1 YOUTH HEALTH AND SOCIAL CHANGE

This chapter gives an overview of approaches, concepts and debates that are relevant to understanding young people's **health** and **wellbeing**, introducing themes that are addressed throughout the book. It offers a framework for discussing contemporary patterns of ill health and for understanding ideas about health and wellbeing that have emerged in the last 20 years. Drawing on sociological concepts and frameworks, the chapter explores the dynamic and changing relationship of young people's health patterns, definitions of their health and wellbeing, the treatment of ill health, and the promotion of wellbeing in post-industrial societies. It highlights the ways in which changing social conditions offer new opportunities and at the same time create limits on how young people live their lives—and the health consequences of these social processes. The focus on the broad population of young people in this chapter is not intended to trivialise the very real health issues faced by young people with specific illnesses and health problems. These issues will be taken up in more detail in the following chapters.

Although most young people are well and experience little ill health compared with the older population, a number of new health issues have emerged, such as obesity, and some, like alcohol and drug abuse, have proved to be enduring. Australia and other Western countries have a high degree of economic prosperity as well as a generally high participation in education by young people. In general, these two elements tend to be associated with good and improving health and wellbeing. An economically prosperous society enables people to have economic security and to enjoy quality health care. High levels of educational participation are associated with the capacity to access knowledge and information that promotes health. The emergence of new health issues among young people at this time and the enduring nature of some older issues is therefore a paradox, inviting closer exploration of the question: what is the relationship between young people's health and society?

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Over the last 30 years, many social changes have had a significant impact on the experience and meaning of the period of the life course that we define as **youth**. These changes can be traced particularly clearly through developments in young people's health and through a consideration of their wellbeing. Broader social changes include the precarious nature of labour markets and the

emergence of new employment patterns, the rise of youth **consumption** and youth markets, the normalisation of digital communications technologies in everyday life, the escalation of educational credentialism, the increased costs of housing, and the polarisation of wealth. Each of these changes has affected all members of our society (Giddens 1991; Beck & Beck-Gernsheim 2002), but has arguably had a particular impact on young people (Wyn & Woodman 2006; Furlong & Cartmel 2007; Heaphy 2007; White & Wyn 2008).

This chapter explores the implications of social change for young people's experiences of health and wellbeing, and for the ways in which professionals address these issues; it discusses concepts of youth and their implications for understanding young people's health and wellbeing.

SOCIAL CHANGE

Social change has resulted in the emergence of new opportunities and also new issues for young people, leading to possibilities that were not open to previous generations (especially the postwar generation born in 1945–60). The argument for this is especially strong with regard to Western societies. For example, in Australia there is evidence of the emergence of a '**new adulthood**' (Dwyer & Wyn 2001) in which young people engage early with adult practices (e.g. student workers, earlier sexual experience) and a shift in approaches to life (keeping options open, being compelled to make choices, assuming individual responsibility even for things that are not in one's control). This approach contrasts with earlier views which proposed that the period of youth had become an 'extended' phase of life, before eventually settling into the traditional, or perhaps expected, pattern of 'adult' life: secure job, marriage, children and buying one's own home. In Europe researchers see the emergence of a 'new youth' (Leccardi & Ruspini 2006) that is reflected in distinctive new patterns of life (marrying in one's thirties, intergenerational interdependence, beginning a process of lifelong engagement with education). In the UK, where it is agreed that youth transitions have undergone significant transformations, Henderson et al. (2007) explore the 'invention' of adulthood by young people, and Furlong and Cartmel (2007) argue that young people must actively shape their identities against a backdrop of changing expectations and possibilities. Analyses of Canadian youth comparing census data from 1971 and 2001 also conclude that there has been a notable change in patterns of living: an increase in the time spent in education, later entry into full-time work, leaving their parents' home, and parenthood (Clarke 2007).

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But the research evidence also shows that there is continuity with the past. Furlong and Cartmel (2007) sound a note of caution about the extent of change in young people's lives, and McLeod and Yates (2006) agree that the

'rhetoric of new times' can be exaggerated. Even those who argue for significant change agree that the structural factors of class, gender, race and geographical location continue to shape young people's possibilities and life chances (Wyn & Woodman 2006; Henderson et al. 2007), and this is particularly reflected in patterns of health and wellbeing. Yet because changes in society affect all groups regardless of class, location or gender, the research also shows that all young people are compelled to engage with the prevailing ideas, opportunities and constraints of their times, and are subject to changing notions of normality. New patterns of social division have an impact on the lives of all individuals (White & Wyn 2008) and, as expectations change, individuals who are disadvantaged may struggle harder than ever to make a life (Wyn 2007a).

The question of social change has resonated particularly in the field of youth health and wellbeing because social relations affect the nature and possibilities of personhood—of who we can be—and in this respect changing social relations have a direct impact on young people's **subjectivities** and on how youth is defined. This interrelationship goes well beyond the idea that social context affects individual wellbeing. Shifts in key social processes (e.g. in the dominant ideas determining a nation's economic management, global processes and market forces) also have a fundamental impact on how health and wellbeing are defined by professionals and managed by governments.

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In order to understand the complex interrelationship of social processes, individual experiences and institutions in contemporary society, many researchers have drawn on the concepts of '**risk society**' and 'individualisation'.

Risk society, individualisation and responsibility

These concepts are tools for understanding the changing relationship between health, wellbeing and society. Writers such as Beck and Lau (2005), Beck and Beck-Gernsheim (2002) and Giddens (1991) have argued that over the last 30 years there has been a significant shift, from a phase called 'first modernity', within which nation states exercised clear control over their dominions, to 'second modernity' or '**late modernity**'. This shift involved the fragmentation of collective ways of life based on the nation state which, combined with globalising processes, has undermined the extent to which individual nation states are in control of, or take responsibility for, conditions such as environmental degradation, employment and labour markets.

The fragmentation of older collective and institutional processes (e.g. institutional religion, trade unions, a single career for life) has resulted in increasing responsibility and costs being placed on individuals. For example, in Australia, predictable conditions and patterns of employment have been replaced by uncertainty and unpredictability (e.g. individual contracts, part-time work, job mobility), and although educational credentials have become

more important they do not guarantee graduates the type or level of employment that they seek. Individuals have therefore been forced to make guesses about which combination of education and work experience will prove most effective for them, and having made these 'choices' they see the consequences of making the 'wrong' decision as a personal matter. Biography has become a conscious project that is actively constructed through intensive effort, rather than being seen as something that unfolds on predictable lines, and adulthood is actively 'invented' rather than simply evolving (Henderson et al. 2007). This active construction of one's biography is called the 'project of the self' (Beck & Beck-Gernsheim 2002) and involves the idea of personal management, even in circumstances where, objectively, an individual has little control.

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These processes have also involved a shift in the relationship between individuals and the state: from individuals as citizens, who have rights to particular benefits and facilities from the state, to individuals as consumers, who make choices from the available options in the marketplace. This change is illustrated by the commitment to shifting the costs of education (primary, secondary and tertiary) onto individuals through the introduction of fees and an ideology of choice in Australia and the UK (Ball 2000). Through this process, individual young people and their families have become positioned as consumers who purchase services and products within educational markets, rather than as citizens who have a right to high-quality education regardless of their capacity to pay. This is an example of how social inequalities in late modernity have become redefined through the 'individualization of social risks' (Beck & Beck-Gernsheim 2002: 39). Individualisation is a process which makes the social processes and structures that create inequality seem invisible, and vests individuals with the responsibility for bearing these risks. As a consequence, young people tend to underestimate the impact of social class, gender, race and the dynamics of labour markets on their life chances and their wellbeing (Dwyer & Wyn 2001; Evans 2002; McLeod & Yates 2006; Furlong & Cartmel 2007).

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The following case study illustrates how these processes can operate at the level of individual experience. Adam completed secondary school in 2006 in a rural area of Victoria. He describes in his own words his experiences in the first year after leaving school, at age 18. His story illustrates the beginning of an educational and personal trajectory in which he devises a complex strategy to become a paramedic. The failure to get into the course he was aiming for has meant leaving home to take up an alternative course (nursing), a decision

that he hopes will keep his options open because he does not actually want to become a nurse. Moving away from home has brought concerns about managing his health without family support. He is also concerned about the effects of abandoning regular sport and leisure activities because of the pressures of financial cost and time while he works a number of jobs to survive economically. He acknowledges that his strategy is placing him under pressure, and he is aware of the risks he faces (failure to reach his occupational goal, poverty and ill health) as he outlines his ways of managing these risks: trying to eat 'healthily', juggling work and study.

CASE STUDY: ADAM

If my enter score had been 3 points higher I would have made it into my first choice, a paramedics course near where I live and where many of my school friends now attend. Instead I had to look for alternatives and have started nursing at a regional university 300 kilometres from home. I don't really want to do nursing. My dream is to be a MICA paramedic and I hope to transfer back home next year. I have found the initial transition really hard. I have gone out of high school where it's sort of relaxed into the real world. I found it difficult to meet people at first and with some of the academic work like referencing it has been hard. And I have got a bit stressed out. It would be good to be back at home because I would have parents to cook for me and I wouldn't have to worry.

I have to cook and all that for myself now but I'm trying to eat healthily. I don't do any sports any more because I don't have the time and I can't afford it, so karate and swimming has gone down the wayside and I can't surf up here any more because I'm miles away from the beach. I used to get up at 5 am and go for a surf every morning before school. The surf was just down the road from my house. So there's a few things that I miss out on. I've made a few friends but no real close friends. And all my friends, they've sort of all gone to uni and I suppose going through the same sort of transition that I am, but a lot of them went to city campuses and Peninsular Uni. So a lot of them are still back at home, back on the Peninsular, so I don't get to see them very much.

I need to work to support myself so I work three to five nights a week at the Sports Club as a bartender. I can't get Youth Allowance because my parents earn too much and I haven't been out of home for 18 months. I try to get back home once a month or so but because of work it's sort of hard. I've got to work a lot on the weekends as well. I'm actually trying to find a job that will allow me to work Monday to Friday nights instead of weekend nights but I'm having a lot of trouble finding a job that will allow that.

(Wyn et al. 2008)

Adam's story is repeated by many other young people of his age (Wyn et al. 2008). His living circumstances clearly have implications for his health and wellbeing through 1) managing the pressure and stress of study and work,

and 2) less access to personal support networks, leisure pursuits and physical activity. Adam's story illustrates the 'individualisation' of responsibility for managing complexities that are often out of his control, the identification of risks (of failure and not being healthy), and being conscious of the need to find ways of managing this.

The project of being 'healthy'

Health has moved to centre-stage in the process of individualisation. As Beck and Beck-Gernsheim comment, maintaining health has become one of the most central 'projects of the self' in today's society and it has to be constantly reproduced by individuals. From the standpoint of the rational and responsible individual in today's society, the body itself is an outcome of conscious choices and actions. This means that responsibility for good health and overall wellbeing is seen not only as a good thing, but a necessary thing and a moral obligation. Failure to reach the standards of health, fitness, wellbeing and optimisation that are the individual's responsibility is often accompanied by guilt. The 'project of the self' involves an orientation towards self-management within various 'codes of success, and engaging in self-surveillance and monitoring one's body' (Beck & Beck-Gernsheim 2002: 140).

Being healthy has come to hold a significance that is beyond simply being well. Beck and Beck-Gernsheim argue that being well has become a form of 'salvation' (2002: 140). They argue that whereas freedom from affliction and ultimate happiness were once seen as attainable through the afterlife, these values have become a goal for everyday life. Health has come to take on a 'transcendental' meaning—a kind of secular salvation—and consequently the body and everything connected to it has taken on immense significance (2002: 141).

In this era of heightened significance of the body, the popular media, and especially advertising, provide an overwhelmingly visible, unavoidable representation of standards of bodily performance that children and young people are invited to desire, but that are almost impossible for most to achieve. Yet in achieving particular ideals of physical appearance and performance, the imperative to control the body, either by controlling food or by shaping the body through exercise or surgery, may work against being well. Indeed, a number of researchers have linked this aspect of individualisation with the high rates of anxiety among young women (Donald et al. 2000; Wyn 2000; Harris 2002) and with youth suicide (Fullagar 2003). For this reason, health researchers have turned their attention to exploring the ways in which young people construct their identities and manage their lives.

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These ideas have been explored by Rose (1989, 1999), who argues that risk society provides a context for particular behaviour around health and illness through the emergence of **consumer identities**. He suggests that health and wellbeing have become a form of consumption—something that individuals choose and purchase—and that through media representations and official discourses, individuals are 'offered an image and a set of practical relations of the self and others' (Rose 1999: 87). Focusing on the significance of 'self-responsibility' for health and wellbeing, Rose's work analyses how contemporary society creates a situation where individuals feel they have autonomy and freedom (to choose to be healthy) but are in fact obliged to make particular choices and to achieve particular outcomes. This dynamic is described in more detail in the following section.

The individualisation of health and the rise of wellbeing

The individualisation of responsibility for health has been accompanied by the emergence of particular concepts, ideas and uses of language, and 'wellbeing' is a key example. The idea of wellbeing has become increasingly significant, both in the popular media and in official (e.g. educational and **health promotion**) policies and documents over the last 20 years. This is illustrated by Sointu's study of the rise of the concept of wellbeing in UK newspapers (the *Guardian* and *Daily Mail*) from 1985 to 2003 (Sointu 2005). She found an exponential growth in articles and features on wellbeing over this time, with an increasing emphasis on the moral and social responsibility that individuals hold for managing their personal wellbeing at home and at work. In the 1980s, there were 53 articles specifically on wellbeing and 25 on economic wellbeing—the single most frequent focus. By 2002–03 the number of articles mentioning wellbeing had risen to 440, but economic wellbeing was a specific focus in only 31 instances. Over this time, the categories of 'women and wellbeing' (135 articles), 'health and wellbeing' (185 articles) and 'children and wellbeing' (134 articles) had emerged as very significant issues (2005: 258). Sointu's analysis of the content of these articles reveals how the idea of personal wellbeing has become promoted and accepted as an individual obligation and a lifestyle choice, and traces the decline of the idea of wellbeing as something that is related to wider social structures and processes.

The idea of wellbeing is not simply a popular phenomenon. A quick audit of contemporary educational policies reveals the rapid rise of the idea of wellbeing in educational documents, and the emergence of wellbeing divisions, units and sections of education departments, starting in the early 1990s (Wyn 2007b). Wellbeing has become an official **discourse** and a preoccupation within institutions that have responsibility for young people. At the same time, new forms of professional knowledge and expertise about wellbeing have emerged, including those that aim to provide a scientific and objective approach to identifying individuals who are **at risk**.

Sointu's analysis shows how the idea of wellbeing has come to emphasise the responsibility of individuals for their health, shifting away from older interpretations of this term as a description and measure of social health. There are a number of related ideas and processes that support this more individualised conception of wellbeing (Figure 1.1).

Figure 1.1: *Individualisation processes and wellbeing*

New professional knowledge	The emergence of a professional industry (riskfactorology) based on the identification of individual risk factors that are objective and measurable and can be located in the individual or their family.
Blaming the victim	A shift from national approaches to health promotion to the choosing consumer who bears personal responsibility for their health (that is, encouraging people to make the 'right' choices about food, hours of work, conditions of work and leisure) and the blaming of individuals who fail to make the correct and moral choices about their lives.
Technologies of the self	Increasing control over individuals through processes that internalise the 'correct' attitudes and behaviours in relation to health and wellbeing. This means that new subjectivities are being formed.
Citizens as consumers	The rise of the consumption of health and self-help, and an undermining of traditional sources of authority (e.g. medical) about young people's health.

The individualisation of health and wellbeing is illustrated by Evans et al. (2003), who discuss how obesity is constructed as an individual health problem that should be addressed through the health curriculum in schools. They argue that obesity as a risk factor has risen to epidemic proportions in Western societies and that tools that measure obesity, such as the Body Mass Index (BMI), are contentious because they are based on simplistic notions of what a 'normal' body should be. As many researchers have identified (e.g. Gard & Wright 2001), the relationship between obesity and weight and between weight and health is far more complex than this measure implies.

Evans et al. (2003) show how young people who fail to make the 'right' food choices are seen to be morally inferior. They analyse how terms such as 'obesity' and 'overweight', which appear to have a basis in science, have become a metaphor for the moral failings of wilful overeating and failure to exercise. Their analysis supports an argument that in a 'blame the victim' culture fat is interpreted as a shameful sign of neglect of one's body (2003: 225). They also point out that while the issue of obesity has become seen as a national crisis and in this sense public attention is drawn to it as a social problem, its solution is seen to be a personal issue, to be solved through the inculcation of better attitudes to food and exercise.

Figure 1.2 describes differing contemporary approaches to wellbeing that are associated with a range of sites of practice and the implications of these approaches for individuals. It illustrates the broad scope of wellbeing in contemporary society and the ways in which wellbeing is widely seen to be an individual responsibility.

Figure 1.2: *Contemporary approaches to wellbeing and implications for the self*

Type of wellbeing	Implications for individual/self
Economic	A quality that one might lose without lifelong investment in learning. A need to keep up with the latest developments. Interconnectedness, successful entrepreneurship, interdependence and community through networking. Capacity to relate to others.
Workplace	Displaying the 'authentic self' at work: flexibility, initiative, creativity and productivity and self-monitoring of one's employee identity. Wellbeing is a personal choice (but can be utilised for the production of good and efficient workers who produce more).
Consumerist	The market offers opportunities to buy and create a desirable image. Using (purchasing) 'beauty' routines, relaxation techniques and practising alternative health practices. Measuring up to defined norms and standards.
Educational	Self-motivating, competitive, capable of reflexivity, self-aware. Engagement in and completion of school. Further education or full-time work.
Spiritual	Wellbeing is associated with having a worldview and sense of meaning about life. The self is secondary to a transcendental power. Connecting with others who hold the same view. Demonstration of beliefs through ritual or everyday behaviour.

A number of researchers have explored how the process of individualising responsibility for wellbeing has emerged within educational settings. For example, Gard and Wright (2001) illustrate how schools have come to play a part in ensuring that young people take up this responsibility. They show how health and physical education curricula explicitly aim to create individuals who can see that health and wellbeing is a choice they must make, and that failure to do so places young people at risk of being seen as irresponsible and immoral. Their work focuses on the way in which control is exercised over young people's subjectivities (the wider range of possibilities that frame young people's sense of self) through health curricula. Young people are engaged in **identity** work at school, as elsewhere, and through these processes they learn what the available possibilities or 'subject positions' are and experience the effects of choosing the wrong subject positions.

This process can be seen in the way that young people take up the messages they get through their Physical Education classes. For example, Kendra, who was interviewed for a Physical Activity research project (Wright et al. 2005) when she was in Year 10 (aged 16) felt that she had fallen into 'unhealthy' practices, and was unhappy about changes in her weight and shape. Comparing herself with what she looked like when she was younger, she said:

I didn't like it. I feel better about myself now, being physical and being able to do stuff with myself. Eating healthy, trying to get myself back on track. To what I used to be. Like, I hated it. I didn't like being the way I was. I wasn't active. I didn't do nothing. I just sat around, ate food all the time. Didn't do nothing. Now I go to school, I get up every morning and feel really good about myself and stuff. I don't like being fat and nobody likes me and everyone just used to pick on me.

While her commitment to undertaking more physical activity and eating more healthily is positive, her narrative reveals the extent to which she has taken on a sense of shame and personal failure for being 'fat'. She sees a connection between being fat and being unlikeable. Expressing a negative moral judgment about her failure to be physically active and doing 'nothing' and eating food 'all the time' in the past, she sees herself as being to blame.

Kendra's story highlights the considerable challenge that faces policy-makers, theorists and practitioners in the field of young people's health and wellbeing. Various initiatives (e.g. health promotion and fitness programs) that aim to improve young people's health and wellbeing can have unintended consequences. While individuals do have responsibility for managing their wellbeing, curricula and programs that focus on this responsibility can inadvertently foster 'unhealthy' attitudes by young people towards their bodies (Wright & Burrows 2004).

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The question of the consequences of health policies directed at young people is taken up in the following section through a brief consideration of the way in which broader government approaches to governing youth have an impact on young people's health and wellbeing.

Young people and the state

It is important to acknowledge that young people's health and wellbeing is a political as well as a social issue. The jurisdictions of health and education (and how young people are seen and treated there) are both crucially underpinned by the economic approaches taken by governments. Under monetarist economic policies, the institutions that affect young people have been strongly influenced by market forces. There are many analyses of the way in which educational institutions have been influenced by changing economic policies, especially in the ways in which young people's learning is managed (e.g. Marginson 1999; Ranson 2003; Lingard 2005). But less attention has been paid to the impact of changing economic policies on how young people's health is managed, both in educational institutions and in the health sector.

Mizen's analysis (2004) provides a useful framework for the development of such an understanding. He describes how in the UK monetarist policies have thrust economic goals into the foreground, narrowing the fiscal responsibility of the state for young people while at the same time hugely expanding the reach of monitoring, surveillance and control over both young people's lives

and the institutions in which they spend their time. One of the ways in which this has been achieved, Mizen argues, is through the introduction of age-based measures (e.g. universal exams and tests undertaken at a particular age, youth wages, age-related social security benefits) that create and impose constraints on young people's lives and obscure the nature of social and economic inequalities on which different outcomes are based. This has been accompanied by a progressive reduction of public support for young people, minimising the provision of social welfare and encouraging the development of categories of 'deserving and undeserving' youth (Mizen 2002: 14–16).

Following Mizen, it is possible to see several developments that are closely related to monetarist approaches by the state:

1 Health (medical) discourses provide an important source of legitimation for the use of universal age-based categories of youth and for the identification of exclusionary measures to define target groups.
2 Despite the evidence for the benefits of more inclusive, youth-oriented support, health is defined as an individual responsibility.
3 Health care is offered within rapidly developing markets offering a fee for services that young people and their families 'choose'.

The reduction of universal support for health is perhaps ironic because, as a result of the social change described above, young people's need for support is increasing. For example, in Australia the rate of young people aged 12–14 living in out-of-home care has increased from 4.3 to 5.8 per 1000 young people between 2001 and 2006 (AIHW 2007). The research shows that there is an association between young people's level of social support and the number of health problems they face; those living in social circumstances where they have little social support are also those who have the highest rates of ill health (AIHW 2007). There is also evidence that families living in neighbourhoods characterised by greater community investment, trust and organisational affiliations tend to function better (Korbin & Coulton 1995, quoted in AIHW 2007: 94), and safe neighbourhoods are associated with better psychological wellbeing and educational achievement in young people (Meyers & Miller 2004, quoted in AIHW 2007: 94).

A constant theme in the literature on social change is the close relationship between social processes and relations and the concepts we use. This section has identified a number of ways in which the social conditions of late modernity have affected both young people's experiences of health and wellbeing and the nature of professional discourses. In the following section this issue is taken up through a brief consideration of the way in which the concept of youth is implicated in approaches to health and wellbeing.

CONCEPTS OF YOUTH

Programs, policies and strategies that aim to address young people's health and wellbeing are fundamentally influenced by the concept of youth being

employed. There are many extended discussions of the 'youth question' and how youth is conceptualised (Allen 1968; Lesko 1996; Cohen 1997; White & Wyn 1997; Mizen 2002). These discussions have in common the view that youth is historically and socially specific. That is, what it means to be 18 years of age, for example, is far from constant across time and space. While chronological age is an objective measure, how age is experienced and what it means is less objective; for example, the exact beginning and end points of youth are not clear. The Australian Institute of Health and Welfare (AIHW) states that 'it is a widely accepted statistical convention to define young people as those aged between 15–24 years of age', but acknowledges that 'it is much harder to specify a set age group when a sociological definition of young people is employed' (AIHW 2007: 2).

Figure 1.3 gives a summary of commonly used approaches to the idea of youth and the ways in which these approaches impact on policies and programs. It illustrates how ideas about youth have a profound influence on the value that professionals place on young people, on what they define as the problems facing youth and what they see as the solutions. The schema represented in the figure draws attention to some of the core differences in approach that continue to have an impact on policies, programs and research projects that address young people's health and wellbeing. For example, it illustrates the difference between contemporary approaches that emphasise the incompleteness of youth (in a developmental sense) and those that emphasise the social construction of youth as resulting in diverse meanings and experiences. The figure also draws attention to an emerging consensus that the insights of different disciplines on the experience and meaning of youth are relevant. This enables a more critical stance on the assumptions underlying policy formation.

The different definitions and their uses create tensions and divisions that are played out in the field of young people's health (Eckersley et al. 2006). This is illustrated by closer consideration of two key ideas prevalent in discussions of young people's health and wellbeing: 1) the tendency to focus on young people as adults of the future and the related tendency to downplay young people's role in the present; and 2) the idea of a **mainstream** that ensures against risk and obscures the diversity of young people's lives.

Young people as future/present

The question of development is an especially important one in the field of young people's health and wellbeing. While the term 'development' has many applications, it is often used to signify the fact that young people are still in a phase of (biomedical and psychosocial) development and are yet to become complete as adults; it tends therefore to view youth as inherently unstable and vulnerable. An example is provided by the AIHW, which states that youth is 'a period of rapid … change … from dependent children to independent adults' and 'young people who are unable to make this transition smoothly can face significant difficulties in both the short and long term' (AIHW 2007: vii). Some

Figure 1.3: *Conceptions of youth and their implications for policies and programs*

Conception of youth	Implications for practice in policies, programs and research
■ Primarily a phase of psychosocial and physical development between childhood and adulthood which is universal ■ A category defined by chronological age ■ Primarily a deficit state on the way to completion (adulthood)	■ Youth is important because young people represent the future and youth is a prelude to adulthood. ■ Failure to go through developmental stages at the prescribed time will result in failure to transition correctly into adulthood and therefore young people are inherently at risk. ■ Professional interventions may assist individuals at risk to become normal or mainstream. ■ Research seeks to determine the biological constraints that define youth and that make them vulnerable, e.g. research on the development of the frontal lobe of the brain.
■ Primarily a culturally constructed phase of life which is socially and historically specific ■ A social process, defined by social relations, i.e. an outcome of official definitions and youth actions	■ Youth is shaped by the relationship between social context and individual action, and its meaning and experience will differ across time and space, as does childhood and adulthood. ■ Youth is a transitional stage. ■ Youth represents both a threat to society (e.g. youth gangs, antisocial behaviour) and hope for the future (e.g. technologically savvy, well educated). ■ Interventions may ameliorate negative conditions (e.g. poverty, homelessness). ■ Research seeks to explore young people's diverse experiences and to document the construction of youth through institutional practices and professional discourses.
■ An outcome of both psychosocial development within individuals and the impact of social conditions and processes	■ Social and legal recognition of youth through processes supporting young people's active role in decision-making ■ Young people are recognised as making a contribution to society in their own right. ■ Cross-sectoral collaboration brings benefits in terms of addressing young people's needs. ■ Research seeks to draw simultaneously on different disciplines (e.g. psychological and sociological) and to recognise complexity in young people's lives.

youth researchers have criticised this approach because it tends to position young people *exclusively* as being in deficit and as inherently vulnerable and to see their **capabilities** as being a lesser version of 'adult' capabilities (Lesko 1996). This approach means that 1) the focus is on vulnerability rather than on understanding the positive contribution that young people make (because this phase of life is devalued in itself); 2) it provides a rationale for making interventions into young people's lives 'for their own good'; and 3) it leads to a non-reciprocal approach: young people must learn to participate in adult-defined processes because it is their future, but adults do not need to understand young people's worlds.

The assumption that young people are significant *only* because they are becoming adult is a powerful one, reflected in many of our institutions and public processes. Young people are not expected to take part in decision-making within institutions (schools, health centres and services, juvenile justice) which are relevant to them, and they are largely unwelcome (except as consumers) in public spaces. Young people's involvement in social processes is often justified as a rehearsal for 'real' participation in the future. Information that has been collected through research *on* young people (generally large-scale surveys and tests) is still in many quarters regarded as being more relevant and useful than research *with* young people (generally involving a mix of research techniques, including innovative qualitative approaches).

An alternative approach to youth development emphasises the role that young people play in the present. This is reflected in widespread interest in how to ensure that young people participate in decision-making about their health, learning, neighbourhood and environment (Holdsworth et al. 2008). Active engagement in decision-making is not important just because they may become civic-minded and actively engaged adults in the future, but because they can contribute new knowledge, understandings and processes that benefit everyone (Wierenga et al. 2003). This may be especially significant in a rapidly changing world, where young people are engaging with issues and using technologies that were unknown to their parents' generation (Wyn & Woodman 2006). In addition, just as adults' wellbeing is positively associated with feeling that they belong and have a say in decisions affecting them, so is young people's. Research shows that young people's wellbeing is enhanced through social and economic participation in society (VicHealth 2005).

Many health practitioners promote the need to blend a biomedical view of youth as a transition to adulthood with a more sociological view that recognises youth as an important part of our society. For example, they see youth-specific services as a crucial strategy for promoting young people's **mental health** (Bruun & Hynan 2006; McGorry et al. 2007).

Mainstream and at risk/diversity

The notion of young people at risk, juxtaposed against a mainstream, is also influential, and the term 'risk factor' has achieved widespread use with reference to youth. The pre-eminence of the idea of risk factors is particularly significant in the field of youth health in which adolescence is seen as an 'age of risk' defined primarily by vulnerabilities (Scott 2007). It is therefore useful to explore reasons for caution about using risk factors as a tool for managing young people's health. While some behaviours may demonstrate a strong causal link to particular health outcomes across a population, such as the link between binge drinking and cirrhosis of the liver, the link between individual behaviour and outcomes is more complex. In many instances the identification of 'risk factors' in young people is simply a way of placing responsibility on individual young people or their families in disregard of the wider social processes that contribute to the adverse outcome. It is important to identify the probability of

associations between individual behaviour and health outcomes, but it is also important that we do not lose sight of the social conditions, such as poverty, that affect young people's health outcomes.

Various researchers in Australia and the UK (e.g. Hil 1999; France 2008) point out that the process of identifying risk factors tends to mean singling out particular behaviours, which then become the focus, obscuring the relationships between these factors and the social conditions that contribute to positive health and wellbeing. Wishart et al. (2006), conducting research in Canada, have found that approaches based on the idea of 'youth at risk' militate against a **social justice** approach and can produce youth who do in fact become at risk. They found that singling out young people for special attention through programs that were intended to help them often had the opposite effect. By being identified as 'at risk' the young people came to see themselves as different from and inferior to their peers and began to identify themselves as likely to fail at school.

Risk factors are generally used to target young people who are engaged in 'risky' behaviours. But one of the effects of this process is to label young people in terms of their behaviour (e.g. as obese, anorexic, binge-drinkers). As *they* become categorised as 'vulnerable' so the problem becomes *theirs*, rather than the social circumstances that create the conditions for eating disorders or drug abuse. The identification of discrete 'risk factors' creates the possibility for professional interventions in young people's lives, employing a framework that makes the social conditions that create health problems invisible and vests the problem in ('vulnerable') young people.

The concept of a mainstream (into which the 'at risk' are to be integrated through targeted interventions) is also problematic because it is often based uncritically on assumptions about what is normative. Two factors in particular invite a questioning of the idea of a mainstream. First, increasing cultural diversity through immigration and the arrival of refugee and asylum-seeking populations has increased the social and cultural diversity of our young population. For example, while the proportion of overseas-born Australians remains at one in five, there has been an increase in arrivals from Asian countries (especially China and India), a decrease in arrivals from European countries, and an increase in recent arrivals born in countries affected by war and political unrest (ABS 2006). Second, processes of social change mean that what was normative for one generation may not be so for later generations (Wyn & Woodman 2007).

The idea and use of risk factors continues to be debated between social analysts and adolescent health experts (e.g. Hil 1999; Homel 2000). The positions taken up between the proponents in these debates often focus on the use of strategies aimed at particular problems and those identified as being 'at risk', or universal strategies that address the causes of health problems such as poverty or lack of access to appropriate health services. As the example above has shown, targeted strategies are often seen as ignoring the social and economic conditions that cause problems. It is, however, commonly recognised

that addressing young people's health and wellbeing is not a matter of *either* targeted *or* universal approaches—both are relevant in their place and the key is to enable a complementarity between the two approaches.

The challenge lies in understanding how concepts of youth influence the questions that researchers ask and impact on the ways in which policies are framed and implemented. Multidisciplinary approaches are increasingly seen as a way to meet this challenge, drawing on expertise and well-rehearsed discipline-based certainties, but also being open to new insights that can be generated by a synthesis of different approaches. This is especially productive at the level of methodology, and involves approaches that explore what young people think and experience as well as implementing measures that have been constructed about young people.

The challenge lies in understanding how concepts of youth influence the questions that researchers ask and impact on the ways in which policies are framed and implemented.

CONCLUSION

In concluding, I return to the paradox of young people's ill health in contemporary society. While most young people are well, changing social conditions have created new health threats, such as obesity and bullying, as well as challenges, and government programs continue to address ongoing problems such as drug use, mental health problems and violence. In this chapter I have argued that social conditions, including the pressures created by the individualisation of responsibility for negotiating life, the fragmentation of social relations and increased expectations on young people to manage multiple responsibilities, underpin patterns of health and wellbeing.

The chapter has explored changes in the way in which health is seen, including the emergence of a predominantly individualised notion of wellbeing, and the rise of services and professionals who address this. While the social causes of ill health, such as poverty, marginalisation and **exclusion**, are generally acknowledged, the overwhelming focus on individual wellbeing and programs that target one dimension in a web of connected elements that produce poor health inevitably falls short. In part, the paradox of youth ill health is a product of the tendency to 'fix' health problems once they have arisen and a failure to address the conditions that enable the problems to occur.

KEY CONCEPTS

Social change
Individualisation
Risk society
Wellbeing
Youth
Mainstream
At risk

FOR FURTHER EXPLORATION

1. What are the key social changes that have had an impact on young people's health and wellbeing?
2. How does 'individualisation' obscure inequality?
3. Describe, with one or more examples, how maintaining health and wellbeing has become a central element in the 'project of the self'.
4. Explore different concepts of youth, drawing on different disciplines such as sociology and psychology, and examine the ways in which these are reflected in approaches to young people's health problems and their solutions.