Policy Paper

Youth Health and Wellness 2015

foundations

Children have the right to good quality health care, clean water, nutritious food and a clean environment so that they will stay healthy. CRC Article 24.[ii]

Contents

About Yfoundations

Yfoundations' mission is to create a future without youth homelessness. We represent young people at risk of, or experiencing, homelessness; and the services who provide direct support to them. Yfoundations provides advocacy and policy responses on issues relevant to young people affected by homelessness, and issues relevant to service providers. Our vision is to ensure that all young people have access to appropriate and permanent housing options that reflects their individual need.

Since its formation in 1979 Yfoundations has called for reform and improvement to broader systemic responses to youth homelessness and young people at risk of homelessness, to promote, protect and build on existing good practice and excellence and to ensure that youth homelessness remains a priority in public policy on homelessness, youth affairs, youth justice, education, child protection, employment, health/wellbeing and housing. In accordance with the United Nations convention on the rights of the child[iii] we advocate that every child has the right to appropriate care and protection.

In pursuit of these goals, we have identified five 'foundations' that are essential components to end youth homelessness and assure young people thrive. They include:

- Home and Place
- Safety and Stability
- Health and Wellness
- Connections
- Education and Employment

These foundations place youth homelessness within a broader context. Recognising that the issue is intimately connected to a broad range of societal determinants, and that ending youth homelessness will require genuine coordination across all service systems that support young people. They provide a framework for reaching out to other service areas to explore collaborative and integrated solutions. We believe it is vital that each young person has the opportunity within each domain to thrive. More information about these foundations is available on the Yfoundations' website.[iv]

Executive summary

Children and young people are living, learning and negotiating transitions into adulthood in an increasingly complex and challenging world. Young people have significant opportunities and choice available to them, but also unprecedented uncertainty and risk. Successful transition into independence requires resilience, emotional intelligence and positive social and emotional health.

Wellbeing during childhood and adolescence is the foundation for good health throughout adult life, and has significant influence on adult life satisfaction. Historically, education and intellectual development were purported to be the most important predictors of adult life satisfaction. More recently however, it has been noted that the emotional health of a young person is a powerful determinant of adult life satisfaction.[v]

According to the Australian Research Alliance for Children and Youth (ARACY), the health status of Australian children and young people is 'moderate'.[vi] Young people are starting to smoke at an older age, which is encouraging, however the rate of teenage pregnancy is high and child safety (which encompasses child abuse, youth suicide and injury related deaths) is poor when compared with other high-income countries. The increasing prevalence of mental health disorders among young people is of significant concern as is the rate of overweight and obesity among children and young people. Across the world, the health of adolescents has improved far less than that of younger children over the past 50 years.[vii]

Young people face significant barriers in accessing health care in Australia. Young people may find it difficult to access unbiased, reliable, trustworthy health related information for various reasons including living arrangements, spiritual, cultural or sexual identity and poverty, and informal information sources such as Internet sites and peers are often consulted in the first instance. The Internet provides great opportunities for the dissemination of information to people who would otherwise be excluded. This is particularly relevant given that many young people are connected to the Internet via their smartphones. However, it is also presents significant risks, notably concerning the potential for misdiagnoses or the provision of inaccurate information pertaining to critical or fatal health related issues. Disenfranchised young people, including those: living in rural or regional locations, experiencing homelessness, from low socio economic communities, Culturally and Linguistically Diverse (CALD) groups, Aboriginal families and Lesbian Gay Bi- sexual Transgender Queer Intersex (LGBTQI) young people, face even greater exclusions to health care.

The increasing rate of poverty in Australia is exacerbating the disparity in health and wellness outcomes between those raised within low socio economic households and their wealthier peers. There are large inequalities in areas such as income and family unemployment, where Australia currently ranks among the bottom third of all OECD countries.[viii] The consequences of these inequalities are evident across a wide range of outcomes areas, most notably in measures of poverty/deprivation, early childhood vulnerability, educational attainment and representation in child protection and Out of Home Care/ Specialist Homelessness Services and Juvenile Justice. [ix]

Adolescence and early adulthood represent a key time to intervene. It is critical greater emphasis be placed on improving the health and wellness of adolescents within the national health care agenda. All young people need to be able to access relevant, age appropriate health care and information. It is important they have the skills and literacy required to make informed decisions regarding their health. Intervening early prevents problems developing, while improving the resilience of the current generation and that of the next. [x]

This paper is not presenting any new research or findings. A plethora of data and research is available that pertains to all areas of youth health. This paper has drawn upon much of that literature, from Australia and overseas, to highlight a number of key issues that require urgent attention from the Australian Government and broader community.
It seeks to reinforce prior discourse emphasising the importance of adolescent health within the life span and the need to build greater momentum around ensuring all adolescent Australians are healthy and well.

To improve the health of our current generation of young people and future generations, it is crucial that greater investments be made into early intervention and prevention strategies. Focusing on the early years will have the greatest impacts on health outcomes and ensure our young people thrive.

Recommendations

- Adolescent health needs to be a key priority of Government policy and research agenda. Resources should be devoted to increasing the evidence base on prevention of, and early intervention in, poor health during adolescence.
- From existing and new data, develop evidence-based strategies targeting the specific health care needs of all young people from a developmental perspective, taking into

account the dynamic nature of these needs.

- Acknowledging that previous efforts made regarding improving early childhood health, subsequently led to substantial improvements in child public health, a similar emphasis needs to be placed on adolescent health to obtain a similar level of benefits.
- Greater focus should be given to the 'life course approach' in the development of health care systems and policy frameworks. This approach acknowledges the importance of adolescence to outcomes across the lifespan.
- Developing more collaborative intersectoral working across the service Sectors that are working with young people. Education and training agencies, the Justice system, youth and community groups, housing and health care providers, and young people need to work in unison, taking a 'whole of adolescent approach' to the services they provide. Strategies will be more effectual if they are considered from a broader perspective rather than in isolation.
- Greater engagement with and participation of young people within health policy and program development. Recognizing the skills and capacities of young people, and empowering them to take ownership of their own health, rather than viewing them as 'recipient' or 'consumer'. Adolescents need greater opportunities to be involved in creating the adolescent health agenda. This will ensure that the most pertinent issues remain at the forefront of the agenda and strategies developed are targeted and relevant. It is imperative that specific focus be placed on ensuring the voices of marginalised young people are also included.
- Investment into developing a robust and well-trained workforce that is prepared and equipped to support the needs of adolescents. Designing and delivering specific training for health service professionals working with young people, to improve understanding of the age group and their needs.

Youth Health and Homelessness

Every night in Australia, thousands of young people go to sleep without the safety, stability and support of a family home. Youth are resorting to abandoned buildings, Specialist Homelessness Services (SHS) refuges and/or other short term, makeshift shelters, couch surfing with friends and sometimes strangers or sleeping in a car. All youth have strengths, but youth experiencing homelessness often lack positive opportunities and support to apply them.

Children residing outside their family home are some of the most vulnerable young people in Australia. They are more likely than their peers to have:

- Experienced abuse, neglect or family violence at home;
- Dropped out of school;
- A mental disorder;
- Been involved with criminal activity and the juvenile justice;
- Misused drugs and alcohol; and
- Become dependent on welfare payments.

Around half of all adults who are homeless had their first experience of homelessness before they were 18 years of age.[xi]

A young person cannot adequately end their experience of youth homelessness if they are unable to access the support necessary to live a healthy and safe life. The need for young people to feel healthy is fundamental to the foundation of wellness. Wellness refers to being healthy in every facet of life. The World Health Organisation defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[xii] As recognised in the International Convention on the Rights of the Child, every young person has the right to make healthy life choices and access health care services when required.[xiii] It is thus important that all young people are encouraged and supported to achieve their optimum *Health and Wellness*.

For young people experiencing homelessness, and who may also be struggling with issues around cultural identity or sexuality, barriers in accessing health care may be especially profound. For example, LGBT young people experiencing homelessness (for which many this is common) are coping with multiple levels of marginalisation concurrently, each layer compounding the other. Social exclusion and marginalisation happens systematically through the daily actions of individuals. For individuals who are stigmatised by multiple identities

(homeless, LGBTQI, mentally ill or a drug user), distress and isolation may be cumulative.[xiv]

The Importance of Youth Health

The Australian Medical Association (AMA) defines 'youth' as those between 10-24 years.[xv] During this period of life significant and distinct change occurs, which creates a unique challenge for young people, their families and the systems supporting them. The AMA has highlighted the urgency in responding to the specific health care needs of this group

Adolescent health is a relatively new specialty within public health agenda and recognition is mounting around the importance of outcomes within this growth period to the life span.[xvi] Historically, adolescence was considered as the transition period between early childhood and adulthood. Health related needs of 10-24 year olds were considered from an early childhood perspective.

Previously adolescence and early adulthood were considered to be 'healthy years', as terminal conditions such as cancer and cardiovascular disease were low among this group.[xvii] There is strong evidence to suggest however that child and adolescent health outcomes are directly linked to health in adulthood. There is research affirming the relationship between health related behaviours that typically begin in adolescence (tobacco and alcohol use, obesity, and physical activity) and the epidemic of non-communicable disease we are currently witnessing among adult populations. It is thus evident that greater investment into understanding youth health in conjunction with specific targeted strategies responding the needs of this group is required if we are to affect significant change in the health of our current generation of young people are adults of the future.[xviii]

In addition, there are certain groups of young people who face even greater challenges accessing healthcare, including Aboriginal and Torres Strait Islander, culturally and linguistically diverse (CALD), those experiencing homelessness, young parents, unemployed, young offenders, young people living with a disability or chronic illness, those living in rural and remote areas and those marginalised due to their sexuality.[xix]

A quarter of the world's total population[xx] is aged 10-24. It is the largest population of youth in history and comprises 1.8 billion people. Young people aged 12 to 24 represent nearly 20 per cent of the Australian population and 28 per cent of all households contain a young person.[xxi] Young people contribute approximately $50 billion to the gross national income.[xxiixxiii] It is

therefore encouraging to see that there is a focus on young people preconception to 24 years with the Government agenda in Australia[xxiv]. Every young person has a unique set of talents, strengths and interests, which when supported, can benefit the individual and wider community.

The importance of investing in early childhood development is well established. Less emphasis however has been placed on ensuring that young people remain healthy throughout adolescence and into early adulthood. In recent years, advancements into adolescent health have highlighted the importance of adolescent health and its impact on health outcomes across the lifespan. Adolescence represents the second fastest growth spurt after infancy and periods of great change offer opportunities for intervention.

It is a time associated with heightened risk taking behaviours and experimentation. Experimentation is linked to the development of resiliency and coping mechanisms, which are critical attributes to overcome adversity in adult life however they can also create uncertainty and trepidation within a young person. Adolescence is a time when many psychiatric disorders begin[xxv]. Neuropsychiatric disorders including substance misuse, contribute to nearly half of non-fatal Disability Adjusted Life Years (DALY)[xxvi] in people aged 10-24 years.[xxvii]

Advancements in neuroscience and early child development research indicate that a young brain continues to grow and change well into its mid twenties. This is contrary to previous knowledge suggesting that brain maturation occurred during the early childhood phase of development. Brain development (notably the prefrontal cortex (executive functioning, self control) and limbic system (emotional regulation, reward processing, appetite, pleasure seeking) during early years and adolescence influences risk taking behaviours and emotional balance throughout adulthood.[xxviii]

It is therefore unsurprising that the primary cause of illness and death between the ages of 10 and 24 are largely preventable and include road traffic accidents and suicide.[xxix] It may be plausible to therefore argue that greater investment into targeted strategies, that better support young people through this period of experimentation and change may affect the unnecessary loss of life of our young people.

Areas of Need

A. Child Abuse, Neglect and Trauma [xxx] [xxxi]

Early life exposure to adverse childhood experiences like trauma, abuse or other forms of maltreatment, has been linked to alterations in the brain structure and can lead to life-long consequences.

Physical wounds heal but research is showing that the effects on a child's social, emotional and future physical health is far more damaging than we once thought Neurobiological stresses within the response systems have significant consequences for health and emotional wellbeing.[xxxii] Child abuse is divided into four types: physical abuse, neglect, sexual abuse and emotional maltreatment. Most children suffer from a combination of these types.

Short or long term physical, sexual and emotional abuse or neglect during childhood, can be associated with developmental delay and impairment, substance misuse in adulthood, teen pregnancy, incapacitated social functioning, cognitive and neurological impairment, low academic achievement, delinquency and adult criminal behaviour, subsequent victimization of their own children, homelessness and premature death.[xxxiii]

Characteristically, survivors of childhood abuse exhibit early onset of mental health difficulties and a tendency towards chronicity, lowered self-esteem and sense of hopelessness[xxxiv]. Many traumatised people adopt extreme coping strategies in order to manage anxiety and overwhelming emotional distress including: suicidality, substance abuse and addictions, eating disorders[xxxv], self harming behaviours such as cutting and burning, and dissociation. Many coping strategies become risk factors for later physical health issues. Homelessness[xxxvi] and interactions with the justice system[xxxvii] are common outcomes for people with history of trauma.

Risk factors for child abuse and neglect include having a disability, low socio-economic status (often concomitant with sole parent family), homelessness, parental substance misuse or mental illness and family violence.

A 2007 Australian University-initiated study of over 21,000 older Australians found child abuse survivors are almost two and a half times as likely to have poor mental health outcomes, four times more likely to be unhappy even in much later life and more likely to have poor physical health. [xxxviii] The same study found that physical and sexual abuse increases the risk of having

three or more medical diseases, including cardiovascular events in women, and in social and lifestyle aspects, a higher prevalence of broken relationships (lower rates of relationships in later life cause lower levels of social support and an increased risk of living alone) and an increased likelihood of smoking, substance abuse and physical inactivity. [xxxix]

Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches. Trauma in the early childhood shapes brain and psychological development, sets up vulnerability to stress and to the range of mental health problems.[xl]

Child abuse and neglect in Australia is not a new phenomenon. Attempts to implement strategies to best support young people have been documented since the 1960's when many Australian States introduced mandatory reporting laws for suspected child abuse. One limitation of the current child protection system is its focus on the residual end of the pathway, investigating families, and cases of abuse once they've occurred. The system is failing to invest sufficient resources into preventative measures, including early intervention strategies that work to support families who may be struggling to care for their children.

At the other end of the care spectrum, there is growing momentum around 'trauma-centred' models of care. For example the Trauma-Informed Care and Practice (TICP) is an approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics. This is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment[xli]. Trauma specific interventions are an opportunity for a systemic approach that ensures all people who come into contact with the health system receive support that is sensitive to trauma and understand its effect on behaviour and health outcomes.

The most recent AIHW *Child Protection Australia* 2012/13 report highlighted a 29% increase in the number of children who were the subjects of substantiations, rising from 31,527 in 2010-11 to 40,571 in 2012-13 from 2010/11. From 30 June 2009 to 30 June 2013, the rate of children aged 0-17 on orders increased from 7.0 to 8.2 per 1,000 and the rate of Australian children in out-of-home care at 30 June increased between 2009 and 2013-from 6.7 to 7.8 per 1,000.[xlii] The increase in numbers was consistent across the country and has been attributed to influential factors including legislative changes, enhanced public awareness and inquiries into child protection processes, along with real increases in abuse and neglect.

The prevalence of child abuse and neglect in Australia is high. The rate of non-accidental deaths for young people under 19 years is 0.76 per 100,000 compared with 0.28 per 100,000[xliii], which is higher than the best international rate. Child abuse is typically presented as physical or sexual abuse however it is neglect and emotional abuse that comprises the majority of substantiated cases.[xliv] Given the insidious nature of child abuse, the figures representing young people affected by abuse is likely to be underestimated in official statistics and data collections.

In addition to the physical and emotional costs on the individual, there are significant economic costs to the broader health care system. Utilisation of the health care system is significantly higher for those who have been abused or neglected in childhood, as a result of an overall poorer lifetime health. Physical and sexual abuse during childhood may lead to higher annual health system costs for mental health, emergency department, hospital outpatient, pharmacy, primary care and specialist care services [xlv].

Taylor et al[xlvi] estimated that the annual cost of child abuse and neglect for all people ever abused in Australia was $4 billion in 2007, while the value of the burden of disease (a measure of lifetime costs of fear, mental anguish and pain relating to child abuse and neglect) represented a further $6.7 billion and could be as high as $30.1 billion. The report also estimated that the lifetime costs for the population of children in Australia reportedly abused for the first time would be $6 billion, with the burden of disease representing a further $7.7 billion and could be as high as $38.7 billion, including the monetary value of the pain and suffering that survivors' experience.[xlvii]

The level of abuse is unacceptably high and the long term costs makes failing to address the problem more expensive than addressing it.

Recommendations:

- Trauma informed practice should be encouraged through the provision of training to those working with young people, and resources to their organization to allow attendance at training without detracting from the care and support of the young people they assist.
- Increased resources proportionate to the increase in substantiated claims of child abuse need to be invested in helping those who have been abused and preventing abuse from occurring.

B. Mental health

Adolescence is a critical time for mental health. Several decades of research have shown us that the promise and potential lifetime benefits of preventing, mental, emotional and behavioural disorders are greatest by focusing on young people and that early interventions can be effective in delaying or preventing the onset of such disorders.

Mental health literature affirms that onset of disorders including schizophrenia, depression and anxiety typically occurs during the adolescent or pre-adolescent phase, even though symptoms may not manifest until well into adulthood[xlviii]. It is therefore important that young people are protected during their formative developmental years and given every opportunity to grow into mentally stable and physically well adults.

The prevalence of mental health disorders in young Australians is high. In 2009 it was reported that 24% of the total youth population (12-25), which equates to just over one million young people, had a mental illness yet young people (16-24) receive less treatment than average when compared to total population with mental illness.[xlix] Mental illness in childhood and adolescence creates a significant clinical and social burden on the individual, their family and society. If mental illness is diagnosed and treated early, the sharp increase in it prevalence in young adults may be reduced. Andrews et al estimated that using a best-case scenario, and if treatment were applied to 100% of the population with mental illness, 40% of the burden of disease would be averted.[l]

At present, mental disorders among young people are a major contributor to the (50%) burden of disease in children and young people in Australia aged 10-24 years. [li][lii][liii] Of notable concern, is the increasing prevalence of mental disorders among adolescents[liv] in particular depression and anxiety disorders. From recent neurodevelopmental research, we have learnt that 75% of mental disorders present before the age of 24, and 50% before age 14.[lv] The most common age group for the onset of anxiety and impulse control disorders is 11-15 years, for substance misuse disorders it is ages 19-21, and for mood disorders its is 24-30 years[lvi]. Also, neuropsychiatric disorders are the leading cause of disability in 20-24 year olds.[lvii] The above highlights the importance of investing in prevention and early intervention strategies to ensure young people are given adequate, relevant and timely mental health support.

Experiencing a mental health problem is a risk factor for both self-harm and suicide. Poor mental health and suicide are inextricably linked with 90% of suicides attributable to mental illness.[lviii] In 2002, Australia had one of the top 12 rates of male youth suicide.

Evidence suggests that more than 90% of people who present to hospital with self-harm have a mental disorder, the most common being depression [lix]. A history of mental illness, in particular depression, as well as the presence of more than one mental disorder are also strong predictors of suicide. [lx] While not all young people who self-harm or contemplate suicide have a mental health problem, these behaviours do suggest the experience of psychological distress.
In March 2015, The Australian Bureau of Statistics (ABS) published data presenting suicide as the leading cause of death in children aged 5 -17 years.[lxi]

The number of young people who die by suicide in Australia each year is relatively low compared with the number who self-harm. It is difficult to estimate the rate of self-harm as evidence suggests that only 10% of young people who self-harm will present for hospital treatment.[lxii] Evidence from Australian studies suggest that 6-7% of Australian youth aged 15-24 years engage in self-harm in any 12-month period.[lxiii] Lifetime prevalence of self-harm is higher, with 15-19 year old females and males rating 17% and 12% respectively, and 20-24 year old females and males rating 24% and 18% respectively, self-harming at some point in their life.[lxiv] While suicide is more common among young men, self-harm is more common among young women.

Taken together, suicide and self-harm account for a considerable portion of the burden of disability and mortality among young Australians. It is estimated that 21% of "years life lost" due to premature death among Australian youth in 2004 was due to suicide and self-inflicted injury.[lxv] In addition, non-fatal suicidal behaviour and self-harm are associated with substantial disability and loss of years of healthy life. [lxvi]

Supportive, two parent families are a protective factor against mental illness.[lxvii] It is therefore plausible that the increasing rate of family violence and family breakdown are contributing factors to the rising rates of child youth mental illness.[lxviii]

Recommendations:

- The resilience of young people should be increased by promoting raised awareness amongst young people of mental illness and of adaptive strategies for good mental health.
- There should be further efforts to reduce family breakdown through youth-focused family-centered approaches.

C. Sexual health

Sexual inquiry and development typically begins during adolescence. However perceptions and behaviours regarding sex may have far reaching consequences in later life including contracting Sexually Transmitted Illness (STI)'s and unwanted pregnancies. It is important that young people are supported and guided through this critical phase. Communication with parents and friends and connections to school are protective factors against unwanted or unsafe sexual behaviours. [lxix]

STIs

Young Australian's are sexually active. The 2013 National Survey of Australian secondary Students revealed that 69% of all respondents had experienced some form of sexual activity and 50% of year 12 respondents had experienced sexual intercourse. The survey revealed that the vast majority of young Australians feel confident in the decisions they make regarding their sexual health. Those that are sexually active feel positive about it and those that aren't sexually active feel confident and empowered about their decisions. [lxx] Given the challenging nature of sexual development these findings are encouraging.

There are some trends however that are concerning. For example, one quarter of respondents reported having an unwanted sexual experience.[lxxi] Almost half of respondents cited 'inebriation' (49%), as the primary reason for the unwanted sexual encounter, and thirteen percent reported having not using any contraception during their last sexual experience. The fact that young people are engaging in unwanted sex is concerning, however the overconsumption of alcohol by a large number of young people and decisions against using contraception may lead to greater health concerns.[lxxii]

Although young people feel knowledgeable about HIV, the level of Knowledge regarding STI's remains poor. Knowledge relating to chlamydia, Hepatitis and herpes was particularly poor, which is concerning given rates are of Chlamydia are high among young people and have been increasing over the last decade.[lxxiii]

Of further concern is the lack of awareness regarding the Human Papillomavirus (HPV) among young people, and just over half of respondents (52%) had been vaccinated. [lxxiv]

Teen Pregnancy

Complications during pregnancy are higher for teenagers.[lxxv] Teen mothering is associated with less supportive family environment, higher risk of child abuse and neglect and poorer educational outcomes.[lxxvi] Low labour force participation, coupled with low school attainment

prior to motherhood, means that by age 30, teenage mothers are significantly more likely to live in poverty and are less likely to have a partner who is employed.[lxxvii] Teenage mothers suffer from poorer mental health in the three years after birth compared with other mothers and they have 30% higher levels of mental illness two years after the birth (after which they start to converge to the population average).[lxxviii] Impaired foetal growth is more common in pregnancy in girls under 18 years and is a potent precursor of adult diabetes.[lxxix]

Using OECD reporting methods, Australia's teenage birth rate, ranks 22nd out of 34 OECD countries which is 15 births per 1,000 teenage females. , The Australian rate was slightly lower than the OECD average (16.3) and substantially higher than Switzerland and Japan the best ranked OECD countries.[lxxx] The national average for teenage mothers is 4.2%, compared with Indigenous population 22.6%. The figure in the NT of teenage mothers is particularly high with 30.7% of all Indigenous mothers being of teenager age.[lxxxi]

Recommendations:

- *Increased awareness of good sexual health practices needs to be promoted amongst young people through peer education, and other programs.*
- *Increased support to teenaged mothers to alleviate the increased risks to health and wellbeing of both mother and child.*

D. Drugs and alcohol

Alcohol

Harmful alcohol use has been identified as one of the leading preventable causes of death and a key risk factor for chronic diseases (such as cancer) and injuries worldwide. Misuse of alcohol including binge drinking[lxxxii] leads to a range of problems including individual health issues, lower life expectancy, reduced productivity in the workforce and absenteeism, accidents, violence and other alcohol-related offences (e.g. public nuisance offences), as well as drink driving.[lxxxiii]

The societal cost of alcohol consumption on the Australian community is significant. In 2010, the total costs to society of alcohol-related problems were estimated to be $14.352b. Of this, $2.958b (or 20.6%) represents costs to the criminal justice system, $1.686b (or 11.7%) comprises costs to the health system, $6.046b (or 42.1%) involve costs to Australian productivity and $3.662b (or 25.5%) are costs associated with traffic accidents.[lxxxiv]

In addition, it was estimated that a further $6.807b in costs to society could be attributed with someone else's drinking.[lxxxv]

Adult drinking behaviours are established during adolescence. It is during this period of experimentation that young people are trying alcohol for the first time, and developing patterns of behaviour that may be carried into adulthood. Although it is important for young people to have the freedom and personal agency to make informed choices around alcohol consumption. However it is also important for young people to feel they are supported during this process of learning and change. Young people may be easily influenced by behaviours they have witnessed in the media, or within their family home and may also be persuaded to behaviour contrary to their instinct if they feel pressure from their peers. Regular alcohol consumption or binge drinking during adolesce predicts heavier alcohol consumption, binge drinking and poor health outcomes later in adult life.[lxxxvi] Thus its imperative healthy alcohol related behaviours are established during adolescence.

Australians begin to drink alcohol at a young age. The Australian School Students Alcohol and Drugs Survey established that 73% of 12-year-old students have tried alcohol, which increases with age to 91% of 15 year olds[lxxxvii]. Perceptions of alcohol consumption including intentions and behaviours is greatly influenced by mass media and advertising[lxxxviii]. At present, young Australians are exposed to a high level of alcohol advertising. This may be in the form of: billboards, posters, Internet or magazine adverts, on promotional materials and other sources. In Australia Alcohol related behaviours are strongly influenced by media and advertising campaigns. Often these campaigns are targeted at young people.

A study undertaken by the commonwealth Department of Health and Aging found that exposure to alcohol related advertising among 13-17 year olds was only slightly less than among 18-29 years olds[lxxxix]. Being exposed at an early age normalises and popularises perceptions around alcohol consumption and has been associated with increased alcohol consumption later in life[xc]. It is plausible to therefore suggest that greater restrictions around advertisements and marketing strategies promoting alcohol consumption or alcohol related products may have the opportunity to influence alcohol related behaviours including consumption of young people.

There are encouraging signs that alcohol related behaviour among young people is changing. In 2013 the AIHW reported fewer adolescents (12–17) drinking alcohol; an increase in the proportion of young people abstaining from alcohol altogether[xci] and an increase in the age young people were trying alcohol for the first time.[xcii] However the economic and social costs of alcohol consumption and alcohol related behaviours on young Australians is significant. For example it was estimated that 2643 young people between 15-24 died from alcohol attributable injury (15% of all deaths in this group).[xciii] A significant proportion (24%) of young people are

drinking at risky levels.[xciv] [xcv] Drinking at risky levels was the leading cause of death and injury for young Australian aged 15-24 years.[xcvi]

Cigarette smoking

Overall, less young people are beginning to smoke in Australia. This decline may be attributable to public awareness campaigns relating to health outcomes, tighter restrictions around smoking in public spaces, greater regulations around legal purchasing age and increased costs of cigarettes. The latter has affected the overall smoking behaviours of teenagers, with 33% less young people (12-15 year) purchasing cigarettes between 1987 and 2005.[xcvii] The rate of daily smokers have almost halved since 1991.[xcviii]

A recent study however showed that the proportion of 16-17 year old students who smoked in 2011 was the same as in 2008. This may indicate greater difficulty in affecting the smoking behaviours of young people once they've been established.[xcix]

Other drugs

It is encouraging to see the age in which young people (14–24) are trying illicit drugs for the first time is increasing (from 16.0 years in 2010 to 16.3 years in 2013) and that the total number of young people using illicit substances has declined since 1993.[c] In 2013 the age in which first use was reported for both cannabis and meth/amphetamines was significantly higher.[ci]

The use of cannabis remains to be the commonly used illicit substance with 15% of all secondary school students aged between 12 and 17 years reporting the use of cannabis at some time in their life. The number of young people using cannabis remained consistent between 2008 and 2011.[cii]

The prevalence of other drugs use, including crystal methamphetamine or 'Ice' is increasing with the reported use more than doubling between 2010 and 2013'.[ciii]

Recommendations:

- *Address the promotion of a culture of drinking in some sports and media.*
- *Promote increased awareness of the risks of smoking and drug use*

E. Food and nutrition

Adolescence is a time of significant physical and bodily change, and young people require a well-balanced and nutritious diet to facilitate growth during this period. The majority of young Australians however are currently eating well below the minimum recommended consumption of vegetables with less than 5% of 5-24 year olds meeting the daily requirement[civ]. Adequate nutrition is essential during periods of rapid physical, social and emotional development. However in addition to the well known benefits of a good diet on physical health, there is now evidence affirming the importance of diet during adolescence, due to its potential role in modifying mental health over the life course.[cv] Fruits and vegetables, wholegrains, fish, lean red meats and olive oils, are rich in important nutrients such as folate, magnesium, b-group vitamins, selenium, zinc, mono- and polyunsaturated fatty acids, polyphenols and fiber, which have already been reported as of relevance in depressive illnesses[cvi], which are highly prevalent among young Australians. One in every five adolescents likely to experience a diagnosable depressive episode by the age of 18. [cvii]

An area where improvement is possible is greater monitoring of foods available to adolescents, more encouragement around healthy eating and engaging parents in supporting adolescents to maintain good nutrition during a difficult life stage.

Poverty is a key determinant of food consumption and nutrition among young people. Families or young people who are reliant on welfare payments as sole income or majority income face significant barriers to nutrition due to the cost of healthy food.[cviii] With the rising cost of housing, transport and education, parents are struggling to adequately provide nutritious food for their children. Other factors such as limited availability or for some people limited household storage and food preparation capacity can also contribute to poor nutrition choices.[cix]

For example, young people experiencing homelessness often consume higher amounts of energy-dense, nutrient-poor foods and lower amounts of fresh fruit and vegetables and staple food items.[cx] They often struggle to find enough food to meet their daily nutritional requirements and experience hunger, anxiety, stress and embarrassment[cxi].
Further, homeless young people view healthy as time intensive and often unattractive, fast food is viewed as quicker, easier and more convenient. They often crave the convenience and instant gratification of fast foods.[cxii]

In addition to inadequate diet and nutrition, a significant number of young people are failing to meet the national physical activity guidelines.[cxiii] Sedentary indoor activities are often the recreational activity of choice and young people are spending less time outdoors or engaged in physical exercise. The benefits of physical activity among young people are well established [cxiv]. In particular team sports provide young people with physical health benefits, while also cultivating the development of important skills and attributes including resiliency, self-discipline, self-confidence and friendship.

Recommendations:

- *Further promotion and education around good nutrition and exercise.*
- *Develop strategies to reduce the cost of healthy eating for low-income families.*

F. Body Image and Eating Disorders

Eating Disorders

The exact number of Australians suffering from eating disorders is unknown. The last official estimate by the Australian Institute for Health and Welfare suggested that there were 23,464 people with eating disorders in Australia[cxv] however no Australian data was used to generate this estimate and Anorexia Nervosa (AN)(male and female) and Bulimia Nervosa (BN)(female only) were the only disorders included. Binge Eating Disorder (BE) or Eating Disorder Not Otherwise Specified (EDNOS), which have a higher prevalence, were not included in the study. The ABS is not currently collecting data regarding eating disorders.

From population based surveys it has been estimated that the real figure of Australians affected is closer to 1,000,000 or 4% of the total population, with females accounting for 64% of this total. The only Australian study undertaken in 2008 reported the rate of disordered eating behaviour to have doubled in ten years to 2005.[cxvi]

Eating disorders typically present during adolescence however behaviours can be misinterpreted as 'puberty blues'. The AIHW reports health system expenditure for eating disorders for 2012 was estimated to be $99.9 million.[cxvii]

Eating disorders are debilitating. Almost a million people are living with a clinical eating disorder, yet only 22% are accessing specialist treatment.[cxviii] Without early and appropriate intervention, eating disorders are likely to persist long term leading to significantly reduced quality of life, life expectancy, and loss of life. Mortality rates are almost twice as high for people

with eating disorders and 5.86 times higher for people with AN.[cxix] One in ten people with AN do not live more than 10 years after the onset of the disorder.

AN is the third most common chronic disease (after asthma and obesity) amongst females 15-24 years with onset typically 13-18. The onset of BN is typically 16-18.[cxx] As eating disorders are often developed during adolescence, educational and social development of the individual can also be impaired.

Early diagnosis and effective treatment is essential. The lifetime prevalence of eating disorders for the total population is estimated to be 9%, with 15% of all women requiring clinical intervention at some point in their life.[cxxi] Long tern complications on AN and EDNOS include kidney failure, heart failure, osteoporosis and infertility. Individuals are more likely to abuse drugs and alcohol than the general population and comorbidities including mental illness (obsessive compulsive disorders, bi-polar) are common.[cxxii] One of the main comorbidities from BED is obesity.[cxxiii]

The cost burden of this insidious illness is not borne only by the sufferers, but also their carers and/or families.[cxxiv] The burden of disease from eating disorders is estimated at $52.6billion. This estimate is slightly larger than the estimated value of the burden of diseased for anxiety and depression of 41.2 billion.[cxxv]

Recommendations:

- *Improve data collection relating to prevalence of eating disorders and improve availability and treatment services for young people.*

Body image

Positive body image plays a vital role in psychological and physical health and development, not only in regard to the way you feel about your body, but in many areas of life.[cxxvi] In particular, people with positive body image have more positive self-esteem,[cxxvii] [cxxviii] better self-acceptance and a healthier attitude towards food and eating.[cxxix] Adolescence is typically when young people begin to evaluate their bodies, often precipitated by dramatic changes occurring as a result of puberty, and grow dissatisfied with their natural body shape. There is evidence suggesting that the age in which body image becomes important is declining.[cxxx]

Negative self-image may affect children's feelings and thoughts and lead them to modify their behaviour and develop physical or psychological problems[cxxxi]. Negative body image can affect

self-esteem and general well being, inhibit participation in social activities and lead to serious health issues such as depression and social isolation.
Significant numbers of children as young as 8-9 years (boys and girls) are now concerned with their body image. In a study of 87 girls from South Australia, one in four primary school girls reported dieting to lose weight [cxxxii].

Children who were dissatisfied with their body image were more likely to have poorer social and emotional wellbeing and physical health.[cxxxiii]

It is important that all children and young people are exposed to positive body image messaging that encourages individuality and promotes 'health' rather than 'size'. Young people need to feel supported and proud of their physical bodies regardless of their shape. Programs that build self esteem and self confidence in young people will assure that young people have the opportunity to develop a positive self image during their formative years.

Recommendations:

- *Further resourcing of programs to build self-esteem and good body image in young people.*
- *Address promotion of negative body images in some media and advertising.*

G. Obesity and Overweight

Obesity is a significant concern for young people in Australia. Australia is ranked fourth in terms of obesity rates with an increasing prevalence[cxxxiv]. Obesity early in life can lead to many health problems, in childhood, adolescence & adulthood. In the short term, young people often experience poor psychological wellbeing and are at risk of cardiovascular conditions, asthma and type 2 diabetes.

Access economics estimates that obesity is the causal factor attributable to the following conditions among the Australian population. Longer term, overweight and obesity lead to adult obesity, increased rates of heart disease, diabetes, cancers, gall bladder disease, osteoarthritis and endocrine disorders.
In addition, overweight and obesity during the early stages of life is associated with lower educational attainment, income and self-esteem and higher rates of bullying and discrimination. [cxxxv]. The prevalence of obesity is higher in low socio economic status (SES) areas than in high SES areas.

- 24% of type 2 diabetes

- 21% of cardio vascular disease (CVD)
- 25% of osteoarthritis
- 21% of colorectal, breast, uterine and kidney cancer. [cxxxvi]

Access economics estimates that the total cost of obesity to the Australian economy, including productivity cost and lost wellbeing is already 21 billion a year.[cxxxvii] [cxxxviii]

In 2011 AIHW estimated that 35% of young people (12-24 years) were overweight (23.3%) or obese (11.3%).[cxxxix] Socio economic status (SES) is associated with rates of overweight and obesity. The prevalence is higher in low SES areas than in high SES areas.

Given that the prevalence of overweight and obesity among young people appears to be increasing, this is of significant concern for the current generation of young people and the public health system supporting them.

H. Access to healthcare

Young people consume health services differently than older people. Often they don't identity with having a sustained medical illness, but rather identify feeling unwell as momentary. Typically they are more likely to access a health service once a condition becomes acute or chronic. Preventative health care is seldom sought.[cxl]

Young people experience significant barriers to accessing health care. This may be due to a number of reasons including: lack of autonomy or own Medicare card; availability, flexibility or location of health service and insufficient money to travel, discomfort in disclosing health concerns, concerns regarding confidentiality, complicated referral processes, communication or language difficulties, lack of experience, education or information regarding their health, cultural boundaries, and fear of discrimination or stigma.[cxli] [cxlii]

Young people typically seek medical assistance from a friend or family or the Internet prior to seeking professional advice, which is consistent with the underrepresentation of young people evident within general practice consultation data.[cxliii] Specialist youth practitioners are often confined to major cities[cxliv] and hospitals may not have adequate resources to provide developmentally appropriate care to a young person. This is particularly notable in rural or regional areas where medical services are often limited.

Young people seeking information regarding their sexual health have concerns relating to confidentiality of GP services. This is particularly relevant for young people residing in rural and regional areas. In rural areas, or where GP and allied health care is minimal, there may only be one GP servicing four or five communities. A young person may not want to visit the local GP as it's the only Doctor in town and frequented by or associates of friends or family. A young person may fear a breach of confidentiality in these circumstances, which may result in the young person getting in trouble for their behaviour or sexual activity. A typical outcome may be for the young person to avoid disclosing personal, yet critical information to the Doctor such as sexual history, complete avoidance of visiting the GP, or seeking medical support from an alternative, less credible source. Young people typically do not have the means (vehicle, license, money for bus ticket) to travel long distances to visit an alternative Doctor.

Recommendation:

- *Greater acknowledgement of the way in which young people identify with health, access and consume health services and greater consideration given to the barriers that all young people experience when accessing health care, with notable consideration given o marginalised subgroups of young people.*

I. Marginalised Groups of young people

Marginalised young people are a heterogeneous group, who often have multiple and complex needs. A number of factors may contribute to a young person becoming marginalised. These include family poverty, homelessness, disability, involvement in crime or with the juvenile justice system, and sexual or cultural identity. While they experience the same health problems as the broader youth population, their access to healthcare is complicated by psychosocial factors including lack of safe or adequate housing, inadequate access to financial support, education or employment, and a mistrust of health services. [cxlv]

Young people who identify with other minority populations or experience other forms of marginality may experience multiple forms of discrimination, which increases their risk of poor mental health, reduced social participation and economic disengagement. [cxlvi]

Marginalised young people often access health care less than the general youth population and they are harder to reach. Typically preventative health care services are not sought, but rather crisis services are accessed once acute care is required. Young men and Indigenous young people are the least likely to access healthcare, which places them at higher risk.

One group that faces significant barriers to health care are young LGBTQI people. The effects of heterosexist discrimination on the health and wellbeing of gender and sexual identity minorities has been well documented. [cxlvii]

Hetero-sexist discrimination leads to social isolation and alienation, which contribute to higher rates of poor health outcomes among young LGBTQI people compared with the general population. The rates of depression, anxiety and psychological distress are reported to be much higher than national averages and have not declined since 2006.[cxlviii]Research suggests that young LGBTQI often use drugs to alleviate the feelings of social isolation, increasing their health risks compared with the general population. [cxlix]

Another marginalised group are those experiencing homelessness. This group of young people have greater physical, social and emotional health concerns than other young people who may live in stable and secure housing. The homeless experience results in sleep deprivation, difficulties in maintaining personal hygiene (which may result in lice and skin problems) and inadequate diet and poor nutrition.[cl] Young people experiencing homelessness typically experience higher rates of communicable diseases and injury, and poor dental health. Young people experiencing homelessness are at-risk of falling victim to violent crime, being abused on the street and victimizing others through such activities as theft, assault or drug dealing.[cli]They are more likely to make poor sexual health choices, typically engaging in unsafe sex leaving them at risk of contracting sexually transmitted infections and unplanned pregnancies. Poor health is further exacerbated by a lack of medical attention, which may be due to a limited access to health care including the inability to pay for medical services.[clii]

Similarly young people in care, those from Culturally and Linguistically Diverse (CALD) backgrounds and Aboriginal young people all have unique health needs. These needs must be carefully considered within the adolescent health paradigm.

Recommendation:

- *The distinct health needs of youth subgroups be made a priority within health care systems. There needs to be greater recognition of the diversity within youth, and that the needs of young people varies greatly.*
- *Greater investment is needed in reaching out to marginalised young people, to ensure they are accessing appropriate health care when required and have the opportunity to be as healthy and well as other young people.*

Cost/ Benefits of Investing in Youth Health

From an economic and social perspective, the greatest return on investment occurs during the earliest stages of life.[cliii] Skills (cognitive and non-cognitive) acquired during early on facilitate later learning.[cliv] Investment in education of adolescents has clear benefits to individuals and their health, but it is also a strategy for enhancing employment, human rights, social capital and community wealth.[clv] A healthy workforce has the potential to shape a country's economic prospects.[clvi]

It is encouraging that economic priority-setting techniques are gaining momentum as a rigorous approach to tackling adolescent health. By comparing the costs of preventive interventions with the long-term benefits of those interventions, benefit-cost analysis provide a tool for determining what kinds of investments have the greatest potential to reduce the physical, mental, and behavioural health problems of young people.[clvii]

There are a number of studies that clearly demonstrate the financial benefits to investing in youth health including: child abuse and trauma[clviii], obesity[clix], alcohol misuse, and mental health[clx]. To illustrate the costs involved, the case of mental health is outlined.

Mental Health

Almost a quarter of young Australians have a mental illness.[clxi] The financial cost of mental illness in people aged 12-25 is significant. Access Economics reported the financial cost to be $10.6 billion. Of this:

- $7.5 billion (70.5%) was productivity lost due to lower employment, absenteeism and premature death of young people with mental illness;
- $1.6 billion (15.5%) was the deadweight loss from transfers including welfare payments and taxation forgone;
- $1.4 billion (13.4%) was direct health system expenditure;
- $65.5 million (0.6%) was other indirect costs comprising informal carer costs and the bring-forward of funeral costs.

The financial costs are distributed in the following: the individual (22.7%), families and friends (1.6%) and the Australian government (50.6%) (mainly through taxation revenues forgone and welfare payments), State/territory Governments (3.3%), employers (4.3%) and society (17.5%).

If the burden of disease (lost wellbeing) is included, the costs are distributed in the following: individuals (73.7%) the Australian government (17.2%), State/territory governments (1.1%), family and friends (0.5%), employers 1.4%, and society (5.9%).[clxii]

Reducing the prevalence of mental health within the young population may lead prevents significant social and financial costs across other Sectors including juvenile justice. The exact prevalence of mental health disorders among young people within the NSW juvenile Justice system is unknown. The 2009 NSW Juvenile Justice Annual Report[clxiii] presented that 88% of young people in custody, displayed symptoms of mental illness that was consistent with a clinical disorder. The 2009 Young People in Custody Survey (YPICHS), which included data from all nine Juvenile Justice Centres and Juvenile Correctional Centre, found that 87% of participants had at least one psychological disorder, and 73% had two or more psychological disorders present.[clxiv] There was an average of 3.3 past and/or current psychological disorders for each participant.[clxv]

It is estimated that those with a mental health disorder are at least 6 times more likely to be incarcerated than the general population of young people.[clxvi]

The cost of incarcerating a non-Aboriginal young person is $8,000 per year. The cost of incarcerating an Aboriginal young person is $121,000.[clxvii]

Recommendation:

- Cost Benefit analyses hold great promise for influencing policies related to children, youth, and families. *These figures indicate that financial savings are possible when early intervention strategies are implemented and mental illness is identified and treated in the early stages of life and prior to a young person entering the justice system. This is relevant for reducing the total number of young people incarcerated, and for Aboriginal young people in particular, who make up 36% of the juvenile justice system.*

Conclusion

Adolescence is a crucial time in the growth and development of young people. It is a time when behaviours are established, many of which are sustained across the life span. It is a time when young people choose a career path, where they gain and develop necessary skills and competencies, establish an identity and obtain greater responsibility and independence.

This period of intense physical, social and emotional change may invoke feelings of excitement, trepidation and uncertainty within a young person. But there are also significant societal and familial pressures experienced. Pressures include, having the perfect body, excelling at school, being sexually active and experimenting with drugs and alcohol. There are expectations on young people to become responsible adults, yet developmentally the adolescent brain is still transitioning through a significant growth phase and is not always ready to tackle the responsibilities associated with adulthood. For marginalised young people, who may be without the guidance or support of positive adult relationships, this transition period can be even more challenging.

These pressures are contributing to the social and emotional stability of young Australians. From a youth health perspective, a shift is required towards focusing resources on issues that become prevalent during adolescence and which require very different responses to other life phases. Greater awareness around sexual and reproductive health, substance misuse, mental health, injury, obesity and chronic physical illness are needed to support young people through this transition.

The total global burden of disease in 10-24 year olds is increasing and it is estimated that 70% of premature adult deaths are largely caused by behaviours that are developed during adolescence. [clxviii] Thus early intervention and prevention strategies targeting adolescent health provide an enormous opportunity to affect significant change to the lives of young people today, and the generations of adults to come.

There is still so little discourse within the non-communicable disease agenda regarding the importance of adolescents as a target population for universal prevention.

In addition to the social benefits associated with improving youth health, there are also significant economic benefits. A number of studies have highlighted the impact on adult health outcomes when sufficient investment is made in early intervention and prevention strategies.

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[ii] https://www.unicef.org.au/Discover/What-we-do/Convention-on-the-Rights-of-the-Child/childfriendlycrc.aspx
[iii] Joint Standing Committee on Treaties, The Parliament of the Commonwealth of Australia, (1998), United Nations Convention in the rights of the Child, 17th Report
[iv] https://yfoundations.org.au/
[v] Layard et al (2013). What Predicts A Successful Life? A Life course model of wellbeing, IZA, Discussion Paper No. 7682, October 2013
[vi] Australian Research Alliance for children and Youth, 2010. Report Card, The Wellbeing of Young Australians,
[vi] Sawyer et al, 2012, Adolescence: a foundation for future health, Lancet 2012; 379: 1630–40. Published Online April 25, 2012 DOI: 10.1016/S01406736 (12) 60072-5
[vii] ibid.
[viii] Australian Research Alliance for Children and Youth. The Nest Action Agenda. Improving the Wellbeing of Australia's Children and Youth While Growing our GDP by over 7%. 2013
[ix] ibid.
[x] For example, eight out of ten obese teenagers go on to be obese adults. Guo S and Chumlea C.1999. Tracking of body mass index in children in relation to overweight in adulthood. *American Journal of Clinical Nutrition*, 70, 145-148
[xi] Unaccompanied children under 16 years accessing Specialist Homeless Services fact sheet, June 2014

[xii] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, and 19-22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[xiii] *Article 24* - States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. Australia ratified this Convention in 1990.
Convention on the Rights of the Child. Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49

[xiv] Roche, B, (2005). Sexuality and Homelessness, Crisis
[xv] AMA, position Statement, 2013, The Health of Young People
[xvi] Sawyer et al, 2012, Adolescence: a foundation for future health, Lancet 2012; 379: 1630–40. Published Online April 25, 2012 DOI: 10.1016/S01406736 (12) 60072-5
[xvii] ibid.
[xviii] Australian Medical Association, 2013, the health of young people, Position Statement
[xix] AMA, Position Statement, 2013, The Health of Young People
[xx] Sawyer et al, 2012, Adolescence: a foundation for future health, Lancet 2012; 379: 1630–40. Published Online April 25, 2012 DOI: 10.1016/S01406736 (12) 60072-5
[xxi] Muir K, Mullan K, Powell A, Flaxman S, Thompson D, Griffiths M (2009), State of Australia's Young People: a report on the social, economic, health and family lives of young people, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, Canberra, 2009, p. 14
[xxii] National Strategy for Young Australians, http://www.youth.gov.au/sites/Youth/bodyImage/Documents/NatStrat.pdf
[xxiii] The total national income reported for June 2014 was $ 1549805, ABS data,
5206.0 - Australian National Accounts: National Income, Expenditure and Product, Jun 2014
[xxiv] Strategic health plan for children, young people and families 2014 – 2024
[xxv] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. Arch Gen Psychiatry 2005; 62: 593–602.
[xxvi] The World Health Organisation defines DALY **as:** One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences. http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/

[xxvii] Gore FM, Bloem PJN, Patton GC, et al. Global burden of disease in young people aged 10–24 years: a systematic analysis. *Lancet 2011*; 377: 2093–102.
[xxviii] Giedd JN, Blumenthal J, Jeff ries NO, et al. Brain development during childhood and adolescence: a longitudinal MRI study. Nat Neuroscience 1999; 2: 861–63.; Blakemore S-J. The social brain in adolescence. *Nat Rev Neuroscience* 2008; 9: 267–77; Raznahan A, Lerch JP, Lee N, et al. Patterns of coordinated anatomical change in human cortical development: a longitudinal neuroimaging study of maturational coupling. Neuron 2011; 72: 873–84.; Petanjek Z, Judas M, Simic G, et al. Extraordinary neoteny of synaptic spines in the human prefrontal cortex. Proc Natl Acad Sci USA 2011; 108: 13281–86; Paus T, Keshavan M, Giedd JN. Why do many psychiatric disorders emerge during adolescence? Nat Rev Neurosci 2008; 9: 947–57. ; Shaw P, Kabani NJ, Lerch JP, et al. Neurodevelopmental trajectories of trajectories of the human cerebral cortex. J Neurosci 2008; 28: 3586–94.
[xxix] Sawyer et al, 2012, Adolescence: a foundation for future health, Lancet 2012; 379: 1630–40. Published Online April 25, 2012 DOI: 10.1016/S01406736 (12) 60072-5
[xxx] Definitional issues are discussed in Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C. and De Bortoli, L. (2008). The Cost of Child Abuse in Australia, Australian Childhood Foundation and Child Abuse Prevention Research Australia: Melbourne p. 29, although no standard definition exists.
[xxxi] Numerous studies and reviews have examined the impacts of childhood abuse and neglect on long-term outcomes such as depression, suicide, self-injury and risk taking behaviour (such as alcohol and drug abuse) (Arias, 2004; Roberts et al, 2004; Springer et al, 2007; Molner et al, 2001, Tenney-Soeiro and Wilson, 2004; Johnson, 2004; Dube et al, 2003; Thompson and Kaplan, 1996). Many of these associations are linked in a graded fashion: for example, greater severity of abuse and neglect lead to higher rates of depression and drug use (Dube et al; 2003 and Springer et al, 2007). As cited in Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C. and De Bortoli, L. (2008). The Cost of Child Abuse in Australia, Australian Childhood Foundation and Child Abuse Prevention Research Australia
[xxxii] Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. Eur Arch Psychiatry Clinical Neuroscience. 2006; 256(3):174–86.
[xxxiii] Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C. and De Bortoli, L. (2008). The Cost of Child Abuse in Australia, Australian Childhood Foundation and Child Abuse Prevention Research Australia

[xxxiv] Henderson, A S & Brown, G S, 1988, 'Social support: the hypothesis and the evidence', in Henderson, S & Burrows G (eds), Handbook of Social Psychiatry, Elsevier, Amsterdam, pp 73–85; Harris, T O, 1988, 'Psychosocial vulnerability to depression', in Henderson, S & Burrows, G (eds), Handbook of Social Psychiatry, Elsevier, Amsterdam, pp 55–71; Romans, S E, Walton, VA, Herbison, G P & Mullen P E, 1992, 'Social networks and psychiatric morbidity in New Zealand women', Australian and New Zealand Journal of Psychiatry, Vol 26, pp 485–492

[xxxv] American Psychiatric Association, 1993, Practice guidelines for eating disorders, American Journal of Psychiatry, 150, pp 207–228

55 Flemming, J, 1997, 'Prevalence of childhood sexual abuse in a community sample of Australian women', Medical Journal of Australia, No 166, p 65–68

[xxxvi] Smith, J, 1995, 'Being Young & Homeless: Analysis and discussion of young people's experiences of homelessness', The Salvation Army Youth Homelessness Research Project, Australia, In Robinson, C , 2002, ''I Think Home is More than a Building'': Young Home (less) People on the Cusp of Home, Self and Something Else" Urban Policy and Research, Volume 20, Issue 1, 2002, Taylor & Francis http://www.tandfonline.com/doi/pdf/10.1080/08111140220131582

[xxxvii] Johnson, H, 2004, 'Drugs and crime: a study of incarcerated female offenders', Research and Public Policy Series, No 63, Canberra, Australian Institute of Criminology, http://www.aic.gov.au/documents/e/b/8/%7Beb8a400c-e611-42bf-9b9f-b58e7c5a0694%7Drpp63.pdf

[xxxviii] Draper, R B, Pfaff, J, Pirkis, J, Snowdon, J, Lautenschlager, N & Wilson, I, 2007, 'Long-Term Effects of Childhood Abuse on the Quality of Life and Health of Older People: Results from the Depression and early prevention of Suicide in General Practice Project', JAGS

[xxxix] Draper, R B, Pfaff, J, Pirkis, J, Snowdon, J, Lautenschlager, N & Wilson, I, 2007, 'Long-Term Effects of Childhood Abuse on the Quality of Life and Health of Older People: Results from the Depression and early prevention of Suicide in General Practice Project', JAGS

[xl] Prof Louise Newman, Testimonial, Adults Surviving Child Abuse 2012 '*The Last Frontier' Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* ASCA.

[xli] Mental Health Coordinating Council (MHCC) 2013, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction,* Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA)

[xlii] AIHW 2014. Child protection Australia 2012-13. Child welfare series 58. Cat. no. CWS 49. Canberra: AIHW

[xliii] Australian Research Alliance for Children and Youth (2008). *The Wellbeing of young Australians Technical Report,* Allen Consulting Group and Unicef.

[xliv] O'Donnell et al . 2008.Child abuse and neglect. Is it time for a public health approach? *Australian and New Zealand Journal of Public Health* Vol. 32.4

[xlv] Bonomi AE, Anderson ML, Rivara FP, et al. Health Care Utilization and Costs Associated with Childhood Abuse. *Journal of General Internal Medicine.* 2008;23(3):294-299. doi:10.1007/s11606-008-0516-1.

[xlvi] Taylor, P, Moore, P, Pezzulo L, Tucci J, Goddard, C & De Bortoli, L, 2008, 'The Cost of Child Abuse in Australia', *Australian Childhood Foundation and Child Abuse Prevention Research*, Melbourne

[xlvii] Taylor, P, Moore, P, Pezzulo L, Tucci J, Goddard, C & De Bortoli, L, 2008, 'The Cost of Child Abuse in Australia', *Australian Childhood Foundation and Child Abuse Prevention Research*, Melbourne; Access Economics, 2008, 'The Cost of Child Abuse in Australia Report', *Australian Childhood Foundation and Child Abuse Prevention Research*, Monash University, http://www.childhood.org.au/11810843-62E5-42F8-9ECF-6C61E9AC309/FinalDownload/DownloadId-3EED48FD17CBE32E0801F5C6CB40ED55/11810843-62E5-42F8-9ECF-06C61E9AC309/~/media/Files/Research/Research%20Cost%20of%20Child%20Abuse%20in%20Australia%202009.ashx

[xlviii] Gaetz and Scott, (2012). Live learn grow. Supporting Transitions to adulthood for homeless youth, as framework for the foyer in Canada

[xlix] Access Economics, 2009, Economic Impact of youth mental illness and the cost effectiveness of early intervention

[l] Andrews G, Issakidis C, Sanderson K, Corry J, Lapsley H (2004) 'Utilising survey data to inform public policy: comparison of the cost effectiveness of treatment of ten mental disorders', British Journal of Psychiatry, 184, 526-533

[li] Gore FM, Bloem PJN, Patton GC, et al. Global burden of disease in young people aged 10–24 years: a systematic analysis. Lancet 2011; 377: 2093–102.

[lii] Australian Bureau of Statistics (2008) Australian Social Trends, 2008, ABS Cat No 4102.0, Canberra.

[liii] Begg S, Vos T, Barker. B., Stevenson C, Stanley L, et al. 2007. *The Burden of Disease and Injury in Australia, 2003. Canberra, AIHW.*

[liv] Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez A (2007) The burden of disease and injury in Australia 2003, AIHW Cat No PHE 82.

[lv] Kessler R, Bergland P, Demler O, Jin R, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comoridity Survey Replication. Arch Gen Psychiatry 2005; 62: 593–602.

[lvi] 106 Kessler R, Bergland P, Demler O, Jin R, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comoridity Survey Replication. Arch Gen Psychiatry 2005; 62: 593–602.; Andrade L, Caraveo-Anduaga JJ, Berglund P, et al, for the WHO International Consortium in Psychiatric Epidemiology. Cross-national comparisons of the prevalences and correlates of mental disorders. Bull World Health Organ 2000; 78: 413–26.; Christie KA, Burke JD Jr, Regier DA, Rae DS, Boyd JH, Locke BZ. Epidemiological evidence for early onset of mental disorders and higher risk of drug abuse in young adults. Am J Psychiatry 1988; 145: 971–75.

[lvii] Gore FM, Bloem PJN, Patton GC, et al. Global burden of disease in young people aged 10–24 years: a systematic analysis. Lancet 2011; 377: 2093–102.

[lviii] Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez A (2007) The burden of disease and injury in Australia 2003, AIHW Cat No PHE 82.

[lix] Kegg K. Self-harm. Lancet. 2005 Oct 22-28; 366(9495): 1471-1483.

[lx] Beautrais AL. Risk factors for suicide and attempted suicide amongst young people. Aust NZ J Psychiatry. 2000 Jun; 34 (3): 420-36; Rey JM, Dudley MJ. Depressed youth, suicidality and antidepressants. Med J Aust. 2005 182(8): 378-9; Schmidt P, Muller R, et al. Suicide in children, adolescents and young adults. Forensic Sci Int. 2002 Jul 17; 127(3): 161-7.

[lxi] https://www.humanrights.gov.au/news/stories/abs-data-will-help-us-better-understand-children-s-suicide?mc_cid=e621b9ede4&mc_eid=214b6b1fd1

[lxii] De Leo D, Heller TS. Who are the kids who self-harm? An Australian self-report school survey. Med J Aust. 2004 Aug 2;181(3): 140-144.
[lxiii] De Leo D, Heller TS. Who are the kids who self-harm? An Australian self-report school survey. Med J Aust. 2004 Aug 2;181(3): 140-144.
[lxiv] Martin G, Swannell SV, et al. Self-injury in Australia: a community survey. Med J Aust. 2010 Nov 1;193(9): 506-510.
[lxv] Australian Institute of Health and Welfare. Youth Australians: their health and wellbeing. 2007 Cat. no. PHE 87. Canberra: AIHW.
[lxvi] Australian Institute of Health and Welfare. Youth Australians: their health and wellbeing. 2007 Cat. no. PHE 87. Canberra: AIHW.
[lxvii] Stanley F (2001) 'Child health since Federation' in ABS (2001) Year Book Australia 2001,
ABS Cat No 1301.0.
[lxviii] Stanley F (2001) 'Child health since Federation' in ABS (2001) Year Book Australia 2001,
ABS Cat No 1301.0.
[lxix] WHO 2005. Western Pacific region adolescent sexual and reproductive health. Viewed 21
April 2010, <www.wpro.who.int/ sites/rph/data/adolescent.htm>.
[lxx] Mitchell A, Patrick K, Heywood W, Blackman P, Pitts M. (2014) 5th National Survey of Australian Secondary Students and Sexual Health 2013, (ARCSHS Monograph Series No. 97), Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia
[lxxi] Mitchell A, Patrick K, Heywood W, Blackman P, Pitts M. 2014. 5th National Survey of Australian Secondary Students and Sexual Health 2013, (ARCSHS Monograph Series No. 97), Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia
[lxxii] ibid.
[lxxiii] AIHW, Young Australians, Health and Wellbeing, 2011
[lxxiv] Mitchell A, Patrick K, Heywood W, Blackman P, Pitts M. 2014. 5th National Survey of Australian Secondary Students and Sexual Health 2013, (ARCSHS Monograph Series No. 97), Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia
[lxxv] Laws PJ, Abeywardana S, Walker J and Sullivan EA (2007) Australia's mothers and babies 2005. Perinatal statistics series no. 20. Cat. no. PER 40. Sydney: AIHW National perinatal Statistics Unit.
[lxxvi] Isaacs JB (2006) Cost-effective investments in children, The Brookings Institution
[lxxvii] United Kingdom Department of Health (2007) Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts, at www.everychildmatters.gov.uk/teenagepregnancy, accessed May 2 2008.
[lxxviii] United Kingdom Department of Health .2004. 'Long-term consequences of teenage births for parents and their children, teenage pregnancy research programme', Research briefing number one, March.
[lxxix] Norris SA, Osmond C, Gigante D, et al. 2012. Size at birth, weight gain in infancy and childhood, and adult diabetes risk in five low- or middle-income country birth cohorts. *Diabetes Care*; 35: 72–79.
[lxxx] AIHW, Young Australians, Health and Wellbeing, 2011
[lxxxi] Australian Bureau of Statistics. 2005. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2005, ABS Cat No 4704.0, Canberra.
[lxxxii] See Courtney & Polich 2009
[lxxxiii] Collins .,D, J & Lapsley., H.M. 2008. *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/2005*. National Drug Strategy Monograph series no. 66. Canberra: Commonwealth Department of Health and Ageing
[lxxxiv] Matthew Manning, Christine Smith and Paul Mazerolle (2013).The societal costs of alcohol misuse in Australia Trends and issues in Criminal Justice, Australian Institute of Criminology, No. 454 April 2013
[lxxxv] Laslett A et al. 2010. The range and Magnitude of Alcohols harm to others, Fitzroy, Victoria: AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health
[lxxxvi] Fergusson D, Lynskey M, Horwood L. (1994) 'Childhood exposure to alcohol and adolescent drinking patterns'. Addiction, 89:1007-16; Jefferis BJMH, Power C, Manor O. (2005) Adolescent drinking level and adult binge drinking in a national birth cohort. Addiction100:543–9.
[lxxxvii] White V, Hayman J. (2006) Australian secondary students' use of alcohol in 2005. National Drug Strategy Monograph Series No. 58. Australian Government Department of Health and Ageing,Canberra, 2006.
[lxxxviii] Anderson P, de Bruijn A, Angus K et al. (2009a) Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. Alcohol 44:229–43.
[lxxxix] Sandra C. Jones and Christopher A. Magee,(2011,)Exposure to Alcohol Advertising and Alcohol Consumption among Australian Adolescents, Alcohol and Alcoholism Vol. 46, No. 5, pp. 630–637, Advance Access Publication 5 July 2011
[xc] ibid.
[xci] http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs/2013/alcohol/
[xcii] ibid.
[xciii] Australian Research Alliance for Children and Youth (2008) The wellbeing of young Australians Technical Report, Allen Consulting Group and UNICEF.
[xciv] This is deemed to be seven drinks per male per day, five drinks per day per female.
[xcv] Australian Research Alliance for Children and Youth (2008) The wellbeing of young Australians Technical Report, Allen Consulting Group and UNICEF.
[xcvi] Access Economics PTY Limited. 2009. Potential benefits of a national strategy for child and youth wellbeing, report for Australian Research Alliance for Children and Youth (ARACY)
[xcvii] White and E Bariola V (2012). Australian secondary school students' use of tobacco, alcohol, and over-the counter and illicit substances in 2011 report, Drug Strategy Branch, Australian Government Department of Health and Ageing
[xcviii] ibid.
[xcix] White and E Bariola V (2012).
[c] http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs/2013/illicit-drug-use/ (table)
[ci] http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs/2013/illicit-drug-use/
[cii] White E and Bariola V. (2012). Australian secondary school students' use of tobacco, alcohol, and over-the counter and illicit substances in 2011 report, Drug Strategy Branch, Australian Government Department of Health and Ageing
[ciii] http:/www.aihw.gov.au/alcohol-and-other- drugs/ndshs/>
[civ] ARACY report card. The wellbeing of young Australians. Technical report
[cv] Jacka FN, Kremer PJ, Berk M, de Silva-Sanigorski AM, Moodie M, et al. 2011. A Prospective Study of Diet Quality and Mental Health in Adolescents. PLoS ONE 6(9): e24805. doi:10.1371/journal.pone.0024805
[cvi] Please see Jacka FN, Overland S, Stewart R, Tell GS, Bjelland I, et al. 2009. Association between magnesium intake and depression and anxiety in community-dwelling adults: the Hordaland Health Study. Aust N Z J Psychiatry 43: 45–52; Tolmunen T, Hintikka J,

Ruusunen A, Voutilainen S, Tanskanen A, et al. (2004) Dietary folate and the risk of depression in Finnish middle-aged men. A prospective follow-up study. Psychother Psychosom 73: 334–339.

[cvii] Birmaher B, Ryan ND, Williamson DE, Brent DA, Kaufman J, Dahl RE, Perel J, Nelson B. Childhood and adolescent depression: a review of the past 10 years. Part I. J Am Acad Child Adolesc Psychiatry. 1996 Nov; 35(11):1427-39; Lewinsohn PM, Hops H, Roberts RE, Seeley JR, Andrews JA. Adolescent psychopathology: I. Prevalence and incidence of depression and other DSM-III-R disorders in high school students. J Abnorm Psychol. 1993 Feb;102 (1):133-44.

[cviii] Nolan M, Williams M, Rickard-Bell G, Mohsin M (2006) Food insecurity in three socially disadvantaged localities in Sydney, Australia. *Health Promotion J Austr*alia **17**, 247–54. ; Gallegos D, Ellies P, Wright J (2008) Still there's no food! Food insecurity in a refugee population in Perth, Western Australia. *Nutr Diet* **65**, 78–83; VicHealth. Food for All 2005–10: program evaluation report. Victoria: Victorian Health Promotion Foundation; 2011.

[cix] Brimblecombe J & O'Dea K 2009. The role of energy cost in food choices for an Aboriginal population in northern Australia. Medical Journal of Australia 190(10):549-51

[cx] Crawford et al. (2014), Sustaining dignity? Food insecurity in homeless young people in urban Australia, *Health Promotion Journal of Australia* 25(2) 71-78 http://dx.doi.org/10.1071/HE13090
Submitted: 18 October 2013 Accepted: 14 May 2014 Published: 18 August 2014

[cxi] Whitbeck LB, Chen X, Johnson KD (2006) Food insecurity among homeless and runaway adolescents. *Public Health Nutr* **9**, 47–52.

[cxii] Crawford et al. (2014), Sustaining dignity? Food insecurity in homeless young people in urban Australia, *Health Promotion Journal of Australia* 25(2) 71-78 http://dx.doi.org/10.1071/HE13090 Submitted: 18 October 2013 Accepted: 14 May 2014 Published: 18 August 2014

[cxiii] Australia: the Healthiest Country by 2020A discussion paper by the National Preventative Health Taskforce http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/A06C2FCF439ECDA1CA2574DD0081E40C/$File/discussion-summary.pdf

[cxiv]

[cxv] Begg et al 2007

[cxvi] Hay P, Mond J, Buttner P, Darby A 2008 "Eating disorder behaviours are increasing: Findings from two sequential community surveys in South Australia" PloS ONE, February, Issue 2, e1541

[cxvii] The Butterfly Foundation. (2012). Paying the Price, The economic and social impact of eating disorders in Australia

[cxviii] ibid.

[cxix] Arcelus J, Mitchell A, Wales J, Nielsen S 2011 'Mortality Rates in Patients With Anorexia Nervosa and Other Eating Disorders: A Meta-analysis of 36 Studies', Arch RCH Gen Psychiatry, 68(7): 724-731.

[cxx] The Butterfly Foundation. 2012. Paying the Price, The economic and social impact of eating disorders in Australia

[cxxi] The Butterfly Foundation. 2012. Paying the Price, The economic and social impact of eating disorders in Australia

[cxxii] ibid.

[cxxiii] Spitzer R, Yanovski S, Wadden T, Wing R, Marcus M, Stunkard A, Devlin M, Mitchell J, Hasin D & Horne R .1993, Binge Eating Disorder: A Multisite Field Trial of the Diagnostic Criteria, *International journal of Eating Disorders*, 13(2) 137-153.

[cxxiv] http://thebutterflyfoundation.org.au/nsw-coronial-inquiry-links-eating-disorders-and-suicide/

[cxxv] Access Economics. 2010. Positive Family Functioning, Report for the Department of Families, Housing, Community Services and Indigenous Affairs

[cxxvi] Wertheim, E.H, Paxton, S.J, & Blaney, S 2009, 'Body image in girls'. In L. Smolak & J.K. Thompson (Eds.) Body image, eating disorders and obesity in youth (2nd edition), Washington, DC: American Psychological Association.

[cxxvii] Tiggemann M. 2005. 'Body dissatisfaction and adolescent self esteem: Prospective findings' Body Image; 2: 129–35; Paxton, S. J, Neumark-Sztainer, D, Hannan, P. J, Eisenberg, M 2006, 'Body dissatisfaction prospectively predicts depressive symptoms and low self-esteem in adolescent girls and boys', Journal of Clinical Child and Adolescent Psychology, 35, 539–549.

[cxxviii] People with positive self-esteem are more confident in who they are and what they do. For instance, people who have high self-esteem are more capable, more in control of their life, make friends more easily, are less likely to experience depression and have better general wellbeing.

[cxxix] Katzer, L, Bradshaw, A.J, Horwath, C.C, Gray, A.R, O'Brien, S, Joyce, J (2008) 'Evaluation of a 'non-dieting', stress reduction program for overweight women: a randomized trial', American Journal of Health Promotion 22(4): 264–274; Avalos, L, Tylka, T.L, & Wood-Barcalow, N 2005, 'The Body Appreciation Scale: Development and psychometric evaluation', Body Image 2, 285–297.

[cxxx] Growing Up in Australia: The Longitudinal Study of Australian Children, chapter 7

[cxxxi] Cash T (2002). A negative body image. Evaluating epidemiological evidence. In T Cash &T Pruzinsky (Eds) *Body image: A handbook of theory, research, and clinical practice* (276) New Y ork: Guilford

[cxxxii] Dohnt H.K., &Tiggemann,M. 2006. Body Image concerns in young girls: The role of peers and media prior to adolescence. *Journal of Youth and Adolescence*, *35 p.* 141–151.

[cxxxiii] http://www.growingupinaustralia.gov.au/pubs/asr/2013/asr2013g.html

[cxxxiv] Bettering the Evaluation and Care of Health, 2006-07 (BEACH) as cited in Britt H, Miller GC, Charles J, Bayram C, Pan Y, et al . 2008. General practice activity in Australia 2006–07, AIHW Cat No GEP 21, General Practice Series No 21, Canberra.

[cxxxv] AIHW 2011

[cxxxvi] Access Economics 2009

[cxxxvii] Former Minister of Health Ms. Roxon 2007, the Minister also stated that making obesity a National Health Priority Area will help drive collaborative efforts aimed at tackling obesity at national, local, state and territory levels, and ensure that obesity receives the attention it deserves as a matter of urgency.

[cxxxviii] Access Economics PTY Limited .2009. Potential benefits of a national strategy for child and youth wellbeing, report for Australian Research Alliance for Children and Youth (ARACY)

[cxxxix] AIHW 2011

[cxl] Cummings, M and King M. 2012. Youth Health Services, Improving Access to Primary Care, *Australian Family Physician* 41. No 5

[cxli] ibid.

[cxlii] Van Dyke, N., Maddern, C.M., Walker, R. & Reibel, T. 2014. Young People's Experiences with Health Services Final Report. Commissioner for Children and Young People, Perth, WA

[cxliii] General practice activity in Australia – BEACH, as cited in AMA Position Statement. 2013. The Health of Young People

[cxliv] AMA, Position Statement, 2013, The Health of Young People

[cxlv] Cummings, M and King, M. 2012

[cxlvi] McClintock, M. 2005. Everyday Fears: A Survey of Violent Hate Crimes in Europe and North America. A Human Rights First Report.

[cxlvii] Please refer to: Leonard, W., Lyons, A., & Bariola, E. 2015. A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBTQI) Australians. Monograph Series No. 103. The Australian Research Centre in

Sex, Health & Society, La Trobe University: Melbourne

[cxlviii] Leonard, W., Lyons, A., & Bariola, E. 2015. A closer look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBTQI) Australians. Monograph Series No. 103. The Australian Research Centre in Sex, Health & Society, La Trobe University: Melbourne

[cxlix] McCabe, S., Bostwick, W., Hughes, T., West, B., & Boyd, C. 2010 The relationship between discrimination and substance use disorders among lesbian, gay and bisexual adults in the United States. American Journal of Public Health, 100(10), 1946-1952.

[cl] http://www.cyh.com/healthtopics/healthtopicdetails.aspx?p=240&np=300&id=2116

[cli] Kufeldt, K., & Burrows, B. A. 1994. Issues affecting public policies and services for homeless youth. Ottawa: Human Resources Development Canada.

[clii] Higgitt, N., Wingert, S., & Ristock, J. with Brown, M.,Ballantyne, M., Caett, S.,Coy, K., Quoquat, R., & Operation Go Home. 2003. Voices from the margins: Experiences of street-involved youth in Winnipeg. Winnipeg: University of Winnipeg. Retrieved from http://ius.uwinnipeg.ca/pdf/ Street-kidsReportfinalSeptember903.pdf

[cliii] Carneiro P, Heckman J (2003) Human Capital Policy NBER working paper series, National Bureau of Economic Research.

[cliv] ibid.

[clv] The World Bank. World development report 2007: development and the next generation. Washington, DC: The International Bank for Reconstruction and Development/The World Bank, 2007.

[clvi] The World Bank. World development report 2007: development and the next generation. Washington, DC: The International Bank for Reconstruction and Development/The World Bank, 2007.

[clvii] Australia: the Healthiest Country by 2020A discussion paper by the National Preventative Health Taskforce http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/A06C2FCF439ECDA1CA2574DD0081E40C/$File/discussion-summary.pdf

[clviii] Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C. and De Bortoli, L. 2008. The Cost of Child Abuse in Australia, Australian Childhood Foundation and Child Abuse Prevention Research Australia: Melbourne.

[clix] Access Economics, Growing Cost of Obesity, 2008

[clx] Access Economics, 2009, Economic Impact of youth Mental Illness and the Cost Effectiveness of Early Intervention

[clxi] Access Economics, 2009, Economic Impact of youth Mental Illness and the Cost Effectiveness of Early Intervention

[clxii] ibid

[clxiii] NSW Department of Juvenile Justice, Annual Report 2008-2009, 24.

[clxiv] Indig D et al. 2009. NSW Young People in Custody Health Survey: Full Report (Justice Health and Juvenile Justice, 2011) 145.

[clxv] ibid. 144.

[clxvi] Causland R, Baldry E, Johnson S and Cohen A. (2013) People with mental health disorders and cognitive impairment in the criminal justice system. Cost benefit analysis of early support and diversion. Report presented at the Australian Human Rights Commission and University of New South Wales roundtable *Access to Justice in the Criminal Justice System for People with Disability*, held at the University of NSW 2013

[clxvii] Causland R, Baldry E, Johnson S and Cohen A. (2013) People with mental health disorders and cognitive impairment in the criminal justice system. Cost benefit analysis of early support and diversion. Report presented at the Australian Human Rights Commission and University of New South Wales roundtable *Access to Justice in the Criminal Justice System for People with Disability*, held at the University of NSW 2013

[clxviii] WHO. Global health risks: mortality and burden of disease attributable to selected major risks. Geneva: World Health Organization, 2009.