.2 per cent). Calls relating to mental health issues had more than doubled in the past three years and calls relating to emotional and/or behavioural management issues had shown an upward trend.

Ten per cent (1032) of the callers reported engaging in deliberate self-injury and current suicidal thoughts were reported by 315 callers (3.4 per cent).
Young people and mental health services in rural areas

Access to health services has been identified as problematic for rural young people, (Kenyon et al. 2001, Wyn et al. 1998). Research also suggests that there is a lack of access to, and availability of, mental health services, especially specialist services, in rural areas (Francis et al. 2006, Hodges et al. 2007). Barriers to service seeking in rural communities include stigma, lack of anonymity, logistical difficulties (cost, availability of transport), lack of acknowledgement of mental health issues, self-reliance and myths indicating that mental illness is a form of insanity (Francis et al. 2006, Hodges et al. 2007).

Young rural people can go to great lengths to hide aspects of their identity that may be stigmatising, even at the expense of hiding information from potential supports. For example, a young person with a mental illness may only tell their family, while friends and teachers, who could be strong supports, remain unaware (Bourke 2002, 2003).

Furthermore, because rural areas have a smaller population, there are fewer choices of friends and social networks. For young people, this means that they may have the same peers at school, at sports clubs, youth groups and in social circles. Those who ‘fit in’, ‘fit in’ in all networks; but those who are marginalised, tend to be marginalised in all networks.

Families where a parent has a mental illness

ABS estimates suggest that between 21.7 per cent and 23.5 per cent of children in Victoria (approximately 250,000 children) are living in households where a parent has a mental illness (Maybery et al. 2006) and that 34,666 children live in families where a parent has a severe mental illness being assisted by specialist mental health services. Around half of the adults attending a specialist mental health service also have drug and/or alcohol-related difficulties.

Most children of parents with a mental illness remain well – some may just need support and others may be at more risk of injury and/or abuse or of developing severe disorders themselves. Between a quarter and a half of these children will experience some psychological disorder in childhood, adolescence or adulthood (compared with 10–20 per cent of others in the population) and 10–14 per cent will be diagnosed with a psychotic illness at some point in their lives (compared with 1–2 per cent of the general population) (cited in Department of Human Services 2007c).

The Victorian Government’s Families where a parent has a mental illness strategy (FaPMI) aims to reduce the impact of parental mental illness on all family members through timely, coordinated, preventive and supportive action. The priority is on better understanding the needs of families where a parent has a mental illness and the associated risks for all family members, including children (Department of Human Services 2007c).
Case studies

The Victorian Indigenous Surf Titles

More than just a competition, the seventh Indigenous Surf Titles gave many young Indigenous Victorians their first taste of the inclusive, enticing culture of surfing.

Held in February 2007, and attracting more than 150 competitors from Victoria's Indigenous communities, the titles featured competitive events for all experience levels, alongside learn to surf programs taught by Indigenous coaches.

The Victorian Indigenous Surf Titles strongly promote youth involvement and self-esteem, as well as highlighting water safety, physical activity and healthy lifestyles to the Indigenous community.

Supported by Surfing Victoria and Sport and Recreation Victoria’s Indigenous Sports Program, the event has been developed in strong partnership with the local Indigenous Wathaurong community.

Surfing Victoria has also created a pathway from the titles to the rewarding world of professional surfing. The winner of the open men’s event now has access to a wildcard for the pre-Bells Beach event – the winner of which receives entry into the Bells Beach Classic.

Anecdotal evidence from participants suggests that the Indigenous Surf Titles are providing Indigenous youth with a fun, worthwhile experience. Older community members have expressed their enjoyment in watching the young people participate, and being able to take part alongside them.

Max Wells, executive director of Surfing Victoria, says the success of the program is illustrated in its expansion since it began in Warrnambool with local competitors: ‘It’s truly becoming a statewide event now. We have people travelling from as far away as Swan Hill, Kerang, the Latrobe Valley, Phillip Island, metropolitan Melbourne and Warrnambool to compete.’

As well as driving the event, Surfing Victoria provides funding and supplies surfboards and wetsuits for participants who need them.

Funding for the 2007 Victorian Indigenous Titles was also received from the Victorian Government’s Indigenous Sport and Recreation Program and the Play it Safe by the Water campaign, and from VicHealth. Other sponsors included the CMFEU, the Victoria Police community policing unit and Wathaurong Glass.
Family and community group conferencing

Since 2006, young people and families in the Wodonga area have had access to Family and Community Group Conferencing (FCGC), a community-based partnership between the Upper Hume Community Health Service and five local high and primary schools, police and the Centre for Adolescent Health, Melbourne.

The program focuses on four areas: wellbeing of the child or young person; engagement at school; school attendance; and family conflict and restorative practices. It puts the child or young person involved at the centre of the program, highlighting their strengths and identifying their needs.

Working closely with family support agents to build stronger networks and communities around families, the program has been successful in improving the wellbeing and educational achievements of many local young people.

One child supported by the program was a nine-year-old Aboriginal boy who had been subject to child protection intervention. He was attending school irregularly and had trouble regulating his own emotions that, at times, was leading to violent or threatening behaviour.

Working with a mental health counsellor, the young person attended a Family and Community Group Conference with his extended family members and adult friends. Although initially reluctant to join the ‘circle’, he gradually got involved in a discussion about his strengths and attributes.

By the end of the conference, he with his family group, had developed some strategies for managing his stronger emotions and putting in place services to support his family. His school later reported a much greater engagement at school, and follow up indicated that his family relationships had improved immensely.

FCGC has benefits for many children, especially when time is taken to prepare family members so they can genuinely participate and address issues of concern to them.

By focusing on the voice of the child at the centre of this work, family members become empowered to make decisions, with professionals and family friends as partners and resource providers.
Girls on the Go

With an emphasis on mental, physical and emotional health, the Girls on the Go program targets young women aged 11–18 who are struggling with disordered eating, poor body image, weight issues, or low self-esteem and confidence.

The program encourages young women to consider their health holistically, rather than emphasising weight, exercise or dietary concerns. Over 10 weeks, the program covers topics including body image and self-esteem; physical activity; healthy eating; safety and assertiveness; mental health; stress and relaxation; trust and confidence.

Since it was established in 2002 by the Greater Dandenong Community Health Service Youth Team, Girls on the Go has been run in partnership with schools. It is evaluated through surveys with students before and after the program, and through health promotion evaluation methods endorsed by the health promotion plan, including pre and post surveys.

Around 200 young people have attended the program over the past five years, and many have made valuable progress. Through the evaluation surveys, participants have noted that they feel more confident and positive, more relaxed, and better able to protect themselves. Others observed that through the program, they had made new friends and (importantly) had some fun.

Tania has been very concerned about her body image since she was in Year 7 (she is now in Year 9), constantly putting herself down. It was during her Year 8 school year that she visited a GP due to illness and was told by the GP that she should take diet pills so she ‘could look like all the other girls in Springvale’. Tania was willing to share her story with other participants during the program and allow the others to share their stories and support one another with the new knowledge that others were experiencing the same feelings. This support greatly increased Tania’s self-esteem, confidence and body satisfaction to a level where she is now able to present her experience of Girls on the Go to other girls who are currently participating in the Girls on the Go program.

Kate has a disruptive, unsettled home life that has greatly affected her moods and feelings about her own body image. She was also one of the quietest participants to have participated in the Girls on the Go program. Throughout the program Kate was an interested participant and active in most group activities, however, she rarely spoke and never shared her story with the rest of the group. She was well supported in the group and encouraged to participate to her level of comfort. In the months after finishing the program the facilitators were extremely pleased to see that Kate had become one of the most vocal members of the group, had a smile on her face and was comfortable talking in the group environment. She made friends with two other participants with whom she remains friends at present. Her self-esteem and confidence levels have increased dramatically. Kate was one of the participants who recently presented in front of young people and workers at a community-run youth forum about her experience in Girls on the Go, something she would never have volunteered for prior to Girls on the Go.
BodyThink

BodyThink is a fun, interactive and inclusive workshop that aims to build young people’s self-esteem, body image and media literacy.

It was created as a partnership between the Victorian Government, the Dove Self-Esteem Fund and the Butterfly Foundation in response to the Victorian Government’s Parliamentary Inquiry into Young People and Body Image in 2005.

Targeting young people aged 10–15, BodyThink is designed to show young people how ‘ideal’ images of beauty are created, so that they can get a better perspective on the world portrayed by media and advertising. It also helps them identify and deal with their feelings about their physical appearance.

Teachers and health and community professionals who attend the half-day BodyThink training are given information, tools and materials they can use to inspire young people to think more deeply about body image and self-esteem.

In the first year, 275 people attended the BodyThink training, and went on to deliver the program to almost 14,000 young people.

Comments from young people who have attended the program reveal a dramatic shift in attitude:

After the presentation I felt better about myself. I’ve realised I don’t look that bad and I can accept myself more.
Julie (13)

It helped me look at celebrities differently and realise that no one is perfect and I shouldn’t place so much pressure on myself to be perfect either.
Sophie (14)

More than helping me change the way I think about myself, it helped me to think differently about other people. Everybody has the right just to be themselves.
Ben (16)

I learnt that losing weight, which is something I have wanted to do for a long time, is really not going to make me happy. I thought it would, but now I realise that no matter what size you are or aren’t, happiness comes from within.
Sarah (16)
The FReeZA program was launched in 1996 as a key youth initiative under the Victorian Government’s Turning the Tide drug and alcohol strategy. A pioneering youth development program, FReeZA supports young people to stage events for other young Victorians.

Over the past 10 years, FReeZA has generated hundreds of live band gigs, dance parties and other cultural, recreational and artistic events in a range of supervised and safe venues.

As well as creating unrivalled development opportunities for the young people who join FReeZA committees, FReeZA events give more young Victorians the chance to enjoy great entertainment in a drug-, alcohol- and smoke-free environment.

The program also creates important performance opportunities for young musicians and emerging artists locally, and on a broader stage. FReeZA has been the springboard for many Victorian bands and musicians – especially those who’ve had the chance to showcase their talent through the statewide FReeZA Push Start Battle of the Bands competition.

Since 1997, more than 850,000 young people have attended FReeZA events and more than 7000 young people have participated on FReeZA committees in metropolitan, regional and rural Victoria.

Participants credit FReeZA with influencing changes in local culture, and young people’s attitudes to drugs and alcohol.

As Bob Cummings, who facilitates and supports the Murrindindi FReeZA committee in the Shire of Murrindindi, reflects, 'The program relies heavily on the support and involvement of the community, and they wouldn’t keep supporting us if the kids didn’t do such a great job.'

‘Young people know what the program is about, and they know what to expect when they come to our events. FReeZA really is a fantastic way to teach young people that they can have fun without drugs or alcohol – and give them a step into community life while we’re at it.’