



**Young people's health in Australia in the 1980s:
A social history**

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Thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy
July 2002

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Abstract

Interest in young people's health in Australia in the 1980s grew out of concern about the lack of health services and developed into more communitarian ideas. This thesis recovers the documentary record of three phases in the development of responses to young people's health in the 1980s and the contribution made by young people, health workers, youth workers, educators and governments. That evidence is refracted against the accounts of key informants who worked in adolescent/youth health and youth affairs during the 1980s. It is also set against the context of changing ideas about political economy and the role of government.

In the first phase, the late 1970s and early 1980s, the focus was on establishing acceptable and accessible health services for young people in hospital and community settings and education for the health work force to achieve this. The second phase occurred in the mid-1980s. The uptake of Alma Ata ideas in health and the influence of International Youth Year (IYY) resulted in greater attention to three things: the impact of social and environmental factors on young people's health; the need for health promoting social change to address these factors; and the importance of young people's participation in policy, program and service development.

The third phase was characterised by the dilution of the Alma Ata agenda. The rise of economic rationalism and the retreat of the state from welfare provision in the late 1980s saw the concept of social justice reduced to the notion of providing for the 'most disadvantaged' only, to the detriment of broader policies that might have enhanced the life chances of all young people. Australia's Health for All Strategy was captured by a targets and goals exercise which turned attention back to illness and problem behaviour and conflated the health of young people with that of children. In the absence of National and State policy to provide direction and coordinate efforts, work in young people's health became fragmented. Funding followed specific health problems and the sector took shape around those problems. HIV/AIDS, drug use, and homelessness dominated the agenda amidst increasing concern about the rise in youth suicide.

Young people may have had better access to health services at the end of the 1980s, due to the re-introduction of universal health care by the Commonwealth Labor government and the establishment of community-based health services in some states, but the increase in homelessness and unemployment and the rise in suicide suggest that for many, the underlying causes of health problems had not been addressed. This thesis shows that many ideas with potential and merit were not advanced in the 1980s and the recommendations of numerous reports to government, including reports of consultations with young people,

were ignored. There is a need for renewed attention to the way social and environmental factors and the policies of a range of government departments interact to benefit and compromise the health of young people. This requires a research agenda that moves beyond a focus on individuals to reveal population patterns of health, and a model for research that, in the words of American epidemiologist Nancy Kreiger, shows 'the inextricable and ongoing intermingling - at all levels - of the social and biological'.

Statement

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

Judith Peppard

July 2002

Acknowledgments

I wish to acknowledge my supervisor, Neville Hicks, for his encouragement and constructive comments, and the Australia Rotary Health Research Fund for helpful support. I wish to thank my key informants for the time they committed to the interviews, and my fellow students, especially Jan Patterson, Vivienne Moore and Katrina Hall, for their support.

This thesis is dedicated to my mother, Winnie Grandy, and father, William Hunt, whose belief in education was and continues to be an inspiration, and to my children, Isabel and Herbie, for their love and encouragement.

CHAPTER ONE

INTRODUCTION AND METHODOLOGY

1.1 Introduction

Young people's health emerged as an issue in Australia in the 1980s through a combination of social and economic factors and specific health concerns. Increases in unemployment and homelessness among young people led to concerns about their social and emotional wellbeing and their access to health services. This was particularly acute in the early 1980s when there was no universal health care in Australia. Cost and fears about confidentiality prevented many from receiving the health care they required. Young people's alcohol and other drug use was on the government agenda throughout the 1980s. Their need for sexuality information and education was given high priority when HIV/AIDS was diagnosed in Australia in 1982.

Initially the focus was on health services. The advocacy of the Australian Association for Adolescent Health (AAAH), a non-government organisation established in 1978 to 'promote the health of the youth of Australia' (AAAH Constitution, 1978), contributed to the recognition of the need for services and there were a range of responses in the early 1980s. Education was provided for health workers in some hospitals, adolescent/youth wards were established and youth arts projects were introduced to give young people a voice in the hospital setting. Adolescent outpatient units conducted outreach programs and community education. Multi-service youth health centres were set up in some states and universal health care was re-introduced by the Hawke Labor government in 1984, making health services more accessible for many young people.

The mid 1980s saw the beginning of policy initiatives in young people's health. These were instigated partly in response to International Youth Year (IYY), which was celebrated in 1985. The Commonwealth government gave priority to young people in the National Campaign Against Drug Abuse (NCADA) and the National HIV/AIDS strategy. Media campaigns encouraged young people to reduce their alcohol consumption and practice safer sex. These campaigns were supported by drug education and HIV/AIDS education programs in schools and in the community and training was provided for health professionals, teachers and youth workers in HIV/AIDS and drug education.

Despite these efforts, at the end of the 1980s young people's health was still a concern. Research published by the Commission for the Future pointed to increasing pessimism among Australian young people, describing them as 'casualties of change' (Eckersley, 1988). A Human Rights and Equal Opportunity Commission (HREOC) Inquiry found that homelessness had increased during the 1980s, that government's efforts to meet the

accommodation and health needs of homeless young people were far from adequate and the causes of homelessness had not been addressed (HREOC, 1989). In 1989, unemployment among young people began to rise at a time when government policy shifted responsibility for income support for them back to the family. This placed pressure on low income families and left many young people without adequate income support (Maas, 1990; Hartley, 1990; Bessant, 1993).

A United Nations report on the social health of children in ten industrialised countries provides further evidence of a decline in the social health of Australian young people (UNICEF, 1993). In the early 1990s Australia had the highest rate of annual deaths by suicide among fifteen to twenty-four year olds at 16.4 per 100 000 and the third highest percentage of children living in poverty, after the United States and Canada (UNICEF, 1993, p. 45). The same report concluded that the progress of the 1970s had been stalled in the 1980s. When each nation was compared against its own best performance between 1970 and 1989, based on the indicators of infant mortality, government spending on education, teenage suicide and income distribution, it was found that, after some progress during the early to mid 1980s, Australia had returned to just above 1970 levels (UNICEF, 1993, p. 45).

In light of these developments there is a need to examine Australian efforts in young people's health during the 1980s. Many of the people who worked in the sector during that time were employed in short term 'innovative' projects and have moved on and new people have entered the field. This thesis offers information to them about how work in young people's health was conceptualised and carried out during the 1980s—a history of the ideas that informed developments, where they came from, the action they generated and the difference they made. It provides a critical review of developments in Australia from 1980 to 1990 to establish an empirical base for improvements in policy and practice.

1.2 Conceptual presumptions

A study of young people's health brings into play ideas about health and how health is created, and ideas about young people themselves: that is, the expectations held within a society about the business of being young and the kinds of things 'healthy' young people get on with at this time in their lives. The way these ideas are interpreted and acted upon will determine the nature of the young people's/youth health project and the kinds of activity undertaken to promote young people's health. Following Canadian educator Roger Simon, I am using the word 'project' in the way it was used by Sartre (1963), 'as an activity determined by both real and present conditions *and* certain conditions still to come which it is trying to bring into being' (Simon, 1987, p. 372, emphasis in the original). Adolescent health/young people's health in Australia could be usefully conceived as a project being brought into being in the 1980s. The way that project came into being, and the form it took, was influenced by the values and perspectives of those who participated in it and by external events that shaped its possibilities and its limitations.

This social history of young people's health has drawn on the ideas set out in the Declaration of Alma Ata (WHO, 1978b). My studies in public health and my experience in working in young people's health in the 1980s have reinforced for me the importance of those ideas. They include: recognition of the social determinants of young people's health and working across sectors to address them; a positive concept of health; a positive concept of young people, one which sees a role for them in the health project; and research and data collection that reveals the way social and environmental factors shape the health of young people generally and contribute to inequalities in health in the youth population. Each of these ideas are examined briefly in the following sections to make explicit the values that guide the analysis of developments of the 1980s and provide a framework and reference points against which those developments will be assessed.

1.3 Public health in its broadest sense

There was growing concern in the 1970s that all was not well with the world's health and health care systems. Since the end of World War 2 there had been a rapid growth in the international health care industry without an increase in the health status of many people. As medical technologies and medical knowledge developed, there had been the belief that these things would solve the health problems facing people around the world. However, it became increasingly apparent that this was not the case and that high technology acute medical care had a limited effect on the health of populations. There was growing evidence that it was public health in its broadest

sense, rather than medical care, that was responsible for most population health improvement.

Wass, 1998, p. 8

In September 1978, the World Health Organization and the United Nations International Children's Emergency Fund (UNICEF) convened a conference at Alma Ata, in Kazakhstan in the former USSR, to consider what might be done to promote population health and reduce inequalities in health between and within countries (WHO, 1978a). The result was the Declaration of Alma Ata (WHO, 1978b), which set out ten principles as a blueprint for achieving 'an acceptable level of health for all the people of the world by the year 2000' (Wass, 1998, p. 8). Those principles incorporate the following ideas: the importance of a positive definition of health; the political, social and economic unacceptability of inequalities in health; the right of people 'to participate individually and collectively in the planning and implementation of their health care'; the planning of national policies and plans for primary health care in coordination with other sectors; and 'a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts' (WHO, 1978b). The Declaration of Alma Ata gave birth to the WHO Health for All by 2000 Strategy. In this thesis I have used the principles of Alma Ata as the basis of my critical review and a reference point for developments in young people's health during the 1980s.

The Alma Ata and Health for All emphasis on reducing inequalities in health had implications for the way work in the health sector was thought about and carried out, the kinds of knowledges required by health departments and health workers and the way they worked with individuals and communities. Health departments concerned about promoting health, not just dealing with illness after it arose, would be required to extend their ambit beyond service provision to the way health and illness are created in social conditions and change those conditions through social policy. The desire of governments to reduce increasing health service expenditure was another, if less altruistic, prod in this direction.

The South Australia Health Commission's Social Health Strategy (1988) captures the spirit of Alma Ata and uses the term 'social health' to describe a way of working that gives attention to impact of environments on population health.

A social view of health is one that recognises the impact (both direct and indirect) which physical, socioeconomic, and cultural aspects of the environment have on the health of the community. A social view of health implies that we must intervene to change those aspects of the environment which are promoting ill health rather than continue to deal with illness after it appears, or continue to exhort individuals to

change their attitudes and lifestyles when in fact, the environment in which they live and work gives them little choice or support for making such changes.

South Australia Health Commission, 1988

The application of Alma Ata and social health ideas requires the social and environmental factors that compromise the health of young people to be identified and addressed. This study examines the extent to which this was done during the 1980s.

1.4 Concepts of health—holistic ideas

During the 1980s the dominant rhetorical model in health policy in Australia was Health for All, whose language reflects the World Health Organization's holistic definition of health as 'complete physical, social and emotional well-being'. The WHO definition, despite criticisms that it is difficult to operationalise, is important in young people's health for three reasons. First of all, compared to other groups in the population, young people are well and healthy (Bennett, 1984; Bowes, 1992). A study of ill health will not tell a lot about the youth population as a whole. Second, when health is defined as wellbeing the people who can contribute is extended. Health is no longer solely the province of those who cure disease, but includes those who work with young people in a variety of capacities and to young people themselves. Third, a positive definition of health is important in Australia because it is consistent with, and inclusive of, Aboriginal and Torres Strait Islander ideas about health. These ideas are closer to the WHO definition than the medically dominated notions that prevail in western industrialised countries, where the term 'health' tends to be equated with illness. The importance of a positive and holistic definition of health is not exclusive to Aboriginal and Torres Strait Islander peoples. A recent review of social, economic and cultural determinants of health in New Zealand has made a similar point about the significance of a holistic idea to the health of the Maori population (Howden-Chapman and Cram, 1998).

The Ottawa Charter for Health Promotion (1986) offers a framework for operationalising the ideas set out in the Declaration of Alma Ata (1978). The Ottawa Charter describes health as 'a resource for everyday life' and 'a positive concept emphasising social and personal resources, as well as physical capabilities'. It states that:

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society that one lives in creates conditions that allow the attainment of health by all its members.

Ottawa Charter, 1986

While it has almost become a cliché, I continue to find this description of health creation useful in young people's health. It draws attention to everyday things and the settings in which young people, and all of us, learn, work, play and love which are fundamental to health. The quotation also suggests that the control and choices young people have over the directions they take in their lives have an impact on their health and raises the question of whether conditions created in Australia during the 1980s contributed to the attainment of health by all young people.

Health exists on a continuum. It is not static but changes constantly in response to the interaction of environmental, cultural, social and personal factors. The position of a person or population group on the health continuum will change over time. While young people as a group tend to be located at the positive end of the continuum, there is evidence to suggest that, during the 1980s, the proportion of young people experiencing problems such as homelessness, and the number who sought to take their own lives, increased in Australia. Such markers must be attended to, but arguments for attention to young people's health should not be lodged only in the hypothesis that their health is getting worse. This would suggest that health resources are only made available when individuals or a groups of individuals reach the illness end of the continuum. A different argument suggests that the business of health is to do with the promotion and maintenance of good health in the community. It is in this area that responses must be sought and arguments for resources to promote and enhance young people's health made.

1.5 Concepts of young people

There has been, and continues to be, debate about the use of the terms 'adolescent', 'youth' and 'young people' to describe people between the ages of twelve to twenty-five, although the age range varies. The term 'adolescent' was adopted when the speciality of adolescent medicine was established in the United States in the 1950s and, in its first report on young people's health (published in 1965) the World Health Organization (WHO) also used 'adolescent' (WHO, 1965). The Australian College of Paediatrics Committee on Adolescence determined in 1979 that the term 'child' should not be used to designate this age group and proposed that 'youth', 'adolescent' or 'adolescence' be used to describe people between puberty and maturity (Australian Association of Adolescent Health Newsletter No. 4, July, 1979). 'Adolescent' was used by the Australian Association for Adolescent Health (AAAH) throughout the 1980s, but in its first constitution (1978) the Association's aim was 'to promote the health of the youth of Australia'.

The terms 'adolescence', 'youth' and 'young people' have been linked to particular views about young people and approaches to their health. 'Adolescent' tends to be used within clinical settings and has an illness/problem connotation. AAAH's preference for the term may have reflected the medical backgrounds of the Association's founding members and their connections with the Society for Adolescent Medicine in the United States. In contrast 'youth' is associated with a sociological perspective which draws attention to young people within their social context. For many youth workers 'youth health' was more acceptable than 'adolescent health' in the 1980s because it signified a social and political agenda and action with young people to effect health-enhancing change (YACA, 1983).

Despite AAAHs adherence to the term 'adolescent', by the mid-1980s 'youth' was often used in reports, policies and programs on young people's health, and 'youth health worker' to describe youth workers who worked with young people on health matters (Robertson, 1985; Connelly and Borger, 1985; Shanahan, 1984; YPDC, 1988; YACSA, 1990). However the term 'youth' has also been criticised for representing the male experience and not being inclusive of young women. One of my key informants commented that:

... 'youth' actually carried the male connotation and so I think that's why we've all argued for the use of the words 'young people' and the national and state policy, I think, is probably in some ways a reflection of that increasing recognition and influence of gender issues.

(M1)

Although there were differing views about terminology, it is not unusual for all of the terms discussed above to be used within the text of the same document. For example, the New South Wales policy *Providing for the Health of Young People* (1991) is described as a 'youth health' policy in its summary statement, uses the term 'adolescence' in its definition and demography sections and 'young people' in the title and other sections. The term 'young people' does have the problem of being ambiguous, begging the question of how young is young and might also be seen to include children. This notwithstanding, 'young people' and 'young men' and 'young women' are the terms I prefer and use most often in this thesis. I believe they are respectful of young people as a whole and inclusive of young women.

Questions to do with terminology are accompanied by questions of definition: that is, how do we define and delineate the population group called 'young people'? The World Health Organization defined adolescence as twelve to twenty in 1965. In 1980 a WHO Asia-Pacific Region report defined adolescence as ten to nineteen years of age, and distinguished between early, middle and late adolescence (WHO, 1980). When the United Nations designated 1985 as International Youth Year (IYY), young people between the

ages of fifteen and twenty-four were designated as 'youth'. In response, the WHO (1986) extended its age definition, proposing that the term 'young people' be used for the composite age range of ten to nineteen (previously called adolescents) and fifteen to twenty-four years (youth), noting that, in practice, the terms 'adolescent', 'youth' and 'young people' tend to be used interchangeably. The WHO's 1989 report on young people's health continued to use the term 'young people' and extended the age to twenty-five (WHO, 1989). The current Commonwealth health policy designates young people as those between twelve and twenty-five (Commonwealth Department of Human Services and Health, 1995).

Absolute age parameters are artificial to some extent, because social and cultural definitions are also important and expectations of young people vary between and within cultures (WHO, 1986). Maggie Brady, an Australian researcher who has worked and conducted research with Aboriginal young people, points out that within Aboriginal cultures, young people are seen within the context of their community, not as a group apart (Brady, 1992). Anderson notes that many of the issues which confront adults in the community, such as finding work, child-rearing, coming to terms with issues of identity and general survival, are dealt with by Aboriginal people when they are much younger, in some cases as young as fifteen years of age (Anderson, cited in Brady, 1990).

Young people from culturally and linguistically diverse backgrounds who have migrated to Australia may experience family and cultural expectations that are different from those experienced by their Australian counterparts (Fairfield Council, 1983). Refugee young people encounter problems related to the loss and trauma they experienced prior to arriving in Australia and, when they arrive here, issues of separation from family, interrupted schooling, extra family responsibilities and identity problems (AYPAC, 1994; Bashir and Schwarz 1988; Fairfield City Council, 1982). All of these things affected the way individuals and groups of young people experienced being young in Australia in the 1980s. There is no 'golden mean' of what it is to be a young person that can be applied to all groups uniformly.

Much health literature presents young people as 'vulnerable' or as people with bad habits which need correcting. They are often the 'target' of media campaigns and health education programs which aim to change their behaviour. In contrast, the Declaration of Alma Ata's emphasis on community participation would see young people as partners in the analysis of health issues and the development of strategies to address those issues. In the words of Canadian academic Leslie Roman, young people must be recognised 'as speakers with political legitimacy and unique epistemic standpoints' (Roman, 1996, p. 1). This thesis incorporates young people's views about health and the health concerns they identified in consultations conducted during the 1980s. It highlights the role they played in

events of the 1980s and includes the reflections of two young people who participated in a health project designed to empower¹ them and their peers.

1.6 Young people and wellbeing

It was the intention of this research to determine whether the health of young people had improved in Australia during the 1980s. The first steps taken in this process were to identify existing research and work in progress on the social health status of young people (twelve to twenty-five) in Australia from 1980 to 1990, identify the best indicators to give a picture of the social health status of young people at the beginning and end of the decade and to find a model for understanding young people's health and wellbeing consistent with Alma Ata and social health ideas.

Assistance in locating sources of information was provided by the South Australian Centre for Economic Studies (Geddes and Nelson, 1993). Initially information was sought about issues such as drug use, sexually transmitted diseases, suicide rates, sexual abuse, unemployment and motor vehicle accidents. Health surveys conducted by the Australian Bureau of Statistics and public hospital separation data were also sought. Pursuit of those indicators seemed natural given the prominence of these topics in the health literature about young people.

However, there were a number of problems with this type of 'health' information. First of all it was illness-oriented and was not consistent with a positive view of health. Secondly, it presented a negative image of young people and their activities, which was not consistent with the positive view of young people, nor was it consistent with the evidence that suggests that young people are generally a healthy group, in their own self-assessment and in the considered view of experts in the field. This raised questions about the views about young people and their development that underpin research and data collection.

My philosophical perspective raised a set of normative questions about the ideas that were desirable for informing data collection in young people's health—the ideas that would best serve young people and be most useful in promoting their wellbeing. This brought me back to the principles of the Declaration of Alma Ata and the kind of research agenda required to progress those ideas—an agenda based on a positive view of health, that gives attention to the social determinants of health and that values young people by including their views, concerns and lived experiences. Starting from this point of view led to two specific lines of inquiry: an investigation of the literature on wellbeing generally and in young people's

¹ The term 'empower' has been interpreted in different ways (Colquhoun et al, 1997). The use of the term in health is discussed in Chapter 2.

wellbeing specifically; and an investigation of the values and ideas that underpin research and data collection. These matters are discussed in detail in Chapter 7.

Developments of the 1980s have been examined against the backdrop of these ideas—a social health approach, a positive definition of health and a positive view of young people which sees a role for them in the health project. This thesis traces the emergence of these ideas in young people's health during the 1980s and my analysis determines whether developments of the 1980s were congruent with these ideas, how powerful they were in the diagnosis of the problems of the decade and the development of responses to those problems.

1.7 Methodology

To meet the requirements of the conceptual framework outlined above, a methodology consisting of three inter-related components was adopted: a literature review and analysis of reports and policy documents produced on young people's health during the 1980s; a review of research and data collection in young people's health during the 1980s; and interviews with people who participated in developments during that time.

The literature review and document analysis were based on the standard historical method of combing many different documents, following leads from one source to another, examining clusters of associated themes and weighing their relative significance. There were four aims for this component of the research: to determine the range of issues in young people's health in Australia during the 1980s, who was raising them and the solutions being proposed; to investigate the way those issues were analysed and understood over the span of the 1980s and the action those understandings generated; to gain information about young people's contributions to developments of the decade; and to identify research on the health and wellbeing of young people and its measurement. Reports and policy initiatives that endeavoured to capture the breadth of young people's health, that revealed the ideas that were influential during the decade and the way those ideas gained momentum across states and nationally, were selected for detailed attention in the body of the thesis.

This range of documents was reviewed to determine the ideas, people and events that influenced developments, the professional groups and agencies that took an interest in or worked in young people's health and the identification of potential key informants. This required an investigation of the following: WHO reports on young people's health to situate developments in Australia within an international context; literature on young people's health in refereed journals; Australian research and data collection about young

people's health; policy and program documents and reports produced in Australia during the 1980s; reports of consultations with young people; and the work of the Australian Association for Adolescent Health, the national non-government organisation for young people's health during the 1980s.

Searches were conducted through university library catalogues and electronic data bases to identify Australian literature on young people's health published in the 1980s. The literature and documents examined fall into the five inter-related categories.

- articles located using the keywords 'wellbeing', 'adolescent health', 'youth health', 'adolescent wellbeing' and 'youth wellbeing' through searches on Medline, Psychlit and Sociofile.
- World Health Organization (WHO) reports on young people's health published in 1980, 1986 and 1989.
- Australian journals, including *Community Health Studies*, *Paediatrics and Child Health*, *The Australian Journal of Social Issues*, *Family Matters*, *Youth Studies and Abstracts*, *Healthright*, *The Drug and Alcohol Review*, *The Drug Education Journal of Australia* and *The Australian and New Zealand Journal of Obstetrics and Gynaecology*.
- the national newsletter of the Australian Association for Adolescent Health (AAAH), minutes of AAAH National Council meetings, the programs and abstracts of the Association's biennial conferences and the 4th International Symposium on Adolescent Health.
- reports of consultations with young people and Australia National Opinion Poll (ANOP) surveys conducted in 1984, 1986, 1988 and 1990.
- reports on young people's health, policy and planning documents and Commonwealth health promotion initiatives aimed at young people.

Materials provided by my key informants and my own archive of papers, draft and completed reports, conference programs and even workshop sign-up sheets, collected during my work in young people's health from 1983 to 1988, added to the information derived from the published literature.

A number of texts and publications have been particularly helpful in the development of this thesis. Christine Griffin's *Representations of Youth* (1993) offered a critical analysis of

the way young people were represented in research conducted in the United States and Great Britain during the 1980s. *Youth in Australia* (Irving et al, 1995) provided information about developments in youth affairs during the 1980s against which initiatives in young people's health could be viewed. *Breaking Out* (eds Kosky et al, 1992) offered a range of perspectives on young people's mental health and findings of research conducted in Australia during the 1980s. Two reports funded by the National Youth Affairs Research Scheme (NYARS), the *National Youth Data Index* (Murdoch et al, 1993), and *Australia's Young People, A Statistical Profile* (Carlton, et al 1993), were also valuable in providing an overview of the kinds of data that were available about young people, their situation and their wellbeing in the early 1990s.

The lens offered by the published literature has been refracted against the interviews with key informants. Reinharz points out that 'Oral history is particularly useful for getting information about people less likely to be engaged in creating written records and for creating historical accounts of phenomenon less likely to have produced archival material' (Reinharz, 1992, pp. 131–2). While this thesis has not adopted an oral history methodology, Reinharz's comment is relevant. As one of my key informants indicated, many of the people who worked in young people's health during the 1980s have moved on (YHP 16). Further, many would not have seen themselves as recorders of events and were unlikely to be formal chroniclers. Rather much of their time and energy was taken up with the immediate issues of the young people with whom they worked and, as another of my key informants noted, chasing funding and fighting for the survival of youth services (YA1). Their understandings of the situations in which they worked, the ideas that influenced their practice and the battles they fought to have young people's health recognised and funded, are an important part of the history of young people's health of the 1980s. Hence the interviews with key informants sought, in addition to enhancing the formal published record, to recover grassroots accounts of those who worked in young people's health during that time.

Two processes were used in the selection of key informants. Firstly key informants were sought in three categories: people who had worked primarily in youth health policy, program or service provision; people who had worked primarily as youth workers or in youth affairs; and people who had worked primarily in medical settings. Secondly key informants were selected who had worked in the sector for much of the 1980s, could bring a national perspective to bear on developments of the decade, had participated in policy and advocacy processes at national and state levels and participated in projects that broke new ground and extended the scope of the youth health project. While not every key informant interviewed met all of these criteria, as a group they did.

Potential key informants were identified in three ways: through the literature review; through the Australian Association for Adolescent Health and its state representatives; and my professional contacts. There were many people who might have been interviewed and the list of the key informants was reviewed over a six month period to determine whether a balance of perspectives, voices and positions on young people's health had been achieved. Thirty-seven people were interviewed. Those interviewed had worked in Queensland, New South Wales, Victoria, Tasmania, South Australia, Western Australia and the ACT during the 1980s. They included people who had held the following kinds of positions: youth workers in generic youth programs and projects; youth health workers; employees of, or office bearers in, peak non-government adolescent/youth health and youth affairs organisations; medical practitioners who specialised in adolescent health, including adolescent psychiatry; and bureaucrats in state health departments.

The interviews endeavoured to find out how those who worked in young people's health experienced the issues and events of the 1980s, both in their day to day work with young people and as advocates for young people's health. More specifically, my interviews sought to: obtain an interpretation of events from people who had participated in them; to obtain views about the frameworks and ideas that influenced developments of the 1980s and how influential those ideas were; changes that occurred during the decade; and gather information about undocumented experiences and events.

The interview was guided by ten open-ended questions pertaining to the following matters: issues in adolescent/youth health at the beginning of the decade, the solutions being proposed to address those issues and the debates that occurred; issues in adolescent/youth health at the end of the decade, the solutions being proposed to address those issues and the debates that occurred; the ideas that informed developments during the 1980s and where they came from; changes that had occurred in policy and practice; the workers in youth health at the beginning and end of the decade and the spheres in which they operated; and undocumented events.

During the first five interviews two problems emerged. Firstly, while some of my key informants recalled events of the 1980s with ease, others found it difficult; and second, the interviews were reproducing information already available through the literature review and document analysis. To address these issues a narrative outlining key points from the findings of the literature review and document analysis was developed for each question. Key informants were invited to respond to the narrative and to add their own views on developments and their experience of events. They were also encouraged to add to or challenge the information contained in the narrative, which they did. The narrative provided for key informants is contained in Appendix 2.

The interviews with key informants were conducted between December 1993 and January 1995. The interviews were taped and transcribed. Individual identities have been disguised through use of a coding system which consists of an upper case letter, to indicate the primary sphere in which the key informant worked, and a number, to designate the individual respondent in each category. The letter 'M' refers to a person who worked primarily in a medical setting, 'YHP' refers to a person who worked primarily in youth health policy and programs, and 'YA' refers to a person who worked primarily in youth work/youth affairs. Individual key informants are designated throughout the text of this thesis in the following way: 'M1' refers to medical setting, respondent 1; 'YHP 13' refers to youth health policy and programs, respondent 13, and 'YA 4' refers to youth affairs/youth work, respondent 4.

The categories were not chosen to draw out differences between perspectives, although that has emerged in some instances, but to incorporate the views of the range of people who contributed to developments in young people's health in the 1980s. To some extent the three categories are arbitrary, because people moved in and out of different aspects of work in young people's health during the 1980s and, in a relatively small sector, workers participated in many kinds of activity and in a variety of roles. Young people taught medical students, physicians chaired the local Community Youth Support Scheme management committee and participated in health consultations with young people, youth workers contributed to health policy development and everyone was an advocate. Commenting on people moving from non-government to government employment during the 1980s, one of my key informants noted that:

we'd always criticised bureaucrats because they didn't know anything and suddenly we all were them!

(YHP13)

Most of my key informants had had an involvement in program and policy development during the decade regardless of their discipline, place of employment and whether they worked in the government or non-government sector. While the interviews did provide information on debates that occurred, the breakdown of people who held opposing views was not necessarily a government and non-government one, nor medical versus non-medical. Further, my key informants had in common a strong commitment to young people's health, regardless of differences in views about the best way forward and the setting in which they operated during the 1980s. This come through in quotations from my key informants that are used throughout the thesis.

The findings of the interviews have been incorporated into the body of the thesis and quotations from my key informants are italicised in the text, to distinguish them from

quotations from published materials. As an ethnomethodology has not been used, quotations have been edited to remove verbalisms and hesitations. No editing has been undertaken to destroy the force of the argument the key informant was making.

Three additional interviews were conducted to supplement the interviews with key informants. One with David Leary, the Coordinator of Come In Drop In Centre in Paddington New South Wales, to gain a perspective on the way a generic youth drop-in centre worked to develop a health component within its program. Two interviews were conducted with former members of the Side Effects Youth Health Drama project to gain their views about how they had experienced the project and whether the objectives of the project had been achieved.

1.8 Summary

Chapter 1 has outlined the rationale for this thesis, the ideas that informed the analysis of developments in young people's health in Australia in the 1980s and the methodology used to build a picture of young people's health at that time, the issues identified and the action taken to address them. Chapter 2 begins the story in the late 1970s, when a group of health professionals established the Australian Association for Adolescent Health, youth workers identified the need for health services and the advocacy of a young woman from Canberra led the Commonwealth Department of Health to commission a report on young people's health.

CHAPTER 2

JUST RECOGNISING THERE WAS SUCH A THING...

2.1 Introduction

my sense of what was happening then (the early eighties) was that just recognising there was such a thing as adolescent health was where it was at, and the Association for Adolescent Health was really Murray Williams and one or two others and David (Bennett) had...relatively recently started his unit in Sydney, so looking back on it my feeling is that really it wasn't about so much identifying particular issues, although I agree with the ones that you talked about, it was more just raising a profile for adolescent health and...I was still I think from memory, still kind of countering the point of view that adolescents were all healthy and you don't need to worry about them and so I guess that was the kind of flavour that I remember about the period.

(M4)

This chapter describes developments in young people's health in Australia at the beginning of the 1980s against the background of pertinent events of the late 1970s. These developments are examined with attention to the issues in young people's health, the way government, health professionals, youth affairs bodies and young people understood and responded to those issues and the ideas that informed their responses. This chapter establishes the terrain from which work in young people's health grew in the 1980s.

2.2 An Australian association for adolescent health

In December 1978, a seminar on the health and medical care of adolescents was held at the Adolescent Medical Unit (AMU) of the Royal Alexandra Hospital for Children in Camperdown, New South Wales. The Commonwealth Department of Health provided funding for fifteen interstate delegates to attend (Williams, 1978) and the multidisciplinary team of the AMU also participated. The background papers and the seminar report give an indication of the issues that concerned health professionals at that time: medical care of adolescents; access to medical and helping services for young people; psychiatric and social treatment for adolescents; the psychological impact of unemployment on young people; and the status of teaching about adolescents in the medical curriculum in Australia (Williams, 1978).

A presentation by two young people who used the services of the Royal Alexandra Hospital for Children provided an insight into the way young people experienced the health system at that time. They were critical of the 'rigid and remote attitudes of many professional workers' and urged doctors 'to look carefully at their own roles and be willing

to modify their approach to the care of younger people' (Williams, 1978, p. 2). Other presenters raised similar concerns, pointing out that young people tended not to see doctors as people they could talk to about 'personal problems, physical development or sexual matters' (Williams, 1978, p. 2).

Those who attended the seminar decided there was a need for an organisation that would promote interest in young people's health, both in the health sector and in the wider community, and provide support for those working in the area (Williams 1978). They established the Australian Association for Adolescent Health (AAAH) to meet this need (Seminar on the Health and Medical Care of Adolescents, Minutes of final meeting, 1978).

The founding members of AAAH followed a precedent set in the United States ten years earlier. A Society for Adolescent Medicine (SAM) had been established there in 1968 (CDH, 1981, p.3; Gallagher, 1982, p. 60). The creation of AAAH could be seen as a move to carve a professional niche for the discipline of adolescent medicine in Australia, but the adoption of 'health' instead of 'medicine' in the Association's name, suggests a broader agenda.

...the ten doctors who came together to start to think about what to do in Australia about adolescent health, were very strong on the notion of pursuing the broader goals of good health rather than a medical model, a narrow medical disease based model.

(M2)

The focus on health meant that the ambit of the Association would extend beyond health care, which was the topic of the seminar, to the notion of health itself and how it is created. This linked AAAH philosophically to WHO's positive definition of health and, to some extent, to the developments that Alma Ata represented. The aim of the Association was stated broadly— 'to promote the health of the youth of Australia' (Seminar on Adolescent Medicine, Minutes of final meeting, Nov 15, 1978). Initially membership was open to 'registered medical practitioners approved by the committee' and other professional disciplines 'as determined by the committee and approved by them' (AAAH Constitution, 1978), but the 1981 Annual General Meeting resolved that new rules were needed for AAAH to accommodate the 'increasing size and scope of the Association' (Newsletter No. 16, May, 1983, p.1). Subsequently AAAH membership was opened to 'individual persons interested in any aspect of adolescent health' and to 'organisations which are interested in or connected with any one or more aspects of adolescent health' (AAAH Constitution, 1984). This influenced the direction taken by AAAH when it became the peak non-government organisation for young people's health in the 1980s.

At the time that AAAH was being established, a group of workers outside the health sector identified the need for health services for young people. They were the project officers working in the Community Youth Support Scheme (CYSS) and the refuge and shelter workers employed through the Youth Services Scheme. The CYSS program was set up by the Commonwealth Liberal Government in 1977 to provide community support for the increasing numbers of unemployed young people in Australia (Irving et al, 1995). The Youth Services Scheme was introduced by the same Government two years later, to provide emergency accommodation for homeless young people (Wilkinson and Vickas, 1984; HREOC, 1989; Irving et al, 1995).

The introduction of CYSS and the Youth Services Scheme resulted in the creation of fifteen hundred new youth work positions over a five year period and a new segment in the youth affairs sector (Ewen, 1983, p. 55). John Ewen, then an academic at the Phillip Institute in Melbourne, described the youth workers employed in these projects as better educated, more politically conscious and operating from value systems that gave priority to social equity and democratisation (Ewen, 1983, p. 55). Ewen also noted that there had been little attention to health policy within youth affairs up to that time (Ewen, 1983). This changed as youth workers came into contact with young people who were unable to receive help for serious health problems because of the cost of services, concerns about confidentiality or because a suitable service did not exist (CDH, 1981, p.21; Wilkinson and Vickas, 1984).

...because there were no services for a lot of those young people in that 17 to 25 age group, and especially young males who start to exhibit their schizophrenia around about that stage, they tended to gravitate towards the Community Youth Support Scheme. And certainly where I was...which had a mental health unit in the area, and so in effect youth workers were seeing people that they perhaps lacked some skills in knowing how to assist because they had no training in mental health.

(YHP8)

little pockets of people got pushed off to places where they could be sort of taken care of... in models that were probably not in the long term, correct, and what you had was workers in those sectors having to do a whole heap of stuff for which they actually had no skills. the refuge workers, they used to do heaps of stuff for which they had no bloody training You know it's not good enough!

(YA4)

Youth workers found themselves dealing with problems, including mental health problems and disorders, for which they had no training, and determined that the health sector was not making adequate provision for young people.

The lack of health services was also raised at the National Youth Conference organised by the Commonwealth Office of Youth Affairs in 1979. Held in Canberra from October 3rd to the 5th, the Conference aimed to find out young people's views about the issues that affected them (National Youth Conference, 1980). The newly-formed Australian Association for Adolescent Health (AAAH) was invited to send a delegate and Narelle Wickham, a young woman employed at a hostel for intellectually handicapped adolescents in Canberra, represented AAAH at the conference (AAAH Newsletter, No 5, Oct, 1979, p.1). The Association's Newsletter reports that Wickham would seek 'where possible, to remind participants of aspects of young people's lives related to health and provisions for their health care' (AAAH Newsletter, No 5, Oct, 1979, p.1). One of my key informants recalled

There was ayouth conference in 1979, it was about the first time when it (adolescent health) got crystallised and it was quite interesting how it was highlighted, actually, by Narelle Wickham.....She was working with very troubled youth. She had experience which most people didn't have in that field. She was like a comet, flashed in and out again, but it just happened that she had the wit to see the political possibilities of such a thing. She was much less naive than most of us were, really.

(M12)

During that three day conference, young people passed resolutions about matters such as alcohol and other drug use, work and leisure, communication with young people in isolated areas, Aboriginal affairs, ethnic groups, women's issues, the environment and health services (National Youth Conference, 1980). Wickham, along with eleven others, was appointed to follow up the resolutions (AAAH Newsletter No 6, May, 1980, p.2), one of which was that 'the need for specific medical (including psychiatric) problems of adolescents be recognised and catered for in adolescent medical units' (National Youth Conference Report, 1980, p. 68). Her advocacy proved effective. Ian Viner, Minister for Employment and Youth Affairs, asked the Minister for Health to examine the Commonwealth's support for health programs for young people.

It was in response to Miss Wickham's efforts that the Conference passed a resolution on the adolescent health problems and that I obtained from my colleague, the Minister for Health, Hon. M. J. Mackellar, an undertaking to examine the Commonwealth's support of programs to meet the special health needs of adolescent youth.

Excerpt from a reference for Narelle Wickham written by
RI Viner, Minister for Employment and Youth Affairs, 1980

In response to Viner's request, Mackellar commissioned the report *Health Needs of Adolescents*, raising the profile of, if not a commitment to, young people within the Commonwealth Department of Health.

2.3 Raising the profile

Health Needs of Adolescents was published by the Commonwealth Department of Health in December 1981 and it reveals how young people's health was conceptualised by the health sector in Australia at the beginning of the 1980s. Another document, *Creating Tomorrow Today*, was published by the Youth Affairs Council of Australia (YACA) a year and a half later in 1983. Its youth policy section provides a youth affairs perspective on young people's health. These two reports are examined in detail because together they reflect the views of the constituencies that formed around young people's health in the early 1980s.

Health Needs of Adolescents is conceptually similar to the report of a meeting on adolescent health convened by World Health Organization's Regional Office for the Western Pacific in 1980. This is not surprising as two Australians played key roles in the WHO meeting: Peter Eisen, Medical Director, Child and Adolescent Psychiatric Services, Austen Hospital, Heidelberg, Victoria, was rapporteur for the Working Group; and David Bennett, who had recently established the Adolescent Medical Unit at the Royal Alexandra Hospital for Children in Sydney, was a consultant to the Working Group and chaired the meeting (WHO, 1980). Like the WHO report, *Adolescent Health in Australia* gives principal consideration to young people between the ages of twelve and nineteen and adopts four problem themes or groupings as the framework for considering young people's health (CDH, 1981, p. 4). Those themes are: biological issues; risk-taking behaviour; sexually-related problems; and psychiatric and emotional problems. The health problems of young people are identified and discussed within each theme and tend to be located within their physical characteristics and risk-taking behaviour (CDH, 1981, pp. 4–13).

This framework is used or cited, with minor variations in wording, in Australian reports and policies on young people's health throughout the 1980s and into the 1990s (CDH, 1981; Bennett, 1984; Connelly and Borger, 1985; Youth Policy Development Council, 1987; N.S.W. Department of Health, 1991), but as a framework for understanding young people's health it has two limitations. Firstly, its starting point is illness and health problems, so it is not consistent with the World Health Organization's positive definition of health nor AAAH's preferred definition. Secondly, because the same social and environmental factors—things such as unemployment, social exclusion and lack of social support—are associated with a range of health problems (Syme, 1986, p. 964; Marmot and

Wilkinson, 1999; Wilkinson and Marmot, 2000), a framework which takes the social situation of young people as its starting point would be more useful.

Health Needs of Adolescents presents young people in ways which are at times contradictory. While the reports states that there is 'no evidence to support the myth of adolescence being a psychological disorder per se' (CDH, 1981, p. 7), its description of adolescence as 'the most vulnerable stage of the life cycle' (CDH, 1981, p.4) and its reference to 'normal adolescent turmoil' (CDH, 1981, p.7) invokes the storm and stress notion that has not held up to scientific scrutiny (Collins, 1991). The contribution young people can make is valued to the extent that a potential role for them within health is envisaged. Their participation in 'various aspects of health and health related services delivery' (CDH, 1981, p. 29) and their involvement in program planning and implementation, are put forward as ideas with promise that have not yet been used in Australia (CDH, 1981, p. 29). The wording of this section of the Commonwealth document is almost identical to that of the WHO report (WHO, 1980, p. 15). Young people's views about the need for accurate information on sexuality and contraception, expressed in a resource paper produced by the National Youth Council of Australia (NYCA), are included (CDH, 1981, p. 23), although there is no citation for the NYCA paper .

Health Needs of Adolescents argues that young people have been neglected within the health system for three reasons: young people are generally well and healthy so do not use services oriented toward curing illness; young people fall between child and adult systems, resulting in institutional uncertainty about where they fit; and health professionals are uncomfortable working with them (CDH, 1981, p. 2). While the authors note that all generalist health services are potentially available to young people and that services for adolescents 'should be designed to complement, not compete, with the general stream of community care' (CDH, 1981, pp. 3–4), they point out that there are few treatment services specifically for adolescents in Australia. The following account of young people's use of casualty departments for primary care, highlights the need.

The point has been made that many adolescents use these services because they are the only visible and accessible source of help. Their attractions were that they were free to uninsured patients, frequently provided 24 hour, seven day a week service and offered a substantial degree of anonymity.

CDH, 1981, p. 21

Further, the authors note that young people use these services despite long waiting times and staff who are often unsympathetic to their needs and who regard them as second class citizens, particularly if they are unemployed (CDH, 1981, p. 21).

In its discussion of mental health services the report suggests that many young people with psychiatric problems go undiagnosed because they are not referred to psychiatric services. It calls for 'an increase in front-line first point of contact personnel' and a potential role for youth outreach workers and youth centre staff (CDH, 1981, pp. 22–23). Schools are put forward as places where young people with mental health problems and disorders might be identified early and referred to psychiatric services, but lack of support by education authorities is a barrier to be overcome (CDH, 1981, p. 22). This is indicative of a common theme in young people's health—ambiguity about where responsibility lies and a tendency to shift responsibility from one group to another to the detriment of young people. It also highlights the need for collaboration across government departments and sectors to achieve better coordination of programs and services.

Health Needs of Adolescents contains ten recommendations. Nine are to do with service provision—five address service provision directly, three relate to removing barriers to care and one is to do with health service evaluation. Only one recommendation deals with health education and health promotion. With regard to service provision, hospitals are asked to do three things: establish units like the Adolescent Medical Unit in Camperdown, New South Wales (one in each state); designate a section of outpatient and casualty departments for young people; and take into account the needs of young people in hospital to be together for mutual support (CDH, 1981, p. 30). In the community, the report recommends the establishment of counselling, referral and outreach, possibly in collaboration with community-based drop-in centres (CDH, 1981, p. 30). To remove barriers to care, three things are recommended: changes to health insurance arrangements to ensure confidentiality of young people seeking services; postgraduate education for health professionals in working with adolescents; and community education about young people's health through organisations such as AAAH (CDH, 1981, p. 31). Finally, greater attention to new approaches to health education and promotion is recommended, to encourage young people to 'make responsible decisions' concerning healthier lifestyles (CDH, 1981, p. 30).

The business of adolescent health was thus constructed in three ways: as service provision; removal of obstacles to care; and to a lesser extent, health education and promotion. It was presumed that those who had a role to play in the enterprise were health service providers, health promotion professionals, school health educators and, potentially, young people themselves. In view of later developments, *Health Needs of Adolescents* is limited in scope for a number of reasons. The analysis does not adequately deal with the social and environmental factors that shape and compromise the health of young people and its recommendations offer no strategies to address them. For example, matters such as the promotion of unhealthy products and practices to young people are discussed in the body of the report but not addressed in its recommendations. Health promotion and health

education are conceived narrowly, as activities for 'developing coping mechanisms and life management skills of youth' (CDH, 1981, p. 24) rather than as changing the circumstances with which young people have to cope.

The Health Needs of Adolescents attracted criticism for its reference to welfare workers' claims of the existence of an 'adolescent syndrome of deliberate pregnancy' (CDH, 1981, p. 9). While the report couched its comments in terms of 'claims by welfare workers', the fact that it was referred to and given the medical term 'syndrome', gave a degree of legitimacy to such claims, even though there was evidence to suggest they were wrong² (Montague, 1981; 1983).

Despite these limitations, *Health Needs of Adolescents* was a public document which attested to the existence of something called adolescent health. It demonstrated that young people had health needs that were not being met and 'inability to pay was a major deterrent to a person seeking health care, particularly in the case of unemployed youth' (CDH, 1981, p. 25). AAAH members contributed to the writing of the report (Bennett, 1988) and it was warmly recommended in a review by Murray Williams (AAAH Newsletter No. 12, 1982, p. 10). Williams, a physician with the Student Health Service at the Canberra College of Advanced Education, was the Secretary of AAAH and editor of the Association's Newsletter at that time. He points out that, while the report is brief in dealing with issues and gives inadequate attention to problems needing psychiatric care and the nutrition needs of young people, it provides a good outline, 'an adequate brief survey', and draws attention to the fact that health services for young people were 'piecemeal and unplanned' (AAAH Newsletter No. 12, 1982, p. 10).

A little over a year after *Health Needs of Adolescents* was published the Commonwealth Liberal Government once again sought young people's views about issues affecting them. In contrast to the 1979 effort, the 1983 consultation was conducted by the Youth Affairs Council of Australia (YACA) and was the beginning of a national youth policy development process conducted in collaboration with the non-government youth affairs sector³ (Irving et al, 1995). *Creating Tomorrow Today* (1983) is the report of the consultation and its health policy provides a counterpoint to *Health Needs of Adolescents*,

² A later study conducted in South Australia provides an insight into the relationship between unemployment and teenage pregnancy (Harris et al, 1987). Harris and colleagues found that most teenage pregnancies were unplanned, refuting the notion that they become pregnant to get benefits. Of those planned, nearly 70% were in a relationship and wanted to have a baby. Less than half knew about or expected government financial support. They concluded that teenage women do not decide to keep their babies to increase their income or to give themselves a job, but because their relationship is stable and mothering is something they want to do (Harris et al, 1987).

³ In 1983 the youth affairs sector was made up of young people, workers with youth, youth organisations and non-government organisations representing youth workers in the Community Youth Support Scheme (CYSS) and the youth refuges and shelters (Irving et al, 1994).

offering a socially critical perspective on young people's health, informed by the views of young people themselves.

Creating Tomorrow Today positions young people, not as 'vulnerable' or a population in need of services, but as citizens taking responsibility for their health, asking why health problems exist and taking action to have their needs met. The document reminds readers at the outset that 'being a young person does not in itself constitute a health risk!' (YACA, 1983, p. 177). The World Health Organization's positive definition of health is adopted and a social health⁴ framework applied in the analysis of issues. Income, housing, employment, education, polluted inner urban environments and promotion of unhealthy products such as alcohol and tobacco are identified as health concerns (YACA, 1983, p. 177). The health policy recommendations call for action in five areas: youth health policy development; structural change; sexuality education; 'production and distribution of health information relevant to young people' (YACA, 1983, p. 185); and provision of health services. This analysis results in a different policy agenda from that of *Health Needs of Adolescents*, one that emphasises changing the 'the social causes of ill health' (YACA, 1983, p. 177). While there are recommendations about service provision, they form part of a much broader strategy to promote young people's health.

One might speculate about how the story of young people's health in Australia would have been different had the recommendations of *Creating Tomorrow Today* been implemented in 1983. There would have been a comprehensive national youth health policy and strategy, developed by the Commonwealth Government in collaboration with young people, the non-government youth affairs sector and relevant government departments. The accompanying strategy would have ensured adequate income support and accommodation for homeless and unemployed young people. Legislation would have been introduced to control the advertising and promotion of unhealthy products, such as poor quality fast foods, alcohol, tobacco and other drugs. Measures would have been taken to prevent discrimination against young people on the basis of sex, sexual preference, race, disability and ethnicity.

With regard to sexuality, education for all students would have been introduced in 1983, soon after the first cases of HIV/AIDS had been diagnosed in Australia. Relevant and accurate health information would have been produced and distributed to young people nationally through funding from the Commonwealth Department of Health (YACA, 1983, p. 185). There would have been education and training on young people's health for health professionals and youth workers, a youth component of the Commonwealth Community Health Program and free and confidential health services for young people throughout the

⁴ I am using the term social health in the sense that it is described in the social health policy of South Australia (1988)—an approach that recognises the need to change the social structures that prevent people, and in particular certain population groups, from achieving good health.

country. Young people would have taken an active role in developing and implementing these services, which would have offered, in addition to treatment for physical and mental health problems, health promotion and health education programs and advocacy on young people's health.

This did not occur. *Creating Tomorrow Today* was not published until July 1983 and by then Australia had a new Commonwealth Labor Government, which commissioned its own study—a survey of young people's attitudes to Government policies and programs (Australia Department of Sport Recreation and Tourism/ANOP 1985). The issues identified in *Creating Tomorrow Today* remained matters of concern throughout the 1980s and into the 1990s and were only partially addressed, if at all. The strategies proposed continued to be recommended in reports and health consultations with young people and re-discovered by governments and politicians from time to time.

The ideas about young people's health contained in *Health Needs of Adolescents* and *Creating Tomorrow Today*, and the people who held them, met within AAAH in the early 1980s. This meant that there would be differing views and emphases within the Association about how best to promote 'the health of the youth of Australia', the role of health professionals, youth workers and young people in that effort and the issues that needed to be addressed. Two of my key informants commented on these tensions.

To some extent in the 1970s and very early 1980s we were actively spending a lot of time trying to influence people in the community to get interested in kids. But once they had started getting interested there was often a philosophy ...hey this is our area lay off. You people in institutions look after your sick kids because we are out here looking after the real world. I think in a way it was quite healthy because it was part of the process of generating interest, and excitement even, in young people's health. But, it had a down side and that was it was 'them' and 'us'.

(M6)

The (health) model was very much individual counselling and I can remember one of the problems that youth workers have always had is that....the models that we used have not really been understood, or certainly not recognised, by health professionals...

(YA7)

...the people who had originally been quite radical in their own way within the field of medicine, who sparked something off, involved a whole pile of people who did not have the constraints of medicine and could be much more radical.

(M4)

While these differences created tensions and debates, they also meant that there would be diversity of views to draw on which could potentially enrich the practice of young people's health as it developed in Australia.

In the early 1980s a range of issues were identified⁵. Some were related to social and economic factors, such as sexuality, including teenage pregnancy, (CDH, 1981; Stanley, 1981; Raphael, 1981; Montague, 1983; McCarthy (ed) 1983) and unemployment (Kosky, 1978; Sweet, 1980; Harris, 1981; Finlay-Jones and Eckhardt, 1981; YACA, 1983). Others were to do with the need for services and the ideas that should guide the practice.

2.4 Sexuality and unemployment

The lack of accurate sexuality information, the absence of school sexuality education, discrimination against gay and lesbian young people and the need for free and confidential sexual health services, were issues raised by young people during the YACA consultation (YACA 1983, p. 85; 183). Many health workers, youth workers and teachers shared these concerns (CDH, 1981; Jerome, 1981; McCarthy (ed) 1983). In 1980 members of AAAH prepared a statement on the medical and social needs of adolescents for the Commonwealth Office of Youth Affairs, in which they argued for recognition of adolescent sexuality and for sexuality education that addressed attitudes and values, not just physiology and anatomy (AAAH Newsletter No. 6, May, 1980, p. 19).

In Victoria the Family Planning Association endeavoured to meet young people's sexual health needs through the ACTION Centre, which had opened in Melbourne in 1976 (Family Planning Association, NSW, 1987). The ACTION (Adolescent Counselling, Treatment and Information) Centre was established as a result of a proposal put forward by Stefania Siedlecky in the mid 1970s. At that time Siedlecky was the Senior Advisor in Women's Health in the Commonwealth Department of Health. Initially three centres were proposed, one each in Melbourne, Sydney and Brisbane. Melbourne was the pilot and the only one established. The others did not proceed because of 'changes in government policies and financial stringencies' (Family Planning Association, NSW, 1987).

The provision of confidential sexual health services to young people was not unproblematic in the early 1980s. There was confusion about the legality of providing contraceptive services to minors without parental consent, a matter further complicated in

⁵ The following gives an indication, but not a comprehensive list, of the concerns identified at that time. Unemployment (Kosky, 1978; Brown, 1981; Harris, 1981; Finlay-Jones and Eckhardt, 1981; YACA, 1983; Sweet, 1980), homelessness (Brown, 1981), motor vehicle accidents (Brown, 1981; CDH, 1981), youth suicide (CDH, 1981; Meares et al, 1981), sexual abuse—'It's always been there' (M5), body shape perception and anorexia (Beumont, 1983), nutrition (Baghurst and MacMichael, 1980; Heald, 1983; Sali, 1983; Pritchard, 1983; Burke, 1983; Rowe, 1983; Wahlquist, 1983; Shears, 1983) and lack of health services for young people (CDH, 1981; YACA, 1983).

Australia by the fact that the laws varied from state to state (CDH, 1981, p.25; Australian College of Paediatrics, 1982). Suzanne Robertson, then an adolescent physician with the Adolescent Medical Unit in Camperdown, New South Wales, raised this issue with the NHMRC on behalf of AAAH (AAAH Newsletter, Oct, 1979). The NHMRC responded in its 89th session, asking the Australia Law Reform Commission to investigate the matter (AAAH Newsletter, Oct, 1979; CDH, 1981, p. 26). Uncertainty was further exacerbated in the early 1980s by reports in Australia of the Gillick case in the UK where, as a result of a court action by campaigner Victoria Gillick against the Department of Health and Social Security, during 1984 UK doctors were banned from providing contraceptive services for young women under sixteen years of age without parental consent. This resulted in a fourfold increase in pregnancies in this age group in Camberwell, a poor inner London suburb (Birch, 1988).

In Australia, confidentiality was a particular concern for young people living in rural communities. One of my key informants described the situation this way.

The other issue thatI frequently had to deal with as a youth worker working with young people, was the lack of confidentiality in mainstream services, particularly GPs and particularly in the country. It relates back into a whole lot of the other things, particularly things like access to reproductive health care and I have very vivid memories of a couple of country trips that I did while I was a CYSS worker and another couple that I did while I was working in another youth program where that was the biggest single health issue that came up in the country. Who else did the young girls go to get the pill or to get advice when there was only one youth worker or youth service and there was often only one or two doctors and often mum and dad socialised with those doctors, or the information went from the doctor to the chemist and the chemist back to the parent, and it would only take one kid getting burnt like that then none of the kids will go to the doctor or that chemist. Which of course meant that they were cut off from what sources of support they could have had because of the lack of confidentiality.

(YAI)

Given this situation it is not surprising that pregnancy among young women was an issue in the early 1980s (Raphael, 1981; Stanley, 1981; Siedlecky, 1983; Montague, 1980, 1983; Clarke, 1984, 1985; Cubis et al, 1985). One of my key informants commented that:

...the community was fixated on teenage mothers. I remember a lot of attention about teenage mothers (at that time) and it wasn't always constructive attention. It was, from my point of view, quite a punitive approach to the issue of young parenthood and focused solely on women...

(YHP16)

Despite a widespread view, fanned by the media, that Australia was experiencing a teenage baby boom in the early 1980s (Montague, 1981), births to teenage women in Australia had declined 49% between 1971 and 1981 (Seidlecky, 1983). A study conducted in Mt Druitt, in Sydney's Western Metropolitan Health Region, with mainly white Australian young women, concludes that, while there was no evidence to suggest that the level of sexual activity differed among various socioeconomic communities, the results of such activity did. There were indications of a greater incidence of teenage parenting in lower socioeconomic communities (Clarke, 1984). This was attributed to several factors: lack of family planning services; lack of knowledge; community attitudes to contraception and abortion; and greater acceptability of the role of mother as 'a natural and inevitable role for women' (Clarke, 1984, pp. 73–74). Clark argues for better sexuality education in schools, from reception to year twelve, support for teenage mothers via increased benefit payments, an investigation of their housing needs and a media program to address negative community attitudes towards them (Clarke, 1984, pp. 75–79).

Another study, commenced in the Hunter Region of New South Wales in 1983, investigated the correlates of pregnancy and sexual experience among young people and came to a similar conclusion—'it may be more useful *not* to see pregnancy as a problem' and instead, 'identify those at risk of having a poor outcome for themselves and their babies' (Cubis et al, 1985, p. 238, emphasis in the original).

We should be less concerned with trying to identify personal, family and social *disturbances* that are associated with becoming pregnant, and more concerned with improving contraceptive knowledge and practices among adolescents and to identify those who are least able to handle the problems that sexual encounters and pregnancy might produce.

Cubis et al, 1985, p. 252 (emphasis in original)

A matter that received little or no attention in the Australian health literature in the early 1980s was the issue of sexual preference. Gay, lesbian and bisexual young people were largely invisible. The impact of discrimination on their social and emotional wellbeing and their need for health information and services received little attention at that time. *Health Needs of Adolescents* (1981) does not mention homosexuality at all and, although referred to briefly in the 1980 WHO Western Pacific Region report on adolescent health, it is dismissed as adolescent sexual experimentation and described as 'common and transient during adolescence' (WHO, 1980, p.9). This ignores the fact that many young people who identify as homosexual during adolescence will continue to do so for the rest of their lives and, while estimates vary, recent research by LaTrobe University suggests that 8 to 11% of high school students will be same sex attracted (Hillier et al, 1998). One of my key informants commented on the silence about homosexuality in the early 1980s,

commending the pioneering work of Twenty-Ten, a youth service established in Sydney in the early 1980s to meet the needs of gay young people (YA4).

In contrast, the increase in unemployment among young people in Australia received much attention during the 1980s (Sweet, 1980, 1988). Concerns about the impact of unemployment on the health and wellbeing of school leavers generated research papers and two longitudinal studies (Kosky, 1978; Tiggemann and Winefield, 1980; Harris, 1981; Finlay-Jones and Eckhardt, 1981; YACA, 1983; Shanahan, 1984; Feather and O'Brien, 1986; Winefield et al, 1989, 1993). Winefield and colleagues concluded as a result of their longitudinal study of school leavers in South Australia, that unemployment is a complex phenomenon and must be viewed within its social context. They found that:

the factors that seemed most important in helping our young people to cope with both unemployment and unsatisfactory employment, were social support, financial security and using their time in constructive activities involving other people.

Winefield et al, 1993, p. 160

Community support for unemployed young people was one of the aims of the Community Youth Support Scheme (CYSS). CYSS projects operated in all states and most were open from nine to five Monday to Friday. This meant that CYSS project officers had daily contact with the young unemployed and they saw that their needs extended beyond vocational training to housing, health and general welfare, as the following quotation indicates.

You do need to take things like what their state of health, mental health you know, all that kind of stuff, into account into the design of the program. I remember being mightily pissed off about something that still frustrates me, but now I accept it as normal, although it is still wrong. That there was this expectation that you would be able to achieve massive change on an individual level quickly through one intervention you take this young kid who is probably 16 or 17 years old. They have been out of school for maybe two or three years. They have had a rotten, rotten, awful, horrible, very bad life. They have no money, nowhere to live tonight and we are supposed to put them into an eight week training program on the 'Introduction to Childcare'. Excuse me but! I remember being passionately angry about the inadequacy of services.

(YA1)

With their strong community base and community management committees, CYSS projects were in a position to generate local responses to those needs, including health needs, and could provide a site for health programs and services. However there was a

tension between the support and advocacy roles of CYSS⁶, which potentially included things like the provision of health programs and political action for social change, and the new guidelines issued by the Commonwealth Government in 1982, which gave priority to the program's employment and training function (Irving et al, 1995, pp. 241; 322).

The importance of a multi-layered social health approach to unemployment among young people is highlighted by the recommendations of a study commissioned by the Commonwealth Department of Health and published in 1984 (Shanahan, 1984). Conducted by Elliott and Shanahan Research consultancy firm, the study aimed to do four things: identify the factors that influence the health of the young unemployed; suggest ways in which the government might improve the lifestyles and health of the young unemployed; assess community attitudes to unemployed young people; and determine successful projects undertaken in Australia to improve the health of unemployed young people (Shanahan, 1984).

The report of that study, *Youth Unemployment—The Disease of the Eighties*, identifies homelessness as 'the single major concern of unemployed youth' and draws attention to the 'desperate need for funding in this area.' (emphasis in the report) and recommends improvement in accommodation programs (Shanahan, 1984, p. 5). It points out that negative community attitudes to unemployed young people have a detrimental effect on their wellbeing, a matter raised a year earlier in *Creating Tomorrow Today* (YACA, 1983). Schools are seen as having an important role in addressing the issues raised by the study. The introduction of school health education, including the topics of nutrition, dangers of tobacco and alcohol, budgeting, food preparation and cooking (for boys and girls) and remedial education, are recommended (Shanahan, 1984). With regard to health services, the report advocates the establishment of multi-service youth centres and adolescent medical units to ensure a holistic and coordinated approach to service provision. Such recommendations required intersectoral action on a number of levels but little action was taken. The Commonwealth Department of Health did introduce a grants program for innovative projects for unemployed youth which operated briefly during the mid-eighties.

⁶ The importance of advocacy, whether as a CYSS worker or a health worker, became evident to me when, as a newly appointed community health youth worker, I conducted a stress management workshop for unemployed young people at a CYSS centre in Sydney's Inner West. At the end of the workshop the participants discussed the source of their stress. It was quite simple. They had no work. A straightforward assessment of their situation. I recall my feeling of powerlessness at the time. I was offering little more than a short-term solution to a structural problem, a problem which needed political attention if the health of these young people and others in a similar situation was to be improved. Further, I realised that if I did not work toward changing this situation I could be in the business of conducting stress management workshops for unemployed young people for a very long time. My dismay must have been visible because the young people quickly moved to reassure me. They told me that it had been a very fine workshop all the same and some of them might come back next week too!

2.5 Building a 'philosophy of care'

One of the tasks of the constituency that formed around young people's health in the early 1980s—those working in adolescent health, youth work, health education and at times young people—was to establish an approach or, in the words of one of my key informants, 'a philosophy of care' (M6) and principles to guide their efforts. It is important to distinguish between young people's health as a public health endeavour and young people's health care, which is one component of a comprehensive public health strategy. I understood the notion of philosophy of care as used by my key informant, to refer to the way young people are cared for at a health service. However, from a public health perspective another interpretation is possible. Philosophy of care could refer to the way a society cares for and values its young people. The latter interpretation offers a useful lens through which developments in young people's health in the 1980s can be viewed.

What was missing in the way young people's health was conceptualised and acted upon in the early 1980s was a framework that directed attention to the social structures that shaped the health of young people. As American public health advocate Lawrence Wallack argues:

with social issues, 'the problem' often is not the problem, but a symptom of a broader set of social conditions or arrangements. Focusing on it to the exclusion of the larger context results in the 'environmental fallacy'. The consequence of accepting this fallacy is that partial solutions are developed—usually in isolation from other partial solutions and the system as a whole.

Wallack, 1984, p. 474

In the case of young people's health, 'the problem' is often presented as lack of services but, from a public health perspective, this is symptomatic of bigger issues, such as why some groups of young people experience poorer health than others, the way social conditions give rise to the need for services, the way community attitudes to young people influence policy approaches to them and the provision of information and confidential health services.

Although those who established AAAH did not claim to be working within a public health framework (pers. comm. Williams, 1997), the signifiers of Alma Ata thinking were evident in the early 1980s in the following ways: in the decision by the founders of AAAH to use the term 'health' instead of 'medicine' and the adoption of the WHO positive definition of health (AAAH, 1978); recognition of the need for collaboration across sectors to promote the health of young people (Court, 1981; CDH, 1981; AAAH Constitution, 1984); the recognition that unemployment and homelessness and the promotion of unhealthy products such as tobacco and alcohol to young people, were health issues, even if no

recommendations were proposed to address them (CDH, 1981; AAAH conference abstracts, 1981); and the possibility that young people might have a role to play in addressing health issues (CDH, 1981; AAAH conference abstracts, 1981, 1983).

The participation of young people in policy, program and service development was recognised by my key informants from all three categories as a concept that was influential in young people's health and youth work in the early 1980s and throughout the decade (M5; M10; YA1; YHP3; YHP7; YHP5; YA4; YA7). The concepts of participation and empowerment came from a number of directions. Internationally, recognition of powerlessness as a broad risk factor for disease led health professionals to investigate the potential of empowerment strategies to change the fundamental causes of poor health (Wallerstein and Bernstein, 1988, 1994). Alma Ata's emphasis on community participation in 'the planning, organisation, operation and control of primary health care...' constituted a formal uptake of these ideas by the World Health Organization (WHO, 1978). Links between WHO and people like Murray Williams and David Bennett, both of whom were committed advocates for adolescent health in Australia, provided a conduit for WHO ideas in young people's health in this country.

Within Australia community participation and empowerment had been part of the ethos of the community health movement from its inception in the 1970s (Baum, 1998) and, although not universally accepted, many community health workers endeavoured to implement these ideas (Baum, 1998). The youth affairs organisations established in Australia in the late 1970s and early 1980s also emphasised empowerment and participation (YACA, 1983; Ewen, 1983; Irving et al, 1995). Collaboration between youth workers and adolescent health workers, within AAAH and in program development in the community, gave further impetus to the uptake of these ideas in adolescent/young people's health.

Writers such as Sally Denshire, at that time an occupational therapist with the Adolescent Medical Unit in Camperdown, New South Wales, argued that participation is health enhancing in and of itself, a way of empowering young people, recognising their capabilities and a means of 'changing the (health) system', to make it more responsive to young people (Denshire, 1984).

Youth participation establishes adolescents and adults as partners and provides a foundation based on strength and competence for working together. Further, this action acknowledges what Eisenstein and others refer to as the 'authority of experience' of the teenager and the validity of experiential learning as part of a positive concept of health.

Denshire, 1985, p. 2

The political implications of youth participation are far reaching. When young people have an active role to play in a health service there is a 'ripple effect' throughout the whole organisation, rather than token youth participation merely being 'tacked on' to an existing service. The shape of a health service changes, there is a redistribution of power, and roles are blurred in some situations...the concept of the 'expert' becomes demystified and professional jargon starts to disappear...

Denshire, 1985, p. 6

Participation and empowerment are not the same thing however, and empowerment does not necessarily follow on from participation. Further, the concept of participation is open to a range of interpretations, and authentic participation will only occur if, like any other endeavour, there is genuine commitment to it and it is adequately resourced. Further, notions of empowerment and participation are often misunderstood. One of my key informants commented on this.

Empowerment was originally a sociological concept. It was intended to apply to classes or groups but it got bastardised down to confidence building for individuals and such a disservice was done to the concepts that we were on about. I include myself as one who still talks about empowerment as being an important principle and one that can be applied at both individual and systemic levels, but which, I think is very, very poorly understood ...It implies big change if you are serious about empowering disempowered groups. I think those people who do understand that run a mile from it. Those who don't, but who think it sounds like a nice idea, tend to individualise and therefore it gets bastardised and loses all its value.

(YA1)

I don't even know if you could call it a debate. The word arrived on the scene and it got adopted and bastardised very quickly and it was kind of taken like it was a bit of holy grail, a kind of motherhood statement that you can't really argue with. I don't think there was enough intellectual vigour in that debate.

(YA1).

Another commented on the challenges of implementing the concept within a health setting:

I think youth participation is a politically complex concept and I think it was embraced with gusto by myself and others (at the beginning of the decade) and it was only in the ensuing years that we realised the political sensitivity associated with young people having a consistent voice in needs assessment and service provision, and an active role, sometimes a paid role. This was something that really flew in the face of the dominant organisational culture and having to remould it with something that was complex—not impossible but quite complex. Particularly in medical settings...

(M10)

Despite these difficulties the idea that young people should participate in the development of policies, programs and services to meet their health needs was taken up in Australia in the early 1980s and persisted throughout the decade, even if what it meant in practice was more contentious and at times mere tokenism.

2.6 Creating a space in the hospital

Hospitals have long been a problematic arena for young people due to the tendency to take technical responses to complex and sensitive problems and uncertainty about whether to treat young people as young adults or mature children. These problems sharpened in the eighties for demographic and epidemiological reasons. As one of my key informants pointed out, improved treatment and management meant that children with chronic illness were surviving into adolescence (M6). The implications for hospitals were twofold: firstly, the interaction between physical changes young people experienced during adolescence and the physical problems associated with their particular chronic illness, resulted in complications which had to be medically managed (M6). This led to increased use of hospital services by young people and extended periods of time in hospital for some (M6). Secondly, the social and emotional needs of young people spending long periods of time and/or having intermittent and extended stays in hospital, needed to be addressed (Australian College of Paediatrics, 1980).

The experiences of young people in hospital are captured in the *Have a Say* video, produced in the early 80s by a group of regular users of the Adolescent Medical Unit, and Jenny Fisher, a social work student on placement at the Adolescent Medical Unit at the Children's Hospital (pers. comm. Sally Denshire, 1997). In the video the young people depict themselves amidst tables, chairs, beds, decor and recreational activities, designed for children and show how they are patronised and talked down to by hospital staff. One of my key informants argued that, to address these issues, it was necessary:

to make sure there was a territory for young people who were regular customers of the hospital, so they had space they could call their own and they were actually part of the scheme of things, rather than infantilised or ignored by the mainstream paediatric services. So (there was) the need for appropriate accessible youth oriented spaces within mainstream institutions like hospitals.

(M10)

Some of these issues were highlighted by the NHMRC in a statement on medical care for adolescents produced in 1980 (AAAH Newsletter No 8, October, 1980), and by the

Australian College of Paediatrics report, *The Health Care of Adolescents*, produced in the same year (AAAH Newsletter No. 6, May, 1980; AAAH Newsletter No.7, Aug 1980; Australian College of Paediatrics, 1980). The College of Paediatrics' report stresses the need for a policy on health care for young people and recommends that special facilities be provided for them in hospitals. The College established a permanent subcommittee on adolescence in the early 1980s (AAAH Newsletter No. 6, May, 1980; AAAH Newsletter No.7, Aug. 1980).

In addition to lack of space for young people, there was the problem of inadequate or no training in working with young people among hospital staff. Those accustomed to working with children were sometimes uncomfortable with young people. Further, as several of my key informants pointed out, there was uncertainty about where responsibility for young people lay within the health system (M6; M11) and when and how they should move into the care of the adult health sector, where there was also a lack of training and experience in adolescent health (M6; M11; M4). One of my key informants pointed out that adult hospitals were better at managing acute illness than chronic illness (M6), a matter that needed to be resolved to allow young people with chronic illness to move into the adult health care setting.

Two of my key informants indicated that adolescent health was viewed with suspicion, marginalised and little understood in hospitals and within mainstream medicine at the beginning of the decade (M6; M9).

There was a very real hostility towards adolescents coming to general hospitals for instance. Another area that actually was of concern, apart from the awareness from the staff and the lack of any services or even specific model of service, was that a lot of adolescents were being inappropriately managed. A good example of that was the number of children that I saw...youngsters, who had gun shot wounds which were clearly self-inflicted, but who were managed in surgical wards ... accidents which were due to reckless behaviour and really self destructive behaviour, who were managed in surgical wards, not adequately followed up, not adequately assessed and so on. I mean they were managed fine surgically, but the mental health side of things was ignored or neglected.

(M9)

My key informants who worked in medical settings indicated that, in the early 1980s, they endeavoured to increase the responsiveness of hospitals to young people. This involved three things: making efforts to develop a philosophy of care (M6); advocating for education and training for hospital staff (M6); and the establishment of youth wards or other space in the hospital where young people could meet, socialise and support each other (M1; M3; M6; M10; YHP15). An adolescent ward opened at Westmead Hospital in

Sydney's Western suburbs in the early 1980s, largely through the efforts of Neil Buchanan and Simon Clarke (Bennett, 1984).

While the hospitals were coming to terms with the changed circumstances and medical treatment of young people, the community services were struggling to do anything about the initiating circumstances. As one of my key informants noted, despite the recognition that the health of young people would be best addressed by a combination of community and hospital programs and services, a relationship between the community and the hospital did not exist in the early 1980s (M6). This changed as AAAH developed links with youth affairs groups and hospital adolescent units established outreach programs and links with community-based youth projects.

2.7 Community responses: the search for a model

As adolescent health advocates sought to create a groundswell of support for young people's health, they found a potential ally in youth affairs. The need for a better relationship with health had been identified by youth workers who experienced the repercussions of the lack of health services generally and mental health services in particular, as the following quotations from my key informants indicate.

I remember a CYSS (centre)...(that was the) closest CYSS to (a psychiatric hospital) and I remember talking many times to ...the coordinator there about that huge dilemma that they had with people who had either psychological something and/or mild intellectual disabilities, and they did not know how to pick between the two either.

(YA1)

One of my key informants commented that many young people were locked out of the treatment services that did exist in the early 1980s because they did not fit the service criteria (YHP7). Another observed that responses to young people's acting-out behaviour were divided along gender lines—young women were sent for therapy and young men placed in the juvenile justice system (YA4). Yet another, from a different state, made a similar point.

Homeless young people were often placed in prison, some in need of mental health care. Giving them an offence was the response to their situation. Young women went to state welfare, young men went to a home run by correctional services—like a remand centre with isolation units, prison type procedures and physical punishment. A high proportion of Aboriginal young people were in this centre.

(YHP10)

In New South Wales youth refuge workers outlined some of these difficulties during a seminar entitled 'The Emotionally Disturbed in the Youth Refuge' (Youth Refuge and Accommodation Association, 1984). A proposal to develop a new accommodation model for 'young persons 12–18 years who are unacceptable to ordinary youth refuges because of the presence of severe emotional/behavioural disorder' (Four Winds, c. 1982–83) was put to the New South Wales government at that time. The Steering Committee reported that 'To date, still NO moves towards recognising that there is any such problem existing amongst our homeless young people' (Four Winds, c. 1982–83, emphasis in the original). As one of my key informants commented:

I think refuges came along at a time when they could absorb a lot of the people who might have otherwise been institutionalised. So in a sense, in a sense I think they were buy-offs. They were never openly agreed buy-offs but I mean they were. Refuges came along and suddenly everything could sort of go in there ...I think we were sort of caught in the dilemma of being services that were clearly taking kids off the streets and off people's hands and once they were with us, most people didn't want to know.

(YA4)

While there was agreement about the need for services to address both the mental and physical health of young people, there was less certainty about what those services should look like. Several of my key informants indicated that the absence of materials influenced developments—the fact that there was nothing there—no theoretical writings (YHP14) no models to work from (YHP5). People wanted to know how their area fit—'how to fit youth into health' (YHP5). A lot happened in an ad hoc way, through networks, people talking to each other about what they were doing and getting ideas (YHP5).

And I mean I think at that time the Adolescent Medical Unit (in Sydney) was trying out new things...everybody was...because there wasn't a clear answer. And even though there was that sense that New York has the answer or San Francisco has the answer, it was like, well, we didn't really know.

(YHP12)

There was however a growing view that, for programs and services to be acceptable and accessible to young people, especially those unwilling to use existing services, change was needed. One of my key informants recalled that:

...those people who were active in adolescent health were active within the health system largely, in trying to get the health system to amend itself...all that stuff about the way facilities looked and felt, the hours they opened, the kind of staff they had, the kind of services they ran, drop in services rather than appointment-based services,

holistic interventions rather than individual health interventions, trying to bridge the gap between the medical side of health problems, you know, the unwanted pregnancies, or the STDs, or the depression, or the violence, with the social aspect of those problems...

(YHP17)

The need for a model that would incorporate and give substance to these ideas was the topic of the final plenary of the Second National Conference on Adolescent Health organised by AAAH and held in Sydney in December, 1981. Swiss epidemiologist Olivier Jeanneret discussed the multi-service youth centres operating in Europe at that time and presented a table which contrasted what he called 'conventional' and 'innovative' poles in health care delivery (Jeanneret, 1981). The table was later reproduced in the monograph *Adolescent Health in Australia* (Bennett, 1984).

Contrasts in Health Care Delivery

Dimensions	Conventional Pole	Innovative Pole
1. Ideology	Conservative: Pathology – or change-oriented.	Radical: growth-oriented.
2. Techniques	Psychotherapy and other formal treatments.	Participation, counselling.
3. Staff	Highly skilled professional: involvement limited.	Non-professional with limited skill involved.
4. Staff/Patient	Roles strictly defined.	Roles sometimes vague.
5. Intake	Defined groups.	Self-selecting
6. Location	Therapist's territory: conventional.	Client's territory, unconventional.
7. Access	Formalised: fixed hours.	Informal: flexible hours.
8. Confidentiality	May include parents, etc.	Anonymity.

Jeanneret, 1981

While the table provides a guide to possible service models, there are two problems. One is that 'the terminology suggests there is a right and wrong way' when many variations are possible (Bennett, 1984, p. 43). The other is that it seems to suggest that staff working in innovative services are 'non-professional with limited skill'. In this scenario neither the highly skilled youth worker nor the highly skilled health professional can locate themselves within the 'innovative' service. This raises a further question. What does the term 'skill' mean and what skills are being valued? The 'highly skilled professional' in young people's health, one would expect, is a person who can operate comfortably in an innovative service in which young people have a voice. Likewise, a person who works comfortably with young people in an informal setting is not devoid of skill, even though perhaps not a trained health professional. Ideally an innovative youth health centre would

offer young people access to highly skilled health and youth work professionals and utilise the skills of the young people who use the centre⁷.

Despite the limitations of Jeanneret's table, his paper was important for three reasons: it drew attention to problems with the 'conventional pole'; pointed to new directions that could be taken in Australia, suggesting that a different approach was possible and even necessary for some groups of young people; and engaged with the question posed by the AAAH conference theme, 'Is Society Responsible?', by suggesting that a health centre for young people could adopt a social change/advocacy role. Jeanneret did warn that some of the youth health centres that had taken this approach in Europe had had restraints imposed by funding bodies (Jeanneret, 1981).

The idea of a 'multi-service' or 'comprehensive' youth health centre outlined by Jeanneret gained currency in Australia at this time. These terms were used to describe a centre which could provide a range of services, including health services, under one roof. The idea was considered by the Cain Labour government after it was elected to office in Victoria in 1982. Victoria's Department of Education and the newly created state Office of Youth Affairs contributed to the planning of a state youth policy. Research conducted as part of the policy development process recommended an approach that 'would go beyond education and training to embrace other social programs', and proposed 'the creation of local youth complexes to offer a wide range of services, including education and training, but also recreation facilities and legal, medical and other advice' (Irving et al, 1995, p. 247). While the Cain government did not take up this option, preferring to give priority to expanding and changing the education system (Irving et al, 1995), the Royal Children's Hospital and Task Force Prahan collaborated to establish a multi-service centre for young people in Broadmeadows, Victoria in 1982 (Stevens and Manallick, 1983; Shanahan, 1984).

The Royal Children's Hospital/Task Force initiative was influenced by an American multi-service youth centre, The Door, A Centre of Alternatives, based in Manhattan in New York City. The Door was established in 1972 by a group of people with diverse health and other professional backgrounds who recognised that the health concerns of many young people,

⁷ The benefits of exchange between highly skilled young people and highly skilled medical practitioners is illustrated by the following event which occurred in 1984. At that time break dance was popular among some groups of young people. A break dance group based at a youth centre in Newtown (an inner west suburb of Sydney) contacted the Adolescent Medical Unit (AMU) of the Royal Alexandra Hospital for Children to get advice about the health risks associated with break dancing, particularly the head spins. This generated some interest in the hospital and the AMU was able to send two physicians and a medical student (all of whom had not previously heard of break dance) to meet the young dancers. The dancers demonstrated the moves and the health professionals advised on how to minimise the harm associated with these activities (Peppard, 1985). This is a situation where highly skilled health professionals and highly skilled young people met to their mutual advantage. The break dancers learned to practise their art more safely. The medical practitioners learned about a youth culture and the work of a community-based youth service. The break dance group later reciprocated by performing at the Children's Hospital open day—at the orthopaedic ward! (pers com, Sally Denshire, April, 1998).

particularly those experiencing greatest disadvantage, were linked to other issues in their lives such as education, employment and accommodation (Denshire, 1984, 1985). Initially conducted on a small scale, the program gradually expanded through a range of funding sources. By 1982 The Door was able to offer education and vocational programs, life skills workshops, health education, clinical services, creative arts and self defence courses (Denshire, 1984,1985). There were many points of entry to the program and young people did not have to be sick or have a problem to attend.

In 1982, Task Force Prahan and the Royal Children's Hospital invited one of The Door's co-founders and its medical coordinator, Lorraine Henricks, to give a presentation on multi-purpose youth centres in Melbourne. John Court, a paediatrician with the Royal Children's Hospital and national president of AAAH, was the contact person for a meeting with Henricks to discuss relationships between health services and youth services (AAAH Newsletter, No 12, 1982). A similar meeting was held in Sydney in June, 1982, organised by the New South Wales branch of AAAH. These meetings generated interest in the concept of a comprehensive/multi-service youth centre as a way of providing health programs and services for young people. As one of my key informants suggested,

... we were very quickly influenced I think, by Lorraine Henricks' visit, and the notion of The Door was the most stimulating and exciting concept that we embraced in the early 1980s.

(M2)

The Henricks' seminars in Melbourne and Sydney resulted in an increase in youth worker and youth organisation membership in AAAH nationally (Newsletter No. 13, 1982) and the establishment of the Umbrella Group in New South Wales. The Umbrella Group was a coalition of people from adolescent health, community health, youth work and the non-government youth affairs sector. Its aim was to investigate ways to set up a multi-purpose youth centre in Sydney (AAAH Newsletter No 17, Sept. 1983; YACON News, 1983).

Delegates from Task Force Prahan and the Adolescent Medical Unit/Umbrella Group attended the First International Workshop on Comprehensive Youth Programs and Youth Advocacy organised by Henricks and held in Toronto, Canada, in May 1983. Information from the workshop was subsequently disseminated through adolescent health/youth work networks in Australia. A seminar on multi-service youth centers, held at the Youth Affairs Council of New South Wales in July 1983, was attended by representatives from community health centres, youth refuges, the New South Wales Family Planning Association and the Student Initiatives in Community Health Program (Seminar on Multi-Service Youth Programs Attendance Sheet, 27 July, 1983). This suggests interest from a range of organisations. In South Australia, Salisbury Council based its planning for the

Shopfront Youth Health and Information Service, which opened in 1983, on The Door (Chung, 1989). By 1983 the concept of a comprehensive/multi-service youth centre or youth health centre was being seriously considered or implemented in three states—Victoria, South Australia and New South Wales.

Not everyone was convinced of the value of this approach. I recall that in New South Wales, where funding for non-government youth centres amounted to enough money to employ one full-time youth worker with little, if any, remaining for programs, the possibility of replicating a centre like the Door, with its budget of four million US dollars a year, seemed remote. One of my key informants from another state commented on the continual struggle for survival that characterised the youth sector.

The network doesn't get down to discussing the nitty-gritty of philosophies and models. People are too busy chasing funding and the political process; always fighting for survival.

(YHP1)

However the youth affairs sector recognised that many of the issues it was dealing with—unemployment, homelessness, sexuality, drug use, and poverty—had an impact on the health of young people and were in fact, health issues (YACON, 1982; YACA, 1983; Williams, 1984; Chung, 1989). Further, the youth affairs sector saw that Commonwealth and State health departments were not making adequate provision for young people and were potential sources of program and service funding. As one of my key informants noted, giving issues a medical label anointed them with the social status of medicine and made them more likely to attract funding than:

if the local youth centre, staffed by 1.5 youth workers, puts in submissions on top of their already over-stretched role. In medical settings you have secretarial support, you have specialist workers, you often have a lot of space and high tech equipment, and all those assets can be used for youth health from an adolescent medical base...by the local youth centre.

(M10)

2.8 Community-based initiatives

As adolescent health workers and youth workers collaborated in the establishment of health programs and services at community level (Williams, 1984; Peppard, 1984), the term 'youth health worker' emerged to describe youth workers employed by health agencies and youth workers who had health as their primary employment brief. Initiatives such as Shopfront Youth Health Centre in Salisbury, South Australia, the Western Area

Adolescent Team in Mount Druitt, New South Wales and the Youth Health Service in Perth, Western Australia, endeavoured to develop new models and programs for working with young people on health.

Planning for Shopfront Youth Health and Information Centre commenced in 1982 and the Centre opened in 1983 through a joint funding arrangement between the South Australian Health Commission and Salisbury Council (Chung, 1989). Located in Salisbury, an outer working class suburb of Adelaide, Shopfront was had a strong community health ethos and sought to integrate health promotion, prevention and early intervention.

The concept of a youth specific one stop shop for health care was an entirely new way of thinking about young people and their health. The concept emerged as a result of a heightened awareness of the specific health needs of young people. In the early eighties, youth agencies such as youth programs.... community health agencies, schools and welfare offices, were seeking new more appropriate models of service delivery for young people regarding their health needs. The City of Salisbury chose to respond to adolescent needs by taking a pro-active role in the provision of health services for young people...

The research for the Shopfront proposal highlighted the inability of existing health services to meet the health needs of young people, and the need to create an accessible responsive service to fill this gap...Using information available from the Door, a youth health centre based in New York in the USA, it seemed that a holistic, multi-dimensional, integrated youth health service was the most appropriate option. The Shopfront Centre was based upon this model of health care...

Chung, 1989, p.4

The Shopfront philosophy recognises the influence of social, environmental and financial factors on young people's health and the fact that many of these things are beyond the control of the young person. Specific groups of young people are not targeted—issues are. Shopfront commits itself to providing a 'contemporary, innovative and experimental response to the health needs of Young People' (Chung, 1989, Appendix 1, p. 1) and aims to facilitate the integration of health services for young people, promote good health and awareness of healthy lifestyles, provide an information and resource base for young people and local, state and federal governments and lobby for services in the northern area (Chung, 1989, p. 4). In stating the intention to lobby for services, the founders of Shopfront locate the centre within a political action model.

Shopfront had sixteen objectives which fall into seven broad areas: provision of services and programs to young people⁸; development and dissemination of information packages for young people; promotion of good health through community awareness programs; building networks with key people in youth and health agencies; providing support for local youth services to address health issues; training of local youth workers in health-related issues; researching local health needs; and policy formulation.

These objectives are ambitious and give an indication of the range of activities the founders of Shopfront felt a young people's health centre should undertake. They represent the possibilities. The resource reality presents a different picture. Shopfront endeavoured to meet these objectives from a personnel resource base of two full-time staff! The two full time staff were a coordinator and a receptionist. A student on placement was an ongoing contributor and, as the program developed, personnel from other agencies, such as the Family Planning Association, provided sessional services on site. This suggests that the poor resourcing that characterised the youth affairs sector was now being transferred across into young people's health. An evaluation of Shopfront conducted in 1989 recommends that resourcing for the centre be increased to allow it to better meet the considerable demands of Salisbury and Adelaide's northern suburbs (Chung, 1989). An understatement.

Salisbury had been an expanding outer dormitory suburb since the 1970s, with the demographic and social consequences which that implies. Mt Druitt was Sydney's larger equivalent. In 1983, the Mt Druitt Hospital established the Western Area Adolescent Team (WAAT) as a young people's mental health unit. The WAAT program sought to reach young people with mental health problems who would not or could not use existing mental health services. Influenced by ideas and written materials from The Door, in particular the notion of not labelling young people who contacted the service, and recognising that the term 'mental health' might deter young people from using the programs and services offered, a decision was taken not to include the term 'mental health' in the name of the team (pers com, Jan Heslop, coordinator of WAAT from 1984-86, 1994). WAAT adopted a community development model which combined health promotion, prevention and early intervention with clinical services such as individual counselling and family therapy.

An evaluation conducted by the Western Metropolitan Health Region in 1986-7, endorsed the silence on the term 'mental health', finding that:

The WAAT represents a half-way point between established clinical services, which see a specific group (eg. Mona Vale Adolescent Services) and a community based

⁸ Services would address relationships and family breakdown, mental health, family planning, employment, education, accommodation and support and drug and alcohol issues.

multi-disciplinary youth service. While still retaining those more traditional health practices of referral and appointment, the team members are developing new methods and approaches to meeting the health needs of young people. Their work with community organisations, helping them set up, developing inter-agency co-operation and assisting on-going services with staff development and resource provision, identify the WAAT as a new model in adolescent services in Australia.

WAAT Evaluation, Draft Report, 1986, p. 35

Like the Western Area Adolescent Team, the Youth Health Service in Western Australia was initiated from a hospital base, the Princess Margaret Hospital in Perth. The Youth Health Service opened in 1983 and its medical director, Suzanne Robertson, was also the coordinator of medical services for young people in the hospital (Bennett, 1984, p. 44). The designation of 'youth health service' rather than 'adolescent medical service', and the location of the Service in the community rather than the hospital, signalled a community development/social health approach and recognition of a role for youth work in young people's health.

The Youth Health Service had a statewide brief and networked extensively with community groups, state youth affairs bodies and the tertiary sector. It provided advice and support on young people's health to the Princess Margaret Hospital, youth agencies in Perth and throughout the state (Bennett, 1984, p. 44; Robertson, Abstract from AAAH conference program, 1985). The Perth Inner City Youth Services acknowledged the role the Youth Health Service played in supporting youth workers and providing information on health to them and the young people with whom they worked in a report entitled *A Year on the Streets* (Williams, 1984, pp. 27–33). Like Shopfront, the Youth Health Service had a big task and limited personnel—an adolescent health physician, a nurse, a social worker and a receptionist—but endeavoured to meet a range of demands within its limited resources.

2.9 Education for health professionals and youth workers

In the early 1980s education and training was seen as a way of increasing the responsiveness of the health system to young people (CDH, 1981, p. 28–29; WHO, 1980; Australian College of Paediatrics, 1980; Williams, 1978). Initially the focus was on education for medical practitioners. The Australian College of Paediatrics drew attention to the need for integration of adolescent medicine into core curricula and training programs for paediatricians in 1980 (Australian College of Paediatrics, 1980). AAAH newsletters advertised fellowships for medical practitioners, most of which were only available in the United States, and a 1980 NHMRC statement on adolescent health recommended education for medical practitioners and paramedical staff (NHMRC, 90th Session, 1980).

By 1983 the agenda was extended further with the NHMRC recommending training for youth workers, community workers, crisis centre workers, workers in alcohol and other drug facilities and family planning clinics (NHMRC, 96th session, October, 1983).

There was a view that health professionals needed to increase their skills in communicating with young people, and to develop an understanding of young people's cultures and lifestyles and an appreciation of the importance of confidentiality to young people (CDH, 1981). Youth workers, on the other hand, were assumed to have these skills but needed knowledge to address health concerns with young people. One of my key informants, who designed programs to educate both groups, recalled that:

trying to bridge the gap between health workers and young people, like trying to make them think young people might be okay to work with..it wasn't as scary as they thought, but also youth workers. If you are taking on some of the health issues, it was exactly the same...they didn't have any health training and they were terrified ...especially in regard to sexuality.

(YHP12)

in terms of health it was important that schools and youth centres and youth drop-in centres and the refuges started participating in health programs...that was really important because they had fantastic access to young people and often young people in big need. And so they were the places it needed to happen.

(YHP12)

In 1980 the NHMRC suggested that hospital multidisciplinary facilities for adolescents should take responsibility for educating medical and paramedical staff (NHMRC, 90th Session, 1980). Units such as the Adolescent Medical Unit in Camperdown, New South Wales, the Westmead Adolescent Program in Western Sydney, the Adolescent Unit at the Royal Children's hospital in Melbourne and the Youth Health Service in Perth, saw education and training as part of their ongoing work. They organised seminars for health practitioners and youth workers and provided placements for medical practitioners through the Family Medicine Program. Agencies such as the Family Planning Association conducted sexuality education programs for health professionals, youth workers and teachers (Wyndham and Needham, 1983). One of my key informants identified Family Planning educators as a group who had made a major contribution to young people's health in the early 1980s and throughout the decade, through their development of sexuality education methodologies which were used in schools, youth and health centres and in community education programs (YHP16).

Education was one of the objectives of AAAH (AAAH Constitution, 1984). The Association carried out its education role through its quarterly newsletter, which contained

articles and a review of recent literature on young people's health, by convening national conferences and through the work of State branches which organised seminars for members and the general public. However, there was no coordinated effort at national or state level. Murray Williams' comment, that health services for young people were 'piecemeal and unplanned' (AAAH Newsletter No.12, 1982, p. 10), applied equally to education and training in young people's health.

2.10 Health in schools

Schools have long been recognised as a site for health promotion in Australia (Rowling, 1994). Public health practitioners encouraged and promoted school health education (Rowling, 1994) and participated in curriculum development (Banfield, 1993). Grant Banfield, a sociologist at Flinders University in South Australia, points out that approaches to school health education often followed trends in public health (Banfield, 1993). In South Australia, the school health education curriculum introduced in the late 1970s and early 1980s reflected the lifestyle theories that prevailed in public health at that time (Banfield, 1993, p. 32). This meant that the curriculum emphasised personal responsibility for health, with behaviour change as the goal of education 'interventions'. Louise Rowling, an academic in health education at the University of Sydney, makes a similar observation. She notes that during the 1970s and 1980s:

the content of health education curricula was focused on the health of the individual through the acquisition of knowledge, the changing of attitudes and the development of skills to underpin healthy behaviours. When community health was mentioned it was in the guise of how the individual could act for the good of the community. The focus was on the individual to meet the demands of society and the world of work.

Rowling, 1994, p. 5

Banfield argues that school health education was introduced in Australia in the 1970s as a social control measure in response to a 'moral panic' over young people's drug use and sexuality (Banfield, 1993). It is not my intention to discount Banfield's argument so much as to suggest that the push for health education, and sexuality education in particular, was also a result of a more emancipatory agenda influenced in part by the women's movement and by the demands of young people. Young people identified their need for accurate information, as opposed to propaganda, about drug use and sexuality, through consultations and in research conducted with them in the early 1980s (National Youth Conference, 1980; YACA, 1983; NYCA, cited in CDH, 1981; Tzirom, in McCarthy, 1983). The Family Planning Association was acutely aware of this need, as the following quotation indicates, and responded by offering sexuality education programs for teachers.

Perhaps for people outside the FPA (Family Planning Association) networks it may be difficult to understand why an organisation like ours which has historically concerned itself with contraception should venture into the field of sex education. The simplest answer to that question lies in the frustration of Family Planning workers trying to undo layers of shame fear, ignorance, distortion and misinformation.

McCarthy, W. (ed) 1983, p. vii

Teachers and health educators formed part of the constituency that developed through AAAH. They contributed to the newsletter, sat on AAAH committees and presented papers at AAAH conferences. In the early eighties, those papers discussed schools in two ways: as places that were detrimental to young people's health; and as places where health promotion could occur, given certain changes, such as respect for students! (McNamara, 1983). Rather than student behaviour change these papers suggest the need for whole school change to promote the health of young people.

It was noted that schools were still academically organised around the small group who planned to enter university and that the needs of many students were not met by these arrangements (Sinclair, 1981; McNamara, 1983). Recommendations to rectify this situation focused on three things: curricula that was planned with staff, in conjunction with students; school activities that were linked to community needs; and the establishment of multi-disciplinary counselling services for students within schools (McNamara, 1983). Health education for adults as well as young people was recommended, as was the introduction of personal development curricula implemented by suitably trained teachers. Further it was suggested that health education curricula be based on a holistic framework which addressed the total health of the individual (Shears, 1983).

While some of these ideas reflect the individualistic thinking of the lifestyle era, the notion that adults as well as young people should participate in health education and the need for change at a whole school level, foreshadow the concept of the health promoting school, which gained prominence internationally and in Australia in the latter part of the eighties (Colquhoun et al, 1997).

2.11 Summary

This chapter has described issues in young people's health in the early 1980s and efforts of the Australian Association for Adolescent Health (AAAH) to establish a constituency for young people's health and draw the attention of Commonwealth policy makers to the health of young people. The need for health services led to the exploration of possible models, an exercise which brought into play broader questions about the ideas and principles that should guide work in young people's health: questions about how to operationalise a positive notion of health; whether health centres should have a social change focus; and what role young people should play in policy, program and service development. These ideas extended beyond service provision to assumptions about health, how it is created and the place of empowerment strategies within health. Chapter three examines how these ideas were further developed and acted upon during International Youth Year (IYY).

I.Y.Y. CHECK LIST.

HEALTH.

- IF:
- The situation of young people in Australia improves meaningfully.
 - A framework for ongoing action has been created.
 - Issues that young people think are important are raised and acted upon.
 - Action is taken at local level to involve young people, to act on local problems and create local solutions.
 - The contribution young people make to their local community is recognised.
 - All levels of government become more responsive to youth and involve them in decision making.
 - International understanding is furthered.
 - Young people understand their world better.
 - The community understands young people more.
 - The institutions that have young people as their clients (like schools) become more accessible, responsive and relevant.
 - You feel able to control your own future more than you did.
 - You have furthered and fought for any of the above.

THEN I.Y.Y. WILL HAVE SERVED A PURPOSE.

CHAPTER 3

INTERNATIONAL YOUTH YEAR (IYY): A SHORT BOOM...

3.1 Introduction

On 17 December, 1979, the United Nations designated 1985 as International Youth Year (IYY) and announced that the themes of the year would be Participation, Development and Peace (Sutar, 1984). Some of the idealism (and a tinge of scepticism) about what IYY might achieve in young people's health in Australia is captured by the *IYY Check List—Health*. The Check List appeared on the last page of the summary of proceedings of the Australian Association for Adolescent Health's third national conference held in Melbourne in December, 1983. Its source is not given but the statement 'if...you feel able to control your own future more than you did...IYY will have served a purpose', implies that it was written by young people. The notation of 'health' in the upper right hand corner suggests it was part of a series of statements, possibly produced by the Youth Affairs Council of Australia or one of its state branches, in anticipation of IYY.

With the Check List as a reference point, Chapter 3 examines health initiatives undertaken under the banner of IYY in and around 1985. Moves to develop a policy on young people's health in New South Wales are described. The explicit comparison of much State policy talk with a *Health for Youth* exercise in the Western Metropolitan Health Region of Sydney indicates both how some themes emerged in policy in young people's health in the mid-1980s, and how much more might have been done to achieve effective policies. Efforts to set up a multi-service youth health centre in South Australia and New South Wales may have given young people's health a higher profile, but it seems that at the end of IYY, Australian adults, including politicians and the medical profession, had still not answered the question 'Adolescent health, what is it?'

3.2 Adolescent Health in Australia

The monograph *Adolescent Health in Australia: An overview of needs and approaches to care* was an IYY initiative of the Australian Medical Association's Standing Committee on Health Education and Promotion (Bennett, 1984, p. 2). Written by David Bennett, Head of the Adolescent Medical Unit at the Children's Hospital in Camperdown, New South Wales, the monograph shows how adolescent health was encapsulated for a medical audience in Australia in 1984. The monograph was distributed to approximately 25 000 doctors via the *Medical Journal of Australia* and aimed to do three things: identify and explain the health needs of adolescents; view those needs within the context of existing services; and provide information for medical practitioners on medical assessment and provision of health care for young people (Bennett, 1984, p. 1). Bennett endeavoured to

provide breadth rather than depth and 'to emphasise areas not commonly addressed in medical literature' (Bennett, 1984, p. 1).

Although the publication was written to meet the information needs of medical practitioners, my key informants who worked in youth health policy and programs identified 'the jeans book'⁹ as an important publication of the decade. Its citation in Australian youth health policy documents and reports throughout the 1980s and into the 1990s supports this view (Connelly and Borger, 1985; YPDC, 1987b; NSW Dept of Health, 1985, 1991). Due to demand, the monograph was reprinted by the AMA in 1985, through a grant from the Commonwealth Office of Youth Affairs (OYA). The copy I hold bears the IYY logo and acknowledges the OYA grant.

Adolescent Health in Australia is similar in structure and content to the 1981 Commonwealth Department of Health report *Health Needs of Adolescents*, but there are changes which suggest that Alma Ata ideas were gaining ground. For example, Bennett points to the need to move away from a 'relatively narrow focus on the physiological determinants of health and illness, toward a broader perspective, integrating biological, psychosocial and sociological information' and cultural perspectives (Bennett, 1984, p. 12) and, while the WHO problem-based categorical framework is used, greater attention is given to social and environmental factors within each category (Bennett, 1984, p. 12). At times Bennett seems to struggle with the categorical framework's narrowness, changing the descriptor of one of the categories, from 'sexually related problems' as designated in *Health Needs of Adolescents*, to 'adolescent sexuality', denoting a movement beyond a problem-based framework to the notion of sexual wellbeing.

Rather than presenting young people's sexuality as problematic, Bennett argues that most sexually active teenagers 'tend to be discriminating and basically monogamous, particularly during the later years of adolescence' (Bennett, 1984, p. 23). Social and environmental factors affecting young people's sexuality, such as mixed messages from the media, the impact of advertising, social attitudes to young people's sexuality, access to contraception and availability of sexual health services, are highlighted. Bennett argues that access to sexual health information, professional advice and services is a right of young people (Bennett, 1984, pp. 28–29). He challenges the notion that denying access to contraception prevents sexual activity, pointing to US research which found that young people tend to be sexually active for two years before seeking contraception. He concludes that it is 'the act of a mature and thoughtful person to seek protection against pregnancy prior to becoming sexually active' (Bennett, 1984, p. 29).

⁹ The cover of *Adolescent Health in Australia* featured of a pair of blue jeans as the background.

Pregnancy in young women is discussed differently from the 1981 Commonwealth report. Rather than suggesting that young women might be choosing to become pregnant to receive the Single Parent Benefit, *Adolescent Health in Australia* cites US research which found that 'welfare benefits did not serve as economic incentives to child bearing outside marriage' (Bennett, 1984, p. 25). Bennett also makes the point that good antenatal care leads to better outcomes for young women and their babies. This draws policy attention to the need for support for pregnant young women and suggests that teenage pregnancy in and of itself may not be problematic but the lack of good antenatal care for young women is (Bennett, 1984, p. 27).

The section on risk-taking behaviour identifies both intrinsic and extrinsic factors, but the emphasis is on the extrinsic or social factors that contribute to and increase the chances of harm to young people—the availability of potentially dangerous things like motor vehicles and media 'ill health promotion' of products such as alcohol and tobacco are highlighted (Bennett, 1984, p. 21). Bennett concludes that ultimately, 'society has to move to a position where drug taking behaviour will become increasingly unfashionable' (Bennett, 1984, p. 21).

Despite greater attention to social and environmental factors, the monograph retains a focus on the individual. This is particularly evident in the category of psychiatric and emotional problems which acts as a kind of a catch-all for a range of concerns and once again reveals the limitations of the problem-based model. There are three headings within the category of psychiatric and emotional problems: stress among young people; vulnerable young people; and mental health problems and disorders. 'Disadvantaged youth' is a sub-heading within the section on vulnerable young people. The source of the concept of 'vulnerability' is given as *Policy Statement—Health Services for Adolescents* produced by the Department of Health, New South Wales¹⁰ and the term is used to describe young people who are 'at risk for physical, emotional, psychophysiological and social disorders' (Bennett, 1984, p. 32). The following groups are identified as 'at risk' or 'vulnerable': Aboriginal young people, migrant adolescents, significant loss groups, adolescents with chronic illness and/or disability, adolescents whose parents suffer chronic physical or mental illness, victims of physical, emotional or sexual abuse, homeless and unemployed young people and those experiencing poverty with extreme material deprivation, and pregnant adolescents and teenage parents (Bennett, 1984, p. 32).

While perhaps seen as a means of drawing attention to a range of social issues in young people's health, the way the notion of vulnerability is presented in the monograph suggests that vulnerability is a characteristic of an individual rather than a phenomenon created by

¹⁰ This is one of the few pieces of evidence that such a document existed at that time, although no date is given for the Policy Statement in the monograph. The Policy Statement, its origins and its fate are discussed later in this chapter.

social structures. This implicit location of problems within the 'at risk' or 'vulnerable' individual leaves the historical and social causes of 'vulnerability' invisible and ultimately unaddressed (Boland and Jamrozik, 1989; Edwards and Hicks, 1990). There is nothing inherently vulnerable about being an Aboriginal young person. It is disenfranchisement of Aboriginal and Torres Strait Islander people and institutionalised racism that are problematic (Hawes, in Irwin 1984, p. 11).

Another problem with the section of the monograph that deals with psychiatric and emotional problems is the inclusion of unemployment within this category. This suggests two things: that unemployment is a psychiatric or emotional problem of an individual, rather than an issue created in the changing structure of the labour market; and that 'disadvantage' can be analysed and understood in the same way as psychiatric disorders and emotional problems. This is clearly not the case.

Once an issue is conceptualised as a psychiatric or emotional problem, the solution becomes service provision and therapy for 'at risk' individuals rather than changing the social structures that create 'vulnerability' (Boland and Jamrozik, 1989; Edwards and Hicks, 1990; White, 1994). While it is important that services are available to young people who require them, if service provision is the only matter given attention in youth health policy and program development, policy makers and health workers are 'at risk' of ignoring and therefore perpetuating the social and environmental conditions which generate preventable health problems (Boland and Jamrozik 1989; Edwards and Hicks, 1990; White, 1994).

Adolescent Health in Australia provides an outline of the services available to young people that is similar to the one provided in the 1981 Commonwealth report¹¹, but the discussion of the need for new models shows the results of international influences and collaboration between adolescent health and youth work. Swiss epidemiologist Jeanneret is cited in support of new kinds of services and a role for young people in those services. Jeanneret's chart describing 'conventional' and 'innovative' poles of health care delivery is reproduced in the monograph (Bennett, 1984, p. 44) and the notion of young people's participation in 'the design, development and delivery of adolescent health services' is endorsed, if only for services of a 'non-traditional nature' (Bennett, 1984, p. 43).

¹¹ The monograph identifies the following health services: hospital casualty and emergency departments, due to their accessibility; special adolescent outpatient units and adolescent wards in hospitals; services provided by general practitioners who, it is suggested, have an important role to play; school and student health services; community health centres, although it states that these are underutilised by young people; community-based psychosocial services provided by multidisciplinary teams; public mental health services; drop-in centres and services like the Action Centre in Melbourne which function on a drop-in model and provide information, counselling and health care; clinical, education and information services offered by the Family Planning Association; CYSS centres for unemployed young people; and refuges.

Following Jeanneret, the term 'innovative' is used to describe community-based initiatives such as Task Force in Broadmeadows and the Shopfront Youth Health and Information Centre in South Australia. This use of the term 'innovative' to designate non-traditional health services for young people persisted into the late 1980s and 1990s, despite the fact that a generic term like 'innovative' gives little indication of what a program or service does. While innovation is an important characteristic for a health service for young people (and any other group for that matter), use of this term to designate a service type may serve to marginalise it, situating it outside of the ongoing business of health departments and maintaining its status as experimental, and therefore expendable. Once the value of a program or service initiative has been established, one would think it would be incorporated into the broader continuum of health planning, to make room for the next wave of innovation.

While *Adolescent Health in Australia* can be criticised for not achieving a sharper focus on the need for health-enhancing social change, it could also be argued that the act of drawing the attention of health departments and the medical profession to the health of young people, and the monograph's argument for more flexible health programs and services, constitutes a change agenda for the health sector at least.

Adolescent Health in Australia concludes with an invitation to the Australian government to establish a 'comprehensive, integrated health service for all adolescents by 1990' (Bennett, 1984, p. 52). This is a cheeky call by Bennett because the words are taken verbatim from a draft policy statement on health services for adolescents written by a committee established by the New South Wales Department of Health in late 1983. As the draft policy appeared to be going nowhere at the time (Hill, 1984), Bennett, who was one of the authors, must have seen the need to renew the call to action.

That draft policy was entitled *Policy Statement—Health Services for Adolescents*. It was one of two planning exercises undertaken in New South Wales as a result of IYY. The second, a youth health strategy for Sydney's Western Metropolitan Health Region, was published in 1985 (Connelly and Borger, 1985). The processes and content of these two initiatives are discussed in the following section, to provide an insight into the way policy (sometimes) gets done.

3.3 Policy making in New South Wales

In late 1983 I was one of several people representing Sydney's metropolitan health regions who attended a meeting with a senior official of the New South Wales Department of Health to discuss the writing of a state youth health policy. The Minister for Health had

noted that 1985 was International Youth Year and wanted to have an adolescent health policy in place before the year commenced. My recollection of the tone of the meeting was that the Minister's desire for a health policy for young people was a whim, not to be taken too seriously, but one which must be indulged.

There was an assumption that it would be a simple matter for those present to write a policy in four months, with no additional personnel support or funding from the Department. Further, if it could not be done perhaps those present did not know their area very well—professional credibility on the line! Any attempt to explain that one of the themes of IYY was youth participation, and that it would be appropriate to involve young people in the policy development process, seemed futile in the 'Yes Minister' climate of the meeting. Nonetheless those present appreciated the importance of the opportunity, the potential benefits of having a policy in place and, considering that 'no' was not really an option, the writing of the policy began and a draft was submitted to the Department of Health in late 1983 or early 1984.

The copy I hold is entitled, *Policy Statement—Health Services for Adolescents*, and has the designation of 'draft discussion document' (NSW Department of Health, circa 1984¹²). It is not dated, and may not be the final version, however I believe the bulk of the work save the fine tuning is there. *Policy Statement—Health Services for Adolescents* draws on previous Australian and WHO writing on adolescent health, adopts the age range 12 to 19 to designate adolescence and the four WHO categories of adolescent health problems (New South Wales Department of Health, 1984, p. 3). The impact of social change on young people's health is noted but not developed. The notion of 'vulnerability' is introduced (New South Wales Department of Health, 1984, p. 5). The description of existing services for young people is similar to that found in earlier Australian reports (CDH, 1981; Australian College of Paediatrics, 1980; Bennett, 1984) and the inadequacy of existing services is highlighted. The objective of the policy statement is to provide a 'comprehensive integrated health service for all adolescents by the year 1990' (New South Wales Department of Health, 1984, p. 8).

Five of the eleven policy recommendations are to do with service provision and four of those deal with mental health services for young people. These recommendations include the establishment of equitably distributed community-based psycho social services, inpatient services for psychiatrically-disturbed adolescents, therapeutic day care services and, in association with community psychosocial services, short-term accommodation should be provided for 'emotionally disturbed adolescents who require placement away from home as an adjunct to their treatment' (New South Wales Department of Health,

¹² The draft policy statement is cited without a date in the monograph, *Adolescent Health in Australia* and in the WHO report, *Young People's Health: A Challenge for Society*. Both were written in 1984, so it would seem that the draft policy was completed in late 1983 or early 1984.

1984, p.12). The desperate need for accommodation for young people with mental disorders has been highlighted by key informants interviewed for this study. The call for 'equitably distributed' community-based psychosocial services is a response to the fact that the few services that did exist in New South Wales were 'concentrated in three metropolitan health regions' (New South Wales Department of Health, 1984, p. 7). The final recommendation pertaining to services was that specialist adolescent medical units and special accommodation arrangements for adolescents in hospitals be provided.

The other six recommendations deal with health promotion, prevention, early identification of 'at risk' adolescents, the participation of young people in the design and development of services, training of health professionals, research, 'clear guidelines governing responsibilities of and relationships between services and liaison with other departments' (New South Wales Department of Health, 1984, p. 14) and finally, the establishment of a supra-regional adolescent health advisory group to oversee and review policy implementation. The cost of this ministerial whim could be very high!

Despite the rush to have the draft policy written, when submitted to the Health Department little action was taken to progress it. A letter written by Peta Hill, the Secretary of the New South Wales Branch of AAAH, to Bernie McKay, refers to this matter. McKay was Secretary for Health in the New South Wales Department of Health after a stint as Chief Executive Officer of the South Australia Health Commission. McKay had written to AAAH requesting advice on health activities that might be organised for IYY. Among other things, Hill suggested that:

Completion of the policy statement on health services for adolescents should be viewed as a major priority for IYY. The Association is aware that a Departmental Task Force has submitted a draft policy document that has been upgraded following input from workers in the field. The tabling of this report in the near future will enable the issues and recommendations to be publicly acknowledged.

Hill, P., Hon. Secretary, New South Wales Branch of AAAH, August, 1984

While the Departmental Task Force was awaiting a response to its draft policy, the Western Metropolitan Health Region of Sydney was conducting its own IYY initiative—the development of a youth health strategy for the region. That strategy was entitled *Health for Youth: a Strategy for Western Sydney* and it was published in March 1985. Its authors were Peter Connelly, a former youth representative on the Youth Affairs Council of New South Wales who was appointed specifically to work on the development of the strategy, and John Borger, an officer with the Western Metropolitan Health Region. Together they put the IYY principles of participation and development into practice by consulting with young people as part of the strategy development process and recognising the potential of young people to contribute to the promotion of their own health.

Health for Youth: a Strategy for Western Sydney refers to earlier WHO and Australian documents on young people's health and includes the four problem-based categories found in those documents, but the problem-based categories do not form the framework for the strategy. The findings of the consultation and the social and environmental context of the Western Metropolitan Health Region do.

In preparing this report, discussions were held with a wide range of community health centres, young people, youth workers and organisations about health issues affecting young people. It was frequently pointed out that the health issues of young people in Western Sydney could not easily be separated from related issues like rapid population increases, employment/unemployment, housing, transport and distance, education, lack of community resources, discrimination and so on.

Connelly and Borger, 1985, p. 9

The development process and the ideas underpinning the strategy resonate with those of the Declaration of Alma Ata and show how these ideas might be operationalised in a youth health strategy at regional level. *Health for Youth* was important for three reasons: it emphasised the way social and environmental conditions in Western Sydney shape the health of the young people who live there (Connelly and Borger, 1985, pp. 5–6); it locates young people's health within a conceptual framework that takes into account sociological, historical and cultural concepts of young people (Connelly and Borger, 1985, pp. 2–3); and it was produced by a health authority through consultation with young people, youth workers and health workers, modelling an intersectoral approach to health planning.

The strategy highlights health issues for specific groups. Young refugees, young gays, young men and young women have been added to the groups identified in previous Australian reports on young people's health¹³—but the issues have been identified by those groups during the consultation process. The process is important. It is not 'one group naming the problem for another' (Wallerstein and Bernstein, 1994, p. 141), but the relevant groups of young people naming the issues for themselves. The document does not designate specific groups as 'other' or 'different' but as groups of young people who have concerns similar to those of their counterparts, but who, in some circumstances, need specific attention and additional resources to address their health needs. Further, *Health for Youth* points to the way factors such as racism, discrimination, unemployment and lack of income support, create an environment in which it becomes more difficult for some groups of young people in the community to achieve good health, suggesting that these matters need to be dealt with in health policies and strategies.

¹³ They are Aboriginal young people, young migrants, significant loss groups, disabled young people, homeless young people, teenage parents, survivors of physical, emotional or sexual abuse, unemployed young people, and psychologically-disturbed young people.

As with earlier Australian reports, *Health for Youth* highlights the lack of acceptable and accessible health services for young people.

In terms of service delivery to young people it is important to understand the way they “organise” their lives. Many policies and programs are ineffective because they do not “make sense” to the client groups they are designed to assist. The health system appears to be isolated from many of the recent developments in the youth sector, and as a consequence provides services which are inappropriate for and inaccessible to young people.

Connelly and Borger, 1985, p.4 (emphasis in original)

To address this matter, *Health for Youth*'s preferred strategy is to increase the capacity of community health to work with young people. Even though few young people used community health services unless specifically referred, some outreach programs had met with some success. The employment of youth health workers, continuous training for health workers, development of strategies to facilitate better use of community health centres by young people and the employment of community nurses to work with them, are recommended (Connelly and Borger, 1985, pp. 50–51).

The focus on *community* health centres rather than the establishment of designated *youth* health centres is of interest, given the prominence the latter concept enjoyed in Australia at that time. It suggests that the authors and their regional supervisors felt that a community health approach was the preferred option. The *Health for Youth* strategy does however endorse the New South Wales Family Planning Association's proposal to establish a youth action centre in Sydney, albeit with the following conditions: that it be developed as a multi-purpose youth resource centre; that it be developed and managed as a joint project of community groups in Western Sydney, the Family Planning Association and the Department of Health; and that it be located in Western Sydney (Connelly and Borger, 1985, p. 29). Despite the obvious politicking to have the centre based in Sydney's Western Metropolitan Health Region, these conditions suggest that there was some support for the notion of a multi-service youth centre provided that it was managed as a joint project with community groups.

The need for better coordination of programs and services for young people and the development of solutions at various levels of government is emphasised throughout *Health for Youth*. The concluding statement warns against one-off approaches.

For an improvement in the health of young people in Western Sydney, it is imperative that existing health systems be encouraged to be more responsive to young people. This will occur throughout IYY with “one-off” projects. However if a more lasting change is to be achieved, it is necessary to see these projects as the components of a comprehensive youth health plan which will be implemented over the next decade as additional resources are made available.

Connelly and Borger, 1985, p. 49

Neither the articulation of issues in the Western Metropolitan Health Region nor the Ministerial whim produced a youth health policy for the state of New South Wales in 1985, but some of the material from the *Policy Statement—Health Services for Adolescents*, and from Western Sydney’s *Health for Youth*, appeared in a paper entitled *Health Care for Youth—Policy Guidelines* which was distributed by the NSW Department of Health in December 1985. The covering letter states that the document had been approved by the Department of Health’s Policy Review Committee and was recommended to those health services with a client group that included young people. It further stated that the guidelines were designed to improve the responsiveness of health services to the needs of young people and to complement the themes of IYY. The work of ‘many people in the Health Department’ was acknowledged, but it was noted that the policy guidelines drew heavily on the report, *Health for Youth: A Strategy for Western Sydney* (Department of Health, NSW, December, 1985).

Comparative scrutiny of *Health Care for Youth—Policy Guidelines* shows that borrowings from the draft discussion document *Policy Statement—Health Services for Adolescents*, were minimal, ensuring that little expenditure would be required. They include four things: the *Policy Statement*’s age range of 12 to 19 instead of Western Sydney’s 12 to 25; recognition that a range of government instrumentalities provided services to adolescents; the need for attention to accommodation arrangements for young people in hospital; and the need for young people with psychiatric illnesses and emotional disturbances to be separate from adults in hospital and day services. There is no suggestion that new services will be established. The potentially costly recommendations put forward in the draft discussion document *Policy Statement—Health Services for Adolescents*, are largely ignored.

As indicated in the covering letter, the *Policy Guidelines* contains much more that was selectively culled and rewritten from sections of *Health for Youth*, but the document produced as a result of this culling and rewriting is much impoverished. The opening sentence of the *Policy Guidelines* is telling. Rather than the social and cultural background to the concept of youth provided in *Health for Youth*, the opening statement of *Policy Guidelines* is, ‘Young people are predominantly disease free...’

In the manner of documents produced to answer a ministerial whim, *Policy Guidelines* may have been a rush 'cut and paste' job. However, a careful reading suggests that it had been crafted to appease those arguing for more attention to young people's health, while ensuring that the New South Wales Department of Health would not be required to allocate additional resources to the area. The writer or writers of *Policy Guidelines* have used all the signifiers of a progressive youth health document consistent with new public health ideas, but in a diluted form. For example, the notion of young people's rights is written as a right to information, rather than a right to health care. The principles of care outlined in *Health for Youth* are included, but the principle of empowerment is omitted and the principle of participation modified. Described in *Health for Youth* as:

...young people should be able and resourced to participate in decision making processes which affect their lives.

Connelly and Borger, 1985, p. 22

in *Policy Guidelines*, the statement becomes:

Young people should be encouraged to participate in decision making processes which affect their lives.

NSW Department of Health, 1985, p.5

As can be seen, the notions of enabling and resourcing are missing.

The onus to respond to the unmet health needs of young people is placed on those working in existing programs and services, with no additional resources offered by the Department of Health. *Policy Guidelines* genuflects to the emancipatory themes of IYY, but commits the Department of Health to nothing. It was distributed at the end of IYY, when the political momentum had passed. The whole process provides an example of the way potentially emancipatory ideas can be used to give the semblance of 'something being done', while maintaining the status quo.

There was yet another policy endeavour in New South Wales during IYY—a youth health policy developed by the health subcommittee of the New South Wales IYY committee (which was made up of young people and health professionals who worked with them). That policy emphasises a positive notion of health, young people's participation in the production of information for their peers and in health policy, program and service development and the need for accessible services (New South Wales IYY Committee Health Subcommittee, 1985). However, a youth health policy for New South Wales was not completed and published until 1991. One member of the committee that produced the 1991 policy had contributed to the writing of the 1984 State Department of Health's draft *Policy Statement—Health Services for Adolescents*. Another had contributed to the IYY

subcommittee's health policy but, by 1991, was no longer a 'young person' according to the IYY definition. One of my key informants commented that 'Policy committees went right through the 80s (in New South Wales), but never saw the light of day until 1991' (M2).

3.4 Hey hey, it's IYY!

The New South Wales policy development exercise shows that achieving real and long-lasting change is very difficult, even during International Years, which have a way of generating a cacophony of one-off and unrelated events. A case in point is a national workshop entitled *Reaching Today's Youth—A Live-in Communication Workshop on Adolescent Health*, organised by the Commonwealth Department of Health. The Workshop was held in May 1984 in Bowral, New South Wales and the program features the IYY logo.

The AAAH newsletter announced that workshop participants would be individuals who had established a reputation of 'getting through to youth' (AAAH Newsletter No 18, Feb, 1984, p. 6). The thirty people who attended represented diverse interests, including the Commonwealth Department of Health, the AMA, youth affairs, adolescent health and youth health agencies, the media and industries that targeted young people as part of their market (Workshop Program, May, 1984). Participants joined in communication exercises in which they practiced using advertising techniques to present their health programs and services.

The overall aim of the workshop was better communication with youth. As a participant, it was my impression that there was an underlying assumption that health professionals did not know how to communicate with young people and needed to learn from the experts—the experts in this case being workshop facilitator Phil Boas, a proponent of neuro-linguistic programming (NLP), advertisers and television presenters. Workshop participants heard a paper from Coca Cola Export Corporation's David Healy, on what their research was revealing about young people, and practised presenting their health services in formats used by programs such as Channel 9's *Hey Hey Its Saturday!*, which had a target audience of young adults. Television personality Donnie Sutherland, was in attendance as a role model and coach.

The workshop seemed to come out of nowhere and go nowhere. There was strong representation from the AMA, suggesting an interest from that Association. Two of my key informants recalled the workshop as an important event, not because it improved their communication with young people, but because it brought together people working in young people's health across Australia and strengthened the national network created by

AAAH (YHP 16; YHP 2). To that extent, one of the aims of the workshop, 'to create networks to disseminate information to government and state health authorities, youth and health organisations, schools and families' (AAAH Newsletter No 18, Feb, 1984, p. 6), may have been partly realised.

One of my key informants indicated that the workshop had increased his/her interest in use of the mass media as a means of getting health messages to young people (YHP16). My own learning was the irony that, while youth health professionals had to make the case for young people's voices to be heard in health program design, the advertising industry was spending huge amounts of money on research to find out young people's opinions so that they could market their products (many of which could be described as 'unhealthy') to young people.

In contrast to this Commonwealth effort, other IYY projects endeavoured to implement the themes of young people's participation and development. The ACT Health Authority Health Promotion Branch undertook a project to train young people as health advocates to provide information to their peers (ACT Health Authority, 1985). The Australian Association for Adolescent Health organised youth health consultations in Victoria, New South Wales, Western Australia and South Australia, during which four familiar, themes emerged¹⁴, as young people once again undertook to tell health workers and departments what the issues were and what was needed¹⁵ (Burnie, 1985).

A hospital-based project which exemplified the themes of IYY was CanTeen. CanTeen was established by and for young people with support from health professionals who were concerned that the social needs of young people in hospital were not being recognised or met.

...and certainly the issue for me, was that the psychosocial needs of young people with cancer were not even remotely addressed. There wasn't even an awareness that they needed to be...those young people who were ostensibly stuck on a children's ward battling this disease and being given virtually no information at all on their treatment, and the side effects...the physicians with whom I worked and the nursing staff with whom I worked, just had no concept of the fact that the people they were dealing with were not big children or little adults but they were in fact a distinct unique population

¹⁴ Peter Connelly, one of the authors of *Health for Youth* (Connelly and Borger, 1985), attended part of the AAAH consultation held in New South Wales and commented to me that the issues raised were similar to those raised at consultations he had participated in as a 'young person', earlier in the decade, and wondered when the changes young people continually identified through these processes, would be acted on.

¹⁵ The young people said they needed information about health, in particular sexuality, through schools and youth health services; the need for services which respect the privacy of young people and offer information, counselling, and treatment of physical problems; the need for housing for young people, and safe homes and supported accommodation for those who have experienced violence and sexual abuse in their homes; and the need for unemployment benefits to be raised to meet living costs. Issues for rural young people were also raised, in particular the need for inexpensive entertainment in rural areas (Burnie, 1985)

that had specific needs...the service was established ostensibly and set up for the needs of the providers not for the young people.

(M11)

This emotional statement has more austere analogues in the Australian College of Paediatrics policy statement 'Delineating Hospital Roles in Providing Care for Adolescents' which recommended that special facilities for adolescents be provided in hospitals for some of the following reasons:

- (1) Adolescents are neither children nor adults physically, emotionally and socially and do not fit well into existing systems designed for the care of those age groups;
- (2) Children's hospitals are often designed to meet the needs of young children, and staff tend to relate professionally to their parents. Such an environment may inhibit the need for young people to gain control and independence;
- (3) Adolescents have special physical and emotional needs peculiar to their stage of development and both physical facilities and professional staff attitudes need to be sympathetic to those needs

Australia College of Paediatrics, 1986, pp. 1-2

In addition the policy pointed to the need for health care providers who relate comfortably to young people and the benefits of grouping young people together for mutual support.

While CanTeen aimed to address the social and emotional needs of young people who used the services of the hospital, two other projects, one commenced during IYY, the other soon after, were concerned with community-based approaches to health services.

3.5 Community-based youth health centres

During IYY the notion of a multi-service youth centre, based on the model of The Door, received further impetus in South Australia and New South Wales. In South Australia the Minister for Health, John Cornwall, succeeded in convincing the Bannan Labor Government to allocate funds to establish a youth health centre in Adelaide. In New South Wales the Family Planning Association commenced research for a multi-service youth centre in Sydney's western suburbs. Both were designated as IYY projects.

Following a visit to The Door in New York in June 1984, Cornwall set up a Working Party to investigate the feasibility of setting up a similar centre in Adelaide (SAHC, 1985, Second Story, 1986b). The Working Party was made up of representatives from

government instrumentalities with an interest in young people and was advised by a consulting team from The Door (SAHC, 1985, Second Story, 1986b). The consulting team spent eight working days in Adelaide meeting representatives from youth, health and welfare services and conducting workshops and seminars (SAHC, 1985).

The report of the feasibility study recommended the establishment of a health centre for young people and provided advice about the types of programs and services the centre should offer, the personnel required, training needs and the organisational and administrative structure (SAHC, 1985). The name determined for the centre was Second Story, a play on words referring to its location on the second floor of a former Coles retail department store in Adelaide's central shopping district, and the notion of the new opportunities and options the centre would provide for young people.

The process by which the need for the Second Story Youth Health Centre was determined was and, as interviews with my key informants indicate, continues to be, controversial. Many youth workers felt that the consultation had been a token gesture, that their advice had been ignored and the centre would have been established anyway because it was the Minister's 'baby' (YA1). One described it this way.

There were other debates that I remember around that too, like whether it was better to put all these mega bucks that were suddenly available, (a pissy amount of money really when you look back on it but gee, it sounded big to us in those days) whether that should go into one service that would be located in the City or whether in fact it was more important to do stuff out in the country regions, because everybody who had been out there knew it was much worse in the country. At least here in the City you can shop around for a GP. In the country you couldn't even do that.

I remember big debates about whether that was an appropriate use of limited resources and big debates about where Second Story itself should be located. Should it go in the City? Should it go down South? Should it go up North? All that kind of stuff.

(YA1)

Anger about the lack of genuine consultation, the Second Story's connection with a controversial health minister, the level of funding it received and its prime location in the centre of the city, all meant that the task of setting up the new centre was undertaken within a climate of criticism and political scrutiny. An article published in Adelaide's often conservative newspaper, *The Advertiser*, reported that the centre opened to 'praise and a row'—praise from young people and a row between the Minister for Health and a member of the opposition, who expressed concern that the new centre could 'turn children away from going to parents for advice' (Second Story, 1986a).

There was also encouragement from the youth work and health sectors. The Hindley Street Youth Project, which conducted a street work program in the inner city, worked closely with Second Story staff during the first months of the Centre's operation (Second Story, 1986b, p. 19). The Adelaide Children's Hospital Adolescent Team conducted a monthly clinic and individual medical practitioners volunteered their time to provide a medical service before the position of a medical officer was created at the centre (Second Story, 1986b, p. 12).

The principles of operation outlined in the Second Story's constitution were for the most part consistent with ideas current in the mid-eighties about what an alternative or community-based health centre for young people might be like. The Second Story would:

- emphasise the individuality of each adolescent;
- ensure the confidentiality of each adolescent;
- ensure an empathetic and sympathetic approach in dealing with adolescents;
- promote good health and emphasise the prevention of illness;
- be flexible and capable of adapting to the changing needs of adolescents;
- ensure accessibility of services to all adolescents; and
- encourage adolescents to take responsibility for dealing with their own health needs

Second Story Constitution, p. 3

There are two departures from ideas deemed to be important at that time. The first was that, despite the growing use of the terms 'youth' and 'young people' to describe twelve to twenty-five year olds and the designation of Second Story as a 'youth' health centre, the term 'adolescent' is used throughout the statement of principles. The second is that the notion that young people should participate in the development of centre policy, programs, services and evaluation is not included as a principle. As a gesture in this direction however, the Constitution did provide for a position for a young person on the Board of Directors—a director who 'in the opinion of the Minister, reflects the interests of adolescents in the City and Metropolitan area of Adelaide and is or has been a user of services provided by the centre' (Constitution, p. 3).

The other departure is the absence of a role for the Second Story as a social change agent. This absence may be explained by Clause 4.1 of the constitution. The Centre was an incorporated body under the *South Australia Health Commission Act (1975)* and the objectives set out in the Constitution were 'subject to the provisions of clause 4.1' which states that the Centre shall:

have due regard to the role of the Commission as the statutory body responsible for the promotion of health and well being of the people of the State as a whole and shall

assist the Commission by giving effect to the policies from time to time determined by the Commission and will not act in any way adversely to affect the rights or interests of the government of the State of South Australia...

Second Story Constitution, p. 2

Clause 4.1 meant that if the interests of young people's health were at odds with State government policy, the Centre would not be able to act publicly to address this concern. Technically at least, this placed limitations on the Second Story. One of my key informants expressed the view that the potential of the Second Story had not been realised.

There was a lot of ill will about that (setting up Second Story) but nonetheless it was a jolly fine thing to have happen. I don't think it has ever lived up to that dream nor yet do I think it was created in a way which would enable it to live up to that dream and I'm talking about the structural and systemic impact and the impact of Cornwall in particular, some of his minders and a few of the bureaucrats. While I think it is a good thing and a necessary thing to have youth health services, I still have a little marginal residual disappointment that it actually had the capacity to be something much more significant. What would have been more significant in my book was if they had been able to draw the connections at the service...level that are reflected in the emerging systems analysis. (Instead) the policy rhetoric is starting to notice and address the issues, but service provision, and individualist service provision at that, is still seen to be the answer.

(YAI)

Another drawback of the Second Story's incorporation under the Health Commission Act was that all job descriptions and salary levels had to be approved within the Health Commission. The process was often slow and cumbersome. The Second Story aimed to provide a range of entry points to the centre and to develop a program that responded to young people's expressed interests and needs (Second Story, 1986b, p. 4), but the Health Commission had no competitive industrial awards for staff required to conduct the kinds of programs young people wanted, such as rap dancing, drama, aerobics and weight lifting. It took months and a submission to the Public Service Board before a suitable award for part-time instructors was established within the Commission.

Despite these difficulties, in an environment in which little resourcing had been given to young people's health, the allocation of substantial resources to a youth health centre made a statement about the importance of young people and had the potential to effect change in the way health services and programs were designed and implemented. One of my key informants commented that Second Story was important because of:

the symbolism of it—it meant it was legitimate to put money into young people's health.

(YHP3)

While the Second Story was endeavouring to establish 'a new approach to the provision of health services to young people' (Second Story, 1986b, p. 3) the New South Wales Family Planning Association began its research for a youth health centre in Sydney's western suburbs as an IYY project (Family Planning Association of New South Wales, 1987).

The New South Wales Family Planning Association's intention to establish a youth health centre in Sydney is foreshadowed in *Health for Youth* (Connelly and Borger, 1985, p. 29). This suggests that the idea was in the pipeline for some time before the Association succeeded in securing funding for the project. In 1986 Jan Heslop, a community health worker and former coordinator of the Western Area Adolescent Team (WAAT) in Mt. Druitt, was employed to set up the new centre. A progress report produced by Heslop (Heslop, 1986) and the minutes of the inaugural meeting of the Advisory Committee (The Warehouse, 1987), indicate that the recommendations contained in the *Health for Youth* strategy were partially taken up. The location for the centre was Penrith in Western Sydney (Heslop, 1986); the proposal submitted to State and Federal Health Ministers for funding was for a multi-service youth health centre; and the advisory committee for the centre was made up of representatives from local health services, youth programs, local government, the Family Planning Association and Westmead Hospital Youth Access Group (The Warehouse, 1987). The Advisory Committee's role was to 'direct the path the centre would follow' but the Committee would 'have to report to the Board of FPA' (The Warehouse, 1987, p. 2). This suggests that the centre was not a 'joint project of community groups in Western Sydney, the Family Planning Association and the Department of Health' (Connelly and Borger, 1985, p. 29), as recommended in *Health for Youth*, but a project of the Family Planning Association, advised by local health and youth agencies.

The new centre was called The Warehouse, from its location in an old carpet warehouse (The Warehouse, c. 1986–87). Its philosophy and objectives were similar to those of Second Story in their emphasis on designing and implementing 'an alternative model of service delivery tailored directly to the needs of young people' (The Warehouse, c. 1986–87), a program 'consistent with their (young people's) lifestyles, attitudes and needs' (The Warehouse, c. 1986–87), and with 'continuing input and advice from young people living in the west' (The Warehouse, c. 1986–87). Like Second Story, The Warehouse intended to offer a range of services and programs in collaboration with other agencies and introduce a training role once the centre was established (The Warehouse, 1987, p. 3). The Warehouse gave greater attention to provision of specialised services to disadvantaged and

minority groups, in particular young people of non-English speaking backgrounds, Aboriginal young people, young disabled people and rural youth.

While the establishment of multi-service youth health centres in the mid-eighties was not entirely new¹⁶, reports produced by the Second Story, The Warehouse and Shopfront, suggest that the people who worked in those centres felt that they were creating new ways of working with young people on health matters. The Progress Report of the Second Story's first six months of operation describes youth health centres as a 'new phenomenon in Australia' (Second Story, 1986a, p. 2). A review of The Warehouse's first six months of operation states that 'youth health is a relatively new concept and requires a holistic interpretation of the term 'health' (The Warehouse, 1988a).

The two centres had a number of challenges to meet. They were required to turn the idea of a youth health or multi-service centre for young people into the reality of day to day operations. They also had to integrate the cultures of adolescent health, youth work, young people and the various agencies and disciplines that contributed to the centre program, into a cohesive philosophy and modus operandi. Another challenge was developing a team approach to program and service development when many staff were sessional, on short-term contracts, or from outside agencies. A paper on the experience of The Warehouse, presented at the 1988 biennial AAAH conference in Brisbane, attests to some of these difficulties:

The establishment of the centre was fraught with many problems, highlighting the difficulties of establishing an innovative service in a relatively hostile environment...(The experience of the Warehouse) offers a valuable lesson to agencies proposing the establishment of similar centres...and attention will be given in the paper to the special management and team building needs of the staff in such centres...

Neilson, 1988

There were also the matters of determining what hours were most suitable and how young people would respond to and use something called a youth health centre. Both Second Story and The Warehouse endeavoured to make programs and services available at times when young people could use them and strike a balance between an informal drop-in format and the confidentiality, safety and security required for counselling and clinical services. To this end both centres combined structured group programs, such as counselling, clinical services, weight training and budget cooking, with shower and

¹⁶ The Brighton Bexley Youth Centre in New South Wales was established through community health funding in the 1970s, and combined community development and service provision roles, and the Action Centre in Melbourne had been in operation as an informal youth oriented clinical and information service since 1976.

breakfast programs and drop-in times (Second Story Annual Reports, 1986, 1992; The Warehouse 1989, 1990).

The concept of a multi-service youth health centre was identified by my key informants as an idea which had an impact on developments in young people's health during the eighties. My interviews revealed differing views about the value of the idea, with one of my key informants describing the concept as the one-stop shop notion 'tarted up with a health emphasis', while others indicated that The Door had had a positive impact on developments in Australia (M2; M10; YHP 3; YHP5; YHP7; YHP14). One indicated that it was 'one of the most exciting concepts we embraced at that time' (M2) and another identified the opening of the Second Story as an important event of the decade (YHP 3).

Others of my key informants held the view that young people's health needs should be met by mainstream services, in particular community health centres (YA6; YHP2; YHP7). One argued that the concept of a multi-service youth centre, as exemplified by The Door, reflected the notion popular in America of a 'lighthouse project', a costly demonstration project, whereas in Australia there was a preference for policy solutions and universal approaches (YA6). Yet another indicated that the American models adopted during the eighties were medical rather than community-oriented, and not suitable to Australia, which had a commitment to community health and was beginning to apply social justice ideas to issues in young people's health (YHP2).

These issues are important. Policy solutions and social justice are fundamental to the promotion of the health of young people. Ensuring that young people have access to the full range of programs and services they need, including community health services, is essential. However in the 1970s and 1980s few youth projects were funded through the National Community Health Program (Palmer and Short, 1989) and young people tended not to use community health centres unless specific efforts had been made to develop a program or outreach to them (Bennett, 1984; Connelly and Borger, 1985). More recently a literature review of primary care services for young people found that:

mainstream community health services require significant changes to meet the needs of adolescents through service provision. The service culture and structures need to be adolescent-friendly and designed to give adolescents timely and helpful information and services. Co-location of adolescent primary care services to one site offered benefits for greater access by adolescents. Again, community services need to involve effective interagency collaboration to ensure cross program referral and response to the full range of adolescent needs.

Goltz and Edgecombe, 1996, p. 3

One solution to this problem, proposed by Western Sydney's *Health for Youth*, is resourcing and training for community health to undertake projects in young people's health (Connelly and Borger, 1985). While I support this idea, I would also argue that there is also a place for a health centre that focuses specifically on young people within a youth health strategy. The value of such a centre is its visibility, its potential to be a voice for young people within and outside the health system and its ability to respond to young people's interests and cultures. Further, there is some evidence to suggest that a dedicated youth health centre is more likely to reach young people who may be reluctant to use mainstream or generalist health services (Goltz and Edgecombe, 1996, p. 3).

The notion of a multi-service youth centre was also taken up outside the health sector in the mid 1980s. One example is the Come-In Youth Centre, which opened as a drop-in centre in the inner city suburb of Paddington, New South Wales, in 1978. Initially Come-In was open five nights a week from 7:00 pm to 1:00 am and aimed to provide a low key, low pressure approach to young people.

For those young people who did attend the Centre, the provision of 'time out' from difficult situations afforded them the possibility of survival.

Leary, 1991

However, in 1981 a new group started using the centre, a group described as younger and more isolated and whose 'use of drugs, offending behaviour and inability to easily engage were significant facets of their behaviour' (Leary, 1991, p. 3). The Committee responded to the needs of the new group by maintaining the drop-in component for the easy and informal access it afforded young people, but limited the drop-in hours to allow 'more individual time where there was less peer pressure or need to compete for attention' (Leary, 1991, p. 3).

In 1984 the coordinator of Come-in, David Leary, attended the Second International Conference on Comprehensive Youth Programs and Youth Advocacy held in Mexico. Following the Workshop he visited multi-service youth centres in the United States. During this time he became aware of the impact HIV/AIDS was having on inner city young people, and upon returning to Sydney, introduced a program at Come-In to address HIV/AIDS. The Come-In program offered a clinic in 1986-87, through the services of a nurse practitioner seconded to the centre from St. Vincents Hospital and, as the decade progressed, developed specialty areas in HIV/AIDS, housing and education.

3.6 *Adolescent Health: Who Needs It?*

The biennial national AAAH conference, *Adolescent Health: Who Needs It?*, was held in Adelaide in November, 1985, toward the end of IYY. Even though the AAAH conference was held near the end of IYY, and youth participation was one of the themes for the year, the 1985 program suggests that there was little participation by young people, and few papers on youth participation as a strategy. Apart from the opening drama presentation by young people and youth workers, there was one workshop about training young people as helpers, another on young people as peer counsellors, and a workshop presented by young people from the Side Effects Youth Health Drama Project.

Further, youth workers attending the conference indicated that their work had been given little time and marginalised in favour of medical presentations. Only one plenary dealt with youth work and it was entitled, appropriately as it turned out, *Workers with Youth Communique*. It consisted of twelve presentations allotted ten minutes each. One presenter refused to stick to the time, insisting that the multi-faceted program he represented (Shopfront Youth Health and Information Centre) could not be presented in ten minutes and that the work of youth workers had been given low priority by the conference organisers. This 'mini-revolt' suggests two things: firstly, to the extent that youth worker interest in young people's health and their presence at the conference was a result of AAAH's efforts to woo them to the cause, it seems that AAAH had succeeded; and secondly, having taken up the issue of young people's health, youth workers wanted their work acknowledged through the allocation of conference time. The AAAH National Council elected at this conference included for the first time people from nursing and youth work backgrounds. This development reflected the diversity of the Association's membership and marked a change from previous Councils, which had been made up primarily of medical practitioners.

The fact that the conference was held in Adelaide may have been another factor in the presence and high visibility of youth workers and their edginess. South Australia's Health Minister had taken a personal interest in young people's health, made funds available for youth centres to employ health workers, entered a joint funding arrangement with Salisbury Council to establish Shopfront Youth Health and Information Centre and gained Cabinet support to set up Second Story. This meant that the youth affairs sector in South Australia were very aware of young people's health, but many felt that this agenda was being imposed from above without adequate consultation.

Young people's health might have been high on the ministerial agenda in South Australia, but the speech of the Commonwealth Minister for Health, Neal Blewett, to the Adelaide conference, suggests that this was not the case nationally.

...the title of your conference, Adolescent Health—Who Needs It?, assumes that Australian adults, including politicians and the medical profession, have already come to terms with the question 'Adolescent Health—What Is It?'. The answer may be clear to participants at this conference, but I suspect you may be in a minority in the community.

Blewett, Adelaide, November, 1985

These remarks must have been discouraging to conference participants given that AAAH had been in operation for almost six years and during IYY, to those involved at least, it seemed that there had been a lot of activity in young people's health.

Blewett's paper suggests that young people were of interest to the Commonwealth Department of Health in relation to illness or problem behaviour. The 'health' issues he identifies are sports injury, depression and anxiety, STDs, HIV/AIDS, unplanned pregnancy, pelvic inflammatory disease, alcohol, cigarette and other drug 'abuse', high rates of road accidents and poor nutrition. Youth unemployment was seen as a health concern, but its importance played down. The Minister, or his departmental advisers, argued that, while many assume high levels of drug alcohol and cigarette abuse and high rates of road accidents are related to unemployment: 'unemployment is merely an additional complicating factor which certainly exacerbates manifestations of ill health, but rarely is it the critical cause' (Blewett, 1985).

There was some encouraging news from the Minister, who announced Commonwealth funding for a Youth Action Centre, likely to be located in Western Sydney (the centre that became The Warehouse). He pointed to the youth emphasis of the National Campaign Against Drug Abuse (NCADA) and the importance of schools as a site for prevention of HIV/AIDS. At a time when his department was pre-occupied with the national response to HIV/AIDS, he took the opportunity to stress that 'there were no reasonable grounds for exclusion from schools of children or teachers, who have antibodies to the AIDS virus', and that 'demands for identification of children with the AIDS antibody have no basis in protecting the public's health' (Blewett, 1985). Further, the Minister announced that the Better Health Commission, which was conducting hearings across Australia with the aim of developing a Health for All strategy, had a special brief for adolescents and would be organising a workshop on adolescent health. This was good news inasmuch as it signalled that the Commonwealth Department of Health recognised that issues for young people needed to be addressed separately from those of children, and that different policy, program and service approaches were required for these two population groups.

3.7 Summary

The views of my key informants about how important IYY was as a catalyst for change in young people's health in Australia varied, from 'Very important' (M2) to 'A fizzer' (YA4). If we take the IYY check list as a reference point a number of things are clear. Young people 'fought for and furthered', changes in health when invited, and the idea that they should participate in the development of policy, programs and services to meet their needs was given further attention in documents such as *Adolescent Health in Australia*, Western Sydney's *Health for Youth* strategy and projects such as CanTeen. IYY initiatives like Second Story, The Warehouse and CanTeen endeavoured to make 'the (health) institutions that have young people as their clients' more responsive, but these projects tended to be tenuous and isolated rather than part of a strong and coordinated commitment to young people's health at national or state level. While 'some issues young people felt were important' had been raised and occasionally acted on, there was no 'framework for ongoing action' by the end of IYY, except perhaps in Sydney's Western Metropolitan Health Region. One of my key informants described IYY as 'a short boom and a very long bust' (YA1). Certainly IYY did achieve a glimmer of interest in young people on the health horizon but this gradually faded as the very long bust set in. The year ended with no policies in place to coordinate efforts and maintain interest.

CHAPTER 4 ...AND A VERY LONG BUST

4.1 Introduction

Chapter 3 described initiatives in young people's health during International Youth Year, pointing out that, while there were some achievements, no ongoing policy and planning mechanisms were put in place to ensure interest continued beyond 1985. Chapter 4 describes World Health Organization and Australian efforts to bring young people's health within the rubric of Health for All and state planning initiatives that occurred in the wake of IYY. The placement of social justice at the centre of a youth health strategy in Victoria produced a new framework for young people's health, but maintaining government interest and a real commitment proved as elusive as ever. AAAH renewed its push for young people's health to be included in pre-service medical education. In the education sector, schools moved toward a broader framework for health.

4.2 A paradigm shift

In 1984 WHO convened a study group on young people and Health for All by the Year 2000. David Bennett from Australia was a consultant and the rapporteur for the study group which met in Geneva. Its overall task was to write a report on young people's health in preparation for International Youth Year. Its four objectives reflect both the ideas of the Declaration of Alma Ata and the IYY themes of participation and development: 'to review the health and health-related problems of adolescence and youth in the context of current and emerging socio-economic circumstances; to provide an analysis of existing health systems as they apply to young people in the context of primary health care, concentrating on their relevance, the availability of resources and the gaps; to recommend strategies for the active involvement of young people in primary health care; and to consider policy recommendations with regard to the health of young people and to suggest guidelines and priorities' (WHO, 1986, p. 10).

In carrying out its task the study group was assisted by two background papers which related directly to these objectives: *The Shape and Impact of Youth Participation in Health* prepared by Sally Denshire, an occupational therapist with the Adolescent Medical Unit in Camperdown, Australia (Denshire, 1984); and *Health Promotion for Youth in the European Region: Basic Philosophy and Innovative Strategies*, prepared by Peter Franzkowiak, a German sociologist (Franzkowiak, 1983). *The Shape and Impact of Youth Participation in Health* offers a rationale for and gives examples of young people's participation in health. Denshire draws on the models presented at the First International Workshop on Comprehensive Youth Programs and Youth Advocacy held in Toronto,

Canada in 1983, and a report by Shone and McDermott prepared for the Youth Affairs Council of Victoria on young people's participation in policy development at the local level (Shone and McDermott, 1980; Denshire, 1984). Segments of Denshire's paper are quoted directly in the Study Group's report and, although her paper is not cited in the references (nor is Franzkowiak's), Shone and McDermott's report is (WHO, 1986).

Health Promotion for Youth in the European Region: Basic Philosophy and Innovative Strategies describes a paradigm shift in the philosophy and practice of health promotion with young people in WHO's European region. That shift was precipitated by three things:

- recognition that individual behaviour choices are limited or expanded by environmental factors and by the extent to which the individual feels in charge of his/her own life;
- acknowledgment that, to affect a young person's lifestyle, comprehensive activities are required to change both the individual, collective and environmental components of his/her life and lifestyle;
- the movement from a concept of 'lifestyle' as used in the traditional medical sense, as a synonym for behaviour or risky behaviour, to a more sociological understanding which encompasses 'the ways in which individuals and social groups come to terms with their immediate and wider environment'

(Franzkowiak, 1983, p. 1).

Franzkowiak asserts that prevention, as opposed to health promotion¹⁷, often disregards the everyday life priorities of those it wishes to influence and isolates specific behaviours:

...from the overall lifestyle that their 'targets' have opted for, to cope with their lives and also to be part of a reference group or subculture.

Franzkowiak, 1983, p.5

The new paradigm described by Franzkowiak sees health promotion as a 'social and political strategy' (Franzkowiak, 1983, p. 5). It holds that the many factors that affect young people's health, such as culture, work and home environments, cannot be influenced by individuals alone, and that it is no longer appropriate 'to concentrate efforts exclusively on greater personal responsibility for health' (Franzkowiak, 1983, p. 5).

The report of the study group, *Young People's Health: A Challenge for Society*, shows the tensions of a group coming to terms with a new paradigm. The difficulties of

¹⁷ Palmer and Short make a distinction between prevention and health promotion, noting that 'preventive activities tend to be carried out by health professionals on particular clients or population groups. In contrast, health promotion engages individuals and groups in understanding and nurturing their own health' (Palmer and Short, 1989, p. 182)

conceptualising health as a positive entity in a sector focused on illness, and the shift from a concept of health promotion as individual behaviour change to a sociopolitical strategy, are evident. For example, statements arguing that young people's health is 'rooted in the social, economic, and political realities of the world in which they (young people) live' (WHO, 1986, p. 10), sit side by side with the notion of vulnerable groups, designated as high risk groups in the report (WHO, 1986, p. 54), and behaviour change is the goal of health promotion (WHO, 1986, pp. 54–55).

Despite these tensions, the study group takes on board the directive 'to review the health and health-related problems of adolescence and youth in the context of current and emerging socioeconomic circumstances'. It differs from previous WHO reports on young people's health in the following ways. Firstly, the term 'adolescent' has been replaced by 'young people' and the age range is extended to combine the 10 to 19 year age group, designated as 'adolescent' in previous WHO reports, and the 15 to 24 year age group, designated as 'youth' by the United Nations International Youth Year. Secondly, the limitations of a problem based framework are pointed out, as the following quotation indicates:

The listing of problems, even within several broad categories, is of relatively limited value at an international level, because of lack of available data and problems of comparability. Furthermore, 'pure' health issues cannot be usefully separated from health-related issues such as unemployment, income maintenance, housing, transport, and socioeconomic status.

WHO, 1986, p. 42

Finally, the participation of young people in policy and program development and research is seen as a central principle:

Health policy has historically been made by an elite that was often remote from the groups most affected. The pattern has been for adult providers of health care to formulate the issues as they perceive them from various disciplinary angles, and to deal with them accordingly. What is being proposed is that today's advocates of a health care policy geared to youth should join hands with young people in promoting change...What emerged very strongly was the conviction that attitudes must change so that young people come to be considered as a resource rather than a problem.

WHO, 1986, p. 110

Young People's Health: A Challenge for Society was not published until 1986 and by that time it was no longer news. Many of the ideas it contained had already gained currency in

Australia, as the deliberations of a national workshop on young people's health held in Brisbane in 1986 reveal.

4.3 Youth health: it's everybody's concern

As foreshadowed by Neal Blewett in his speech to the national AAAH conference, the Better Health Commission (BHC) organised a workshop on young people's health. Held in Brisbane from February 11 to 13, 1986, the purpose of the workshop was to supplement information provided in the written and oral submissions to the Commission and 'to fill in the gaps in the available information' (BHC, vol 3, 1986, p. 1). The organisers opted for two workshops—a one-day workshop with nineteen young people, which suggests that the message about young people's participation was getting through at a national level, followed by a two-day workshop with twenty-six people from across Australia who worked in health and youth affairs (BHC, vol 1, 1986, pp. 188–189). Professional participants came from a range of sectors and disciplines, including nursing, youth affairs, law, education, medicine, social work and ethnic affairs.

The young people who participated in the youth workshop were from Queensland and their names are recorded in the Commission's report, showing a respect for them and their contribution (BHC, vol 1, 1986, p 188). However, the same consideration was not forthcoming when the young people sought 'direct contact and involvement in the professional workshop' (BHC, vol 3, p. 108). They 'were refused because it was considered impractical and imprudent' (BHC, vol 3, p. 108). The workshop report, *Youth Health: It's Everybody's Concern*, integrates the findings of both workshops and argues that having separate workshops was useful because it demonstrated that 'both groups were 'on about' the same thing, having arrived at that point independently' (BHC, vol 3, 1986, pp. 108–114). However, it might equally be argued that, had the two groups been able to meet and discuss the issues, the workshop would have been enlivened and the resulting report enriched.

Youth Health: It's Everybody's Concern provides a snapshot of the issues and ideas a group of young people from Queensland and 'health professionals and others with an interest in youth affairs' from across Australia deemed important in 1986 (BHC, vol 3, 1986, p. 108). The report has the flavour of the 'paradigm shift' described by Franzkowiak (1983), drawing attention to the impact of social factors such as unemployment and poor education on young people's health. Young people's participation was 'the common thread which ran through and linked all discussions and recommendations' (BHC, vol 3, p. 114) and interagency and intersectoral collaboration is identified as a key strategy, hence the title *Youth Health: It's Everybody's Concern*.

A matter which received considerable attention was the legal situation in Australia regarding provision of health services to minors. In 1986 there was still no national uniform law in Australia regarding consent to treatment for minors, even though the need had been recognised and a request put to the Law Reform Commission by the NHMRC in the early 1980s (AAAH Newsletter No 18, Feb, 1984). The Law Reform Commission suspended work on this issue in January, 1985 (AAAH Newsletter No 21, March 1985, p. 7). It was therefore important that Australian practitioners be well-informed of the outcome of the Gillick case in the UK, which established in 1985 that, while it might be prudent of a doctor to encourage a young person seeking a prescription for contraception to consult with her mother, the doctor was not required to do so (Reich, 1995) providing that he or she was satisfied that 'the young person has the capacity (maturity, understanding and intelligence) to consent to medical treatment' and that it would be 'in her best interests to have that advice and treatment with or without parental consent' (Family Planning Association NSW, 1998, p. 47). As it happened, the outcome of the Gillick case was publicised in the medical press in Australia in 1986 (Bravender-Coyle, 1986; Riches, 1986).

The young people who attended the Better Health Commission workshop also raised the issue of sexuality, in particular their need for information. Their assessment of much of the health information they received was that 'it was "boring", did not speak their language, was "suspect" because of its source (adult/bureaucracy), and poorly distributed' (BHC, vol 3, 1986, p. 111). With regard to sexuality and contraceptive information their advice was:

Educate our parents. Teach them to communicate with us. If that's too difficult, teach us so we can be better parents.

BHC, vol 3, 1986, p. 113

Youth Health: It's Everybody's Concern contains three recommendations. The first is for a series of intersectoral events through which young people could express their health needs, develop strategies to address those needs and debate social policy. Social policy areas designated as needing attention are unemployment, housing, the legal ambiguity surrounding health service provision for young people, curriculum in health education (including sexuality education) and the way institutions such as hospitals, mental hospitals and remand centres deal with young people.

The second and third recommendations address the need for better links between national, state and local bodies, so that information and resources could be shared, and the need for young people's health to be promoted as 'a valid research area' (BHC, vol 3, 1986, p. 108). Action research was seen as particularly relevant, as was strengthening of the links

between research, health and social policy (BHC, vol 3, 1986, p. 113). There is a sense here that efforts in young people's health, whether policy, planning, programming or research, needed to be better coordinated and promoted nationally.

The placement of self-esteem as a central issue in young people's health (BHC, vol 3, 1986, p. 109) does not fit with the direction and content of the rest of the report, which emphasises 'solutions for groups rather than individuals' (BHC, vol 3, 1986, p. 110). It seems patronising to suggest that young people *as a group* have a self-esteem problem. It reinforces the idea of youth as inherently problematic and locates the causes of problems within individuals. The strategies put forward to address self-esteem—'participation, information, advocacy and communication', suggest that 'disenfranchisement' might have been a better term than self-esteem to describe workshop participants' concerns in this area.

Youth Health: It's Everybody's Concern draws attention to the neglect of young people within the health system. One of the guest speakers pointed out that:

...youth's lower mortality rate and the perception of them as a fit and basically healthy group has relegated them to a position of minor importance in the planning of health care.

BHC, vol 3, 1986, p. 112

The fact that 'youth health as an issue had not appeared on Health Minister's conference agenda once in the last three years' (BHC, vol 3, 1986, p. 112), affirmed the need for advocacy. International Youth Year had provided some leverage, but the challenge in 1986 would be to maintain, and in some states establish, young people's health as a legitimate concern for health departments and governments.

4.4 Planning for young people's health

Activities that occurred in the states in the mid-1980s suggested there might be cause for optimism. The ACT Workers with Youth Network prepared a paper on health service provision, indicating that young people's health was establishing its own trajectory within youth affairs, and health departments in South Australia, Western Australia and Victoria commenced policy and planning initiatives.

Principles on the Provision of Health and Health Care Services for Young People was the title of a paper prepared by Sarah Burkinshaw for the Youth Health Group of the ACT Workers with Youth Network to advise the ACT Health Authority on ways to increase accessibility of health services for young people. The Youth Health Group was created in

response to increased interest in young people's health in the ACT (Burkinshaw, 1986, p. 6). The paper shows the way a youth health group within a youth worker network dealt with matters previously taken up mainly by health departments and health agencies. It attempts a marriage between health and youth affairs approaches to young people's health. The influence of health ideas is evident in the adoption of the WHO positive definition of health and the four problem-based themes for considering young people's health. The problem-based framework suggests a problem/individual approach to the health of young people but the paper's attention to the way poverty exacerbates health problems for young people suggests a social health perspective. The paper identifies culture, income support, participation in education, sexual preference, gender and class, as factors that affect the ability of young people to grow, develop and achieve good health. This is consistent with the stance taken by the Youth Affairs Council of Australia three years earlier (YACA, 1983).

The participation of young people is emphasised throughout, and modelled by the Youth Health Group, which included young people as members. Health service needs were determined through a survey of young people conducted by the Group. Better coordination of services and attention to underlying problems and issues are recommended. Services are criticised for being too specific, focusing on one problem or symptom, rather than dealing with the underlying problems and issues (Burkinshaw, 1986). The paper argues that services should be located in places frequented by young people and based on the principles for a youth health service outlined in Western Sydney's *Health for Youth* and in the feasibility study for Second Story Youth Health Centre, again showing the exchange of ideas across Australia and the way organisations drew on each others' work to develop more effective ways of working with young people in health.

The voices and experiences of young people are present in *Principles on the Provision of Health and Health Care Services for Young People*. They inform its development and give authenticity to the work. The strategies are grounded in the experience of young people and practitioners. The emphasis on poverty and social factors follows the move toward greater attention to the social determinants of health found in documents like Western Sydney's *Health for Youth*.

While a small and probably very cohesive group prepared *Principles on the Provision of Health and Health Care Services for Young People* in the ACT, the Future Directions project in South Australia was working to gain consensus across government departments and youth agencies in its planning for young people's health. Begun late in 1985, the Future Directions project sought to establish a process for identifying, discussing and coming to agreement on matters 'crucial to the planning and development of health services over the next 15 years', in collaboration with organisations, groups and

individuals outside and within the health system (SAHC, 1986d, p.1). Youth, health and education were identified collectively as one of two areas to be addressed in the first instance, and an interdepartmental committee, called a Focal Team, was set up to devise and implement a strategy for talking to interested groups and individuals.

The Focal Team was made up of representatives from the Child Adolescent and Family Health Service (CAFHS) Adolescent Team, the Department for Community Welfare and the Department of Education (SAHC, 1986d), and was chaired by Helen Tolsteshev, a community health nurse and head of the Adolescent Team of CAFHS. The Focal Team changed the title of the project from 'Youth, Health and Education' to 'Health Care in South Australia—Future Directions for Young People'. This title fitted with the South Australia Health Commission's brief—'the planning and development of health services'—but it limited the scope of the planning exercise, in name at least, to health care. The planning process consisted of three components: a literature search to identify the issues in young people's health; preparation and distribution of a discussion paper for agency response; and organisation of a workshop to facilitate dialogue and seek clarification of the issues (SAHC, 1986d).

The Future Directions project shows a kind of tug of war between SAHC's desire to restrict the scope of the project to planning for health services and the broader approach advocated by many of the agencies with which it consulted. As a result, over the life of the project, the emphasis changed. The ideas that emerged from the initial literature review are similar to those expressed at the Better Health Commission's youth health workshop and suggest the need for attention to matters such as the impact of unemployment, homelessness and education on young people's health, legal issues in health service provision, health education and the importance of young people's participation (SAHC, 1986d, p. 3). The discussion paper that follows the literature review is informed by data on young people's health and takes a different tack, constructing young people's health as a series of problems: drug and alcohol use and abuse, road crashes, family conflict and violence, suicide, depression and abuse—physical, emotional and sexual (SAHC, 1986, p. 7). No unifying framework or lens is provided to allow these issues to be viewed within a wider social context.

The mixed responses¹⁸ to the discussion paper—some were critical of the narrow focus (Second Story, 1986c), but others praised the discussion paper for clarifying issues in young people's health—led the Focal Team to organise a workshop to facilitate a more common understanding of issues in young people's health (SAHC, 1986, p. 9). What was missing in the process up to this point was the involvement of young people and the way

¹⁸ Twenty-three were received from health agencies, sections of the Education Department and the Department of Community Welfare and agencies associated/interested in young people (Final Report, 1986, p. 7).

their input might have shaped the discussion and future directions. This absence was commented on by some workshop participants, who recommended that young people be included in future consultations.

While the workshop groups had difficulty reaching consensus, all agreed about the need for school health education¹⁹, policy development in young people's health and multidisciplinary, multi-agency training (Future Directions for Young People, Report of the Workshop held 7 August, 1986). These kinds of recommendations suggested that the consultees wished to extend the scope of the project to include planning for young people's health more broadly, including health promotion, but this did not occur. The final report, *Health Care in South Australia—Future Directions for Young People*, returns the emphasis to health care.

There are six recommendations to guide the South Australian Health Commission in its planning for young people's health towards 2001. Four are to do with health service provision, two of which are to do with mental health services, and the fifth is about data collection. This emphasis is consistent with the brief established by South Australia Health Commission, but was not emphasised to the same extent by those who participated in the consultation process. The ideas generated through the consultation are included, to some extent, in the discussion and supporting strategies. The workshop recommendations are outlined in Appendix 3 of the final report of the Project.

My reading of the papers produced by the Future Directions project suggests that the Focal Team was placed in an awkward position. There was a mandate from the Health Commission to consult with health organisations, youth agencies and the community, but the results of the consultation had to be reconciled with the SAHC requirement for 'realistic' recommendations about service provision (as opposed to health education and promotion) that would be 'cost-effective'. The tone of the final report suggests that the South Australian Health Commission saw the project as a cost-cutting exercise. For example one of the proposed strategies is the placement of health workers in youth agencies, such as youth shelters, and the placement of youth workers in health agencies, such as casualty departments of hospitals. While offered as a way of increasing young people's access to services, it is also promoted as a cost cutting measure in a 'constrained economic climate' (SAHC, 1986d, p. 14). Consistent with the cost-cutting mood is the suggestion that all SAHC health services introduce strategies to promote their services to young people, with no additional resources.

¹⁹ There were eight recommendations related to teaching life skills, perhaps the most important issue in the view of workshop participants

The final recommendation, that the consultation process continue, was not implemented, not for lack of interest in young people's health, but because the Future Directions initiative itself was abandoned by the South Australian Health Commission. It seems that it was not well defined from the outset, a passing phenomenon, associated with the rapid change in heads of the Commission that occurred in the mid-1980s. No plan for young people's health to 2001 eventuated in South Australia in 1986, but some ideas generated during the consultation were taken up later. In 1987–88 there was a move to establish better cooperation between health and education through the establishment of the Health Education Interagency Advisory Committee (Health Education Interagency Advisory Challenge Group, 1988; Beckinsale et al, 1997). When the South Australian Health Commission commenced work on a youth health policy, it was coordinated by its Social Health Unit and representatives from government and non-government agencies participated in its development. In that instance too, South Australian Health Commission interest proved difficult to maintain (YACSA, 1990).

While the Focal Team was working to reconcile the views of community agencies with the mandate from the South Australian Health Commission, a review of health services for young people was under way in Western Australia. The focus established for the review was health services, but those who conducted and participated in the review endeavoured to shift the emphasis toward Alma Ata and community development ideas.

The Burke Labor government's focus on specific populations, including young people, was a policy innovation introduced by other State Labor governments in Australia in the mid-1980s (Moon & Fletcher, 1988). During the 1986 election campaign, Burke indicated his intention to conduct a review of adolescent health services (Robertson and Smith, 1987) and, following re-election, he established a ten member working party to undertake that task. The Working Party was convened by Suzanne Robertson, a specialist in adolescent health and head of the Youth Health Service in Perth. It consisted of one representative each from the Department of Education, the Department of Community Services, and the Youth Affairs Council of Western Australia²⁰, six people from the Western Australia Department of Health representing the areas of Youth Health, Nursing, Allied Health, Health Promotion, Research and Planning and Psychiatric Services, and a graduate assistant. The Working Party's brief was to undertake a review of adolescent health services so that a statewide planning strategy for services could be developed (WADH, 1987, pp. i–ii).

The time allotted for the review was three months—from the end of May to the end of August. Two graduate assistants were made available by the Western Australia Health

²⁰ The Youth Affairs Council of Western Australia was a non-government organisation established to advocate for the interests of young people and its membership included youth organisations, youth workers and young people.

Department to help with the task (Robertson and Smith, 1987, p. 119). Prompt media coverage informed the public, resulting in one hundred and one public submissions to the Review (WADH, 1987, p. iii), and one hundred and thirty-three consultations were conducted throughout the state in June and July to facilitate more informal discussion with grassroots organisations (WADH, 1987, p. iii; Robertson and Smith, 1987, p. 119). A huge effort must have been required to conduct the review within such a short time.

The Adolescent Health Services Review produced a document called *Future Health* which was given the status of a position paper rather than a report²¹. *Future Health*, like other reports produced in Australia at that time, adopts the WHO definition of health and notes the interaction between physical, psychological and social factors in young people's health (WADH, 1986, p. 2). Perhaps to send a message to those who set up the review, the authors point out that the terms 'youth' or 'young people' are more acceptable than the term 'adolescent' and are therefore used more frequently. While the Review focused on people between the ages of twelve to nineteen years, the position paper indicates a preference for the United Nations age definition of twelve to twenty-four years of age and draws on epidemiological data for twelve to fifteen, sixteen to nineteen, and twenty to twenty-four year olds, 'in order that changes between these groups are appreciated' (WADH, 1987, p. 1).

Young people's participation in the promotion of their own health is advocated and young people are represented on the Adolescent Health Review Working Party via the Youth Affairs Council of Western Australia. Young people's views about health, derived from national and local sources, are referred to, and the results of a pilot study on young people's utilisation of health services and their perceptions of health services and service providers included (WADH, 1987, pp. 3–6). The strategies recommended in *Future Health* emphasise the importance of young people's participation and community development as a means of achieving this:

The community development process is seen as being in itself preventative. It creates involvement and participation, and may go on to useful social policy action. For young people the knowledge that the community believes that they have something to offer in this process is particularly important.

WADH, 1987, p. 94

The position paper endeavours to locate young people's health within a youth empowerment/community development framework which recognises the impact of social

²¹ It has two components—the position paper itself, and the appendices which include the supporting data, the summaries and analysis of submissions to the Review, analysis of consultations, analysis of questionnaires, descriptions of models of services available, and two Australian College of Paediatrics documents on adolescent health—one on curriculum in adolescent medicine, and the other on hospital roles in providing care for adolescents.

and environmental factors on health. While it leans in this direction, the content is not always consistent with these ideas. Not all of the material presented in the paper fits with the philosophical framework the authors adopt, nor is the material drawn through the framework the Review Committee espouses. At times opposing perspectives are presented uncritically, and ideas about 'psychological immunisation' to reduce risk-taking behaviour sit side by side with Franzkowiak's notion of health promotion as social and political action carried out by young people.

There is a sense that the authors endeavoured to draw together all the research, information and ideas in young people's health available at that time. The position paper's bibliography contains over one hundred references from international and Australian sources, including medical, sociological and psychological literatures, reports produced by youth organisations and surveys conducted with young people in Australia. The kind of analytical work required to achieve a synthesis of such a wide range of materials and to come to an agreed position, would have been difficult given the time constraints and the diversity of interests and backgrounds of the committee members.

Alma Ata ideas are evident in the position paper's identification of adequate housing, income, and employment as health issues and the attention given to matters such as the negative portrayal of young people in the media, isolation, high rental costs, inadequate public transport for young people in rural communities and the way community systems and social networks respond to youth in trouble. The wording focuses attention on the way society and social systems create disadvantage and problems for young people generally and for some groups in particular, and highlights the need for systems to change.

Issues for Aboriginal young people and ethnic young people are discussed with reference to submissions received from those communities. Those submissions 'emphasised their needs for employment, accommodation, adequate income, their own (Aboriginal health) workers and for a life free of discrimination. For this group health issues were seen as secondary' (WADH, 1987, p. 22). *Future Health* points out that, if these prerequisites for health were taken care of, some health problems would disappear and Aboriginal young peoples would be able to more effectively address other concerns.

Future Health draws attention to the basic determinants of health in the first instance, before taking up 'special issues' for young people. The 'special issues' are those revealed by Western Australia mortality and morbidity data and, as happened with the Future Directions project in South Australia, a data-based exercise produces a view of young people's health as illness, problem behaviour and death. The issues identified through the data lens are: motor vehicle accidents, including the relationship between alcohol consumption and accidents; substance misuse; sexuality-related problems (identified as

pregnancy and pregnancy outcomes for adolescent mothers, terminations of pregnancy, STDs, HIV/AIDS and sexual abuse); emotional and behavioural problems, including youth suicide and eating disorders; chronic illness and disabling conditions; and dental care. However *Future Health* establishes the social context that gives rise to the data and endeavours to address the issues in a way that gives attention to social and environmental factors.

One example is the discussion of pregnancy in young women. *Future Health* points to the 'increasing evidence that the low birth weight and perinatal mortality associated with teenage pregnancy is related to socio-economic circumstances, poor support and lack of antenatal care, rather than maternal age' (WADH, 1987, p. 37). The recommendations put forward to address this matter focus on the social determinants of health: provision of sexuality education; development and dissemination of information appropriate to young people; collaboration between community nurses, youth workers and street workers in program and service development; provision of short and long-term accommodation and child care facilities to allow single mothers to participate in further education or job training; introduction of a specialised adolescent pregnancy program at the King Edward Memorial Hospital; and participation of Aboriginal communities in addressing the issues of Aboriginal young women:

measures to reduce the number of confinements of young Aboriginal women, and/or to improve their antenatal care, support systems, and socio-economic circumstances are the most important of all. Action on the part of Aboriginal people themselves must be part of such measures.

WADH, 1987, p. 38

Future Health contains sixty-four recommendations to guide the development of a statewide planning strategy for adolescent services. The recommendations are divided into six categories: organisational strategies (10 recommendations); education and training strategies (18 recommendations); access, the single most important need identified in submissions and consultations (12 recommendations); strengthening current services (16 recommendations); research strategies (1 recommendation, with ten areas for research identified); and long-term strategies (7 recommendations). The recommendations are linked to issues raised in submissions to the Review and during consultations and, as the authors point out, many could have been implemented at little additional cost. They are more to do with working differently than creating new services, and improving collaboration across government departments and between government and non-government agencies. Strategies for strengthening existing services and increasing access to services are proposed and education and training in youth health recommended for the media, young people, parents, youth workers, health workers and social services personnel.

One of the recommendations of *Future Health* is the establishment of another working party to review mental health services which suggests three things: the need for designated psychiatric services for young people. (*Future Health* even suggests that some young people may have been inappropriately institutionalised. Although not specifically stated, this might mean that they were dealt with within the criminal justice system); that the short time allotted for the review had not allowed mental health issues to be adequately considered; or that those with responsibility for young people's mental health within the WA Department of Health, did not see their work fitting comfortably within the broad community development framework adopted by the Adolescent Health Services Review and wanted a separate report.

The priorities for funding contained in *Future Health* are modest, given the Review's high profile and statewide brief: within two years, a Directory of Health and Welfare services which would be established and updated yearly (one would think that this was just a matter of the ongoing business of Departments of Health and Community Welfare, rather than an added extra); regional seminars on youth health in conjunction with the relevant departments and agencies (identified as a high priority in submissions to the Review and by those consulted); and, 'as feasible', increased staffing for the Youth Health Service—an additional medical officer and two social workers to do community development work. Within five years, it was recommended the above initiatives would be continued and consideration given to the possibility of establishing two additional social worker positions for country centres. After ten years, it was envisaged, community youth health services would be integrated with Community Health Centres (WADH, 1987, p. 115).

Despite the modesty of these recommendations, funding was not forthcoming and little attention given to *Future Health* in the Western Australia Department of Health. This must have been disappointing for the Adolescent Health Review Committee, those who wrote submissions to the Review and the people who participated in statewide consultations. Even in the Department of Education, where some of the recommendations of *Future Health* were taken up, the position paper seems to have been forgotten by 1989 (AAAH WA response to the Education Department Discussion Paper, February, 1989). Perhaps those advocating for young people's health did not have enough political clout to carry it off. Certainly the short timeline given to the Review suggests a token rather than a concerted effort. However, in 1988 young people's health was once again catapulted to the centre of public and political attention in Western Australia by the issue of youth suicide (Hart, 1989). The State government would set up yet another working party which, it seems, took little interest in the findings of the Adolescent Health Services Review.

The initiatives in Western Australia, South Australia and the ACT show the occasional floating and variable uptake of Alma Ata ideas in young people's health in the mid-1980s. Another step was needed to put social and environmental factors and social justice at the centre of policy and planning for young people's health. That step was taken in Victoria in 1986.

4.5 Social justice principles

And it always bothered me that a lot of people who...were debating and talking about things and proposing services in the youth sector, both in government and outside of government...didn't see things against the backdrop of institutional and structural inequality...If they did, it was sort of thrown around loosely and so I advocated wherever possible that we had to get back to seeing young people weren't just some homogeneous grouping in society and that there were great differences between young people themselves...I mean, I had no time at all for this sort of notion that all young people were disempowered and whatever. That was just a lot of nonsense. I mean, there are groups of young people that will have and will be able to exercise far more power than other groups of young people as they move through life...so we tried to get away from some of that fairly narrow and constricting stuff that went down in the youth affairs sector and then that's what also starts to define your perception on youth health issues. Because, I mean you couldn't possibly for example, single out say Koori health on a whole lot of individualistic topics. I mean young Koori's health status is fundamentally tied back to their position of economic and social inequality.

(YHP6)

The notion that some groups of young people experienced, or were more likely to experience, greater health problems than others, had previously found expression in young people's health in Australia in the guise of vulnerable groups (Bennett, 1984; NSW Dept. of Health, 1983–1984) and 'groups with special needs' (Connelly and Borger, 1985; NSW Dept of Health, 1985; NSW IYY Committee Health subcommittee, 1985; YACSA, 1985). Increasingly, inequalities in health were being linked to social and environmental factors. This focus was sharpened in 1986, when the Youth Policy Development Council adopted a social justice framework for Victoria's youth health policy (YPDC, 1986; Crooks and Webb, 1988).

The Youth Policy Development Council was established by the Cain Labor government as a result of a review of the coordination of state youth policy. The review recommended that alternative paths to policy creation be established with active participation of young people in policy development. To this end, a broad-based Youth Policy Development Council, made up of representation from young people, youth workers, local government, trade unions, representatives of the Minister and significant departments, was established

(Irving et al, 1995, p. 291). The Council was established through the state *Youth Affairs Act* (1986) and charged with the responsibility of coordinating, developing and implementing 'policies across government departments which impact on young people' (Crooks and Webb, 1988, pp. 20–21). This included making sure departments were sensitive to 'the needs, culture, rights and aspirations of young people' (Crooks and Webb, 1988, p. 21). Mary Crooks, whose background was in policy research, was appointed as the Council's first chair and one third of the Council was made up of young people (Irving et al, 1995, p. 291).

The Council began work on a youth health policy in 1986, with the preparation of a discussion paper for consultation purposes. Both the discussion paper and the resulting youth health policy are entitled *Health for Youth*, the same name as Western Sydney's youth health strategy written a year and a half earlier. To avoid confusion the two documents will be referred to as the *Health for Youth* discussion paper and *Health for Youth* (Victoria). The *Health for Youth* discussion paper was released for public comment by the Minister for Health, David White, in September 1986, during Youth Participation Week (YPDC, 1986) and the consultation was carried out from January to May 1987 (YPDC, 1987a, p. 11). Central to the discussion paper is the concept of social justice.

Social justice can be interpreted and understood in different ways (Starr, 1992) and the approach put forward in the *Health for Youth* discussion paper is a socially critical one which requires a redistribution of resources and power. Five principles together make up the framework: equity—'a more equal distribution of resources to and between young people'; social rights—'to promote equal opportunity and affirmative action in government policies and programs concerning young people'; access—'by young people to government agencies and programs'; effective involvement—'of young people in decision-making in relation to the social, economic, cultural and political life of the community'; and coordination—of 'health policies and programmes concerning young people between government departments and public statutory bodies' (YPDC, 1986, pp. 6–7).

After consultation with over 3000 young people and about a thousand others (YPDC, 1987b), the youth health strategy, *Health for Youth* (Victoria), was completed in December 1987 and launched in February, 1988. While *Health for Youth* (Victoria) requires another edit, its social justice framework provides a tool for the analysis of young people's health that shifts attention toward social change strategies more strongly than any previous document. At the same time it contains ideas from earlier adolescent and youth health documents which, while maintaining the connection with the history of ideas that informed developments in the 1980s, are at odds with the new directions *Health for Youth* (Victoria) seeks to establish.

The equity statement, which locates the cause of disadvantage within social structures, is accompanied by the concept of vulnerable groups. The problem-based framework of biological/medical issues, sexuality-related issues, risk-taking behaviour, and psychiatric and emotional problems is also included, but *Health for Youth* (Victoria) draws attention to two limitations of this framework: it does not allow for the broader issues of social, environmental, economic, political and cultural context in which young people live; and some important issues, such as occupational health, do not fit comfortably within it. This raises the question of why it appeared at all. Perhaps it was included because it had appeared so consistently in previous youth health/adolescent health documents and it was seen as premature to abandon it. Maybe it was argued for by constituencies who deemed it important for classification of health problems. The fact that its limitations are pointed out shows that *Health for Youth* (Victoria) was concerned about coherence of ideas—how they fit, or didn't fit, with the rest of the document.

What difference did the adoption of a social justice framework and consultation with over three thousand young people make to the final policy? Firstly the starting point for the policy is the experience of young people themselves and *Health for Youth* (Victoria) achieves this more consistently than other health documents produced in the mid-1980s. Young people's role in shaping the policy is emphasised throughout and particular strategies can often be traced to the regions and the young people who generated them. Further, what young people can offer to health is clearly stated.

Central to the argument for youth participation in service use and development and in their own health care is our assumption that young people's existing power can be built on, tapped, organised and maybe enhanced, especially in their connection to mainstream health processes and resource allocation...

YPDC, 1987b, p. 70

Secondly, *Health for Youth* (Victoria) places social justice, health promoting social change and redistribution of resources to address differentials in health, at centre of its strategy. Its application of social justice and equity to health is derived from three starting assumptions:

unemployment, poverty, poor working conditions, low educational achievement and occupational skill, homelessness, high rates of crime and lack of access to appropriate health care are more likely to be experienced by the most disadvantaged groups in our society;

commitment to equity assumes that whilst benefiting the common good, those young people structurally disadvantaged are most assisted; and there is a need to identify and dismantle barriers, policies and programs which support and buttress structural

inequalities by ignoring differences amongst young people and hence those young people in greatest need.

YPDC, 1987b, p. 67

The emphasis is both on assisting those most disadvantaged *and* benefiting the common good. This is an important point because the concept of social justice, as we shall see later, is sometimes reduced to the notion of providing for those in greatest need only, abandoning broader programs to promote the health and wellbeing of all young people.

Health for Youth (Victoria) calls on governments to allocate resources with social justice criteria in mind (YPDC, 1987, p. 67):

Questions of health, equity and social justice are inseparable from discussion about information policy for young people. In an unequal society, information distribution will also be unequal. Its accessibility and the capacity of people to maximise its value will vary by social group.

YPDC, 1987b, p. 70

The focus on structural rather than individual change is evident in the section on young people and drug use. Comprehensive bans on advertising are suggested to address the inadequacy of the voluntary codes governing advertising of these products and the targeting of young people by alcohol and tobacco interests. The *Victoria Tobacco Act* (1987), which banned tobacco sponsorship of sporting events and placed other limitations on advertising, is applauded. The introduction of alcohol free public events for young people and community education on alcohol and tobacco are recommended. The policy's commitment to political action is shown by its willingness to identify and take on vested interests. In 1988 some AAAH members would discover just how difficult that could be (AAAH Newsletter No 3, 1988, p. 31).

In other areas the recommendations of *Health for Youth* (Victoria) are similar to those of other reports on young people's health produced in the mid-1980s. Its discussion of services highlights the need for bulk-billing, changing hours of service, making Family Planning services more accessible, improving access to condoms and introducing creative ways of establishing effective liaison between young people and health service providers. A medico-legal study to clarify the legal position regarding young people and health professionals is recommended and, with regard to young people with chronic illness, attention is drawn to the need for better coordination between the Health Department and peak bodies concerned with chronic illness, better coordination of services and the continuation and expansion of adolescent wards in hospitals.

Once again the case is made for more accessible community-based mental health services for young people and greater collaboration between mental health workers and youth workers. Here *Health for Youth* (Victoria) diverges from earlier documents by distinguishing between the:

...small percentage of young people who experience severe mental health problems and the much broader group of the youth population which experience far less serious mental health concerns...there is a distinct gap in services for young people who require support and counselling on more common issues of depression and family conflict.

We would argue therefore that there is an important need for generalist health services which are locally based to provide a counselling role for young people...There are some training implications. Health and youth workers need to establish a demystified and appropriate level of understanding about mental health.

YPDC, 1987b, pp. 75-76

The need for school health education is reiterated and the Education Department called upon to ensure that all students have the opportunity to receive a comprehensive health education:

Parental veto notwithstanding, the consultation confirmed in the strongest possible way the need for health education in schools. We see it also as crucial that these programs have the capacity to reach young people at an early age and with material relevant to particular stages of growth and development.

YPDC, 1987b, p. 78

Curriculum support at central and regional level, support for parent involvement in health education, training of teachers in comprehensive health education, and a program that includes reproductive health issues relevant to young people are recommended (YPDC, 1987b, p. 79).

Coordination strategies include the establishment of a government committee on youth health with a clear cross-portfolio brief, showing the recognition that some of the most powerful influences on young people's health, such as housing, racism, unemployment and income support, could only be addressed through a cross-portfolio approach. A policy unit within the Health Department of Victoria, to maintain a youth health profile in that Department and working links between the Health Department and key youth organisations is called for along with a greater role for local government in young people's health.

In conclusion *Health for Youth* (Victoria) acknowledges:

...that the possibility of realising such outcomes in youth health rests with many more variables than any of the strategies developed here. The concept of youth health reaches into the very essence of wiser debates about the nature of health care in our society; health behaviour and the prospects of preventive self care and the complex links between personal health and the social/physical environment.

YPDC, 1987b, p. 87

Victoria's Minister for Health, David White, launched *Health for Youth* (Victoria) on 18 February, 1988. In his speech the Minister commended the policy, stating that it laid the foundation for future health policies and programs, especially those concerned with young people. He draws attention to the youth health promotion initiatives already under way in his Department such as, Rage Without Alcohol Campaign²², the introduction of the new tobacco legislation and establishment of the Victoria Health Promotion Foundation out of revenue from the tobacco levy. In response to *Health for Youth* (Victoria), the Minister announced that his government would introduce a youth health telephone information service, review the role of specialised youth health services and consider the expansion of youth workers at community health centres and adolescent services. The *Streetwise* comic on HIV/AIDS would be reprinted in Victoria and, in conjunction with the Family Planning Association, information on teenage pregnancy, contraception and sexuality would be produced (White, D., 1988, Speaking notes, Launch of the *Health for Youth*, 18 February).

It is worth noting at this point that some young people who participated in the consultation were sceptical about its value:

One of the first responses we met in starting out on the consultation—especially from young people themselves—was a belief and maybe even a fear, that nothing would happen as a result of their input.

YPDC, 1987b, p. 87

The authors of the report speak directly to these young people, assuring them that their views and concerns shaped the direction of the policies and strategies. While this can be clearly seen throughout *Health for Youth* (Victoria), the fate of the document itself showed that, sadly, their scepticism was well founded. While some of the initiatives announced by the Minister did proceed, the full implementation of the policy and strategy did not.

The Youth Policy Development Council was dependent on the Division of Youth Affairs, located in the Department of Labour, for staff and resources, but had no control over the

²² A series of alcohol free events, sponsorship and community grants for young people to develop their own entertainment locally (Garrard, 1989; Mellor, 1998).

direction of the Division (Irving et al, 1995). One account indicates that policy work was not given high priority in the Department of Labour.

Crooks viewed the Department of Labour as a very masculine environment, emanating from its industrial relations, regulatory and inspectoral roles. It was a culture in which Bentley (the Director General) and Steve Crabb, the Minister, felt comfortable. Policy was considered 'soft', and less important than measures such as program budgeting and performance indicators, which were seen as more than means to ends. Bentley chastised his senior managers at a staff conference for wasting time on policy. Crooks challenged him, arguing that policy should be seen as a clearly articulated framework within which problems could be identified, issues understood and a strategy for achieving outcomes developed: that is, a disciplined systematic way of achieving goals.

The Department of Labour culture and the Director's and Minister's priorities prevailed over the YDPC. Youth activity was seen narrowly, in the context of the labour market, and the YPDC's attempt to extend this through an adolescent health policy was not funded.

Irving et al, 1995, p. 292

Crooks' contract was not renewed when her term ended, despite the fact that she had strong community support, and in 1987 the Council was almost entirely reconstituted with only a part-time chair (Irving et al, 1995, p. 292).

The failure to implement *Health for Youth* (Victoria) and *Future Health* and the difficulties encountered by the Focal Team in South Australia, reveal that planning for young people's health at state level was sporadic, with brief periods of activity, followed by lack of action. Most of the initiatives discussed in this chapter are characterised by much effort from those working in young people's health to garner the best advice the literature could provide, consult with community agencies and young people, to little effect. Hopes were raised but not met.

Despite lack of action on the part of state governments, the documents generated by those initiatives show the development of the sector since the establishment of AAAH by a group consisting primarily of medical practitioners in 1978. The composition of the committees set up to undertake policy development and planning in 1986, show that young people's health was now viewed as a multidisciplinary and intersectoral endeavour and in some cases, one in which young people should have a voice and a role. The social and environmental factors affecting the health of young people and differentials in health within the youth population were beginning to receive policy attention. Victoria had provided a framework which made social justice and social change central to planning for

young people's health and a model for policy development in consultation with young people (Crooks and Webb, 1988).

Lack of acceptable and accessible health services continued to be an issue, but here too there was change. The services proposed in the reports produced in the ACT, WA and Victoria reflect the ideas set out in the Declaration of Alma Ata. They are concerned with social and environmental factors in young people's health, involve young people in their development and collaborate across sectors to ensure services are accessible, community-based and address the whole person, within their social context. This kind of thinking suggests a broader view of the notion of service than the term generally connotes. The term 'service' often suggests a 'doing to' or a 'doing for', with young people as the object of the doing, but most of the initiatives discussed in this chapter emphasise 'doing with' young people.

The way the term 'service' is interpreted in a document locates its philosophical orientation. If 'service' refers to a place concerned with treatment only, then 'service' implies an illness or medical model. If the term 'service' refers to a place where treatment is provided with attention to the way health problems are created in, and exacerbated by, the circumstances in which young people live, and strategies are put into place to address those circumstances and the social determinants of health in partnership with young people, then it might be argued that 'service' is conceptually located within a public health/social health framework.

4.6 Education and training: *I sort of wonder if they missed out on a few things...*

The need for pre-service education in young people's health for medical students and practitioners was one of the issues that led to the establishment of the Australian Association for Adolescent Health in 1978 and it continued to be a concern throughout the eighties (Williams, 1978a; Australia College of Paediatrics, 1980; CDH, 1981; NHMRC, 1980, 1983, 1984; Bennett, 1984; Connelly and Borger, 1985; Burkinshaw, 1986; SAHCd, 1986; WADH, 1987; YPDC, 1987). By the mid-1980s there was no coordinated approach across Australia. In 1987 the National Council of AAAH decided to bring this matter to the attention of the Inquiry into Medical Education and the Medical Workforce (AAAH Newsletter No. 31, 1987). AAAH and the Adolescent Health Care Committee of the College of Paediatrics prepared a conjoint submission to the Inquiry, which asserted that young people's health was not being adequately addressed in medical education, as the tone of the following extract suggests:

The present emphasis in medical curricula, on hospital care, intensive care and relatively uncommon conditions, results in few medical students, and especially few medical graduates, seeing adolescent health issues as important. Teaching opportunities are missed, as the contingencies of hospital employment, staff shortages and economic constraints frequently meant that little time can be spent learning the skills of communicating with adolescents. In addition, organ and disease speciality orientation, or paediatric or adult physician specialisation, may mean that an assessment of the whole adolescent is not undertaken. Enquiry as to adolescent sexual activity is especially likely to be omitted in these situations. Few have the skill to undertake a gynaecological examination with the skill and sensitivity required.

AAAH/ACP, 1987, p. 1

The submission summarises the education and training recommendations of earlier Australian reports on young people's health and outlines specific issues not well addressed by doctors, such as suicide, sexually-related problems and chronic disease in adolescents. A three level curriculum structure, developed by the Australian College of Paediatrics, drawing on the work of the Society of Adolescent Medicine in the USA, is proposed (AAAH/ACP, 1987, Attachments 2 and 3). The authors of the submission argue that medical graduates have a role to play in developing and supporting community activities, assisting young people to participate in addressing their own health, and in health programs and planning (AAAH/ ACP, 1987, p. 2). The role envisaged for medical practitioners here goes beyond a clinical one. The submission had little impact²³.

The need for medical education was highlighted in Western Sydney's *Health for Youth* Strategy. Pointing to the 'significant social and environmental tensions' of Western Sydney, caused by size, diversity, rapid growth, lack of services and limited employment opportunities (Connelly and Borger, 1985, p. 5), Connelly and Borger note that:

The life experience of medical personnel is often very different to that of the people they are treating. For example relatively few people from Western Sydney become doctors when compared with other areas of Sydney. It is important that medical students have a range of experience including involvement with youth workers and young people.

Connelly and Borger, 1985, p. 34

A similar concern is expressed by the ACT Workers with Youth Network (Burkinshaw, 1986). Burkinshaw argues that young people should play a role in the education of medical practitioners, a view supported by a former member of the *Side Effects* Youth Health Drama Project which operated in Sydney's Inner West for two years during the mid-1980s.

²³ As with a number of issues that had little support within the medical profession at large or among clinical educators, there was little response to the AAAH/ACP submission and no sharp analysis or precise recommendations for change in medical education.

I think if anyone out there from the health department is listening they really should consider this, not only in a community environment but within the medical profession training...we did one off, or maybe two off, seminars with doctors, where they studied adolescent health for one day of their seven years or whatever, and, if we think about it, doctors go from high school, so how old would that make them, seventeen or eighteen, they study for about seven years, so then they are twenty -six when they graduate from doctor's school. So I mean they sort of spent all that adolescent time in a pretty hard slog, university is pretty hard work no matter what background they're from, it's hard work, and I sort of wonder if they missed out on a few things

(SE2)

Medical education was not the only education matter that received attention in the mid-1980s. Submissions to the Adolescent Health Services Review in Western Australia identified training of health workers and workers with youth as a matter 'of vital concern' (WADH, 1987, p. 99)²⁴. *Health for Youth* (Victoria) refers to the need for youth worker education in mental health (YPDC, 1987) and Western Sydney's *Health for Youth* gave priority to continuous training for health workers, recommending that training be coordinated by the Health Department in collaboration with the Department of Youth and Community Services and local government. It further recommended that health and youth workers receive their training together and that the Western Metropolitan Health Region produce a youth health training manual for distribution to youth workers and health care workers (Connelly and Borger, 1985, p. 35). In relation to the latter, Connelly and Borger suggest that the training focus for youth workers be on skills in referring young people to relevant health agencies (where they existed) and increasing their knowledge about health problems:

A considerable amount of information and advice about health issues is provided outside the health system. However, workers in other systems have often expressed the view that they lack confidence in providing health advice, especially when undertaking tasks for which they are not adequately equipped or supported. While workers in other systems should not be expected to take on explicit health care roles (eg. medical advice, counselling of young people with defined psychological problems), they have a major role in the early identification of health problems, referral of young people to appropriate services, provision of basic information on health issues and translation of health messages to young people in appropriate settings and via relevant methods.

Connelly and Borger, 1985, p. 35

²⁴ 46% of submissions to the review specified education as a strategy and 33% recommended training (Western Australia Department of Health, 1987, p. 97).

Ideas about who should receive education and training had expanded by the mid-1980s. Recognition that young people's health required intersectoral collaboration meant that education and training would need to occur outside the health sector, for groups whose work might have an impact on young people's health. In addition to doctors, other health professionals, youth workers and sometimes young people, education of teachers, parents and the media was recommended in reports on young people's health (Connelly and Borger, 1985; WADH, 1987).

In Western Australia the *Future Health* position paper took up the issue of media education, drawing attention to four things: the 'unduly negative' portrayal of youth in the media, with its emphasis on drug abuse, suicide and alienated youth; the absence of balance in presentation of youth issues and the absence of constructive proposals to address youth health issues; violence in the media; and advertising of alcohol and cigarettes. The positive role that the media could potentially play in youth health promotion, in particular in promoting responsible sexual behaviour and use of contraceptives, are noted (WADH, 1987, p. 102). The increasing recognition of the importance of schools in health promotion, prevention of drug related problems and the transmission of HIV/AIDS (Blewett, 1988; NCADA, 1987; CDH, 1989) put teacher education squarely on the health agenda (WADH, 1987; YPDC, 1987).

A range of agencies endeavoured to meet the education and training needs identified in reports on young people's health. Training for teachers in sexuality and drug education was provided by some state education departments and agencies such as the Family Planning Association and state alcohol and other drug authorities. AAAH's education efforts revolved around the publication of its quarterly newsletter, occasional reports and the organisation of state and national seminars and conferences. The AAAH newsletter published a review of literature on young people's health until December, 1984, when the editor, Murray Williams, decided to separate the newsletter and the bibliography. Williams continued to make the bibliography available to members who indicated that they wanted it after 1984, but at less frequent intervals (Newsletter No. 20, December, 1984). Sometimes important articles and papers were re-published in the AAAH Newsletter in full. These varied from very technical papers on treatment options for specific adolescent health problems, to papers that addressed social and political matters, such as the Gillick case in the UK. Even though attempts to address education and training needs were made, successive reports in young people's health pointed to the need for better coordination of these initiatives in Australia.

4.7 Health promoting schools

Many of the initiatives described in this chapter saw school health education as central to young people's health. In the early and mid 1980s, much school health education was based on lifestyle theory with its behaviour change goals (Banfield, 1993; Rowling, 1994; Colquhoun et al, 1997, pp. 5–11). Colquhoun and colleagues describe three models or approaches to health education over time. The first is the traditional approach which, broadly speaking, seeks to improve health by producing changes in health-related behaviour. The second, the self-empowerment model, is based on the assumption that:

...the ability of individuals to control their health is seen as a product of the differential processes of socialisation which occur across social groupings. It is contested that these processes produce personality deficits within lower socioeconomic and minority groups. These deficits are constituted in terms of low levels of self-esteem, an external locus of personality control and states of learned helplessness which are deemed to be self-perpetuating in the context of a culture of poverty...this health education model accounts for the existing inequalities in health status between social groups as a product of different processes of socialisation. 'Life skilling' is constituted as the key educative strategy...

Colquhoun et al, 1997, p. 7

The third model, the radical or collective action model, seeks to move away from the 'victim-blaming'²⁵ inherent in traditional and self-empowerment approaches, and engage in socio-cultural change strategies through collective action for health (Colquhoun et al, 1997, p. 8).

The rationale behind this approach is that health is primarily shaped by factors outside the control of individual citizens. These structural factors produce patterns of disadvantage within society which correlate with poor health. The political decision making processes which influence economics, working and living environments, service provision and social relations and, in turn, health are the focus for the interventions based on this model. Critical consciousness raising is the educational process involved in radical/critical health education.

Colquhoun et al, 1997, p. 8

Empowerment is a key concept of this model too, but in this instance the term refers to a process through which groups work together to achieve health promoting change.

Colquhoun and colleagues suggest that these three approaches need not be seen in opposition, and all can make claims to achievements for public health. Baum makes a

²⁵ The notion of 'victim blaming' was put forward by Ryan (1976).

similar point, arguing that the Ottawa Charter provided a framework in which lifestyle and social change approaches could coexist (Baum, 1998). While Baum sees this as a positive development, the dominance of the individualistic model, to the detriment and marginalisation of more radical approaches, is still a concern (Colquhoun et al, 1997). Further, radical language at times is used to mask what are essentially individual change approaches.

Of the three approaches outlined by Colquhoun and colleagues, the radical or collective action model is the most compatible with Alm Ata ideas. These ideas were expressed in the late 1980s in the notion of the health promoting school, which endeavoured to draw attention to the way a whole school community might establish conditions conducive to good health. The development of this concept internationally and in Australia, and its application in school health education, has been the task of the 1990s, but the work of the 1980s laid some of the ground and established a climate in which such ideas could grow. However the adoption of new ideas does not automatically lead to a change in practice and it can be the case that the old ideas are run through new models with little real change.

4.8 Summary

Issues raised in the reports discussed in this chapter persisted as concerns for young people and those who worked with them. While the fate of the documents discussed attests to the difficulty of establishing and maintaining young people's health in public health policy and planning, the ideas generated through the consultation processes, and the networks those processes created, continued to be active long after the ink had dried on the letter advising that youth health policy was not a priority. Those ideas had their own life in the practice of young people's health in hospitals, in the community and in schools. Chapter 5 looks at the way the notion of young people's participation found expression in arts projects introduced in the mid-1980s to give young people a voice in health and as a vehicle through which they could provide health information to their peers.

CHAPTER 5

DEAR *BEATBOX*...THANK GOODNESS YOU EXIST...I DON'T FEEL ALONE ANY MORE

5.1 Introduction

Chapter 4 described the rise and fall of state planning initiatives and young people's participation in policy development in Victoria. Chapter 5 examines the way young people's work in arts projects opened up new possibilities for providing health information and enlivened the look and feel of hospitals. The 4th International Symposium on Adolescent Health held in Sydney in 1987 provided a forum for those projects and a snapshot of Australian achievements in young people's health to March 1987.

5.2 To bring arts and the community into the approach to health is to take a holistic view to health at last (Hastings-Smith, 1988)

Hastings-Smith is an artist and film maker who worked with the Youth Arts Program at the Children's Hospital in Camperdown during 1987-88. Her statement raises the question of whether the holism so often claimed in young people's health is broad enough to encompass the community and the arts. In fact, there was a deal of exploration of what the arts might offer to young people's health in the eighties. Multi-service youth health centres such as Second Story and The Warehouse introduced arts programs in response to the expressed interests and needs of young people (Second Story, 1986a; 1986b; The Warehouse, 1986; Peppard et al, 1988). Programs such as art, dance and drama provided a vehicle for young people's ideas and cultures and sent the message that they had moved in and occupied the space (Denshire, 1996). The need for relevant and accessible health information, highlighted by young people in health consultations (YACA, 1983; Burnie, 1985; BHC, 1986), led youth and health workers and others to investigate the arts as a medium for providing such information (Adolescent Medical Unit, 1984; Borthwick, 1988; Collinge, 1988). International projects also had an impact. The establishment of the Youth Arts Program and the *Side Effects* Youth Health Drama Project at the Adolescent Medical Unit (AMU) in New South Wales, was a direct result of contact with similar projects operating in Sweden and Mexico (Denshire, 1984; Adolescent Medical Unit, 1984).

The possibilities of the arts for young people's health and the difficulties of fitting the arts into health are examined through four projects: the *Streetwise Comics* project, the *Beatbox* television show, the *Side Effects* Youth Health Drama Project and the Youth Arts Program.

Together they show how young people's participation through the arts changes the look and feel of health information and health settings²⁶.

The *Streetwize Comics* project uses a comic format to reach young people between thirteen and twenty years of age. Information about the law, health, welfare and other social issues is conveyed through the stories the comics tell. *Streetwize* was the brainchild of Marrickville and Redfern Legal Centres in New South Wales and began as the Kid's Legal Comics Project (Borthwick, 1988). Initial funding for wages came from the Commonwealth Government's Community Employment Program (CEP), and printing costs were met by the Law Foundation (Borthwick, 1988, p. 105). Young people act as consultants to the project and their personal experiences, languages and cultural forms provide the basis of the comics. Information is given within the context of situations the readers actually encounter, making it relevant, applicable and accessible.

Evaluations showed that young people liked the comics 'for being, in order, educational (and not book or teacher-based), realistic, humorous, and for having good stories' (Borthwick, 1988, p. 106). Borthwick argues from her experience in illustrating school textbooks, that textbook style format does not reach young people.

...our appeal goes beyond format to our whole approach. What appeals to young people may offend adults, but it is based on working closely with young people so that the comics reflect their perspectives, realities and values.

Borthwick, 1988, p. 106

Borthwick's description of the development of *Streetwize Comic No. 7* on sexually transmitted diseases (STDs), shows how the process works and the kinds of information that becomes available to health promotion efforts when young people act as advisers and consultants. The *Streetwize* research team selected the Hunter Valley for its research for the STD comic. They began by approaching groups of young people and asking them to talk about themselves. Through this process they learned that Newcastle had three kinds of young people: Weeds, who wore bright colours and carried surfboards, and went to school; Westies, who wore black T-shirts, rode motor bikes and hung around; and Trendies, fags and rejects, who looked like the *Streetwize* research team! (Borthwick, 1988, p. 106).

Concern about HIV/AIDS was often expressed, but the young people the research team spoke to held the view that the virus was only contracted by gay people. It thus became clear that the comic would need to provide information about STDs and HIV/AIDS, in a

²⁶ The following discussion of the *Streetwize* project and the *Beatbox* television program, draws on the edited version of papers published in the proceedings of the Fourth International Symposium on Adolescent Health held in Sydney in 1987, *New Universals, Adolescent Health in a Time of Change* (Bennett and Williams ed, 1988).

story about characters who were entirely heterosexual. This would give the message that HIV was not limited to the gay community and was spread through unsafe practices such as needle sharing, which was commonplace in the region through tattooing (Borthwick, 1988, p. 106).

The process used by *Streetwize* provides a model of youth participation and enfranchisement that many health programs were trying to achieve and it eventually went national, receiving Commonwealth Department of Health funding in 1987 to produce a comic on HIV/AIDS. Even though Neal Blewett, then Commonwealth Minister for Health, commended the comics (Blewett, 1988, p. 22), when the CEP program ended *Streetwize* was forced to make do on short term grants (Borthwick, 1988, p. 106). This shows the difficulty of maintaining such projects even when their value has been demonstrated. In spite of these difficulties *Streetwize* survived and continues to operate, a testimony to the value of the concept and the determination of the many people who have worked to keep it alive over seventeen years. Two of my key informants recalled *Streetwize* as an important development of the decade (M2; YHP 15):

I think Streetwize was one of the most important influences in accessing, with health information, the kids who don't go to school and don't sort of come into traditional health care.

(M2)

Like *Streetwize Comics*, the television program *Beatbox* was initially funded through the CEP. Begun in 1985, *Beatbox* was produced by and for young people and, while not specifically a health project, it became another medium for health information. Fifteen young people in collaboration with a small production unit from the national public broadcaster, the ABC, produced the show. The young people, who had been unemployed prior to the project, were from Sydney's western suburbs (Collinge, 1988). The program was a response to some of the perceived inadequacies of routine television treatment of youth issues.

When it comes to news it's unfortunate but true that often youth issues are aired only when there's a problem involved. So we get TV specials on, say, teenage alcoholism, unemployment or youth violence. Now these specials or documentaries are sometimes informative, and do try to seek the opinions of young people themselves, but they tend very often to be either sensational or patronising...and they nearly all end up with adults on the screen telling young people what the problem is...what they should think...and what they should do!

Collinge in Bennett and Williams, 1988, p. 110

The producers set out to look at topics that were:

more or less taboo: unspeakable. The sorts of things that adults get embarrassed about, or consider to be obscene in some way, were what we chose. We did this not to be sensational, but because we believe it is precisely these topics that young people want to talk about, because they are interested or confused or they don't have enough information about them.

Collinge, 1988, p. 110

Beatbox was aimed at 15 to 24 year olds, although mail from viewers suggested an audience in the age range of 10 to 30 (Collinge, 1988). The material was 'gathered from the streets' and the program featured topics such as drugs, sexual responsibility and contraception, smoking, masturbation, AIDS, menstruation, suicide, love bites, being gay and tattoos, and offered a forum through which young people could give their views (Collinge, 1988, p. 110—111). *Beatbox* was filmed in the suburbs, rather than the city, and ordinary young people were the stars, rather than TV personalities. Contemporary rock music was combined with social issues. Solutions were not offered—the viewers were left to make up their own minds' (Collinge, 1988, p. 111).

The response was positive. A former member of the *Side Effects* Youth Health Drama Project recalled that many of the young people who attended their performances in Sydney's inner west, watched *Beatbox*. The fact that health issues were addressed by *Beatbox* opened the way for *Side Effects* to take them up in theatre workshops. Letters to *Beatbox* indicate that young people liked the program and that it reached its intended audience.

Dear *Beatbox*...Thank goodness you exist...I don't feel alone any more.

Collinge, 1988, p. 111

After the first twenty-six week series, when the CEP money ran out, the ABC indicated that it was planning to cancel the program. In response to letters and phone calls requesting its return, ABC management reinstated the program. As CEP funding was no longer available, only three young people were re-appointed to work on the program, this time through ABC monies (Collinge, 1988, p. 111).

5.3 *We're here so we can learn to speak to social workers in language they can understand...*

In contrast to *Streetwise* and *Beatbox*, the *Side Effects* Youth Health Drama Project and the Youth Arts Program were located within a hospital, at the Adolescent Medical Unit of the Royal Alexandra Hospital for Children in Camperdown, New South Wales. *Side*

Effects was a community outreach project whereas the Youth Arts Program operated within the hospital, which provided its material and at times, its inspiration. The following discussion of the *Side Effects* project is based on the submission that attracted Commonwealth Health Promotion Program funding²⁷, project publicity materials and separate interviews I conducted with two former members of the group in Sydney in January, 1994. Interview questions were linked to the objectives of the project as outlined in the submission. Respondents were invited to add any comments they wanted to make about the project. They are designated in the text as 'SE1' and 'SE2'.

The *Side Effects* Youth Health Drama Project, or the *Youth Life Project* as it was called in the submission that attracted Commonwealth funding, aimed to provide health information to young people who lived in Area 2 of the Southern Metropolitan Health Region of Sydney. Area 2 included most of Sydney's Inner West, which was described in an unpublished Health Commission report in 1981 as a high risk area for diseases related to psychosocial and environmental stresses (Adolescent Medical Unit, 1984). Unemployment among young people was high, particularly in the suburb of Marrickville, and eight out of the twelve high schools in the area received Disadvantaged Schools Program funding from the Commonwealth Department of Education. (Adolescent Medical Unit, 1984).

Although the AMU provided the physical location and home for the project, performances were to be presented in the community, at Community Youth Support Scheme (CYSS) projects, youth centres, refuges and schools. The project was based on community development and empowerment ideas and the IYY themes of participation and development (Adolescent Medical Unit, 1984). It was also influenced by the work of the CORA theatre project in Mexico (Monroy de Velasco, 1988), and by Australian evidence that showed that most young people receive their information, including health information, from their friends (Youth Bureau, 1979).

The project would take place over a one year period. In the first six months the group would meet twice a week and participate in health education on matters they had identified as important and relevant, and training in performance skills. They would then develop a drama presentation on health issues which would be presented to schools, youth centres, refuges and community groups in the last six months of the project. This was an ambitious schedule, as one of the participants (SE1) interviewed pointed out. Initially ten young people participated, recruited through advertisements and contacts with local youth

²⁷ I was the primary author of the submission for funding for the *Youth Life Project*, which became the *Side Effects* youth health drama project. The project submission was written in 1984. Funding for the project was sought for 1985, International Youth Year, through the Commonwealth Health Promotion Program. The AMU staff and community health workers from Glebe, Newtown and Redfern Community Health Centres contributed ideas and constructive criticism. The implementation of the project was undertaken by the coordinator, Donna Confetti, with support from the AMU and community health workers in Area 2. I was part of the management team for the project during its first eight months of operation.

projects. A weekly honorarium of thirty dollars was paid to each participant in recognition of their efforts and to cover their expenses. They attended workshops on health issues conducted by AMU staff and Area 2 community health workers, and theatre skills workshops, led by the project coordinator, Donna Confetti, who had received her theatre training in London, Amsterdam and Berlin.

Once established, the group changed its name from the *Youth Life Project* to the *Side Effects*, which members felt was more fun, and a good name for a youth health drama project. The performance developed was called *Raging Fever*. It was a twenty minute trigger performance which raised issues and presented information. Similar to *Streetwise Comics*, information was presented within the context of situations young people experience. The performance was presented at local youth centres, refuges and schools, followed by a discussion.

My interviews with two former members of *Side Effects* provide an insight into the way two young people experienced a project designed to increase their health knowledge, empower²⁸ them and the young people for whom they performed, provide health information and increase access to health services for their counterparts in Area 2.

When asked whether their own knowledge of health issues, programs and services had increased as a result of their involvement in the project, and, if so, whether this knowledge had been passed on to their own friendship networks and to the young people who attended performances and workshops, both indicated that it had—‘to this day I am a fountain of gynae knowledge’ (SE1). At a time when the community, health professionals and young people were coming to terms with HIV/AIDS—what it was and what it meant—they incorporated the available information into their performances.

We used to talk about HIV, and thinking back, there was not a lot of people talking about that in 85–86. We were quite interested in it as a group, and learned quite a bit about it and put that stuff into context in our performances...In 1985–86 they'd just got rid of the 4 H's—homosexuals, haemophiliacs, Haitians and maybe homeless, the American high risk groups, so they'd only just turned it from 'the gay plague'—those headlines were still on. I don't think we saw it as a specifically gay thing then. I don't think we talked about it that way.

(SE1)

²⁸ The terms empower and empowerment have different interpretations. Wallerstein and Bernstein (1988, 1994) have written on the notion of empowerment in health, focusing on empowerment as collective action for social change. While the term empowerment may suggest a uni-directional process in which one person or group ‘empowers’ or ‘donates’ power to another, the intention, although not always the reality, of the *Side Effects* project, was a mutual exchange and power-sharing between young people and health professionals.

Both believed that the project had increased the access of individual *Side Effects* members to health services—‘Greer (one of the young women in the group) got David (Bennett) to pierce her nose’ (SE1). They could not say, in the absence of any specific evidence, whether the young people who participated in their workshops increased their use of the AMU or community health services as a result, but indicated that the young people who had attended asked lots of questions and were given the information they requested.

In their view the project had achieved its aim of reaching groups of young people who might not have been reached by mainstream health information.

Yes, definitely. The chances of anyone of that age group, no matter what background, even if they are Anglo, of going in and grabbing pamphlets is zilch as far as I'm concerned. Even today. Maybe it has changed a bit. Even myself at that age. I just feel that pamphlets, they are there, they are accessible, but you never grab them, you don't want to be seen grabbing them. It's daggy. I feel through the project...they were given the opportunity at least...at Marrickville, some of them grabbed them, some of them didn't. But generally they were involved, they had an opinion and their opinions sometimes changed or at least were thought about and discussed.

(SE2)

We certainly reached them in terms of doing stuff with them...People seemed to ask questions which was showing that they were paying really sharp attention and really liked talking about stuff that seemed quite relevant.

(SE1)

It wasn't a super health push (at Marrickville). We mainly left it at the drama thing, but because these shows, Beatbox, were on at the time you could set up situations with television interviewing and because Beatbox was vox popping on health issues, you could put that in. It was something that was on television at the time anyway and it didn't seem like you were heavying anyone to do health.

(SE2)

One of the objectives of the *Side Effects* project was to empower members of the group and those who attended their workshops. The two former members interviewed indicated it had been an empowering experience for them—sometimes. They qualified their statements in the following ways:

When we were taken seriously and invited to do things and just left to do it and not watched over as if we were going to say something offensive, and when people actually invited us to do things, that was quite empowering...like going to conferences,

or talking to medical students at New South Uni as part of their community health lecture...

(SE1)

I think it was very empowering that I got asked to do a lot of things that I wouldn't have otherwise done and got treated quite seriously by the people there (at the AMU).

(SE1)

Well it's one of those ideas that's underrated, the whole idea of social and individual empowerment. I think it's an incredibly slow process, especially when you look at a global scale...But I think for me, growing up as a really skinny male at school, and having all those images bob up in front of me, the Coca Cola man, the Solo man, I didn't recognise it at the time as being really disturbing and unfair, but in hindsight I do. I was incredibly uptight about that...I guess it (the Side Effects project) empowered me because it was something I was able to tackle head on and go straight to the (young) people that the (advertising) was aimed at and say look what's happening to you guys, and, I fell for that stuff too..

(SE2)

When asked if they thought the work of *Side Effects* had been empowering for the young people who attended performances and workshops, they made a number of points. The media analysis workshops might have been empowering because participants took part in activities which would have enabled them to see through the images presented by advertising. Those who attended workshops seemed to engage well with those issues, particularly in Marrickville, where participants were primarily young men:

...there were certain members of the group who were fairly quiet, were not dominant or the most popular people, and as soon as they got up, people would cheer them because they were really funny. As far as self-esteem goes, forgetting the whole environment of youth health, just on a personal level, some people were able to grow or were seen in a different light in the group's eyes. And all of a sudden the person who was not considered funny, not humorous...not a whole lot of fun to be around with, suddenly became the star of Tuesday night.

(SE2)

I think it was good when we weren't being hung over by teachers. There were a few places, one in particular which is closed now. The headmaster didn't want us there and thought that we were going to say something offensive. And we just had really mild, less than Benny Hill, innuendo in our show, and he thought it was disgusting. The teachers hovered like vultures in the workshops in case we had a swear word in it or something. It was a lot of pressure. We were not claiming to be other than what we were I don't think. So that's the kind of atmosphere where I don't know what people got out of it, us or them...But the stuff where people could really talk or where they

came back over a couple of sessions, I think was good, because they could see people the same age as themselves, or younger or just slightly older, not behaving professionally but still being given respect by the adults in the situation...

(SE1)

When asked whether they believed the *Side Effects* project had met its objective of increasing health professionals' 'awareness of the concerns and needs of local young people and access to youth networks' (Adolescent Medical Unit, 1984), one expressed the view that the project had done more work with health professionals than with young people! This was because they were based at the Adolescent Medical Unit and had ongoing contact with health professionals who worked or attended meetings there.

Looking back we actually did a lot more with health professionals than we actually did with young people, a lot more...We would do the show and workshops and have them talk about being teenagers rather than being the doctor, and role-play...and having us just there mucking around and giving them quite a hard time when they would all start moaning in the stretch classes. Toby'd go 'Oh you know Martha Graham's 90 and she's still dancing in New York', like you can't just cry old...

(SE1)

Positive aspects of the project in the view of these two participants were the training in health and drama they received, the opportunities the project opened for them and the fact that their work was valued by AMU and health professionals. One indicated that the honorarium to cover expenses and in recognition of their effort was important—'We always felt our contribution was very important. The thirty dollars a week was acknowledging that—and the fact that people bought us lunch' (SE1). The other thought they should have received more. They had worked very hard and he/she felt that thirty dollars a week was not commensurate with their efforts. (SE2)

There were other criticisms and recommendations for future projects. One was to do with the tension between their role as young people who had received some training to communicate health information to their peers, and the expectation of some community members that they were professional health educators. For example, one respondent recalled an instance when *Side Effects* performers were not able to answer detailed questions about Sexually Transmitted Infections (STDs). They resolved this by organising, through the contacts of the AMU, a talk on STDs for the group who had asked the questions and themselves. They had also been concerned that, if a young person presented a serious emotional problem during a workshop they wouldn't have known what to do because they were not trained counsellors. Although this did not occur, it was still a worry for them. Further, they were not professional actors and the pressure to come up with a show to meet the conditions of the project funding was difficult—'I think the pressure on

having the actual show and the workshops together in a very short space of time was maybe too close'. (SE1)

Despite the above concerns, they believed the idea of a youth health drama project was a good one and that their participation had positive outcomes for them personally. One stated that the environment provided by the project enabled them to learn, be challenged and grow (SE2). They had a number of suggestions for youth health drama projects that might be introduced in the future. They felt that there should be a number of groups, not just one, and the young people involved should have the choice about whether it becomes a professional show or whether it remained as a series of health drama workshops. They believed it was important that young people's work be acknowledged through some form of remuneration, that training be provided and that projects be ongoing, so that the experience gained could be built upon. They suggested the timeline for the project be flexible and that it continue over a longer period of time. A similar project, based at The Warehouse youth health centre in Penrith, was given as a positive example:

I know that the people at Penrith...get a lot out of it. They have a peer education thing there. They were the 'Westies Against Homophobia' in the Mardi Gras parade one year. And the girls I talked to were very smart, and very cluey...they obviously feel they have a lot of background but that wouldn't have happened in six months...it needs to be longer term with support so you can build it up.

(SE1)

As to what not to do, one commented on a project in which young people's ideas and experiences were used to develop a performance and young people participated as actors, but received no money in recognition of their efforts and no training. This was considered unfair and a poor way for such projects to operate.

The *Side Effects* project was funded for 1985 only, but it extended into 1986 through a reduction in the size of the group and pockets of funding found by AMU. As well as performing for young people in Area 2, *Side Effects* contributed to education programs for medical students, conducted workshops at the national AAAH conference held in Adelaide in 1985 and the 4th International Symposium for Adolescent Health in 1987. One of my key informants recalled that '*Side Effects* youth health drama project, under the direction of Donna Confetti, had a big impact and a big message'. (M10)

5.4 Art injection

In contrast to the community emphasis of *Side Effects*, the focus for the Youth Arts Program was the hospital. It was initiated in 1984 by Sally Denshire, an occupational

therapist with AMU. Occupational therapy, among the 'professions ancillary to medicine', probably has the longest and strongest record of responsiveness to the context of the client and of innovative problem-solving. The Youth Arts Program is an example of that. It continued into the 1990s through efforts of Denshire, the artists employed to conduct the programs and the support of AMU.

We got into that by not having access to a ward for young people, so we accessed them by inviting them to come to group programs. And, increasingly, that became an opportunity for activities, and then the use of the creative arts media became integral to that process. As a result of seeing that as a successful model for dealing with chronically ill kids, we were then able to institutionalise this idea with Cell Block (Youth Health Centre). That was the first full-time artist employed in the health system for young people at risk. There have been others since of course, with High Street (Youth Health Centre). This has been really exciting, because that's I think of enduring value, and one of the things we've discovered about dealing with these dreadful problems in the 1990s...

(M2)

The Youth Arts Program was not art therapy, although arts projects may have had therapeutic outcomes for participants, but art in the broadest sense. It was designed to engage young people:

... around a more complete sense of a person, rather than just a patient with troubles or illnesses...It gives kids a sense of their own self-worth, through looking at their talents and abilities, and not just seeing them as 'poor kids in need of help'. So it is very much an empowering thing...but you need to have a mentality that allows you to see the young person, not as a recipient, but as an active participant in their own care.

(M2)

The diversity of the Youth Arts Program and the range and scope of the projects is impressive from 1984 to 1992 (Denshire, 1993, 1994, 1996). They include *The Great Escape* (a super 8 video); *Telling Tales* (a slide tape sequence); *The Ward Game* (a giant board game); *Art Injection I*, (a sculpture made from re-cycled hospital equipment); and *Art Injection II*, (an environmental transformation of the Adolescent Ward and garden) (Denshire, 1994, 1996). *Great Escape 2*, a super 8 film made by young people for public screening in 1986, was regarded by some as instrumental in the opening of the adolescent ward at the Children's Hospital in 1987, after several years of lobbying unsuccessfully for its establishment (Denshire, 1994, p. 6; 1996, p. 96).

What such projects might mean to a young person in hospital is illustrated by the following quotation from a participant in *Art Injection II*:

Boring old black wall, looking at that all the time sends your mind go crazy. Just a white ward and curtains, brown curtains. I think that make you sick, just waking up and looking at that all the time. A soon as Art Injection came around, that all changed, like they were painting all the walls and all the things.

Denshire, 1996, p. 96

Denshire argues that:

involvement in creative occupation offered these young people (those who participated in arts projects) a place within the culture of the hospital as well as in the world outside. Acting on the environment like this seems to develop a sense of identity and a shared awareness of youth culture to counteract what Clarke refers to as hospital shock. Hospital shock can be understood as a kind of culture shock where the sense of personal space, and the presence of familiar ritual and everyday objects are disrupted by the unfamiliar culture of hospital life.

Denshire, 1996, p. 96

Denshire highlights both the benefits and the difficulties that may beset arts programs based in a hospital setting. She describes ongoing debates in relation to 'funding, industrial issues and the institutionalised context of youth arts in hospitals' (Denshire, 1993, pp. 22–23). The 'Casemix—Procedure Identifier' below was developed by Denshire in collaboration with community artists, Buckland and Robinson, and is proposed as a way of recording and reporting on arts activities in an attempt to resolve reporting problems.

Casemix-Procedure Identifier (Tick all procedures performed)

- Assessment/Reassessment
- Coordination/Consultation
- Direct resourcing/Skills exchange
 - Visual arts
 - Performing arts
 - Multi-media
 - Music
- Advocacy/Relational work
- Education/Vocational Training
- Events (exhibition/performance)
- Community cultural development
- Referral to other arts workers
- Unclassified procedure

Denshire, 1993, p. 21

The 'Casemix—Procedure Identifier' attempts to make visible to the hospital administration what an artist-in-residence actually does—a lot! It also provides an example of how the 'work of art' might need to conform to 'hospital/health speak' to be understood in language that the hospital/health setting is familiar with (Denshire, 1993).

A related issue is the valuing, or failure to value, personnel working in a non-medical mode within a health system. Denshire points out that artists working in health settings have a right to permanent employment, like any other staff member, and need to be paid according to their own awards rather than equivalent pay scales (Denshire, 1993, p. 22). She argues that hospital human resources personnel need to seek advice from relevant organisations on this matter. The difficulties Second Story experienced in establishing suitable awards for rap dancing and drama instructors within the South Australian Health Commission, is a case in point. The experience of The Warehouse provides another example of lack of recognition of the contribution the arts can make in young people's health. The initial staffing plan did not envisage employment of an artist until consultations with community groups suggested it:

It was pointed out (through discussions with local workers) there was a need for the centre from the beginning to plan its program in an innovative way. A suggestion was made to incorporate art-type activities as a high priority in terms of outreach education....Again this necessitates re-thinking about staff budget and possible re-allocation of some monies for art consultancy, since most health trained professionals lack expertise in this area.

The Warehouse, 1986, p. 2

Arts activities in health raise the notion of 'fitting in'. Problems of 'fitting in' emerge regularly in young people's health. Young people fall uncomfortably between child and adult systems and are not well recognised in either. They do not fit into health data collection systems because, within these systems, health tends to be conceived narrowly, as illness. Preferred ways of working with young people—spending time, listening to them—whether in an individual consultation or in a group program, may not fit with Medicare or health department funding structures. Reporting mechanisms which record only individual patient contact for funding purposes, do not recognise the richness and diversity of practice in young people's health. These matters presented problems for the youth health centres introduced in the mid-eighties, as they had been for community health in general. The Community Health Accreditation and Standards Program (Australian Community Health Association, 1991) was developed partly to respond to this issue, to reveal the texture and diversity of work in community health.

Youth arts programs provide another example of 'innovative' programs being perceived as short term and dispensable:

...it was disappointing to learn that there were no possibilities to continue with funding from that source (Commonwealth National Health Promotion Program). *Side Effects* was a talented and articulate group of young people who were successfully tackling a long standing neglect of youth participation and consultation in their own health care. The response the project received defied the possibility of the project remaining a token gesture for IYY, propped up by one-off dead end funding principles. There was no doubt that *Side Effects* were effective ambassadors for youth health issues.

Confetti, c. 1986–7, p. 9

Short-term grants for innovative projects are the rule...consequently it is a political reality that influential individuals and organisations are needed to support this work. The involvement and backing of medical, corporate and arts bodies, in collaboration with occupational therapy, can enable youth arts in hospital to achieve social legitimacy in the context of comprehensive provision of adolescent health services. However, the cultivation of this influential backing, in addition to upholding youth participation principles, which require the youth arts team to be accessible and receptive to the needs of young people in hospital, can be problematic. Balancing the conflicting demands of media coverage, visiting celebrities, submission writing and fundraising with everyday service provision is an art in itself!

Denshire, 1993, p. 22

Why is it common to regard arts as 'nice', but not really a serious contributor to health care through self development? Most of it is left to be paid for by donations. Lack of funding commonly prevents the expansion of existing services. Yet the benefits are clear.

Hastings-Smith, 1988, p. 95

Cultural and clinical approaches in combination *can* enhance the healthy development of young people. Their co-existence and complementary richness within an institution can improve the hospital environment and benefit the diverse community that is *hospital*.

Denshire, 1993, p. 24 (emphasis in original)

The arts projects initiated in and for young people's health in Australia in the mid-1980s differed with regard to their purpose and the audience they aimed to reach, but collectively they endeavoured to do the following things: give young people greater visibility and a voice in institutional and community settings (Collinge, 1988; Hastings-Smith, 1988; Denshire, 1994, 1996); provide a vehicle through which young people could design and present health information to their peers (Confetti, 1987; Collinge, 1988; Borthwick, 1988; Manning, 1987); increase community awareness of young people's health concerns (Collinge, 1988); and advocate for institutional change (Denshire, 1994, 1996).

Through their participation in arts projects, young people interrupted and challenged taken for granted notions about themselves, their experiences, their health and what hospitals are about. A former member of the *Side Effects* Youth Health Drama Project recalled:

...that joke we had, 'we're here so we can learn to speak to social workers in language they can understand'.

(SE1)

A lot of people have said that they liked it, but I don't think some of them liked us, sort of rampaging around making noise. I can understand that, in the work setting (the Adolescent Medical Unit), but at the same time, I think it was probably a good thing to have people like us in their working life, because everyone they would see that was our age would be there with a problem, and we were not there with a problem. We were just there.

(SE1)

5.5 4th International Symposium on Adolescent Health

The decision to hold the 4th International Symposium on Adolescent Health in Sydney, Australia, was announced in 1983, indicating that Australia had enough influence internationally, to be accorded the honour. The organisers decided to change the title of the event from 'adolescent medicine' to 'adolescent health'²⁹.

The sheer scope...justifies the broadening from *medicine* to *health*, for many of these *new morbidities*, have social and environmental causes to which responses must be energetic and creative if they are to be addressed.

Bennett and Williams, 1988, p. vii (emphasis in the original)

Two of my key informants identified the Symposium as an important event of the decade (M2; YHP16) and one felt that it had provided an opportunity to celebrate achievements in young people's health in Australia (YHP15). The Symposium may have been seen as a celebration of achievements for two reasons. First of all, the speech of Neal Blewett, then Commonwealth Minister for Health, at the opening of the Symposium, showed a greater recognition of young people's health than had been the case previously. Secondly, the Australian papers presented at the Symposium were characterised by attention to the social issues and underlying factors in young people's health and by a diversity and creativity that suggested a vibrant and active sector. The report of the proceedings, *New Universals*:

²⁹ The previous three symposia had been titled 'adolescent medicine'.

Adolescent Health in a Time of Change (Bennett and Williams (eds) 1988)³⁰, gives an indication of the flavour of the Symposium, the issues addressed and the ideas underpinning international and Australian efforts at that time.

The paper Neal Blewett delivered at the Symposium is notably different from the one he presented at the national AAAH conference in Adelaide, less than a year and a half earlier. His Symposium paper suggests that rather than being a little known entity, adolescent/youth health is important. He announced that approaches to health in Australia were being 'radically transformed' and young people would 'benefit greatly' (Blewett, 1988, p. 20). The transformation described by the Minister, refers to a shift from a notion of health as 'treatment of sick bodies only', towards a social view of health.

When health was about treating illness, life divided neatly into discreet boxes...Unemployment, housing and transport didn't intrude on the health ministry then. They do now...health promotion people must now do more than purvey information about health risks, and that they need to address the problem of establishing supportive environments.

Blewett, 1988, p. 21

The Minister's speech suggests that he or his advisers had been influenced by the ideas set out in the WHO's Ottawa Charter for Health Promotion, which might be described as the theoretical heir of Health for All. The Ottawa Charter was written in October 1986 and heralded internationally the move to a new model for health promotion, characterised by the creation of healthy public policy, community development, intersectoral collaboration and re-orientation of health services (Wass, 1998; Baum, 1998). The Minister's reference to his Department's funding for the 2nd International Health Promotion Conference, to be held in Adelaide in 1988, suggests that he and his advisers had been briefed on the developments that the Ottawa Charter represented.

It is abundantly clear that the health sector alone, as presently constituted, is quite unable to resolve the health problems young people experience. (The) World Health Organization and our own Better Health Commission, and youth at the latter's workshops, all agree on this. Major impacts on youth health come from lack of employment, housing problems, dealing with institutions like the legal system and education system. None of these is under the formal aegis of the Departments of Health.

Blewett, 1988, p. 22

³⁰ The editors adopted a paper format for the proceedings, and, while the tone, coverage and principle referencing of the speakers was preserved, funding constraints required the contributions to be edited to two thousand words (Bennett and Williams, 1988, p. vii), so in some cases, the exact words of the author were modified in the editing process to fit into the shorter format.

Blewett describes the Government's financial incentives for young people to stay in school, and the assistance offered for housing homeless young people under 18, as health services. His paper gives an indication of the importance he placed on HIV/AIDS prevention, highlighting the key role of schools in sexuality education, the need to increase condom availability and promote condom use to young people and to ensure that young people have relevant and accessible information about HIV/AIDS. To that end the Minister announced his Department's intention to fund a *Streetwise* comic on HIV/AIDS for national distribution.

Blewett's closing comments emphasised health promotion and identified 'adolescents themselves' and 'policy makers and administrators in other sectors' as the two targets for health promotion (Blewett, 1988, p. 23). The Minister's speech was encouraging, even suggesting that the health of young people might at last receive concerted attention in the Commonwealth Department of Health.

The theme of the Symposium, the impact of rapid social change on young people's health, was taken up in papers presented at the opening ceremony and the first plenary (Fourth International Symposium on Adolescent Health Programs and Abstracts, 1987). In the same way that health is often construed as illness, social change often appears in adolescent health literature as a threat, almost as an illness. The speakers who presented at the opening ceremony held differing views. Australian media guru Phillip Adams makes the poetic but despairing statement that:

As the tempo of the times increases, as evidenced by our video games and computer programs, and by the hyperbolic bombardment of the sound and fury of news masquerading as information, we have created a generation of kids whose alleged street wisdom is a veneer over an aching void of vulnerability. Never have young people been told so much, and never have they known so little.

Adams, 1988, p. 3

MacIntyre, a researcher with the Medical Research Council's Medical Sociology Unit in Glasgow, Scotland, followed Adams in the program, and presents a more positive perspective. She challenges 'this gloomy perspective' suggesting that 'few changes are in themselves wholly good or wholly bad for health' (Macintyre, 1988, p. 4). She argues that, while urbanisation and immigration are often said to have bad effects, people continue to move to cities and more developed countries because they see the benefits in a higher material standard of living, new educational and employment opportunities and access to better health services. Citing statistical evidence from the UK, she points out that many indices of health improve when people come to live in cities and in more developed countries, and that lamentations about erosion of 'traditional family values', ignore

increasing freedom of women and young people from oppressive family structures. With regard to media, she argues that:

We talk about exposure to new ideas and cultural beliefs encountered through travel and the media, as if young people will become confused and culture shocked; but are there not benefits to be derived from new ideas and from pluralism, such as decreases in ethnocentrism and xenophobia?

Macintyre, 1988, p. 6

MacIntyre acknowledges that factors such as unemployment, migration, urbanisation, civil war, political oppression, famine, threat of nuclear war, and changes in sexual mores and family structures, do have real impacts on young people's health but she suggests that it is important to recognise that some change has been beneficial. She points out that today's young people should live longer, with less disease and have higher standards of living, that women and minority groups should be treated more equally, and that leisure and control of family size, is now greater (Macintyre, 1988, p. 6).

Naidu, a social scientist who at that time was working with the Unit for Child and Youth research at the Tata Institute in Mumbai, supports MacIntyre's position. She points out that most empirical evidence deals with the negative aspects, such as confusion over values, identity crisis, conflict between generations, alienation, youth unrest and drug addiction (Naidu, 1988, p. 31—32). In contrast, her work with young people in India reveals the benefits of social change, including increased aspirations and mobility, increased participation, a more secular and egalitarian outlook and scientific attitude and industriousness (Naidu, 1988, p. 32).

Peter Franzkowiak, who had been a member of the 1984 WHO Study Group on Young People and Health for All, closed the first plenary by challenging the audience. His paper, *Life in the Fast Lane*, reframes the notion of young people's 'risk-taking', so beloved of the literature in adolescent health. He argues that 'engaging in risk taking practices serves important functions in growing up', and that 'participants regularly associate it with reasonable benefits for themselves' (Franzkowiak 1988, p. 44). Criticising the deterrence-oriented approach of much health education, Franzkowiak argues that instant condemnation and deterrence are of little value in health promotion with young people.

Adolescents, claiming reasonably that risk-taking has benefits for them, are critical of professional prevention. Moreover they revile the adults' double standards, which condone risk-taking for themselves, and which shrug off, as irrelevant to individualised risks, the environmental threats, which adolescents believe to be of tremendous ecological significance.

Franzkowiak, 1988, p. 44

Franzkowiak's suggestions for the way forward are similar to those outlined in the Ottawa Charter—health advocacy and mediating between different interests in society to promote health. Franzkowiak emphasises the importance of young people's participation, citing the 1986 WHO report to which he had contributed in support of this idea (Franzkowiak, 1988, p. 45). Although the term is not used, some of his ideas suggest the concept of 'harm minimisation', which informed the health promotion work of Australia's National Drug Strategy from the 1980s (Hawks and Lenton, 1995). One of my key informants recalled Franzkowiak's reframing of the notion of risk-taking at the Symposium as important in his/her thinking on young people's health (YHP16).

Two papers offer an insight into Australia's response to the HIV/AIDS epidemic and the issues that had to be confronted to prevent transmission of the HIV/AIDS virus among young people. Niland and Lowe, from the Anti-discrimination Board, point to matters to do with human rights, psychosocial attitudes to sexuality and drug use, legal issues and political concerns such as minority rights, that must be taken into account in HIV/AIDS prevention (Niland and Lowe, 1988, p. 23). They describe Australia's policy response up to March 1987 as 'uneven'. On the positive side, they point to education programs for homosexual men on safer sex practices, clean needle programs and funding of the various AIDS organisations (mainly gay) to carry out support, counselling and education (Niland and Lowe, 1988, p. 25). In contrast, they note the failure of the New South Wales Department of Education to provide a policy response to HIV/AIDS, despite the urgency of the situation and parental support for HIV/AIDS education in schools. Further, that Department had banned *Streetwise Comics*, eliminating a potential source of information for young people.

McLaws and Cooper, from the NHMRC AIDS Unit, focus on another aspect of HIV/AIDS—the fact that different groups of young people will experience the epidemic in different ways. They identify homelessness as one factor that puts young people at greater risk of contracting the virus.

WHO reported that IVDUs (intravenous drug users) with HIV/AIDS were significantly younger than non-IVDUs. Homeless female and male adolescents who are IVDUs, may turn to prostitution to support themselves and their habit, which would increase their risk of contracting HIV. Our mobile service (Outreach Bus) in inner Sydney, found that six percent of 200 homeless adolescents tested positive for HIV antibodies.

McLaws and Cooper, 1988, p. 115

Like Niland and Lowe, McLaws and Cooper emphasise the importance of community and school-based education, in particular education about safe sex practices and how to reduce

risk during drug-taking. They conclude by highlighting the needs of homeless young people, intravenous drug users and the situations in which some young people live.

Intravenous drug use and prostitution by adolescents are...infrequent risk taking activities, which education about risks of infection is unlikely to curb. Adolescents following these practices as established lifestyle should be certainly targeted with education programs, but changes in their lifestyles will need more street care and rehabilitation unit.

McLaws and Cooper, 1988, p. 116

The Symposium program shows the range of issues addressed by Australian presenters. They include: the health of Aboriginal young people; young gay men; young women; sexual health of young women in detention centres; young people with cancer; refugee young people; and young migrants (Fourth International Symposium on Adolescent Health, Program and Abstracts, 1987). The fact that only one paper on the health of Aboriginal and Torres Strait Islander young people appears in the program is surprising and suggests that the organisers had poor links to Aboriginal and Torres Strait Islander organisations and communities, or that the Symposium had not been well promoted with those groups.

In contrast, three Australian presentations dealt with the health of migrant and refugee young people (Bashir and Schwarz, 1987, 1988; Eisenbach, 1987; Wald, 1987). This focus reflected the arrival in Australia of increasing numbers of young people from southeast Asia who had fled repressive regimes and left families behind in uncertain and dangerous situations in the late 1970s and early 1980s. A survey conducted by Rivendel Adolescent Unit in Concord, New South Wales, revealed some of the problems—psychological concerns around identity, self-esteem and peer acceptance, compounded by loss and clash of cultural values, major depressive disorder, post-traumatic stress syndrome, including survivor guilt, psychosomatic disturbances and perceptual disturbances (Bashir and Schwarz, 1988, pp. 36–37).

A growing number of young people needed help, but many families did not understand the function of health and welfare services in Australia, having only used extended family and local community arrangements in their country of origin. They were often reluctant to seek help for emotional problems in particular, so western-style services were inappropriate. Health workers, on the other hand, were aware of their own lack of familiarity with cultural issues and endeavoured to overcome these barriers by establishing a mutual exchange within the Sydney Indo-Chinese Youth support group (Bashir and Schwarz, 1988).

The strategy Rivendel adopted for working with refugee young people was to conduct residential holiday camps. Boys and girls aged five to nineteen years, of Vietnamese, Kampuchean, Laotian and Burmese background, attended. Good relationships were emphasised and cooperation between workers from different cultures served as a model for young people. In some instances, the workers from those communities themselves began to deal with some of their own feelings of loss, grief and depression. The fact that the workers themselves 'were able to recount their own sufferings, and to mobilise grief at long last' (Bashir & Schwarz, 1988, p. 37), illustrates the benefits of a holistic approach to a community as opposed to a more narrow individual targeting. Within this broad framework, it was also possible to meet the specific needs of individual young people. Those requiring individual attention were identified during the camps and plans were put into place for follow up and support (Bashir and Schwarz, 1988, p. 37-38).

This project is of interest for five reasons: it is a model of a mental health program developed in a way that is sensitive to the values and cultures of the young people it wanted to reach; it utilises the expertise and knowledge of young people and their communities; it provides the programs through a medium (youth camps) acceptable to those young people and their communities; it aims to develop cultural sensitivity among health workers; and it establishes a network of health and welfare resources directed towards the needs of refugee young people. This model could be used more broadly in mental health promotion and mental health service provision with young people and becomes particularly important in light of concerns raised by my key informants, and in reports on young people's health, about the need for a community-based and health promotion emphasis in young people's mental health.

Another theme of the Symposium which resonated with Alma Ata ideas was young people's participation. This was reflected in the Symposium structure and program. A youth health festival, *Korobra*, was conducted concurrently with the Symposium and the welcome to the Symposium was done jointly by David Bennett, the Symposium convenor, and Cathy Stonestreet, convenor of *Korobra* Youth Health Festival. This gave symbolic recognition, at least, to young people's presence. One day of the Symposium was designated for feedback and interaction between *Korobra* and Symposium participants. This was described as 'a direct voice to youth' (Fourth International Symposium on Adolescent Health, 1987). And finally, the concept of youth participation was addressed in a number of Symposium papers (Borthwick, 1988 Carr-Gregg, 1987; Collinge, 1988; Monroy de Velasco, 1988; Peppard et al, 1988; Stonestreet, 1987), some of which were presented collaboratively by young people and health/youth workers (Carr-Greg, 1987; Confetti and the *Side Effects*, 1987; Peppard et al, 1988). One paper entitled 'On the receiving End' was presented by a member of the *Side Effects*, Cathy Albury (Fourth

International Symposium on Adolescent Health, 1987). It was one of the few papers that attracted media attention.

Korobra was attended by ninety young people from twelve to twenty-three years of age. Most were Australian but there were young people from Bangladesh, Indonesia, New Zealand, the USA and Zimbabwe. The majority of overseas participants were sponsored by the Australian Development Assistance Bureau. Australian participants were either sponsored privately, usually by parents, or by agencies such as the Community Youth Support Scheme (CYSS), the Red Cross, ACROD (Australian Council for Rehabilitation of the Disabled), AAAH and Marrickville Youth Resource Centre (Casey, 1988, p. 122). *Korobra* aimed to ensure that young people had a presence throughout the Symposium, that their views would be heard and skills recognised alongside of those of professionals and that, through their participation, professionals' awareness and knowledge of the health needs of young people would increase (Casey, 1988, p. 121).

The daily evaluations written by *Korobra* participants were mainly positive, and in their view the best outcome of *Korobra* was the opportunity to make new friends. While the day designated by the Symposium for communication between young people and professionals did allow young people to open dialogue, and did bring 'some health professionals to realise that young people wanted a say in their own health care', there was scepticism about whether action would emerge from the dialogue (Casey, 1988, p. 122).

As one of my key informants stated:

Korobra Youth Health Festival was a parallel event with the Fourth International Symposium on Adolescent Health...and I think it was symptomatic of the high ideals but the horrible realities of trying to marry two groups that had such unequal power bases, but we just refused to see this and we just kept on going...and OK the two events did occur in the same city over the same time frame...and I gather it was very challenging to amalgamate a group of highly paid professionals and a group of young people from all over the world—but we tried and I guess that's something. That we did try to do it and it meant that the attempts that are being made in the nineties are of a much better quality because of the stumbling around we did in 1987.

(M10)

The organisation of a concurrent youth health festival and the allocation of a segment of the Symposium for young people to present their work, suggests that, in principle at least, young people's contribution was beginning to 'be accorded new value' (Bennett and Williams, 1988, p. vii), and that professional dominance had stepped back to allow the voices of young people to be heard. Young people's participation has been maintained in

subsequent international symposia on adolescent health³¹ and the International Association for Adolescent Health, established at the Symposium, intended to 'actively pursue the participation by youth in the development of its structure and programmes' (Williams, 1988, p. 124).

The final plenary of the Symposium featured papers on WHO initiatives (Friedman, 1988) and international trends in adolescent health (Blum, 1988b). These papers re-emphasised the Symposium themes of young people's participation and the importance of social and environmental factors in young people's health. Blum asserts that the 'health problems and concerns of young people are deeply rooted in the social, political and economic realities within which they live' and describes unemployment and underemployment as 'the most pressing health problems today' (Blum, 1988b, p. 70).

Health problems constitute complex issues which are unlikely to have simple solutions. It is not feasible in most societies to revert to the old ways in values and social structures. Broad intersectoral approaches on a collaborative basis with young people themselves are needed.

Blum, 1988b, p. 71

The final plenary of the Symposium also saw the establishment of the International Association for Adolescent Health (Williams, 1988). The announcement was made by Murray Williams, who had been instrumental in setting up AAAH in Australia nine years earlier. Fifteen countries participated in discussions to establish the International Association and Williams would chair the committee that would guide the Association's efforts in its inaugural year. This meant that Williams' considerable energy would now be directed towards the international forum, but his contribution to the Australian Association was acknowledged in a tribute written by David Bennett entitled *Our Man in Canberra*, and published in the AAAH Newsletter (AAAH Newsletter No. 34, 1987).

The mood of the Symposium was positive. There was a sense that young people's health was beginning to achieve recognition in Australia and was poised to move into an accelerated development phase. The Minister's speech indicated that the Commonwealth Department of Health was about to take up the notion of health promotion as put forward in the Ottawa Charter, with attention to the impact of social and environmental factors in health, and collaboration across portfolios and sectors, to address young people's health. However, another paper presented at the Symposium seemed to point in a different

³¹ Three hundred young people from Canada participated in the 6th International Symposium on Adolescent Health held in Vancouver in 1995 but only seven young people attended from the United States, despite that country's proximity to Canada (Pers. com. Pamela Murray, 1997). This suggests that the matter has not been given great importance in the United States. Pamela Murray, Head of Adolescent Health Services at the Pittsburgh Children's Hospital, organised funding for two young people from her service to attend. She told me that she probably would not even have considered involving young people had she not worked in adolescent health in Australia during the 1980s.

direction. The paper was written by Stephen Leeder, an academic in Public Health at the University of Sydney, and since Leeder would chair Australia's Health Targets and Implementation (Health for All) Committee, it is worthy of attention.

Blewett's and Leeder's papers make an interesting comparison in light of developments in the Commonwealth government and Department of Health at that time. Stephanie Short, an academic who has written extensively about public health policy in Australia, describes a heyday of a reform-oriented Labor government which occurred in Australia between 1983–1987, when 'progressive public servants were able to develop significant policy innovations, in the name of making public services more accessible and responsive to the needs of individuals in the community' (Short, 1998, p. 142). Short argues that after 1987 this changed and 'there was increasing emphasis on managerial control and accountability' (Short, 1998, p. 142). Financial constraint became more important in the public policy environment as the new public sector management dominated policy decision-making and ushered in an era in which agencies were required to 'manage for results' (Short, 1998, p. 124). Citing Howe, Short notes that following 1987, 'the real power in government was with the Expenditure Review Committee, and the emphasis in social policy shifted from the notion of 'social wage' to 'social justice' (Short, 1998, footnote 4, p. 236). The way the concept of social justice was interpreted for this exercise is discussed in Chapter 6 of this thesis.

Short also draws attention to conflicting models of community participation, distinguishing between a model of community participation and activism adopted by the community health movement, and the notion of consultation in which the government endeavours to find out the views of 'consumers' of services (Short, 1998, p. 132). She points out that:

The distinction between these two types of community participation is evident...in the use of the economic term 'consumer' rather than the social term 'community group' or the more classical referent, 'citizen'.

Short, 1998, p. 133

Further, Short observes that, while reformist health minister Neal Blewett believed in 'strengthening the community constituency for reform in health care' the new managerialism saw decreasing support for community activism in the health policy process (Short, 1998, p. 142). It is interesting, therefore, to see these two kinds of approaches represented at the 1987 Symposium. At the same moment in which Blewett emphasises, even celebrates, the coming of the new public health ideas set out in the Ottawa Charter, and health promotion as an intersectoral, interdepartmental endeavour focused on social change, Leeder foreshadows the coming of the new managerialism described by Short and

others, and an era in which fiscal policy dominates Commonwealth government decision-making.

Leeder identifies five trends that would shape hospital-based services in Australia in the future: effectiveness and equity; cost containment; organisation by area; prevention and health promotion; and attention to the needs of minority groups (Leeder, 1988, pp. 79-81). The juxtaposition of equity with effectiveness and cost containment talk, raises the question about how these two fit together. For example, the kinds of strategies and resource allocation required to achieve equity in health may be at odds with cost containment requirements. The Government would resolve this conflict by shifting its emphasis in social policy from the more universalist notion of 'social wage' to a narrow definition of 'social justice' (Short, footnote 4, p. 236), one which emphasised a residual targeted approach which addressed issues for the most needy only (Maas, 1990), but Leeder does not take up this question in his paper.

Instead he identifies an 'urgent need for instruments which will allow policy makers to compare outcomes knowing their relative costs' (Leeder, 1988, p. 80). He acknowledges the difficulties of determining service and program outcomes and cost effectiveness, but emphasises their importance. The way 'effectiveness' will be interpreted, the kind of evidence required to demonstrate effectiveness and whose evidence will be admissible, is also unclear, but this is perhaps Leeder's point. These things are still to be established. Leeder acknowledges the uneven distribution of health care in Australia, the lack of quantitative data about this and describes the 'reduced access to health services and lower quality of life of less privileged people' as an ethical problem for service providers (Leeder, 1988, p. 80). He suggests that little action can be taken until the relationship between socioeconomic class and health is better understood.

In contrast to Blewett, Leeder does not emphasise a broad notion of health and interdepartmental and intersectoral collaboration to create health. He notes the importance of health promotion, but does not indicate which view of health promotion informs his thinking. The emphasis on cost containment looms large and the audience is reminded that the spending of health dollars is partly a product of political pressures, 'a compromise between conflicting interests' (Leeder, 1988, p. 81). He advises those advocating for services for young people, to engage with the current planning context and demonstrate the effectiveness of their programs.

5.6 Summary

The 'outbreak' of young people's voices through arts projects in the mid-1980s shows the value of their participation and the insights they bring to the health project. In a relatively new sector like adolescent/youth health there is a need for creativity, flexibility and opportunities to trial and evaluate new models, programs and strategies. Leeder's warnings about the increasing pressures on the health dollar and the need to work politically and in competition with other groups to gain resources, suggests that the way forward for young people's health could be difficult. In a time of government cost containment, funding of the known and safe is more likely. Some of the ideas put forward by Leeder—the need for health promotion, health education and information provision and attention to equity issues—were already recurring themes in young people's health in Australia. However, while there had been some encouraging developments, health programs and services for young people were not widespread in Australia in the mid-1980s. Centres like Second Story and The Warehouse were relative fringe dwellers on the health scene, still struggling to find their feet. Hospital-based services and programs for young people, while relatively more secure, were still the exception rather than the rule. Leeder's presentation was in contrast to the optimistic mood of the Symposium, but was perhaps a harbinger of difficult times ahead. The Symposium, while seen as a celebration by some, may have marked the end of the 'short boom' instigated by IYY and the beginning of the 'very long bust', which was how one of my key informants summed up the impact of IYY. (YA1)

CHAPTER 6 ...NOT MUCH OF A PROMISE AT ALL

6.1 Introduction

For a lot of young people the promise of the 80s was not really much of a promise at all. I mean there were problems to do with unemployment, there were problems to do with fears of getting a disease (HIV) or something happening to you. There were issues of youth suicide lurking around and somehow there seemed to be a segment of the population being left behind, only getting pushed to the front when there was basically a problem that could be pedalled, and in our case it was drugs, and to some extent AIDS, so the only associations with youth tended to be fairly negative ones...

(YHP7)

By the end of the 1980s, in the absence of national and state youth health policy and a framework to provide direction and to coordinate efforts, work in young people's health became fragmented. Funding followed specific health problems and the sector assumed shape around those problems. HIV/AIDS, drug use, and homelessness dominated the agenda among increasing concerns about the rise in youth suicide. This chapter examines developments of the late-1980s against the background of Commonwealth youth policy efforts and Australia's Health for All Strategy. The way HIV/AIDS, drug use, homelessness and the health of homeless young people were understood and the strategies put in place to address these issues are examined.

6.2 Youth policy and social justice

Actual (youth) policy development in Australia can be understood in four phases. The first began in the early 1970s, and was concerned with modes of adjustment to continuing high levels of unemployment; this was a period of transition in youth policy. The second had its origins in the mid-seventies, and was related to a discussion of youth policy which would provide a youth guarantee, a concept imported from overseas. The third phase was related to the focus of youth as Priority One during the early part of the Hawke Labor government. Here youth policy was clearly turned into a policy of education and training. The final phase of policy development occurred in the wake of International Youth Year. By contrast to the 'universalist' approach of the late 1970s and early 1980s, which supposedly would focus on all, youth policy was now related more clearly to 'disadvantaged' or 'marginalised' youth.

Irving et al, 1995, p. 235

During the 1980s the youth policy effort of the Hawke Labor Government focused on education and training as the solution to youth unemployment but the growth in the youth

labour market turned out to be in part-time work and low-skilled jobs (Sweet, 1988), so in retrospect this approach was short sighted. More education did not necessarily equate to more jobs for young people (Bessant, 1993). In 1989 the Human Rights and Equal Opportunity Commission (HREOC) released *Our Homeless Children*, the report of its inquiry into homelessness among children and young people. The report, often called the Burdekin report after Brian Burdekin, the high profile HREOC Commissioner who headed the inquiry, drew public attention to inadequacies in Commonwealth government youth policy in areas of income support, support for families, accommodation and health services (HREOC, 1989; Irving et al, 1995). The government responded by introducing the Youth Social Justice Strategy in its 1989–90 budget. The names of three government ministers are on the Social Justice Strategy budget statement circulated for community consumption: Brian Howe MP, Minister assisting the Prime Minister on Social Justice; Peter Duncan MP, Minister for Unemployment and Education Services; and Peter Staples MP, Minister for Housing and Aged Care.

The Strategy maintained the emphasis on education, training and employment, but added 'measures to ensure that those missing out would have better access to these opportunities' (Howe et al, 1989, p. 4). More than half of its expenditure was directed 'specifically at homeless young people and those at risk of becoming homeless' (Howe et al, 1989, p. 6), suggesting that the government wanted to address, or be seen to be addressing, the issues raised by the HREOC report. The needs of 'particularly disadvantaged young people' would be met through income support and better access to secure accommodation and health services. The 'respective roles of government, young people and their families and local communities' would be taken into account in resolving those problems (Howe et al, 1989, p. 4).

The invocation of the role of the family here may be telling. Critics of Labor's youth policy performance in the 1980s argue that, despite all the social justice talk, the government was reluctant to take on the issue of income support for young people and shifted responsibility for them back to the family (Maas, 1990; Hartley, 1990; Bessant, 1993). Frank Maas, then a researcher with the Australian Institute for Family Studies, argues that:

Over the years, the authorities responsible in these areas have sought that level of responsibility (for income support for young people) they could minimally assume and no more. This is most clearly the case between the state government departments and the Commonwealth, but since the middle of the decade Commonwealth policy makers have also sought to shift as much responsibility as possible back onto the family.

Maas, 1990, p. 19

In an era of high unemployment, this placed additional pressure on low income families (Bessant, 1993) and, given the connections between homelessness and physical and sexual abuse revealed by *Our Homeless Children* (HREOC, 1989), family support was not an option for many young people because of irretrievable breakdown in family relationships.

Maas suggests that policy makers assumed that the community, in the form of its elected representatives in Parliament, was not willing to 'make payments for the unemployed, unsupported students and the homeless, sufficient for them to live at more than below poverty line standards' (Maas, 1990, p. 22). He points out that the Commonwealth Labour Government emphasised economic policy at the expense of social policy and, while social justice—that is the notion that all young people should have 'an opportunity to participate in personal development, community life and decision making' (Howe et al, 1989, p. 4)—had been one of the most clearly articulated aspect of social policy, there was 'no sense of vision regarding the characteristics and qualities of the society that all people should have access to—the kinds of lives to which young people should be able to aspire' (paraphrased from Maas, 1990). Instead there was:

...a sense of uncertainty as to the value that should be placed on youth, and consequently a lack of commitment to a full investment in the future to be offered the young...Policy developments described earlier, where assistance for 18-20 year olds has been reduced and responsibility shifted back onto families, have complicated the process of becoming adult and have created for young people a twilight zone between youth and adulthood.

Maas, 1990, p. 23

To rectify this situation, Maas calls for 'a set of policies which embodies a valued role for young people in our society' (Maas, 1990, p. 23). He makes five recommendations which touch on matters that continue to be relevant in the early twenty-first century: that eighteen years of age be established as a clear marker of adulthood; that this marker be recognised through restoration of the full adult rate of unemployment benefits to eighteen year olds and by making Austudy 'a more generous symbol of support for those foregoing current income to develop knowledge and skills for the future, *our* future' (emphasis in original); that the impact of the parental income test be reduced and the current rate of living away from home allowance be offered to all recipients, including those living at home; that support be provided for families supporting their children; and housing assistance be provided for young people (paraphrased from Maas, 1990). He concludes that the government's continued resort to residual targeted programs does not address 'the need for a comprehensive approach to the place of all young people in Australian society' and that problems such as homelessness among young people 'will most certainly be alleviated by more universal assistance' (Maas, 1990, p. 24).

Maas' point is an important one. When social justice is interpreted as providing services and programs to the most needy only, important preventive social policy work is neglected. A situation is created in which more young people are likely to fall into the pool of the disadvantaged or most needy. Social policy becomes similar to an illness approach in health, in which services are provided only after problems arise. One of my key informants commented on the narrow interpretation of social justice adopted by the Commonwealth Labor government in the 1980s. One of my key informants commented on the way:

...governments, in this instance any power broker I think, adopts and bastardises language. I think that happened with social justice. Social justice got translated from a concept of justice to a concept of access and participation and I don't think that equals justice. Underneath this more jaded exterior there still beats the heart of a real idealist.

(YAI)

Irving and colleagues agree. They note that, even though youth policy was often couched in terms of equity and social justice, its actual operation was even more rationalist than under the Liberals (Irving et al, 1995, p. 248). Bessant argues that the new substrata of dependent young people created by inadequate government policies, flies in the face of 'official discourse about 'the special provision for disadvantaged youth' (Bessant, 1993, p. 101).

This new sub-class emerged as a result of the failure of government policy to include avenues in which those who are not suited to the extreme competition of the greasy credentialing ladder have a viable option in which they can be active and productive and in which they can succeed.

Bessant, 1993, p. 101

Pointing to the trend toward education directed at meeting the needs of industry and commerce, Bessant argues that the broader functions of education, those relating to equity and personal development, need to be reinstated. She concludes that

The official talk of 'equity', 'social justice', 'the active society' and the 'clever country' which has accompanied the youth policies of the Labor Government has been in sharp conflict with its achievements. In practice the government's main concerns are to keep the unemployment figures down by increasing the retention rates and at the same time fashioning the education system to meet the demands of the corporate sector and 'national priorities'.

Bessant, 1993, p. 102

The issues raised by Maas, Bessant and others (for example see White, 1994) were also raised by several of my key informants. One commented that, by the end of the eighties,

youth policy had become subservient to economic policy, causing other issues to become peripheral (YA3). Others recalled controversy at the end of the decade about the value of policies which encouraged young people to stay in school longer to increase their potential to find work (M6; YHP 13; YA 1; YA7). One referred to:

...a study, which I think must have come out of the end of the 80's, showed that, in a survey of young people in years 11 and 12, more than 30% of them did not want to be at school, but there was no where else to go. So school became a kind of holding spot.

(M6)

Others commented that:

Kids were being fed a myth about what education gives you...you know you kind of assume that you're acquiring skills that you will then be able to use to increase your income and apply in the workforce, when the reality is that they might have been more educated, but they weren't more vocationally skilled and there weren't any jobs there anyway.

(YHP13)

I think we are no longer sensitive to youth unemployment. I actually think we do less now than we have done to find young people a role in our society through work, and I think we have given up on them frankly.

(YHP16)

...the whole job search and work tests and Skillshare development was so market-orientated to the point where the market becomes the most important thing. The wellbeing of people, the capacity for people to survive and cope even when they don't have work went out the door.

(YHP15)

Government policy has been directed more and more to institutions which provide training. It is very expensive, diverts funds or if you like, utilises funds for young people. It's not productive because you have a stream of people who have been trained with high expectations who don't get employed. I think that the policies which generated unrealistic expectations, and I think there were a number of such for young people, were potentially destructive. Unfulfilled expectations are a very painful thing I think, for any of us. I think that policies towards the end of the 1980s we were creating that situation.

(M6)

Summing up the Commonwealth's youth policy effort in the latter part of the 1980s, Irving and colleagues observe that:

The period 1983—90 was a game of snakes and ladders for youth affairs structures. The period of IYY was a definite ladder, followed by a slide down a snake at its conclusion. The effects of managerialism and economic rationalism, combined with a lower youth unemployment rate and the end of the International Year, pushed youth down, if not completely off the agenda.

Irving et al, 1995, p. 287

Commonwealth youth policies, and the policies of a range of government departments, have an impact on young people's health. It is therefore important that advocates engage with the policy making process and comment on the potential health impact of proposed policy measures (Kemmm, 2001). One of my key informants commented that:

And all the health promotion in the world...won't amount to anything but a hill of beans unless it properly addresses some of those key dynamics that are at work in the labour market, in the housing market, in our class structures...

(YHP6)

The lack of a coordinated policy for young people's health and the fragmentation of the sector was seen by a number of my key informants as an issue at the end of the decade (M2; M5; M7; M8; YHP17) and some saw it as evidence of a lack of real commitment to young people's health. (M7; M8; M9; YHP 15; YHP 17)

Once the agenda got set up it became very issue bound. Funding was issue bound, campaigns and projects were issue bound. Instead of having general health education you had the issues of specific health education going into schools, going into teacher education programmes. And it was about AIDS, it was about drugs, it wasn't about the general approach to life and wellbeing. I think that had a very big influence on the late 80's and it also meant there wasn't the money or the time or the political or bureaucratic interest in doing so many other things. That's very important ...

(YHP17)

One referred to a 'scattergun approach' to policy, planning and programming in his/her state:

...looking at the solutions being promoted at the end of the decade, youth (health) policy clearly was being touted as some way of...making some sense of this complex picture and it was government responsibility to take the lead. Not to do it all, but to take the lead. And they were brought reluctantly at times to do it and I think there were times when they were even less than reluctant...

(YHP15)

Another emphasised the importance of a comprehensive approach to young people's health:

(We need) a comprehensive view on adolescent health, because it's still being lost now. There are 20 different organisations taking on health, drug and alcohol people with drug and alcohol, sexuality people with sexuality, parenting people with parenting. I still think there is something to be said for a comprehensive approach.

(M5)

6.3 Health for All

The need for a national policy and a coordinated approach to young people's health might have been met when the Commonwealth Department of Health embarked on the development of a national Health for All strategy. This work was undertaken by the Health Targets and Implementation (Health for All) Committee, chaired by Stephen Leeder, and provided an opportunity for young people's health to become part of a mainstream public health initiative. This did not occur. Instead, the Committee's report, *Health for All Australians* (1988), places young people together with children as a population group. There is little reference to Australian reports which argued that adolescent/youth health needs were different from those of children and should be considered and addressed separately. This suggests that adolescent/youth health advocates had not taken Leeder's advice to engage with the current planning context (Leeder, 1988).

Health for All Australians was the first attempt to develop national health targets and goals within a new public health framework and must be considered in that light. The terms of reference set by the Health Ministers established the framework and scope of the initiative. The Committee's brief was to determine areas where health goals would be set, define 'specific and measurable health targets which Australia can aim to achieve within a stated period' (Department of Community Services and Health (DCSH), 1988, p. 4), propose preventive strategies, estimate cost and determine a process for ongoing monitoring, review and evaluation of national health goals and strategies. The two underlying principles that guided the committee's work were 'increasing the health status of all Australians and decreasing the inequalities in health status between population sub-groups' (DCSH, 1988, p. 4).

At one level—partly the level of rhetoric—there are similarities between the ideas contained in *Health for All Australians* and those found in youth health documents produced in the mid-eighties. The WHO *Health for All Strategy*, which was the rhetorical antecedent to *Health for All Australians*, is guided by a social view of health, and recognises the role of poverty in creating poor health. It emphasises the need for a

coordinated and comprehensive approach to health promotion and prevention, collaboration across sectors and structural change. However, *Health for All Australians*, like many youth health documents, shows the difficulties of coming to terms with a new paradigm. This is particularly evident in the way the issue of poverty is dealt with.

Health for All Australians examines four explanations of why inequality in health exists in Australia, and adopts two as the basis for its work: a cultural/behavioural position which locates problems within the culture of poverty and the behaviours and lifestyles of people of low socio-economic groups; and a materialist/structural explanation, which emphasises 'the conditions under which people live and work, increased exposure to commercial pressures to consume unhealthy products, and the ways in which healthy choices are sometimes more difficult for the poor than for the affluent' (DCSH, 1988, p. 56). These two explanations appear to be at odds with one another, as each implies different kinds of health promotion action and different emphases for policy and program development. The adoption of both explanations by the Health for All Committee may reflect irresolvable differences among committee members representing state governments of differing political persuasions, and lack of agreement in the public health sector itself. It may even reflect a shortage of acumen in political philosophy among the committee members. As discussed in Chapter 4, similar dissonances can be found in policy and planning initiatives and reports on young people's health (Bennett, 1984; SAHC, 1986a, b, and c; WADH, 1987).

Health for All Australians recognises that 'the greatest improvements are likely to occur in concert with reductions in poverty' (DCSH, 1988, p. 6), but its recommendations do not address poverty directly. The committee places the following caveat on its work:

The Committee saw its task as identifying means under the control of those in the health system—those who commissioned this report—for addressing health differentials directly and impressing on other sectors in government, the private sector, the contributions they could make in addressing avoidable illness.

DCSH, 1988, p. 6

While the social factors that increase the risk of ill health are acknowledged—things such as lack of social support, poverty, violence, stress, unemployment, isolation, divorce and inadequate housing—it seems that goals and targets could not be set for them because data on 'the extent and effects of these is limited' (DCSH, 1988, p. 5). This suggests that availability of data, or measurability, determined whether or not an issue was taken up and funded through a goals and targets exercise, and that, in the absence of data, the issues

most important in determining health, as identified by the report itself, may not be addressed. This seems a myopic approach to health planning.

Moving only marginally away from an illness focus, *Health for All Australians* establishes three categories in which goals and targets will be set—population groups, major causes of illness and death and risk factors associated with specific illness and death. The population group category offers an opportunity to address health in a more positive and holistic manner; however, the majority of targets and goals are located in the categories of major causes of illness and death, and risk factors. Poverty, which is identified as the greatest risk factor in the report, is neatly side-stepped by the suggestion that it is a matter to be addressed outside the health system, in the Social Justice Strategy. The advocacy role that health departments and health programs and services might play in bringing these issues to the forefront of policy making receives scant attention. However, the fact that the report raises the issues of equity and poverty is important, because it brings these matters to the national health agenda.

The overall goal for the population group children and young people, is reduction in 'preventable illness, injury and death among Australian children and adolescents' (DCSH, 1988, p. 20). With the exception of Aboriginal children, no comprehensive national targets were set for this population group, but specific targets for children are found in other sections of the report, in the areas of immunisation, smoking control, injury prevention and unprotected sexual activity (DCSH, 1988). The wording refers only to children, even though the issues of smoking control and unprotected sexual activity apply, for the most part, to people over twelve years of age. Statistical information is presented on tobacco use by young people and targets established by the National Heart Foundation and the Anti-Cancer Foundation in this area are supported. The work of the National Campaign Against Drug Abuse (NCADA) is endorsed and seen as complementary to the Health for All strategy. NCADA's targeting of young people is noted and the preliminary goals and targets of the NCADA are supported.

Young people make other appearances in *Health for All Australians* with the following associations: young men and motor vehicle accidents; young women and pregnancy; immunisation of young people for rubella; young people's knowledge of STDs; the Family Planning Association's provision of specialised services for young people; and data on young people's use of illicit substances. Young people are not mentioned in the area of mental health or occupational health and safety, even though reports on young people's health had drawn attention to these matters (CDH, 1981; Bennett, 1985; Connolly and Borger, 1985; WADH, 1987; SAHC, 1986 (d); WHO, 1986; YPDC, 1987b). The pattern of including young people with children in national health policy and strategies continued in the 1990s (Commonwealth Department of Human Services and Health 1995a) and into

the twenty-first century, resulting in the loss of the emphasis on young people developed during the 1980s, and diffusing and confusing health issues of children and young people.

6.4 Young people and drug use

We need to understand the social causes of ill health. On the basis of that information, a concerted strategy for change needs to be mounted. This statement is not as platitudinous as its simplicity may suggest. To achieve it effectively would be to challenge some of the most influential vested interests in our society. It entails counteracting the pressures currently on young people to be unhealthy.

YACA, 1983, p. 177

In contrast to *Health for All Australians*, the National Campaign Against Drug Abuse (NCADA) and its media arm, The Drug Offensive, did target young people as a population group separate from children. One account concludes, on the basis of the evaluation of NCADA's first three years, 1985 to 1988, that in many respects NCADA was a campaign directed against the young (Irving et al, 1995, p. 265). The accuracy of this assessment depends on several things: whether NCADA targeted the drugs most used by young people; whether the 'drug problem' was constructed as a problem to do with young people's behaviour; and whether the social and environmental factors that promote drug use, and hence contribute to drug-related harm in the youth population, were addressed. Young people are relatively easy targets for the government compared to the wealthy and politically well-connected tobacco and alcohol industries.

Before examining the work of NCADA, it is necessary to put Australia's 'drug problem' into perspective. In 1985, when the campaign began, and to the present moment, it is the legally available drugs, alcohol and tobacco, that cause most harm in the general population and among young people and generate the greatest cost to the government (NCADA, 1986a, pp. 29—30; Collins and Lapsley, 1991). Surveys of drug use by Australian school children conducted during the 1980s consistently show that alcohol, tobacco, analgesics, and to a lesser extent cannabis, were the drugs most commonly used at that time (Homel et al, 1984; Ministry of Education—Schools Division and Health Commission Victoria, 1986; Baker et al, 1987; Christie et al, 1989). In relation to young people, alcohol is arguably of greatest concern in the short term, due to its association with accidents and violence, which are major causes of death, particularly among young men, in the 15 to 25 age group.

The above estimates refer only to deaths and do not include illness and injury in which alcohol is a contributing factor. Further, with regard to the drugs and crime nexus, alcohol causes the most problems for most Australians, including young people, most of the time.

A report commissioned by the South Australian Coalition Against Crime concluded that 'in quantitative terms the drugs/crime problem is really an alcohol/crime problem. The offences associated with alcohol use are numerous, and significant proportions of those offences are serious or fatal (such as assault, homicide) or potentially so (drink driving)' (Atkinson, 1992, p. ix).

By the late 1980s, after many years of hard work, the efforts of the well-organised anti-tobacco lobby began to meet with success at state level. In Victoria and South Australia, legislation was introduced to limit tobacco advertising and funds gained through an increase in the tobacco licencing fee charged by State governments, were used to establish foundations to fund state health promotion activities (Woodward et al, 1989; Hawks and Lenton, 1995). These legislative and fiscal initiatives sent a clear message that tobacco consumption was damaging to health, and provided policy and structural support for NCADA's efforts to reduce tobacco use in the community generally and among young people.

The situation with alcohol was quite different. In 1987 Australia was poised to adopt a progressive national health policy on alcohol (Hawks, 1990). The draft policy is referred to by the Health for All Committee, which praised the document's comprehensive approach to reduction of alcohol-related harm in the community and its recognition of the interdependence of strategies in achieving significant improvement (DCSH, 1988, p. 63). *Health for All Australians* describes the draft policy as:

...one of the most advanced examples of public policy development in the health promotion field in Australia and could prove a strong basis for determining Australia's approach to alcohol problems in the years to come.

DCSH, 1988, p. 62

There is irony in this high praise in light of later developments. The draft policy was not endorsed by the Ministerial Council on Drug Strategy (MCDS) in 1987. In fact, a National Health Policy on Alcohol was not approved until March 1989. Further, the policy adopted in 1989 was substantially different from the 1987 draft. The overall goal of the draft policy, the reduction of national per capita alcohol consumption, does not appear in the final policy, but this goal was endorsed by the Health for All Committee in 1988 and remains on record as a reminder of a more progressive moment in alcohol policy thinking in Australia (DCSH, 1988). Further, the policies relating to availability, price and taxation, advertising and marketing, arguably the strongest elements of the draft policy, were diluted or dropped (Hawks, 1990, 1993). Yet it was those very aspects of the policy that, according to the government's own research, were most likely to have an impact on young people's alcohol consumption (Shanahan, 1987a, 1987b, p. 25).

Research consultants Elliott and Shanahan had been commissioned by the Commonwealth to conduct the research on young people's alcohol use in preparation for NCADA's proposed 'adolescent alcohol abuse' campaign. The research report, prepared by Patrick Shanahan, emphasised the need for the campaign to be accompanied by structural change strategies (Shanahan, 1987a, 1987b, p. 25).

...frequent comment has been raised in regard to the need for well-intentioned media campaigns to be supported by structural, legal or environmental change as well.

Certainly, community concern at the availability of alcohol and insufficient policing of current laws on the purchase of liquor, represent structural aspects that need to be examined.

Shanahan, 1987b, p. 38 (emphasis in original)

Shanahan recommends that serious consideration be given to a complete ban on television advertising of alcohol or the introduction of a more restrictive code of practice; to consideration of a change to the drinking age, including separation of the age at which drinking and driving become legal, and introduction of an ID card; to greater enforcement of retail trade and surveillance of buyers of alcohol; and to reduction of availability. With regard to the latter, Shanahan concludes that making alcohol more freely available would be a retrograde step, and that 'parents seemed to be prepared to accept an inconvenience to them to protect their children specifically and youth generally' (Shanahan, 1987a, p. 29). The fact that some of these changes were being considered in the draft National Health Policy on Alcohol is noted (Shanahan, 1987b, p.25; Hawks, 1990, 1993) but, as indicated earlier, the draft policy was modified to exclude those changes.

The process by which the policy was 'watered down', through the efforts of the South Australian government, influenced by the wine interests in that state, has been well documented (Hawks, 1990, 1993), but in relation to young people's health and wellbeing, a number of things are clear. First of all, despite the fact that Shanahan's research was available to the government as early as April 1987, and the structural changes recommended were on the table in the form of the draft national alcohol policy, these changes were not taken up, in 1987 or later. Secondly, it was not community concern about underage drinking, or the health of young people that prevented them from being taken up, but the 'health' of the wine industry (Cornwall, 1989, p. 113-114; Cornwall, 1991).

The National Health Policy on Alcohol adopted by the Commonwealth in 1989 does give attention to young people, in the sections on education, advertising and marketing. The first objective under the heading of education is 'to assist the community, particularly young people, to develop understanding, attitudes and behaviour which will enable them to minimise and avoid the harmful consequences of alcohol use' (NCADA, 1989, p. 9). The

target of this objective seems misplaced. It was not young people but the government that was unable to minimise the harmful consequences of alcohol use by introducing the policy measures required and just saying no to the alcohol industry. A similar point can be made about the fifth objective in the education section, which is almost humorous in a dark way. The objective is 'To foster a community attitude which reduces the pressure placed on young people to be seen to be successful, attractive and healthy by consuming alcohol' (NCADA, 1989, p. 9). Given the community's concern about alcohol advertising's appeal to young people, as revealed by the government's own research (Shanahan, 1987a, 1987b), it would seem that it is not the community's attitude but the alcohol industry's advertising, that exerts pressure on young people to be seen as 'successful, attractive and healthy by consuming alcohol' (NCADA, 1989, p. 9).

The second half of the document contains 'examples' of strategies to prevent alcohol related harm. The fact that they are only examples signals little or no commitment to their implementation. One of those examples refers to industry self regulation of advertising and acknowledges public concern that the system is 'not working uniformly in a way calculated to protect the health interests of the population' (NCADA, 1989, p. 9). However, the policy points out the code governing alcohol advertising is 'under review', suggesting that public concerns about this matter would be addressed. At the time of the adoption of the Policy, the results of that review were imminent.

In 1988 the Trade Practices Commission asked the Media Council of Australia (MCA) to review the four voluntary codes governing advertising of alcohol, tobacco, therapeutic goods and slimming products, with the aim of strengthening them. For the first time public representatives were invited to sit on the Councils that would review the Codes (Saunders, 1989). AAAH was invited by the Commonwealth Government's Youth Bureau to send a delegate to each of the Code Councils to represent the interests of young people (AAAH Newsletter No 3, 1988).

The inadequacy of the voluntary code governing alcohol advertising and the impact of alcohol advertising on young people had been a concern in Australia for some time (Hawks, 1984, 1995; Saunders and Yapp, 1987; Shanahan, 1987a, p. 27; NCADA, 1989, p. 9). This concern was strengthened by the finding that, between 1985 and 1988, young people's alcohol consumption remained stable at a time when consumption across all other age groups in Australia had decreased, and it was suggested that one of the reasons for this stability may have been the targeting of young people by alcohol advertising (Makkai and McAllister, 1990, p. 305).

Responsibility for reviewing and making changes to the code lay with the Alcohol Beverages Advertising Code Council (ABACC), which was constituted under the Media

Council of Australia. The AAAH nominee to the ABACC was Andrew Ball, a drug and alcohol physician with both hospital and community health appointments. Ball was president of the New South Wales Branch of AAAH and, in addition to his clinical experience, had an understanding of professional and community views on alcohol issues through his work in community health education and prevention programs.

The ABACC had fourteen members, including the four public members representing consumer affairs, ethnic affairs, the status of women and youth affairs; one nominee from the Commonwealth Department of Health; and nine other members who represented a range of alcohol, media and advertising interests³² (Media Council of Australia, 1988). The chair of the ABACC, elected at the inaugural meeting of the Council, represented the Australian Associated Brewers and was a marketing strategist for Bond Brewing. The structure of the Council ensured that the alcohol industry members, those they employed to do their advertising and the media members, 'had the numbers', and were in a position to vote for changes to the codes that would not limit their business interests. The development of a firmer and more workable code seemed unlikely in these circumstances. Andrew Ball outlined these matters in a letter to the Chairman of the ABACC.

Even though formal bloc voting may not have occurred, it was quite apparent during the discussions that rarely, if at all, did any alcohol industry, media industry, or advertising industry representatives hold dissenting views. In fact throughout the meeting, these members spoke in support of one another and it appeared consensus had been reached even prior to the discussions.

Excerpt from letter written by Andrew Ball, AAAH representative on the Alcoholic Beverages Advertising Code Council (ABACC), to the Chairman of ABACC,
12 Dec, 1988

The minutes of ABACC meetings, correspondence between Andrew Ball and the Chairman of the ABACC, and between Ball and the president of the Australian Medical and Professional Society on Alcohol and Drugs, suggest that the development of the new code was subject to the same political manoeuvring that accompanied the modification of the National Health Policy on Alcohol.

Time for preparation, discussion and debate on the content of the new code was limited. Those attending the inaugural meeting of the ABACC, held on 11 May, 1988, had only five working days to prepare their submissions to the meeting (Margaret Conley, 1988). The second meeting, held on 17 June 1988, received seven submissions, but due to lack of

³² These members included nominees from the Australian Publishers Bureau (APB), the Federation of Australian Commercial Television Stations (FACTS), Federation of Australian Radio Broadcasters (FARB), the Outdoor Advertising Association of Australia (OAAA), the Australian Association of National Advertisers (AANA); Australian Associated Brewers (AAB), The Australian Wine and Brandy Producers Association and the Distilled Spirits Industry Council of Australia (DSICA).

time, those who had prepared submissions were unable to speak to them. Submissions that dealt with the question of whether legislative controls were preferable to a voluntary code, were not considered appropriate to the work of the Council at that time (Minutes of ABACC Meeting, 17 June, 1988), nor were submissions concerned with enforcement of the codes—that is, matters such as the sanctioning of offending advertisers and ‘ensuring the system allows for this to be done before an advertising campaign has run its course’ (Conley, 1988, p. 1). After only three Council meetings, a new Alcoholic Beverages Advertising Code was approved (Minutes of ABCC meeting, 12 July 1988) and referred to the Media Council of Australia.

There is evidence to suggest that assurances provided by the Chairman of the ABACC at the 12 July meeting, when the new Code was approved by the Council, influenced the voting of public members. During the meeting the Chairman indicated that there would be ‘a substantial change in the way agencies and advertisers approach the Code in future’ and that the code would be interpreted conservatively. Public members may have voted for a code which they deemed to be less than satisfactory with the understanding that a conservative approach would be applied to its interpretation, and that the need for such an approach would be communicated to the MCA. Andrew Ball raises this matter in a letter to the Chairman of ABACC.

As you are aware, the prime focus of my concerns, both expressed during the Code Council meetings and in my submission, was on the interpretation and implementation of the proposed code. These concerns were also expressed by at least three other public members. I believe that the assurance you gave that these concerns would be conveyed to the MCA, had a very significant effect on the discussion of the Code Council and the final vote. In particular, Graham Forbes stated in the final meeting on July 12th, that he was prepared to vote in favour of the proposed code with the understanding that its interpretation would be “conservative”...

In no way am I questioning your word, but unfortunately (as we have already experienced with such campaigns as Kix) personal assurances from various liquor media and advertising industry members will not prevent ‘cowboys’ from appearing on the scene who will push the codes to the limit. Therefore the Advertising Standards Council must be made aware of our specific concerns and hopefully be guided by our recommendations, even though we have been advised that making such recommendations is outside our brief.

Letter from Andrew Ball to the Chairman, ABACC, December 12, 1988, p. 2

Ball was the only member of the Council who voted against the code adopted at the July 12 meeting (Minutes of ABCC meeting, 12 July, 1988, p. 7). The Chairman of the ABACC, in his report to the Media Council of Australia on the deliberations of the

Council, indicated that there was only one dissenting vote and that the dissenting member made objection to two clauses only (Chairman's report, 18 July, 1988). After making minor amendments to the numbering and positioning of clauses, the Media Council submitted the code to the Trade Practices Tribunal.

The Trade Practices Tribunal found the proposed new Code unsatisfactory. It recommended changes to the wording of some of the clauses and the addition of a new clause to be the first clause, that advertisements 'should not have strong or evident appeal to children and adolescents' (ABACC, 10 January 1989). The ABACC reconvened on 10 January, 1989, to consider these changes. The Chairman expressed 'disappointment with the Tribunal's expressed attitude to the work of the Council', stating that the code the ABACC had produced was 'definitive and hard in its rules, and expressed in a positive and interpretable way', and that the Tribunal appeared to have 'softened some of the clauses'. He indicated that there was 'strong industry support for the new code' (ABACC 10 January 1989, p. 3).

Some of the changes proposed by the Trade Practices Tribunal were accepted by the ABACC. Others were challenged, with some members arguing that the new Clause One, which stated that advertisements 'should not have strong or evident appeal to children and adolescents', needed an 'interpretive' section. The addition of the following interpretive or qualifying statement was suggested:

The aim of this clause is to ensure that no advertisement for alcoholic beverages should be calculated to promote the purchase or consumption of alcoholic beverages by children or adolescents. The term 'strong or evident appeal' should be read in this context.

ABACC 10 Jan, 1989, p. 6

This 'interpretive' sentence was passed by the majority of the Council, but the member from the Department of Health, Margaret Conley, abstained due to concerns with the meaning of the phrase 'should be calculated', and Andrew Ball voted against the resolution, preferring to leave the phrase without interpretation (ABACC 10 January, 1989, p. 6). The ABACC also recommended changes to the Tribunal's proposed wording for Clauses 9 and 10, which dealt with associations between alcohol consumption and success and alcohol consumption and relaxation respectively (ABACC 10 January 1989, pp. 4-5). These changes were supported by a majority of those present, with Ball voting against, preferring the Tribunal's wording of the clauses. The amended Code was then approved, with Conley abstaining and Ball voting against (ABACC 10 January 1989, p. 7).

It appears that this time the Media Council of Australia did not support the changes recommended by the ABACC. The Code it submitted to the Trade Practices Tribunal did not contain the 'interpretive' addition to Clause 1 (Letter to Pat Auld from Chairman of the ABACC, 23 February, 1989). The Trade Practices Tribunal, on its part, made further changes to the wording of the Alcoholic Beverages Advertising Code, in an attempt to make it stronger, before returning it to the Media Council of Australia for endorsement. The Media Council, without referring the Code back to the ABACC (ABACC, 23 February, 1989), advised the Trade Practices Tribunal that there should be no objection to the changes it had made (MCA, 7 March 1989).

Whether the new Alcoholic Beverages Advertising Code authorised in June 1989 was an improvement on the earlier one is questionable, with at least one public health advocate arguing that it was weaker, more ambiguous and therefore likely to be more difficult to adjudicate than its predecessor (Saunders, 1989). As Conley pointed out in her initial submission to the Media Council of Australia, the effectiveness of the Code would depend on how it was implemented and how advertisements were adjudicated. The AAAH Newsletter, reported on the Association's entry into 'the politics of the corporate world' (Bennett, 1988) and described the experience this way:

In all four Councils, public members were heavily outnumbered by industry and media representatives and struggled to have their views noted, In the Cigarette (Tobacco) Code Council, public members totally rejected the new code and submitted a Minority Report to the MCA (Media Council Of Australia), the hosting body. Andrew Ball acted alone in dissenting from certain clauses in the alcohol code while Tony Arklay, although not entirely unhappy with the therapeutic advertising code, seriously questions the implementation and complaints procedures.

AAAH Newsletter No 3, 1988, p. 31

The fact that the Code only covered advertising, not other types of alcohol promotion, continued to be problematic. This matter was highlighted by David Hawks, then Professor of Addiction Studies at the National Centre for Research into the Prevention of Drug Abuse at Curtin University, in a letter to the Chairperson of the Trade Practices Tribunal dated 10 January, 1989. Hawks calls into question the sincerity of alcohol industry assurances that there was no intention to target children and young people:

As someone with a long-standing professional interest in the effects on adolescents of alcohol advertising, I was gratified by your insistence that the amended Alcohol Advertising Code include the paragraph: 'The advertising of alcoholic beverages should not have strong or evident appeal to children or adolescents whatever the persons or class of persons to whom the advertising is directed'.

While I would hope that the inclusion of such a clause in the code itself would occasion greater responsibility in the advertising of alcohol on television and in the print medium, it is to another area of advertising that I would draw your attention.

Virtually coincidental with the alcohol industry's acceptance of the amended code, and their insistence that it will be adhered to in spirit as well as in letter, and the view of Mr Tony Sernack of Bond Brewing that 'we will stay well within the paddock and away from the electric fence', Bond Brewing announced its sponsorship of the Wildcat basketball team in Western Australia. The Wildcats were previously sponsored by the Quit Smoking Campaign precisely because they are popular with young people and have a high television profile. Their use as a vehicle for advertising Emu Export Lager (which is incidentally a full-strength lager) can only be calculated to take advantage of this popularity and high profile.

The article announcing this new sponsorship deal, published in *The West Australian* on 21 December, 1988, juxtaposed an announcement of a 'Live-in with the Wildcats' coaching camp for youths aged 9 to 17 years.

It is my understanding that as a condition of the sponsorship, Wildcat players will wear colours identified with Emu Export Lager and moreover play on a field decorated with Emu Export Lager motifs.

My concern in essence, is that while the formal advertising of alcohol may be rendered more responsible by reference to the amended Code, and in particular that clause which you have inserted, the advertising of alcoholic beverages by virtue of their association with sporting events will not be subject to such constraint. Given the popularity of such sporting events, and in particular their popularity with young people, the laudable concern shown by your membership will be entirely circumvented.

Letter to Chairperson, Trade Practices Tribunal from David Hawks, January, 10, 1989

NCADA launched the 'adolescent alcohol abuse' campaign in March 1988. The name chosen for the campaign, 'adolescent alcohol abuse', suggests that the NCADA saw the issue of young people and alcohol as an issue to do with young people's behaviour and their 'abuse' of alcohol. This kind of thinking leaves invisible the underlying factors such as marketing of alcohol to young people, availability of alcohol and pricing, which are contributing factors in young people's alcohol use. The campaign, which was part of NCADA's media and information strategy, proceeded without the policy support recommended by Shanahan's research. The evaluation of the campaign suggests that there had been some positive outcomes. Awareness of alcohol use as a public health concern had increased (Elliot and Shanahan, 1989, p. 20). There was an increase in the numbers of young people feeling confident to say no when they'd had enough (Elliot and Shanahan,

1989, p. 32) and fewer young people tried to get drunk (Elliot and Shanahan, 1989, p. 27), but other findings were worrying.

There had been an overall increase (8%), since 1988, in the numbers of sixteen to eighteen year olds drinking (Elliot and Shanahan, 1989, p. 23), an increase (8%) in numbers drinking on more than three days in the last fortnight, and an increase in the proportions of teenagers consuming seven or more drinks on the last occasion (Elliot and Shanahan, 1989, p. 24). This was particularly the case among young males. Among sixteen to eighteen year olds surveyed, 47% believed that 'boys their age in general' fit the heavy drinker description (Elliot and Shanahan, 1989, p. 26). The number of sixteen to eighteen year olds claiming to have personally bought alcohol had gone up since 1988, suggesting an increase in alcohol availability for underage drinkers (Elliot and Shanahan, 1989, p. 25). Although one campaign would not be expected to effect change, these findings suggest that the situation may have worsened, providing some support for Shanahan's argument that the campaign needed to be accompanied by structural change strategies.

The adolescent alcohol abuse campaign represented only one component of NCADA's strategy for young people. In NCADA's first two years thirty-one or approximately one third of all the projects funded were described as youth projects—sixteen had youth as their primary focus and fifteen had youth as a secondary focus (NCADA, 1987, p. 35). There were education and information projects, such as school and TAFE drug education programs, and projects which aimed to provide counselling, accommodation and welfare services for young drug users (NCADA, 1987, p. 35). The focus on heroin in the early stages of the television campaign, aimed at 'at risk' fifteen to twenty year olds (NCADA, 1989, pp. 27–28), seems misplaced given the very small number of young people who use this drug. Despite the problems with the 'adolescent alcohol abuse' campaign outlined in this chapter, the targeting of alcohol would seem appropriate given the high percentage of young people who use this drug.

There are indications that, at the end of the 1980s, the community and young people were more aware of the impact of alcohol on young people's health (NCADA, 1989, p. 28; Australia Youth Bureau/ ANOP 1991). Several of my key informants identified this as one of the major changes of the decade (YHP1; YHP4; YHP13). They suggested that there had been a shift, from a focus on illegal drugs to greater attention to and awareness of the health problems created by the legal drugs of alcohol and tobacco, and a recognition that these drugs were responsible for most drug-related harm among young people. This is a positive achievement which can be attributed in part to the education work of the NCADA in schools and in the community.

In the area of illicit drug use, the harm minimisation strategy adopted by NCADA enabled Australia to avoid the 'second wave' of HIV infection through injecting drug users (Hawks and Lenton, 1995, p. 296). The first needle exchange programs were introduced during NCADA's first three years of operation. The evaluation of NCADA's first three years confirmed their importance. The continuation and expansion of these programs, in collaboration with the National HIV/AIDS Strategy, was recommended (NCADA, 1989). The value of needle exchange programs was shown by an Australian study conducted with injecting drug users (IDUs) in 1989–90. The study 'suggested a HIV prevalence of less than 2% in all centres except Sydney, where prevalence was less than 5%' (Ross et al, 1993). When compared with approximate figures for HIV infection among IDUs in New York (60%), Edinburgh (51%), Geneva (52%) and Bangkok (40%), cities which did not have needle exchange programs (Binder, 1994), this achievement is impressive and suggests that the introduction of education and needle exchange programs by NCADA had a protective effect for young people who inject drugs.

This achievement in relation to injecting drug users offers a challenge to the suggestion that in its first three years of operation 'NCADA was a campaign directed against the young' (Irving et al, 1995, p. 265). However, on the issue of young people and alcohol, it could be argued that the interests of young people were not well served. NCADA funded media campaigns and drug education programs in schools and TAFE to 'help' young people change their drinking behaviour. New and more effective strategies for drug education were developed (Wheller, 1990). In good faith, young people participated in activities designed to enable them to resist pressure to consume alcohol in the 'shout' situation (McPherson et al, 1988) and practised decision-making skills in role plays (DASC, 1989). The alcohol industry, in contrast, was not required to participate in any such activities. Its behaviour and practices in relation to advertising and promotion of alcohol, as Hawks (1989) points out, remained, for the most part, unchanged.

6.5 Young people and sexuality: *A new kind of honesty*

Recognition of young people's sexuality, the need for school and community-based sexuality education and confidential sexual health services, were issues identified in the early and mid-1980s by the Family Planning Association (McCarthy, 1983; Kovacs et al, 1986a; 1986b), adolescent and youth health advocates (Bennett, 1983, 1984; Connelly and Borger, 1985), researchers (Collins and Harper, 1985; Collins and Robinson, 1986; Neuendorff, 1986; Siedlecky, 1983, 1986, 1987; Cubis et al, 1985, 1986) and young people themselves (YACA 1983; AAAH 1985; Better Health Commission, 1986). Australian research suggests that, during the 1980s, the mean age of first intercourse for young people was about sixteen years of age (Cubis, 1992) and, by the age of eighteen, approximately

60% of Australian teenagers had had sexual intercourse (Wyn, J. et al, 1989). Further, most sexual experiences among young people occurred within the context of a 'steady, stable and loving relationship' (Cubis, 1992). Despite these figures it seems that the family unit was not providing reliable information about sexuality, contraception and prevention of sexually transmitted infections for many young people (McCarthy, 1983; Neuendorff, 1986). While schools might have been able to fill this gap (Neuendorff, 1986, p. 64), in 1987 Seidlecky pointed out that there was still no comprehensive sexuality education in Australian schools (Seidlecky, 1987).

The need for sexuality education took on a new urgency with the diagnosis of HIV/AIDS in Australia (Ballard, 1989; Commonwealth of Australia, 1988; DCSH, 1989), but initially there was poor understanding of the virus and its transmission. At first it was thought that homosexual and bi-sexual men who had sex with multiple partners were the only people affected (Ballard, 1989, p. 354). By 1986 it was recognised that practices such as having sex without a condom and sharing needles caused transmission of the virus and that these practices were 'widespread throughout the community and not restricted to particular groups' (Commonwealth Department of Human Services and Health, 1993, p. 1).

The National Advisory Committee on AIDS (NACAIDS), established in 1984, was given responsibility for public education (Commonwealth Department of Human Services and Health, 1993, p. 39). Research commissioned by NACAIDS to 'guide the design and implementation of a public information campaign', revealed that young people were engaging in practices that could expose them to the virus and were poorly informed about how the virus was transmitted (Commonwealth Department of Human Services and Health, 1993, p. 2). NACAIDS identified young people as a priority and established a Working Group on AIDS Education for Students and Adolescents in 1987 (Commonwealth Department of Human Services and Health, 1993, p. 39).

In 1988 the Commonwealth Department of Health published a policy discussion paper, *AIDS: A time to care—a time to act*, which again identified young people as a priority group and recommended HIV/AIDS education through a range of media and social settings. Schools were identified as important sites for education and it was reported that education authorities had 'already accepted their responsibility to promote HIV awareness programs at all levels of schools' (Commonwealth of Australia, 1988, p. 144). *AIDS: A time to care—a time to act* emphasises the need for preventive education that is 'honest, explicit and comprehensive' and 'realistic in its assumptions about the attitudes, skills and behaviour of young people' (Commonwealth of Australia, 1988, p. 143). The Commonwealth would ensure that education resource materials were available to be adapted to suit the particular circumstances of each state. Programs were required to:

provide factual information on HIV within the broader context of sexuality and relationships; build upon and promote student self-esteem and communication and decision-making skills; encourage students to examine critically and to understand their own and others' values; and explore the total range of choices in preventing sexually transmitted diseases, including the right to say no.

Commonwealth of Australia, 1988, p. 144

In addition to schools, TAFE colleges, universities and youth training centres were funded to provide HIV/AIDS education. Priority was given to training youth workers in HIV/AIDS education and counselling (Commonwealth of Australia, 1988, p. 145), further establishing a role for youth work in young people's health. Consultation with young people in program development was seen as important principle in HIV/AIDS prevention (Commonwealth of Australia, 1988, p. 143) and the ABC's *Beatbox* was put forward as a good example of young people's participation in education about HIV/AIDS and 'responsible television programming' (Commonwealth of Australia, 1988, p. 143).

The importance of education to the prevention effort generally, and for young people in particular, was confirmed by research conducted internationally and in Australia (Greig and Raphael, 1989, p. 211; Goldman, 1992, p. 15; ANCA, 1989, p. 15). Increasingly HIV/AIDS was being described as 'young person's disease' (Greig and Raphael, 1989, p. 211; Goldman, 1992, p. 15). Australian research found that young people were reluctant to use condoms (Chapman and Hodgson 1988). The risks for young women were of particular concern because they were more likely than their male partners to contract the virus through heterosexual intercourse (Wyn et al, 1989) and 'males are more likely to dictate the terms of the relationship' (Waters, 1989, p. 26). One study found that 30% of young women had sex when they did not want to and, in the case of TAFE women, this figure was considerably higher (Abbott, 1988-9).

Lack of recognition of the very existence of gay young people, in what Rofes describes as 'the classroom closet', was an issue for those endeavouring to reach this group with education and information (Parnell, 1992). Young gay people often found the school environment uncomfortable and hostile. State AIDS Councils reported that the young gay men they were in contact with had not received accurate information about safe sex and 'almost none had experienced genuine understanding and support for a safe homosexual lifestyle' (Parnell, 1992, p. 203). The gay community acted quickly to establish safe sex norms, and AIDS Councils in some states established peer education programs for and with young gay men (Timewell et al, 1992).

There was also a need to reach heterosexual young people. Research conducted at Macquarie University in New South Wales suggested that this might prove difficult for a number of reasons: the lack of closeness to the epidemic; the absence of an identifiable

heterosexual community, hence the difficulty of establishing safe sex 'norms' in that community; and 'the very different expectations men and women have of relationships' (Kippax et al, 1990).

Australian researchers Greig and Raphael (1989) found that programs more likely to succeed involve young people in message design, use young people's own language and deliver the message through someone who is credible to them. Further, more successful programs give as much attention to the positive aspects of behaviour change as the negative ones, promote assertiveness and self-esteem in young women and use a combination of strategies and a variety of sources to deliver the message. School-based sexuality education was more effective when regular classroom teachers were used rather than visiting specialists and when there was widespread support for the education program from teachers, parents and students.

While there was a lot of focus on schools, groups of young people who had left school for a range of reasons also needed education and information. Many of these young people were in contact with youth workers and youth agencies. The high number of quality applications for HIV/AIDS prevention funding from youth organisations, led ANCA³³ to convene a workshop in February 1989 to investigate the needs of 'high risk' youth. Through the Workshop the Commonwealth sought to bring together key groups and individuals working with Australian young people to consider the impact of HIV on the youth population. In particular, workshop participants would: examine existing initiatives to protect young people from HIV, support and treat them; develop a better understanding of how the lifestyles and problems of young people affect community education on AIDS; examine strategies to enhance the effectiveness of AIDS education and delivery of services; and facilitate the development of networks among agencies, community groups and individuals working in AIDS prevention and service delivery (ANCA, 1989, p. 12).

The report of the High Risk Youth Workshop extended the ideas contained in the discussion paper *AIDS: A time to care—a time to act*, by linking the likelihood of young people's exposure to the virus to the social and economic conditions in which they lived. Particular attention is given to the needs of Aboriginal and Islander young people, gay and ethnic young people and the development of resources in language and media accessible to these groups.

The recommendations contained in the High Risk Youth Workshop Report read like a summary of the recommendations of many reports produced about young people's health

³³ Australia National Council on AIDS (ANCA) was established in 1988 to provide advice to the Commonwealth Minister for Health, a role previously undertaken by National Australia Council on AIDS (NACAIDS) and the Aids Task Force. Ballard has provided a useful account of the genealogy of these two organisations and their morphing into one organisation, ANCA, in 1988 (Ballard, 1989)

in the 1980s. They point to the impact of social and environmental factors in the transmission of HIV, the need for user friendly services, training for health professionals and community workers and education for peer educators to provide information, counselling and support to young people on all sexually transmitted diseases, including HIV/AIDS. Young people's participation in program development is seen as an important principle.

Prevention of the transmission of HIV/AIDS among young people in Australia required a major shift in community thinking. In the first instance, it required recognition of young people's sexuality, the fact that many young people were sexually active and that some identified as bi-sexual and homosexual. Homosexual acts were still illegal in some states in the 1980s, or stigmatised where the ages of consent for homosexual people were different from those for heterosexual people (Patterson, 1992). This made it difficult for educators to gain access to the group most affected by HIV, due to concerns about possible prosecution for aiding and abetting illegal behaviour (Patterson, 1992, p. 366).

These concerns have meant for example, that clear messages have not been given to young people regarding sexual behaviour... This fear was heightened in Western Australia, when the Parliament, in legalising homosexual acts in private between males over the age of 21 years, denounced sexual relations between people of the same sex and included a specific prohibition against the encouragement or promotion of such behaviour in schools.

While it is unlikely that a court would find that the provision of safe sex information amounted to promotion of homosexual behaviour amongst young adults, it is tragic that such prudery may have resulted in infections amongst young gay men which could have been avoided through unambiguous safe-sex information.

Patterson, 1992, p. 367

In the second instance, prevention of the transmission of HIV/AIDS required recognition of injecting drug use by young people. It was important that young people who injected drugs had access to clean syringes so that they would not share needles. State and territory drug laws which prohibited self administration were obstacles that had to be overcome to achieve this goal, as they acted as barriers to young people obtaining clean needles and syringes and getting information about safe injecting practices (Patterson, 1992, p. 366).

Thirdly, the identification of schools as primary sites for health promotion and prevention, meant that school personnel would need education to undertake sexuality and HIV/AIDS education, develop policies to address confidentiality and prevent discrimination on the basis of HIV status and introduce precautions for dealing with blood spills. There were

concerns that many schools did not have the experience, expertise or desire to do so (Niland and Lowe, 1988; Parnell, 1992; Goldman, 1992).

The Commonwealth Department of Health, under the leadership of Neal Blewett, undertook public health reforms to contain the spread of HIV/AIDS in Australia. Media campaigns and education and training programs for teachers and youth workers were funded and clean needle programs were introduced to prevent spread of the virus among injecting drug users. Australia's work in this area has been recognised as a health promotion success story, internationally and in this country (Altman, 1995; Baum, 1998) and the role of the gay community in this effort acknowledged (Ballard, J, 1989; Altman, 1992; Timewell et al, 1992; Altman, 1995). The Ottawa Charter provided the framework for Australia's HIV/AIDS Strategy (Commonwealth Department of Human Services and Health, 1993; Baum, 1998). This suggests that the Ottawa Charter's emphasis on community participation in issue analysis and the development of solutions and intersectoral collaboration for health promoting change, produces results. The leadership provided by Neal Blewett and his commitment to participatory processes is also significant. One of my key informants identified Blewett as a Health Minister, 'You don't get a better one...' (YA6), who had made an important contribution to young people's health during the 1980s through the HIV/AIDS Strategy.

Discussing changes in community attitudes that occurred during the 1980s, one of my key informants observed that:

I think, I think as sad as it is, the AIDS epidemic pushed a lot of things forward. And the fact that initially it was gay men who were affected by the disease...they had a history of being organised. They already had an established lobby base and they were politically very powerful. So when they were affected by the disease, the disease mobilised that organisation in a different way and I think they contributed a hell of a lot to challenging sexual norms...acceptance, acceptance of sexuality and acceptance of gayness. And they also pushed forward a whole kind of new notion of sexual responsibility, I'd say, speaking as a straight woman.

You know, during the mid eighties it was expected that I was on the pill...Now it's not, I can be on the pill or I don't have to be on the pill because there is an expectation that the guys take some responsibility in that, because they should use condoms. And those behavioural changes I attribute to the kind of the push of the gay lobby. Because they had to do that in their own lives. They had to start taking that sexual responsibility and they didn't want to not be sexually active. And also you know there was all the caring that went with that. A lot of gay people cared for each other in a way that I hadn't seen before.

...the disease, allowed you to go into places, allowed health educators to go into places and teach people about condoms because it was a life-threatening situation. Whereas five years before, they wouldn't have been allowed to do that because it would have been (seen as) encouraging promiscuity. So I mean it didn't get rid of a lot of those attitudes, but it did provide a new, a new route of access I think. And I would see that as a major change, a major new kind of honesty...

(YHP13)

6.6 Home and homelessness among young people

In the field of social policy the recognition of a problem determines whether there will be a response. The understanding of a problem shapes its solution. Problems do not simply exist outside the policy making system - which goes round selectively 'mopping them up'. Problems emerge and develop as the web of assumptions and beliefs is spun by the politically active. And, of course, assumptions and beliefs are connected with the economic and political interests of those who hold them.

Low and Crawshaw, 1985, p. 23

Nicholas Low and Bruce Cranshaw, Australian researchers in environmental planning, highlight the difficulties of raising and defining issues for policy attention. In Australia, homelessness among young people was initially perceived as a temporary crisis. As the demand for accommodation services increased, it became apparent that the 'crisis' was more than temporary and that, in addition to providing accommodation and support, strategies needed to be put into place to address the causes of homelessness (YRAA, 1984, pp. 3-4).

The issue of homelessness among young people attracted attention throughout the 1980s (YACA, 1983; NHMRC, 1984; YRAA, 1984; Low and Crawshaw, 1985), but the release of *Our Homeless Children*, the report of the Human Rights and Equal Opportunity Commission Inquiry, in 1989, galvanised public opinion and spurred the government into action. The Inquiry addressed youth homelessness from a rights rather than a needs perspective and took an holistic approach to the issue. It investigated the causes of homelessness, government responses to homelessness, the situations of specific groups of homeless young people and the impact of homelessness on young people's health (HREOC, 1989). The report will be referred to in this discussion as the Burdekin Report, after the Commissioner who headed the Inquiry.

Pat Carlen, a Professor of Criminology working in the United Kingdom, outlines two types of primary causes of homelessness—social structural and precipitating causes (Carlen, 1994, p. 18). Carlen argues that structural causes are 'located in the gap between low incomes and the price of housing; housing and welfare policies; and housing and welfare

legislation' (Carlen, 1994, p. 18) and precipitating causes are the immediate and situational ones that occur either 'because of, for example sexual abuse, family conflict, divorce or bereavement; or upon discharge from an institution' (Carlen, 1994, p. 18). In Australia homelessness among young people has been attributed to a combination of the structural and precipitating factors outlined by Carlen: families under stress; family poverty and isolation; youth unemployment; the inadequate provision for children in the care of the State; and physical and sexual abuse of children in their home (YRAA, 1984; HREOC, 1989; Hartley, 1993; Chamberlain and MacKenzie, 1992, 1994).

Carlen notes that a major point of agreement in the literature on homelessness is that there is no generally accepted definition (Carlen, 1994, p. 20) and suggests that one reason for this is that 'the definition adopted has clear policy implications. There has been a noticeable reluctance for local authorities (in the UK) to employ a broad definition of homelessness as this would require them to accept a greater responsibility for housing the homeless' (Carlen, 1994, p. 20). The HREOC Inquiry found that, regardless of the measurement used, the numbers of homeless young people in Australia had increased during the 1980s and the age and nature of the homeless population had changed. The homeless were getting younger and the profile of the homeless no longer conformed to the skid row pattern of the 1960s (HREOC, 1989).

The Burdekin Report was critical of Government inaction on this issue, pointing to the unheeded recommendations of earlier reports, some commissioned by the Government itself. For example, the evaluation of the Commonwealth Government's Youth Services Scheme conducted in 1983, found that 60% of requests for accommodation were not met in most states and recommended an increase in funding for additional and different types of facilities. Referring to this matter the Burdekin Report states that:

It is most disturbing to this Inquiry that we are making the same observation more than five years later. In the intervening period the situation has become urgent. Indeed for many homeless children and young people it has become desperate.

HREOC, 1989, p. 12

Youth worker reports that many young people seeking accommodation were homeless due to physical and sexual abuse in their home of origin are noted (HREOC, 1989, p. 90).

It is quite clear from this and other evidence presented to the Inquiry that physical and sexual abuse of children is widespread in our community... While limited resources meant we could not delve into the causes of child abuse or the means by which it may be prevented—and we will not, therefore deal with those issues in detail in this Report—we must record our profound concern at the inadequacy of efforts which have been made to deal with the abuse of children within the home. The substantial

link between child abuse and ultimate homelessness is, in many cases beyond question.

HREOC, 1989, p. 91

The Burdekin Report draws attention to issues for Aboriginal young people and refugee young people, pointing to the impact of historical and cultural factors. In the case of Aboriginal children and young people, the historical context of 'European intervention, policies of assimilation, the removal of thousands of children from their families' and the resultant damaging of traditional kinship systems 'which left many Aboriginal people not knowing who their families were' are highlighted (HREOC, 1989, p. 129). Further, the report points out that for this group, the cultural meaning of 'home' must be taken into consideration in policy responses.

Aborigines have repeatedly stressed that, for them, home is wherever a family member extends sustenance, whether physical or emotional...the extended family network and family obligations and expectations mean that a person living even temporarily with relatives is not 'homeless'.

HREOC, 1989, p. 29

Because this view does not fit easily with the Government's structures for family support, it is often the case that Aboriginal families do not receive Government benefits for children and young people for whom they are caring (HREOC, 1989).

In the case of refugee young people in Australia without their families, the Commission concludes that the information presented to the Inquiry suggests a situation 'not fully consistent with Australia's obligations under international and domestic law relating to the protection of children generally' (HREOC, 1989, p. 142).

The isolated refugee youth shares all the problems of the adult refugee. He suffers the anxiety of an uncertain future, the stress of learning a strange language, the difficulty of understanding a new culture and memory of a traumatic, even cruel, Asia. But in addition to these stresses, he suffers the greater degree of separation from his family. He no longer has the security, the emotional support in facing problems or other advice in making decisions that the family contact provides.

HREOC, 1989, p. 141

The Burdekin Report made seventy-seven recommendations in six key areas: accommodation and support; job training; education; legal needs; support; and health. Recognising that homelessness generates a range of health problems for young people, which are further exacerbated by the lack of health care, eleven recommendations are to do

with health services. The recommendation that acceptable and accessible health services for homeless young people be established, echoes those of youth health reports produced throughout the 1980s. This time the Commonwealth Government responded by introducing the Innovative Health Services for Homeless Youth (IHSY) Program in its 1989—90 Youth Social Justice Strategy (Howe et al, 1989).

Seven million dollars over four years, to be cost-shared with the States, was allocated to the IHSY Program (Howe et al, 1989, p 12). The Program was aimed at young people in metropolitan areas and seen as complementary to government initiatives already in place under the NCADA and the national HIV/AIDS programs. Community-based services, with experience in dealing with young people, would receive funding through this initiative to provide 'an integrated service covering health care, rehabilitation and counselling support or by providing access to a network of complementary services' (Howe et al, 1989, p. 12).

In 1989–90, the first year of the IHSY Program, only seven projects were funded—one in Parramatta, New South Wales, one in the Northern Territory and five in Queensland (Commonwealth Department of Health, Housing, Local Government and Community Services, 1993). After years of a conservative Bjelke-Peterson government, Queensland moved quickly to take up this funding. As Queensland's new Labor Government had not yet established a youth health infrastructure in the State Department of Health, the Australian Association for Adolescent Health (AAAH) received a one-off grant to resource and support the IHSY agencies during the first six months of the program (McLean, 1993, p. 30). The IHSY program in Queensland was based on a collaborative and consultative approach to service provision - a primary health care focus within a social justice framework (McLean, K. 1993, pp. 22-23). One key informant recalled how important it was to develop positive relationships with, and trust between, the community and government sectors after years of the Beljke-Peterson Government. They pointed out that, while this was time-consuming, it was essential to the achievement of a collaborative community-based model. The same key informant praised the Queensland strategy of placing programs in youth agencies which already had a track record of working with young people, a view supported by the first evaluation of the IHSY Program in Queensland (McLean, K. 1993, p. 30).

It seems that a year and a half after the report of the HREOC Inquiry Burdekin again saw the need to prod the Government to action on the issue of homelessness and health services. In June/July 1990, the hearings of the National Inquiry into Homeless Children were reconvened (Hartley, 1990, p. 27). Burdekin reported on deaths of homeless young people from drug overdose, which could have been prevented if health services had been set up. He also noted the:

...failure of State and Commonwealth governments to agree on who was responsible for under 16 year olds; the continuing high incidence of child abuse among homeless children, lack of State government consultation with the community sector in seeking solutions, poor coordination between those services that did exist, very limited attention to preventive action, including the development of family support programs, and not enough emphasis on community-based programs.

Hartley, 1990, p. 27

The submission to the reconvened Inquiry prepared by the Australian Institute of Family Studies (AIFS) reports that there had been little change since *Our Homeless Children* had been published in 1989 and pointed to the 'tendency for economic perspectives to predominate over social perspectives in policy decision making' (Hartley, 1990, 28). The AIFS submission highlights the need for Governments and the community to:

determine a workable, realistic and flexible balance of family, State and individual responsibility for young people in different circumstances, and be more realistic about what constitutes adequate income support, in the absence of waged work, for young people with no parental support.

Hartley, 1990, p. 28

6.7 Young people and mental health

I think by the end of the decade it was accepted within health circles at least, that mental health was probably one of the two or three most important issues in adolescent health, whereas it had been a very much fringe and peripheral at the start of the decade.

(M4)

Ironically, it was the increase in youth suicide that brought young people's mental health and wellbeing to the attention of governments and health departments at the end of the 1980s. In the same way that the pattern of homelessness changed in Australia during the 1970s and 80s, with the homeless becoming younger, so the pattern of suicide changed. Previously more common among middle-aged men and women, by the end of the 1980s suicide became more common among the young. Young men were particularly affected. The rate for 15 to 24 year old males rose throughout the 1980s, peaking at 27.88 per 100,000 in 1988 and almost as high in 1990 at 26.96 per 100,000 (Commonwealth Department of Human Services and Health, 1995b, p. 8). Comparative data has shown that in the early 1990s Australia has one of the highest youth suicide rates of industrialised countries.

The youth suicide rate in Australia is high by international standards. The 1993 World Health Statistics Annual prepared by the World Health Organization (WHO) shows that this country recorded the fourth highest rate in a list of 14 countries for suicide deaths among males 15 to 24 years of age, and also for females in the same age group in 1990-91, the latest year for which comparative data was available.

Commonwealth Department of Human Services and Health, 1995b, p. 21

Such figures must have been an embarrassment for the government, because suicide has dominated the youth health agenda in the nineties and into the twenty-first century. But, as two of my key informants pointed out:

The difficulties here are, are we now dealing with a mental illness or are we dealing with a natural reaction to the difficulties of life and I think that issue has become an important one.

(M6)

...suicide was always a bit of a blind alley in a way, in that even though it's a very important event, and relatively common cause of death in adolescence, it is such a rare event that any of the intervention strategies are unlikely to really have a great impact on the overall suicide rate. I think in the late 1980s we were beginning to realise what we need to do is intervene in the whole area of youth mental health rather than trying to go and set up suicide prevention strategies. So that kind of broadened out...

(M4)

The way a society responds to an issue will depend on how it understands the issue and the assumptions and beliefs that underpin such understandings will influence the responses adopted (Low and Crawshaw, 1985, p. 23). Richard Eckersley, a researcher and social commentator with CSIRO, argues that responses to increases in depression and suicide among young people must be sought within the culture itself and action taken at a social and cultural level (Eckersley, 1988). He is critical of the emphasis on personal factors in youth suicide research which:

encourages, however unintentionally, a view that is already too prevalent: that we are dealing with what are essentially personal problems: that is the sufferers are those who, through misfortune of their own failings and weaknesses, face difficulties related to home, school or work, and are having trouble coping with life or living within the law.

Eckersley, 1988, p. 40

Eckersley's argument becomes particularly cogent when one considers the groups of young people who have been identified as being 'at risk' of suicide: those with mental

illness, Aboriginal and Torres Strait Islander young people and young males living in rural and remote areas (Commonwealth Department of Human Services and Health, 1995, p. 2). More recent research has found an elevated risk to survival in young men who were neither employed nor students (Morrell et al, 1990; 1999) and that young gay men (15 to 17) experience more suicide ideation and make more attempts than their counterparts (Nicholas and Howard, 2000).

For all of these groups suicide cannot be understood or addressed without attention to the way structural factors and the social context affect their sense of wellbeing. This means that mental health promotion and suicide prevention policies and strategies need to attend to matters such as unemployment, racism and homophobia and community attitudes to mental illness. As one of my key informants indicated, by the end of the 1980s, there was a need to 'go back a few steps and look at the stresses on young people and why they exist, rather than developing resources for bottom end crisis situations'. (YHP2)

While Eckersley emphasises the importance of social and cultural factors, other researchers have highlighted mental illness as a key factor in suicide, pointing to international and Australian research which indicates that many or most 'individuals who suicide have evidence of a psychiatric disorder at the time of their death' (Commonwealth Department of Human Services and Health, 1995b, p. 28). This suggests the need for better treatment facilities and support for young people with mental health problems and disorders.

Whether the emphasis is on mental health promotion or service provision, it seems that young people were failed on both counts during the 1980s. The lack of a health promotion and community development focus in mental health was raised as an issue by my key informants in all three categories—those who worked in medical settings; in youth health policy and programs; and in youth work and youth affairs (M4; M6; M7; M8; YHP3; YHP8; YA6). One of my key informants expressed the view that the few mental services that did exist were 'a law unto themselves', they tended not take a community approach to mental health and seldom participated in collaborative community-based initiatives. (YHP 15) Another noted that the Commonwealth did not have a national mental health promotion strategy until the early 1990s and even then there was little mention of young people. (M8)

In relation to mental health services, the need was identified consistently in reports on young people's health throughout the 1980s (CDH, 1981; Bennett, 1984; SAHC, 1986d; WADH, 1987; YPDC, 1987), to little effect. Related to the lack of mental health services, was the lack of support for youth workers who dealt with young people with mental health

problems and disorders (YA4; YA7; YA1; YHP8). As one of my key informants commented:

We had needle exchange, and it was an important service to do, but given that we had far more young people who were suffering very severe psychiatric problems but we weren't doing anything with them...and I have been very frustrated about that and obviously HIV was an important issue, but in this state it paled against what was happening with psychiatric issues with young people. There were lots of us who were working in the community, we had no resources, we had...significant breakdown of relationships, a lot of trauma and depression and associated issues. We weren't able to deal with those, there was just no debate on that.

(YA7)

Another stated:

In my view, what has happened is that there has been an increase in more adequate services for young people over the decade. However, the increases have been marginal and nowhere near what has been required. The fact is that although young people form a very significant proportion of the population, possibly a quarter of the population, they certainly do not receive a quarter of the health funds and yet in my area, mental health area, they are at the point the most vulnerable and the point at which most could be done because this is the point at which the severe mental disorders start yet there has been no recognition, practically no recognition, in that fact. I think that what has been done is lip service has been paid to these needs. They certainly just do not exist in comparison with the services that go to adults and I think this is a huge problem.

(M9)

It is not a matter of mental health promotion versus treatment. A multi-layered and comprehensive approach is required to promote the mental health and wellbeing of young people. As one of my key informants commented:

...there is tension between those two directions and I think in a context of no money, you are pushed into, I mean there is a very strong view that limited mental health resources should be used for the most seriously mentally ill youth. I don't actually think that is right. I think we should be pushing for more resources so that we can do both. I think we are failing substantially to look at mental health promotion, mental health education...

(M8)

Further, it is not just a matter of providing services. Those services need to be acceptable and accessible to young people and their communities.

It is not the intention of this thesis to analyse the extensive work done on youth mental health promotion and suicide prevention in Australia the 1990s, but to ask whether the government's failure to address the social and environmental factors that shape and compromise the health of young people and the unheeded recommendations of numerous reports produced during the 1980s, may have contributed to a climate in which young people were not valued nor given the support they needed.

6.8 Summary

As Maas and others have pointed out, the Commonwealth youth policy focus on education and training to the neglect of issues such as accommodation, and the policy of shifting responsibility for income support back to the family, left many young people in a twilight zone between childhood and adulthood and placed additional pressure on low income families. While the National HIV/AIDS Strategy and the National Campaign Against Drug Abuse identified young people as a priority and generated new sources of funding for young people's health, the lack of a coordinated approach meant that other important issues were neglected. It could be argued that lack of attention to the social determinants of the health of young people and a tendency to blame young people for their predicament by urging them to undertake more education or to just change their behaviour, contributed to a situation which affected their health and wellbeing negatively. The rise in homelessness documented by the HREOC Inquiry and the increase in suicide among young people, attests to this neglect and may, as Eckersley suggests, be symptoms of a social malaise which goes much deeper. The rise in suicide points to a wider issue, that of the wellbeing of young people, how it is conceived, understood and measured, which is discussed in Chapter 7.

CHAPTER 7

KNOWING YOUNG PEOPLE'S HEALTH

7.1 Introduction

Interest in young people's health developed in concert with the rise of Alma Ata and social health ideas internationally and in Australia. The implementation of those ideas in young people's health requires research and data collection that are philosophically in tune with them. There is a need for research and data collection that is informed by a positive view of health, takes into account the impact of social and environmental factors on young people's health and young people's views about health and the things that affect their wellbeing. Chapter 7 examines the assumptions underpinning health research and data collection about young people and argues for an approach that is more consistent with Alma Ata thinking.

7.2 Concepts of health and wellbeing

The founding members of AAAH regarded the positive definition of health adopted by the World Health Organization (1946) and reaffirmed in the Declaration of Alma Ata (1978), as important in young people's health. The positive definition is difficult to operationalise in a sector concerned mainly with illness, but offers several advantages in the approach to the health of young people. Young people are a comparatively healthy population group and positive measures are useful in the assessment of changes in relatively well individuals (and, I would add, populations), that may result from health promotion efforts (Patrick and Bergenar, 1990, p. 168). My own experience suggests that a positive view of health is more acceptable to young people than a focus on illness, death and risk behaviour. It opens up possibilities for imagination, investigation and action and moves past the view that health is about the things one should not do, a kind of latter day puritanism. It has the capacity to include things like artistic expression, spirituality, the environment and world peace. During the 1980s, young people indicated that world peace and the environment were important to them and affected their sense of wellbeing (YACA, 1983; Commonwealth Department of Sport Recreation and Tourism/ANOP 1985, Goldenring, 1988; Commonwealth Youth Bureau/ ANOP 1991).

A positive definition of health is important in Australia because it fits with Aboriginal views about health. Maggie Brady, an Australian researcher who has worked and conducted research with Aboriginal young people, points out that within Aboriginal cultures, young people are seen within the context of their community, not as a group apart (Brady, 1992). Aboriginal understandings provide insights about the meaning of health that are relevant to studies of both Aboriginal and non-Aboriginal young people. Kirke and

colleagues (1993) point out that the term 'pukulpa', from the Western Desert group of Aboriginal languages, is used in the way non-Aboriginal people use the word 'health' and implies a state of wellbeing and happiness.

In Aboriginal terms, being 'healthy' is understood to encompass the wellbeing of an individual within his or her total environment, including the extended family and community. Health business includes matters such as regaining tenure over tribal lands, ensuring children have tucker, being able to undertake social responsibilities and participate in ceremonial life...

Kirke et al 1993, p. 99

This statement points to three things necessary to the attainment of health: the material, such as 'ensuring kids have tucker'; participation in community life through undertaking social responsibilities; and the spiritual, suggested by 'participation in ceremonial life'. It also draws attention to the political work of gaining tenure over tribal lands, a reminder that health-enhancing social change may require political action. Kirke makes the point that clinical parameters of morbidity and mortality are inadequate indicators of Aboriginal health status because they neither show people in connection with their community and the wider environment, nor reveal the positive aspects of community life. The same is true of young people. Understanding their health requires an approach that goes beyond measurement of morbidity and mortality and sees young people within their social context and the context of community life.

Studies of resilience in young people conducted by Resnick and colleagues in the United States have shown that connectedness and spirituality, broadly defined, are important (Resnick et al, 1993). Elaine Norman, an academic in social work with Fordham University in New York, describes the genesis of interest in the study of resilience—that is, studies that investigate why it is that some young people survive and thrive in the face of adversity and others do not (Norman, 1995, p. 15). Norman suggests that two strands of scholarship met in the new focus on resilience: firstly, research on coping and stress which moved scholars' attention away from the emphasis on risk factors and directed it toward the coping skills individuals utilise to meet environmental challenges; and second, clinical research where scholars became 'disillusioned with the efficacy of the clinical disease model which emphasised pathology and injury, victimisation and learned helplessness' and sought 'to find hope in the midst of an excess of stress and adversity' (Norman, 1995, p. 18). Resnick makes a similar point:

Much of scientific inquiry in adolescent health has traditionally focused on the correlates of problemness or pathology. Here a focus on resiliency means that inquiry is directed toward understanding *success* and *wellbeing*, identifying those factors that

buffer against the stresses of everyday life which might otherwise result in adverse physical, social or psychological consequences.

Resnick et al, 1993, p. S4 (emphasis in the original)

Norman points out that, because of the 'fragmented manner' of the genesis of resiliency research, there was a need for definitional clarity. She commends a model developed by Kumpfer who makes a distinction in terminology between characteristics of the person (resiliency factors) and characteristics of the environment conducive to resiliency (protective factors). Norman praises the clarity of Kumpfer's model, which she describes in the following way:

She (Kumpfer) separates qualities of the environment from characteristics of the individual and calls (a) negative characteristics of the environment *risk factors*, (b) positive characteristics of the environment *protective factors*, (c) negative characteristics of the individual *vulnerability factors*, and (d) positive characteristics of the individual *resiliency factors*. All of these *interact* to result cumulatively in adaptation or maladaptation of the individual.

Norman, 1995, p. 20 (emphasis in original)

The focus here is on individuals. So too is the focus in the study conducted by Resnick and colleagues which investigated resiliency in American high school students from socially and economically diverse backgrounds. The study 'repeatedly found that caring relationships between children and adults, including relationships within and outside the family, were central to the development of resilient adolescents and young adults' (Resnick et al, 1993, p. S4). While low family stress, that is the absence of things such as 'parental unemployment, poverty, domestic violence, and parental substance use', also function as protective factors, caring and connectedness (to school and family) and spirituality were stronger predictors of resilience (Resnick et al, 1993, p. S5). Resnick emphasises that, while 'reducing the prevalence of poverty must remain an enduring goal', young people's underlying need for belonging must also be acknowledged, and 'more than an economic determinism is needed to promote adolescent health' (Resnick et al, 1993, p. S7).

I agree that 'more than an economic determinism' is needed, but there is a danger that a research agenda based on resilience could increase the focus on the individual to the neglect of the social determinants of young people's health, even though Resnick warns against this.

Caring, while extraordinarily important in the lives of young people, is not a substitute for correcting fundamental threats to health, rooted in economic disparities that have become increasingly manifest due to both deliberate government policies and a

shifting economic infrastructure that strains the ability of families and individuals to thrive and function.

Resnick et al, 1993, p. S7

American epidemiologist Nancy Kreiger highlights the limitations of studies of individuals and suggests that there is a need to distinguish between determinants of disease in individuals and determinants of disease in populations (Kreiger, 1994, p. 891). Following Rose, she points out that causes of cases and causes of incidence may not be the same:

As Rose has shown, these two sets of causes are *not* necessarily the same and require different research questions: asking 'why do some individuals have hypertension?' is not equivalent to enquiring 'why do some populations have much hypertension, whilst in others it is rare?'. The former emphasises individual susceptibility and intervention aimed at high risk individuals, whereas the latter highlights population exposures and the need to shift the distribution of disease in the entire population (which will always have its outliers) to a healthier state.

Kreiger, 1994, p. 892

Kreiger's statement suggests some important questions for research in young people's health: do some groups of young people experience greater adversity than other groups and, hence, have to demonstrate resilience more often than other groups?

7.3 Social and environmental determinants of health

The most powerful determinants of health are the environmental and social conditions in which people live. Evidence from the United Kingdom (Terris, 1994; Eames et al, 1993; Davey-Smith et al, 1990; Black, 1980) and more recently, Australia (Broom, 1984; Health for All, 1988; National Health Strategy, 1992; ACOSS, 1993, Health and Welfare), has shown that the poor, however they may be defined, bear the greater burden of illness in society. That proposition stands on evidence going back to the 17th century and prevails still. Also the 1990s literature makes more of relative than of absolute deprivation. Even in societies that are well off absolutely, the groups that are most deprived of material resources and social ones tend to have worst health (Marmot and Wilkinson, 1999; Evans, 1994).

In his classic overview of social and environmental factors in disease prevention Syme notes that, although the importance of environmental factors such as socioeconomic status has been known for some time, much less is known about the way environmental factors affect health or how illness might be prevented by environmental interventions (Syme, 1986, 1992).

It is surprising that one of the most persistent and pervasive observations in public health remains so little understood. One of the reasons for this may be that socioeconomic status so powerfully influences disease rates that most researchers statistically remove it from analysis so that other factors can be studied without its overwhelming influence.

Syme, 1986, p. 957

Syme makes three points in support of his argument for greater attention to social and environmental factors: population approaches to disease prevention are more cost effective than treatment of individuals; changing health compromising behaviours in individuals has proved difficult; and certain patterns of illness continue to persist in specific sub-groups of the population, despite the fact that individuals come and go from the group. Further, Syme draws attention to Cassel's argument, that a wide variety of disease outcomes are associated with similar circumstances and to study only one disease entity may cause features common to a number of health problems and behaviours to be overlooked (Syme, 1986, p. 964).

Identification of the social correlates of disease is often inhibited by the data producing process: both the collection and interpretation of data contain value components and assumptions that are not always stated (Kreiger, 1992, 1994). Highlighting the silences in US public health data, Kreiger points out that there is little available that shows the differentials between people of different socioeconomic status and ethnic background. She points to four underlying assumptions that have influenced approaches to collecting and presenting US public health data in the past:

1. the belief that the US is a 'classless' society
2. the belief that racial/ethnic differences can be discussed without reference to racism
3. the belief that gender differences can be discussed without reference to sexism
4. the dominance of individualistic biomedical and 'lifestyle' theories of disease causation.

Kreiger, 1992, p. 418

Kreiger notes that, even when data about social inequalities in health are collected, explanations for these problems often blame the poverty and ill health of the poor on fundamental defects in their character, a view not too far removed from the 'culture of poverty' thesis put forward in *Health for All Australians* in 1988 (DCSH, 1988, p. 56). In the case of research about young people and their health, Australian researchers Jamrozik and Boland comment that often a homogeneity is assumed that ignores the wider structure of socioeconomic differences and divisions of social class (Jamrozik and Boland, 1991). In

light of their examination of the research in young people's health conducted in Australia between 1983 and 1988, they conclude that:

...if research concerned with young people's health was to have explanatory value and lead to more effective preventive and developmental policies and methods of intervention, the perspective on young people needed to be widened so that young people and their health problems were appropriately perceived in the context of the society as a whole, with all its socio-economic, cultural, gender and above all, class divisions. Secondly, if many causes of young people's health problems were causally linked to the social environment in which they lived—as it was claimed in much of the rhetoric on the subject—then more research would need to be focused on that environment rather than solely on the young people themselves.

Jamrozik and Boland, 1991, p. 3

Kreiger calls for the development of new theory and models for epidemiology which incorporate social and environmental perspectives. Pointing to the need for better integration of biologic and social understandings of current and changing population patterns of health and disease, she advocates an ecosocial model which acknowledges and reveals 'the inextricable and ongoing intermingling—at all levels—of the social and biological' (Kreiger, 1994, p. 896). She argues for a model that:

... *requires* considering multiple levels when seeking to understand patterns at any given level, and likewise highlights the need to frame questions broadly, regardless of the level at which the investigation is being conducted.

Kreiger, 1994, p. 897 (emphasis in original)

What is needed, according to Kreiger, is an image which:

...does not mandate a singular answer, applicable for all diseases, but does specify a range of questions - about social structure, cultural norms, ecologic milieu, and genetic variability—that must be systematically addressed when analysing any specific situations...it directs epidemiologists to think about individuals in the context of their everyday lives, as shaped by their intertwined histories—as members of a particular society, and as biological creatures who grow, develop, interact and age.

Kreiger, 1994, p.897

Kreiger suggests that a social and ecological point of view will do three things: serve as a reminder that 'people are but one of the species that populate our planet' and that the health of all organisms are interconnected (Kreiger, 1994, p. 898); include social class as a fundamental category, shifting discussion away from the term person when what is really meant is social group; and shift attention away from the notion of 'special' group to focus on what makes populations 'special'—'their enforced marginalisation from positions of

power' (Kreiger, 1994, pp. 898–899). I have made a similar point earlier in this thesis regarding the way the term 'vulnerable' has been used to describe 'special groups' of young people in health literature in Australia, obscuring the causes of their 'vulnerability' (See Chapter 3).

Finally, Kreiger points out that an ecosocial framework would require:

...situating the social context of such health 'behaviours' if they are to be comprehended, let alone changed. And with regard to prevention, it would encourage research on not only those factors deemed amenable to intervention through the medical care system, the work of public health departments, or the efforts of solo individuals, but also on the broader determinants of health that can be changed only through more widespread social action.

Kreiger, 1994, p. 899

Kreiger's thesis has particular relevance to studies of young people's health. Throughout the 1980s, Australian reports drew attention to the importance of social and environmental factors, even if only in rhetoric (Jamrozik and Boland, 1991), and there is a need for a research agenda that will provide information on these matters to guide policy development, not only in health but across sectors and government instrumentalities.

In the UK, social inequalities in relation to health have been studied since the beginning of the 20th century with recent efflorescences in the Black report in the early 1980s and the Marmot and Wilkinson studies of the 1990s. In that intellectual context other researchers have queried whether the inequalities apparent in children and in the adult population apply to young people. West's study found a relative equality (MacIntyre and West, 1991) but Glendinning and colleagues, while able to confirm West's findings when they used parental occupation as an indicator of socioeconomic status for young people, found an emergent pattern of health inequalities 'once the focus of attention is shifted to young people's current social class position' (Glendinning et al, 1992, p. 679). Mathers' analysis of differentials in health among Australian young people revealed:

...clear socioeconomic differentials in the health of young Australians aged 15–24 years according to a range of indicators of mortality, illness and accident rates and health service use. Disadvantaged young adults have worse health, whether measures of disadvantage are based on family income, education, employment status, or socioeconomic disadvantage of area.

Mathers, 1996, p. v

It would therefore seem that inequality in health exists within the youth population as it does with other groups and that it is related to unequal shares of social and material goods.

The need for a better understanding of the impact of social and environmental factors on young people's health and a reexamination of the values underpinning health promotion efforts has been highlighted by a number of Australia researchers (Kippax et al, 1990; Boland and Jamrozik, 1989; Jamrozik and Boland and 1991; Bush, 1991, 1992; Moore and Saunders, 1992; Stewart, 1992, 1993; Wyn, 1994). Wyn questions the usefulness of safe sex messages which urge young women to insist on condom use, when the negotiation of safe sex in heterosexual relationships occurs within the context of unequal power and assumes a particular type of sexual activity which gives priority to male pleasure (Wyn, 1994). It follows that research and data collection about young people and their sexuality needs to provide a better understanding of power within relationships, the impact of sexism on young women's ability to act on the messages they receive from media campaigns and how young men see their responsibility. Wyn observes that:

The campaign to increase community awareness of HIV has successfully placed sexuality within the public arena. The prevention of infection with STDs requires, in addition, that conventional assumptions about heterosexuality be challenged at a public level, such that young women take a more active part in negotiating their sexual relationships...this requirement runs counter to the prevailing messages many young women receive about femininity which emphasise vulnerability and powerlessness.

Wyn, 1994, p. 38

Sociologist Alan Patience raises concerns about the psychosocial wellbeing of young men, drawing attention to the impact of Australia's cultural climate (Patience, 1992). He describes the Australian culture as a hard culture, and argues that, in addition to young men, the wellbeing of Aboriginal and Torres Strait Islander young peoples, culturally and linguistically diverse young people, young women and young gay and lesbian people, is affected by a home-grown racism, sexism and homophobia. He holds that initiatives to promote the emotional and social wellbeing of young people generally, and prevention of suicide among young men in particular, need to take account of the history of Australia and address the social and cultural practices it has produced. Patience's argument recalls Eckersley's thesis (1988), that the reasons for suicide among young people must be sought within the culture. Patience calls for development of new theory for understanding young people and their mental health in Australia, one which incorporates the interaction of Anglo-Celtic culture with the complexity of Aboriginal cultures, multiculturalism, and the cultures of the Asia-Pacific region (Patience, 1992, p. 50).

Moore and Saunders, who have investigated drug use by young people, are critical of the way data are collected about young people's drinking in Australia. They argue that data about 'how much' alcohol young people consume have limited value for health promotion and the development of harm minimisation strategies. They suggest that information about

the meaning young people assign to drinking, and the context in which they drink, is more useful (Moore and Saunders, 1992). Australian researcher Robert Bush draws attention to the values implicit in much research on the drinking practices of young people 18 to 25 years of age. Bush has conducted research on young people and drinking situations and points out that the pattern of going out once or twice a week to commercial sites to drink tends to be viewed in two different ways by researchers: it is either described as 'binge drinking' with a set of risky consequences; or alternatively, 'as a direct and symbolic expression of newly found social independence' which occurs once a week because young people have limited funds (Bush, 1992, p. 4). Bush notes that the practice of purchasing drinks in a group or 'the shout', takes on different meanings when viewed from these different perspectives:

The binge style view might see this style of purchase as a risk behaviour because shouting tends to increase consumption levels through the obligations imposed on group members.

The alternative view would see the group purchase as symbolic of newly found freedoms to legally use the licensed environment; a way of expressing one's sense of social independence within the context of a friendship group.

In fact, this view gives a good clue about why the activity is so popular. I suggest its a view more in tune with the values of the transition years than the rather limited, but popular idea that group purchase can be explained away as 'peer pressure'.

Bush 1992, p. 4

As well as being more in tune with the values of young people, I would argue that the latter view takes a more respectful stance towards them.

Moore and Saunders point to another concern regarding the way data is collected about young people's drinking, which recalls issues raised by Nancy Kreiger. They note that data collection activities in Australia have ignored 'macrostructural factors such as poverty, high unemployment, racism and inadequate housing, which might relate to drug use problems' (Moore and Saunders, 1992, p. 31). They concur with Reinerman and Levine that:

We cannot allow any administration to get away with a drug policy based on forcing young people to 'just say no', when that administration has just said no to virtually every single government program that might enrich the experience and improve the life chances of young people.

Reinerman and Levine, cited in Moore and Saunders, 1992, p. 31

Canadian educationalist Leslie Roman takes this matter up in relation to notions of 'youth-at-risk', arguing for:

...the epistemic, methodological and political stances to alter as well as to challenge, official policy discourses that naturalise the spectacle of youth-at-risk. I argue that when (educational) researchers and policy makers create youths as subjects at risk...(young people) also become subjects of blame and pathology and, thus, are constructed as deserving particular paternalistic state interventions. Such constructions not only trivialise or silence altogether the voices of youth, they also distract from the larger structural realities of late capitalism and long standing inequalities of distributive and social justice that are the real and complex culprits with respect to many of the problems young people face today.

Roman, 1996, p. 2

There is long-standing evidence that the most powerful determinants of health are the social conditions within which people live. This applies as much to young people as to adult populations and requires more attention in data collection activities than it has been given in the past. Linking arguments put by Keiger and Australian research, I have made a case for research and data collection which provides information about young people within the context of their lives, that reveals differentials in health in particular groups of young people and asks why these differentials exist. As Krieger points out, the processes whereby public health data are produced are usually cast in apolitical terms, but:

...no data bases have ever magically arrived, ready made, complete with pre-defined categories and chock full of numbers. Instead, their form and content reflect decisions made by individuals and institutions, and, in the case of public health data, embody underlying beliefs and values about what it is we need to know in order to understand population patterns of health and disease. In other words they are a social product, and are neither a gift passively received from an invisible donor, nor a neutral collection of allegedly inevitable empirical facts.

Kreiger, 1992, p. 413

When it is the health of young people that is being discussed, the data will contain information revealing beliefs and values about the meaning of the term health and how the health of young people is created. It will also reflect concepts about young people and the expectations held within society more generally about 'the business' of being young: that is, the kinds of things 'healthy' young people are getting on with at this particular time in their development.

7.4 Concepts of young people

Youth/adolescence remains a powerful cultural and ideological category through which adult society constructs a specific stage as simultaneously strange and familiar. Youth/adolescence remains the focus of adult fears and pity, of voyeurism and longing.

Griffin, 1993, p. 23

Given the power of the social, an investigation of the state of young people's health requires a working understanding of the meaning of this time of life. While young people are generally a well and healthy population group who make a positive contribution to Australian society, media representations and much theorising focuses on the negative and problem behaviour, a position which has not served young people well.

Researchers who have investigated the way young people are portrayed in the media in Australia agree that they have been depicted alternately as victims, outsiders, perpetrators of crime or voice of social conscience (Finch, 1993; Bessant, 1993; Sercombe, 1993; Boland and Jamrozik, 1989; Bessant and Hill, 1997). Walton has pointed out that young people only become visible in the media when they pose a problem and/or through their cultures: that is the way they look and/or their spectacular appearance or lifestyle (Walton, 1993). Media rarely display young people as valued members of the community. Leslie Roman, a Canadian researcher in Educational Studies at the University of British Columbia points out that:

Youth is a landscape for journalists, social workers, media, social scientists and educators, and simultaneously, it is an inaudible voice in public debates over concerns that crucially affect its conditions of existence. The missing presence of youth themselves (as speakers with political legitimacy and unique epistemic standpoints) from most forums in which they are the literal, metaphorical, and political subjects should not go unremarked.

Roman, 1996, p. 1

The absence of the voice of young people and the proliferation of negative stereotypes of them in the media did not go unremarked in Australia during the 1980s. The national consultation conducted by the Youth Affairs Council of Australia in 1983 found that concern was 'constantly expressed by young people about their treatment by the media' (YACA, 1983, p. 218). The YACA report drew attention to the following matters: the limited access young people have to the media; negative media stereotyping and misrepresentation of young people; the manipulative use of advertising directed at young people; the possibility of a more positive use of media which promotes a positive lifestyle; and the centralised control of the media in Australia (YACA, 1983, p. 218). Western

Australia's *Future Health* raised similar concerns in 1987 and it would seem that little progress has been made. In 1994, Mikyla Thompson, speaking for many young people in South Australia, expressed the view that the media associates youth with irresponsibility, untrustworthiness, rebelliousness, drugs and sex, and presents young people as 'a basic hindrance on society' (Thompson, 1994; Bessant and Hill, 1997).

Despite media images of youth in turmoil, theorists working in Australia, the UK and Canada have refuted the notion that 'psychological turmoil is universal and normal for adolescents' (Bennett, 1984; Offer et al, 1988; Collins, 1991; Coleman and Hendry, 1990) and G. Stanley Hall's 'storm and stress' theory of adolescence has largely been discounted (Collins, 1991), nonetheless the possibility remains that young people are still scapegoats for social turmoil and such images persist and continue to influence research and policy responses to young people (YACA, 1983; Drury and Jamrozik, 1985; Bessant, 1993; Bessant and Hill, 1997; Roman, 1996).

In addition to the images generated by the media, contemporary understandings of young people have been influenced by research undertaken within the disciplines of sociology and psychology, internationally and in Australia. Developmental psychology has arguably had the greatest influence on Australian thinking and research in young people's health. Theorists such as Havighurst, Jessor and Erik Erikson are frequently cited in adolescent health literature (Bennett, 1984; Nutbeam, 1993) and their work has generated models that informed research and reports produced in Australia during the 1980s and into the 90s (Bennett, 1984; Raphael, 1993; Nutbeam, 1993). However the conceptual limitations of the work of these theorists has been pointed out by other researchers (Gilligan, 1982; Kroger, 1989; Bush, 1991; Griffin, 1993; Johnson, 1993) and the usefulness of Jessor's Problem Behaviour Theory in the Australian context has been questioned (Bush, 1991).

Havighurst (1972) has contributed the idea of developmental tasks that must be achieved by young people in the process of attaining adulthood³⁴ (Bennett, 1984; Johnson, 1993), however researchers writing from a feminist perspective argue that the developmental tasks proposed by Havighurst do not take into account young women's experience

³⁴ My first encounter with the concept of developmental tasks was in 1983 at a seminar for medical students on adolescent health. I was in my mid-thirties at the time and new to the field of adolescent health. My reactions are interesting in light of the above criticisms. My first thought was that they provided a useful framework from which to view young people's development: that is, young people, like children, had certain tasks they needed to achieve before they could move into adulthood. However, as I examined the list of tasks on the overhead projector more closely I became a bit uneasy. I had the distinct feeling that I had not yet completed them, nor had many of my friends! I felt that my identity was still forming and changing. I had just changed my occupation again and had done so many times, depending on where I was living and the opportunities available; and, with regard to determining sexual orientation as a task to be completed during adolescence, at least three people I knew in their mid-30s had recently 'come out'. The second area of uneasiness was in relation to the task of acquisition of skills for future economic independence in a time of high unemployment. This was 1983, the year that unemployment peaked during the 1980s. I wondered at the time whether a person who had not successfully achieved the task of attaining a job was doomed to be an adolescent forever. Would they be considered abnormal in some way and be referred for therapy?

(Gilligan, 1982; Griffin, 1993; Johnson, 1993). Kroger points out that Erikson's identity concept needs to be substantially modified to account for male and female experience adequately (Kroger, 1989, pp. 32–33) and others have argued that the entire model reflects male experience only (Gilligan, 1982; Griffin, 1993; Johnson, 1993). Christine Griffin, a psychologist with the University of Birmingham working from Gramscian, post-structuralist and feminist perspectives, points out that, in addition to young women, the experiences of young people of colour and young gay and lesbian people tend to be absent in much of the research that has generated theories of young people. These criticisms suggest that, to adequately reflect the diversity of young people, new approaches to theory development are needed.

Jessor's Problem Behaviour Theory (PBT) may not be relevant to the drinking behaviour of eighteen to twenty-five year olds in Australia according to the evidence presented in Robert Bush's study of young people and drinking situations (Bush, 1991). Designating the time between eighteen and twenty-five years of age as transition years, Bush argues that in this age group, PBT is 'more likely to predict young men's drinking than young women's drinking because it defines the antecedents of drinking proneness in masculine terms' (Bush, 1991, p. 103). He points out that PBT does not take into account, at a theoretical level, differences in meaning attributed to drinking behaviour by young men and young women, nor does it recognise that young men and women can follow different pathways through the transition years in relation to drinking (Bush, 1991).

Bush raises other questions about the usefulness of Problem Behaviour Theory in the study of the drinking behaviour of young people within the Australian context. He points out that:

It is a construct which is defined by what is assumed to be a universally static and homogeneous norm for youth drinking...youthful drinking situations are examined from the perspective of an adult world view about expectations of youth drinking rather than from the perspective of the young drinker's definition of the drinking situation.

Bush, 1991, p. 97

Highlighting the cultural differences in attitudes to drinking in the United States and Australia, Bush argues that drinking by eighteen to twenty-five year olds (and even underage drinking) is a cultural norm in Australia, and could hardly be considered deviant (Bush, 1991; 1992).

Another limitation of Problem Behaviour Theory noted by Bush and others is that it couples indicators of transition proneness with problem drinking proneness.

...(the) general indicators of a transition towards an independent young adulthood are also the very predictors of problem drinking. As Sadava points out, to take a normal transition pathway is to increase problem proneness within this theoretical framework. Zucker observes that because transition proneness and problem proneness are conceptualised in similar ways it is difficult to determine whether typical drinking practices in the transition years represent 'deviant' or normal psychosocial development.

Bush, 1991, p. 99

Bush concludes that, with regard to the drinking of eighteen to twenty-five year olds, 'the social context is more varied and less deviant than PBT prescribes' (Bush, 1991, p. 97).

Erikson's concept of youth as a time of identity crisis has not been supported by empirical studies of young people (Coleman and Hendry, 1990). Coleman and Hendry found no evidence to show that any but a small minority experience a serious identity crisis, that 'in most cases relationships with parents are positive and constructive, fears of promiscuity among the young are not borne out by research findings and studies do not support the belief that the peer group encourages anti-social behaviour unless other factors are present' (Coleman and Hendry, 1990, p. 201). They conclude that, there is no evidence to suggest a higher level of psychopathology during the adolescent years than at other times. Offer and colleagues come to a similar conclusion as a result of their comparative study of young people in ten countries (Offer et al, 1988).

Three possible explanations are put forward by Coleman and colleagues for why beliefs about young people, generated by traditional theory, differ from empirical evidence: that psychoanalysts and psychiatrists see a selected population, encouraging a one-sided perspective; that sociologists have often seen young people as being at the forefront of social change and have 'confused radical forces with the beliefs of ordinary young people'; and the role the mass media plays in publicising particular behaviours, such as vandalism and drug taking, which are threatening to adults (Coleman and Hendry, 1990, p. 201).

The absence of the social in research in young people's health in Australia in the 1980s has been highlighted by several commentators (Boland and Jamrozik, 1989; Edwards and Hicks, 1990; White, 1994). Bolland and Jamrozik's analysis found that surveys were the preferred method in research in young people's health in Australia between 1983 and 1988, and questionnaires containing a predetermined choice of answers, were the favoured research instrument. They found few studies on qualitative aspects of health (Boland and Jamrozik, 1989, p. 15) and observed that the broad health area most researched during the eighties was that of drug use and 'abuse', with physical development and physical illness a distant second and AIDS, third (Boland and Jamrozik, 1989, p. 15). This emphasis presents a skewed picture of young people. It suggests they are a population group concerned

primarily with alcohol, tobacco, other drugs and sex, supporting, albeit unintentionally, the view of young people so often presented in the media. Edwards and Hicks, in their review of Australian literature on young people's health to 1990, conclude that:

By making adolescence the 'master-status' of young people, current thinking closes down discussion of the social dimensions of their experience. This restrictive understanding of adolescence leads to acceptance of psycho-emotional distress, problems and conflict, as natural aspects of its passage, instead of socially generated phenomena. Feminists point out that, within the orbit of medical thought and practice, women are conceptualised as less than social beings because they are 'hostage' to their physiology (Clarke, 1983). Adolescents are conceptualised in a similar vein: professional and popular theorising assumes that they are 'driven' by psychic states and processes, fuelled by physiology. Their social beings and social locations of their problems are discounted.

Edwards and Hicks, 1990

While writers have argued for more attention to sociological understandings in young people's health, within sociology itself, competing theories exist and influence the way issues are defined as problematic and the nature of the solutions proposed. Lowry, for example, pointed out that even sociologists as distinguished as Merton and Nisbet, were not immune to cultural bias in their choice of problem (Lowry, 1974).

Griffin's review of the youth research conducted in Britain and America in the 1980s identifies both mainstream and radical perspectives jostling in psychological and sociological research. She describes mainstream perspectives as those which offer causal stories that are 'used to justify hegemonic discourses around youth and adolescence' and which are characterised by their 'tendency to investigate young people as both the source and the victim of a series of social problems' (Griffin, 1993, p. 3). In contrast, she describes radical perspectives as those which take a perspective 'formed through theoretical, political and methodological critiques of the mainstream' and which tend to be informed by structural and post-structural analyses that *deconstruct* the association between young people and social problems (Griffin, 1993, p. 3, emphasis in the original).

During the 1970s and 1980s, mainstream sociological approaches were challenged by radical youth cultural analyses, in particular the research on youth subcultures conducted at the Centre for Contemporary Cultural Studies (CCCS) in Birmingham (Hall and Jefferson, 1976; Hebdige, 1979; Brake, 1980). The work of CCCS was influenced by Marxist cultural analysis and gave attention to the meanings and roles of young people's musical styles and cultural forms (Griffin, 1993). The predominant discourse in radical analysis was resistance theory, which:

...turned the ideological tables on mainstream analyses, presenting the activities and attitudes of particular young people, not as evidence of 'deviancy' or 'deficiency', but as resistance to their subordinated social position.

Griffin, 1993, p. 204

By the beginning of the 1980s, researchers working within a radical perspective in Australia and the United Kingdom argued that resistance theory (or the theory of cultural reproduction) was overly simplistic and tended to romanticise working class youth cultures (Walker, 1984) and gave little attention to young women (McRobbie, 1980), people of colour and gay and lesbian young people (Griffin, 1993).

Irving and colleagues suggest that the major academic discourse of youth in the 1980s in Australia was that of transition to adulthood (Irving et al, 1995). Writing in 1990, Yeatman, drawing on the work of Clare Wallace, describes the notion of transition in this way:

the transition to adulthood should be seen as part of a process of social and cultural reproduction which takes place on three levels - through the labour market (transition from school to work), through the housing market (the transition to an independent residential unit) and through the family (the transition from home of origin to home of destination).

Yeatman, 1990, p. 3

Yeatman adds a fourth layer of transition:

...the assumption of political and civil citizenship (the transition from subsumption under the domestic government of parents to assumption of independent responsibility for one's political choices, and for one's civil and criminal actions).

Yeatman, 1990, p. 3

However the concept of transition became increasingly problematic 'as older youth appeared unable to achieve the status of full time employment which traditionally had appeared as a marker on the road to independence' (Irving et al, 1995, p. 231). In 1983 the Youth Affairs Council of Australia (YACA) pointed to problems with this idea of young people:

To continue to see youth as a phase of life in which a transition occurs from one form of lifestyle to an 'adult' one is to disguise the social reality that such symbols as a job, financial independence or independent accommodation are being increasingly denied to young people. This makes the concept of transition not only inappropriate to young people but a falsehood.

YACA, 1983, p. 120

Further, YACA argued that the term 'transition' itself is problematic, as it implies an inadequacy in young people, a need to 'catch up' to older people (YACA, 1983, p. 117). I concur with this view and would add that the term is problematic because it supports a view that young people require little policy attention, they are just passing through and will 'grow out of it'. Designated as 'in transition', young people inhabit a kind of nether world in which they have no real status, no place to stand, or, in the words of Australian researcher Rob White, 'no space of their own' (White, 1990). Wyn and White have commented on this tendency for young people to be seen as 'incomplete adults', rather than citizens in their own right (Wyn and White, 1997, p. 3). To see young people as complete citizens is to see the importance of their participation in community life, rather than people waiting in the wings to become something.

Researcher Clare Wallace, who conducted a longitudinal study of young people in the UK during the 1980s, raises questions about the position and role of young people in a society in which the transition has become difficult to achieve (Griffin, 1993) and the age definition of 'youth' extends ever upward. Wallace points out that young people growing up during the 1980s were the first generation in the post-war period to encounter mass unemployment and, as a result, the process they experienced was different to that of their counterparts in previous decades. Wallace concludes that the social changes that occurred in the 1980s call for a reassessment of the models used to understand young people's behaviour in the past. Australian researchers Poole and Goodnow agree (Poole and Goodnow, 1990).

Wallace argues that the role of young people within the community and the family needs to be reconstructed. Her study documents the disillusionment, poverty, and purposelessness of many young people in the UK, but it also reveals their creativity, critical awareness and the fact that many are finding alternatives in adversity. She states that these positive aspects of young people need to be recognised and that the experiences of gay and lesbian young people and the development of sexual identities also need to be addressed in life course research.

Similarly, within health there has been interest in giving greater attention to the positive in the studies of resilience in young people. However the notions of 'resiliency' and 'agency' have evolved from different research traditions and may not refer to the same thing. Using Griffin's typology, the notion of 'agency' has evolved from the radical stream of youth research which, in the case of Wallace's work, recommends change to social structures which have marginalised young people. In this context, 'agency' refers to action taken by young people to change their situation. The notion of 'resiliency' has emerged from a model which focuses on the individual.

Australian sociologist Lesley Johnson argues that a linear model of development which assumes a kind of norm with a sequence of specific tasks to be achieved is not useful in understanding the experiences of young women. She notes that women revisit the experiences they had when they were young throughout their lifetime, adding new meanings and interpretations to past experiences³⁵. In this sense, 'developmental tasks' are not completed but are part of an ongoing life process, and the challenges encountered in youth, continue to present themselves for new and potentially richer understandings as experience accumulates throughout the lifetime. The Youth Affairs Council of Australia made a similar comment in 1983, pointing out that identity formation was not a pursuit exclusive to the young but 'a lifelong task and challenge' (YACA, 1983, p. 120).

Johnson's approach is useful because it moves away from a notion of young people as 'deviant', 'other', or in some way exotic, and suggests that they are encountering issues similar to those that affect all people throughout their lifetime. They are encountering them within the context of particular cultures, social and economic circumstances, historical time, place and policy climate, that determines the form the challenges take and the options they have for responding to them. As Wyn and White point out, youth is most productively conceptualised as a social process, the meaning of which is socially mediated (Wyn and White, 1997, p. 9).

Griffin identified three issues facing radical research in the 1990s: the analysis of power relationships around gender, sexuality, race, class and age; the role of the researcher; and the relationship between culture, structure and individual agency (Griffin, 1993). She found that few British and American researchers working in the radical stream addressed the question of young people's enfranchisement in relation to education, training, job market, sexuality and family life, and points out that what is missing in most research texts is the voice of young people themselves. She suggests that forming closer links between young people and researchers is one possible direction for the future. In the area of health research this idea fits well with the notion of popular epidemiology put forward by Brown (1992; 1997).

There is a need to reassess the theories that informed research in young people's health during the 1980s to move toward an understanding which recognises and incorporates the way social structures affect the experience of being young and the health and wellbeing of young people. I have argued the need to move away from theories which endeavour to establish 'norms', towards a view of young people which acknowledges and celebrates their diversity, a project best achieved in partnership with them and their communities. In an endeavour to incorporate the voices of people who grew up in Australia during the

³⁵ Whether this applies equally to men would be a legitimate question for further research.

eighties into this discussion, I proceed below to examine consultations and surveys which were conducted with them during the decade to ascertain their views about health and the matters that concerned them at that time.

7.5 Young people's views about health

Throughout the eighties young people 'spoke up' about issues that affected their health in surveys and consultations conducted nationally, at state level and locally. In some cases their opinions were sought as part of youth policy development (YACA, 1983; YPDC, 1987b) or because the government wanted their views about its youth policies (Commonwealth Department of Sport Recreation and Tourism/ANOP, 1985; Commonwealth Office of Youth Affairs/ANOP, 1987, Commonwealth Youth Bureau/ANOP, 1991) and the things that worried them most (Commonwealth Department of Sport Recreation and Tourism/ANOP, 1985; Australia Office of Youth Affairs/ANOP, 1987; Commonwealth Youth Bureau/ ANOP, 1991). At other times the government, health agencies and health workers asked young people for views about health, their health concerns (AAAH, 1985; BHC, 1986; YPDC, 1987b) and the world issues that caused them the greatest worry (Eckersley, 1988).

Through these processes young people consistently drew attention to world issues such as nuclear war and the environment. They also expressed concern about survival matters such as unemployment and income support, accommodation generally and safe homes and supported accommodation for those who had experienced violence and sexual abuse in their home of origin (AAAH, 1985; Commonwealth Youth Bureau/ANOP, 1991). The need for information about health and sexuality was continually raised in health consultations as was the importance of confidential health services that respect privacy and offer counselling and treatment (YACA, 1983; AAAH, 1985; BHC, 1986; YPDCb, 1987). At times young people also emphasised the importance of their participation in identifying and addressing their own health concerns (YACA, 1983; BHC, 1986).

Arguably the most ambitious and extensive health consultation conducted with young people during the 1980s was Victoria's *Health for Youth*.(Victoria) Three thousand young people participated over a five month period from January to May 1987 (YPDC, 1987b, p. 11). The report of the consultation and resulting youth health strategy gives an indication of the issues young people identified and how they thought about and experienced them. The consultation found that young people associated health with matters such as exercise, eating the right food, alcohol and tobacco, sexuality, mental health, stress and depression, but they also indicated that structural factors such as unemployment, environment, income,

housing, discrimination and the threat of nuclear war had an impact on their health. Once again the lack of accessible and acceptable health services figured prominently.

The lack of mental health services received particular attention. Young people defined mental health positively as a 'sense of well-being, being at peace with the environment and self, ability to cope' (YPDC, 1987b, p. 47). They identified depression, anxiety, grieving, isolation and stress caused by relationships, school pressures and discrimination related to gender, race and disability, as mental health issues that concerned them and their friends. The lack of a positive and preventive approach in mental health was seen as problematic, as was the stigma associated with the whole area of mental health. The report suggests that it was not only young people, but also general health and welfare workers in contact with young people, who experienced mental health services as inaccessible and felt the need for better links and closer working relationships (YPDC, 1987b, p. 47-48).

As in previous health consultations, young people expressed the need for accurate information about sexuality, drug use and nutrition and for school health education about these issues. The section on nutrition takes the matter further, arguing for healthy food in school canteens and in 'young people's favourite hang outs' and media campaigns 'to promote change in attitudes about healthy diets and promote better eating' (YPDC, 1987b, p. 44).

With regard to sexuality, the importance of services where confidentiality is assured and where staff are comfortable dealing with young people and their sexuality, is raised. Further, similar to the young people who attended the Better Health Commission workshop in Brisbane, young people in Victoria highlighted the need for someone to talk to about sexuality issues and for parents, teachers and youth workers to be better informed.

Many young people expressed the need to be able to talk trustingly and confidentially with someone about problems. Yet there was some indication that parents had not discussed sexual issues with their children.

YPDC, 1987b, p. 33

Drugs and young people's health was described as 'one of the most dominant themes to come out of the consultation' (YPDC, 1987b, p. 39). Alcohol and tobacco received the greatest attention, with passing attention only paid to drugs such as caffeine, tranquillisers, parents using valium and serepax, painkillers and marijuana. 'Even less reference was made to hard drugs such as heroin' (YPDC, 1987b, p. 39). Alcohol consumption and abuse were seen as major issues. Young people commented that television advertisements, which they saw as having a powerful influence, presented drinking alcohol as glamorous, adventurous and very grown-up:

Commercials showing healthy happy people telling you the wonders of alcohol. It sounds so good, why not try it yourself?

YPDC, 1987b, p. 39

Health for Youth (Victoria) reports that young people 'were adamant' that alcohol, tobacco and other drug related advertising on television and in popular print media be 'restricted if not banned altogether' and that alcohol advertising should be 'curbed or abolished in prime TV time and in popular youth magazines' (YPDC, 1987b, p. 40). This is ironic given the machinations that occurred around the development of the national alcohol policy at about the same time as this consultation was being carried out (See Chapter 6 of this thesis). Attention was also drawn to the lack of entertainment for young people and the need for alcohol-free entertainment (YPDC, 1987b, p. 41).

The issue of occupational health did not come spontaneously from young people but was raised by those conducting the consultation, who were concerned about reports that workers in the under twenty year old age group experienced a high rate of occupation accidents, with those in the twenty to twenty-four year age group experiencing the second highest rate (YPDC, 1987b, p. 9). The consultation showed that young people had little awareness of occupational health and safety matters. However, as one young woman who was working in a milk bar pointed out, even if young people were well informed about occupational health and safety issues, high rates of unemployment mitigated against their ability to take action—if you want to keep your job you are reluctant to talk to the boss about matters such as lifting heavy crates (YPDC, 1987b, p. 51).

Health for Youth (Victoria) provides a snapshot of the health concerns of young people in Victoria in 1987. The youth survey report produced by ANOP Market Research in 1990, provides an overview of changes in young people's attitudes and outlook from 1984 to 1990, as expressed in opinion polls conducted at two-yearly intervals during that time. In 1990, young people are described as 'somewhat less optimistic'. Their greatest concern at the end of the decade was the environment (79%), followed in order of importance by unemployment, 'making ends meet', AIDS, homeless young people, education, drugs, the possibility of nuclear war, problems in family relationships and alcohol (Commonwealth Youth Bureau/ANOP 1991).

A comparison of data over the six year period suggests that young people's financial worries increased steadily from 1984 to 1990 and their personal concerns about unemployment had returned almost to 1984 levels (Commonwealth Youth Bureau/ANOP, 1991, p. 22). The 1990 survey identifies five trends in young people's attitudes since the ANOP surveys began: young people had more concerns than in previous studies about

their employment and financial situation; young people's personal concerns about their own employment prospects had increased and their perceived causes of unemployment had changed, with greater emphasis in 1990 on economic causes; young people's awareness of educational allowances had increased, but there was a decline in 'awareness of what the government had done for young people'! (exclamation mark added); young people were receptive to messages about training and expected to re-train during their lifetime; and their concerns about drugs had declined but youth homelessness had become an important issue and concern about AIDS had increased (Commonwealth Youth Bureau/ANOP, 1991, pp. 17–19). Perhaps the most dramatic change is the high ranking young people gave to the environment in 1990, a matter to which the ANOP dismisses as a general community concern rather than a youth issue.

The ANOP report concludes that, while young people do remain optimistic, there has been a worsening of their situation and the way they see their prospects at the end of the decade. It would appear that life has become more difficult, a matter which commentators such as Richard Eckersley have drawn attention to and which may be reflected in the rise in suicide, particularly among young men. When the results of the ANOP surveys are compared to the issues that emerged in health consultations, there are a number of similarities. Unemployment is consistently identified and given priority, as are issues to do with accommodation, income and to a lesser extent nuclear war and drug use. The finding that young people ranked income support or 'making ends meet' at the same level as unemployment in 1990, shows an increased concern about this issue over the decade, although it seemed that this concern was not shared by adults in the community:

While the under 25s are often genuinely worried about their financial circumstances, the rest of the community underestimates young people's concerns about making ends meet.

Commonwealth Youth Bureau/ANOP, 1991, p. 6

This suggests that, even though, in the words of Resnick, more than an economic determinism is required to address the health of young people, economic matters were a cause of great concern to many young people at the end of the 1980s. Further, it would appear that in consultations and surveys conducted throughout the 1980s, young people made the same points over and over again. However, it seems that a kind of political amnesia is operating, in which each new government rediscovers the possibility and potential of consulting with young people but fails to act on the information to create long-lasting change. As young people tend to grow up, they are not there to remind governments that they were asked the same questions and gave similar responses in 1983, 1984, 1985, 1986, 1987, 1988 and 1990, and that the health concerns they endeavoured to bring to government attention have still not been addressed.

7.6 Summary

This chapter argues that there is a need to move beyond indicators of morbidity and mortality toward new models for understanding young people and their health and wellbeing. Such models need to draw on the diversity of the Australian community and take into account the way social change affects the experience of being young. Such a model must address those things which young people themselves have identified as important, their cultural understandings of health and wellbeing and include young people themselves as active participants in the research project. To be epidemiologically sound, the model must also provide information on inequalities and differentials in health within the youth population to better inform policy efforts to address such inequalities.

CHAPTER 8 DISCUSSION

8.1 Introduction

This thesis lays out the documentary record of developments in young people's health in Australia in the 1980s and describes the work of the many people who endeavoured to put young people's health on the agenda of governments and policy makers during that time. The record shows that, while there were some achievements, these achievements were minimal and ideas that had the potential to make a difference were not acted on.

8.2 Achievements

By the end of the 1980s it could be argued that there was greater awareness of young people's health in Australia. The social needs of young people in hospital were better recognised. Outpatient and adolescent/youth wards had been established in some hospitals and the Australian College of Paediatrics (1987) had published a policy statement on the needs of adolescents in hospital. Community-based youth health centres had been introduced in some states and youth centres had added health programs and clinics to the range of services they provided. Many of these health programs and services show the influence of Alma Ata ideas and collaboration between the health and youth affairs sectors. They emphasised a voice for young people in policy, program and service development and the importance of addressing the whole person within their social context. In efforts to develop a coordinated approach to young people's health, policy and planning initiatives were attempted in the mid-1980s. While these policies were not adopted, they laid the groundwork for future efforts and the youth health policies introduced in New South Wales, Victoria and South Australia in the early 1990s were able to build on the fledgling efforts of the mid 1980s.

Australia's prompt response to the HIV/AIDS epidemic and the adoption of Alma Ata ideas and the Ottawa Charter framework as the basis of the HIV prevention strategy, meant that the structural and social changes required to contain the epidemic were implemented. By the end of the 1980s young people's need for accurate and relevant sexuality information was better recognised. Sexuality education was more common, if unevenly spread, across schools. There was greater awareness of gay and lesbian young people and their health and education needs, but discrimination was still and continues to be a major concern (Hillier et al, 1998). Funding for curriculum development and teacher training provided through the National HIV/AIDS Strategy and NCADA, raised the profile of health in schools and, in the early 1990s, health was designated as one of the eight national curriculum areas. The harm minimisation approach adopted by NCADA and the

introduction of strategies such as needle exchange programs, succeeded in preventing the transmission of a second wave of HIV/AIDS to young people who injected drugs.

8.3 Unfinished business

While these initiatives can be applauded, at the end of the 1980s it was still the case that the basic infrastructure for young people's health was not in place. In the absence of national and state policies and funding for generic programs, important issues were neglected and connections between issues and their underlying causes were not realised at policy level. The Declaration of Alma Ata and the WHO Health for All strategy, emphasised the importance of social change to reduce inequalities in health but, while much was made of the social 'threats' to young people's health and the needs of vulnerable or special groups during the 1980s, in practice little was done to address those 'threats', except perhaps in the area of HIV/AIDS prevention. The attempts of policy makers, practitioners and at times young people, to apply social justice and social change ideas in policy and planning for young people's health in the mid-1980s were short-lived. While the jostling of old and new paradigms is evident, neither old nor new ideas were implemented as states failed to act.

Nationally, the situation was not much better. Even though the Commonwealth Minister for Health, Neal Blewett, heralded a new era for health in his speech at the 4th International Symposium for Adolescent Health in 1987, one in which attention would be given to participatory processes and health enhancing social change to benefit young people, this did not eventuate. *Health for All Australians* contains only echoes of Alma Ata. Its emphasis on targets and goals returned attention to illness and problem behaviour and grouped young people with children as a population group. This suggests that young people's health continued, in the words of one of my key informants, to be 'the poor cousin of a paediatric specialty' (M10). By 1988 the glow of IYY had faded. There was no coordinated and comprehensive policy for young people's health nationally or in the states. Instead the emphasis was on prevention rather than health promotion. HIV/AIDS and alcohol and other drug use dominated the agenda, and attempts to introduce the structural changes required to support NCADA's 'adolescent alcohol abuse' campaign were scuttled by powerful alcohol interests.

The holes in Commonwealth youth policy in areas of accommodation (HREOC, 1989; Irving et al, 1995) and income support (Maas, 1990; Hartley, 1990; Irving et al, 1995), were exposed by the Human Rights and Equal Opportunity Commission's Inquiry into homelessness among young people. The 'tendency for economic perspectives to predominate over social perspectives in policy decision making', highlighted by research

undertaken by the Australian Institute for Family Studies (Hartley, 1990, p. 28), meant that the prerequisites for health for many young people were not in place. The finding in 1990, that young people's second greatest concerns were equally unemployment and "trying to make ends meet", indicates that they were feeling the pressure (Commonwealth Youth Bureau/ANOP 1991).

The need for health services for young people, which was one of the issues that led to the establishment of AAAH in 1978, was still a concern at the end of the 1980s. The initiatives introduced in hospitals and in the community during the 1980s were not widespread and tended to be relegated to the realm of 'innovations' rather than part of the main game. In 1989 the HREOC Inquiry pointed to the inadequacy of health services for homeless young people and recommended the establishment of more community based health services to meet their health needs. One of my key informants commented that

... the major change really was the awareness of the needs of adolescents in the community, in the professions, many places. The great disappointment at the end of the 80s was that we only marginally increased the bottom line services and that the task for us for the future really,... is how do we translate all this rhetoric into some sort of actual reality and that will mean tackling where the health dollar goes currently.

(M9)

These were not merely the views of a frustrated local. A similar point was made by Robert Blum, Director of the Adolescent Health Program at the University of Minnesota. Blum conducted the consultancy that preceded the establishment of the Centre for Adolescent Health in Melbourne in 1991. He concluded that adolescent health was 'barely visible on the academic or clinical landscape in Australia in the late 1980s' (Centre for Adolescent Health, 1994, p. 3). One of my key informants had already noticed that the landscapes were not very fertile.

I'm concerned about the way the academic story is unfolding in adolescent health. I think it needs a much more holistic and rigorous base and a much more representative, interdisciplinary group to progress it, rather than the current medical domination of the academic field. I notice that at the Adolescent Medical Unit there's the first Fellow in Adolescent Medicine and the position is held by a medical person. I think its very important that before the end of the decade there's an interdisciplinary post graduate post that's open to all disciplines, so that the field is a holistic, contemporary field, rather than a sort of poor cousin of a paediatric speciality.

(M10)

8.4 A philosophy of care?

I have argued that a 'philosophy of care' could refer to the way the society values and cares for its young people. The record presented in this thesis suggests that such a philosophy did not exist in Australia the 1980s, either in the provision of the material necessities of life or in making the health programs and services young people required available. Young people were not 'accorded new value' in social policy, in public health or the clinical environment and social and environmental threats to their health were not addressed. There is a need to recapture the principles of Alma Ata in young people's health, to truly accord young people new value within the culture and to work in partnership with them to achieve health for all.

APPENDIX 1

THE AUSTRALIAN ASSOCIATION FOR ADOLESCENT HEALTH (AAAH) 1978–1990

A.1 Introduction

This appendix examines the work of the Australian Association for Adolescent Health (AAAH) from its inception in December 1978 to the end of 1990, with emphasis on the national body rather than the state branches. The analysis is based on information contained in the Association's National Newsletters³⁶, the minutes of National Council and Executive meetings from May 1985 to November 1990³⁷, my interviews with key informants and my experience as a National Council Member from 1986 to 1989. While much of this information has been incorporated into the body of the thesis, this Appendix allows a specific focus on the work of the AAAH during the 1980s—its early development, structure, membership, funding, its education and policy work and its advocacy for young people's health.

A.2 The early eighties—(to) coordinate and catalyse interest

AAAH was established on 15 November 1978, at a seminar on the health and medical care of adolescents held at the Adolescent Medical Unit (AMU) of the Children's Hospital in Camperdown, New South Wales. The Seminar was funded by the Commonwealth Department of Health. Physicians with an interest in adolescent health from across Australia attended, as did the multidisciplinary team of the AMU. Two young people gave a presentation about their experiences in hospital and with the health care system (Williams, 1978b). This constellation of medical practitioners, health professionals and young people, with the addition of youth workers and educators, formed a constituency that worked through AAAH to promote young people's health during the 1980s.

The founding members of AAAH followed a precedent set in the United States ten years earlier, where a Society for Adolescent Medicine (SAM) was established in 1968 (Gallagher, 1982, p. 60). However, there was one important difference. The Australian Association decided to focus on health, rather than medicine.

³⁶ This refers to AAAH Newsletters produced from December 1978 to the end of 1990.

³⁷ The minutes of the AAAH National Council and Executive meetings from May 1985 to November, 1990 have been examined. The minutes are held at the Professional Centre (formerly the Science Centre Foundation) in Darlinghurst, New South Wales. Minutes of meetings planned for 7–8 September 1989 and May 1990 were not in the files held at the Centre. I have been unable to locate minutes of meetings held in the early eighties, prior to the Association's incorporation. I have therefore drawn on the information contained in the AAAH Newsletters, which provide a good account of the Association's activities from its inception in 1978 until 1985.

From the outset, AAAH members networked widely to promote interest in the health of young people. The Association offered support to the newly established National Youth Affairs Advisory Group³⁸ (March, 1979); sent a delegate to the National Youth Conference (May, 1979); and prepared a statement on the medical and social needs of adolescents at the request of the Commonwealth Office of Youth Affairs (May, 1980). Within the health sector, AAAH members participated in a WHO Asia-Pacific Region Working Group on Adolescent Health (Eisen, 1980); entered discussion with the National Health and Medical Research Council about young people's health needs (October, 1980); and participated on an Australia College of Paediatrics' working party to prepare a document on the health care of adolescents (May, 1980). Writing in 1988, David Bennett, then head of the AMU at the Children's Hospital in Camperdown and a founding member of AAAH, described the role of the Association at the beginning of the decade as:

...(to) coordinate and catalyse interest and enthusiasm among its far-flung members, and, via its voluntary secretariat, serve as a central reference point, offering information, advice and support.

Bennett, 1988

AAAH quickly sought to extend its disciplinary base. At the second national AAAH conference held in Sydney in 1981, presentations were invited from physicians, teachers, social workers, youth workers and psychologists (*Dangers to adolescent health—is society responsible?* 2nd National Conference on Adolescent Health, 1981). Young people were represented by the National Youth Advisory Group. Recognising the enthusiasm generated by the conference, the incoming president, John Court (a paediatrician with the Royal Children's Hospital in Melbourne), urged participants to continue the momentum by organising locally when they returned to their communities (Court, 1981).

The first AAAH constitution was written by James Watson, a medical practitioner from Perth who attended the Seminar on Adolescent Medicine. It states the Association's aim as 'to promote the health of the youth of Australia' and its membership as open to 'registered medical practitioners approved by the committee' and other professional disciplines 'as determined by the committee and approved by them' (AAAH Constitution, 1978). At the 1981 Annual General Meeting it was resolved that new rules were needed for AAAH to accommodate the 'increasing size and scope of the Association' (May, 1983).

Two things happened in 1982 which influenced the writing of the new rules and the direction taken by AAAH. Firstly, South Australia expressed concern about the medical orientation of AAAH's constitution, in particular the membership clause, and established

³⁸ The National Youth Advisory Group was established by the Office of Employment and Youth Affairs to advise government on youth policy (Irving et al, 1995).

its own Association for Adolescent Health in affiliation with the national body (October, 1982); and secondly, AAAH invited Lorraine Henricks, medical coordinator of The Door, Centre for Alternatives in New York, to present workshops on multi-service youth centres in Melbourne and Sydney. Youth affairs organisations and youth workers were specifically invited to attend and some became members of AAAH (July, 1982). Murray Williams, a medical practitioner with the Student Health Service at Canberra College of Advanced Education and the editor of the AAAH Newsletter, commented on these developments.

We hope that Lorraine's visit will be the beginning of a significant phase in the development of youth services in this country, and that AAAH can live up to the expectations of those who look to us for help.

July, 1982, p.1

A new constitution was adopted at the 1983 Annual General Meeting in Melbourne which opened membership to 'individual persons interested in any aspect of adolescent health' and to 'organisations which are interested in or connected with any one or more aspects of adolescent health' (AAAH Constitution, 1984). The new constitution contained the following objects: to encourage public and professional interest in the welfare and health care of young people; to promote and encourage cooperation between organisations and individuals interested in adolescent health; to promote research in adolescent health; to promote education in and maintenance of standards of health care for young people; and to promote the interests and extend the interests of any organisations concerned with adolescent health.

These objects were similar to those of the US-based Society of Adolescent Medicine³⁹, but diverged in their emphasis on the health and welfare of young people and the promotion of public interest in this matter. Further, AAAH's decision to focus on health rather than on medicine, its adoption of a broad intersectoral membership policy and a notion, albeit undefined, that young people should have a voice within adolescent health, further differentiated the Association from its US counterpart and located it philosophically within the new public health/primary health care paradigm emerging internationally from the World Health Organization.

Over half of the participants at the national conference held in Melbourne in 1983 were from disciplines other than medicine (February, 1984). The outgoing president of AAAH, John Court, commented on the Association's increasingly diverse membership in his report to the 1983 Annual General Meeting—'the fact that 40% of our members are non-medical

³⁹ SAM's objectives included improvement of the quality of adolescent health care, investigation of diseases that affect adolescents, stimulation of the creation of health services, improvement in communication among health professionals providing health care, and improvement in the quality of training for those providing health care to adolescents (Gallagher, 1982).

graduates attests to the trans-professional basis of our Association' (Newsletter No. 18, February, 1984, p. 7). At the Melbourne conference it was announced that the Fourth International Symposium on Adolescent Health would be held in Sydney in 1987, hosted by AAAH. This led the National Council to engage the services of the Science Centre Foundation to assist with the organisation of the Symposium and manage the Association's administrative affairs. AAAH became incorporated in 1984 (Bennett, 1988).

From the time of incorporation to the end of the 1980s, the National Council was concerned primarily with four things: further definition of the role of AAAH; determining how to carry out that role within its limited resources; education and training initiatives, including the organisation of national conferences and the International Symposium; and development of a modus operandi and a position on young people's health that had the support of its diverse membership (minutes, National Executive and Council meetings, May, 1985–November, 1990).

A.3 Role, structure and funding

While AAAH began its existence as a national association, state branches began to form almost immediately. By 1985 branches were operating informally in New South Wales, Victoria, Western Australia and formally in South Australia, which had incorporated separately (Bennett, 1988). Recognising the importance of state-level advocacy and the increasing interest in young people's health from state governments, AAAH's National Council called a special meeting in November 1985 to discuss relationships between the national body and the state branches to discuss matters of concern and provide direction to the incoming Council (Special meeting on national-state relationships, 20 Nov 1985). The meeting identified the role of state branches primarily as promoting interest in young people's health at state level. Most states carried out this role by organising lectures, seminars and workshops for its membership and the public (special meeting on national-state relationships, 20 Nov 1985).

The states asked the 1986 Council to attend to three things: provide a measure of autonomy for state branches by making the constitutional changes necessary to allow branches to have their own by-laws and finance; provide financial support for state activities; and change the structure of the National Council to allow representation from all states (special meeting on national-state relationships, 20 Nov 1985). The constitutional changes needed to establish state branches were made in 1985 (Bennett, 1988). Council responded to the directives of the Special Meeting by allocating branches twenty per cent of the membership fees collected from their state (minutes AAAH Executive meeting, 1 April 1986). In 1986, National Council ratified branches in New South Wales, Victoria, Western Australia, South Australia and Queensland (AAAH Annual Report 1985–86).

The increasing intersectoral nature of AAAH membership was reflected in the make-up of the 1986 Council, which included, for the first time, members with backgrounds in nursing, education and youth work in addition to medical practitioners. The new Council defined its role as: fostering communication between National Council and state branches through the newsletter; lobbying on young people's health issues; surveying important issues in young people's health; policy development; and ensuring that the decisions made by the council were carried out (minutes of Council meeting, 13 June 1986). The receipt of a development grant from the Commonwealth Department of Health's National Community Health Program Fund in 1986 enabled Council members to meet twice a year, and facilitated 'more coherent development of the Association's activities' (May 1986). A grant received through the Commonwealth Program of Assistance to Youth Organisations (PAYO) funded New South Wales and South Australian branches to undertake projects in rural areas, to reach workers who were unable to participate in AAAH activities due to geographical distance (special meeting on policy and state roles, 7 Nov 1986; National Council meeting, 7 Nov 1986).

Funding and membership fees were ongoing issues for AAAH. The fact that the membership included youth workers (who were often in poorly paid and insecure employment situations), students and, potentially, young people (although this matter remained controversial within the Association), meant that a low subscription fee was needed, or, alternatively, a flexible fee scale to facilitate membership by people on different income levels. In 1987 letters protesting the high cost of membership were received from Western Australia, New South Wales and the ACT, resulting in the investigation of a range of fee structures (minutes of Council meeting, 23 February 1987). The matter was resolved in 1988, when AAAH introduced three categories of payment—full fee rate, low income or concessional rate.

The membership fees and the grant the National Association received through the National Community Health Program Fund were used for four things: to purchase the administrative services of the Science Centre Foundation; to fund four Executive and two National Council meetings a year; and to print and distribute the national newsletter (position statement of AAAH Treasurer, Executive meeting, 25 May 1987). Most of the activities of AAAH—production of the national newsletter, media advocacy, conference organisation, policy development and representation of AAAH on relevant Commonwealth and State committees—were undertaken by individual members as part of their professional roles and in their own time.

In 1987 the National Council identified the need for a national development officer to extend Association activities in the areas of advocacy and policy development. The move

to seek funding for a national development officer was not supported unanimously (minutes of teleconference, 21 September 1987). This may be because the national body already received funding through the Commonwealth Community Health Program Grants and, for some Council members, funding for the development of state branches was a higher priority. However, the motion was carried and AAAH applied to the Commonwealth Youth Bureau's PAYO program, unsuccessfully, for funding for a national development officer (minutes, Executive meeting, 15 February 1988).

I recall informal discussions at this time about whether the funding received through the Commonwealth Community Health Program Grant might be better used to establish the position of national development officer, rather than to purchase the services of the Science Centre. It was argued that, because Science Centre staff did not have specific expertise in young people's health, requests for information and support that came to the Centre had to be rerouted to a relevant person within the Association. If the call was not directed to the most suitable person in the first instance, it meant that the inquirer might have to make two or three phone calls to get the information or support they were seeking. This was seen as a disadvantage for AAAH subscribers. Further, the experience of the New South Wales branch, which had employed a project officer through the PAYO grant, had shown that the Association's advocacy capacity could be increased through having a full-time person devoted to AAAH business. However, successive AAAH annual reports indicate that the services of the Science Centre Foundation were highly valued and considered indispensable by many Council members who were carrying out AAAH business on top of already busy workloads in their own organisations. While I recall that the option of dispensing with the services of the Science Centre to employ a national development officer was discussed informally, the minutes show that this idea was never put forward as a motion.

As the branches grew and strengthened, state level work became more important. By the end of the 1980s branches had been established in all states and the ACT. AAAH became a federation of state bodies. This structure was formalised at a Special General Meeting held in November 1990, which passed a motion that National Council representatives would be elected at state AGMs and the national Executive elected from the representatives of the States (minutes of Special General Meeting, 27 November 1990).

A.4 The AAAH Newsletter

The need for information and education in adolescent health was one of the concerns which led to the establishment of AAAH (Williams, 1978), and one of the vehicles for meeting this need was the publication of the national newsletter. Throughout the eighties

the AAAH Newsletter was published three or four times a year and provided information on adolescent and youth health issues, developments in young people's health, funding possibilities and education and training programs. The task of editing the newsletter was initially undertaken by Murray Williams who continued in this role until the end of 1987. In 1988 the responsibilities of editor were taken up jointly by Helen Tolstoshev, Head of the Adolescent Health Team in the Child, Adolescent and Family Health Service (CAFHS) in South Australia, and Ralph Hampson, a social worker with the Adolescent Unit of the Royal Prince Alfred Hospital in Sydney, New South Wales.

Under the editorship of Williams the content ranged from highly technical articles about managing specific medical problems of young people to book reviews, newspaper clippings on young people's health, developments in youth affairs and information about AAAH activities and initiatives. The flavour of the early newsletters and the range of topics Williams considered of interest are illustrated by the following titles from literature reviews published in the 1980–81 newsletters: *Ecological considerations in the creation and use of child growth standards*; *Punk rocker's lung: pulmonary fibrosis in a drug snorting fire eater*; *The Hare Krishna movement—what attracts the western adolescent*; *Unemployment and its effects on the teenager*; *Nephrotic syndrome in the second decade of life*; and the *Effects of age on pelvic inflammatory disease in nulliparous women using a Copper 7 Interuterine Contraceptive Device*.

Much of the content of the early newsletters was geared toward a medical audience and the training opportunities advertised were often for medical practitioners and available only in the United States or Canada (for example, Newsletter No. 3 May, 1979). When more youth workers joined the Association as a result of the workshops on multi-service youth centres held in 1982, the medical emphasis of the AAAH Newsletter was brought to the attention of the editor. Williams responded in the following way:

As a corollary to these developments (youth worker attendance at workshops on multi-service youth centres), we should stress that this newsletter's 'medical' bias reflects the fact that its editor and most of its readers are medical practitioners. The changing nature of AAAH means that changes in the newsletter's scope are also essential, but to do this we need materials from various sources.

Newsletter No. 13, July, 1982, p. 1

Subsequently more information about developments in the youth affairs sector was included in the newsletter and contributions from youth workers and non-medical members were invited and encouraged (Newsletter No. 13, July, 1982, p. 1).

Initially, each newsletter contained a review of recent literature on adolescent health. When the newsletter became too bulky, Williams published the literature review

separately, making it available to members who requested it (Newsletter No. 20, December, 1984). In the period leading up to the establishment of the International Association for Adolescent Health in 1987, the newsletter increasingly reported on international developments, in particular in countries of the Asia-Pacific Region.

When Murray Williams retired from the position of editor at the end of 1987, he had produced thirty-four newsletters over nine years (Newsletter No. 34, October, 1987). In the final newsletter that he edited, he commented on the growth of AAAH from:

...an embryonic but enthusiastic small group to a respected and active national organisation. With a current membership of over 400 it is accepted that we represent an important point of view and that we can make valuable contributions in medical and social areas.

Newsletter No. 34, October, 1987, p.1

At the same time, he observed that AAAH had lost some members. He attributed this to two things: AAAH had not fulfilled the expectations of some members; and the 'lack of career structure in adolescent health for the various disciplines' (Newsletter No. 34, October, 1987, p. 1). With regard to the 'unfulfilled expectations' referred to by Williams, it was perhaps the case that AAAH's decision to focus on health rather than medicine and its open membership policy resulted in too broad an ambit to maintain the interest of those whose primary concern was adolescent medicine. In trying to accommodate a range of disciplines and perspectives and generate a groundswell of interest in young people's health, AAAH may have suffered from not being medical enough for some and, at the same time, not radical enough for others.

When Helen Tolstoshev and Ralph Hampson took up the editorship of the newsletter in 1988, they introduced a new format. A theme was selected for each newsletter, allowing more detailed attention to specific youth health issues. This served the practical purpose of streamlining the newsletter and was also consistent with developments in the youth health sector which was becoming more focused on specific issue areas (Chapter 6 in this thesis). Newsletters published from 1988 to the end of 1990 addressed the following themes: the Bicentennial, young people and sex, age of consent, young people and their families (Newsletters No. 1-4, 1988); youth suicide (the most requested issue—pers. comm., Helen Tolstoshev, Nov. 15, 1994), AAAH—the organisation, the impact of the media on young people's health, young people and drugs (Newsletters No. 1-4, 1989); community education, multiculturalism, and community response to 'at risk youth' (Newsletters No. 1-3 1990). State branches each took responsibility for an edition of the newsletter, providing an opportunity for branches to draw national attention to issues that concerned them.

Throughout the eighties AAAH newsletters published material written by young people. This practice was formalised by Tolstoshev and Hampson, who introduced a segment called *Get Real*. Young writers were invited to contribute poems, stories and articles related to the theme of each newsletter and were paid a small honorarium for their writing. However, they contributed as individuals rather than as an organised group with a position on youth health issues, so while *Get Real* gave young people a designated space within the newsletter, it did not constitute a political voice for young people within AAAH, nor did it claim to do so.

A.5 Education and training

In addition to the publication of the national newsletter, AAAH endeavoured to implement its education and training agenda through networking with relevant government departments and organisations, through the advocacy of individual members by their work on committees and within their own organisations and through the biennial national conferences and the international symposium.

In the early eighties AAAH members succeeded in drawing the attention of bodies like the Commonwealth Office of Employment and Youth Affairs, the Commonwealth Department of Health, the National Health and Medical Research Council, the Australian College of Paediatrics and the Family Medicine Programme, to the need for education and training in adolescent health. Individual members of AAAH contributed to the writing of reports which highlighted the need for education and training for medical practitioners, health workers, youth workers and young people. They offered education opportunities within their own organisations which were advertised and promoted in the Newsletter.

The need for medical education was highlighted in a paper presented by Murray Williams at the seminar at which AAAH was established in 1978. Concerned that there had been little progress in medical education in adolescent health since AAAH had been established, the National Council decided in February 1987 to make a submission to the Inquiry into Medical Education and the Medical Workforce. Reporting on this decision the newsletter states that:

There are numerous deficiencies in current medical training concerning adolescent health care; these include almost total neglect of adolescents and young adults as subjects worthy of special medical attention and the scarcity of teaching about conditions which are particularly significant for this age group. Even larger gaps exist in the consideration of psychosocial issues such as the effects of unemployment and

homelessness and the development of communicative skills and sensitivity in dealing with all patients, not only adolescents.

Newsletter No. 31, March, 1987, p. 1

AAAH collaborated with the Adolescent Health Care Committee of the College of Paediatrics to prepare a joint submission to the Inquiry (AAAH and ACP, 1987). To emphasise inaction on this matter the Submission draws attention to earlier efforts which called for education and training in adolescent health. While the submission's emphasis is on medical education, many of the documents it cites advocated education and training for other health care workers and youth workers (AAAH and ACP, 1987).

In addition to the publication of its national newsletter, AAAH endeavoured to meet its education brief through the organisation of biennial national conferences and the Fourth International Symposium on Adolescent Health held in Sydney in 1987. The biennial conferences and the International Symposium were AAAH flagship events for AAAH during the eighties. They served to promote the Association and provided an opportunity for people from across Australia to meet, share their work and hear from international speakers about developments in other countries and in WHO. The state branches took the responsibility for organising the conferences with support from the national body.

As with the AAAH Newsletter, the conference organisers endeavoured to meet the needs of a wide audience and incorporate a degree of participation by young people. Conference themes endeavoured to encapsulate the breadth of the adolescent/youth health endeavour and presentations provide an indication of the issues of concern at the time the conference was held and the priorities and work of state branches. Conference presentations dealt broadly with the following matters during the 1980s: health promotion for young people, health service provision, interventions to address specific health problems of young people, school health education, results of research in young people's health and, to a lesser extent, the impact of social and environmental factors on young people's health.

The 1981 National Conference and the Fourth International Symposium on Adolescent Health, both held in Sydney, drew attention to the social aspects of young people's health and the impact of social change (*Dangers to adolescent health—is society responsible?*, 1981; Bennett and Williams, 1988). Nutrition and environmental effects on young peoples health were the themes of the 1983 national conference held in Melbourne (*Third National Conference on Adolescent Health, Summaries of Papers and Workshops*, 1983). Keynote papers at the national conference held in Adelaide in 1985 gave attention to the development of youth health services and service models (*Adolescent health—who needs it?*, 1985), whereas the national conference held in Queensland in 1988, *Adolescent health—who cares?*, heard papers on the lack of improvement in young people's health

(Raphael, 1988–9); loss and grief in adolescents (Tolstoshev 1988–9), youth suicide prevention (Hart, 1988–9) and young people and HIV/AIDS (Abbott, 1988–9), reflecting the concerns that emerged toward the end of the decade. The worsening health of young people in Australia and youth suicide were again the focus of the national conference held in Perth in 1990, the latter foreshadowing the growth in concern about this issue that occurred in Australia in the 1990s (AAAH Biennial Conference, 1990).

Papers on young people's sexuality and the role of schools in health, were presented at all conferences. With regard to sexuality, prevention of teenage pregnancy and support for young parents was a focus of the early eighties with prevention of HIV/AIDS and STDs receiving greater attention in the second half of the decade. There was only one paper that dealt specifically with issues for gay and lesbian young people in the conferences held from 1981 to 1988. It was presented at the International Symposium in 1987. Papers on schools addressed the impact of the processes of schooling on health, the need for schools to change to be more health-enhancing, nutrition and the school canteen, approaches to drug education and strategies in sexuality education. Other matters dealt with more sporadically in conference papers were: the impact of unemployment on the health of young people; young people and chronic illness; use of the arts in health promotion with young people; sexual abuse; social justice, including young people's access to resources and participation; and young people and the media. The range of issues addressed at AAAH conferences and the International Symposium illustrates the breadth of the sector. As AAAH became more concerned with policy development from 1986, it endeavoured to establish priorities for policy attention without losing the scope of adolescent/youth health.

A.6 Policy matters

In the mid-eighties the AAAH National council began to give greater attention to policy. In 1986 Suzanne Robertson, then National president of AAAH, described policy development as 'vital to the effectiveness of the Association' (July 1986, p. 4). This reflected the International Youth Year concern with youth policy including health policy for young people (Irving et al, 1995; WHO, 1986) and the development of youth health policy and/or strategies in some states (Connelly and Borger, 1985; YPDC, 1986; Robertson, 1986; SAHCd, 1986; Burkinshaw, 1986). Policy development was important for AAAH for three reasons: the Association was increasingly called on by government departments, youth organisations and the media, to provide advice on young people's health; in order to provide such advice the Association needed a policy position that reflected the shared principles of the Association's multidisciplinary and intersectoral membership; and a policy was needed so that AAAH could respond to workers in the community, who wanted

to know 'what AAAH supports and who they represent' (minutes of special meeting on policy and state roles 7 Nov 1986).

In November 1986, a special meeting was called to discuss policy and the role of state branches in policy development. While Robertson saw policy development as 'a major function of the State Branches' (July 1986, p. 4), the states saw their role more in responding to the media on issues in their state, being a voice for those working in youth health and encouraging young people's participation in the Association and in policy development (special meeting on policy and state roles 7 Nov 1986). The states asked National Council to take the lead in policy development by designating a coordinator for policy and a member of Council to speak publicly for the Association on policy issues (special meeting on Policy and State roles 7 Nov 1986).

Drawing on the work of state branches and the issues highlighted in the Association's 1985–86 Annual Report, the national Executive designated ten areas for policy attention in 1987⁴⁰. Five are similar to those identified at the seminar at which AAAH was established in 1978—service provision, maintenance of standards of health care, issues in service provision, utilisation of health services by young people and research into adolescent health—suggesting that these matters were still of concern. The remaining five issues—the needs of rural youth and homeless and alienated young people, multicultural issues, youth participation, the development of networks/relationships between regional and local bodies and an extended training agenda which included youth workers and young people—show a broadening view within AAAH of what constitutes a health issue and greater awareness of diversity among young people and differentials in health among population groups.

The special meeting decided that branches would contribute to policy development in two ways: identify issues requiring policy attention; and develop policy in areas in which they had an established interest and/or expertise (special meeting on policy and state roles 7 Nov 1986; minutes of National Council meeting 23 February 1987). A process for policy development was adopted by National Council in May 1987. The principles to guide policy development consisted of excerpts from two documents: the 1986 World Health Organization report on young people's health, which had a strong emphasis on young people's participation in policy development (WHO, 1986); and the social justice principles contained in Victoria's *Health for Youth* consultation papers (YPDC, 1986).

⁴⁰ The ten areas National Executive identified for policy attention in 1987 were: service provision; maintenance of standards of health care; issues in service provision and direct services for young people; services for rural young people and utilisation of health services by young people; training needs of youth and health workers and young people; research into adolescent health; homeless and alienated young people; networks/relationships between regional and local bodies; youth participation; and multicultural issues (minutes of national Executive meeting 8 Dec 1986).

The Council recommended that policy position papers consist of five components: a statement of the problem/issue; a description of the population affected, including size, demography, cultural background, employment status; current approaches to the issue; recommendations; and a bibliography (minutes of National Council meeting 25 May 1987). National Council and the Science Centre would coordinate policy development by resourcing the policy work of state branches, providing state branches with information on work being done in other states and keeping a register on work in progress and specific expertise of individual members of the Association. Policies would be ratified at a general meeting of Council (minutes of National Council meeting 25 May 1987).

This approach was seen as useful for three reasons. State members of AAAH participated in youth health and youth work networks in their area and could develop policy responses to youth health issues based on the way young people and workers were experiencing these issues. Geographical closeness would enable people to meet, debate the issues and work through philosophical differences to come to an agreed upon position. Young people would be able to participate in the policy development processes in state branches that had youth membership (minutes of National Council meeting 25 May 1987). In practice, however, it proved to be unrealistic and too ambitious. The branches were relatively new organisations, still in establishment phase, with fluctuating membership and attendance at meetings and seminars. They did not have the resources to undertake the research required to develop policy statements. At the end of 1987 state branches asked National Council to set policy priorities (minutes of Council meeting 16 Nov 1987).

To address this matter the National Council decided to conduct a one-day workshop for Council members prior to the first meeting of 1988. The purpose of the workshop was twofold: to establish policy priorities for the Association; and to develop a corporate plan for the next three to five years (minutes of Executive meeting 16 Nov 1987; minutes of Council meeting 16 Nov 1987). The workshop, held on 7 March, identified five issues for policy attention over the coming three to five years: family relationships; adolescent stress; sexual health; health education; and chronic illness. First priority was given to family relationships and an information subcommittee was established to conduct a literature search as the basis for policy development on this issue.

Organisational goals were set in seven areas: action on youth health issues; development of the organisation (fundraising, public relations, membership and youth participation); research; education and training for health professionals and youth workers; establishment of a database on young people's health; international relationships in young people's health; and publication of a directory outlining 'key personnel, centres, experts and decision makers in youth health' (minutes of National Council meeting 8 March 1988).

The 1988 corporate plan enabled AAAH to link policy and organisational goals and provided direction for the Association to the end of the 1980s and into the 1990s. The process through which the corporate plan had been developed enabled AAAH to achieve a degree of coalescence of the range of views and perspectives on adolescent health and youth health of its broad and far-flung membership.

A.7 Advocacy

AAAH's advocacy in young people's health is intertwined with other events which drew attention to and generated resources for young people's health during the eighties. However, there is evidence to suggest that AAAH was instrumental in getting young people's health on some agendas and that its new public health/primary health care philosophy influenced the shape and direction taken in adolescent and youth health in Australia in the 1980s.

The Association's networking in the early eighties put young people's health on the agenda within the Commonwealth Office of Youth Affairs. The advocacy of AAAH's delegate to the National Youth Conference in 1979 resulted in the publication of *The Health Needs of Adolescents* by the Commonwealth Department of Health in 1981. Reports in the AAAH Newsletter and minutes of AAAH meetings suggest that the Association maintained a positive relationship with the government and non-government youth affairs sectors throughout the 1980s.

Ideas generated in the 1982 AAAH seminars with Lorraine Hendriks influenced the development of community-based youth health services such as Shopfront, Second Story and The Warehouse. Individual members of AAAH provided leadership in the establishment of community-based youth health services, either as board members, directors or coordinators, and the AAAH Newsletter reported on and encouraged these ventures. The introduction of services for homeless young people in Queensland was facilitated by the National Association and the Queensland branch of AAAH. AAAH managed the funding provided through the Commonwealth Innovative Health Services for Homeless Youth (IHSY) Program for an interim period, while an infrastructure for young people's health was established in the Queensland Department of Health (Newsletter No. 3, 1990, pp. 1 and 22).

There was, and continues to be, controversy about the value of the multi-service/youth health centre model with suggestions that resources would be better used to promote young people's use of community health centres and education for general practitioners. Such arguments suggest that AAAH's effort in creating interest in the concept of a community-

based youth health service was of limited value. However, while community health and general practitioners have a fundamental role to play in young people's health, a range of strategies is required. As one of my key informants pointed out, services need to be provided in a way that makes them accessible to young people and, within that continuum, there is a place for a specialised youth health service. Another key informant stated that, through contact with the young people who used youth health services, a greater understanding developed within medical circles of the complex backgrounds of many and the difficult situations they faced (M2). In 1989 the Human Rights and Equal Opportunity Commission's Inquiry into Homeless Children highlighted the health needs of this population group and identified Shopfront and Second Story youth health services as service models which were able to meet the varied needs of homeless young people.

The idea that young people should participate in writing health information materials and the development of services to meet their needs was put forward and debated within AAAH throughout the 1980s. This idea became a principle in many youth health documents produced by government and non-government organisations during the decade, and was a recommendation of the High Risk Youth Workshop, sponsored by Australia National Council on AIDS in 1989. This is not to suggest that AAAH was the only source of these ideas or that the concept and meaning of youth participation was uncontested within the Association, but AAAH, with its multidisciplinary and intersectoral membership, had given space and a forum in which the notion of youth participation in young people's health could be raised.

In 1988 the Commonwealth Government's Youth Bureau invited AAAH to engage in a different kind of advocacy. The Bureau asked the Association to nominate public members to represent the interests of young people on four Advertising Codes Councils governing, respectively, tobacco, alcohol, therapeutic goods and slimming products. Through the Codes Councils AAAH representatives worked with other public health advocates to try to change the way potentially harmful products such as alcohol and tobacco are promoted to young people. AAAH's entry into 'the politics of the corporate world' (Bennett, 1988, p. 4) is described in the Newsletter:

In all four Councils, public members were heavily outnumbered by industry and media representatives and struggled to have their views noted. In the Cigarette (Tobacco) Code Council, public members totally rejected the new code and submitted a Minority Report to the MCA (Media Council Of Australia), the hosting body. Andrew Ball acted alone in dissenting from certain clauses in the alcohol code while Tony Arklay, although not entirely unhappy with the therapeutic advertising code, seriously questions the implementation and complaints procedures.

Newsletter No 3, 1988, p. 31

This experience generated within AAAH an appreciation of the challenges of 'influential advocacy' (Bennett, 1988, p. 4) and, although one member of the National Council queried whether AAAH was or should be a 'political' organisation (minutes of National Council meeting 17–18 March 1989), reports in the national newsletter show that the AAAH members who represented the interests of young people on the Codes Councils believed that this type of advocacy was an important aspect of AAAH's work.

Promotion of research in adolescent health is one of the objects of the AAAH constitution and a goal of the corporate plan that guided the Association's effort into the 90s. In 1990 Helen Tolstoshev, then president of AAAH, met with a representative of the Australian Rotary Health Research Fund to discuss possible projects for funding (minutes of National Council meeting 27 November 1990). Tolstoshev's initiative was one of the first steps in a process which led the Australian Rotary Health Research Fund to designate adolescent health as a priority for research funding in the triennium 1993 to 1995, thereby meeting an objective of AAAH since its inception (AAAH Newsletter No 1, 1991).

While AAAH succeeded in drawing attention to young people's health within the youth affairs sector and within groups such as Australian College of Paediatrics and the National Health and Medical Research Council, one of my key informants expressed the view that adolescent health 'was not on the agenda (in medical circles) to the extent that I would like it to be' (M3). Further, the absence of young people as a population group distinct from children in the 1988 National Health Strategy suggests that AAAH did not succeed in getting adolescent health, as an entity separate from child health, addressed in public health nationally.

However, my key informants who had been members of AAAH during the 1980s indicated that the Association was important for four reasons: it created a constituency for young people's health, particularly at the beginning of the decade when 'just recognising there was such a thing as adolescent health was where it was at' (M4); it broke down the barriers between different professional groups and established a model for young people's health that encouraged collaborative work across sectors; it provided a forum in which discussion and debate could occur among people from a range of sectors and professions; and it provided support for the relatively small group of people working with young people on health issues in hospital and in the community.

A.8 Summary

AAAH was established in Australia in 1978 to draw attention to the unmet health needs of young people in Australia. While the impetus came from medical practitioners, the

Association's interest in new models of health service provision, particularly community-based youth health services, led AAAH to extend its membership to people from a range of disciplines and professional backgrounds. Throughout the 1980s AAAH endeavoured to create an organisational structure, culture and position on young people's health that could accommodate the diversity of its membership and a range of perspectives on the best way to promote young people's health and meet their health needs. Through the national newsletter and biennial national conferences AAAH worked to inform and educate its members and the community about developments in young people's health in Australia and overseas. The development of state branches led to more state-based activity and by the end of the decade AAAH had become a federation of state branches.

While AAAH achieved a degree of success in generating interest in young people's health within the youth affairs sector, it was less successful within the health and medical sectors. Nonetheless, AAAH council meetings, seminars and workshops created a space in which individuals from a range of disciplines and sectors could meet, explore and debate directions for adolescent/young people's health, develop an agreed position or, in some cases, agree to disagree. Perhaps AAAH's greatest achievement was its ability to work with the tension that existed between different disciplines and political perspectives to create a dialogue and an atmosphere in which people could listen to each others ideas and work together toward the common goal of promoting young people's health.

A.9 AAAH National Office Bearers 1978–1990

November 1978–November 1981

President: James Watson
Secretary: Murray Williams
Treasurer: Suzanne Robertson

1982–1983

President: John Court
Secretary: Murray Williams
Treasurer: Fay Ranking

1983–1985

President: Murray Williams
Vice-President: John Court
Secretary: David Bennett
Treasurer: Neil Buchanan

1986

President: Suzanne Robertson
Vice-President: David Bennett
Secretary: John Court
Treasurer: Simon Clark

1987

President: David Bennett
Vice-President: Suzanne Robertson
Secretary: Judy Peppard
Treasurer: John Court

1988

President: David Bennett
Vice-President: Helen Tostoshev
Secretary: Judy Peppard
Treasurer: John Court

1989–1990

President: Helen Tolstoshev
Vice-president: David Bennett
Secretary: Ralph Hampson
Treasurer: Di Fitzjames

APPENDIX 2

INTERVIEWS WITH KEY INFORMANTS

QUESTIONS AND NARRATIVE

Question 1

What were the key issues/concerns in youth health at the beginning of the decade?

Narrative

The key issues in adolescent health identified by adolescent health workers at the beginning of the decade were: youth unemployment; suicide; teenage pregnancy; lack of sexuality education; drug use; lack of health services that targeted young people specifically and were accessible and relevant to their needs; lack of training of doctors and other health professionals to work with young people; and lack of data about the health of young people.

Youth unemployment was identified by the government and youth workers as an issue, but it was not necessarily seen as a health issue. Adolescent health and the need for health services for young people was mentioned briefly in some reports from the non-government sector, but adolescent health received little attention in government youth affairs documents and in literature on youth work at the beginning of the decade.

Question 2

What were the solutions being proposed to address these issues at the beginning of the decade and who was proposing them?

Narrative

The solutions proposed by adolescent health workers at the beginning of the decade were things like:

- the development of multi-service youth centres based on models like The Door in New York, a 'one-stop shop' run by a multidisciplinary team that could deal with the range of issues young people brought to the service—youth participation in program development and delivery was part of the philosophy of these centres
- pre-service and in-service training of health professionals to work with young people so that young people's needs would be better met in generalist health services
- the establishment of a national database on adolescent health, so that workers would have a clear picture of the nature and extent of adolescent health problems and a baseline from which to measure interventions
- health promotion and health education people saw the establishment of school-based health education curriculum and training of youth workers and teachers to

conduct sexuality, nutrition and drug education programs with young people as solutions to the problems

- youth workers tended to see youth unemployment as a structural problem so solutions they advocated were for job creation programs in the short-term combined with a long-term structural change. Income support and the role and status for unemployed young people were among solutions proposed by academics and the non-government youth affairs sector. Government solutions to unemployment revolved around job creation and increased education and training for young people—the role of student.

Question 3

What were the debates that occurred within the sector?

Narrative

There were debates between the government and non-government sectors in youth affairs about the best approach to take to address unemployment. Within adolescent health there was a degree of agreement about the model of a multi-purpose youth centre as an appropriate means of addressing health issues for young people. There was agreement about youth participation as a principle in program development, but how the principle could be best implemented was a subject of debate.

Question 4

What were the key issues/concerns in youth health at the end of the decade?

Narrative

The key issues were:

- income support for young people
- youth homelessness and provision of health services for homeless young people
- violence and abuse of young people; young people's position in the labour market
- increasing youth suicide and attempted suicide
- the health of Aboriginal young people
- racism
- the media
- changing family structure
- the need for sexuality education including HIV/AIDS education
- prevention of the spread of HIV/AIDS among young people
- substance use among young people

- the need for more youth health services
- lack of youth health policy at national level and in some states
- lack of a role for young people in society
- lack of a database for the health of young people

Question 5

What were the solutions being proposed to address these issues at the end of the decade and who was proposing them?

Narrative

Youth and adolescent health workers were advocating for youth health policy and long-term planning to address the health needs of young people. They advocated for policies that would address structural causes of health problems among young people as well as more specific health concerns. The provision of multi-purpose youth centres with clinical services was still seen as a solution. Participation of young people in policy and program development was an important principle. Young people's participation in health promotion as peer educators was an important strategy. While the social determinants of health were acknowledged in policy documents, strategies and implementation plans tended to focus on the provision of services for young people as a solution, still reflecting an individualistic approach to the health of young people.

The government response to HIV/AIDS and drug use was broad-based community education using media campaigns and social marketing approaches. Money went into the government and non-government sectors for these issues.

Government solutions to youth unemployment seemed to be more training for out-of-school young people and keeping young people in education for longer periods of time and placing more responsibility for financial support of young people back on the family.

Question 6

What were the debates within the sector at the end of the decade?

Narrative

Debates within the youth health field occurred between people who supported a social marketing/media campaign approach to youth health promotion and those who supported community development approaches. The targeting of individual behaviours for change, an approach based in part in behaviourist psychology was seen by some youth and youth health workers to be a 'victim - blaming' approach that did not address the environmental and cultural context which gave rise to the problem in the first place. Within the youth

field, structural reform was advocated by some non-government workers and government policies that kept young people in training programs were criticised.

Question 7

What were the ideas that influenced developments of the decade and where did they come from? For example, books, people, events, documents? How influential the ideas were they and what difference did they make?

Narrative

- health as a positive concept—Ottawa Charter of Health Promotion—gave legitimacy to many ideas entering health through youth work and social theory
- links between low socioeconomic status and poor health: reducing inequalities in health between rich and poor, men and women, people of different cultural backgrounds
- empowerment, participation, development and peace
- multi-service youth centres
- John Cornwall, David Bennett, The Australian Association for Adolescent Health
- the creation of services, which in turn generated the push for policy
- concern for the environment

Question 8

What were the key developments or changes that occurred in policy and practice of youth health in the 1980s and the factors that influenced these developments?

Narrative

- there was an introduction of services which generated the push for policy; greater knowledge about program provision, research about young people's health
- International Youth Year
- AAAH got youth health on the agenda
- politicisation of the field through joining with youth workers

Question 9

Who were the workers in youth health at the beginning and end of the decade and what were the spheres in which they operated?

Narrative

- at the beginning of the decade there were not youth health workers as such, but adolescent physicians and teachers and health workers who were part of multidisciplinary teams
- at the end of the decade there was a new group calling themselves youth health workers

Question 10

Do you recall any important undocumented programs and events that occurred during the decade?

BIBLIOGRAPHY

AAAH—see Australian Association for Adolescent Health

ABACC—see Alcoholic Beverages Advertising Codes Council

Abbott, S 1988–9, 'AIDS and Young Women', *The Bulletin of the National Clearinghouse for Youth Studies*, University of Tasmania, vol 7, no. 4, 1988–vol.8, no. 1, 1989, pp. 38–41.

ACT Health Authority, Health Promotion Branch, Youth and Schools Section, 1985, *Report—International Youth Year Project*

Adams, P 1988, 'The Best and Worst Time to be a Child', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.

Adolescent Medical Unit 1984, 'Youth Life Project', Submission to Commonwealth Health Promotion Program, Camperdown, NSW.

Albury, K 1987, 'On the Receiving End', abstract presented at The Fourth International Symposium on Adolescent Health, Sydney, 26–31 March.

Alcohol Beverages Advertising Codes Council 1988, Chairman's report to Media Council of Australia, 18 July.

———1988, Minutes Inaugural Meeting, 11 May

———1988, Minutes Meeting, 17 June

———1988, Minutes Meeting, 12 July

———1989, Minutes Meeting, 10 January

———1989, Letter from Chairman of the ABACC to Pat Auld, Executive Director, Media Council of Australia, 23 February.

Altman, D 1992, 'AIDS and the Discourses of Sexuality', in RW Connell, and GW Dowsett (eds), *Rethinking Sex: Social Theory and Sexuality Research*, Melbourne University Press, Carlton.

———1995, in 'Health Australia: Promoting Health in Australia, A review of the infrastructure supports for national health advancement, discussion paper, NHMRC, Canberra

AMU—see Adolescent Medical Unit

ANCA—see Australia National Council on AIDS

Atkinson, L 1992, *Drugs and Crime: Facts and Fictions: a report to the South Australian Coalition Against Crime Working Group on Alcohol, Drugs and Crime*, Crime Prevention Unit, Attorney Generals Department, SA.

Australia Community Health Association 1991, *Manual of Standards for Community Health—Community Health Accreditation and Standards Program (CHASP)*, 2nd edn, Southwood Press, NSW.

Australia Council of Social Services (1993) *Warning: Poverty is a Health Hazard*, Research Report No. 7, Canberra.

Australia National Council on AIDS 1989, *High Risk Youth Workshop Report: Sydney 23–24 February*, AGPS, Canberra.

Australian Association for Adolescent Health, 1978, *Constitution*, AAAH, Sydney.

———1981, *Secretary's Report 1978–1981*.

———1981, *Dangers to Adolescent Health—Is Society Responsible?* 2nd National Conference on Adolescent Health, 10–11 December: Program and Abstracts, Sydney.

———1983, *Third National Conference on Adolescent Health 8–10 December: Summaries of Papers and Workshops*, Melbourne.

———1985, *Adolescent Health—Who Needs It?* 4th National Symposium on Adolescent Health, 21–23 November: Program and Abstracts, Adelaide.

———1988, *Youth Health—Who Cares?* Biennial National Conference, Brisbane, 1–3 September

———1990, *Future Shock into Future Health: report of proceedings of AAAH Biennial National Conference: 28–30 November*, Perth, Western Australia.

———1984, *Constitution*, AAAH, Sydney.

———1985, Minutes of National Council meeting, May.

———1985, Minutes of Special Meeting on National - State Relationships, 20 November.

———1986, Minutes of National Council meeting, 6 June.

———1986, Minutes of Special Meeting on Policy and State Roles, 7 November.

———1986, Minutes of National Council meeting, 7 November.

———1986, Minutes of National Executive meeting, 8 December.

———1987, Minutes of National Council meeting, 23 February.

———1987, Treasurer's Position Statement, National Executive meeting, 25 May.

———1987, Minutes of National Council teleconference meeting, 21 September.

- 1987, Minutes of National Executive, 16 November.
- 1987, Minutes of National Council, 16 November.
- 1988, Minutes of National Executive meeting, 15 February.
- 1988, Minutes of National Executive meeting, 3 March.
- 1988, Minutes of National Council meeting, 3 March.
- 1988, *Report of National Council Planning Workshop*, 7 March.
- 1989, Minutes of National Council meeting, 16–17 March.
- 1990, Minutes of Special General meeting, 27 November.
- 1990, Minutes of National Council meeting, 27 November.

- 1985, Proposal to Commonwealth Office of Youth Affairs' Programme for Assistance to Youth Organisations.
- 1988, *Annual Report: 1987/88*, AAAH, Sydney.

- 1979, *AAAH Newsletter*, no.2. March
- 1979, *AAAH Newsletter*, no. 4, July
- 1979, *AAAH Newsletter*, no. 5, October
- 1980, *AAAH Newsletter* no. 6., May
- 1980, *AAAH Newsletter* no. 7, August
- 1980, *AAAH Newsletter*, no. 8, October
- 1982, *AAAH Newsletter*, no. 12, March
- 1982, *AAAH Newsletter*, no. 13, July
- 1982, *AAAH Newsletter*, no.14, October
- 1983, *AAAH Newsletter*, no. 16, May
- 1983, *AAAH Newsletter*, no.17, September
- 1984, *AAAH Newsletter*, no. 18, February
- 1984, *AAAH Newsletter*, no. 20, December
- 1985, *AAAH Newsletter*, no 21, March
- 1986, *AAAH Newsletter*, no. 27, May
- 1986, *AAAH Newsletter*, no. 28, July
- 1987, *AAAH Newsletter*, no. 31, March
- 1987, *AAAH Newsletter*, no. 34, October

- 1988, *AAAH Newsletter*, no. 1
- 1988, *AAAH Newsletter*, no. 2
- 1988, *AAAH Newsletter*, no. 3
- 1988, *AAAH Newsletter*, no. 4
- 1989, *AAAH Newsletter*, no. 1
- 1989, *AAAH Newsletter*, no. 2
- 1989, *AAAH Newsletter*, no. 3

—1989, *AAAH Newsletter*, no. 4

—1990, *AAAH Newsletter*, no. 1

—1990, *AAAH Newsletter*, no. 2

—1990, *AAAH Newsletter*, no. 3

—(WA Branch) 1989, *Student Services 1989 and Beyond: A Framework for Student Service Delivery*, Submission to the Ministry of Education, Western Australia.

—Australian College of Paediatrics 1987, '*Conjoint Submission to Inquiry into Medical Education and Medical Workforce*', AAAH, Sydney

Australian College of Paediatrics 1980, 'Recommendations for Adolescent Health Care' *Australian Medical Association (AMA) Gazette*, 4 December, pp. 29 and 31.

—1986, '*Policy Statement—Delineation of Hospital Roles in Providing Care for Adolescents*', in consultation with the Adolescent Health Care Standing Committee of the College, ACP, Sydney.

Baghurst, KI and MacMichael, AJ 1980, 'Nutrition Knowledge and Dietary Intake in Young Australian Populations', *Community Health Studies*, vol. IV, no. 3, pp. 207–213.

Baker, W, Homel, P, Flaherty, B and Trebilco, P 1987, *The 1986 survey of drug use by secondary school students in New South Wales*, In House Report Series, New South Wales Drug and Alcohol Authority.

Ball, A 1988, Letter to Chairman of the Alcohol Beverages Advertising Council dated 12 December.

Ballard, J 1989, 'The Politics of AIDS', in Gardner, H (ed), *The Politics of Health: The Australian Experience*, Churchill Livingstone, Melbourne.

Banfield, G 1993, 'School Health Education in South Australia: A Sociological Analysis', MEd thesis, Flinders University of South Australia

Bashir, M and Schwarz, M, 1988, 'Asia in Australia: from adversity to resiliency and strength—some aspects of the mental health of Asian refugee children', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin

Baum, F 1998, *The new public health: an Australian perspective*, Oxford University Press, Melbourne.

Beckinsale, P, Foster, S, Gay, J, Peppard, J and Smith, B 1997, 'Collaborations in the development of health promoting schools', in D. Colquhoun, K Goltz, and M Sheehan (eds), *The Health Promoting School: Policy, Programs, and Practice in Australia*, Harcourt, Brace and Company, Marrickville, NSW

Bennett, DL 1977, 'The Medical Needs of Australian Adolescents', *Medical Journal of Australia*, vol. 2

———1983, 'An International Focus on Adolescent Sexuality', *International Children's Rights Monitor*, vol. 1, pp. 9–11.

———1984, *Adolescent Health in Australia: An overview of needs and approaches to care*, Australian Medical Association, Glebe, NSW

———1987, 'Message from the Symposium Chairman', *4th International Symposium on Adolescent Health: Program Abstracts and Proceedings 26–31 March*, Sydney.

———(ed.) 1985, *Problems of Adolescents at Work and Play*, The Australian Association for Adolescent Health, Bridge Printery, Rosebery, NSW

———1988, 'Australian Association for Adolescent Health—Highlights of the First 10 Years', presentation to the 1988 AAAH Annual General Meeting

———Robertson, SI and Leu, EM 1979, 'Growing Awareness of Adolescent Medicine in Australia', paper presented at the Second International Symposium on Adolescent Medicine, Washington, D.C.

———and Williams, M (eds) 1988, *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.

Bessant, J 1993a, 'Policy Paradoxes—the disempowerment of young people under the Labor government', *Australian Journal of Social Issues*, vol. 28, no.2, pp. 983–91.

———1993b, 'A patchwork: The life-worlds and "cultures" of young Australians: 1900–1950' in R White (ed), *Youth subcultures—Theory, History and the Australian Experience*, National Clearinghouse for Youth Studies, Hobart

———and Hill, R (eds) 1997, *Youth Crime and the Media*, National Clearinghouse for Youth Studies, Hobart, Tasmania

Better Health Commission 1986, *Looking Forward to Better Health*, vol 1, AGPS, Canberra.

———1986, *Looking Forward to Better Health*, vol 3, AGPS, Canberra, pp.108–114

Beumont, P 1983, 'Body Shape Perception—treatment and outcome in anorexia nervosa', abstract presented at the Third National Conference on Adolescent Health, Melbourne, 8–10 December.

BHC—see Better Health Commission

Binder, H 1994, 'Syringe Exchange in Australia', *ICAA News*, vol. 3 no. 4.

Birch, D 1988, 'Teenage Sexuality and the British Media', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin

Black, D 1980, *Inequalities in Health: report of a research working group*. Department of Health and Social Security, London.

Blewett, N 1985, *The Commonwealth Commitment to Adolescent Health*, address to the Third National Conference on Adolescent Health 21–23 November, Adelaide.

Blewett, N 1988, 'Government Approaches to Adolescent Health', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.

Blum, RWM 1988a, 'The Chronically Ill Adolescent' in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin
——1988b, 'Adolescent Health—A Global Perspective' in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin
——and Mann Rinehart P. 1997, 'Connections that make a difference in the life of youth', *Youth Studies Australia*, vol. 16, no. 4, pp. 37–50.

Boland, C and Jamrozik, A 1989, *Young People and Health*, National Youth Affairs Research Scheme, Canberra

Borthwick, P 1988, 'Streetwise Comics' in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Canberra

Bowes, G 1992, *Contemporary Threats to Adolescent Health*, lecture given in the 1992 Dean's lecture series, University of Melbourne.

Brady, M 1991, *The Health of Young Aborigines: A Report on the Health of Young Aborigines aged 12 to 25*, National Clearinghouse for Youth Studies, University of Tasmania.

Brake, M 1980, *The sociology of youth cultures and subcultures: sex and drugs and rock 'n' roll*, Routledge and Kegan Paul, London.

Bravender-Coyle, P 1986, 'Children, medical treatment and contraceptive agents—is parental consent necessary?' *Medical Journal of Australia*, vol. 144, April 14, pp. 416–423.

Broom, D 1984, 'The Social Distribution of Illness: Is Australia More Equal?' *Social Science and Medicine*, vol. 18, no. 11, pp. 909–917.

Brown, N 1981, Opening address to *Dangers to Adolescent Health—Is Society Responsible?* 2nd National Conference on Adolescent Health, December 10–11, Sydney.

Brown, P 1992, 'Popular epidemiology and toxic waste contamination: lay and professional ways of knowing', *Journal of Health and Social Behaviour*, vol. 33, pp. 267–281.

———1997, 'Popular epidemiology revisited' *Current Sociology*, vol. 45, pp. 137–156.

Burke, L 1983, 'Nutrition in Sport', abstract presented at the Third National Conference on Adolescent Health, 8–10 December, Melbourne.

Burkinshaw, S 1986, *Principles on the provision of health and health care services for Young People*, ACT Workers with Youth Network.

Burnie, H 1985, *Youth Speak Up: A report of youth health consultations held in New South Wales, Victoria, Western Australia and South Australia*, Australian Association for Adolescent Health, Sydney.

Bush, R A 1991, 'The drinking social context among young men and women—a psycho-social developmental perspective', PhD thesis, Macquarie University.

———1992, 'The Transient Years 18–25', *Drugs in Society*, no 1, March, pp 2–5.

———1995, 'The social context of young men and women's drinking: a psycho-social developmental approach', in VJ Callan and Patrick C.L Heaven (eds), *Adolescence: An Australian Perspective*, Jossey-Bass, Melbourne.

Bussell, G J 1986, Letter (August 14) re WAAT Evaluation, sent to Christopher Scarf, Chief Executive Officer Western Metropolitan Health Region, NSW Department of Health.

Carlen, P 1994, 'The governance of homelessness: legality, lore and lexicon in the agency—maintenance of youth homelessness', *Critical Social Policy*, issue 41, vol. 14, no.2, pp. 18–35.

Carr-Gregg, M 1987, 'CanTeen—An Australian Initiative in the Psychosocial Care of Adolescent Oncology Patients', abstract presented at Fourth International Symposium on Adolescent Health 26–31 March, Sydney.

Casey, D 1988, *Korobra*, in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.

CDH—see Commonwealth Department of Health

Centre for Adolescent Health 1994, *Three Years On*, review prepared for the Victorian Health Promotion Foundation, Parkville, Victoria.

Chamberlain, C and MacKenzie, D 1992, 'Understanding contemporary homelessness: issues of definition and meaning', *Australian Journal of Social Issues*, vol. 27, no. 4, pp. 274–297.

—1994, 'Temporal dimensions of youth homelessness', *Australian Journal of Social Issues*, vol. 29, no. 1, pp. 1–25.

Chapman, S and Hodgson, J 1988, 'Showers in raincoats: attitudinal barriers to condom use in high risk heterosexuals', *Community Health Studies*, vol. 12, no. 1, pp. 97–105.

Charter for an International Association for Adolescent Health 1988, in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.

Christie, P, Cormack, S, Wyllie, C and Bungey, J 1989, *Survey of Alcohol, Tobacco and other Drug Use by South Australia School Children—Final Report*, Drug and Alcohol Services Council of South Australia, Adelaide.

Chung, D. 1989, *Youth Health Services in the North: An Evaluation of the Shopfront Service*, Northern Community Health Research Unit, South Australia Health Commission.

- Clarke, M 1984, *Facts, Myth and Stigma: a report on teenage pregnancy and parenting*, Health Education Unit of the NSW Department of Health, Western Metropolitan Health Region.
- 1985, 'Teenage Pregnancy and Parenting: facts, myth and stigma', *Healthright*, vol. 5, no. 1, pp. 13–19.
- Coleman, J and Hendry, LB 1990, *The Nature of Adolescence*, Routledge, London.
- Collinge, A 1988, 'Reaching Out Through Television', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.
- Collins, DJ and Lapsley, HM 1991, *Estimating the Economic Costs of Drug Abuse in Australia*, Department of Community Services and Health in association with NCADA.
- Collins, JK 1991, 'Research into Adolescence: a Forgotten Era', *Australian Psychologist*, vol. 26, no. 1, pp.1–9.
- and Harper, JF 1985, 'Sexual behaviour and peer pressure in adolescent girls', *Australian Journal of Sex, Marriage and the Family*, vol. 6, no. 3, pp. 137–142.
- Robinson, L 1986, 'The contraceptive knowledge, attitudes and practice of unmarried adolescents', *Australian Journal of Sex, Marriage and the Family*, vol. 7, no. 3, pp. 32–52.
- Colquhoun, D, Goltz, K, and Sheehan, M 1997, *The Health Promoting School: Policy, Programs, and Practice in Australia*, Harcourt, Brace and Company, Marrickville, NSW.
- Commonwealth of Australia 1988, *AIDS: a time to care, a time to act—towards a strategy for Australians*, Policy Discussion Paper, AGPS, Canberra.
- Commonwealth Department of Health, 1981, *The Health Needs of Adolescents*, AGPS Canberra.
- 1984, *Reaching Today's Youth—A 'Live-in' Communication Workshop (18–20 May) on Adolescent Health: workshop program*.
- 1987a, *Taking the Initiative: report on National Campaign Against Drug Abuse 1985–1986*, AGPS, Canberra.
- Commonwealth Department of Health, Housing, Local Government and Community Services 1993, 'Progress Report on the National Review of State and Territory Evaluations of the Innovative Health Services for Homeless Youth Program' (draft), prepared by staff of the Health Promotion Strategies Section, Health Development Branch.

Commonwealth Department of Health, Housing, Local Government and Community Services 1993, *National Women's Health Program—Evaluation and Future Directions*, AGPS, Canberra.

Commonwealth Department of Human Services and Health 1993, *National AIDS Campaign 1986–1992: An Overview*, submission by the AIDS/Communicable Diseases Branch for the Evaluation Panel Review of National HIV/AIDS Programs, AGPS, Canberra

———1994, *The Health of Young Australians: a draft paper*, AGPS, Canberra.

———1995a, *The Health of Young People—A National Policy for Children and Young People*, AGPS, Canberra.

———1995b, *Youth Suicide in Australia: a background monograph*, prepared by the Special Health Services Section, Primary Health Care Group, AGPS, Canberra.

Commonwealth Department of Sport Recreation and Tourism/ANOP 1985, *Young Australians Today: a report on a study of the attitudes of young Australians 1984*, AGPS, Canberra.

Commonwealth Office of Youth Affairs/ANOP 1987, *Survey of Community Attitudes to Issues Affecting Young People 1986*, AGPS, Canberra.

Commonwealth Youth Bureau/ANOP 1991, *Community Attitudes to Issues Affecting Young People and to DEET Policies and Programs 1990*, AGPS, Canberra.

Condon, J 1992, 'Pregnancy, abortion, adoption and pregnancy' in Kosky, R, Eshkevari, HS and Kneebone, G (eds), *Breaking Out, Challenges in Adolescent Mental Health in Australia*, AGPS, Canberra.

Confetti, D c. 1986–7, *The side effects manual of theatre games and role plays for youth: no previous experience necessary*, AMU, Petersham, NSW.

Confetti, D and *Side Effects* Youth Health Drama Group 1987, 'Use of Live Theatre in Health Promotion', abstract presented at Fourth International Symposium on Adolescent Health 26-31 March, Sydney.

Conley, M 1988, Letter to G.P. Auld, Convenor of the Cigarette and Alcoholic Beverages Advertising Code Council, undated but stamped April 27, 1988.

Connelly, P and Borger J 1985, *Health for Youth—A Strategy for Western Sydney*, New South Wales Department of Health, Western Metropolitan Health Region.

Cormack, S, Christie, P, Wylie, C and Bungey, J 1989, *Trends in Alcohol and Other Drug Use Amongst South Australian School Children: 1986–1988*, Drug and Alcohol Services Council of South Australia, Adelaide.

Cornwall, J 1989, *Just For the Record—The Political Recollections of John Cornwall*, Wakefield Press, Kent Town, South Australia.

Cornwall, J 1991, Interview in 'Over A Barrel', *Four Corners*, Australian Broadcasting Corporation, 27 May.

Court, J 1981, address to Final Plenary Session (audio recording), *Dangers to Adolescent Health—Is Society Responsible? 2nd National Conference on Adolescent Health 11–12 December*, Sydney.

—1983, 'Fat is Beautiful', abstract presented at Third National Conference on Adolescent Health 8–10 December, Melbourne.

Crooks, ML and Webb, M 1988, 'Health for Youth', *Bulletin of the National Clearinghouse for Youth Studies*, vol. 7, no. 3, pp. 20–22.

Cubis, J 1992, 'Contemporary trends in adolescent sexual behaviour', in R. Kosky, HS Eshkevari, and G. Kneebone (eds), *Breaking Out, Challenges in Adolescent Mental Health in Australia*, AGPS, Canberra.

Cubis, J, Lewin, T and Raphael, B 1985, 'Correlates of pregnancy and sexual experience in Australian Adolescents', *Journal of Psychosomatic Obstetrics and Gynaecology*, vol. 4, pp. 237–254.

Cubis, J, Cowan, A, Lewin, T 1986, 'Sexual experience, attitudes, and decision making in Australian adolescent females' in L Dennerstein and I Fraser, (eds), *Hormones and Behaviour*, Excerpta Medica, Amsterdam, Elsevier Science Publishers B.V. (Biomedical).

Daniel A and Cornwall J 1993, *A Lost Generation?*, Australia Youth Foundation, East Sydney.

DASC—see Drug and Alcohol Services Council of South Australia

Davey-Smith G, Bartley M, Blane, D (1990) 'The Black Report on socio-economic inequalities in health 10 years on' *British Medical Journal*, vol. 301, pp. 373–377

Dawson, L 1987, 'Health Problems of Aboriginal Youth' abstract presented at Fourth International Symposium on Adolescent Health 26–31 March: program and abstracts, Sydney.

DCSH—see Department of Community Services and Health

Denshire, S 1984, *The Shape and Impact of Youth Participation in Health*, working paper prepared for the Study Group on Young People and "Health for All by the Year 2000", World Health Organization, Geneva.

—1985, *Aspects of Youth Participation in Health Services*, unpublished paper.

—1993, 'Work of Art—occupational analysis of a children's hospital youth arts program', *Youth Studies Australia*, Winter: pp. 18–24.

—1994, *Youth Arts Archive—your guide to the Youth Arts Program 1984–1992*, AMU, Royal Alexandra Hospital for Children, NSW.

—1996, 'A Decade of Creative Occupation: The Production of a Youth Arts Archive in a Hospital Site', *Journal Of Occupational Science: Australia*, vol. 3, no. 3, pp. 93–98

—and Bennett, DL 1985, 'Have a Say: Networking with Teenagers in a Hospital for Children', *International Journal of Adolescent Medicine and Health*, vol. 1 nos. 1 and 2, pp. 217–224.

Department of Community Services and Health 1988, *Health for All Australian: report of the Health Targets and Implementation (Health for All) Committee*, Australian Health Minister's Advisory Council, AGPS, Canberra

—1989, *National HIV/AIDS Strategy: a policy information paper*, AGPS, Canberra.

—1993, *National AIDS Campaign 1986–1992: An Overview*, Submission by the AIDS/Communicable Diseases Branch for the Evaluation Panel Review of National HIV/AIDS Programs, AGPS, Canberra.

Drug and Alcohol Services Council of South Australia 1989, *Action Counts: Teaching Strategies in Drug Education*, DASC, Adelaide.

Drury, S and Jamrozik, A (1985) 'Conceptual issues of relevance to social policy and services for young people', in A Jamrozik (ed.) *Issues in Social Welfare Policy 1985: Perceptions, Concepts and Practice*, University of New South Wales, SWRC Reports and Proceedings No. 54.

Eames, M, Ben-Shlomo, Y and Marmot, MG (1993) 'Socio-economic differentials in wealth and health', *British Medical Journal*, vol. 307, pp. 1097–1102

Eckersley, R (1988) *Causalities of Change: The Predicament of Youth in Australia*, Commission for the Future, AGPS, Canberra.

Eckersley, R 1988, 'Casualties of Change—Social and Economic Issues Affecting Youth', *The Bulletin of the National Clearinghouse for Youth Studies*, University of Tasmania, vol. 7, no. 4, 1988—vol. 8, no. 1, 1989, pp. 3–8.

Education Department of South Australia 1992, *Teacher Education and Community Health (TEACH) Project—final evaluation*, Miller Mahon Consultants, Adelaide.

Edwards J and Hicks, N 1990, *The Sick Adolescent or the Social Adolescent?* Department of Community Medicine, University of Adelaide.

Eisen, P, 1980, 'Report on the Manila Conference', *AAAH Newsletter*, no. 6, May, p. 3.

Elliott and Shanahan Research 1989, *Adolescent Alcohol Abuse Evaluation Survey*, NCADA, December.

Eisenbruch, M 1987, 'Cross Cultural Research in Adolescent Health', abstract presented at Fourth International Symposium on Adolescent Health 26–31 March: program and abstracts, Sydney.

English, B 1981, 'Impact of Societal Change', paper presented at *Dangers to Adolescent Health—Is Society Responsible? 2nd National Conference on Adolescent Health 10–11 December*, Sydney.

Erikson, EH 1968, *Identity, youth, and crisis*, WW Norton, New York.

Evans, RG, Borer, M L and Marmor, T A (eds) 1994, *Why are some people healthy and others not?—the determinants of health of populations*, Aldine de Gruyter, New York.

Ewen, J, 1983, *Youth in Australia*, Phillip Institute of Technology, Centre for Youth and Community Studies, PIT Press, Bundoora, Victoria.

Fairfield City Council 1982, *A Fair Go for Ethnic Youth Conference 18 November: A Report of the Proceedings*, Fairfield City Council.

Family Planning Association (FPA) of New South Wales 1987, *Background Information*, Western Metropolitan Health Region, Penrith
—1998, *Sexuality and the law: a guide for health and community workers in New South Wales*, Ashfield, New South Wales.

Feather, N T and O'Brien, GE 1986, 'A longitudinal study of the effects of employment and unemployment among school leavers', *Journal of Occupational Psychology*, vol. 59, pp. 121–144.

Finch, L 1993, 'On the Streets: Working class youth culture in the 19th century', in R White (ed), *Youth subcultures—theory, history and the Australian experience*, National Clearinghouse for Youth Studies, Tasmania.

Finlay-Jones J and Eckhardt, B 1981, 'Psychiatric disorder among the young unemployed', *Australian and New Zealand Journal of Psychiatry*, vol. 15, pp. 265–270.
—1984, 'A social and psychiatric survey of unemployment among young people', *Australian and New Zealand Journal of Psychiatry*, vol 18, pp.135–143.

Finlayson, P, Reynolds, I, Rob,M, and Muir, C 1987, *Adolescents: Their Views, Problems and Needs: A Survey of High School Students*, Hornsby Kuringai Area Health Service, Sydney.

Four Winds c. 1982–3, 'Summary of the Proposal for a Specialised Adolescent Accommodation Unit to serve the Western Region', Sydney .

Fowler, G 1997, 'Alcohol and healthy public policy: development of the National Health Policy on Alcohol', MPA thesis, Flinders University of South Australia.

Franzkowiak, P 1983, *Health Promotion for Youth in the European Region: Basic Philosophy and Innovative Strategies*, working paper prepared for the Study Group on Young People and Health for All by the Year 2000, World Health Organization, Geneva.
—1985, 'Growing Up into the 1980s: An Ecological Framework for Health Promotion for Youth', in U Laaser, R Senault and H. Viefhues (eds), *Primary Health Care in the Making*, Springer-Verlag, Berlin.

Freidman, H 1988, 'WHO Initiatives in Adolescent Health and Some Future Directions, in DL Bennett and M Williams (eds), *New Universals—Adolescent Health in a Time of Change*, Brolga Press, Curtin.

- Gallagher, JR 1982, 'The Origins, Development, and Goals of Adolescent Medicine', *Journal of Adolescent Health Care*, vol. 3, pp. 57–63.
- Garrard, J 1989, 'How effective are drug educators? Issues of evaluation in drug education', paper presented at the Fourth National Drug Educators Workshop 7–10 November, Adelaide.
- Garner, P 1988, 'Television, Violence and Young People', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.
- Geddes, E and Nelson, J 1993, *Youth Health Project: Progress Report*, South Australia Centre for Economic Studies.
- Gillick v West Norfolk and Wisbech Area Health Authority* 1985, pp. 47, 53.
- Gilligan, C 1982, *In a Different Voice: Psychological Theory and Women's Development*, Harvard University Press, Cambridge.
- Glendinning, A, Love, JG, Hendry, LB and Shucksmith, J 1992, 'Adolescence and Health Inequalities: extensions to MacIntyre and West', *Social Science and Medicine*, vol. 35, no. 5, pp. 679–687.
- Goldman, JDG 1992, 'AIDS education in Australian schools', in *HIV/AIDS Education: current issues and research on Australian YOUNG PEOPLE and HIV/AIDS*, YSA Resource No 1, National Clearinghouse for Youth Studies, Hobart.
- Goldenring, J 1988, 'Psychological Effects of the Threat of Nuclear War on Young People', in DL Bennett and M Williams (eds), *New Universals—Adolescent Health in a Time of Change*, Brolga Press, Curtin.
- Goltz, K and Edgecombe, G 1996, *Adolescent primary care services: a review of the literature*, research monograph, Victorian Department of Human Services, Adolescent Services Development Unit, Melbourne.
- Greig, R and Raphael, B 1989, 'AIDS prevention and adolescents', *Community Health Studies*, vol XIII, no. 2, pp. 211–219.
- Griffin, C 1993, *Representations of Youth—The Study of Youth and Adolescence in Britain and America*, Polity Press, Cambridge.

Hall, S and Jefferson, T (eds) 1976, *Resistance Through Rituals: Youth Subcultures in Post War Britain*, Hutchison, London.

Harris, R 1981, 'Coping Methods and Unemployment', paper presented at *Dangers to Adolescent Health—Is Society Responsible? the 2nd National Conference on Adolescent Health 10–11 December*, Sydney.

Hart, B 1988–9, 'Youth Suicide: Prevention Task Force Position Paper', in *The Bulletin of the National Clearinghouse for Youth Studies*, University of Tasmania, vol 7, no.4, 1988—vol.8, no 1,1989, pp. 48–51.

Hartley, R. 1990, 'Homelessness Still a Problem', *Family Matters*, issue no. 27, pp.27–28.

———1993, 'The Social Costs of Youth Homelessness', in Sykes, H (ed), *Youth Homelessness: Courage and Hope*, Melbourne University Press.

Hastings-Smith 1988, 'The Role of the Artist in Health Care Settings' in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.

'Have a Say', 1980, video produced by young people at the Royal Alexandra Hospital for Children and Jenny Fisher, a social work student on placement at the AMU.

Havinghurst RJ 1972, *Developmental Tasks and Education*, D. McKay, New York.

Hawks, D 1984, 'In Letter and In Spirit: An Analysis of the Intention of Alcohol Advertising', paper presented to The Fourth Annual Conference of the Medical Society on Alcohol and Drug Related Problems, Sydney.

———1989, Letter (10 July) to Chairperson, Trade Practices Tribunal.

———1990, 'The watering down of Australia's health policy on alcohol', *Drug and Alcohol Review*, vol. 9, pp. 91–95.

———1993, 'The formulation of Australia's National Health Policy on Alcohol', *Addiction*, vol. 88, (Supplement) 19S–26S.

———and Lenton, S 1995, 'Harm Reduction in Australia: Has it worked? A review', *Drug and Alcohol Review*, vol. 14, pp. 291–304.

Hayes, R and McAlpine, S, 1988, 'Towards the rights of minors—complex legal process', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin, ACT.

Heald, F 1983, 'Nutrition and the Adolescent', abstract of paper presented at the Third National Conference on Adolescent Health 8–10 December, Melbourne.

Health Education Interagency Challenge Group 1988, *Report to the Human Services Committee of Cabinet*, South Australia.

Hebdige, D 1979, *Subculture: The Meaning of Style*, Methuen, London.

Heslop, J 1986, 'Progress Report to FPA Board—Development of Youth Health Centre', FPA, Sydney.

Hill, P 1984, Letter (22nd August) to BV McKay, NSW Dept of Health, on behalf of the New South Wales Branch of the Australian Association for Adolescent Health.

Hillier, L, Dempsey, D, Beale, L, Matthews, L and Rosenthal, DA 1998, *Writing themselves in: a national report on the sexuality, health, and wellbeing of same-sex attracted young people*, National Centre in HIV Social Research: Program in Youth/General Population, LaTrobe University.

Homel, P, Flaherty, B and Trebilco, P and Dunoon, D 1984, *Highlights of the 1983 survey of drug use by secondary school students in New South Wales*, In House Report Series, New South Wales Drug And Alcohol Authority.

Howard, J 1981, 'In the Best Interests of the Adolescent', paper presented at *Dangers to Adolescent Health—Is Society Responsible? the 2nd National Conference on Adolescent Health 10–11 December*, Sydney.

Howe, B, Duncan, P and Staples, P 1989, *Towards social justice for young Australians 1989–90 Budget*, budget related paper no. 9, AGPS, Canberra.

Howden-Chapman, P and Cram, F 1998, 'Social Economic and Cultural Determinants of Health' background paper no. 1, National Health Committee: Health Determinants Program, New Zealand.

HREOC—see Human Rights and Equal Opportunity Commission

Human Rights and Equal Opportunity Commission, 1989, *Our Homeless Children: report of the Inquiry into Homelessness Children*, AGPS, Canberra.

—1993, 'Human rights and mental illness: report of the national inquiry into the human rights of people with mental illness', National Inquiry Concerning the Human Rights of People with Mental Illness, AGPS, Canberra.

Irving, T, Maunders, D and Sherington, G 1995, *Youth in Australia—Policy, Administration and Politics*, Macmillan Education, South Melbourne

Irwin, J 1984, *Abbreviated Proceedings of the Adolescent Health Seminar*, Brisbane.

Jamrozik, A and Boland, C 1991, *Health Issues for Young People*, presented at Issues Workshop on Youth Health Policy 31 May, South Australia Health Commission, Adelaide.

Jeanneret, O 1981, 'Trends in Medicosocial Services for Adolescents', paper presented at *Dangers to Adolescent Health—Is Society Responsible? the 2nd National Conference on Adolescent Health 10–11 December*, Sydney.

Jerome, B 1981, 'Major Issues in Adolescent Sexuality', paper presented at *Dangers to Adolescent Health—Is Society Responsible? the 2nd National Conference on Adolescent Health 10–11 December*, Sydney.

Johnson, L 1993, *The Modern Girl: Girlhood and Growing Up*, Allen and Unwin, Sydney.

Jones, A 1983, 'Bi-cultural conflicts—problems for ethnic teenagers', abstract of paper presented at the Third National Conference on Adolescent Health 8–10 December, Melbourne.

Kalucy, R 1988 'The Last Things Revisited', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.

Kelly, PC, 1993, *Australia's young people: a statistical profile*, National Youth Affairs Research Scheme and Australian Bureau of Statistics, catalogue no. 4123.0

Kemm, J 2001, 'Health Impact Assessment: a tool for healthy public policy', *Health Promotion International*, vol. 16, no. 1, pp. 79—85.

Kippax, S, Crawford, J, Connell RW, Dowsett, G and Waldby, C 1990, 'Establishing Safe Sex Norms in the Heterosexual Community', presented at the 4th National Conference on AIDS August 1990, Canberra.

Kirke, K and Divakaren-Brown, C, Priest, K and Roder, D 1993, *Aboriginal Health Statistics Chart Book*, South Australia Health Commission.

Kosky, R 1978, 'Observations on the Psychological Effects of Unemployment on Young People', background paper for Seminar on Health and Medical Care of Adolescents November 13–15, Sydney.

Kosky, R, Eshkevari, HS and Kneebone, G (eds) 1992, *Breaking out: challenges in Adolescent mental health in Australia*, AGPS, Canberra.

Kovacs, GT, Dunn, K and Selwood, T 1986a, 'Teenage girls and sex: the Victorian Action Centre Survey' *Australian Journal of Sex, Marriage and the Family*, vol. 7, no. 4, pp. 217–224.

—1986b, 'Gynaecological and sexual profile of new patients attending a family planning clinic', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, vol. 26, pp. 235–238

Kreiger, N 1992, 'The Making of Public Health Data: Paradigms, Politics, and Policy', *Journal of Public Health Policy*, vol. 13, pp. 412–427

Kreiger, N 1994, 'Epidemiology and the web of causation: has anyone seen the spider?' *Social Science and Medicine*, vol. 39, no. 7, pp. 887–903

Kroger, J 1989, *Identity in Adolescence: the balance between self and other*, Routledge, London.

Leary, D and Remafedi, G 1987, 'Health needs of Gay Young Men', abstract presented at The Fourth International Symposium on Adolescent Health 26-31 March, Sydney.

Leary, D 1991, *A Future in the midst of chaos and change—report on the work of the Come In Youth Resource Centre*, Paddington, New South Wales

Lee, C, Clarke, S and Crandon, AJ 1987, 'The incidence of genital tract infection and abnormal cervical cytology in a group of adolescent girls admitted to a Sydney detention centre', abstract presented at The Fourth International Symposium on Adolescent Health 26-31 March, Sydney.

- Leeder, S 1988, 'Hospital-based adolescent services in the future', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.
- Lepani, B 1988, 'Living with the Work Ethic', in DL Bennett and M Williams (eds), in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.
- Low, N and Cranshaw, B 1985, 'Homeless youth: patterns of belief', *Australian Journal of Social Issues*, vol. 20, no. 1, pp. 23–34.
- Lowry, RP 1974, *Social problems—a critical analysis of theories and public policy*, D. C. Heath and Company, Lexington, Massachusetts.
- Maas, F 1990, 'Shifting responsibility— a decade of youth policy' in *Family Matters*, issue no. 26, April, pp. 19–24
- MacIntyre, S 1988, 'Overview of social change', in DL Bennett and M Williams (eds) , *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.
- and West P 1991, 'Lack of class variation in health in adolescence: an artefact of an occupational measure of social class? *Social Science and Medicine*, vol. 32, no. 4, pp. 395–402.
- Makkai, T and McAllister, I 1990, 'Alcohol consumption across the lifecycle in Australia, 1985–1988', *Drug and Alcohol Dependence*, vol. 25, pp. 305–313.
- Manderson, L 1989, 'Consuming images: adolescence, food and culture', *The Bulletin of the National Clearinghouse for Youth Studies*, vol. 7, no. 4, 1988–vol. 8, no. 1, 1989, pp. 33–37.
- Manning, L, 1987, 'She Screams Out' Young Women, Drama, and Health Promotion', abstract presented at The Fourth International Symposium on Adolescent Health 26–31 March, Sydney.
- Marmot M and Wilkinson, RG (eds) 1999, *Social determinants of health*, Oxford University Press, New York.
- Mason, G 1990, *Youth suicide in Australia—prevention strategies*, report to the Department of Employment, Education and Training (Youth Bureau), AGPS, Canberra.

Mathers, C 1996, *Health Differentials in Young Australian Adults*, Health Monitoring Series No. 4, AIHW, Canberra.

MCA—see Media Council of Australia

McCarthy, W (ed) 1983, *Teaching about sex: the Australian experience*, Australian Federation of Family Planning Associations, George Allen and Unwin, Sydney.

McLaws ML and Cooper D, 1988 'AIDS and Adolescents', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.

McLean, K 1993, *Innovative health services for homeless youth program: evaluation report*, Youth Health Policy Unit, Queensland Health.

McNamara, R 1983, 'The Need for Change in Schools', abstract of paper presented at the Third National Conference on Adolescent Health 8–10 December, Melbourne.

McPherson, MA, Palin, MN and Wheller, R 1988, *Alcohol without tears: a set of lessons*, Drug and Alcohol Education Program In-house Publication Series, no. 11, TAFE, NSW.

McRobbie, A 1980, 'Settling accounts with sub-cultures: a feminist critique', *Screen Education*, vol. 34, pp. 37–49.

Mearns, R, Kraiuhin, C and Benfield, J 1981, 'Suicide in Adolescents', paper presented at *Dangers to Adolescent Health—Is Society Responsible? the 2nd National Conference on Adolescent Health 10–11 December*, Sydney.

Media Council of Australia 1988, Memorandum (29 April) to members of Alcoholic Beverages Advertising Codes Council re agenda for meeting 11 May.

———1989, Memorandum (March 7) to all members of the Codes Councils, Chairman of the Advertising Standards Council and Federal Directors of the AFA and AANA.

Mellor, N 1998, 'Intersectoral and Community Approaches to Alcohol and Drug Problems', in M Hamilton, A Kellehear, G Rumbold, (eds), *Drug use in Australia: a harm minimisation approach*, Oxford University Press, Melbourne.

Middleton, M 1985, 'The effect of schooling on adolescent health', abstract presented at AAAH 4th National Symposium on Adolescent Health: Adolescent Health—Who Needs It? 21–23 November, Adelaide.

———1988, 'The effect of schooling on adolescent health', *The Bulletin of the National Clearinghouse for Youth Studies*, vol. 7, no. 2, pp. 44–47.

Ministry of Education: Schools Division and Health Commission Victoria 1986, *Report on the survey of drug use among Victorian post primary students*, Melbourne, Victoria.

Monroy de Velasco, A 1988, 'CORA: a Mexican experience in integrating sex education into adolescent health services', in DL Bennett and M Williams (eds), *New Universals: Adolescent Health in a Time of Change*, Brolga Press, Curtin.

Montague, M 1980, 'Are teenagers having babies?' *Australian and New Zealand Journal of Sociology*, vol. 16, no. 3, pp. 76–80.

———1981, *Labour force or labour ward: is this a choice young women are making?* research report, Brotherhood of St. Laurence, Fitzroy, Victoria.

———1983, 'Baby booms and benefit bludging—are young women the victims of a myth?', *Community Health Studies*, vol. VII, pp. 136–145.

Moon, J and Fletcher, C 1988, 'Does Mr. Burke make a difference? New Government and policy change in Western Australia 1983–1987', *Politics*, vol. 23, no. 1, pp. 78–89.

Moore, D and Saunders, B 1992, 'Youth drug use and the prevention of problems—why we've got it all wrong', *The International Journal on Drug Policy*, vol. 2, no. 5, pp. 29–33.

Morgan, P, Wallack, L, Buchanan, D 1989, 'Waging drug wars: prevention policy or politics as usual' in *Perspectives on Adolescent Drug Use*, The Haworth Press, pp. 99–124.

Morrell, S, Taylor, R, Quine, S and Kerr, C 1990, 'Suicide and Unemployment in Australia 1907–1990', *Social Science and Medicine*, vol. 36, no. 6, pp. 749–756.

———1999, 'A case control study of unemployment status and mortality in a cohort of Australian youth', vol. 49, no. 3, *Social Science and Medicine*, pp. 383–392

Mount Druiitt Hospital and Western Sydney Department of Health 1986, *Western Area Adolescent Team Draft Evaluation Report*.

Murdoch, S, Kambouris, N and Findlay S, 1993, *National Youth Data Index: report to National Youth Affairs Research Scheme*, National Clearinghouse for Youth Studies, University of Tasmania, Hobart.

National Campaign Against Drug Abuse 1986a, *National Drug Education Program*, AGPS, Canberra

—1986b, *An Australian Guide to Drug Issues*, CEIDA, AGPS, Canberra.

—1987, *Taking the Initiative: National Campaign Against Drug Abuse 1985–1986*, AGPS, Canberra

—1989a, *National Health Policy on Alcohol*, AGPS, Canberra

—1989b, *The National Campaign Against Drug Abuse 1985–1988: evaluation and future directions*, Monograph Series no. 12, AGPS, Canberra.

National Health and Medical Research Council 1980, report from 90th session.

—1983, *Community Health Care for Adolescents*, 96th session.

—1984, *Health Needs of Homeless Youth*, approved 98th session.

—1995, *Health Australia—promoting health in Australia: a review of the infrastructure supports for national health advancement*, discussion paper, AGPS, Canberra.

—1996, *Effective School Health Promotion Towards Health Promoting Schools*, AGPS.

National Health Strategy, 1992, *Enough to make you sick: how income and environment affect health*, research paper no. 1, AGPS, Canberra.

National Youth Conference, 1980, *National Youth Conference 3–5 October 1979*, Cassell, Australia.

Neilsen, G 1988, 'The Warehouse: lessons for adolescent health', abstract presented at Adolescent Health—Who Cares? 1–3 September, Brisbane.

Neuendorff, DJ 1986, 'Teenage Awareness of Family Planning Matters', *Australian Journal of Social Issues*, vol. 21, no. 1, pp. 57–66.

New South Wales Department of Health c. 1983–4, *Policy Statement—Health Services for Adolescents*, draft discussion document, North Sydney, New South Wales.

—1985, *Policy guidelines: health care for youth*, North Sydney, New South Wales.

—1991, *Providing for the health of young people*, State Health Publication No: (SPP) 91–125, North Sydney, New South Wales.

New South Wales IYY Committee Health Subcommittee 1985, *Hospitals should be a lot more fun—draft policy statement*, Sydney.

Nicolas, J and Howard, J 2000, 'Better dead than gay?', *Youth Studies Australia*, vol. 17, no. 4, pp. 28–33.

Niland C and Lowe D 1988, 'Adolescents and AIDS—the legal and public policy response', in DL Bennett and M Williams (eds) *New Universals—Adolescent Health in a Time of Change*, Brolga Press, Curtin.

Norman, E 1995, 'Personal Risk Factors Related to Substance Misuse: Risk Abatement and/or Resiliency Enhancement?', in TP Gullota, GR Adams, and Montemayor (eds), *Substance Misuse in Adolescence*, Advances in Adolescent Development Annual Book Series vol. 7, Sage Publications, London.

Nun, K 1988, 'Personal Hopefulness in an Age of Despair', in DL Bennett and M Williams (eds) *New Universals—Adolescent Health in a Time of Change*, Brolga Press, Curtin.

Nutbeam, D 1993, 'Warning! Schools can damage your health: alienation from school and its impact on health behaviour', *Journal of Paediatrics and Child Health*, vol. 29, supplement 1, S25–S30.

O'Connor, I 1985, 'Youth, the Law and Health Care: Emerging Issues in Service Delivery', abstract presented at AAAH 4th National Symposium on Adolescent Health: *Adolescent Health—Who Needs It?* 21–23 November, Adelaide.

Offer, D, Ostrow, JD, Howard, KI and Atkinson, R 1988, *The teenage world: adolescent's self-image in ten countries*, Plenum Publishing Corporation, New York.

Palmer, D and Collard, L 1993, 'Aboriginal young people and youth subcultures', in R White (ed) *Youth Subcultures, Theory, History and the Australian Experience*, National Clearinghouse for Youth Studies, University of Tasmania.

Palmer, GR. and Short, S 1989, *Health care and public policy: an Australian analysis*, Macmillan, South Melbourne.

Parnell, B 1992, 'Changing Behaviour', in E Timewell, V Minichiello, and D Plummer, , (eds), *AIDS in Australia*, Prentice Hall, Sydney.

Patience, A 1992, 'A Cultural Context for Adolescent Mental Health', in R Kosky, HS Eshkevari, and G Kneebone, (eds) *Breaking Out, Challenges in Adolescent Mental Health in Australia*, AGPS, Canberra.

- Patrick, DL and Bergner, M 1990, 'Measurement of Health Status in the 1990s', *Annual Review of Public Health*, vol. 11, pp. 165–83
- Patterson, D 1992, 'The Law', in E Timewell, V Minichiello, and D Plummer, (eds), *AIDS in Australia*, Prentice Hall, Sydney.
- Peppard, JL 1984, *Report of Community Health Youth Worker: June 15–December 15 1984*, AMU, The Children's Hospital, NSW.
- , Hill, M and Ness, B 1988, 'Youth participation in health services: practical issues at the Second Story', in DL Bennett and M Williams (eds) *New Universals—Adolescent Health in a Time of Change*, Brolga Press, Curtin.
- Poole, M and Goodnow, J 1990, 'The Changing world of children and youth in Australia', *Youth Studies Australia*, vol. 9, no. 2, pp. 12–19
- Pritchard, J 1983, 'Nutrition in Schools', paper presented at the Third National Conference on Adolescent Health 8–10 December, Melbourne
- Raphael, B 1981, 'Preventative Psychiatry of Adolescent Pregnancy and Abortion', paper presented at *Dangers to Adolescent Health—Is Society Responsible? the 2nd National Conference on Adolescent Health 10–11 December*, Sydney.
- 1988–9, 'Adolescent health—who cares?', *The Bulletin of the National Clearinghouse for Youth Studies*, University of Tasmania, vol 7, No. 4, 1988–vol. 8, no 1, 1989, pp. 27–32.
- 1993, 'Adolescent resilience: the potential impact of personal development in schools', *Journal of Paediatrics and Child Health*, vol. 29, supplement 1, S31–36
- and Lynch, D 1988, 'Waiting for the End of the World', in DL Bennett and M Williams (eds) *New Universals—Adolescent Health in a Time of Change*, Brolga Press, Curtin.
- Reich, WT (ed), 1995, *Encyclopedia of Bioethics* (2nd edn), Macmillan, New York.
- Reid, J (ed) 1982, *Body, Land and Spirit, health and healing in Aboriginal society*, University of Queensland Press, St. Lucia, Qld.
- Reinharz, S 1992, 'Feminist Oral History' in *Feminist Methods in Social Research*, Oxford University Press, Oxford, New York.

Resnick, R, Harris, LJ and Blum, RW 1993, 'The impact of caring and connectedness on adolescent health and well-being', *Journal of Paediatrics and Child Health*, vol. 29, supplement 1, S3–9.

Riches, A 1986, 'Contraceptive advice for minors: yes or no?', *Medical Practice*, April, pp. 25–26.

Robertson, S, 1985, 'Health Service Models', abstract presented at AAAH 4th National Symposium on Adolescent Health: Adolescent Health—Who Needs It? 21–23 November, Adelaide.

——(comp) 1990, *Family Relationships*, monograph no. 1, AAAH, Darlinghurst, NSW.

——and Smith, J. 1987, 'Adolescent Health Services Review—Western Australia', abstract presented at Fourth International Symposium on Adolescent Health 26–31 March, Sydney.

Roman, L 1996, 'Spectacle in the dark: youth as transgression, display, and repression', *Educational Theory*, vol. 46, no. 1, pp. 1–22

Ross, MW, Wodak, A, Loxley, W, Stowe, A and Drury, M, 1993, *Staying Negative: a summary of the results of the National AIDS and Injecting Drug Use Study, 1989–1992*, ANAIDUS, Sydney.

Rowe, C 1983, 'Food Additives and Behaviours', abstract of paper presented at the Third National Conference on Adolescent Health 8–10 December, Melbourne.

Rowling, L 1994, *Post war history of school health in Australia*, briefing paper for NHMRC Health Advancement's Standing Committee's Health Promotive Environments Working Party.

Ryan, W 1976, *Blaming the Victim*, Vintage Books, New York.

SAHC—see South Australia Health Commission

Sali, A 1983, 'The Eating Habits of Young Australians', abstract of paper presented at the Third National Conference on Adolescent Health 8–10 December, Melbourne.

Saunders, B 1989, 'The New Codes on Alcohol Beverages Advertising: Who Benefits?' *Media Information Australia*, no. 54.

Saunders, B and Yap, E, 1987, *Alcohol Advertising: an evaluation of the Australian system of self-regulation*, Addiction Studies Unit, Curtin University of Technology, Western Australia.

Second Story, 1985, *Constitution*, Second Story, Adelaide, Adelaide

—1986(a), *Progress Report: September 1985–February 1986*, Second Story, Adelaide

—1986(b), *Annual Report 1985–86*, Second Story, Adelaide

—1986(c), *Response to the Future Directions Papers for Young People*, Second Story, Adelaide

—1992, *Annual Report 1991–92*, Second Story, Adelaide

—1994, *Annual Report 1993–94*, Second Story, Adelaide

Seminar on Health and Medical Care of Adolescents, 1978, Minutes of final meeting November 13–15, Sydney.

Attendance Sheet for Seminar (July 27) on Multi-Service Youth Programs 1983, New South Wales.

Sercombe, H 1993, 'Youth Theory: Marx or Foucault?' in R White (ed), *Youth subcultures—theory, history and the Australian experience*, National Clearinghouse for Youth Studies, University of Tasmania.

Shanahan, P 1984, *Youth unemployment—the disease of the '80s: a study conducted for the Commonwealth Department of Health*, Elliott and Shanahan Research, North Sydney.

—1987a, *National Campaign Against Drug Abuse Media Education Campaign Adolescent Alcohol Abuse*, Elliott and Shanahan Research, North Sydney.

—1987b, *Summary of Background Research for the Development of Adolescent Alcohol Abuse Campaign*, Elliott and Shanahan Research, North Sydney.

Shears, L 1983, 'Education for Health', abstract of paper presented at the Third National Conference on Adolescent Health 8–10 December, Melbourne.

Shone, J and Mc Dermott, J. 1980, *Youth 2009—local youth policy development*, Youth Affairs Council of Victoria, Melbourne.

Short, S 1998, 'Community activism in the health policy process: the case of the Consumers' Health Forum of Australia', in A Yeatman (ed), *Activism and the Policy Process*, Allen and Unwin, St Leonards, NSW.

Sinclair, K 1981, 'What are Schools All About?', paper presented at *Dangers to Adolescent Health—Is Society Responsible? the 2nd National Conference on Adolescent Health 10–11 December*, Sydney.

Siedlecky, S, 1983, 'Trends in Teenage Pregnancy in Australia: 1971–1981', *Australia Journal of Obstetrics and Gynaecology*, vol. 23 no. 31 pp. 129–135.

—1986, 'Current usage of and attitudes towards contraception in Australia' *Healthright*, vol. 6, no. 1, pp. 7–16.

—1987, 'Sexuality, education and the needs of young people' *Healthright*, vol. 6, no. 1, pp. 11–16

South Australia Health Commission, 1985, *Report of the working party into the feasibility of establishing an adolescent centre in Adelaide*, SAHC, Adelaide

—1986 (a), *Health care in South Australia—future directions for young people: some statistics about young people*, Policy and Projects Unit, SAHC, Adelaide.

—1986 (b), *Health care in South Australia—future directions for young people: summary of responses to 'Issues' Discussion Paper of the Future Directions for Young People*, SAHC, Adelaide.

—1986 (c), *Health care in South Australia—future directions for young people: report of workshop 7 August*, SAHC, Adelaide.

—1986 (d), *Health care in South Australia—future directions for young people: a report of the project and recommendations*, SAHC, Adelaide.

—1988, *A Social Health Strategy for South Australia*, SAHC, Adelaide.

—1991, *Youth for health for youth—a context paper and draft policy*, SAHC, Adelaide.

—1993, *The health of young people in South Australia: policy and strategic directions*, SAHC, Adelaide.

South Australia Health Commission Act (1975) Section 48—Second Story Established, proclaimed July 11, 1985.

Stanley, F 1981, 'Teenage pregnancy—medical risks to mother and baby', paper presented at *Dangers to Adolescent Health—Is Society Responsible? the 2nd National Conference on Adolescent Health 10–11 December*, Sydney.

Starr, K 1991, 'Justice for whom?—a critique of the Social Justice Strategy of the South Australian Education Department', *South Australian Educational Leader*, vol. 2, no. 5.

Stephens, L and Manallack, B 1983, 'Task Force at Broadmeadows', workshop presented at the Third National Conference on Adolescent Health 8–10 December, Melbourne.

Stewart, F 1992, 'The Politics of the AIDS phenomenon—where do young women stand?', in *HIV/AIDS Education: current issues and research on Australian YOUNG PEOPLE and HIV/AIDS*, YSA Resource no 1, National Clearinghouse for Youth Studies, University of Tasmania.

Stewart, F 1993, 'What's a girl to do? AIDS, young women and the development of safe sex health promotion', paper presented at the Youth Studies Symposium, Hobart Tasmania.

Stoker, L and Suchting, . 1987, 'Sexual Health needs of Young Women', abstract presented at Fourth International Symposium on Adolescent Health 26-31 March, Sydney.

Stonestreet, C 'Welcome by Kathy Stonestreet (Convenor of Korobra)', at Fourth International Symposium on Adolescent Health 26-31 March, Sydney.

Suter, K 1984, 'International Youth Year: 1985', *Australian Journal of Social Issues*, vol. 19, no. 1, pp. 60–66.

Sweet, R 1980, 'A labour market perspective on transition programs', paper presented at a Conference of Tasmanian High School Vice Principals.

———1988, 'The youth labour market: a twenty-year perspective', in *The Bulletin of the National Clearinghouse for Youth Studies*, University of Tasmania, vol 7, no. 3, pp. 31–36.

Syme, SL 1986, 'Social Determinants of Disease', in Maxcy-Rosenau-Last, (eds) *Public Health and Preventative Medicine*, 12th edn, pp. 953–970.

Taylor, S 1993, 'Sub-versions: feminist perspectives on youth subcultures' in R White (ed) *Youth subcultures—theory, history and the Australian experience*, National Clearinghouse for Youth Studies, University of Tasmania.

Tesh, S 1988, *Hidden arguments: political ideology and disease prevention policy*, Rutgers University Press, New Brunswick.

Terris, M, 1994, 'Determinants of health: a progressive political platform', *Journal of Public Health Policy*, vol. 15, no. 1.

The Warehouse—Penrith Youth Health Centre c. 1986–87, *Philosophical background to project and aims of youth health centre*, Penrith Youth Health Centre, NSW.

———1986, *Progress Report to FPA Board re Development of Youth Health Centre*, Penrith Youth Health Centre, NSW.

- 1987, *Minutes of inaugural meeting of Advisory Committee*, Penrith Youth Health Centre, NSW.
- 1988a, *Report on the Review of The Warehouse Operations July 1987–January 1988*, Penrith Youth Health Centre, NSW.
- 1988b, *Youth Health Policy Group: draft*, Penrith Youth Health Centre, NSW.
- 1989, *Annual Report 1988–89*, Penrith Youth Health Centre, NSW.
- 1990, *Annual Report 1989–90*, Penrith Youth Health Centre, NSW.

Thompson, M 1994, *Newsletter of the Youth Affairs Council of Australia*, Spring edition.

Timewell, E, Minichiello, V and Plummer, D (eds) 1992, *AIDS in Australia*, Prentice Hall, Sydney.

Tiggemann, M and Winefield, AH 1980, 'Some psychological effects of unemployment in school leavers', *Australian Journal of Social Issues*, vol. 15, no. 4.

Tolstoshev, H 1988–9, 'Responding to Adolescent Loss and Grief', *The Bulletin of the National Clearinghouse for Youth Studies*, University of Tasmania, vol 7, no. 4, 1988–vol. 8, no 1, 1989, pp. 84–86.

—, Wald, S and Ashley, D 1987, 'Adolescent health: the development of a community health service initiative for adolescents, parents and health professionals', abstract presented at Fourth International Symposium on Adolescent Health 26-31 March, Sydney.

Townsend, P. and Davidson, N (eds), 1988, *Inequalities in Health*, Penguin, London.

United Nations Children's Fund 1993, *The Progress of Nations*, Burgess of Abingdon, New York, USA.

WAAT—see Western Area Adolescent Team

Wade, R 1987, 'Adolescent health in a secondary school—a pilot program', abstract presented at Fourth International Symposium on Adolescent Health 26-31 March, Sydney.

WADH—see Western Australian Department of Health

Wahlqvist, M 1983, 'Nutritional Mythology in Adolescence', workshop presented at the Third National Conference on Adolescent Health 8–10 December, Melbourne.

Wald, S. 1987, 'Health Risks and Concerns of Recently Arrived Adolescent Migrants', abstract presented at Fourth International Symposium on Adolescent Health 26-31 March, Sydney.

Walker, J, 1984, *Rebels with our applause? a critique of resistance theory in Paul Willis's ethnography of schooling*, Department of Education, University of Sydney.

Wallace, C 1987, *For richer, for poorer: growing up in and out of work*, Tavistock, London.

Wallack, L 1984, 'Drinking and driving: toward a broader understanding of the role of mass media', *Journal of Public Health Policy*, December, pp. 471-496.

——— and Dorfman, L 1996, 'Media advocacy: a strategy for advancing policy and promoting health', *Health Education Quarterly*, vol. 23, no. 3, pp. 293-317.

Wallerstein, N and Bernstein, E 1988, 'Empowerment education: Freire's ideas adapted to health education', *Health Education Quarterly*, vol. 15, no. 4, pp. 379-394.

——— 1994, 'Introduction to community empowerment, participatory education, and health', *Health Education Quarterly*, vol. 21, no. 2, Summer, pp. 141-148.

Walton, P 1993, 'Youth subcultures, deviancy and the media', in R White (ed), *Youth subcultures—theory, history and the Australian experience*, National Clearinghouse for Youth Studies, University of Tasmania.

Waters, B 1989, 'AIDS and Australian Youth', *Youth Studies Abstracts*, vol. 8, no. 2, May, pp. 25-30.

Wass, A, 1998, *Promoting health—the primary health care approach*, 2nd edn, Harcourt Saunders, Sydney.

Wearing, B 1981, 'Is the nuclear family failing?', paper presented at *Dangers to Adolescent Health—Is Society Responsible? the 2nd National Conference on Adolescent Health 10-11 December*, Sydney.

Adolescent Health Services Review, Western Australia Department of Health, 1987, *Future Health*, position paper, WADH, Perth.

Western Area Adolescent Team, 1986, *Western Area Adolescent Team evaluation project—draft report to Steering Committee*, Western Metropolitan Health Region, Sydney, NSW.

Wheller, R 1990, 'How to design and develop third generation drug education programs', *Drug Education Journal of Australia*, vol. 4, no. 2, pp. 139–47.

White, D, 1988, Speaking Notes—launch of the Health for Youth Report, 18 February.

White, R 1990, *No space of their own—young people and social control in Australia*, Cambridge University Press, Melbourne.

———1994, 'Young people, unemployment and health', in C Waddell and AR Petersen, (eds) *Just Health—inequality in illness, care and prevention*, Churchill Livingstone, Melbourne.

WHO—see World Health Organization

Wilkinson, E and Vickas, G 1984, *Beyond refuge: a study of longer term housing Projects for youth in inner Sydney*, Housing Information and Referral Service and The Youth Refuge and Accommodation Association, NSW.

Wilkinson, R and Marmot, M (updated 9 July, 2000), *Social Determinants of Health: The Solid Facts*, [Online] Available: <http://www.who.dk/healthy-cities/sf.htm> [1 July 2001]

Williams, M, 1978a, *Teaching about Adolescence in Australian Medical Schools*, discussion paper presented at Seminar on the Health and Medical Care of Adolescents in Australia, AMU, Camperdown, NSW.

———1978b, *Summary Report on 'Seminar on Health and Medical Care of Adolescents: 13–15 November'*, Sydney.

———1982, 'Adolescent Health and the GP', *Australian Family Physician*, vol. 11.

———1988, 'An International Association for Adolescent Health', in DL Bennett and M Williams (eds), *New Universals Adolescent Health in a Time of Change*, Brolga Press, Curtin.

Williams, N (ed) 1984, *A Year on the Streets*, Perth Inner City Youth Service, Perth, WA.

Winefield, A, Tiggeman, M and Winefield, HR, 1989, 'Socio-economic status and changing work attitudes in high school students', *Australian Journal of Social Issues*, vol. 24, pp. 303–312.

Winefield, A, Tiggeman, M, Winefield, HR, and Goldney, RD, 1993, *Growing up with unemployment—a longitudinal study of its psychological impact*, Routledge, London.

Woodward, A, Roberts, L, Reynolds, C 1989, 'The nanny state strikes back: the South Australian Tobacco Products Control Act Amendment Act, 1988', *Community Health Studies*, vol. XIII, no. 4, pp. 403–409.

World Health Organization 1965, *Health Problems of Adolescence*: report of a WHO Expert Committee, World Health Organization Technical Report Series No. 308, Geneva.

—1978a, *Primary health care: report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September*, WHO, Geneva.

—1978b, *Declaration of Alma Ata*, WHO, Geneva.

—1980, *Final report—regional working group on health needs of adolescents*, Regional Office for the Western Pacific, Manila.

—1986, *Young people's health—a challenge for society: report of a WHO Study Group on Young People and "Health for All by the Year 2000"*, Technical Report Series No. 731, WHO, Geneva.

—1989a, *The Health of Youth*, background document, Technical Discussions, WHO, Geneva.

—1989b, *Report on the Technical Discussions on the Health of Youth*, World Health Organization, 42/Technical Discussions/13, WHO, Geneva.

—1997, *The Jakarta Declaration on Health Promotion in the 21st Century*, Fourth International Conference on Health Promotion, Jakarta.

—and Health and Welfare Canada, 1986, *Ottawa Charter for Health Promotion*, Ottawa, Canada.

Wyn, J, 1993, *Young women's health—the challenge of sexually transmitted diseases*, Youth Research Centre, University of Melbourne.

—1994, 'Young women and sexually transmitted diseases: the issues for public health', *Australian Journal of Public Health*, vol. 18, no. 1, pp. 36–39.

—and White, R, 1997, *Rethinking Youth*, Allen and Unwin, Sydney.

—, Wilson, B, Stewart, F, and Dwyer, P 1989, *Lifelong, incurable and fatal: young people, AIDS and government response*, report no. 3, Dept of Labour, Victoria.

Wyndham, D 1983, 'No news and bad news—a brief history of sexuality education in Australia' in W McCarthy (ed), *Teaching aboutsSex—the Australian experience*, Allen and Unwin, Sydney.

—and Needham, R 1983, 'Family planning associations in Australia: key events from 1926 to 1983', in *Healthright*, vol. 3, no. 1, November, pp. 7–18.

YACA—see Youth Affairs Council of Australia

YACON—Youth Affairs Council of New South Wales

YACSA—see Youth Affairs Council of South Australia

Yeatman, A, 1990, 'Issues in youth income support: their context and development', Working Paper No. 7, *Working Papers in Sociology*, Flinders University, Adelaide.

Youth Affairs Act 1986, (Vic)

Youth Affairs Council of Australia, 1983, *Creating Tomorrow Today*—youth policy report based on nationwide consultation, St. Kilda.

Youth Affairs Council of New South Wales, 1982, *Annual Report 1981–82*, Sydney, NSW
—1983, 'International Focus on Youth Advocacy', in *YACON News*, June/July.

Youth Affairs Council of South Australia, 1985, *Youth Policy*, YACSA, Adelaide.
—1990, *Towards a youth health policy for South Australia—a discussion paper*, YACSA, Adelaide.

Youth Bureau, 1979, *Young people and information: a study of the information needs of young people, as seen by the young and those working with them*, Dept of Industrial Affairs and Unemployment, Adelaide.

Youth Policy Development Council, 1986, *Health for youth—a discussion paper for Victoria*, Victoria Department of Health, Melbourne.

—1987a, *Health for youth—a consultation throughout Victoria: January—April*, Victoria Department of Health, Melbourne.

—1987b, *Health for youth—final report*, Victoria Department of Health, Melbourne.

YRAA—see Youth Refuge and Accommodation Association

Youth Refuge and Accommodation Association, 1984, "The emotionally disturbed in the youth refuge", record of discussion 1 August.