Supporting young people's health and safety: perspectives on drugs, alcohol and sexual health

Michael Gard
Southern Cross University
Supporting Young People's Health and Safety: Perspectives on Drugs, Alcohol and Sexual Health
Centre for Children and Young People
Background Briefing Series, no.9

Dr Michael Gard
for Southern Cross University’s postgraduate programs in Childhood and Youth Studies
This Background Briefing has been developed as part of the Graduate Certificate, Graduate Diploma and Master of Childhood and Youth Studies developed and delivered by the School of Education and the Centre for Children and Young People at Southern Cross University.

These awards meet a recognised need, expressed by a range of professionals, for contemporary knowledge and skills to assist them to work more effectively with children, young people and their families.

This and other Background Briefing Papers, together with more information about these awards, can be accessed at

www.scu.edu.au/chilhoodstudies

SUGGESTED CITATION

© 2012 Centre for Children and Young People, Southern Cross University, Lismore, NSW Australia
ISSN 1838-5524
Engaging Children and Young People: Background Briefing

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Key concepts</td>
<td>3</td>
</tr>
<tr>
<td>Who are young people?</td>
<td>3</td>
</tr>
<tr>
<td>The moral dimension of young people’s health</td>
<td>4</td>
</tr>
<tr>
<td>What is health?</td>
<td>5</td>
</tr>
<tr>
<td>What is safety?</td>
<td>7</td>
</tr>
<tr>
<td>The context of Young People’s Health</td>
<td>9</td>
</tr>
<tr>
<td>The health of young Australians</td>
<td>9</td>
</tr>
<tr>
<td>The health of young people internationally</td>
<td>10</td>
</tr>
<tr>
<td>Drugs and Alcohol</td>
<td>12</td>
</tr>
<tr>
<td>Epidemiology of drug use by young Australians</td>
<td>12</td>
</tr>
<tr>
<td>Harm minimisation and drug use</td>
<td>15</td>
</tr>
<tr>
<td>Sexual health</td>
<td>17</td>
</tr>
<tr>
<td>Future directions</td>
<td>19</td>
</tr>
<tr>
<td>References</td>
<td>21</td>
</tr>
</tbody>
</table>
About the Author

Dr Michael Gard teaches, researches and writes about how the human body is and has been used, experienced, educated and governed. This work includes projects on the science of obesity, the history of sport, and the sexual and gender politics of dance education. With Carolyn Vender Schee, he is currently writing a book about the historical and contemporary relationships between schools and public health policy. Amongst other things, this work considers the evolution of public health practice and policy in schools as well as the ways in which contemporary health policies make schools and children increasingly available for corporate exploitation.

For further details and a list of Michael’s publications visit http://works.bepress.com/michael_gard1/

Acknowledgements

Special thanks to the following people for their assistance with this Background Briefing paper:

- Dr Renata Phelps, School of Education and Centre for Children and Young People, Southern Cross University;
- Ms Deana Leahy, School of Education and Centre for Children and Young People, Southern Cross University.

Inviting your Critical Engagement

Photos used throughout this publication are sourced from Shutterstock (http://www.shutterstock.com). They have been selected to highlight the diversity of ways in which children and childhood can be represented.

We encourage you to engage critically with these images as you reflect on the idea that 'childhood' is socially constructed. Ask yourself, 'What message about children or childhood is being conveyed through this image'? 'How do these images challenge my understandings of children and childhood'? 
Introduction

Being told that there is not one right answer to a question can be frustrating, especially if your aim is to make positive change. It can also seem like something of an evasion on the part of the person giving the answer; a way of covering up for a lack of knowledge.

In the case of the health and safety of young people the uncertainties are particularly deep and numerous. Perhaps the most obvious reason for this is that the health and safety of young people are inherently political matters. This means that the truth – if there are truths to be found – will always be tangled up with other agendas and there will always be a variety of reasons why people will choose to believe certain things.

To take an obvious example, consider sex education. Some of you will be aware of a long running debate in a number of Western countries concerning the place of sex education in schools. On the surface, this debate is often seen as a simple confrontation between conservative and liberal minded parents, politicians and educators. On the one hand, conservatives have generally advocated for either no sex education in schools at all - arguing that sex education should be handled by parents - or programs that teach abstinence only. On the other hand, liberals have tended to favour what is often called ‘comprehensive’ sex education in which a comparatively broad range of topics could be addressed.

Of course, sex and sexuality, particularly as they relate to young people, are ‘hot button’ issues and this tends to exacerbate the existing political differences between people. In other words, people on either sides of these debates tend to distrust each other and accuse their opponents of pushing an ideological agenda rather than looking at ‘the evidence’.

But what does the evidence show? To begin with there is a long list of reasons why it is not easy to know a great deal about the sexual lives of young people, not least of which are the practical and ethical problems involved with doing research into these matters. As a result, it is hard to know with any certainty how much, and what kind of, difference any education program might make.

In the United States for example, both sides of the conservative/liberal divide point to research studies that they believe prove them right and the other side wrong. In fact, it is not at all clear that research into sex education has helped to reduce conflict and
suspicion or increase consensus. As with other debates, many people seem determined to hold to their position, regardless of what evidence emerges.

But even if we put aside all the practical problems of producing reliable knowledge about the sexual behaviour of young people and the effectiveness or otherwise of education programs, there remain a set of questions about what is ‘healthy’ or ‘normal’ sexual behaviour.

At the risk of laboring the point, your approach to educating young people about sex is clearly going to be affected by your attitudes to what kinds of behaviours are, and are not, acceptable. After all, many people would say that there are differences between what constitutes socially acceptable, permissible or ‘normal’ behaviour and what is strictly legal or illegal.

To push this example just a little further, what should our attitude to homosexuality be in school sex education? Some people, for example, will be in favour of a frank and robust approach to sex education, but may not be in favour of education that might be interpreted as endorsing anything other than heterosexuality.

So even if we agree that we should have sex education that doesn’t simply tell young people not to have sex, exactly what should sex education be about? And should the answer to this question vary in schools which draw children from communities with different religious, cultural and socio-economic backgrounds?

This Background Briefing paper thus invites you to consider the complexity of young people’s health and safety, particularly in the areas of sex and drugs. We will consider some of the underlying concepts and debates that might help us to approach our work with children and young people, and we will consider a wide range of research fields, including history, sociology, psychology and epidemiology, as well as policies that have been developed and implemented by governments and other public health authorities.

In all of this, our approach will be to try to broaden the range of questions you might ask yourself when thinking about the ‘best’ or ‘right’ course of action to a particular health and safety issue concerning young people. We veer away from offering unequivocal opinions about policy and practice - if there are answers to be found, these are for you to generate and then present an argument for. Importantly, in fields as complex as the health and safety of young people it would seem unfair to dismiss one person’s conclusion only on the basis of it being different from one’s own.
Key concepts

Who are young people?

What kind of person do we have in mind when we talk about ‘young people’?

In her Background Briefing paper titled Understanding Children and Childhood, Virginia Morrow (2011) explores the historical, cultural and political contexts that influence how we come to understand notions of children and young people. She explains how childhood, and similarly notions such as youth or adolescence, are socially constructed, and carry with them particular ideas which find their way into our social policies and professional practice.

For example, in contexts where children were used to do hard and dangerous manual labour - a common practice around the world in the 19th century - people often thought of childhood in much more limited and perhaps less romantic terms than we do today. More recently, a number of historians have described the way the idea of the ‘teenager’ emerged in the middle of the 20th century.

The important point here is not that teenagers (as we currently understand the term) did not exist. Rather, what this tells us is that, for various reasons and at a particular moment in history, at least some adults felt the need to give a new label to a section of the population. In the case of ‘teenager’, this label signals the beginnings of a separate youth culture, new ways of behaving and being a young person and, importantly, new ways for authority figures (parents, schools, governments etc) to try to manage young people.

There is obviously a range of ages and age groups that might come under the category ‘young people’ but it is surely fair to say that there is a strong tendency in Western societies to think and talk about the category of ‘young people’ in broad-brush ways.

One example of this is the tendency to think about young people as essentially innocent and in need of protection. We see this tendency in almost all areas of health and safety policy and debate. Many of those working in the area of childhood obesity argue that we should try to prevent children from seeing advertisements for ‘junk food’. Part of the logic for this point of view seems to be that many or most young people are dangerously vulnerable to the tactics of food marketing and, therefore, in need of protection.

Similar kinds of arguments are raised by people concerned with what they see as the media-driven ‘sexualisation’ of young people, particularly girls. In fact, in this example, the idea of young people’s innocence is especially prominent. Not only are young people assumed to be in need of protection from the products and images that the media offers, there is also a motivating desire to preserve and maintain their sexual innocence.

This is certainly not to suggest that people who feel this way are mistaken. There clearly are important issues to be confronted here. The point is that one’s understandings of what young people are (Are they innocent? Are they able to work things out for themselves? What is the ‘right’ level of sexual knowledge and awareness for a young person of a particular age to have?) is surely going to make a difference to the actions one might take – or not take – to protect them.
The moral dimension of young people’s health

I hope that, even in these brief examples, you can see that almost any discussion of the health and safety of young people moves us quickly into moral debates rather than a simple analysis of ‘the facts’. This is important to remember for a number of reasons but two are most obvious.

First, moral considerations can sometimes help and sometimes hinder our thinking about what to do about an issue. On the one hand, in a context where existing evidence does not point to a clear decision or course of action, our moral judgments and dispositions may be the most important guide we have.

On the other hand though, we can probably all think of examples in which a person’s moral convictions seem to have clouded their judgment. In fact, a person’s moral convictions can sometimes appear to stop people thinking rationally about a particular issue at all.

A second reason why thinking about the moral dimensions of young people’s health and safety is important can be seen when we move beyond personal morality to what we might call collective morality. Here we encounter the idea of ‘moral panic’ - a concept which offers us a lens through which we might analyse how particular issues come to prominence.

The concept of moral panic has a long academic history and was originally developed with the behaviour and representations of young people in mind. In general terms, though, it refers to the role the media plays in generating fear and concern about particular things.

Depending on the actual subject matter, a moral panic may actually relate to young people as ‘innocent’ or young people as ‘threats’. In recent years the media has given a great deal of attention to issues such as paedophilia, teenage binge drinking, violent computer games and internet pornography.
In their own ways, each of these issues has tended to position young people as more or less vulnerable, more or less at fault, and more or less able to fend for themselves. In the case of violent video games for example, much of the media comment has been very critical of people who wanted to ban certain games. Rather than seeing young people as innocent victims, they saw the problem primarily in terms of overly protective parents and intrusive politicians. In fact, the concern about a ‘nanny state’ taking over our lives and trying to protect us from all dangers has become something of a moral panic in itself.

The central point though is that, in a world so saturated by media, it is important to think about its role in shaping our beliefs about the health and safety of young people. This does not mean that we should necessarily dismiss certain concerns. However, there is a difference between a media story and the actual health and safety of young people. There may be specific reasons why particular stories receive a lot of media attention and these reasons may not always be obvious to media consumers.

It is also surely reasonable to consider the ways in which media coverage might influence the policy agendas of governments and health authorities and the resources that flow as a result of these agendas.

In short, then, the ways in which we think about young people - our theories about them - can shape the things we decide to do for or to them.

**What is health?**

It does not take us very far to point out that there are many different definitions of, and theories about, health but the point still needs to be made. At a basic level we need to keep in mind that how a society perceives the concept of health tells us important things about that society.

For example, in the early years of the European public health movement in the 18th and 19th centuries, reformers tended to view health as a social matter. That is, promoting health meant doing something about the conditions in which people lived, such as improving the quality of water supplies and improving general sanitation.

This social view of health was also shaped by the prevailing rudimentary level of knowledge about the causes of health and disease. But as we moved into the 20th century, the efficacy and prestige of more biological and scientific understandings of disease began to dominate, leading to what became known as the bio-medical model of health.

By about 1970 the limitations of the bio-medical model were becoming more obvious, particularly with the relative decline of infectious diseases (at least in Western countries) and increases in chronic
disease. New times produced new ways of thinking about health and the 1970s and 1980s gave us more ‘holistic’ theories of health. This holistic view saw health as much more (or sometimes not even) the absence of biological disease or physical disability. Instead, advocates for this new model talked about the emotional, psychological and even spiritual dimensions of health.

So we can see that people’s understanding of what health is has varied across time. But there is also good research to show that a person’s ideas about health are strongly influenced by their age, socio-economic status and cultural background. For example, some research suggests that younger people tend to prioritise the absence of disease and the ability to do things in their definitions of health, whereas older people often factor in the quality of their relationships and their overall happiness and satisfaction with life (Germov, 2009).

One of the most interesting things about health in the 20th and 21st centuries is that, as medical science found cures for many common diseases and life expectancy increased, people’s general anxiety about health also seemed to increase (Le Fanu 2000). In some ways, it seems that the healthier we get, the more threats to our health we perceive.

It is partly for this reason that the concept of ‘risk’ has become an important theoretical resource for thinking about health. This is equally true for children and young people as it is for adults. Put simply, some researchers have argued that modern Western countries are now hyper-aware of health risks and we see risk in almost every aspect of our lives (Furedi, 2002).

Amongst other things this means that we put a lot of energy – perhaps too much - into avoiding risk. A simple example of this could be the replacement of grass with synthetic flooring in children’s playgrounds to reduce the risk of injury or, in some cases, the removal of playground equipment altogether. The important point here is that we need to remember that different societies have different ideas about what level of risk is acceptable and how far we need to go in order to protect young people from risk.

But the concept of risk is important in another way. It is one thing to be aware they exist but we still need to make decisions about how or whether the risks to young people should be communicated. So when we are trying to educate young people about their health or developing health awareness campaigns, how much should we focus on the bad things that can happen? By emphasising risk do we inadvertently contribute to a more fearful and risk-averse society? How much freedom to explore and experiment should we allow young people? Perhaps more to the point, is emphasising risk an effective way of promoting health and well-being?

Certainly, research in the area of smoking behaviour suggests that constantly telling young people about the long-term health risks of smoking is not very effective in reducing their tobacco usage (Heart and Stroke Foundation of Canada, 2005).

Interestingly, the idea of risk has also become important in neurological studies of young people’s brains. This is a controversial area of research but some researchers argue that young people – especially teenagers – have brains that make them more likely to take risks (Galvan et al., 2007). Some
even suggest that boys are more likely to have ‘risk seeking brains’ than are girls (Steinberg, 2008). If this research turns out to have some validity, it would mean that young people are biologically inclined to participate in behaviours that have an element of risk attached to them, such as bungy jumping, taking illegal drugs and binge drinking.

As a theory, the idea of the risk-seeking teenage brain has many problems with it and it is far from universally accepted (see Lightfoot, 1997). However, such theories about ‘hard-wired’ behaviour have been extremely popular over the last couple of decades. Despite being based on a very poor understanding of the relevant science, John Gray’s book *Men are from Mars, Women are from Venus* sold millions of copies all over the world and popularised some very strange beliefs about the ways in which men’s and women’s brains are different.

In a similar way, there is a tendency in Western societies to accept certain kinds of behaviour as ‘normal’ for young people. A couple of obvious examples of this are dangerous driving amongst young men and the alcohol fuelled ‘party culture’ that some young people participate in. In both cases, these behaviours are seen by some as a natural expression of being young. But are they?

**What is safety?**

The difference between concepts like ‘health’ and ‘safety’ is not always clear-cut. Dangerous driving is probably more a question of safety although the consequences for a person’s health can obviously be far reaching. As a result, I do not always draw a clear distinction between health and safety. In many instances it would simply not make any sense to do so.

If anything, however, the concept of safety does draw our attention to the general environment in which young people live as opposed to specific aspects of health. A ‘safe environment’ could be thought of as one in which the chances of having a physical accident are low. In fact, we could say that, in general terms, while ‘health’ is mostly concerned with the inner physical, social and psychological workings of the body, ‘safety’ refers to traumas and accidents that represent an attack to the exterior of the body.

Rather than thinking in terms of the various adverse things that can happen to a person, we might also think about safety in general policy terms. In other words, what is the role of other people – including friends, relatives, governments, companies – in creating a safe environment? What responsibility does the individual have to keep themselves safe and at what point in a person’s life does this responsibility begin?
Although we would probably all agree on the importance of creating a safe environment in which young people can grow and flourish, there are surely examples where a concern for safety might go too far and be counter-productive. If we prevent young people from potentially dangerous forms of physical activity, we reduce their opportunities for developing physical skill, don’t we? Currently, there are also many researchers who argue that the modern preoccupation with keeping children’s environments hygienic and germ free might actually prevent them from developing strong immune systems (for a discussion see Weiss, 2002).

The safety of young people has also become big business. There is now a huge range of safety devices that parents can buy which may or may not make their children safer. Actions like reducing the driving speed limits around schools – an action that costs nothing for the individual road user – appears to be an effective way to reduce collisions between children and cars, while buying a child a mobile phone for ‘safety reasons’ may actually make no difference at all to a child’s general safety.

Alongside the concept of risk we have the somewhat less dramatic idea of ‘harm’. To some extent, the concept of harm is used in policy circles to de-emphasise the moral dimensions of health and safety matters. We can see this tendency in a concept like ‘harm minimisation’; a term that is widely used in the area of drug and sexuality education. In most areas in which it is applied, harm minimisation implies that certain kinds of behaviour are either normal or inevitable and that we need to accept this fact. Having done this, our job is to help young people to manage these behaviours in a less dangerous way. I hope you can see, however, that even though a harm minimisation approach may claim to be less moralistic, it still has moral dimensions and even a moral agenda.

If we keep this in mind, signing up to the harm minimisation world-view means that we are prepared to allow certain behaviours to happen. So, if we are talking about illegal drug taking or sexual activity, a harm minimisation approach tends to assume that the behaviour is not so dangerous that we need to stop it at all costs.

To take an extreme alternative example, we would not take a harm minimisation approach to young people trying to kill themselves by jumping off cliffs or self-inflicting catastrophic self harm. In these cases we would probably want to do everything in our power to stop these behaviours from happening in the first place, an approach we might call ‘zero tolerance’.

However, as many readers will be aware, zero tolerance is exactly the kind of approach some people would prefer to take to the drug taking and sexual activity behaviours of young people. That is, they believe it would be better to put most of our energy into convincing (or forcing) young people not to participate in these behaviours at all.

There are obviously many differences between zero tolerance and harm minimisation approaches to the health and safety of young people, but perhaps the most important and fundamental difference is that they are usually based on very different ideas about what is ‘normal’ and ‘good’. In other words, they are matters for moral judgement, not just hard scientific evidence, and this is what makes them so difficult to resolve.
The context of young people’s health

Although we have made the point that deciding how, when and where to intervene in the health and safety of young people is not simply a matter of looking at the evidence, statistics and other research data inevitably play a central role in the development of policy and practice. For this reason, there is always value in knowing where to find research on young people and being familiar with the organisations that are most influential in this field of knowledge.

The health of young Australians

The Australian Institute of Health and Welfare (AIHW) produce a report - every four years - on the health and wellbeing of Australia’s young people. This report focuses on adolescence but encompasses those aged 12–24 years. The release of their fourth such report in 2011 provides data not only of the current statistical context but of trends since 1998.

Generally, Australia’s young people fare well in terms of many of the national indicators of health and the 2011 report provides some very positive findings. Youth mortality rates halved between 1987 and 2007, due mainly to declines in the rates of injury. Cancer survival continues to improve. Smoking and illicit substance use declined by 48% each since 1998 and almost all sexually active Year 10 and Year 12 students use contraception (AIHW, 2011a).

Less positively, over one-third of young people are considered overweight or obese, with less than half (46%) meeting physical activity guidelines and 95% do not consume recommended amounts of fruit and vegetables. Considerable numbers of young people are drinking alcohol at levels considered to place them at risk of short-term harm (30%) and long-term harm (12%), and 19% are using illicit substances. Teenage birth rates compare unfavourably with other OECD countries, with Australia ranking 22nd out of 26 countries in terms of teenage pregnancy rates, and with the rate five times as high among young Indigenous women (AIHW, 2011a).

Data from the AIHW report (2011a) further indicate that Indigenous young people, as a group, face significant health issues across a broad range of indicators compared with non-Indigenous young people. For example, they are six times as likely to die from assault and four times more likely to die from suicide. They are ten times as likely to have notifications for sexually transmissible infections; three times as likely to live in overcrowded housing and two to three times as likely to be daily smokers.
Young people living in remote areas are also identified as a group in need, with higher death rates, more dental decay and less access to general practitioners (AIHW, 2011a).

While these regular reports highlight many critical issues about the health of Australia’s youth, they also emphasise that there is still a great deal that we do not know, due to insufficient research, inadequacy of indicators and measures and/or non-availability or difficulties in collecting data. Such areas where further measures are perceived as needed include matters related to sun protection, sexual and reproductive health, sexual assault, oral health, mental health, sleep disorders, and the effects of climate change (AIHW, 2011a).

There are a wide range of environmental, family, community and socio-economic factors which influence health and wellbeing outcomes for young people. As identified by AIHW (2011a), these include: family functioning; parental health and disability; social capital; community and civic participation; school relationships and bullying; child protection; exposure to violence and crime; environmental tobacco smoke; homelessness; overcrowded housing; education; employment; income; and the socioeconomic status of young people’s parents. Much research, both quantitative and qualitative, has occurred internationally to examine the direct and indirect associations and relationships between these factors and health outcomes.

Mallett, Rosenthal & Keys (2005), for example, have researched the connections between drug and alcohol use and homelessness. While earlier research had shown that many homeless young people use drugs, both injected or otherwise, more frequently than their home-based peers, this study shed light on the relationship between young people’s drug use and their pathways into homelessness.

Qualitative interviews were conducted with 302 homeless young people aged 12–20 years. One-third of the participants indicated that personal or familial drug use was a critical factor in them leaving home and, of these, just over half indicated that personal drug use was a direct or indirect cause of their homelessness. A further one-quarter indicated that familial drug and alcohol use was the critical factor that led them to leaving home and one-quarter indicated that their drug use only began after they became homeless. Family conflict, if not family breakdown, was implicated in all four pathways out of home.

The health of young people internationally

While Australia’s young people face particular health issues, we are (in many respects) very privileged in terms of our access to health services and facilities. This is a point that becomes more evident when considering trends and statistics about the health and safety of young people around the world. However, the differences we find in other countries might also help us to see one’s own country with fresh perspective.
While minority world (developed) countries face similar health issues (such as drug and alcohol use, road safety and sexual health), the prevalence and nature of these issues can, in some cases, be quite different in majority (developing) countries.

Take, for example, road safety. Worldwide, an estimated 1.2 million people are killed in road crashes each year and as many as 50 million are injured. Around 85% of all global road deaths, and 96% of all children killed worldwide as a result of road traffic injuries occur in low-income and middle-income countries (Pedan, et al, 2004).

While high-income countries are generally seeing a decrease in road accident related deaths, projected trends in low-income and middle-income countries “foreshadow a large escalation in global road traffic mortality over the next 20 years and possibly beyond” (Pedan, et al, 2004, p.37).

In Australia, our focus is often placed on young drivers’ risk-taking behaviour, and connections between drinking and driving. In many South East Asian countries issues such as the use of motorcycle helmets by children and young people and pedestrian safety are a major focus.

The Millennium Development Goals (MDGs), established in 2000, are a set of eight internationally agreed development aspirations for the world’s population to be met by 2015, each with numerical targets and indicators for monitoring progress. The health agenda is very much in evidence in the MDGs - it is explicit in three of the eight goals, eight of the 18 targets, and 18 of the 48 indicators and special priority is given to the health and well-being of women, mothers and children (WHO, 2005).

Whereas mothers and children were previously thought of as targets for well-intentioned programmes, they now increasingly claim the right to access quality care as an entitlement guaranteed by the state. In doing so, these entitlements have transformed maternal and child health from a technical concern into a moral and political imperative (WHO, 2005).

The MDGs galvanized countries and the international community in a global partnership that, for the first time, articulated a commitment by both rich and poor countries to tackle a whole range of dimensions of poverty and inequality in a concerted and integrated way (WHO, 2005).

Health outcomes for children and young people are also firmly established within the United Nations Convention on the Rights of the Child (UNCRC). Three key Articles relate directly to health, namely Article 6 (the inherent right to life, survival and development); Article 23 (related to the rights of disabled children to special care and support); and Article 24 (the right to best possible standards of health and health care). However the protection, participation and provision elements of UNCRC have further implications. Articles 12 (the right to express a view) and Article 13 (the right to information) have particularly important implications in terms of health provision and education, a point we take up a little later in this Background Briefing.
Drugs and alcohol

Now let’s turn our focus to one of the key areas of health and safety that is seen as a priority for work with young people, namely drug use.

It is customary to preface discussions about drugs by including a definition such as the following:

*A drug is any substance, solid, liquid or gas that brings about physical and/or psychological changes to the human body* (Australian Drug Foundation’s Druginfo Clearinghouse, 2008).

Clearly, then, any discussion of drug use plunges us immediately into a broad base of information about a huge and diverse range of drugs. This topic also brings together understandings from a wide range of academic fields. In addition, because the concept of a drug is so broad, the kinds of substances we might be most concerned about can change quite quickly. To take a simple example, while the issue of steroid use for muscle growth has historically been confined to elite sport, there is growing evidence that more and more young people, particularly young men, are using these substances to boost self-esteem and physical attractiveness (Copeland, Peters & Dillon 2000).

The use of the term ‘evidence’ requires some examination. When people use the term ‘evidence’ they sometimes refer to, amongst other things, media reports. Relying on the media for information about drug use is obviously risky. For example, taking media commentary at face value could create the impression that our society is facing unprecedented issues in relation to drug and alcohol use by young people. The issue of binge drinking has garnered a great deal of attention in recent years even though there remains considerable confusion about what binge drinking is, not to mention uncertainty about the amount of regular drinking that causes long term health damage (Measham & Brain 2005).

Drug use is not a new phenomena, and the use of various substances for religious, spiritual and recreational purposes can be traced back through the history of human civilization (Lang, 2004). As Lang explains, what has changed over time relates more to the types of drugs being used and the social contexts of their use. So to really understand the nature of drug and alcohol use within our society, or by particular social groups such as children and young people, we need appropriate, reliable data.

**Epidemiology of drug use by young Australians**

A key source of information related to drug and alcohol use in Australia is the Australian Institute of Health and Welfare’s National Drug Strategy Household Survey report. The last such survey was completed in 2010 (AIHW, 2011b) by 26,648 Australians aged 12 years and over (although comparative data is available for 14 years and over only). There are a number of key findings in relation to young people and drug use which are of particular interest:
• The mean age at which people in Australia first used most licit and illicit drugs have changed very little between 1995 and 2010.

• 3.8% of teenagers (12–17-year-olds) smoked tobacco and 2.5% smoked daily. Males were generally more likely to be daily smokers than females except in the 12–17 years age group, where females were more likely to be daily smokers (3.2%) than males (1.8%).

• A higher proportion of 12–17-year-olds abstained from alcohol (61.6%) than had consumed it in the last 12 months (38.4%). The proportion of 12–15-year-olds and 16–17-year-olds abstaining from alcohol increased in 2010 (from 69.9% in 2007 to 77.2% and from 24.4% to 31.6%, respectively).

• For tobacco and alcohol, the mean ages of initiation remained relatively stable between 1995 and 2010, at about 16 years for tobacco and 17 years for alcohol.

• The age groups most likely to have used illicit drugs in the previous 12 months were those aged 20–29 years (27.5%) and 18–19-year-olds (25.1%). Least likely to have ever used an illicit drug were teenagers aged 14–17 years (18.7%) and those aged 40 years or older (32.6%).

• Among illicit drugs, cannabis had the youngest average age of initiation, at 18.5 years, followed by inhalants (19.5 years) and hallucinogens (19.8 years).

• Overall, people in Australia aged 14 years or older had their first experience with drugs by trying alcohol and tobacco, at the average ages of 16 and 17 years, respectively. This pattern appears to be changing, with the youngest age groups reporting the use of some illicit drugs at a younger age than either smoking or drinking. For example, in 2010 12–15-year-olds and 16–17-year-olds had their first drug experience with inhalants, with an average age of initiation of 9.7 years and 13.1 years respectively. In comparison, 12–15 year olds and 16–17-year-olds did not start smoking and drinking, on average, until they were 13.1 and about 14.6. For 18–19-year-olds, the earliest drug experience was with painkillers/analgesics (14.5 years on average), a year before they started smoking and drinking.

• Different age groups are concerned about different drugs, with older people more concerned with excessive alcohol use (45.8% for those aged 50–59 years compared with 31.9% for those aged 18–19 years), and younger people more concerned with tobacco use (22.6% for those aged 12–17 compared with about 14% for all age groups over 30 years).

• In 2010, amongst people aged 14 years or older the most common reason that an illicit substance was first used was curiosity (79.0%), followed by peer pressure (48.8%) and wanting to do something exciting (20.0%).
Conducting research in areas such as illicit drug use is not without considerable ethical, legal and practical difficulties, particularly in relation to children and young people. The approach to sampling (selecting participants in a study) influences results considerably.

Lim et al (2010) have conducted an interesting study using self-administered questionnaires distributed to young people aged 16–29 at a music festival in Melbourne from 2005 to 2008 to collect information on drug use, demographics and other risk behavior. This group of young people were considered useful for monitoring trends in illicit drug use since the use of such drugs was much more common in this sample than in the National Drug Strategy Household survey. The study revealed that 44% of those surveyed had used illicit drugs in the past month. However the prevalence of recent illicit drug use decreased significantly from 46% in 2005 to 43% in 2008, with a downwards trend in the use of amphetamines and cannabis, but a significant increase in use of hallucinogens, ecstasy and inhalants. Drug use was more common among men, and older participants.

A similar study was conducted at a Sydney music festival by Wilson et al. (2010) and results suggest that certain aspects of drug use are normalised among festival attendees, suggesting that these groups could be targeted when delivering drug education and prevention programs.

Various studies have been undertaken into the consequences associated with drug and alcohol use. It is broadly acknowledged that misuse of drugs and alcohol can have flow-on health implications. Hospitalisation can result from acute intoxication and related injuries (including car and other serious accidents), dependence, withdrawal symptoms, psychotic disorders and amnesia. However, a range of research has linked drug use to other personal and social issues.

In a recent study, for example, Epstein (2011) investigated the links between adolescent computer use and alcohol use. The research indicated that those young people who drank in the past month used the computer more hours per week (excluding time for school work) than those who did not - there were no differences in hours based on alcohol use for computer use for school work. Drinking also was found to be associated with more frequent social networking and listening to/downloading music.

Although it is important to keep in mind the assumptions and research techniques that lie behind the findings of all research, this is particularly true in drug use research. For example, many studies attempt to isolate ‘factors’ that lead to drug use and sometimes speak in terms of specific ‘causes’. However, in order to measure the effect of a ‘factor’, researchers need to narrow their focus and, by necessity, not consider other factors.

So, if a researcher wants to measure, say, the effect of unemployment on drug use she or he must offer a strict definition of both ‘unemployment’ and ‘drug use’ and assume that both of these things can be studied in isolation from other circumstances and events in a person’s life. But does it make sense to do this? Can we really treat social variables like employment status as if they were elements in a mathematical formula? Or should we instead try to
understand a person’s drug use in the full complexity of their life?

The quantitative ‘factorial’ approach to research in this area stands in contrast to more exploratory, qualitative research which tends to be more interested in people’s own explanations for their behaviours and actions, and in studying the complex and often unpredictable interplay of influences. Longer-term studies which include interviews and case study analysis of groups and individuals can provide us with quite different understandings of the nuances of drug use by young people.

McCrystal, Percy, & Higgins’ (2006) UK-based research followed the drug use patterns and behaviours of 90 young people who reported cannabis use from the age of 11/12 years. The study revealed high levels of both licit and illicit drug use after a four year period, compared with young people who had not used cannabis by the age of 15. This qualitative, case study research provides insights into the complex social contexts and behaviours of this group, including detachment from school, increasing levels of crime and antisocial behavior, and difficulties in communication with parents/guardians.

The study particularly highlights the existence of a ‘hidden’ high risk group of young people who continue to attend school regularly, whilst reporting high levels of illicit drug use and behaviours associated with such activities. The research raises questions about the extent to which young people’s needs are being met by existing school-based drug education and prevention initiatives which are often delivered through a standardised strategy for all school aged young people.

**Harm minimisation and drug use**

Some would argue that the ‘war on drugs’ and prohibition have been expensive failures, with enormous personal, social and financial costs. It is often pointed out that such policies have failed to reduce the availability and consumption of illegal drugs, that they have not made our communities safe or reduced police corruption; and that they have resulted in unnecessary criminalisation and incarceration, with enormously damaging consequences, particularly amongst Indigenous and young people.

Harm minimisation offers an alternate approach as it treats drug use as a health and social issue rather than solely a legal one. Proponents of the approach argue that minimising the harm done by drugs will be more successful than resorting to tough, law-and-order sanctions for personal drug use (International Harm Reduction Association, 2009).

While there is no clear or precise definition (Kleinig, 2008), harm minimisation might be understood broadly as the range of policies, programs and projects which aim to prevent and reduce the risk of drug-related harm, including such approaches as
prevention, early intervention, specialist treatment, supply control, safer drug use and abstinence.

Harm minimisation does not necessarily mean approval of drug use or support for legalisation, and should not be equated with the legalisation of drugs. It is an approach that aims to reduce the adverse health, social and economic consequences of alcohol and other drugs by minimising or limiting the harms and hazards of drug use for both the community and the individual without necessarily eliminating use. Some examples of harm minimisation are:

- Safe injecting rooms and the provision of sterile needles and syringes to people who inject drugs so as to minimize risk of them contracting blood borne infections such as HIV and hepatitis B and C;
- Training bar staff in responsible service of alcohol, to reduce the risk of intoxication;
- Provision of public transport, and designated driver programs to reduce risks of injury and fatality by separating drinking from driving; and
- Providing those who smoke tobacco with less harmful nicotine delivery systems, such as non-smokable tobacco.

Harm minimization strategies are not, however, without controversy. Some express concern that harm minimisation communicates a condoning of drug use. When employed in schools, for instance, the approach targets all teenagers and implies an expectation that all teenagers are using drugs; all are sexually active, and so on.

Some argue that teenagers need clear messages concerning abstinence and approaches which do not ‘normalise’ drug use. Another argument against the approach is that harm minimisation does not deal with the underlying reasons for drug misuse.

Harm minimisation, as an approach, accepts that some young people will choose to use drugs, despite our best efforts to discourage this. It does not necessarily mean that we, as individuals, or as a society, condone that use. Indeed, this qualification should remind us that no matter what approach we take to young people’s drug use, moral judgements are unavoidable, a point that can sometimes be forgotten when we talk in terms of what ‘society’ condones or deems unacceptable. In this context, the term ‘society’ may simply be a way of disguising the fact that we are talking about the views of the majority or even just a powerful minority. In other words, who, exactly, do we mean when we say ‘society’?
Sexual health

Since ancient Greece and Rome sexual conduct has been understood, at least in part, as a marker of health. In fact, in contrast to some areas of health policy that are relatively new, history tells us that sex has for millennia been linked with economic, mental, social, physical, moral and spiritual wellbeing. Sex, to say the least, comes with a lot of baggage. If anything, this complexity multiplies when we consider the sexual lives of young people.

At this point it is probably sufficient to say that questions about how, when and where young people should sexually express themselves are not easy to contain within narrow analytical frames. For example, school education about sex has been and, for some people, still is treated as a matter of human reproduction. But this view becomes more difficult to sustain when you take into account that young people who do not identify themselves as heterosexual have always been in schools and, to some extent, are increasingly visible and vocal about their presence.

So what may have started out looking like an essentially biological area of education, begins to look much more political as the sexual diversity of young people is increasingly acknowledged. For example, why should certain ways of being sexual be privileged over others?

Sex is obviously a matter of public morality but even here it intersects with other areas of human social life. The rapid uptake of new forms of information technology, computers and mobile phones means that new questions about what is moral and safe sexual activity need to be addressed. In fact, the interplay of sex and technology is a particularly interesting area because new ways of using technology have generated what could be seen as new ways of being sexual and, by extension, being harmed.

It is perhaps also inevitable that sexual relations between young people link with other important social issues such as the status of girls and women, gender-based violence and the capacities of young people to be assertive and find pleasure in their relationships. In other words, sex is not just sex. Sexual relationships are also one of the places in social life where broader issues and problems are played out at on a personal level.

One key area of sexual health is the prevention of sexually transmitted infections (STIs), an issue that connects closely with the concept of harm minimisation that I have discussed already. It is broadly acknowledged that a lack of knowledge about STIs, inconsistent condom use, and a lack of communication and negotiation skills can contribute to adolescents being at increased risk of STI infection (Sales & DiClemente, 2010).
HIV rates amongst young people have been rising somewhat in recent years. In 2008 the rate of infection was 3.1 per 100,000 young people aged 12–24 years, an increase from 2.1 per 100,000 in 1998 – 76% of these young people were male and one-in-five of those infected in 2008 (18%) reported acquiring HIV from heterosexual contact. The proportion of cases due to injecting drug use has declined from 9% to 2% (AIHW, 2011b). However young people are now affected by other STIs such as chlamydia, human papillomavirus, donovanosis, gonorrhoea and syphilis at a rate of 1,045 per 100,000. This is nearly 4 times the rate for 1998 (although this is partly accounted for by increases in testing).

Faced with statistics of this kind there is value in not rushing to hasty conclusions about what should be done. For example, those who advocate for an emphasis on abstinence in sex education may view it as inappropriate for young people to be learning about (or at least learning much about) STIs. We also need to remember that if discussions about STIs with young people are not handled sensitively there is the danger of adding to the stigma that surrounds these diseases, which could be quite detrimental and even highly dangerous if young people are then afraid to consider, talk about, or consult medical advice related to STIs.

While young people who are able to discuss sex with their parents report a reduced likelihood of early sexual initiation, decreased risk of unintended pregnancy and increased condom use (see review by Kirby, van der Suijs, & Currie, 2010), young people often report feeling more comfortable discussing sexual matters with their friends rather than parents.

In fact, a number of trials of peer-led sex education programs have taken place. For example, Mellanby et al. (2001) compared peer-led sex education programs with those delivered by adults. Their study suggests that the peer-led programs were more effective in establishing conservative norms and attitudes than those delivered by adults, but were less effective in conveying factual information or getting young people involved in workshop activities. This work suggests that both adult and peer-led sex education programs have a role to play.

Education concerning relationships, particularly building strong and positive relationships, might also be considered a key part of the sexual health of young people. But again, this area of conversation requires critical and reflexive engagement by professionals. Values, beliefs and biases can again have both subtle and not-so-subtle influences on the messages conveyed and there are particular challenges in balancing the rights and freedoms of individuals and the health and education policies that governments and other authorities might deem desirable.

Some very interesting research which will be both informative and eye-opening for many adults has involved open-ended, in-depth interviews with young people around sexual identity and relationships (for example, Allen, 2005). This research provides a window into the world of young people, revealing the tensions, struggles, sensitivities but also the strength and support which they gain from their relationships. While these case studies cannot in any way be generalised to all (or even other) young people, such research provides an appreciation of not only the views of young people themselves, but also an insight into the need for sensitive and respectful conversations which enable young people to feel comfortable to talk to adults about their sexual identities and lives.
In this Background Briefing we have tended to talk about particular health and wellbeing issues, and approaches to addressing them, in isolation. That is, much of the research into drug use and sexual behaviour often attempts to create a specific strategy to solve a specific problem.

However, there is growing awareness that a person’s health related behaviours are part of the overall fabric of their lives. Sometimes it will be pointless trying to intervene in, say, a person’s drug taking behaviour without understanding other factors that might support or facilitate the behaviour. This has led some policy makers to explore ‘multi-sectoral’ or ‘inter-sectoral’ approaches to health promotion. In practice, these terms can mean many different things but the overall rationale here is that if we have a range of policies that, in different ways, encourage and support certain behaviours, they are more likely to be successful than a single policy intervention.

An obvious example of this are programs that seek to influence a young person’s experience and success in schooling and, at the same time, providing some kind of welfare support if they are homeless or living in poverty. In many respects, this approach picks up more holistic ideas about health and wellbeing that have been around for many years.

Most obviously, the Ottawa Charter for Health Promotion, an international agreement signed in 1986, called for health authorities around the world to consider the complex interplay of factors that both supported and undermined health. The list of potential factors is long, of course, but they include matters of socio-economic status, employment, education and access to health infrastructure.

More recently, there have been those who have argued that economic justice plays a part in the health of nations (Wilkinson & Pickett, 2009). That is, they suggest that a smaller gap between rich and poor leads to better overall health, although this research does appear to have some important weaknesses.

Another development that we highlighted in this Background Briefing, concerns the role of young people in shaping and creating policies and interventions that affect their lives. The UNCRC, together with new research and practice prompted in good part by Childhood Studies theory, is placing a growing emphasis on the participation of young people in various aspects of health provision. From
the seminal work of Priscilla Alderson in the 1980s and 1990s around consent to health care treatment (see for example Alderson, 1993) it has now become far more common practice for young people to have a say in not only health provision, but also in health education.

Numerous writers (including Webb et al, 2009) have highlighted the many positive impacts from consulting with children, and incorporating them into the health-care and health education processes in both developed and developing country settings. They argue that children can contribute effectively to health alliances and transform their lives and health.

This increasing emphasis on voice, participation and agency of young people in health education and health provision is opening up exciting opportunities for research and development in a broad range of contexts, from schools and community organisations, to changes in policy and broader public health agendas. Increasingly, those delivering services to young people and their families are perceiving new ways of engaging with young people in order to ensure health care and education provision best meets their needs.

Although the kinds of programs that result from a shift like this vary, the importance of this shift should not be underestimated. As the Australian researchers White and Wyn (2008, p.103) argue:

...despite the wide range of policies affecting youth, there are common themes. One of these is futurity—the valuing of young people for what they will become. This tendency underlying many youth policies is inevitably in tension with the increasing acknowledgement that young people should participate in policy decision making. Underlying this tension is contestation about the extent to which young people can be regarded as citizens in any sense, or whether they are simply citizens in training.

One of the things that flows from this is that we could conceivably move beyond just consulting with young people about the kinds of health interventions they would prefer. The logic of participation also suggests that young people might, to a large extent, be the arbiters of what health and wellbeing support they need and the kinds of behaviours that fall under these headings.

Despite everything that you will read, drug use and sexual behaviour are not necessarily matters of health concern at all. At the very least, we need to acknowledge that seeing drug use and sexual behaviour as health issues only makes sense in particular circumstances and that a person's perceptions of their own behaviour should have a bearing on our desire to intervene in their lives.
References


About the Centre for Children and Young People

The Centre for Children and Young People (CCYP) was established at Southern Cross University in 2004. The CCYP works collaboratively with organisations, particularly in regional and rural areas, to enhance policy and practice related to the well-being of children and young people.

The Centre has three priority areas: Research, Education and Advocacy.

For more information about the CCYP, visit ccyp.scu.edu.au

About the Course

The Graduate Certificate, Graduate Diploma and Master of Childhood and Youth Studies are awards which have been developed collaboratively by the Centre for Children and Young People and the School of Education at Southern Cross University, Australia. The awards meet a recognised need, expressed by a range of professionals, for contemporary knowledge and skills to assist them to work more effectively with children, young people and their families.

The course seeks to be an innovative, professionally relevant, practical and interdisciplinary qualification for people working, or intending to work, with children, young people and their families. Applicants can enrol in any one of the awards or complete individual units as professional development.

Units are delivered externally so that students can successfully study at a distance. Each unit has authentic and professionally relevant assessment and the five core units involve optional but highly recommended summer/winter intensive workshops of 2 days duration. Students who are unable to attend are able to engage with workshop content and processes live online or via recorded formats.

The course incorporates innovative and appropriate use of technology to support students’ learning, opportunities for regular engagement with tutors and fellow students and (where appropriate) multimedia elements.

The course is underpinned by a deep respect and regard for children and young people and for their views and perspectives. It also incorporates an understanding that children and young people can benefit immensely from positive relationships with adults – parents, teachers and the myriad professionals with whom they may engage over the course of their childhood. The course embraces multidisciplinary perspectives in the belief this can enhance service provision and lead to improved outcomes for children and young people.

For more information about these awards, visit www.scu.edu.au/chilhoodstudies
Centre for Children and Young People
Southern Cross University
PO Box 157
Lismore NSW 2480

Phone 02 6620 3605
Fax 02 6620 3243
Email: ccyp@scu.edu.au

www.ccyp.scu.edu.au