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Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing

2018



AIHW

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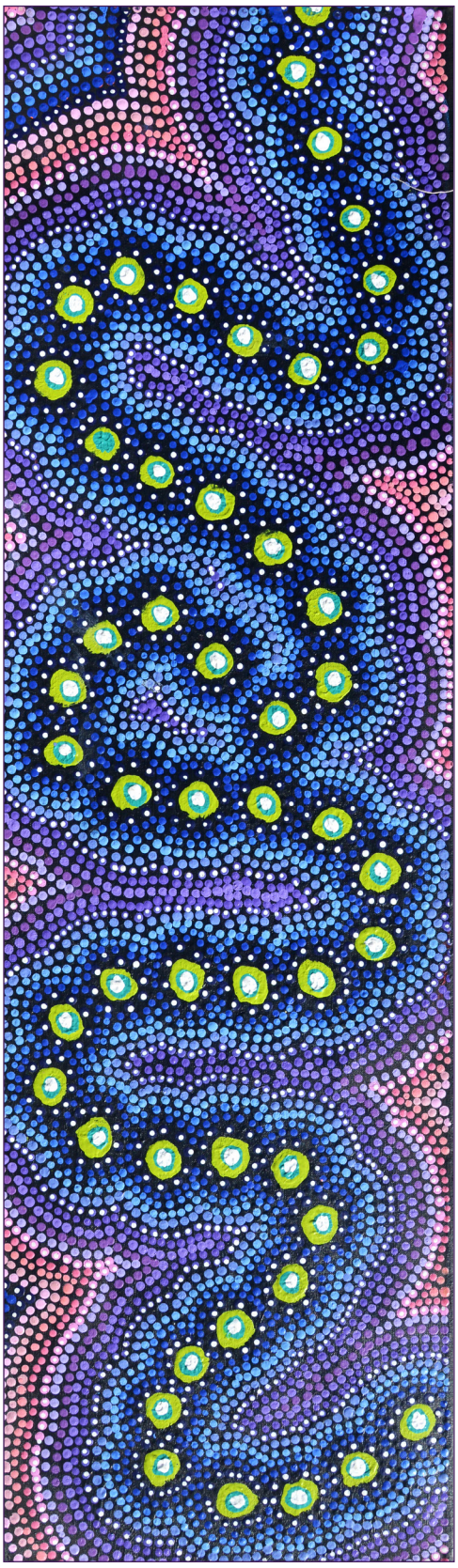
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Abbreviations

AATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey
ABDS	Australian Burden of Disease Study
ABS	Australian Bureau of Statistics
ACARA	Australian Curriculum, Assessment and Reporting Authority
ACT	Australian Capital Territory
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AODTS	Alcohol and Other Drugs Treatment Services
AOM	acute otitis media
ARF	acute rheumatic fever
ASGS	Australian Statistical Geography Standard
BBV	blood-borne virus
BMI	body mass index
CHCI	Child Health Check Initiative
CNS	Clinical Nurse Specialists
CP NMDS	Child Protection National Minimum Data Set
CSOM	Chronic suppurative otitis media
COAG	Council of Australian Governments
DALY	Disability-adjusted life years
DoH	Department of Health (Commonwealth)
DS NMDS	Disability Services National Minimum Data Set
ENT	ear, nose and throat
ETD	eustachian tube dysfunction
GP	general practitioner
HIV	human immunodeficiency virus
HPF	Aboriginal and Torres Strait Islander Health Performance Framework
HREOC	Human Rights and Equal Opportunity Commission
IARE	Indigenous Areas (ABS classification)
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian modification
JJ NMDS	Juvenile Justice National Minimum Data Set
K5	Kessler 5-item
K10	Kessler 10-item
LHD	Local Health District
MBS	Medicare Benefits Schedule
NAIDOC	National Aborigines and Islanders Day Observance Committee

NAPLAN	National Assessment Program—Literacy and Numeracy
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NDA	National Disability Agreement
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NEET	not in employment, education and training
NHMD	National Hospitals Morbidity Database
NHMRC	National Health and Medical Research Council
nKPI	National Key Performance Indicators
NMD	National Mortality Database
NMDS	National Minimum Data Set
NNDSS	National Notifiable Diseases Surveillance System
NPDC	National Perinatal Data Collection
NSW	New South Wales
NT	Northern Territory
NTER	Northern Territory Emergency Response
NYIF	National Youth Information Framework
OME	otitis media with effusion
OSR	Online Services Report
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
PHN	Primary Health Network
PM&C	Department of Prime Minister and Cabinet
Qld	Queensland
RHD	rheumatic heart disease
RSE	relative standard error
SHS	Specialist Homelessness Services
SHSC	Specialist Homelessness Services Collection
STI	Sexually transmissible infection
Tas	Tasmania
Vic	Victoria
SA	South Australia
TAFE	Technical and further education
WA	Western Australia
WHO	World Health Organization
YLD	years lived with disability
YLL	years of life lost

Symbols

—	nil or rounded to zero
n.p.	not publishable because of small numbers, confidentiality or other concerns about the quality of the data
n.a.	not available
..	not applicable
†	estimate has a relative standard error of 25% to 50% and should be used with caution
<	Less than
>	More than

Summary

Youth is a key transition period in a person's life. It is a time when decisions are made about relationships, education and career paths, employment and finances. The social, economic, environmental and technological changes that have occurred in recent decades mean that young people now face issues that previous generations may not have experienced.

Young Aboriginal and Torres Strait Islander people may face additional obstacles in making a successful transition to adulthood. The effect of inter-generational trauma, racism and prejudice, and socioeconomic disadvantage are all relevant in understanding the experiences of young Indigenous people today.

The *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing* report was produced by the Australian Institute of Health and Welfare with input from an expert advisory group and young Indigenous people. It provides a comprehensive information on the health and wellbeing of Indigenous youth.

Young Indigenous people

A total of 241,824 Indigenous people aged 10–24 lived in Australia in 2016, representing 5% of the total Australian youth population. Most young Indigenous people lived in non-remote areas of Australia, including *Major cities* and *Inner* and *outer regional* areas. Indigenous youth, however, represented a greater proportion of the total youth population that lived in less urban areas, such as *Remote* and *Very remote* areas of the country.

Social determinants and health risk factors

In 2016, around 2 in 5 Indigenous people aged 15–24 were fully engaged in full-time work, full-time study or combining both. The proportion of Indigenous people aged 20–24 who had Year 12 or equivalent attainment increased from 47% in 2006 to 65% in 2016.

In 2016, 4% of Indigenous people aged 10–24 were classified as homeless.

The proportion of Indigenous people aged 15–24 who smoked daily declined from 45% in 2002 to 31% in 2014–15. Nearly one-third of young Indigenous people, however, are current daily smokers.

Most Indigenous people aged 10–14 (54%) and 15–17 (58%) were in the normal weight range in 2012–13. For youths aged 18–24, just over one-third (34%) were within the normal weight range.

Wellbeing

In 2014–15 over three-quarters (76%) of Indigenous people aged 15–24 said, they were happy all or most of the time in the previous 4 weeks. More than 6 in 10 (61%) Indigenous people aged 10 to 24 recognised their traditional homelands or traditional country, and over two-thirds (69%) were involved in cultural events in the previous 12 months.

Around two-thirds of Indigenous people aged 15–24 experienced 1 or more personal stressors in the previous year, the most common being not being able to get a job, and 1 in 3 reported being treated unfairly because they were Indigenous.

Most Indigenous people aged 15–24 (67%) experienced low to moderate levels of psychological distress in the previous month, while 33% experienced high to very high levels.

Health status and outcomes

More than 6 in 10 Indigenous youth considered themselves to be in excellent or very good health in 2012–13. The most prevalent long-term health conditions reported by young Indigenous people were respiratory diseases, such as asthma, and eye and vision problems.

Burden of disease analyses show that for Indigenous people aged 10–24 the leading contributors to the disease burden were suicide and self-inflicted injuries (13%), anxiety disorders (8%), alcohol use disorders (7%) and road traffic accidents (6%).

The mortality rate for young Indigenous people has declined, from 70 per 100,000 in 2005 to 67 per 100,000 in 2015. In the period, 2011–2015 there were 674 deaths recorded for Indigenous people aged 10–24. Injury and poisoning accounted for the majority of these deaths, including suicides, land transport accidents and assaults.

Most of these deaths are potentially avoidable. Around 83% of deaths of young Indigenous people in 2011–2015 were classified as avoidable deaths.

Health and welfare services

There was an increase in the proportion of Indigenous youth receiving an Indigenous health check between 2010 (6%) and 2016 (22%). In 2015–16, Indigenous youth represented a third of all treatment episodes provided by alcohol and other drug treatment services.

Almost 9,000 Indigenous people aged 10–17 were on care and protection orders at 30 June 2017, and nearly 8,000 were in out-of-home care. Young Indigenous people continued to be over represented in the justice system, representing 43% of young people in youth-justice supervision in 2014–15.

Data gaps

Data on some important issues affecting young Indigenous people are lacking. Some of the key data gaps include culturally appropriate data that measures wellbeing, treatment of mental health conditions, data on sexual health including use of contraception and sexual health services, use of primary health care services, and survey data for the 10–14 year age group.

A bright future, but not without challenges

The report highlights the education, language and cultural capital of young Indigenous people among other strengths. It shows that young Indigenous people are in good health and that their mortality rates have fallen.

Yet, there are aspects of young Indigenous people's health and wellbeing that require attention. Some of the issues identified include tobacco smoking, alcohol and substance use, mental health problems, injuries and experiences of violence.

Most of the deaths of young Indigenous people are due to potentially avoidable conditions given timely and effective health care. It is therefore important that services are available and accessible to Indigenous youth that facilitate health and happiness and provide support in times of need.



1

Introduction

1.1 Background

Every human being is entitled to the enjoyment of the highest attainable standard of health, encouraging a life lived in dignity (United Nations Economic and Social Council, 2000). In this report, the focus is specifically on young people. Youth is a critical transitional period from being dependent children to independent adults. It is characterised by significant physical, intellectual, emotional and social development. The terms 'youth' and 'young people' are used throughout this report to refer to those aged 10–24. The term 'adolescence' is also used to describe this age group (Sawyer et al. 2018).

There is often a paucity of attention and resources devoted to young people—frequently they are lost in systems that focus on either children or adults. Yet investment in youth is both socially and economically powerful. It provides a triple dividend by producing benefits for young people today, into adulthood and for future generations of children (Patton 2016). By focusing on youth, it is possible to build on the historic improvements that have been made in childhood outcomes, such as declining childhood mortality rates, and accelerate action against health inequities. For these reasons, youth is characterised as an age of opportunity (United Nations Children's Fund 2011).

The World Health Organization (WHO) notes that there is a sound public health case for devoting greater attention to youth (WHO 2017). Youth is a period when decisions are made about relationships with family and peers, education and career paths, employment and finances. The WHO recognises the importance of youth for health over the lifespan, noting that important health behaviours often begin or are consolidated during adolescence. These behaviours include unsafe sex, drug, tobacco and alcohol use, poor diet and physical inactivity (WHO 2017). The social, economic, environmental and technological changes that have occurred both nationally and internationally in recent decades mean that young people now face issues that may not have been apparent for previous generations.

While all young people face these challenges, the impact of historical legacies and some current practices mean that young Aboriginal and Torres Strait Islander people may face additional obstacles in making a successful transition to adulthood. The effect of inter-generational trauma, racism and prejudice, and socioeconomic disadvantage are all relevant in understanding the experiences of young Indigenous people today.

The importance of focusing on the health and wellbeing of young Indigenous people is reflected in Australian Government planning, including the National Aboriginal and Torres Strait Islander Health Plan 2013–23, the Implementation Plan goals for the Health Plan, and the Closing the Gap Refresh discussion paper. For example, the Health Plan specifies as a goal that Aboriginal and Torres Strait Islander youth get the services and support they need to thrive and grow into healthy adults (DoH 2013).

The health and wellbeing of young Indigenous people is influenced not only by person level factors (such as health risk factors) but also by broader factors, such as the availability of opportunities, including access to schooling and higher education, and having the resources to access these opportunities, such as finances, prior education, shelter and food security. For young Indigenous people, having a strong sense of self, connection to family, kin, Indigenous language, and culture are integral to having a strong personal identity and to positive development. For example, some research suggests that having a strong cultural identity can protect young Indigenous people against challenges to their social and emotional wellbeing (Zubrick et al 2004).

This report focuses on the health and wellbeing of Indigenous youth. It is important to understand how Australia's young Indigenous people are faring so that their successes may be celebrated and areas where they need support can be identified and acted on. The aim of this report is to present a current, accurate, comprehensive, and accessible information source on young Australian Aboriginal and Torres Strait Islander people. The report is intended to be used to monitor progress over time on important measures of young Indigenous people's health and wellbeing to inform evidence-based policy.

1.2 Indigenous youth health indicator framework

An Indigenous youth health indicator framework (Figure 1.2.1) was developed for this report and in response to the need for policy makers and evaluators to have an accessible compendium of information that integrates evidence from diverse data sources. The framework's was informed by existing indicator frameworks that focus on youth and Indigenous health. It was developed by the AIHW with guidance from an expert advisory group. The advisory group consisted of members with expertise in Indigenous health, children, adolescent, and youth health, Aboriginal healing, culture and spirituality, mental health, injury, sexual and reproductive health, respiratory health, primary care, and education.

Existing frameworks that informed the development of the present framework include the National Youth Information Framework (NYIF), the World Health Organisation Adolescent Health framework and Lancet Commission on Adolescent Health and Wellbeing framework. These frameworks provided a starting point from which a range of health and wellbeing measures were reviewed and considered for inclusion. Indicators from the Aboriginal and Torres Strait Islander Health Performance Framework (HPF) were reviewed to inform the selection of indicators and data sources and to ensure relevance and appropriateness to the Australian Indigenous context.

The Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing indicator framework has 4 main areas, as below. A full list of indicators is presented in Appendix A. While all indicators in the framework are reported on, material additional to the indicators is incorporated throughout the report to provide context and a more nuanced picture of the Indigenous youth population.

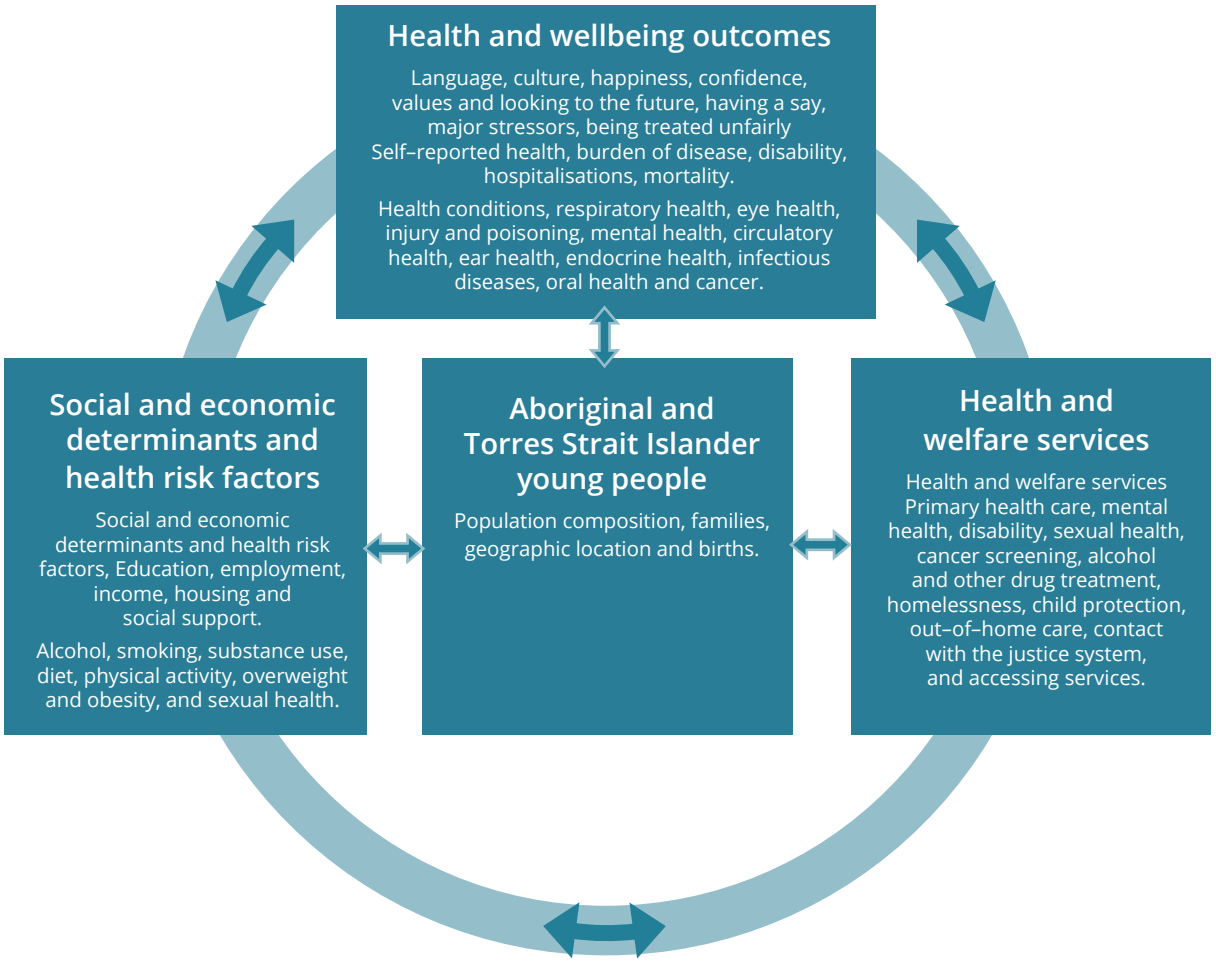
Young Indigenous people: young Indigenous people are central to this work and are therefore represented in the middle of the framework. Rather than including indicators, as is the case in the areas below, this area encompasses key demographic data that provides a population overview.

Health and wellbeing outcomes: provides a broad view of health and wellbeing. Data on how young people are faring and challenges they experience are a focus of this section. Information on mental health is included. Illness is also addressed through data on the burden of disease, disability, hospitalisations, mortality and specific health conditions.

Social determinants and health risk factors: includes social and economic factors that influence the health and wellbeing of young Indigenous people. These factors are referred to as the social determinants of health. Health risk factors, which include more personal and behavioural influences on health are also included.

Health and welfare services: covers the health and welfare services that young people have access to and use. Data relating to primary care, mental health, disability services, sexual health services, cancer screening, drug and alcohol treatment, homelessness, child protection and contact with the justice system are presented.

Figure 1.2.1: Framework for the Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing report



During the development of this indicator framework, another Indigenous adolescent health framework was published (Azzopardi et al. 2017). There are similarities between the Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing framework and Azzopardi et al. framework, including the population of interest (Indigenous Australians aged 10–24), a focus on health outcomes, risk factors, and determinants. This report builds on the work of Azzopardi et al. by drawing from a broader range of data sources (such as 2016 Census and administrative AIHW data sets), using updated data, providing disaggregation of data by state and territory and remoteness areas and by providing time trend data for key indicators.

Data sources

The main data sources used in this report are outlined below (Table 1.2.1). Further detail on the key data sources is provided in Appendix C. Additional methodological information about data sources is provided at the beginning of each chapter.

Table 1.2.1: Data sources for Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing, 2018 report

Administrative	Survey	Other
National Hospital Morbidity Database, 2015–16	National Aboriginal and Torres Strait Islander Social Survey, 2014–15	Census of Population and Housing, 2016
National Mortality Database, 2011–2015		
AIHW Child Protection Collection, 2016	Australian Aboriginal and Torres Strait Islander Health Survey, 2012–13	Census of Population and Housing, 2011
AIHW Juvenile Justice National Minimum Data Set, 2015–16	Mission Australia Youth Survey Report, 2017	Census of Population and Housing, 2006
Alcohol and Other Drugs National Minimum Data Set, 2015–16	Sexual Health and relationships in young Aboriginal and Torres Strait Islander people (Goanna survey), 2014	AIHW Burden of Disease Database, 2011
National Notifiable Disease Surveillance System, 2016	Online Services Report, 2015–16	
National Community Mental Health Care Database, 2015–16		
Specialist Homelessness Services database, 2016–17		
National Perinatal Data Collection, 2016		

Data gaps

While this report uses a broad range of data sources, gaps remain in the availability of nationally representative data of a high quality on the health and wellbeing of young Indigenous people. Table 1.2.2 outlines some of the major gaps and highlights opportunities for data development work. Filling these gaps would help build a more complete understanding of young Indigenous peoples' health and wellbeing outcomes, the factors that influence these outcomes and their use of health and welfare services. Subsequently, it may strengthen evidence-based, decision-making and policy in this area.

Table 1.2.2: Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing data gaps

Measures	Gaps	Type of gap
Health and wellbeing outcomes		
Age groups	Data for age group 10–14 is limited compared to age groups 15–19 and 20–24, as both the Australian Aboriginal and Torres Strait Islander People Health Survey 2012–13 and The National Aboriginal and Torres Strait Islander Health Survey 2014–15 are geared towards adults.	Data
General health and wellbeing	Mental health. Gaps include an understanding of conditions for which Indigenous youth are receiving treatment and the type of treatment received.	Analysis
	Wellbeing. Gaps include national data using a measure of wellbeing (which differs from psychological distress) that is culturally-and age-appropriate.	Data
Disability	There is inconsistency in the measurement of disability across data sources, such as the Census and NATSISS.	Data
	There is a need for longitudinal data to establish a natural history of Indigenous youth with disability.	Data
Morbidity	Hospital data at a lower level of geography (below state and territory, remoteness area, PHN), particularly for PHNs that encompass an entire state or territory, such as the Northern Territory, Tasmania, the Australian Capital Territory.	Data
	Detailed eye health and dental health data are lacking. Data provided as part of the Northern Territory Remote Aboriginal Investment is an example of more detailed data.	Data
	In a recent wave of data collection, biomedical data (such as heart and lung health, fitness) was collected as part of the Longitudinal Study of Australian Children. No such data are available for the Indigenous-specific Longitudinal Study of Indigenous Children.	Data
Mortality	Data are for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory only. Other states and territories have a small number of Indigenous deaths, and identification of Indigenous deaths in their death registration systems is relatively poor, making the data less reliable.	Analysis

Table 1.2.2 (continued): Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing data gaps

Measures	Gaps	Type of gap
Social determinants and risk factors		
Economic	Individuals are counted as employed by the ABS if they worked one or more hour in the reference week. This also applies to labour force participation statistics.	Analysis
	Census data on household tenure type is available for Indigenous households only and not for young Indigenous people specifically.	Data
Social	Limited data are available on the type of unfair treatment experienced. Forms of racism experienced, such as being tailed by security in shops, may not be fully captured.	Data
	Detailed data on driver licensing is not available.	Data
	Removal from natural family. Little information is available on the impact of removal (for example impacts on health, wellbeing, educational and economic participation, service use).	Analysis
	Cultural engagement activities in urban areas may differ from those in remote areas. Activities such as involvement in music, art and sport carnivals should be captured as part of cultural engagement measures.	Data
	Data on the number and proportion of young Indigenous people who want to know more about their culture are lacking.	Data
Risk factors	The assessment of physical activity against guidelines in the 2012–13 AATSIHS differed between remote and non-remote areas. For both remote and non-remote areas, the guidelines are a simplified assessment against the national guidelines.	Data
	Sexual health. Nationally representative data of a type similar to that collected as part of the Goanna study is absent.	Data
Health and welfare services		
Service use	Primary health care use—GP practice data are limited to that sourced from MBS/PBS datasets and pooled data from GP medical software, which is not readily available for analysis.	Analysis
	Indigenous national key performance indicator (nKPI) data on Indigenous-specific primary health care is collected in aggregate, with unit-record data not submitted. Youth specific data are not available.	Analysis
Expenditure	The Productivity Commission produces an Indigenous expenditure report, the most recent of which was published in 2017 with 2015–16 data. This product uses data supplied by Australia governments. As the data are not supplied with an age group disaggregation, it is not possible to report on specific Indigenous youth expenditure.	Data

Report structure

This report structure and appendices are outlined below. Note that the online supplementary tables provide data and the notes for each of the figures presented in the report.

Chapter 1: Introduction. This chapter includes background information on the report, framework, data sources and gaps.

Chapter 2: About young Indigenous people. This chapter includes demographic information on the Indigenous youth population.

Chapter 3: Social and economic determinants. This chapter includes social and economic factors that influence the health of young Indigenous people. Data on education, employment, income, housing and social support is included.

Chapter 4: Health risk factors. This chapter includes information on use of alcohol, smoking, substance use, diet, physical activity, weight status and sexual health.

Chapter 5: Wellbeing. This chapter includes information reported by young Indigenous people about how they are faring and includes data on language, culture, happiness, stressors and psychological distress.

Chapter 6: Health status and outcomes. This chapter includes information on self-reported health, the disease burden, disability, morbidity and mortality.

Chapter 7: Health conditions. Health conditions that are faced by young Indigenous people are discussed. This includes a focus on respiratory health, eye health, injury and poisoning, mental health, circulatory health, ear health, endocrine health, infectious disease, oral health and cancer.

Chapter 8: Health and welfare services. This chapter includes information on the use and availability of some health and welfare services accessed by young Indigenous people. Data relating to services for primary health care, mental health, disability, sexual health, cancer screening, homelessness, child protection and out-of-home care, contact with the justice system and service access is included.

Chapter 9: Young Torres Strait Islander people. This chapter focuses specifically on Torres Strait Islander youth, including demographic information, health outcomes, determinants and service use.

Appendix A: Includes the indicator framework used.

Appendix B: Provides more data on non-Indigenous comparisons.

Appendix C: Includes more detailed information on the key data sources and data quality issues.



2

About young Indigenous people

Young Indigenous people are a diverse group of Australians. This chapter presents an overview of the Indigenous youth population by focusing on key demographic characteristics such as population size and composition, families, geographic distribution and births. To provide additional context, some demographic data on the non-Indigenous population is included.

Box 2: Main data sources and key issues

Census of Population and Housing

- The estimates of the Aboriginal and Torres Strait Islander population in this report are based on 2016 Census of Population and Housing counts of Aboriginal and Torres Strait Islander Australians, adjusted for net undercount as measured by the Post Enumeration Survey. The extent of under coverage of Aboriginal and Torres Strait Islander Australians in the 2016 Census and the relatively small sample size of the Post Enumeration Survey to adjust for that under coverage means the estimates should be interpreted with a degree of caution.
- Census data on families were derived by the ABS rather than reported directly by respondents. Family and household structures were created by the ABS based on a family or household reference person.

Births, Australia, 2016

- The ABS Births Registrations collection provides statistics on live births registered in Australian in the calendar year.
- The collection records a birth as Aboriginal and/or Torres Strait Islander birth where at least 1 parent reported being an Aboriginal person, Torres Strait Islander, or both on the birth registration form.

National Perinatal Data Collection

- The AIHW National Perinatal Data Collection (NPDC) includes all births in Australian hospitals, birth centres and the community, and produces statistics on the pregnancy and childbirth of mothers, and the characteristics and outcomes of their babies.
- Data presented by Indigenous status are influenced by the quality and completeness of Indigenous identification of mothers, which is likely to differ among jurisdictions.

Note: See Appendix C for more information about all key data sources.

2.1 Population

5 in 100 young Australians are Indigenous

In 2016, there were an estimated 4 million young people aged 10–24 in Australia. An estimated 241,824 of these 4 million Australians were Aboriginal and/or Torres Strait Islander (123,935 males and 117,889 females). This constituted 5% of the total youth population in Australia.

Among young Indigenous people, 220,089 (91%) identified as Aboriginal only; 11,331 (5%) identified as Torres Strait Islander; and 10,404 (4%) identified as both Aboriginal and Torres Strait Islander.

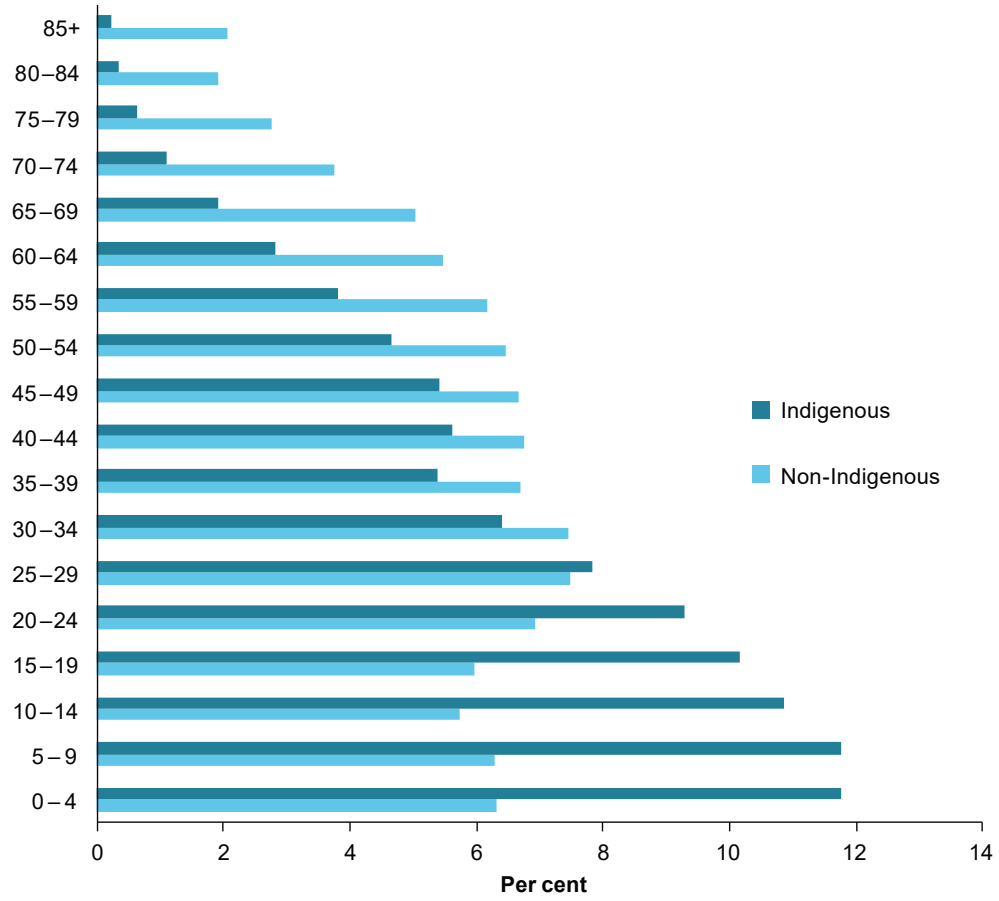
Table 2.1: Indigenous and non-Indigenous Australians, by sex and age group, 2016

	Male		Female		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
Indigenous						
10–14	44,344	11.1	42,301	10.6	86,645	10.9
15–19	41,426	10.4	39,691	9.9	81,117	10.2
20–24	38,165	9.6	35,897	9.0	74,062	9.3
10–24	*123,935*	*31.1*	*117,889*	*29.5*	*241,824*	*30.3*
25 or over	178,367	44.8	190,486	47.6	368,853	46.2
Total population	**398,413**	**100.0**	**399,952**	**100.0**	**798,365**	**100.0**
Non-Indigenous						
10–14	691,104	6.0	653,941	5.5	1,345,045	5.7
15–19	714,149	6.2	679,888	5.8	1,394,037	6.0
20–24	826,809	7.1	793,203	6.7	1,620,012	6.9
10–24	*2,232,062*	*19.2*	*2,127,032*	*18.0*	*4,359,094*	*18.6*
25 or over	7,856,563	67.7	8,223,666	79.8	16,080,229	68.7
Total population	**11,604,626**	**100.0**	**11,787,916**	**100.0**	**23,392,542**	**100.0**

Source: AIHW analysis of ABS 2018.

The Indigenous Australian population has a younger age structure than the non-Indigenous population. More than one-third of Indigenous Australians are younger than 15, whereas around one-fifth of the non-Indigenous population are under 15. Contributions to this include a higher birth rate (2.2 for Indigenous women and 1.8 for all women) for the Indigenous population than for the non-Indigenous population (AIHW, 2016a) (Figure 2.1.2)

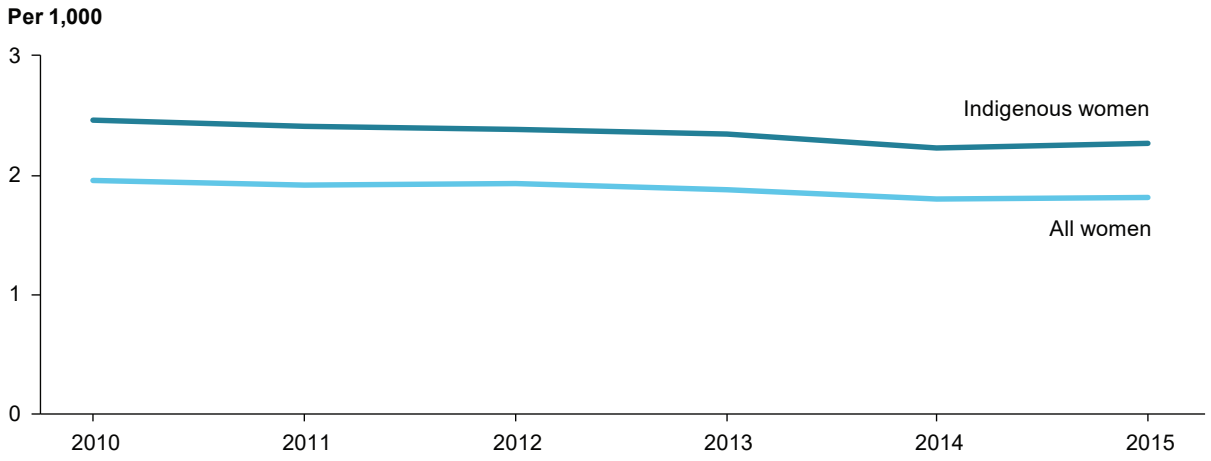
Figure 2.1.1: Age structure of the Australian population profile, by Indigenous status, Australia, 30 June 2016



Note: Proportions are calculated separately for Indigenous and non-Indigenous populations.

Source: AIHW analysis of ABS 2018.

Figure 2.1.2: Time trend of fertility rate by Indigenous status, Australia, 2010–2015



Source: ABS 2017a.

2.2 Geographic location

Indigenous youth live mainly in non-remote areas

In 2016, a majority of Indigenous people aged 10–24 lived in non-remote areas of Australia. Most lived in *Major cities* (39% or 94,135) followed by *Inner regional* areas (24% or 58,583), *Outer regional* areas (20% or 47,794), *Very remote* areas (11% or 14,530) and *Remote* areas (6% or 26,782) (Figure 2.2.1). However, a large proportion of all young Australians living in *Very remote* areas (67%) were Indigenous (Table 2.2.1).

Table 2.2.1: Indigenous people aged 10–24 by remoteness, 2016

	Number	% of the Indigenous youth population	Indigenous youth as a % of all youth
Major cities	94,135	38.9	2.8
Inner regional	58,583	24.2	7.4
Outer regional	47,794	19.8	13.1
Remote	14,530	6.0	28.6
Very remote	26,782	11.1	66.6
Total	**241,824**	**100.0**	**100.0**

Source: AIHW analysis of ABS 2018.

In 2016, most young Indigenous people lived in New South Wales (34% or 81,198) and Queensland (28% or 68,598). The proportion of young Indigenous people who lived in other states and territories was lower: Western Australia (12% or 29,686), the Northern Territory (9% or 21,063), Victoria (7% or 17,465), South Australia (5% or 12,930), Tasmania (4% or 8,501) and the Australian Capital Territory (1% or 2,317) (Figure 2.2.1). A large proportion of all young Australians aged 10–24 living in the Northern Territory were Indigenous (43%) (Table 2.2.2).

Box 2: ABS Remoteness structure definitions

This report uses ABS definitions to classify remoteness.

Major cities of Australia is defined as those areas where geographic distance imposes minimal restriction upon accessibility to the widest range of goods, services and opportunities for social interaction.

Inner regional Australia is defined as those areas where geographic distance imposes some restriction upon accessibility to the widest range of goods, services and opportunities for social interaction.

Outer regional Australia is defined as those areas where geographic distance imposes a moderate restriction upon accessibility to the widest range of goods, services and opportunities for social interaction.

Remote Australia is defined as those areas where geographic distance imposes a high restriction upon accessibility to the widest range of goods, services and opportunities for social interaction.

Very Remote Australia is defined as those areas where geographic distance imposes the highest restriction upon accessibility to the widest range of goods, services and opportunities for social interaction.

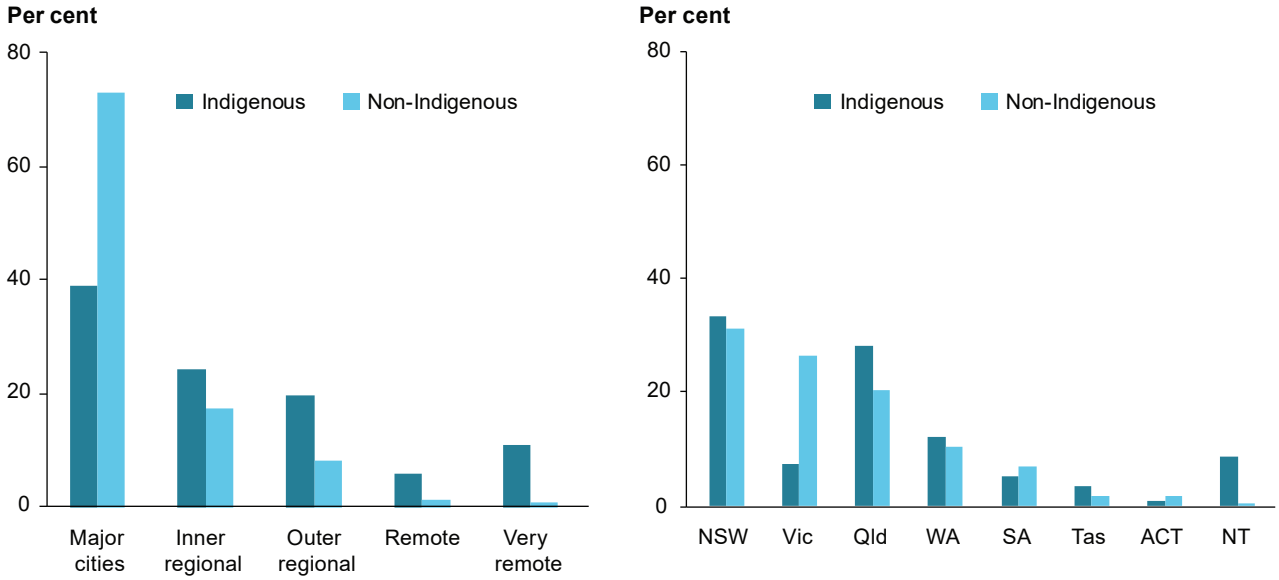
Table 2.2.2: Indigenous people aged 10–24 by state and territory, 2016

	Number	% of the Indigenous youth population	Indigenous youth as a % of all youth
New South Wales	81,198	33.6	5.6
Victoria	17,465	7.2	1.5
Queensland	68,598	28.4	7.2
Western Australia	29,686	12.3	6.2
South Australia	12,930	5.3	4.1
Tasmania	8,501	3.5	9.0
Australian Capital Territory	2,317	1.0	2.9
Northern Territory	21,063	8.7	42.6
Australia[(a)]	**241,824**	**100.0**	**5.3**

(a) Includes territories other than New South Wales, Victoria, Queensland, South Australia, Western Australia, Tasmania, the Northern Territory and the Australian Capital Territory.

Source: AIHW analysis of ABS 2018.

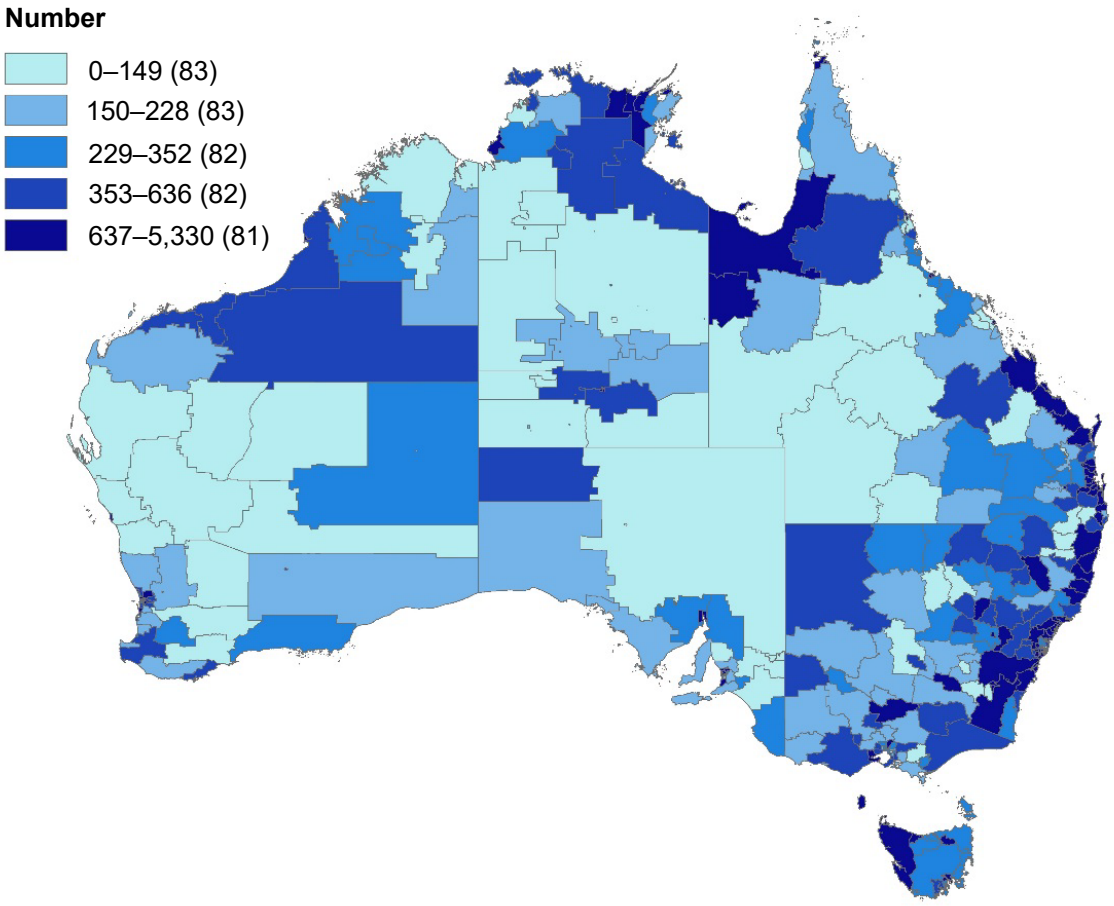
Figure 2.2.1: Proportion of young people aged 10–24 by Indigenous status, remoteness and state and territory, 2016



Source: AIHW analysis of ABS 2018.

The ABS produces geographic information on Indigenous areas (IAREs) within Australia. The first map below (Figure 2.2.2) shows that Indigenous areas with a higher number of Indigenous youth often encompass major population centres, with a large number being located in the eastern region of the country. However, when the proportion of young population that is Indigenous is mapped by Indigenous areas (Figure 2.2.3), the results reveal a different picture. Higher proportions of young people who are Indigenous are located in the northern and western regions of Australia, as well as some areas in New South Wales and Queensland (Figure 2.2.3).

Figure 2.2.2: Map of the number of people aged 10–24 who identify as Indigenous, by Indigenous Areas (IARE), 2016

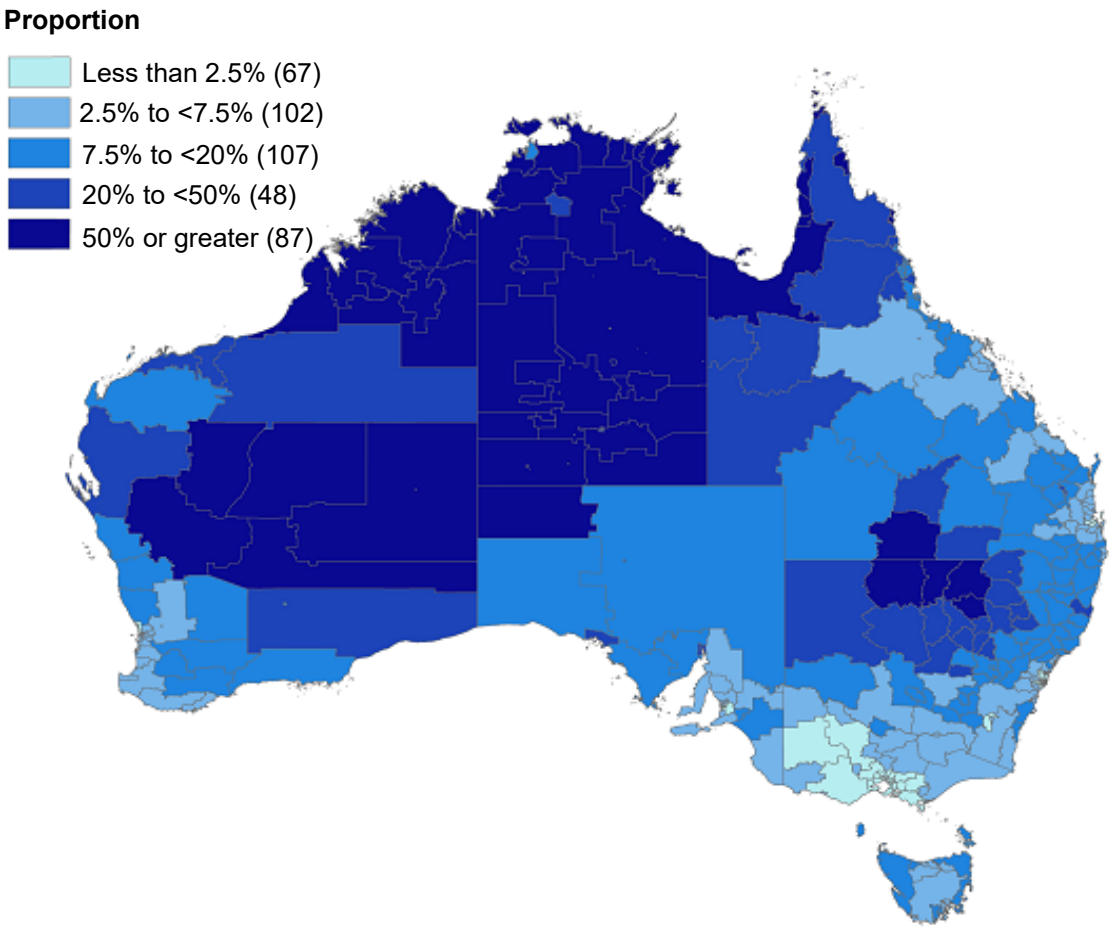


Notes

1. There are 430 total IAREs. This map excludes 'not stated' responses, 'no usual address' and 'migratory-offshore-shipping'.
2. Numbers in parentheses refer to the number of IAREs in each respective category.

Source: AIHW analysis of ABS 2018.

Figure 2.2.3: Map of the proportion of the population aged 10–24 who identify as Indigenous, by Indigenous Areas (IARE), 2016



Notes

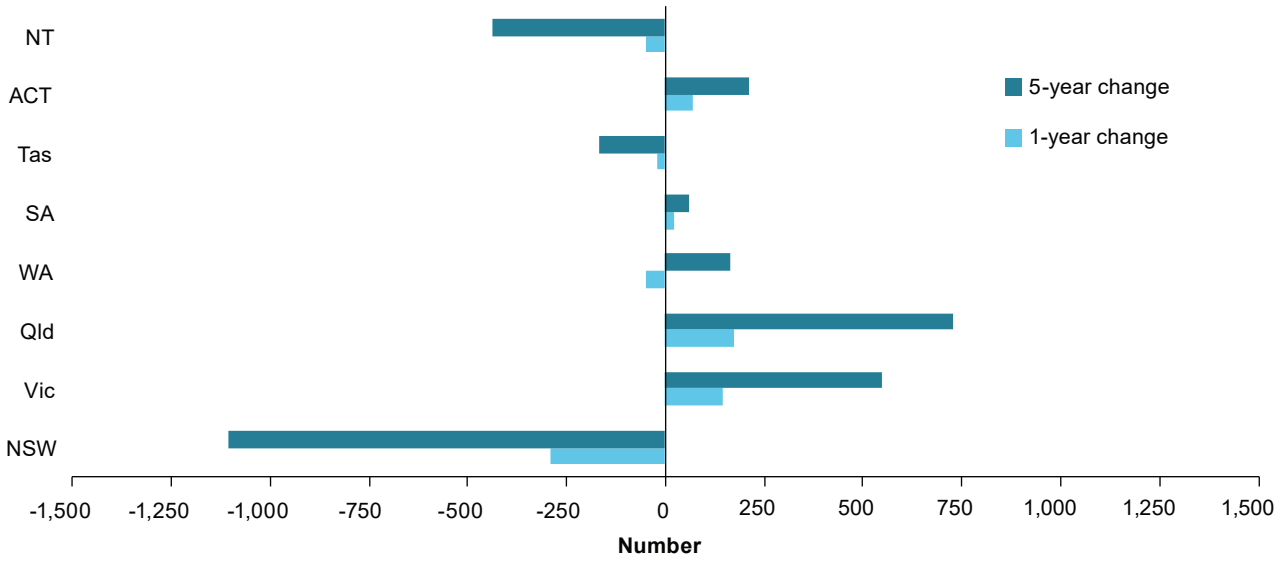
1. There are 430 total IAREs. This map excludes 'not stated' responses, 'no usual address' and 'migratory-offshore-shipping'.
2. Numbers in parentheses refer to the number of IAREs in each respective category.

Source: AIHW analysis of ABS 2018.

Net interstate migration figures show that, in 2016, New South Wales (-289), Western Australia (-49), Northern Territory (-49) and Tasmania (-21) had a negative net inflow of Indigenous people aged 10–24 from a year ago (1 August 2015). Net inflow for all other states and territories was positive, with Queensland (175) and Victoria (143) having the highest net inflow from a year ago (1 August 2015).

In the 5 years between 2011 and 2016, New South Wales (-1,103) had the largest negative net inflow of Indigenous people aged 10–24. The Northern Territory (-437) and Tasmania (-168) also registered negative net inflows. Queensland had the largest increase (727) over this period, followed by Victoria (550), the Australian Capital Territory (210), Western Australia (162) and South Australia (58). Western Australia was the only state or territory that recorded a positive 5-year net inflow but a negative 1-year net inflow, possibly reflecting changing economic conditions in the state (Figure 2.2.4).

Figure 2.2.4: Net inflow of Indigenous people aged 10–24, during the 1-year and 5-year periods to 2016, by state and territory



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

On Census night in 2016, 93% (182,277) of Indigenous people aged 10–24 were at home and 7% (12,814) were elsewhere in Australia. Almost 3 in 4 (73% or 142,979) Indigenous people aged 10–24 had the same usual residence as a year before in 2015 and around 1 in 2 (49% or 95,263) had the same usual residence as 5 years before, in 2011.

2.3 Families

Young Indigenous people most commonly live in couple families

Family and kin play an important role in the lives of young Indigenous people. It is a place where they receive care and support for the life transitions that occur during youth.

According to the 2016 Census, Indigenous people aged 10–24 most commonly lived in couple family households (41% or 87,900), followed by one-parent households (33% or 70,900) and multiple family households (9% or 18,800). Two in every 100 lived in lone person households (3,200) or group households (4,000).

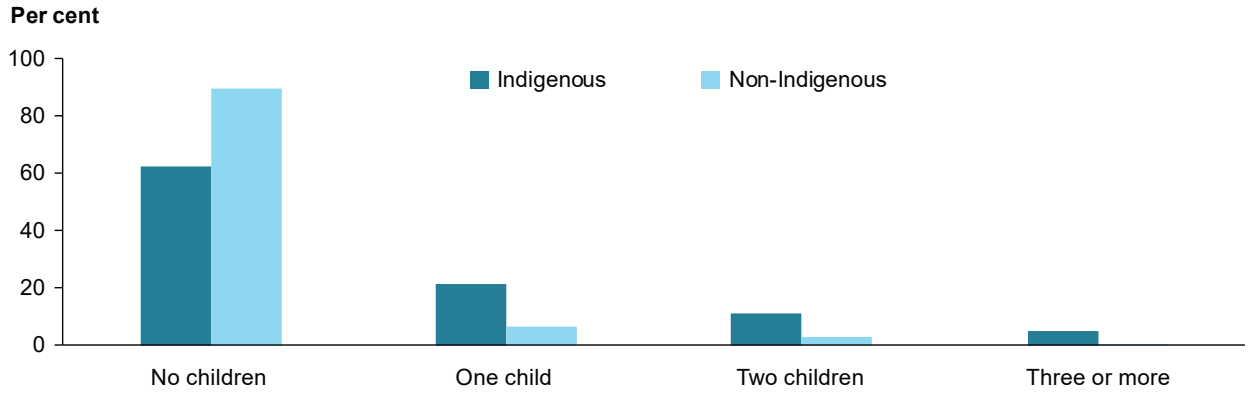
At the time of the 2016 Census, approximately 4,595 (6%) Indigenous people aged 18–24 were in a registered marriage and 10,699 (13%) reported being in a de facto marriage. A similar proportion of young Indigenous males and females were in a registered marriage (5% or 2,298 and 6% or 2,558, respectively). Young females were more likely than males to be in a de facto marriage (15% or 6,411 and 10% or 4,593, respectively).

Most young females have not given birth

Most young Indigenous females aged 20–24 had not given birth (62% or 16,163). Around 21% (5,534) had given birth to 1 child, 11% (2,962) had given birth to 2 children and 5% (1,265) to 3 or more children.

Young Indigenous females aged 20–24 were 3 times as likely to have given birth to one child, and more than 5 times as likely to have given birth to 3 or more children than young non-Indigenous females (7% or 45,459 and 1% or 4,892, respectively) (Figure 2.3.1).

Figure 2.3.1: Young females aged 20–24 by number of children and Indigenous status, 2016



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

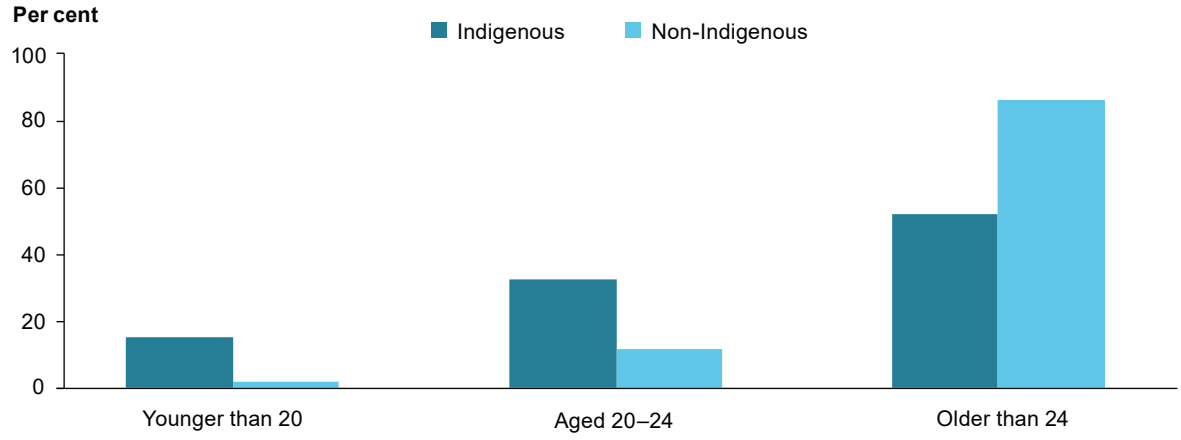
2.4 Births

One in 2 Indigenous women who gave birth are under 24

In 2015, the mean maternal age for Indigenous women was 25.6. This was substantially younger than the mean age for non-Indigenous women, of 30.5 (AIHW 2017b).

Data from 2015 shows that 48% (6,231) of Indigenous women who gave birth were aged 24 or under. This includes 15% (1,991) of all mothers who were aged under 20 and 33% (4,240) of those aged 20–24 (Figure 2.4.1). Of non-Indigenous women who gave birth, 14% (40,393) were under 24.

Figure 2.4.1: Women who gave birth, by maternal age and Indigenous status, 2015



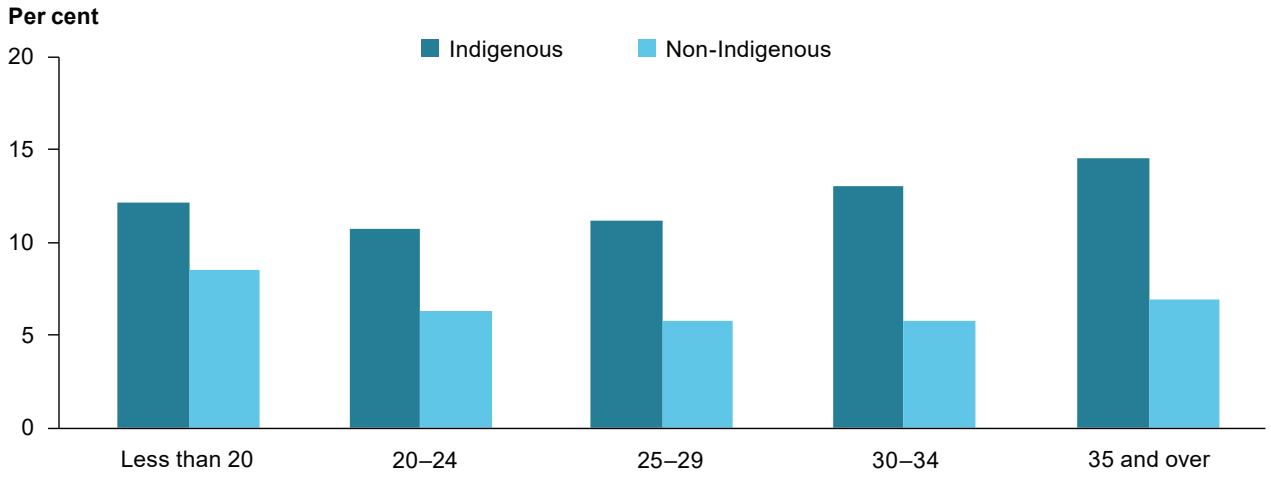
Note: Women with Indigenous status not stated are excluded.
Source: AIHW 2017a (supplementary tables).

Low birthweight babies more common for Indigenous mothers

Across age groups, a higher proportion of Indigenous mothers than non-Indigenous mothers had low birthweight live born babies (Figure 2.4.2). Low birthweight infants (newborns weighing less than 2,500 grams) are at a greater risk of mortality during their first year of life and are more prone to morbidity in childhood and chronic disease as adults. Low birthweight is associated with premature birth and restricted fetal growth (AHMAC 2017).

For mothers under 20, 12% (257) of Indigenous women and 9% (606) of non-Indigenous women had low birthweight live born babies. For women aged 20–24, the corresponding proportions were 11% (446) for Indigenous women and 6% (2,242) for non-Indigenous women.

Figure 2.4.2: Low birthweight live born babies, by Indigenous status of the mother and maternal age, 2014



Note: Birthweight is defined as less than 2,500 grams.

Source: AIHW 2017b.

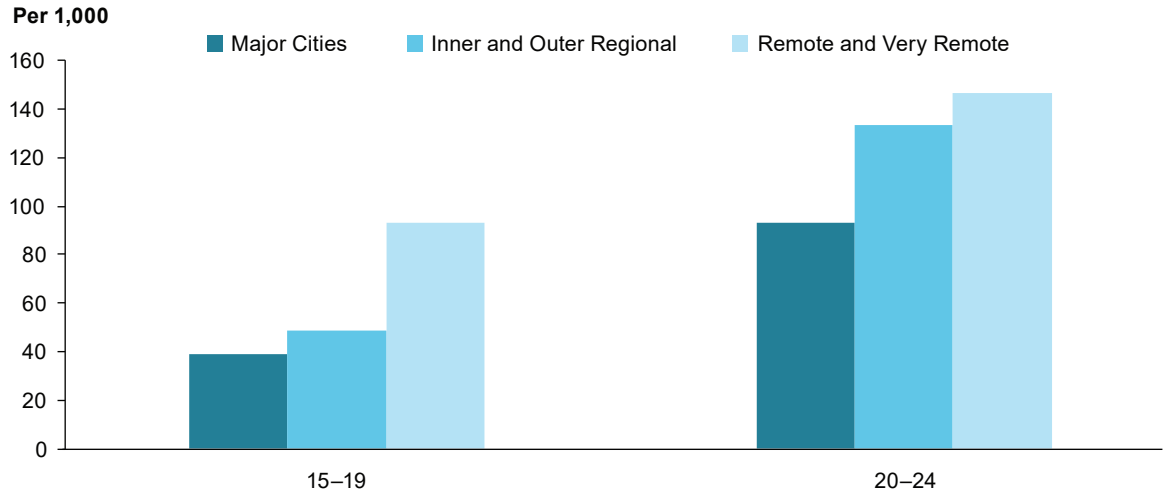
Young Indigenous females have higher fertility rates

The age-specific fertility rate for young Indigenous females is higher than that of young non-Indigenous females. The fertility rate was 55 per 1,000 for Indigenous females aged 15–19 and 124 per 1,000 for Indigenous females aged 20–24. In comparison, the fertility rate for non-Indigenous females was 9 per 1,000 for those aged 15–19 and 43 per 1,000 for non-Indigenous females aged 20–24.

Indigenous females in remote areas had higher fertility rates than those in non-remote areas. Among Indigenous females aged 19 and under living in *Remote* and *Very remote* areas the fertility rate was 93 per 1,000. In *Inner regional* and *Outer regional* areas the rate was 49 per 1,000 and in *Major cities*, the rate was 39 per 1,000.

Similarly, for Indigenous females aged 20–24, the rate was highest in *Remote* and *Very remote* areas (147 per 1,000), followed by *Inner regional* and *Outer regional* areas (133 per 1,000) and *Major cities* (93 per 1,000) (Figure 2.4.3).

Figure 2.4.3: Age-specific fertility rate for young Indigenous females, by age group and remoteness, 2016

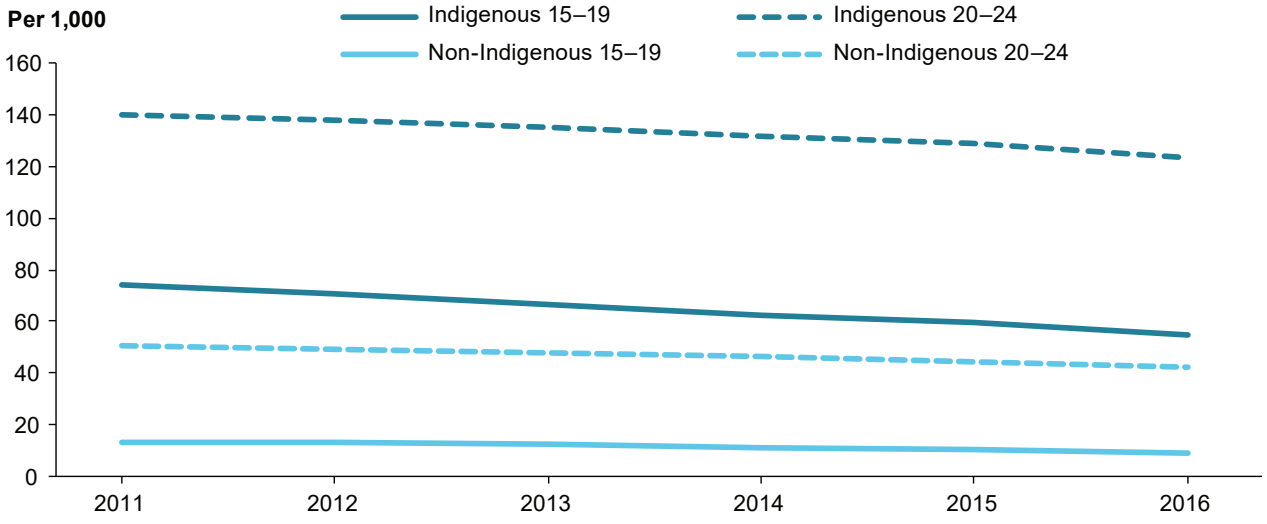


Note: Fertility rates of women aged 15–19 includes births to mothers aged under 15.

Source: ABS 2017a.

Figure 2.4.4 shows that the age-specific fertility rate for Indigenous females aged 19 and under and 20 to 24 declined between 2011 and 2016. For females aged 19 and under, the rate declined from 74 per 1,000 to 54.5 per 1,000. For females aged 20–24, the rate declined from 140 per 1,000 to 124 per 1,000. For both age groups, rates for non-Indigenous women were lower than for Indigenous women.

Figure 2.4.4: Age-specific fertility rate for young Indigenous females, by age group, 2011 to 2016



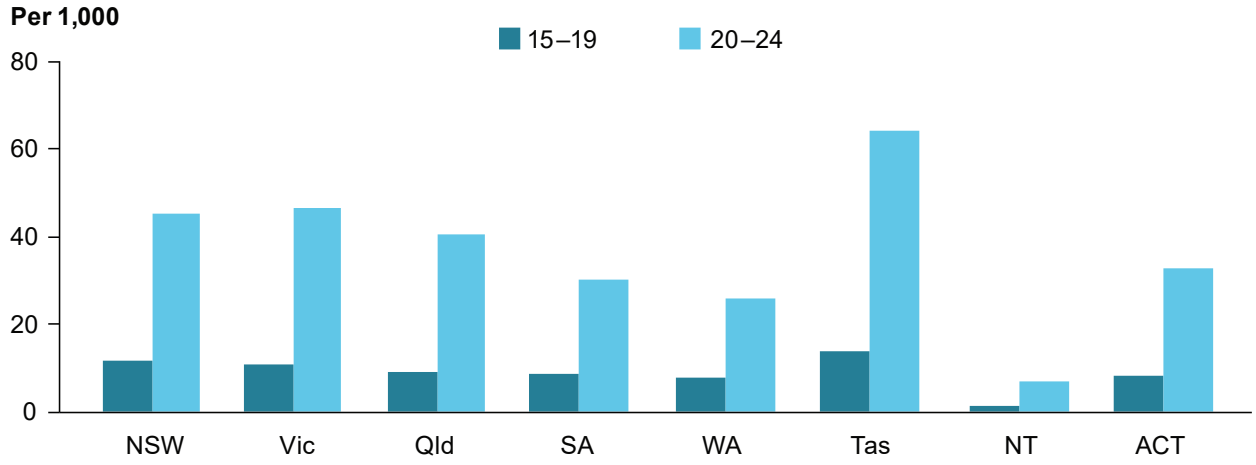
Note: Fertility rates of females aged 15–19 includes births to mothers aged under 15.

Source: ABS 2017a.

In 2011, the paternity rate for Indigenous males aged 15–19 was 9 per 1,000, while it was 36 per 1,000 for those aged 20–24.

Across states and territories, Tasmania had the highest paternity rate for both age groups 15–19 (14 per 1,000) and 20–24 (64 per 1,000), while the Northern Territory had the lowest with a rate of 1 per 1,000 for those aged 15–19 and 7 per 1,000 for those aged 20–24 (ABS 2014a) (Figure 2.4.5).

Figure 2.4.5: Paternity rate of young Indigenous males by age group and state and territory, 2011



Notes

1. Births to Aboriginal and Torres Strait Islander men, where the mother's Indigenous status was non-Indigenous or not stated, per 1,000 Aboriginal and Torres Strait Islander men.
2. 15–19 age group also includes births to fathers aged under 15 years, due to small numbers.

Source: ABS 2014a.



3

Social and economic determinants

This chapter provides data on the main social and economic determinants of health, including education, employment, income and housing. These factors play a key role in shaping the health and wellbeing of young Indigenous people, but young peoples' experiences of these determinants vary across jurisdictions and remoteness areas and with sex and age.

Box 3: Main data sources and key issues

National Aboriginal and Torres Strait Islander Social Survey (NATSISS)

- The ABS 2014–15 NATSISS included a sample of 11,178 Indigenous persons aged 15 years and over, with the responses weighted to provide population estimates.
- Data were collected through personal interviews with selected adults aged 15 and over, while an adult was asked to respond on behalf of a selected child aged under 15.
- The estimates are subject to sampling error and those with a relative standard error over 25% are noted.

Australian Curriculum, Assessment and Reporting Authority (ACARA)

- ACARA collects, analyses and reports statistical and related information about schools and the outcomes of schooling.
- The data reported includes the proportion of Indigenous students meeting national minimum standards. Corresponding student numbers are not included in this reporting.

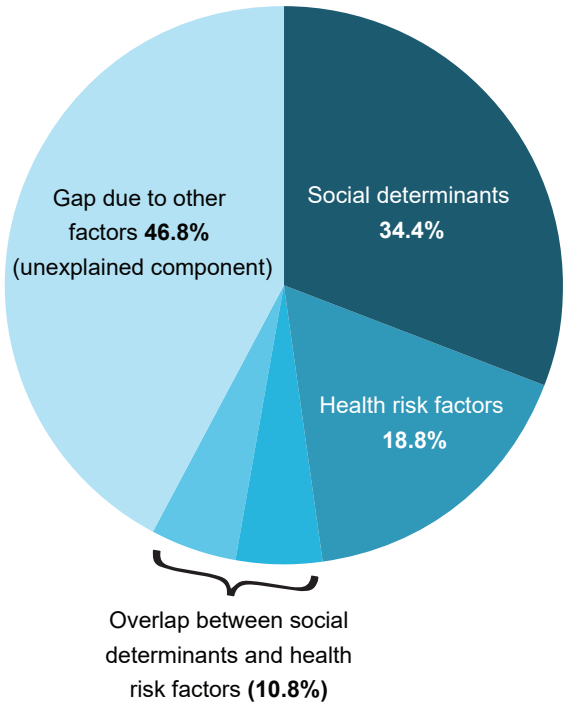
Note: For information on issues to consider for the Census of Population and Housing, see Box 2. See Appendix C for more information about all key data sources.

The importance of social and economic determinants of health outcomes has been demonstrated from AIHW statistical analysis of data from ABS health and social surveys. The aim of this work was to see which factors could explain the gap between Indigenous and non-Indigenous Australians who were in 'good health'.

The results showed that more than half of the health gap (53%) could be explained by 11 factors—5 socioeconomic factors (employment and hours worked, level of schooling, qualifications, housing adequacy and household income) and 6 health risk factors (smoking, binge drinking, fruit and vegetable consumption, body mass index and physical exercise).

An estimated 11% of the total health gap could be attributed to the overlap, or interactions, between the social determinants and health risk factors. This is because the 2 sets of factors influence each other—their combined total contribution to the gap is less than the sum of their separate contributions (Figure 3) (AIHW 2018).

Figure 3: Proportion of the health gap between Indigenous and non-Indigenous Australians explained by differences in social determinants and health risk factors, 2011–13



Source: AIHW 2018.

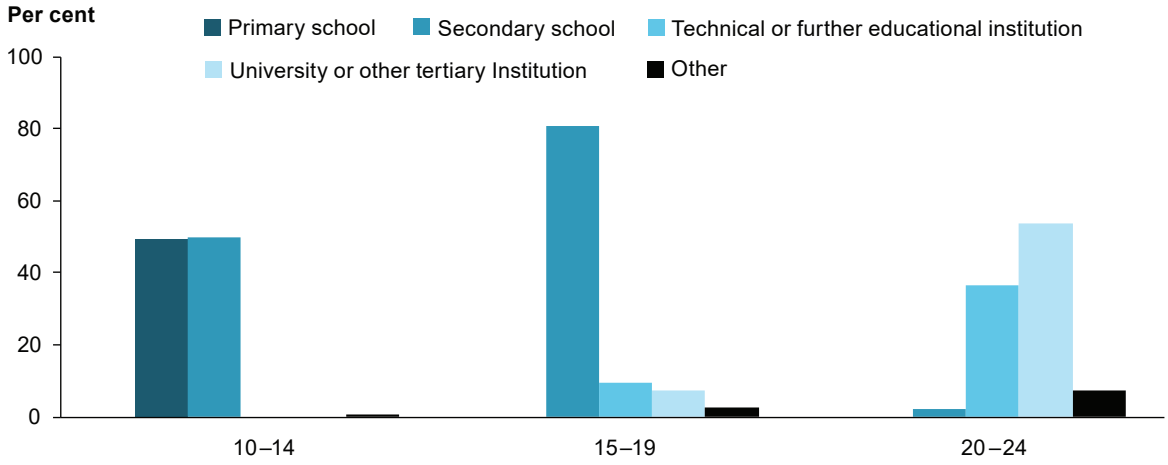
3.1 Education

Participation and engagement in education contributes to positive life experiences and life outcomes for young Indigenous people. Measures of school attendance, literacy and numeracy, and Year 12 attainment are included as Closing the Gap targets, reflecting an understanding from Australian governments that a good education provides a foundation for future life success (AIHW 2017c).

Full-time educational institution attendance decreased with age. In 2016, most Indigenous people aged 10–14 were full-time students (99% or 67,093), while 60% (38,134) of those aged 15–19 and 11% (5,810) of those aged 20–24 were full-time students. This decrease with age could be due to young people transitioning from schooling to employment.

Among young Indigenous people who were current students, around half of those aged 10–14 were attending primary school and around half were attending secondary school (50% or 32,677 and 50% or 32,837, respectively). For students aged 15–19, 81% (31,707) were attending a secondary school, 10% (3,750) were attending a technical or further educational institution, and 7% (2,806) were attending a university or other tertiary institution. Of students aged 20–24, more than half were attending a university or other tertiary institution (54% or 5,001) and 37% (3,400) were attending a technical or further educational institution (Figure 3.1.1).

Figure 3.1.1: Young Indigenous people, by institution attending and age group, 2016



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

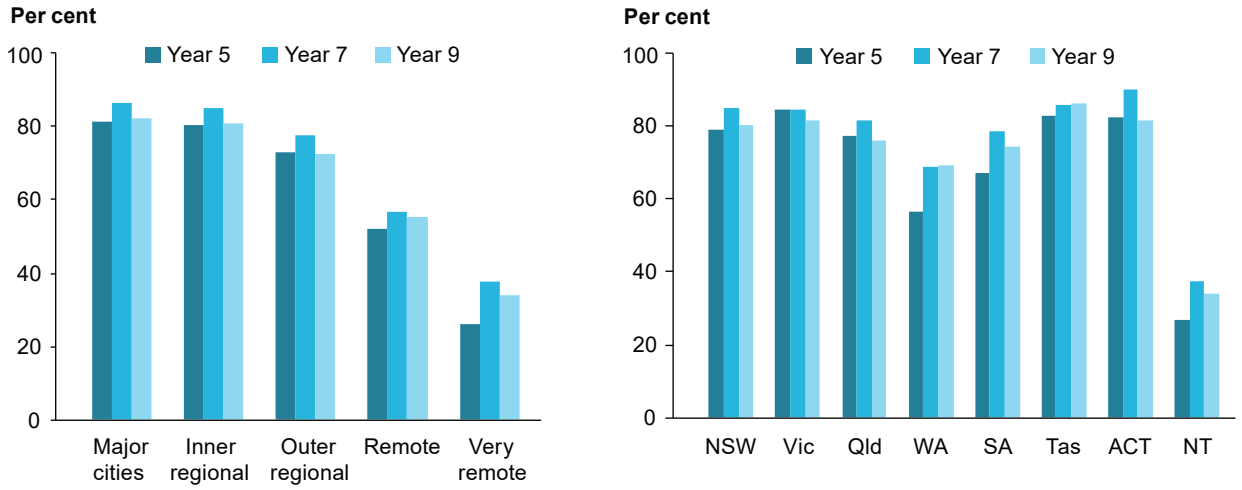
Low proportions in remote areas are meeting national minimum standards

Each year, students in Years 3, 5, 7 and 9 sit the National Assessment Program—Literacy and Numeracy (NAPLAN) tests. NAPLAN tests are the only nationally comparable Australian data source on student literacy and numeracy performance. Consistent with the focus of this report on Indigenous youth, only data for students in Years 5, 7 and 9 are presented in this section.

The proportion of Year 5, 7, and 9 students meeting national minimum standards in reading, writing, and numeracy was lowest in the Northern Territory, where less than half of students in those years met the national minimum standards in reading (27%, 37% and 34%, respectively). States and territories that had the highest proportions of Indigenous students meeting national minimum standards were Victoria (Year 5 reading and Year 7 writing), Tasmania (Year 9 reading, Years 5 and 9 writing and Years 5, 7, and 9 numeracy) and the Australian Capital Territory (Year 7 numeracy).

The proportion of students in Years 5, 7 and 9 meeting national minimum standards for reading, writing and numeracy was highest in *Major cities* and lowest in *Very remote* areas. National minimum standards for reading were met by 26% of Indigenous Year 5 students, 38% of Indigenous Year 7 students and 34% of Indigenous Year 9 students in *Very remote* areas (Figure 3.1.2).

Figure 3.1.2: Proportion of Indigenous students meeting national minimum standards in reading by year group, remoteness and state and territory, 2016

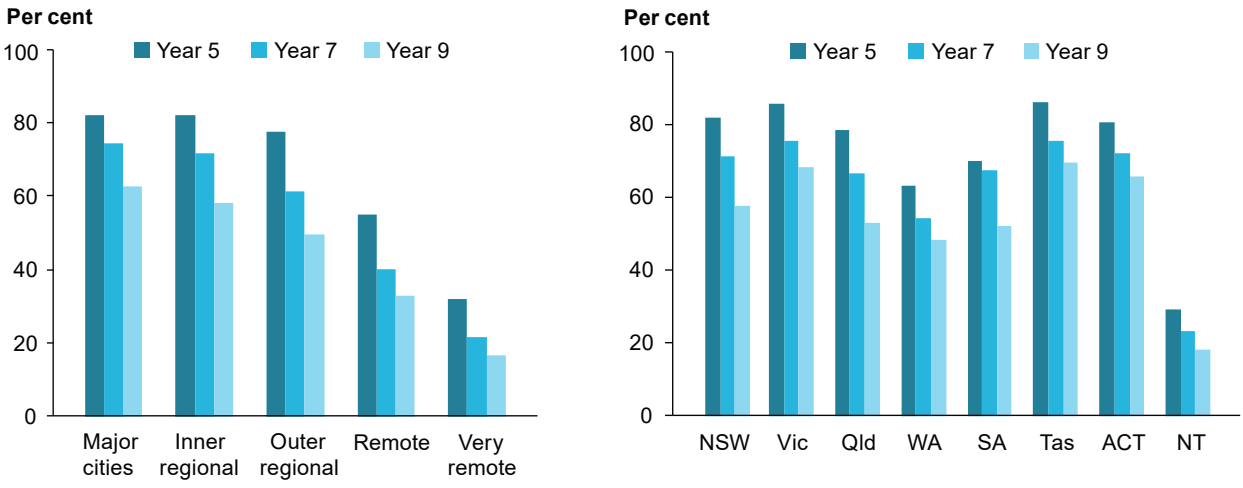


Source: ACARA 2016.

In *Very remote* areas, national minimum standards for writing were met by 32% of Indigenous Year 5 students, 22% of Indigenous Year 7 students and 17% of Indigenous Year 9 students (Figure 3.1.3).

Across states and territories, less than one-third of Indigenous Year 5, 7, and 9 students in the Northern Territory met national minimum standards for writing (29%, 23% and 18%, respectively) (Figure 3.1.3).

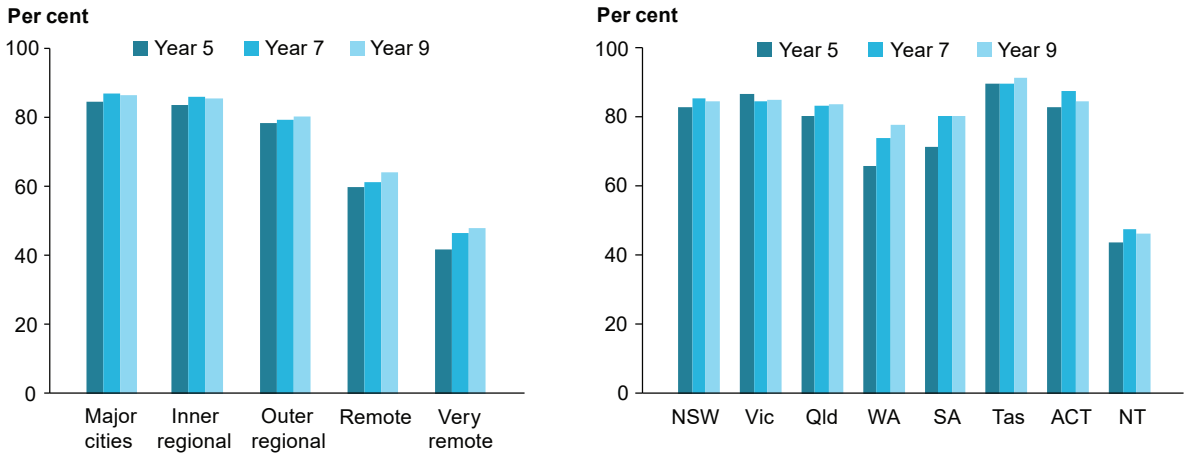
Figure 3.1.3: Proportion of Indigenous students meeting national minimum standards in writing by year group, remoteness and state and territory, 2016



Source: ACARA 2016.

Corresponding proportions for numeracy were somewhat higher. National minimum standards for numeracy were met by 42% of Indigenous Year 5 students, 46% of Indigenous Year 7 students, and 48% of Indigenous Year 9 students in *Very remote* areas (Figure 3.1.4). Similarly to reading, less than half of all Indigenous Year 5, 7, and 9 students in the Northern Territory met the national minimum standards in numeracy (44%, 47% and 46%, respectively) (Figure 3.1.4).

Figure 3.1.4: Proportion of Indigenous students meeting national minimum standards in numeracy, by year group, remoteness and state and territory, 2016



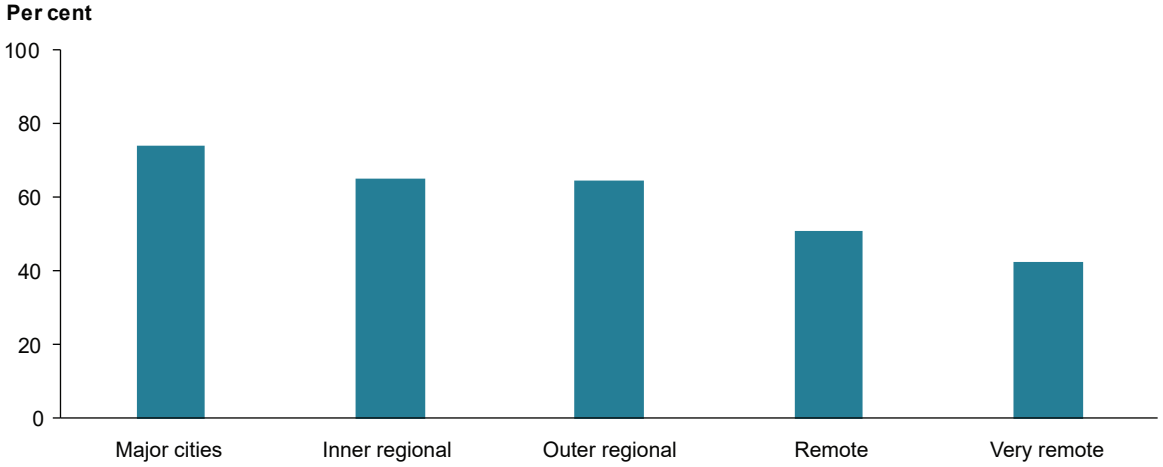
Source: ACARA 2016.

More than 3 in 5 have Year 12 or equivalent attainment

In 2016, 65% of Indigenous people aged 20–24 had Year 12 or equivalent attainment. Year 12 or equivalent attainment was slightly higher for females (67%) than males (64%).

Across remoteness, Year 12 or equivalent attainment was highest for young Indigenous people living in *Major cities* (74%), followed by those living in *Inner regional* (65%), *Outer regional* (65%), *Remote* (51%) and *Very remote* (43%) (Figure 3.1.5).

Figure 3.1.5: Proportion of Indigenous people aged 20–24 with year 12 or equivalent attainment by remoteness, 2016



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

The Australian Capital Territory had the highest proportion of young Indigenous people with Year 12 or equivalent attainment (78%), while the Northern Territory had the lowest proportion (39%) (Figure 3.1.6).

Figure 3.1.6: Proportion of Indigenous people aged 20–24 with Year 12 or equivalent attainment by state and territory, 2016



Source: SCRGSP 2017.

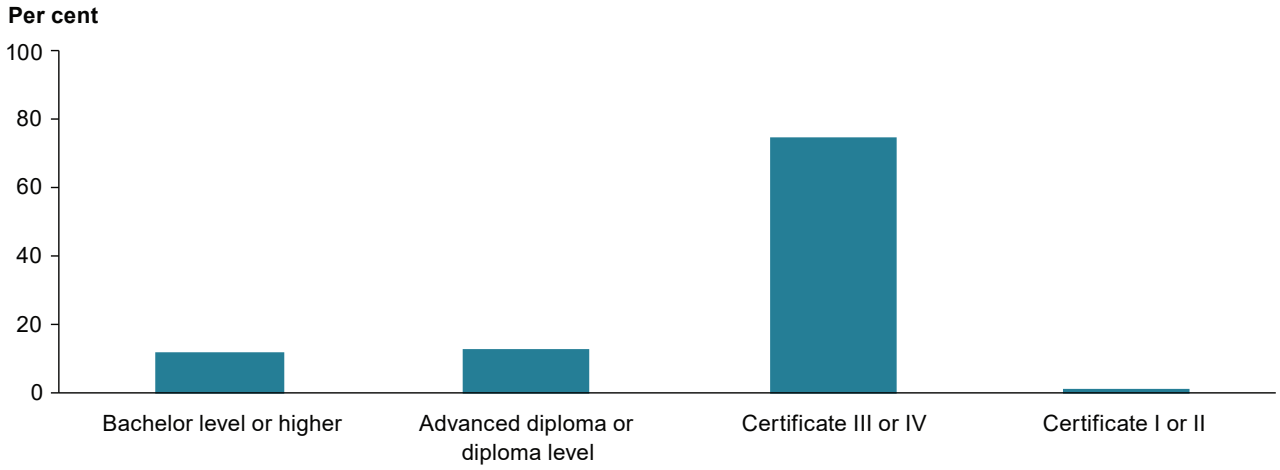
Year 12 or equivalent attainment increased from 47% in 2006 to 65% in 2016, representing an increase of 17.9 percentage points (PM&C, 2018).

Around 3 in 10 have highest qualification at post-schooling level

Post-school qualifications include all educational attainments beyond primary or secondary education. In 2016, 30% (14,854) of Indigenous people aged 20–24 attained a post-school qualification, while around 61% (29,958) had attained secondary education to years 10 and above, and 8% (4,074) had attained secondary education to years 9 and below. Females were more likely to attain post-schooling level (32% or 7,813) than males (29% or 7,039).

Among the Indigenous people aged 20–24 with a post-schooling qualification, most held a Certificate III or IV (74% or 11,058), followed by advanced diploma or diploma (13% or 1,899), bachelor degree or higher (12% or 1,742) and 1% (155) held a Certificate I or II (Figure 3.1.7).

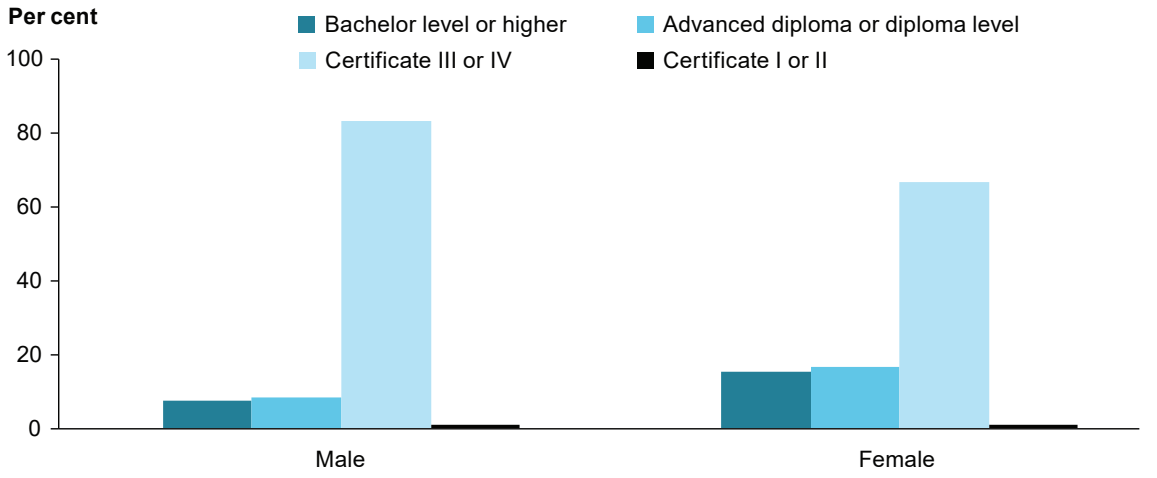
Figure 3.1.7: Indigenous people aged 20–24 with a post-school qualification, by highest level of education attainment, 2016



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

The highest level of post-schooling education attainment varied by sex, with Indigenous females aged 20–24 (16% or 1,208), more likely to have a bachelor degree or higher than males (8% or 536). Females (17% or 1,309) were also more likely to have attained advanced diploma or diploma level than males (8% or 586). However, males were more likely to have highest attainment at Certificate III or IV (83% or 5,844) than females (68% or 5,295) (Figure 3.1.8).

Figure 3.1.8: Indigenous people aged 20–24 with a post-school qualification, by highest level of education attainment and sex, 2016



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

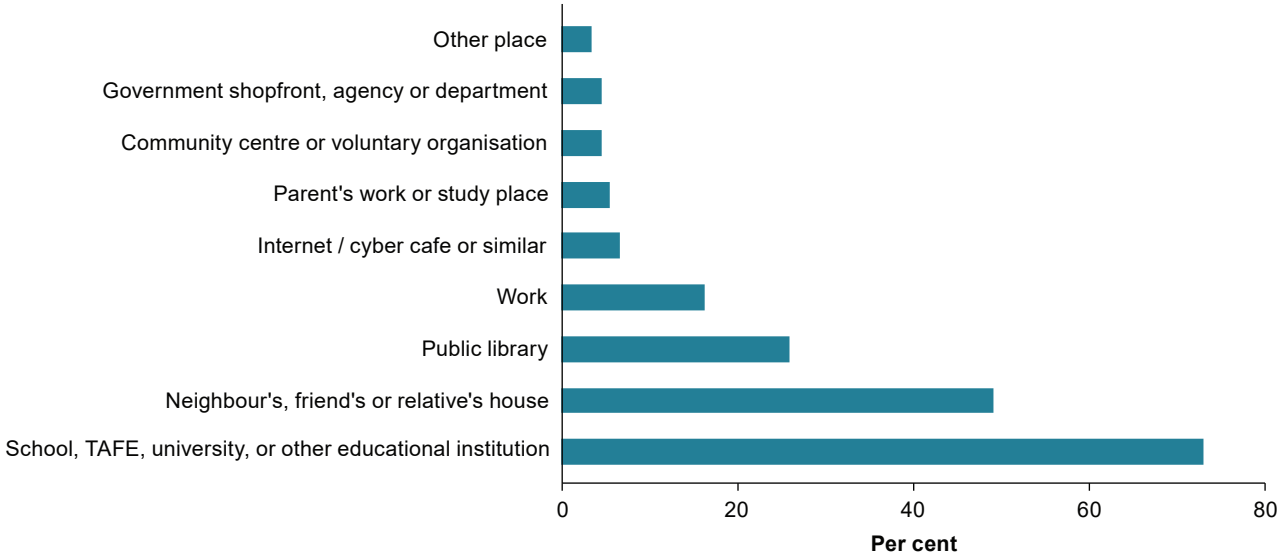
A higher proportion of Indigenous people aged 20–24 living in non-remote areas (34% or 13,624) held a post-school qualification than those in remote areas (15% or 1,745). In non-remote areas, those with post-school qualification were more likely to have a bachelor degree or higher (12% or 1,685) than those in remote areas (4% or 46). Young Indigenous people living in remote areas (87% or 1,017) were more likely to have a Certificate III and IV level qualifications than those living in non-remote areas (73% or 10,006).

Young people accessing the internet at educational institutions

In an increasingly digital world where reliance on information technology continues to grow, access to the internet has become integral to learning and to social interaction and connection. In 2014–15, 92% (195,800) of Indigenous people aged 10–24 indicated that they had accessed the internet at home in the previous 12 months. The proportion of young Indigenous people accessing the internet at home was similar across age groups.

Of the young Indigenous people who accessed the internet in the previous 12 months using supplied equipment (86% or 167,600), the majority (73% or 122,200) accessed the internet at a school, TAFE, university or other educational institution. Other places where the internet was commonly accessed using supplied equipment included a neighbour's, friends or relative's house (49% or 82,400) and a public library (26% or 43,300) (Figure 3.1.9).

Figure 3.1.9: Indigenous people aged 10–24 who accessed the internet using supplied equipment, by access location, 2014–15



Note: Multiple responses item; sum of components may exceed total.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

3.2 Employment

Secure and satisfactory employment can provide young people with financial independence and contribute towards feelings of autonomy, self-confidence and a connection with the community. Employment also allows for professional development in the individual's chosen field, paving the way for future career growth.

Around one-third employed

Data from the 2016 Census shows that around half of Indigenous Australians aged 15 to 24 were in the labour force (51% or 60,645). Around 37% (44,159) of young Indigenous people in this age group were employed and of these 47% (20,714) worked on a part-time basis and 45% (19,852) worked full-time. Males and females were employed at a similar rate (37% or 22,680 and 37% or 21,482, respectively). However a higher proportion of males (15% or 9,272) than females (12% or 7,210) were unemployed (Figure 3.2.1).

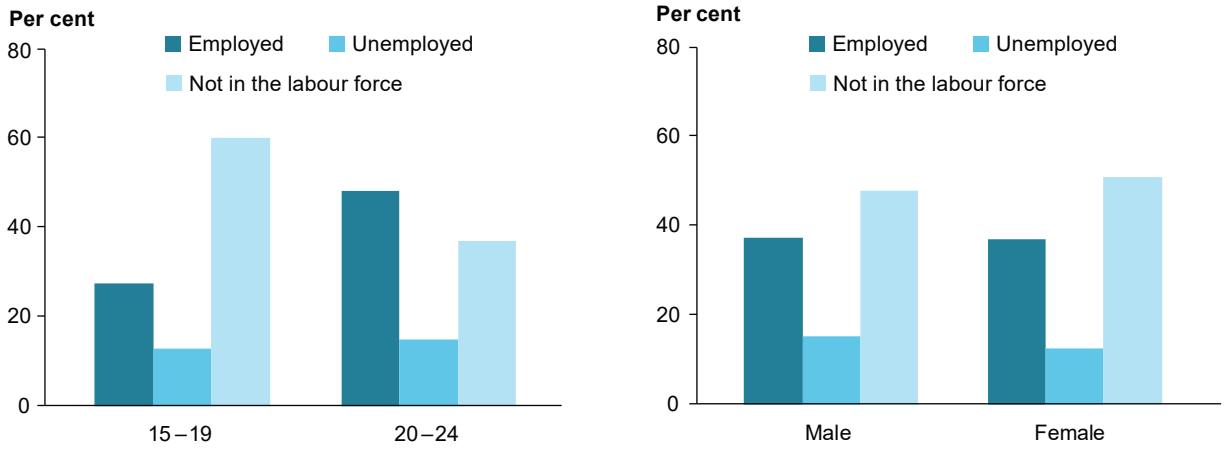
Box 3.2: Labour force and employment data

Respondents to ABS surveys that collect data on labour force status are categorised as either:

- In the labour force includes:
  - the employed ie. those who have worked for at least 1 hour in the reference week
  - the unemployed ie. those who have not worked but who are available to start work and have actively sought work within the previous month.
- Not in the labour force includes those who are neither employed nor unemployed
- Those who are not in education, employment or training are referred to as NEET. The definition of NEET only includes those who have left secondary school.

The proportion of young Indigenous people who were employed increased with age. Figure 3.2.1 shows that 27% (17,473) of Indigenous people aged 15 to 19 were employed and just under half (48% or 26,693) aged 20 to 24 were employed.

Figure 3.2.1: Young Indigenous people, by labour force status, age group and sex, 2016



Note: Employed includes 'employed full-time', 'employed part time', 'employed away from work'.

Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

A higher proportion of young Indigenous people in non-remote areas (54% or 53,598) were in the labour force compared with those in remote areas (35% or 6,839). Additionally a higher proportion of young Indigenous people in non-remote areas were employed (40% or 39,828) compared with those in remote areas (22% or 4,228) (Figure 3.2.2).

Across states and territories, the proportion of young Indigenous people employed was highest in the Australian Capital Territory (55% or 741), followed by Tasmania (43% or 1,831), Victoria (42% or 3,756), New South Wales (41% or 16,730), South Australia (33% or 2,082), Western Australia (29% or 3,868), and the Northern Territory (21% or 2,056) (Figure 3.2.2).

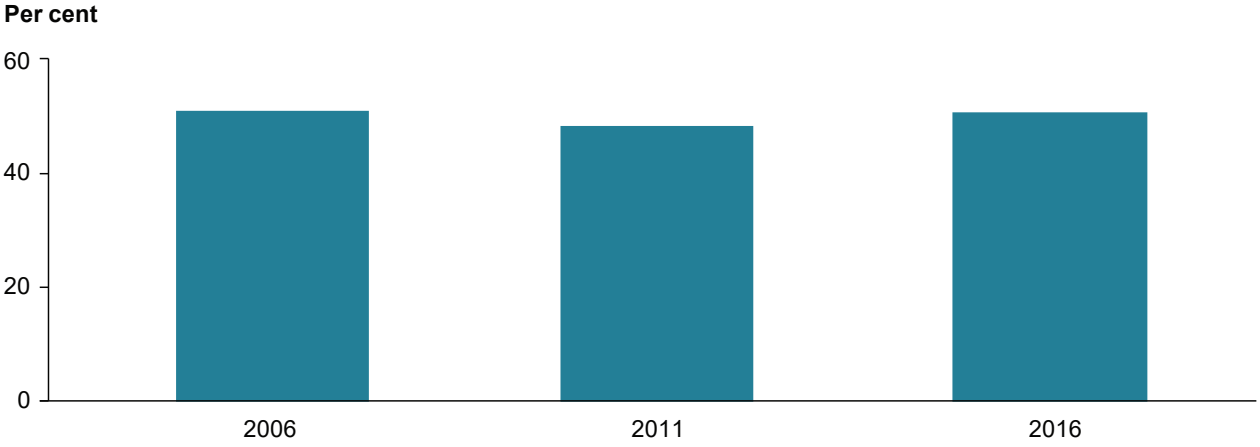
Figure 3.2.2: Indigenous people aged 15–24, by labour force status, remoteness and state and territory, 2016



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

The proportion of Indigenous people aged 15–24 participating in the labour force remained steady from 51% (41,175) in 2006 to 51% (60,645) in 2016. However, proportions of young people employed decreased slightly from 39% (31,967) in 2006 to 37% (44,159) in 2016 (Figure 3.2.3).

Figure 3.2.3: Proportion of Indigenous people aged 15–24 in the labour force, 2006, 2011 and 2016



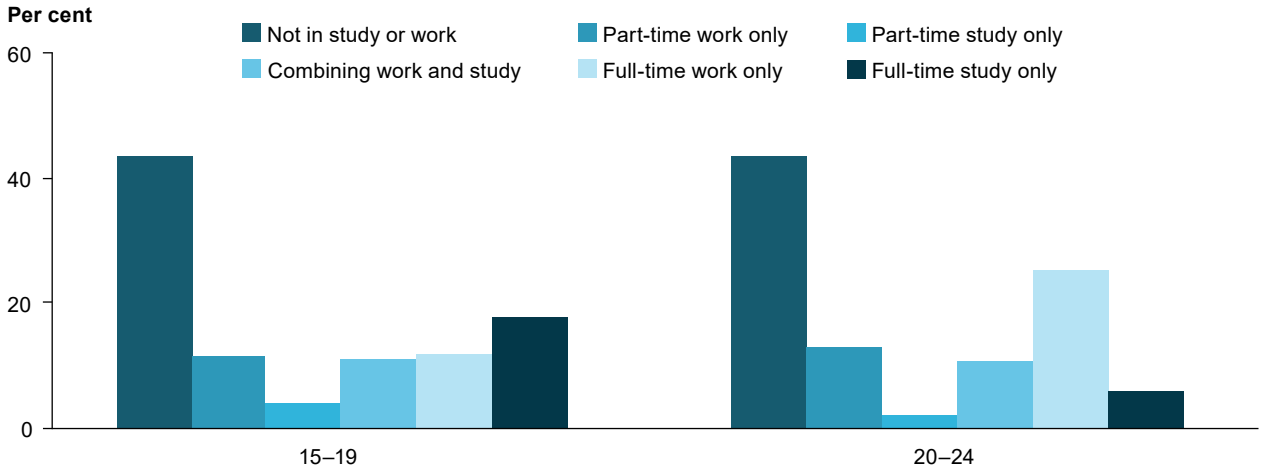
Source: AIHW analysis of ABS 2006, 2011 and 2016 Censuses (using TableBuilder).

Around 2 in 5 fully engaged in employment, education or training

Another measure of young people's engagement is the proportion of those who have left secondary school, and are not in further education, employment or training (NEET). In 2016, around 40% (33,795) of Indigenous people aged 15–24 were fully engaged in full-time work, study or combining work and study, while 18% (15,140) were partially engaged in part-time work or study. Around 42% (35,490) of young Indigenous people were NEET.

Similar proportion of young people aged 15–19 (40% or 12,570) and 20–24 (40% or 21,083) were fully engaged in education, employment or training. While 42% (13,473) of those aged 15–19 and 20–24 (22,018) were NEET (Figure 3.2.1).

Figure 3.2.4: Young Indigenous people, by NEET status and age group, 2016



Note: Excludes those away from work but not studying, as well as those where either education or work status could not be determined.

Source: PM&C 2018.

More males aged 15–24 were fully engaged in education, employment or training (43% or 18,033), than females (38% or 15,761). Conversely, slightly more females (43% or 18,153) were in NEET than males (41% or 17,336) (PM&C 2018).

Those living in non-remote areas were twice as likely to be fully engaged in education, employment or training (44% or 30,564) than those in remote areas (21% or 3,139). Those in remote areas (67% or 10,016) were more likely to be NEET than those in non-remote areas (37% or 25,259).

Across state and territory, the Australian Capital Territory (21% or 954) had the lowest proportion of young Indigenous people to be NEET, followed by Victoria (31%), Tasmania (32%), New South Wales (36%), South Australia (41%), Queensland (43%), Western Australia (51%) and Northern Territory (68% or 4,968).

More young females in health care and social assistance industry

Data from the 2016 Census shows that around 2,922 (5%) Indigenous people aged 20–24 were employed in the health care and social assistance industry. Young Indigenous females (8% or 2,366) were more likely to be in the health care and social assistance industry than males (2% or 559). One factor contributing to this low proportion is the length of training required before employment in many health occupations.

Of the 5% of all young Indigenous people employed in the health care and social assistance industry, 2 in 5 worked in social assistance (42% or 1,212), followed by medical and other health services (23% or 678), hospitals (17% or 501) and residential care services (16% or 457) (Table 3.2).

Table 3.2: Indigenous people aged 20–24 employed in the health care and social assistance industry, by sex, 2016

	Male		Female		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
Hospitals	95	17.0	407	17.2	501	17.2
Medical and other health care services	124	22.2	551	23.3	678	23.2
Residential care services	85	15.2	378	16.0	457	15.6
Social assistance services	233	41.7	976	41.3	1,212	41.5
Total[(a)]	**559**	**100.0**	**2,366**	**100.0**	**2,922**	**100.0**

(a) Totals includes health care and social assistance not further defined.

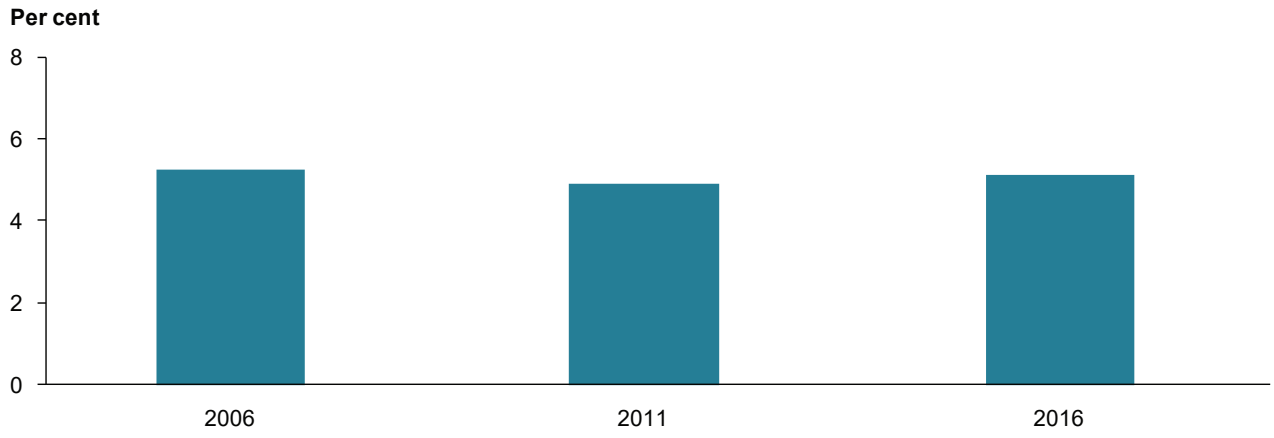
Note: Adjustment of estimates by the ABS, for the purpose of maintaining confidentiality, may result in the sum of components not equalling the total.

Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

In 2016, a higher proportion of Indigenous people aged 20–24 in non-remote areas (6% or 2,592) were employed in the health care and social assistance industry than those living in remote areas (3% or 327).

From 2006 to 2016, the proportion of Indigenous people aged 20–24 in the health care and social assistance industry remained steady with 5% (1,975) in 2006 and 5% (2,992) in 2016 (Figure 3.2.5).

Figure 3.2.5: Indigenous people aged 20–24 in the health care and social assistance industry, 2006, 2011 and 2016



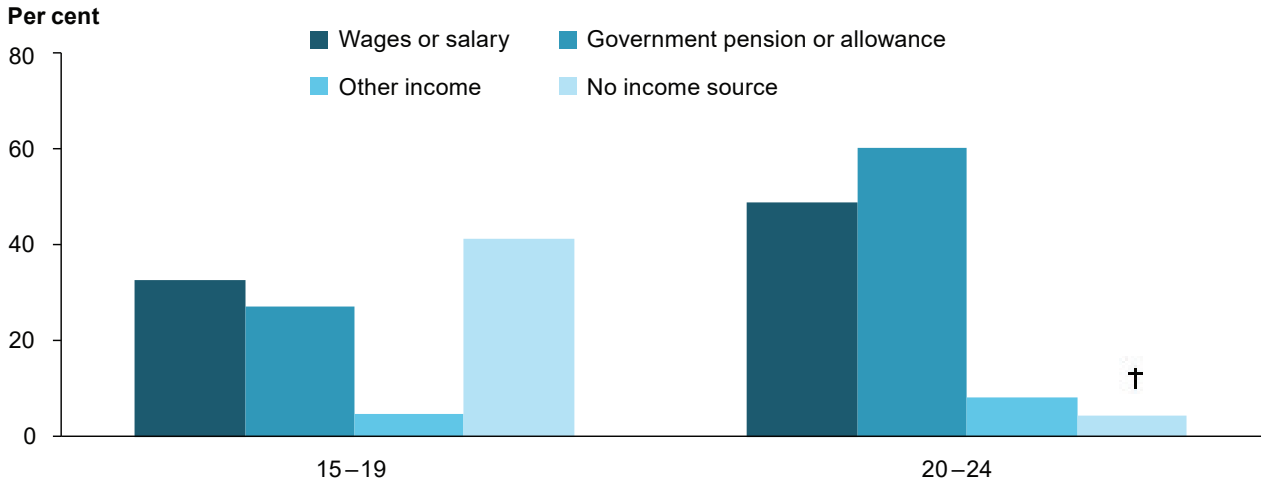
Source: AIHW analysis of ABS 2006, 2011 and 2016 Censuses (using TableBuilder).

3.3 Income

Young people, particularly those attending school, do not have their own source of income and are financially dependent on their families. In 2014–15, just over 4 in 10 (41% or 30,000) Indigenous people aged 15–19 and 4% (2,700) of those aged 20–24 received no personal income.

Those who have an income can obtain this from a variety of sources, including from wages and salaries, government allowances, and other sources, such as businesses. Among Indigenous people aged 15–19, nearly one-third (33% or 23,800) had income from wages or salary and 27% (19,900) from a government payment. For those aged 20–24 almost half (49% or 31,700) had income from wages or salary and 60% (39,000) from a government payment (Figure 3.3.1).

Figure 3.3.1: Indigenous people aged 15–24 by all sources of income and age group, 2014–15



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

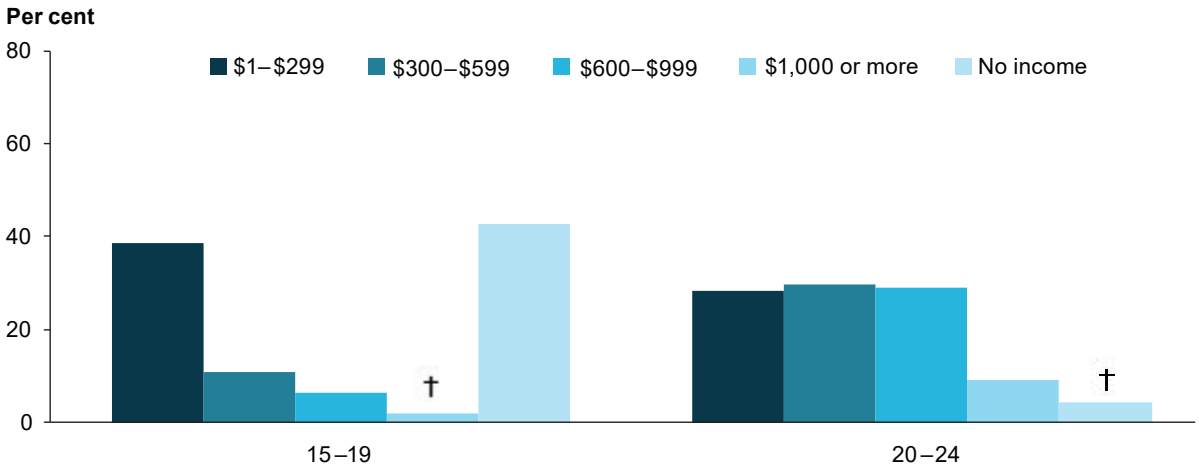
Note: Multiple responses item; sum of components may exceed total.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Older age group more likely to have higher personal weekly income

In 2014–15, most Indigenous people aged 15–19 had no income (43% or 30,000); this may reflect that many of those aged 15–19 are still at school and financially dependent on their parents. Among those aged 20–24, the most common income bracket was $300–$599 (30% or 18,400) (Figure 3.3.2).

Figure 3.3.2: Indigenous people aged 15–24 by weekly income and age group, 2016



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Most young people do not receive government support

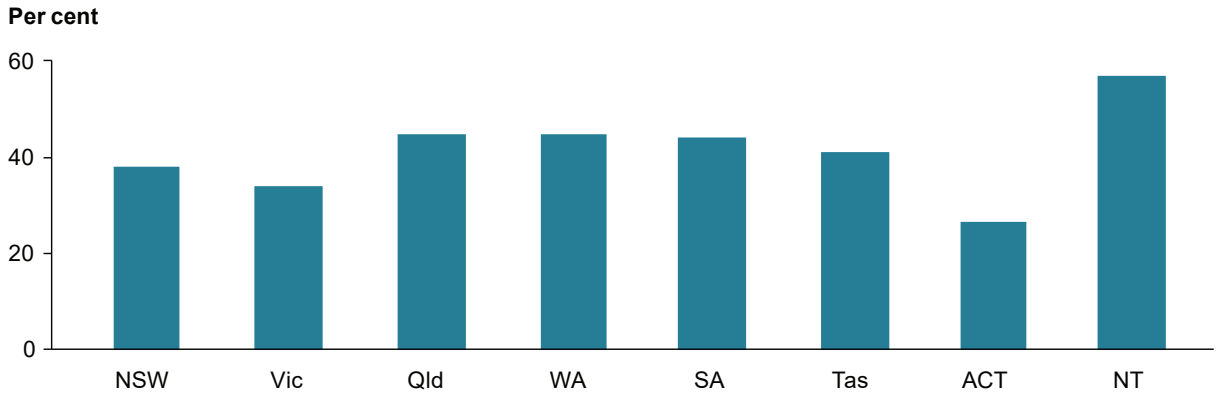
In 2014–15, more than half of all Indigenous people aged 15–24 (57% or 78,500) did not receive government income support while 43% (58,600) received at least 1 form of government support payment.

The proportion of young Indigenous people who received support increased with age, from 27% (19,900) of those aged 15–19 to 60% (39,000) of those aged 20–24. Young Indigenous females (51% or 35,100) were more likely to receive direct government support than males (34% or 23,400).

More than 6 in 10 Indigenous people aged 15–24 in non-remote areas did not receive government income support (61% or 67,800), while 39% (43,200) received government support. In remote areas, 4 in 10 (42% or 11,200) did not receive government support, while 58% (15,400) did.

Across states and territories, young Indigenous people living in New South Wales were least likely to have government support (76% or 33,300) while those in the Northern Territory were most likely (57% or 7,500) to do so (Figure 3.3.3).

Figure 3.3.3: Proportion of Indigenous people aged 15–24 on income support by state and territory, 2014–15

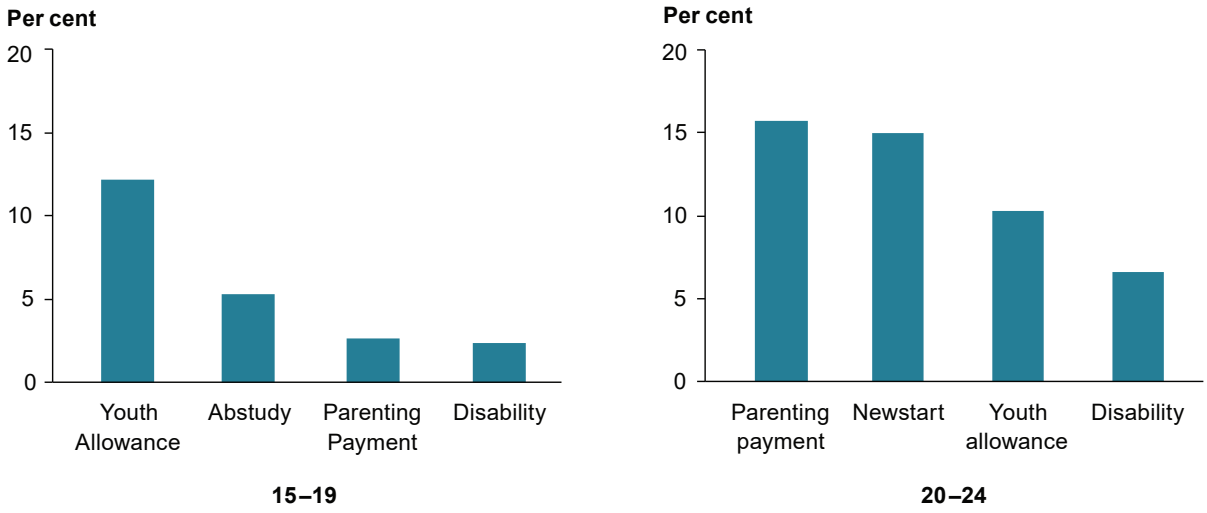


Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

In 2014–15, of the Indigenous people aged 15–19 who received government income, 36% (7,200) were studying full-time or part-time while 64% (12,700) were not studying. For those aged 20–24, who received government income, 25% (9,600) were studying full-time or part-time while 74% (28,900) were not currently studying.

For Indigenous people aged 15–19, the most common type of government income support provided directly was youth allowance (12% or 8,900). The most common type of government income support for those aged 20–24 was the parenting payment (16% or 10,200) (Figure 3.3.4).

Figure 3.3.4: Proportion of Indigenous people aged 15–19 (left) and 20–24 (right) receiving different income support payments by age group, 2014–15

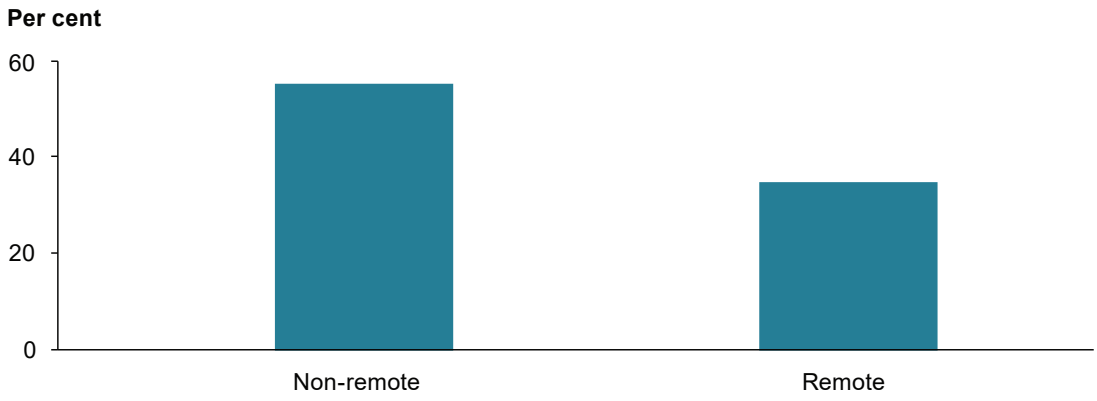


Note: People can receive more than one payment. Newstart Allowance is paid to eligible people from age 21 onwards.
Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Those in non-remote areas more able to raise money in an emergency

Just under half (52% or 67,200) of Indigenous people aged 15–24 lived in households that could raise $2,000 within a week in an emergency. A higher proportion of those living in non-remote areas (55% or 58,000) lived in such households than those living in remote areas (35% or 8,500) (Figure 3.3.5).

Figure 3.3.5: Proportion of Indigenous people aged 15–24 living in households that could raise $2,000 in an emergency, by remoteness, 2014–15

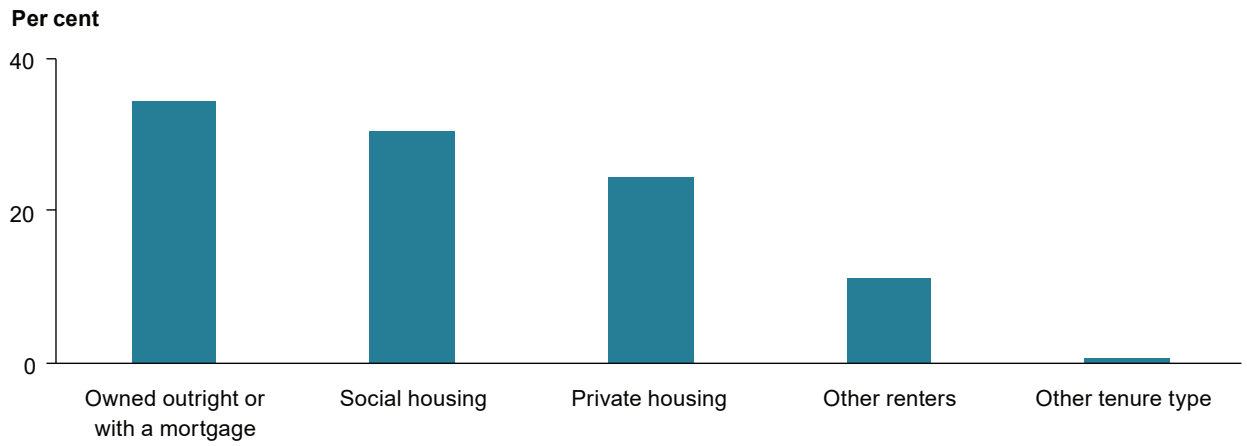


Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

3.4 Housing

Stable housing provides individuals and families with security, shelter, privacy, and safety—factors that are essential for good health and wellbeing. In 2016, around 34% (57,387) of Indigenous people aged 10–24 lived in a dwelling that was owner-occupied (owned either outright or with a mortgage). Another 30% (50,778) lived in social housing (that is, a dwelling rented through a state or territory housing authority or community housing), and around 24% (41,109) lived in a privately rented dwelling (Figure 3.4.1).

Figure 3.4.1: Indigenous people aged 10–24 by household tenure type, 2016



Note: Other renters include person not in same household, other landlord type and landlord type not stated.

Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

Those aged 10–14 (35% or 22,973) and 15–19 (37% or 21,021) were more likely to live in a dwelling that was owner-occupied than those aged 20–24 (29% or 13,392). A higher proportion of those aged 20–24 (30% or 14,157) lived in privately rented dwellings than those aged 10–14 (22% or 14,519) and 15–19 (22% or 12,430). This may reflect changes in young people's accommodation options when moving out of home.

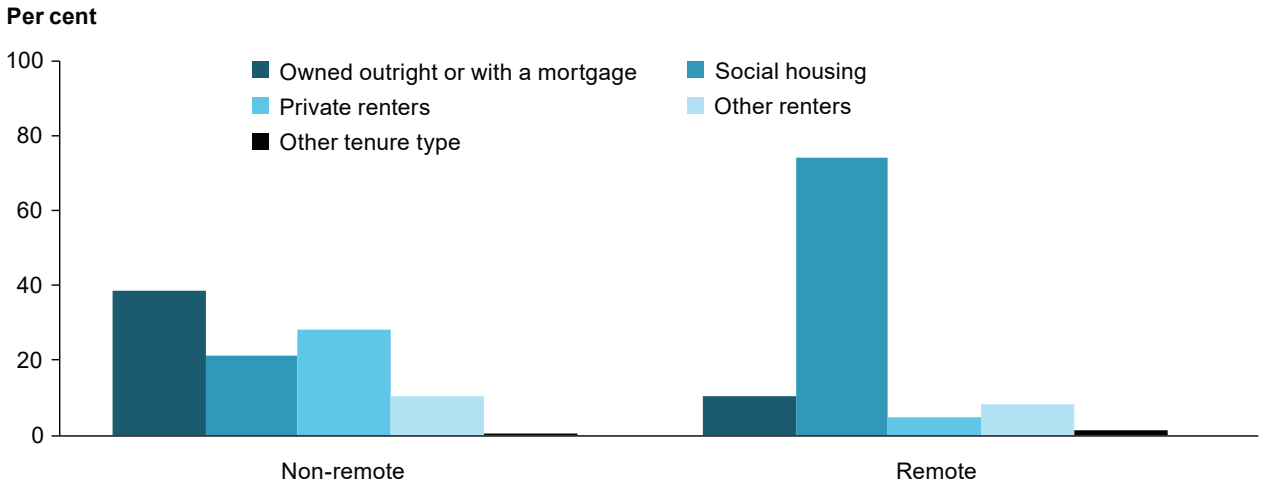
The proportions of young Indigenous people who lived in social housing were similar across age groups—31% (20,224) of those aged 10–14, 30% (17,090) of those aged 15–19, and 29% (13,459) of those aged 20–24.

Those in remote areas and NT more likely to live in social housing

The tenure types of young Indigenous people tended to vary by remoteness. Over 7 in 10 (74% or 20,868) Indigenous people aged 10–24 in remote areas lived in social housing (public or community housing), compared with 2 in 10 (21% or 29,918) of those in non-remote areas (Figure 3.4.2).

Young Indigenous people in non-remote areas were more likely to live in a dwelling that was owned outright or with a mortgage (39% or 54,480) than those in remote areas (10% or 2,909). Young people in non-remote areas were also more likely to live in privately rented dwellings (28% or 39,787) than those in remote areas (5% or 1,321) (Figure 3.4.2).

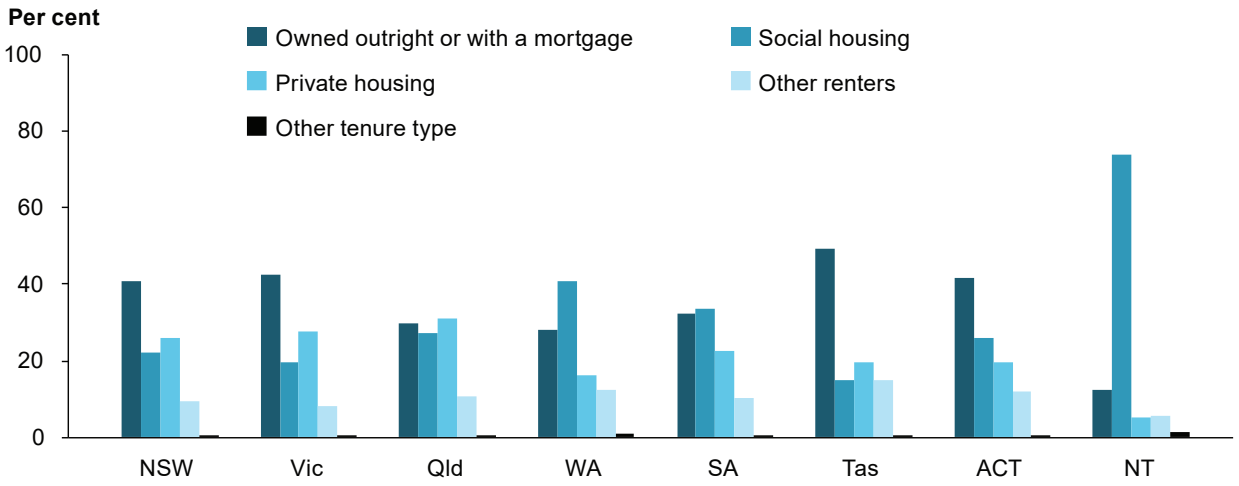
Figure 3.4.2: Indigenous people aged 10–24 by household tenure type and remoteness, 2016



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

The Northern Territory had the highest proportion of young people living in social housing (74% or 10,171) while Tasmania had the lowest proportion (15% or 932). Tasmania (49% or 3,096) had the highest proportion of young Indigenous people living in dwellings owned outright or with a mortgage and the Northern Territory had the lowest proportion (13% or 1,730) (Figure 3.4.3).

Figure 3.4.3: Indigenous people aged 10–24 by household tenure type and state and territory, 2016



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

Overcrowding an issue

The ABS uses the Canadian National Occupancy Standard for Housing Appropriateness to classify degrees of overcrowding. This standard takes into account both household size and composition (Box 3.4). Households that require 1 or more extra bedrooms to meet this housing standard are considered overcrowded and households requiring 4 or more extra bedrooms are considered severely overcrowded.

Box 3.4: Definitions of overcrowding and homelessness

Overcrowding

The Canadian National Occupancy Standard assesses the bedroom requirements of a household based on the following criteria:

- There should be no more than 2 persons per bedroom.
- Children less than 5 years of age of different sexes may reasonably share a bedroom.
- Children 5 years of age or older of opposite sex should have separate bedrooms.
- Children less than 18 years of age and of the same sex may reasonably share a bedroom.
- Single household members 18 years or older should have a separate bedroom, as should parents or couples.

Homelessness

The ABS considers someone homeless if they do not have suitable accommodation alternatives and their current living arrangement:

- is in a dwelling that is inadequate (unfit for human habitation or lacks basic facilities such as kitchen and bathroom facilities)
- has no tenure, or their initial tenure is short and not extendable
- does not allow them to have control of, and access to, space for social relations (including personal—or household—living space, ability to maintain privacy and exclusive access to kitchen and bathroom facilities) (ABS 2012)
- this definition of 'homelessness' includes people who are living in 'severely' overcrowded dwellings. That is, a dwelling that needs 4 or more extra bedrooms to accommodate the people who usually live there.

Census, 2016 estimating homelessness was used in this section. Aboriginal and Torres Strait Islander peoples have been underenumerated in the Census and therefore, estimates of homelessness based on Census data will be an underestimation.

In 2016, one-quarter (25% or 40,762) of Indigenous people aged 10–24 lived in dwellings that were overcrowded (needed 1 or more extra bedrooms). This proportion was similar across youth age groups, with 24% (14,854) of those aged 10–14, 26% (14,134) of those aged 15–19 and 26% (11,772) of those aged 20–24 living in dwellings that were overcrowded.

Similar proportions of young Indigenous males (25% or 20,640) and females (23% or 20,123) aged 10–24 lived in dwellings that were overcrowded.

Severe overcrowding more common in NT and remote areas

Almost 1 in 20 (4% or 5,612) Indigenous people aged 10–24 lived in a household that was severely overcrowded. Young Indigenous people in remote areas were more likely to live in severely overcrowded dwellings (17% or 4,769) than those in non-remote areas (1% or 843).

Across states and territories, the Northern Territory had the highest proportion of young Indigenous people living in severely overcrowded dwellings (26% or 3,544) while no young people in the Australian Capital Territory lived in severely overcrowded dwellings (Figure 3.4.4).

Figure 3.4.4: Proportion of Indigenous people aged 10–24 living in severely overcrowded dwellings, by state and territory, 2016



Note: Severely overcrowded dwellings require 4 or more bedrooms to meet the Canadian Occupancy Standard.

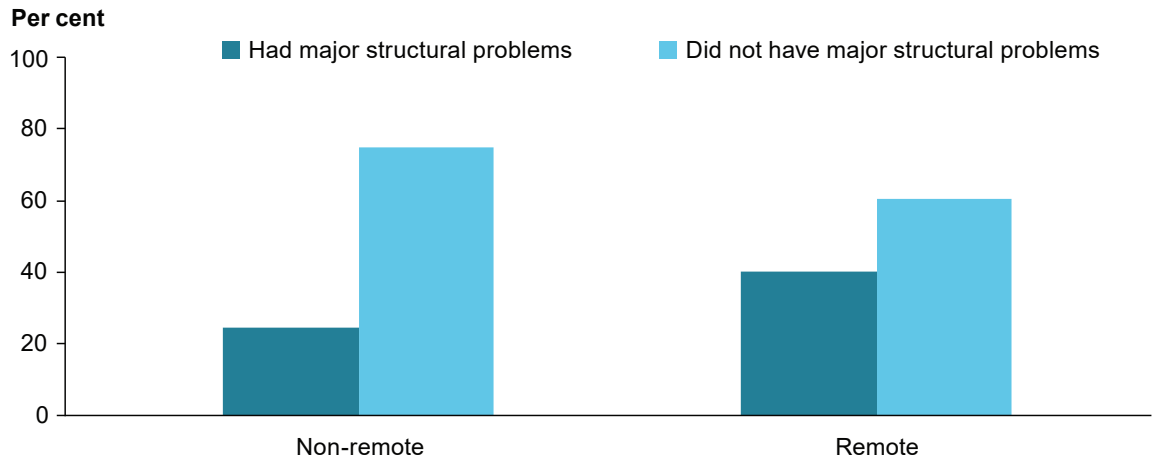
Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

7 in 10 have no major structural problems with their housing

Around 28% or 37,700 of Indigenous people aged 15–24 lived in a dwelling with major structural problems. The most common types of structural problems were major cracks in the walls or floors (40% or 15,200), walls and windows that were not straight (24% or 8,900), wood rot or termite damage (23% or 8,800), major plumbing problems (22% or 8,100) or a major roof defect (20% or 7,500).

Young Indigenous people in non-remote areas were more likely to live in dwellings with no major structural problems (75% or 82,600) than those living in remote areas (60% or 15,800) (Figure 3.4.5).

Figure 3.4.5: Indigenous people aged 15–24 by whether lived in dwelling with structural problems, by remoteness, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Most young Indigenous people lived in dwellings with functional facilities (86% or 117,700). The other 14% (or 19,000) lived in dwellings with facilities that were unavailable or did not work. Among those aged 15–24 who lived in such dwellings, the most commonly reported non-functional facilities were cooking facilities (44% or 8,300), washing machines (39% or 7,400), fridges (26% or 5,000), laundry tubs (25% or 4,700) and baths or showers (20% or 3,700).

A higher proportion of young Indigenous people in non-remote areas (89% or 98,400) lived in dwellings with functional facilities than those living in remote areas (74% or 19,400). Across states and territories, Queensland (92% or 35,300) had the highest proportion of young Indigenous people living in dwellings with functional facilities while the Northern Territory had the lowest proportion (68% or 8,800) (Figure 3.4.6).

Figure 3.4.6: Proportion of Indigenous people aged 15–24 living in dwellings with functional facilities, by state and territory, 2014–15



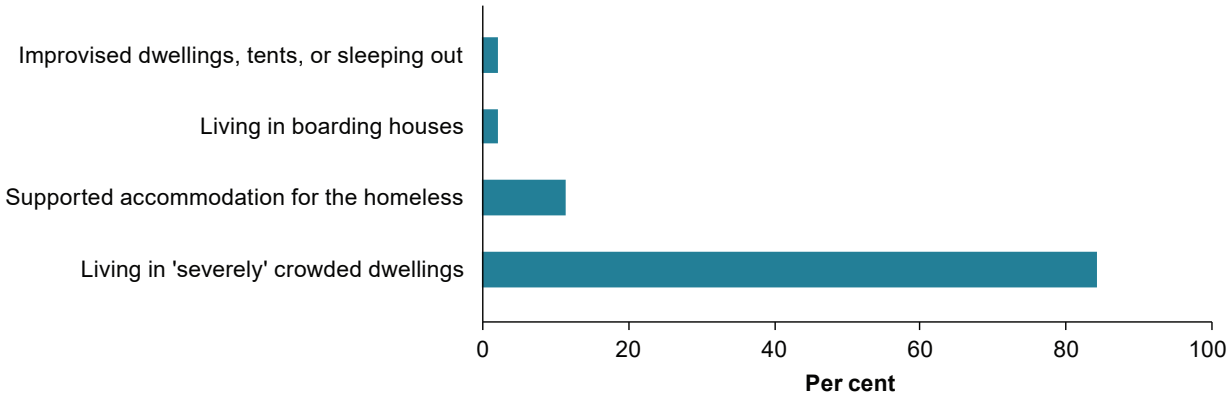
Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Homelessness

In 2016 an estimated 6,680 young Indigenous people were classified as homeless, representing a rate of 4 per 100 of all young Indigenous people compared to 0.4 per 100 young non-Indigenous people (17,092). Of all the homeless young people aged 10–24, 32% were Indigenous.

Among those classified as homeless, more than 4 in 5 (84% or 5,624) were living in severely overcrowded dwellings. Other types of living situations for homeless young people included supported accommodation (12% or 769), boarding houses (2% or 145) and improvised dwellings, tents or sleeping out (2% or 141) (Figure 3.4.7).

Figure 3.4.7: Indigenous people aged 10–24 who were homeless by type of living situation, 2016

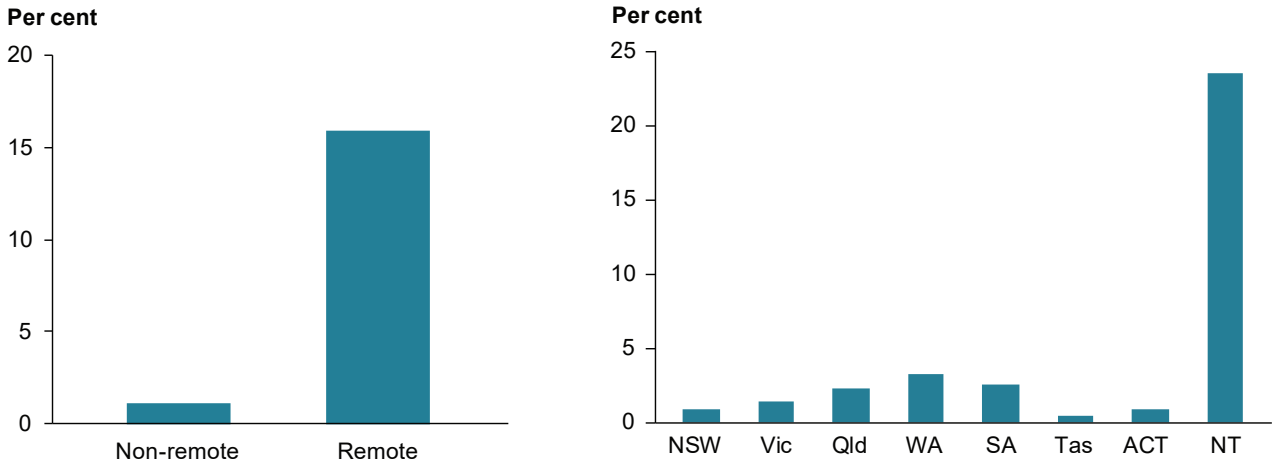


Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

Across age groups, 3% (2,188) of all Indigenous people aged 10–14 were homeless, 4% (2,282) of those aged 15–19 and 4% (2,207) of those aged 20–24 were homeless on Census night in 2016. Similar proportions of young males (4% or 3,309) and females (4% or 3,370) were homeless.

Indigenous people aged 10–24 in remote areas (16% or 4,973) were more than 14 times as likely to be homeless as non-remote areas (1% or 1,706), with most of this related to severe overcrowding (Figure 3.4.8). Across states and territories, the Northern Territory had the highest proportion of homeless young people (24% or 3,711), while Tasmania had the lowest (1% or 32) (Figure 3.4.8).

Figure 3.4.8: Proportion of Indigenous people aged 10–24 who were homeless by remoteness, and state and territory, 2016



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

3.5 Social support

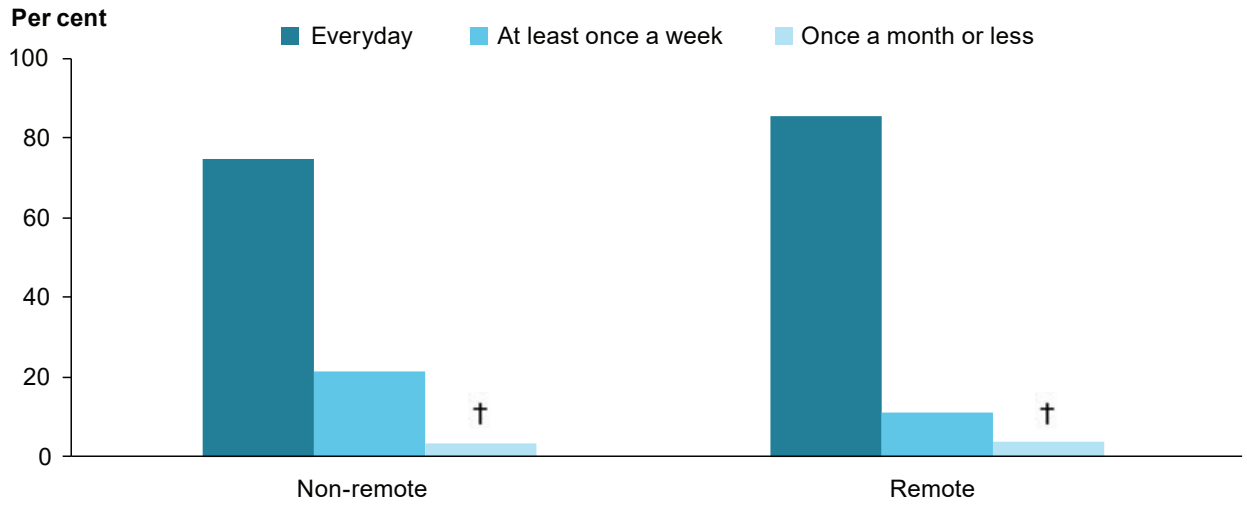
A range of social factors, such as having close relationships and social support, affect the health and wellbeing of young people. Having a number of individuals to confide in indicates the presence of strong support networks. The support provided by these networks protect the mental health of individuals, especially when they encounter the challenges and transitional periods commonplace in youth.

Young Indigenous people have people they can count on

In 2014–15, a majority of Indigenous people aged 15–24 had contact with family and friends outside their households every day (77% or 105,400). A higher proportion of Indigenous youth aged 15–19 had contact with family and friends every day than those aged 20–24 (78% or 56,600 and 75% or 48,300, respectively). A higher proportion of females had daily contact than males (79% or 54,400 and 75% or 51,200, respectively).

Indigenous people aged 15–24 in remote areas were more likely to have daily contact with family and friends than those in non-remote areas (85% or 22,600 and 75% or 82,600, respectively) (Figure 3.5.1).

Figure 3.5.1: Indigenous people aged 15–24, by frequency of contact with family or friends outside the household by remoteness, 2014–15



† Estimate has a relative standard error of 25% to 50% and should be used with caution

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Most Indigenous people aged 15–24 had family or friends to confide in (84% or 115,200). Indigenous youth typically identified 1 to 2 such people (29% or 40,200), with slightly lower proportions able to rely on 5 or more people (27% or 37,600) or 3 to 4 people (27% or 37,000).

Young Indigenous people's participation in selected sporting, social or community events was very high across all age groups but declined with age. Participation was highest for those aged 10–14 (99% or 75,100), followed by those aged 15–19 (98% or 71,300), and those aged 20–24 (96% or 62,500). Participation was high for both males and females (97% or 104,500 and 98% or 104,100, respectively).

3.6 How do young Indigenous people compare?

This report focuses on data about Indigenous youth so that, through the findings, their voice can be heard. Yet there is also value in understanding what the data says about other groups. Some comparison data for key indicators on both young non-Indigenous people and older Indigenous people are therefore presented in Box 3.6.

Social and economic determinants are especially important for understanding the health and wellbeing of young people. Decisions on education, employment and access to secure and suitable housing during youth can affect future life trajectories.

Non-Indigenous people aged 20–24 were more likely to have Year 12 or equivalent attainment than young or older Indigenous people. In addition, non-Indigenous people aged 20–24 were also more likely to be employed than young Indigenous people or older Indigenous people.

Homelessness was higher for Indigenous people aged 10–24 than non-Indigenous people or older Indigenous people. More non-Indigenous people aged 15–24 lived in a household that could raise $2,000 in an emergency than young or older Indigenous people. Similar proportions of young and older Indigenous people and young non-Indigenous people were able to get support in time of crisis from outside the household.

Box 3.6: Social and economic measures: comparison with other population groups

	Indigenous people under 25	Non-Indigenous people under 25	Indigenous people 25 and over
% who had year 12 or equivalent attainment[(a)]	65	89	54
% who are employed[(a)]	48	69	47
Homelessness rate per 100[(b)]	4	0.4	3
% who lived in household that could raise $2,000 in an emergency[(c)]	52	80	53
% who could get support in time of crisis from persons living outside the household[(c)]	93	96	91

(a) For Indigenous and non-Indigenous people aged 20–24.
(b) For Indigenous and non-Indigenous people aged 10–24.
(c) For Indigenous and non-Indigenous people aged 15–24.

Sources: AIHW analysis of 2016 ABS Census, 2014–15 National Aboriginal and Torres Strait Islander Social Survey and 2014 General Social Survey (using TableBuilder).



4

Health risk factors

Actions taken or not taken by individuals can affect their wellbeing and ill-being. In addition to the socio-economic factors discussed in Chapter 3, risk factors such as alcohol use, smoking, substance use, diet, physical activity, weight management and sexual health have an important influence on health. The behaviours of young people in relation to these risk factors can often establish a pattern that resonates throughout life. By understanding young Indigenous people's experiences with these risk factors, it is possible to take measured and appropriate actions to inform, encourage, and support this population to make healthy choices. Such action is likely to benefit individuals and reduce future costs (both social and economic) of illness to governments.

Box 4: Main data sources and key issues

Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS)

- The ABS 2012–13 AATSIHS included a sample of 12,000 Indigenous Australians for the core sample, with sub-samples for various components such as biomedical data for adults. There were 994 respondents aged 10–14, 846 aged 15–19 and 637 aged 20–24.
- Data were collected through personal interviews with selected adults aged 15 and over, while an adult was asked to respond on behalf of a selected child aged under 15.
- The estimates are subject to sampling error and those with a relative standard error over 25% are noted.

Goanna Survey

- The 2014 Sexual Health and Relationships (Goanna) Survey was the first national survey of young Aboriginal and Torres Strait Islander people in relation to sexually transmissible infections and blood-borne viruses undertaken in Australia (Ward et al. 2014).
- The data were collected at Indigenous community events in all jurisdictions, and not through a random sample of young Indigenous people.
- Just under 3,000 Aboriginal and Torres Strait Islander people aged 16–29 were surveyed. Data were collected on demographics, knowledge of STIs and BBVs, risk behaviours, and use of and access to health services.

Note: For information on issues to consider for the NPDC see Box 2 and for the NATSISS see Box 3. See Appendix C for more information about all key data sources.

4.1 Alcohol use

Substance misuse by young people can cause short- and long-term health and social issues. More immediate problems include severe intoxication and subsequent hospitalisation as well as increased risk of injuries, dependence, withdrawal symptoms, psychotic disorders and amnesia. In the long term, substance misuse can lead to addiction, infections, damage to the liver, heart and brain and an increased risk of cancers (Moran et al. 2006).

Box 4.1: National Health and Medical Research Centre (NHMRC) Australian Guidelines to Reduce Health Risks from Drinking Alcohol 2009 (the Guidelines)

Guideline 1: Reducing the risk of alcohol-related harm over a lifetime

The lifetime risk of harm from drinking alcohol increases with the amount consumed. For healthy men and women, drinking no more than 2 standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury. For youth aged 10–24, no or low alcohol consumption is also preferred as a harm minimisation strategy to support still-developing brains.

Guideline 2: Reducing the risk of injury on a single occasion of drinking

On a single occasion of drinking, the risk of alcohol-related injury increases with the amount consumed. For healthy men and women, drinking no more than 4 standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.

Guideline 3: Children and young people under 18 years of age

For children and young people under 18 years of age, not drinking alcohol is the safest option. Parents and carers should be advised that children under 15 years of age are at the greatest risk of harm from drinking and that for this age group, not drinking alcohol is especially important. For young people aged 15–17 years, the safest option is to delay the initiation of drinking for as long as possible.

Guideline 4: Pregnancy and breastfeeding

Maternal alcohol consumption can harm the developing fetus or breastfeeding baby. For women who are pregnant or planning a pregnancy, not drinking is the safest option. For women who are breastfeeding, not drinking is the safest option.

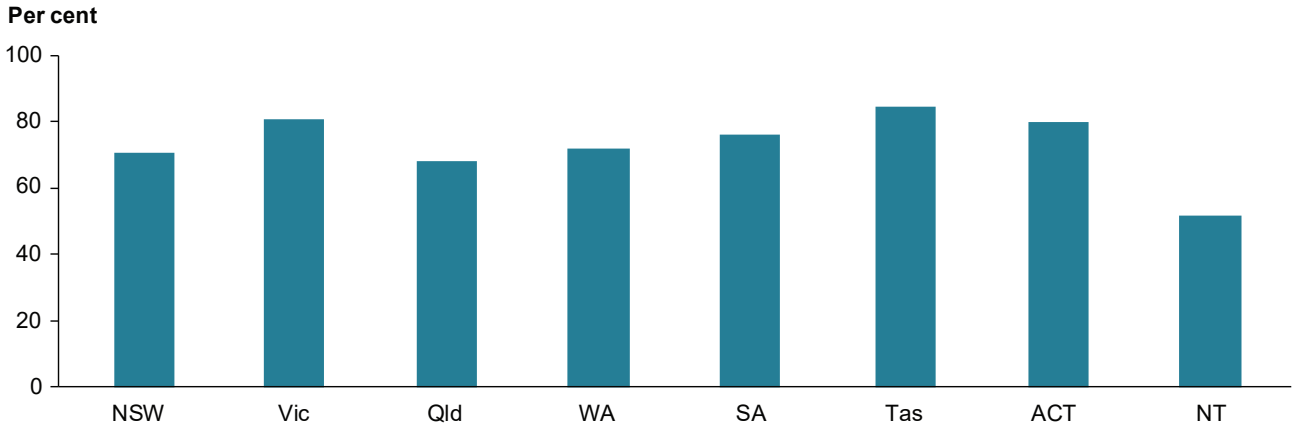
Source: NHMRC 2009.

Most have consumed alcohol, but not frequently

Data from the 2014–15 NATSISS show that 30% (41,300) of Indigenous people aged 15–24 had not consumed alcohol in the previous 12 months, while 70% (96,300) had consumed alcohol. Older youth aged 20–24 were more likely to consume alcohol (83% or 53,600) than those aged 15–19 (59% or 42,700). Males were more likely to have consumed alcohol in the previous 12 months (73% or 50,000) than females (67% or 46,300).

A higher proportion of young people living in remote areas did not consume alcohol in the previous 12 months (40% or 31,200) compared with those living in non-remote areas (28% or 10,600). Across states and territories, the Northern Territory had the lowest proportion of young people who had consumed alcohol in the previous 12 months (52% or 6,600), while Tasmania had the highest proportion (84% or 4,300) (Figure 4.1.1).

Figure 4.1.1: Indigenous people aged 15–24 who consumed alcohol in the previous 12 months, 2014–15



Note: Excludes young people for whom alcohol consumed was not stated.

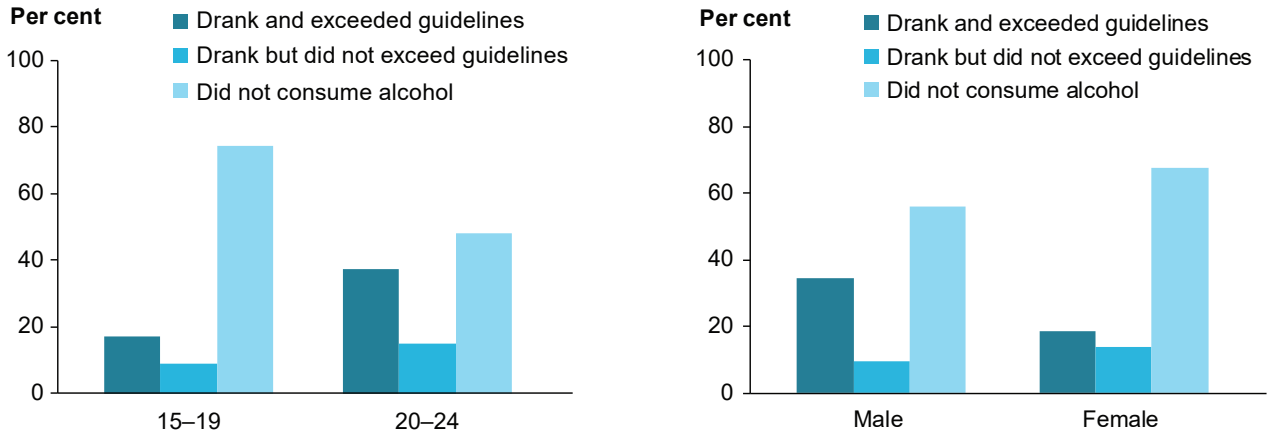
Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Younger age group less likely to exceed single-occasion alcohol risk

Although most young Indigenous people had abstained altogether from drinking in the previous 2 weeks (62% or 83,300), just over one-quarter 27% (36,300) reported drinking that exceeded single-occasion alcohol risk guidelines and 12% (16,000) reported drinking but not to an extent that exceeded the guideline. Indigenous people aged 15–19 (12,200 or 17%) were far less likely to drink and exceed the guidelines for single occasion alcohol risk than those aged 20–24 (23,900 or 37%).

A higher proportion of young Indigenous females either did not drink (67% or 45,800) or consumed alcohol at a level that did not exceed the single-occasion alcohol risk guideline (14% or 9,300), compared with males (56% or 37,700 and 10% or 6,400 respectively). Just over one-third (35% or 23,400) of young Indigenous males and 19% (12,800) of females consumed alcohol at a level that exceeded this guideline (Figure 4.1.2).

Figure 4.1.2: Indigenous people aged 15–24 by whether met single-occasion (short-term) alcohol risk guidelines (2009 NHMRC guidelines) over the previous 2 weeks, age group and sex, 2014–15

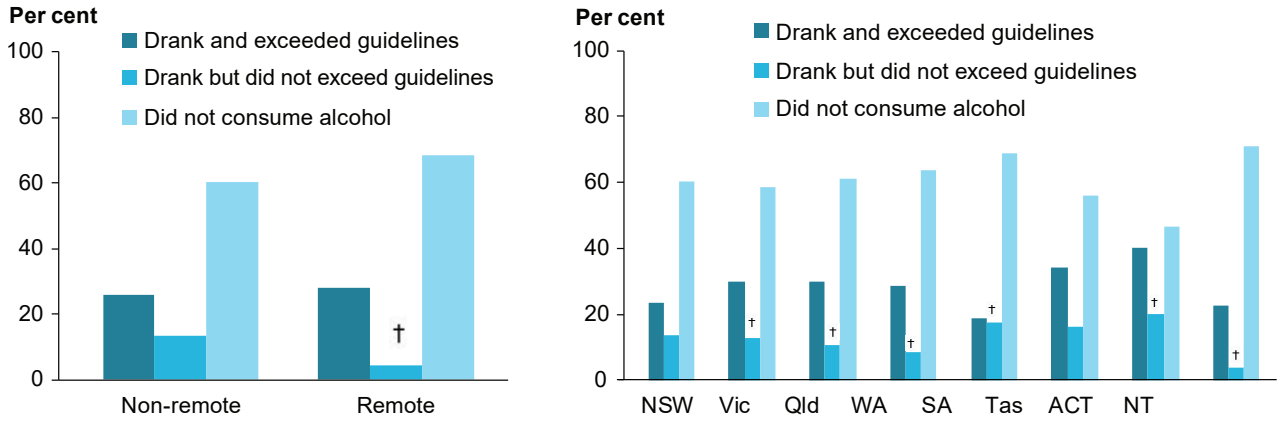


Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

A higher proportion of Indigenous people aged 15–24 living in remote areas did not consume alcohol in the previous 2 weeks (68% or 17,900) compared with those in non-remote areas (61% or 66,600). However 1 in 4 (26% or 28,600) in non-remote areas reported drinking at a level that exceeded single-occasion alcohol risk, compared with 28% (7,400) of those in remote areas (Figure 4.1.3).

Across states and territories, the Northern Territory had the highest proportion of young Indigenous people who did not consume alcohol in the previous 2 weeks (71% or 9,000) and the Australian Capital Territory had the lowest proportion (47% or 700) (Figure 4.1.3).

Figure 4.1.3: Indigenous people aged 15–24, by whether met single-occasion alcohol risk guidelines (2009 NHMRC guidelines) over the previous 2 weeks by remoteness and state and territory, 2014–15

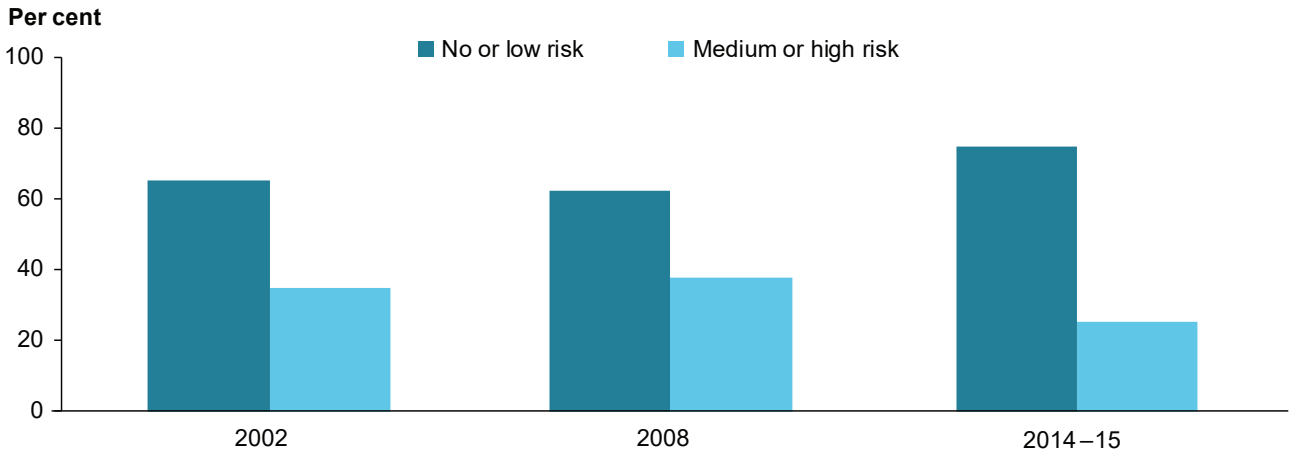


† Estimate has a relative standard error between 25% and 50% and should be used with caution.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Between 2002 and 2014–15, for those who drank, there was an increase from 65% (53,520) to 75% (98,103) in the proportion of young Indigenous people in the no/low risk category for short-term risky alcohol consumption; that is, consuming up to 4 standard drinks for males and 2 standard drinks for females. There was a corresponding decrease from 35% (28,577) to 25% (33,464) in the proportion in the medium/high risk category; that is, consuming 5 to 6 standard drinks (medium risk) or consuming 7 or more standard drinks (high risk) for males and 3 to 4 standard drinks (medium risk) or 5 or more standard drinks (high risk) for females (Figure 4.1.4).

Figure 4.1.4: Indigenous people aged 15–24 who consumed alcohol in the previous 2 weeks, by single occasion alcohol risk (2001 NHMRC short term risk guide) 2002, 2008 and 2014–15



Note: For trends over time, the 2001 NHMRC short-term risk guide was used due to its comparability over time.

Sources: AIHW analysis of 2002, 2008 and 2014–15 National Aboriginal Torres Strait Islander Social Survey (using DataLab).

4.2 Smoking

Smoking a concern in the older age group and in remote areas

More than half of (56% or 77,200) Indigenous people aged 15–24 had never smoked and fewer than 1 in 3 (31% or 42,300) were current daily smokers. Those aged 15–19 were more likely never to have smoked than those aged 20–24 (70% or 51,400 and 40% or 26,200, respectively) (Figure 4.2.1).

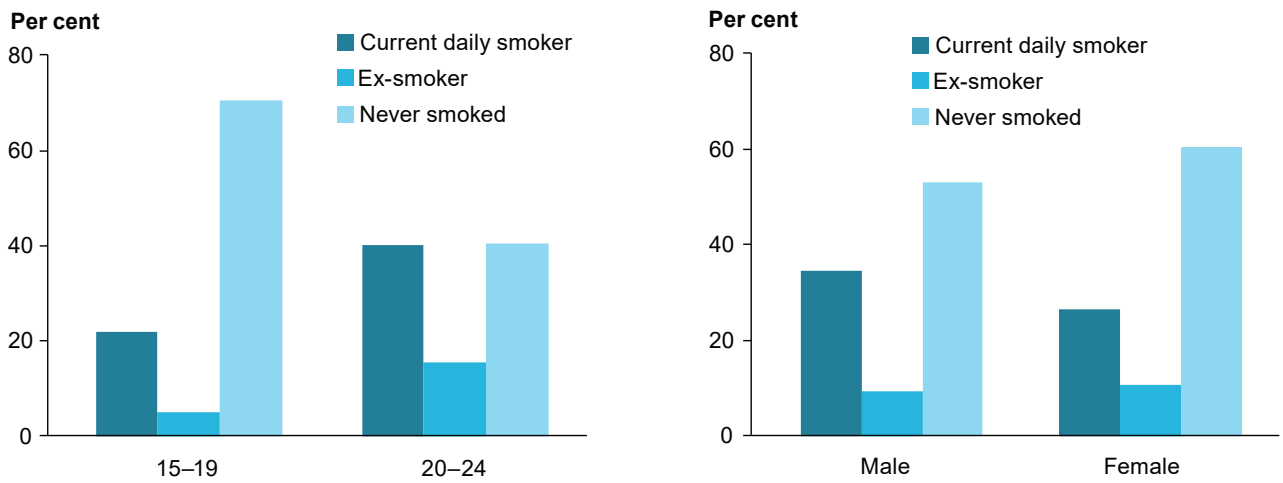
More young Indigenous females (61% or 41,600) than males (53% or 36,300) had never smoked and more males than females were current daily smokers (35% or 23,600 and 27% or 18,200, respectively) (Figure 4.2.1).

Box 4.2: Smoking habit definitions

Smoking habits are categorised using the following groupings:

- current daily smokers—those who smoke daily
- current weekly smokers—those who smoke at least once a week but not daily
- current less than weekly smokers—those who smoke less than weekly
- ex-smokers—those who have previously smoked daily, or smoked 100 or more cigarettes in their lifetime or had smoked pipes, cigars or other tobacco products at least 20 times in their lifetime
- never smoked—those who have never smoked daily and do not fit the above categories.

Figure 4.2.1: Indigenous people aged 15–24 by smoking status, age group and sex, 2014–15

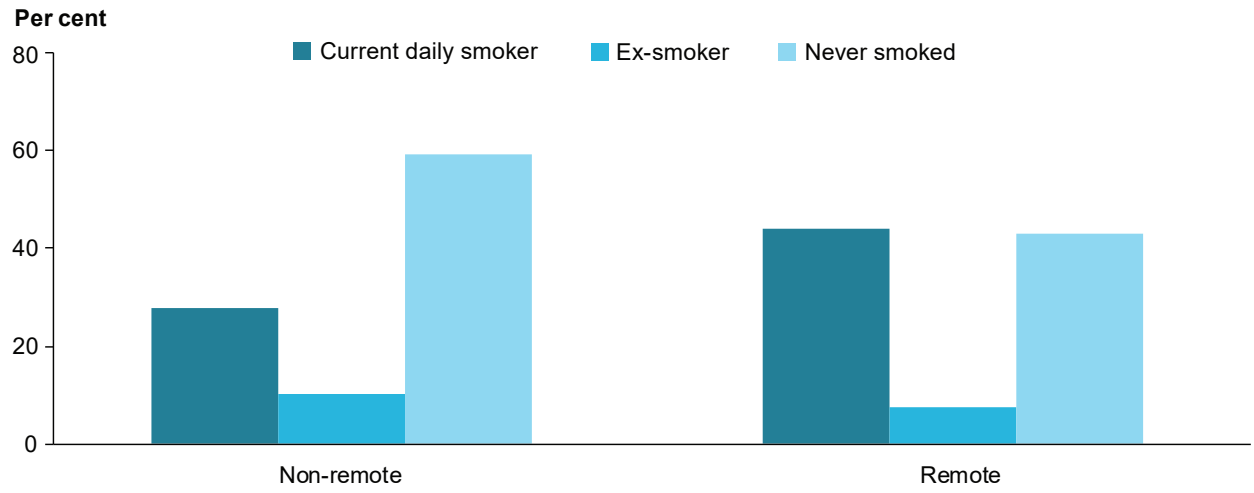


Note: Totals include 'current weekly smoker (at least once a week) and 'current less than weekly smoker'. They are not included here due to data quality.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

The proportion of young Indigenous people who were current daily smokers was lower in non-remote areas than in remote areas (28% or 30,800 and 44% or 11,700, respectively). The proportion who had never smoked was higher in non-remote areas than in remote areas (59% or 65,600 and 43% or 11,400, respectively) (Figure 4.2.2).

Figure 4.2.2: Indigenous people aged 15–24, by smoking status and remoteness, 2014–15



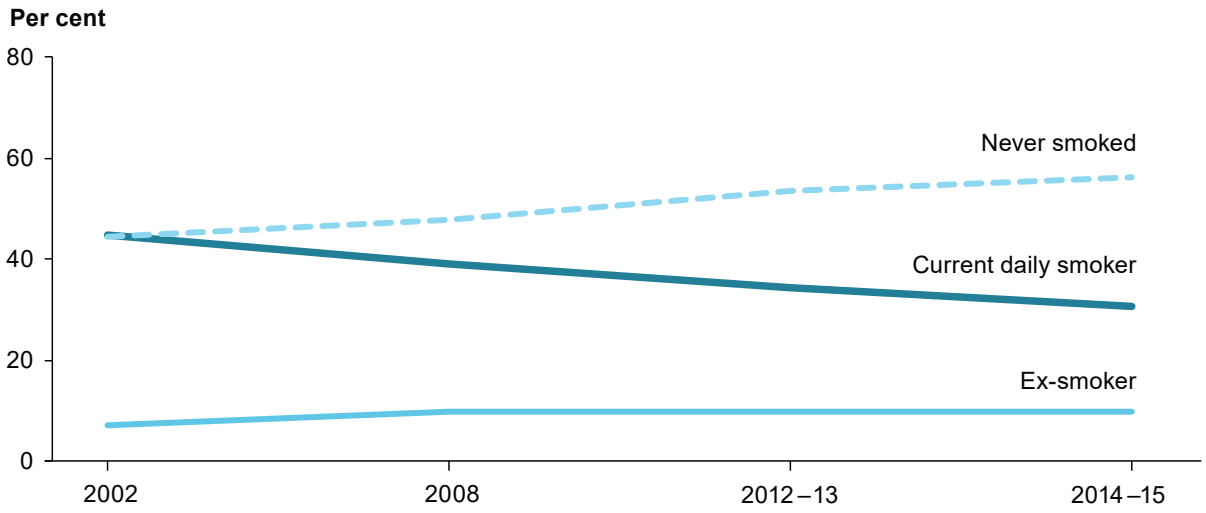
Note: Totals include 'current weekly smoker (at least once a week) and 'current less than weekly smoker'. They are not included here due to data quality.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Across all states and territories, the Australian Capital Territory had the highest proportion of young Indigenous people who had never smoked (67% or 1,000), followed by New South Wales (63% or 27,600). Western Australia (52% or 8,800) and the Northern Territory (46% or 5,900) had the lowest proportion of young Indigenous people who had never smoked.

Between 2002 and 2014–15 there was a decrease in the proportion of Indigenous people aged 15–24 who were current daily smokers from 45% (36,800) to 31% (42,300). There were corresponding increases in the proportion of young Indigenous people who had never smoked from 44% (36,400) to 56% (77,200), and in the proportion of ex-smokers from 7% (6,000) to 10% (13,500) (Figure 4.2.3).

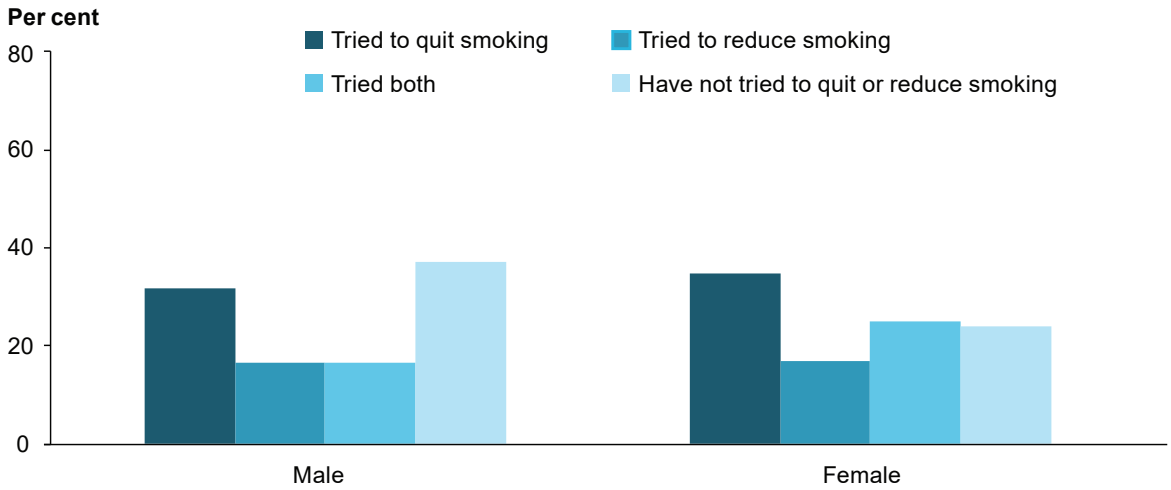
Figure 4.2.3: Indigenous people aged 15–24, by smoking status, 2002, and 2008, 2012–13 and 2014–15



Source: AIHW 2017b.

Almost 1 in 3 (32% or 14,800) Indigenous people aged 15–24 who were smokers had tried to quit smoking. A further 16% (7,500) had tried to reduce smoking and 20% (9,400) had tried to both reduce and quit smoking. Around 32% (14,800) had tried neither. A slightly lower proportion of young Indigenous male smokers (32% or 8,300) than female smokers (35% or 6,900) had tried to quit smoking (Figure 4.2.4).

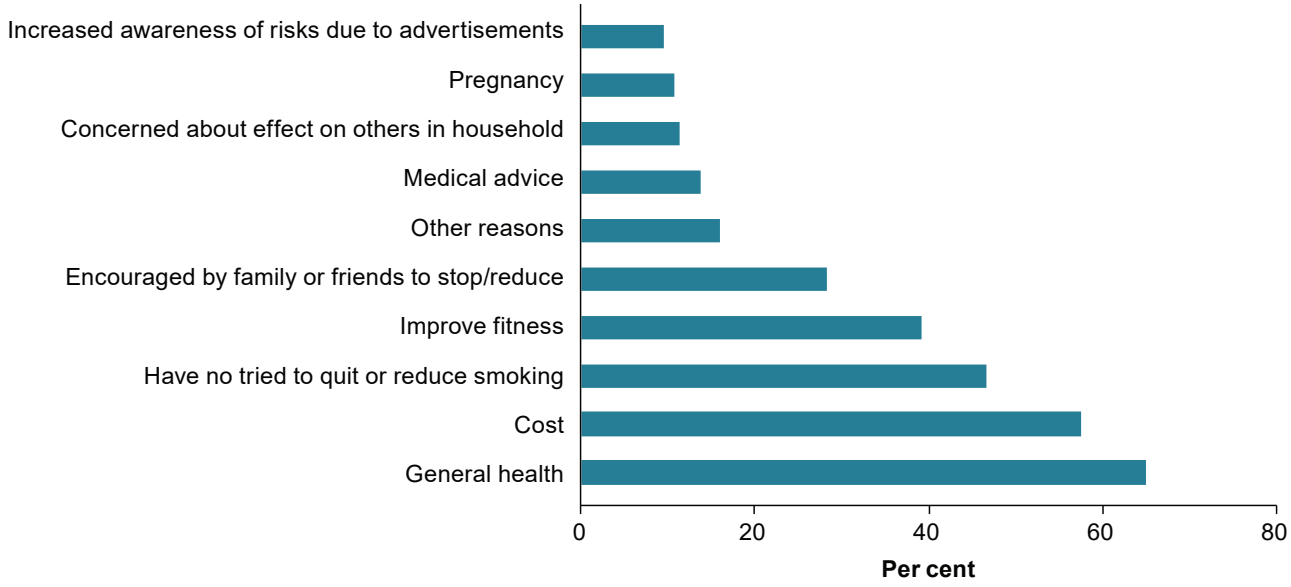
Figure 4.2.4: Indigenous people aged 15–24 who smoked, by whether tried to quit or reduce smoking, and by sex, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

The most common reasons for Indigenous people aged 15–24 trying to quit or reduce smoking were general health (66% or 20,600), cost (59% or 18,200), to improve fitness (40% or 12,400), encouragement from family or friends (30% or 9,000) and medical advice (14% or 4,400) (Figure 4.2.5). Multiple reasons for quitting or reducing smoking could be provided.

Figure 4.2.5: Indigenous people aged 15–24 who tried to quit and/or reduce smoking, by reasons, 2014–15



Notes

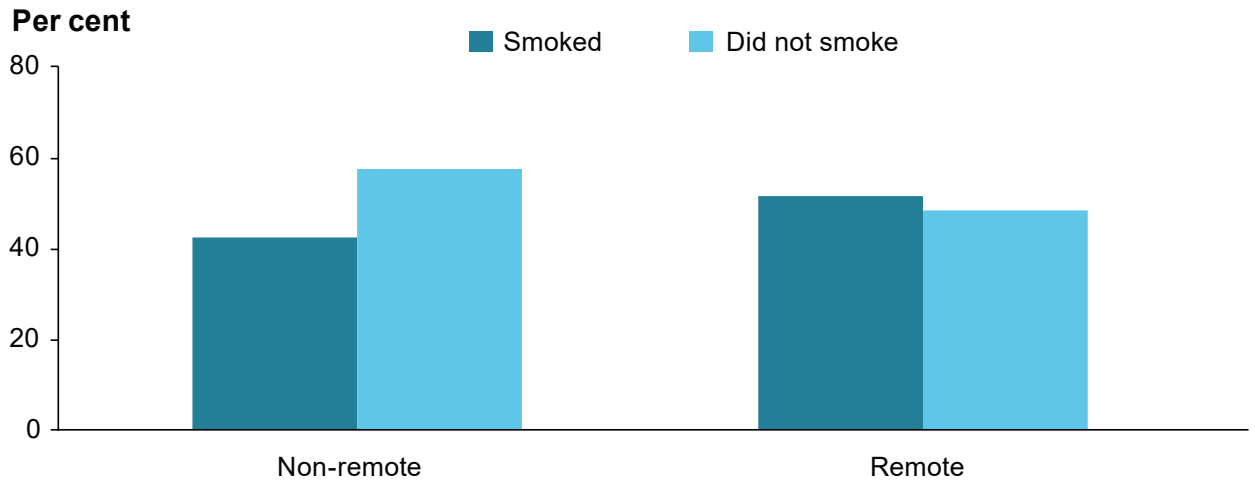
1. Total only includes only 'tried to quit', 'tried to reduce smoking' and 'tried both' as survey question on quitting reasons asked to mention only quitting status.
2. Multiple responses item; sum of components may exceed total.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Less than half of Indigenous mothers are smoking

Data on the self-reported smoking status of Indigenous mothers are available from the National Perinatal Data Collection. Data from 2016 show that less than half (44% or 2,724) of young Indigenous mothers reported smoking during pregnancy. The proportions who smoked were similar for those aged 10–19 (43% and 776) and those aged 20–24 (45% or 1,948). Those in remote areas (52% or 681) were more likely to smoke during pregnancy than those in non-remote areas (43% or 2,019) (Figure 4.2.6).

Figure 4.2.6: Indigenous women who gave birth aged 10–24, by tobacco-smoking status during pregnancy, and remoteness, 2016

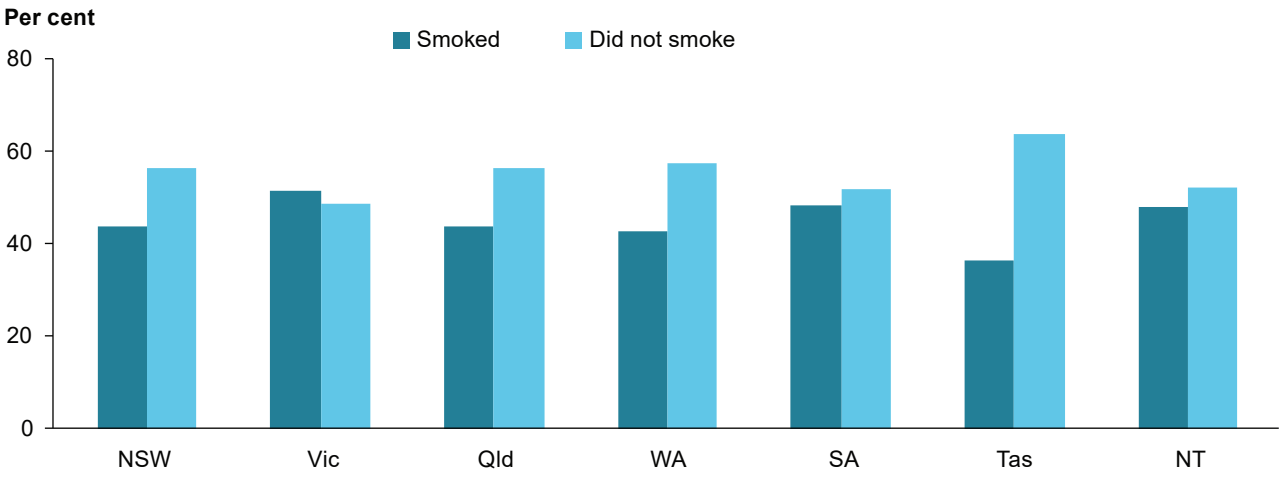


Note: Per cents calculated after excluding records with missing values. Care must be taken when interpreting percentages.

Source: AIHW analysis of National Perinatal Data Collection.

The proportion of young Indigenous mothers who reported that they smoked during pregnancy was highest in Victoria (51% or 179) and lowest in Tasmania (36% or 42) (Figure 4.2.7).

Figure 4.2.7: Indigenous women who gave birth aged 10–24, by tobacco smoking status during pregnancy and state and territory of usual residence, 2016



Notes

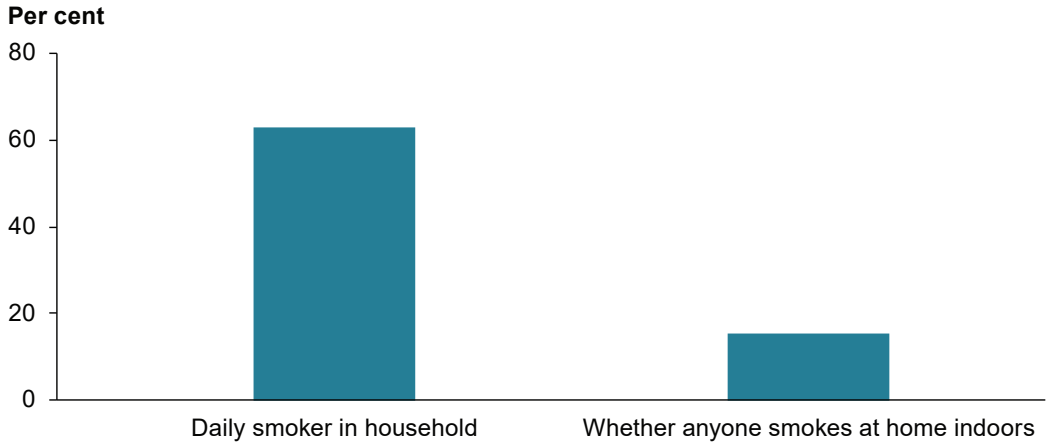
1. Per cents calculated after excluding records with missing values. Care must be taken when interpreting percentages.
2. For WA, 'Smoked' includes occasional smoking. 'Did not smoke' includes 'Not determined' average number of tobacco cigarettes smoked per day in the first 20 weeks of pregnancy and after 20 weeks of pregnancy. For ACT, per cents are available but not publishable due to data reliability.

Source: AIHW analysis of National Perinatal Data Collection.

Passive smoking a concern

More than 3 in 5 (63% or 85,768) Indigenous people aged 15–24 had a daily smoker in their household (Figure 4.2.8).

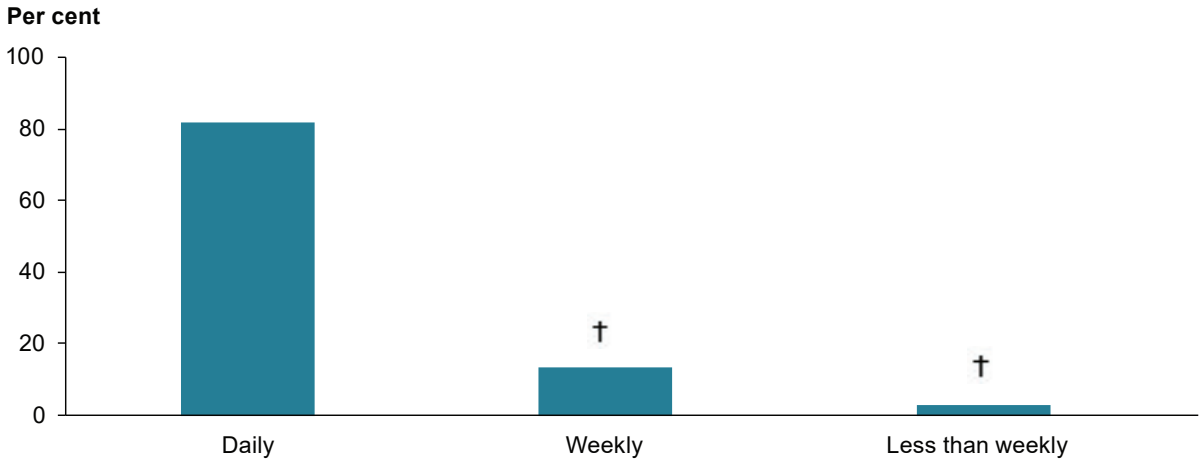
Figure 4.2.8: Indigenous people aged 15–24 by type of exposure to household smoke, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Around 15% (21,155) of young Indigenous people were in a household where someone smoked indoors; for most (82% or 17,316) of these people, the smoking was a daily occurrence (Figure 4.2.9).

Figure 4.2.9: Young Indigenous people in households with smoking inside the house, by frequency of exposure, 2014–15



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

4.3 Substance use

Most young people had not misused illicit substances

In 2014–15, 67% (82,600) of Indigenous people aged 15–24 had not used illicit substances in the previous 12 months, while 33% (40,700) had. Illicit substance use in the previous 12 months was slightly higher for older age group 20–24 (37% or 22,000) than for those aged 15–19 (30% or 19,500). Similar proportions of young Indigenous males (51% or 20,900) and females (50% or 20,200) had used illicit substances in the previous 12 months.

A higher proportion of young Indigenous people in non-remote areas had used illicit substances in the previous year (34% or 34,900) than those in non-remote areas (26% or 5,900). Across states and territories, the Australian Capital Territory had the highest proportion of young Indigenous people that had used illicit substances in the previous 12 months (50% or 700) and the Northern Territory had the lowest proportion (23% or 2,400) (Figure 4.3.1).

Figure 4.3.1: Indigenous people aged 15–24 who used illicit substances in the previous 12 months, by state and territory, 2014–15

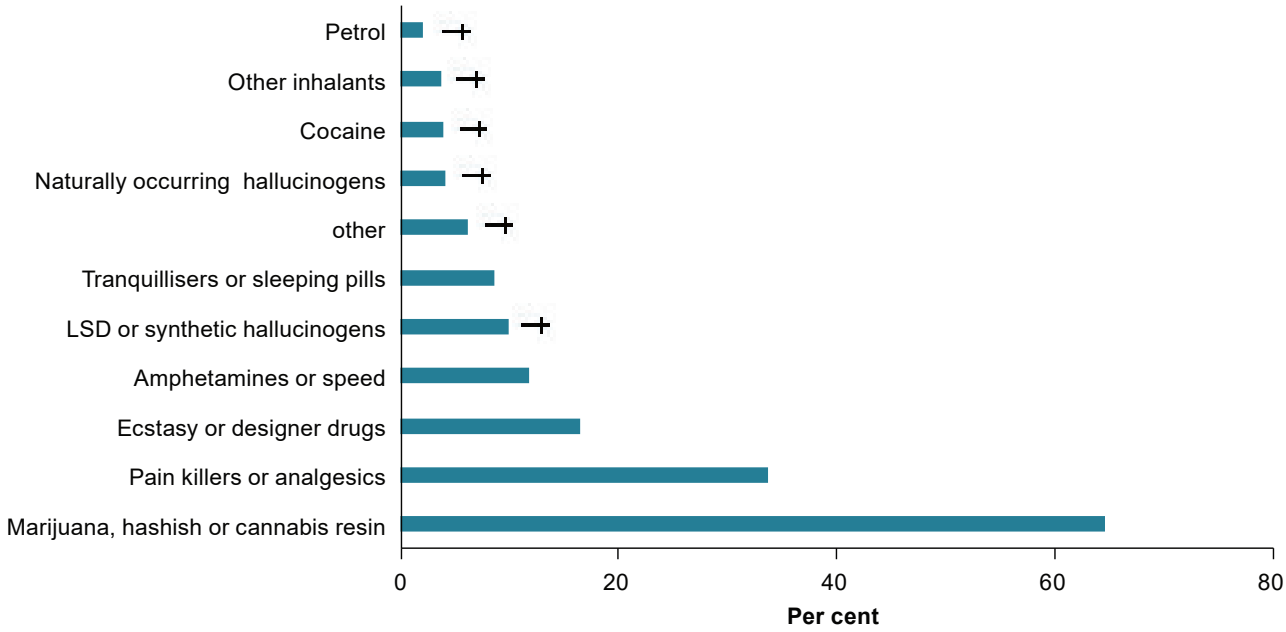


Note: Excludes young people for whom substance use and type was not stated, or not collected.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Of the illicit substances young Indigenous people reported using in the previous 12 months, marijuana, hashish or cannabis resin were the most common (65% or 26,300). Lower proportions reported using painkillers or analgesics for a non-medical purpose (34% or 13,700), ecstasy or designer drugs (17% or 6,700) and amphetamines or speed (12% or 4,800) (Figure 4.3.2).

Figure 4.3.2: Indigenous people aged 15–24 who used illicit substances in the previous 12 months, by type of substance used, 2014–15



† Estimate has a relative standard error between 25% and 50% and should be used with caution.

Notes

1. Other drugs include heroin, methadone for non-medical purposes, kava and other.
2. Excludes young people for whom substance use and type was not stated, or not collected.
3. Multiple responses item; sum of components may exceed total.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

4.4 Diet

Nutritious food is necessary to support the growth and healthy development of young people and to establish healthy eating patterns in later life. Young people's eating habits are shaped by individual preferences as well as cultural and family influences.

Fruit and vegetable intake is accepted as a cornerstone of healthy eating practices and therefore is often used as a proxy for a healthy diet. Adequate consumption of fruit and vegetables is a protective factor against many diseases including coronary heart disease, hypertension, stroke, type II diabetes, and many forms of cancer (NHMARC 2013). This section includes data on the consumption of fruit and vegetables in relation to the recommended servings for optimal health outlined in the Australian Dietary Guidelines (NHMRC 2013).

Table 4.1: Australian Dietary Guidelines, NHMRC, 2013

Age group	Minimum daily intake of fruit	Minimum daily intake of vegetables
Children aged 4–8	1 ½ serve	2 ½ serves
Children aged 9–17	2 serves	5 serves
Adult males aged 18–49	2 serves	6 serves
Adult males aged 50 years and over	2 serves	5 ½ serves
Adult females aged 18 years and over	2 serves	5 serves

Note: A serve of fruit is approximately 150 grams of fresh fruit or 50 grams of dried fruit. A serve of vegetables is approximately half a cup of cooked vegetables or one cup of salad vegetables—equivalent to approximately 75g.

Source: NHMRC 2013.

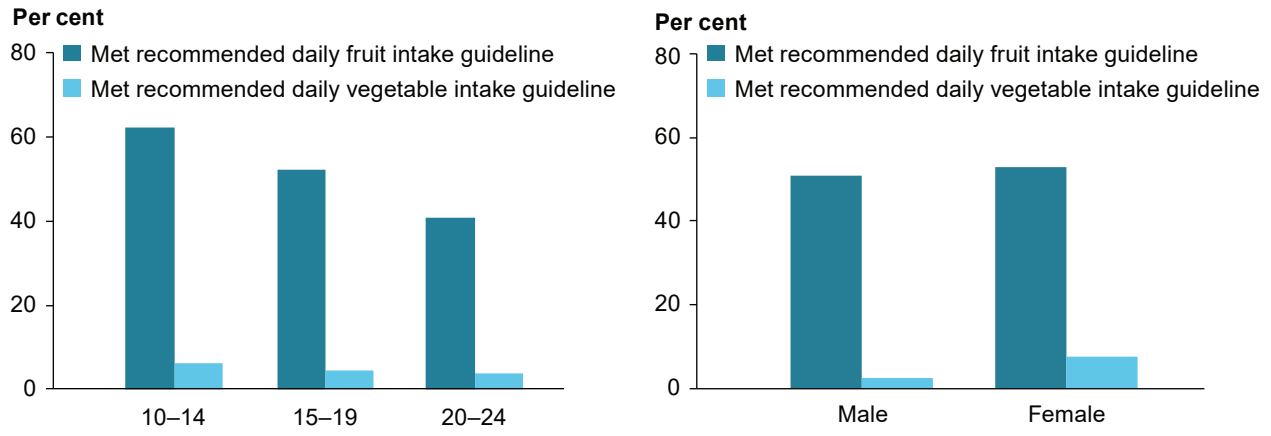
Most young Indigenous people not meeting dietary guidelines

Fewer than 1 in 20 Indigenous people aged 10–24 met both the fruit and vegetable dietary guidelines (7,800 or 4%). The proportion meeting both of these guidelines declined with age. Around 5% (4,100) of Indigenous people aged 10–14 and 4% (2,900) of those aged 15–19 met both the vegetable and fruit intake guidelines, while 2% (1,200) of those aged 20–24 met both guidelines.

Over half (62% or 47,100) of those aged 10–14, 52% (38,000) of those aged 15–19 and 41% (26,400) of those aged 20–24 met the daily fruit intake guideline. A much lower proportion of young Indigenous people across all age groups met the recommended daily vegetable intake guideline. Around 6% (4,700) of those aged 10–14, 4% (3,100) of those aged 15–19 and 4% (2,500) of those aged 20–24 met the daily vegetable intake guideline (Figure 4.4.1).

The proportion of young Indigenous females (6% or 6,100) that met both the daily fruit and vegetable guidelines was twice that of males (2% or 1,800). Around half of Indigenous males and females aged 10–24 met the recommended guideline for daily fruit intake only (51% or 55,000 and 53% or 56,300 respectively). A higher proportion of young Indigenous females than males met the recommended daily vegetable intake guideline only (8% or 8,100 and 2% or 2,500, respectively) (Figure 4.4.1).

Figure 4.4.1: Young Indigenous people, by whether met fruit and vegetable dietary guidelines, by age and sex, 2014–15

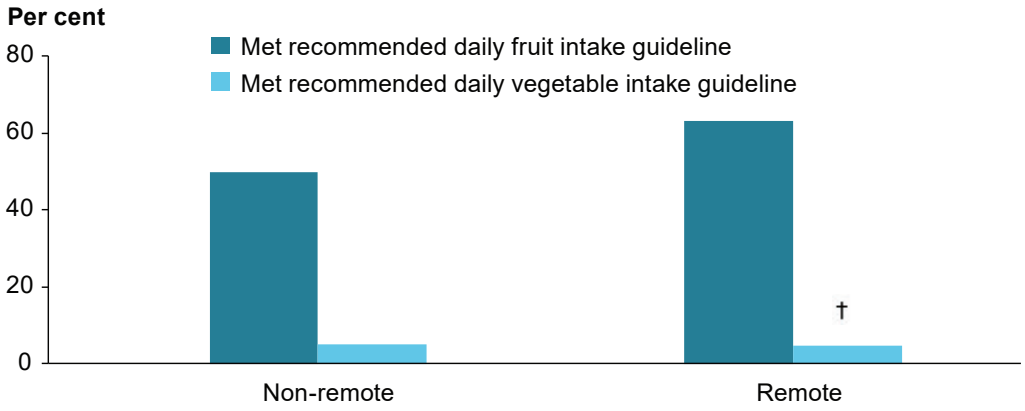


Note: Data are not mutually exclusive.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Similar proportions of young Indigenous people in non-remote and remote areas met both the fruit and vegetable guidelines (4% or 6,300 and 5% or 1,900, respectively). Young Indigenous people in remote areas (63% or 25,700) were more likely to meet the daily fruit intake guideline than young Indigenous people in non-remote areas (50% or 86,400). Similar proportion of young Indigenous people in non-remote areas (5% or 8,800) and remote areas (5% or 1,900) met daily vegetable intake guideline (Figure 4.4.2).

Figure 4.4.2: Indigenous people aged 10–24, by whether met fruit and vegetable dietary guidelines by remoteness, 2014–15



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Note: Data are not mutually exclusive.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

4.5 Physical activity

Being physically active is important for healthy development during youth. Regular activity can improve cardiorespiratory fitness, build strong bones and muscles, help control weight, facilitate wellbeing, and help prevent and treat mental health conditions such as depression. Physical activity is also associated with a reduced risk of health conditions such as cardiovascular diseases, type II diabetes, osteoporosis and some cancers (Okely et al. 2008).

Australia's Physical Activity and Sedentary Behaviour Guidelines are a set of recommendations on the amount of physical activity that Australians should follow to achieve optimal health. The latest Guidelines make different recommendations for different age groups and the guidelines relevant to young people are summarised in Table 4.5.

It is difficult to draw conclusions from the available physical activity data because the 2012–13 AATSIHS, does not fully adhere to the guidelines, as the survey interprets the days collected, and does not assess them on the strength-based guideline.

The analysis below relies on data available in the 2012–13 AATSIHS. There are separate sedentary activity and screen-based activity guidelines.

Table 4.5: Comparison of Australia's Physical Activity and Sedentary Behaviour Guidelines and guidelines used to assess sufficient physical activity in the 2012–13 AATSIHS

Age group	National physical activity guidelines	AATSIHS, non-remote areas	AATSIHS, remote areas
Children aged 5–17	At least 60 minutes of moderate to vigorous physical activity every day. Include a variety of aerobic activities, including some vigorous activity. Activities that strengthen muscle and bone at least 3 days per week.	At least 60 minutes of moderate to vigorous physical activity every day over the three days prior to interview.	At least 60 minutes of physical activity on the day prior to the interview.
Adults	Be active on most, preferably all, days every week. Accumulate 150 to 300 minutes of moderate intensity physical activity or 75 to 150 minutes of vigorous physical activity, or an equivalent combination, each week. Do muscle strengthening activities on at least 2 days each week.	150 minutes of physical activity over five or more sessions per week.	At least 30 minutes of physical activity on the day prior to the interview.

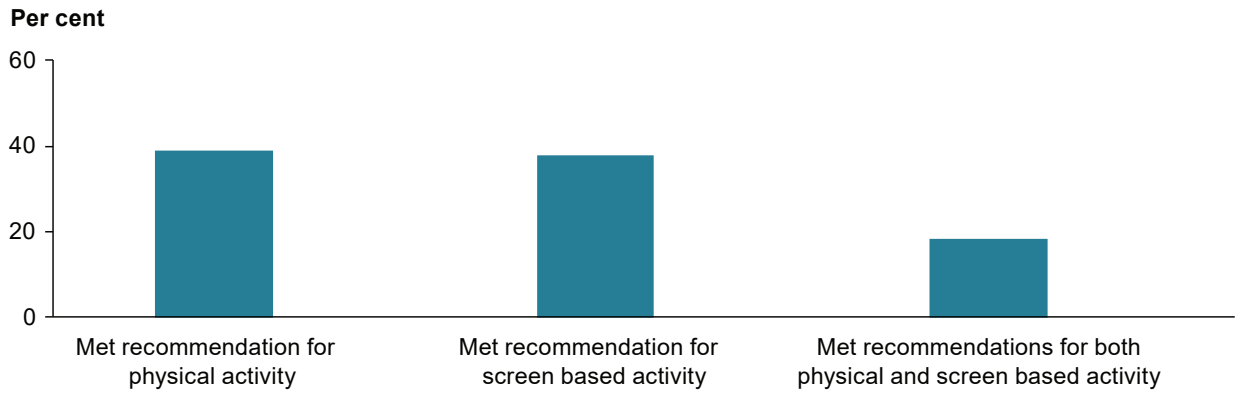
Note: 'Adults' refers to those aged 18–64 in the national guidelines and 18 and over in the AATSIHS. There are separate national guidelines for those aged 65 and over. Screen use guidelines not included in this table.

Source: 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey.

In non-remote areas, physical activity was higher in young males

In 2012–13, around 2 in 5 (39% or 37,400) Indigenous people aged 10–17 living in non-remote areas met the physical activity guidelines on the 3 days prior to interview, 38% (36,200) met the screen-based activity guidelines and 18% (17,500) met both guidelines (Figure 4.5.1).

Figure 4.5.1: Proportion of Indigenous people aged 10–17 who met physical and sedentary activity guidelines in previous 3 days, non-remote areas, 2012–13.



Note: Excludes young people for whom physical and sedentary activity was not known.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

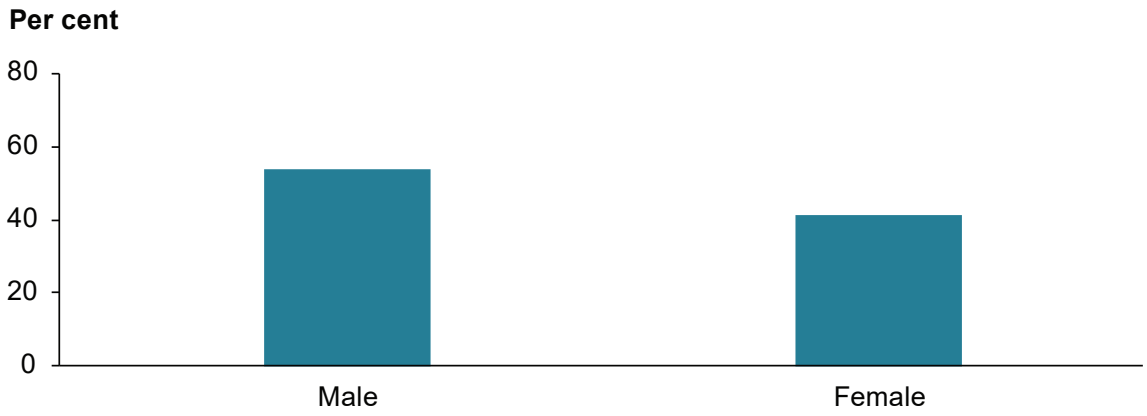
A higher proportion of those aged 10–14 (47% or 28,300) met physical activity guideline than those aged 15–17 (26% or 9,000). A higher proportion of young Indigenous males (47% or 25,900) met the physical activity guideline than young females (32% or 14,900).

Around 42% (25,200) of Indigenous people aged 10–14 living in non-remote areas met the screen-based activity guideline compared with 31% (10,800) of those aged 15–17. A higher proportion of young Indigenous females (40% or 18,700) met those guidelines than males (35% or 16,900).

Around 18% (17,500) of Indigenous people aged 10–17 in non-remote areas met both the physical activity and screen-based activity guidelines. Those aged 10–14 (23% or 13,700) were half as likely to meet both guidelines as those aged 15–17 (11% or 3,800). Young males were more likely to meet both guidelines (22% or 10,900) than females (14% or 6,600).

In 2012–13, just under half of Indigenous people aged 18–24 (48% or 31,600) in non-remote areas met the recommended physical activity guidelines. A higher proportion of young Indigenous males (54% or 18,300) met these guidelines than young females (41% or 13,400) (Figure 4.5.2).

Figure 4.5.2: Proportion of Indigenous people aged 18–24 who met physical activity guidelines in the previous week by sex, 2012–13.



Note: Excludes young people for whom physical and sedentary activity was not known.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

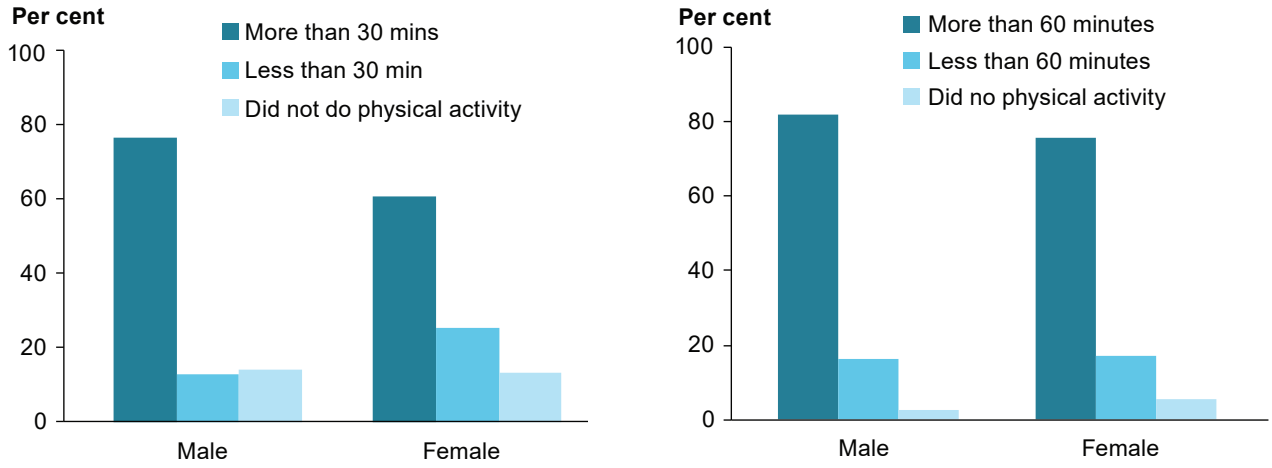
Comparing exercise intensity, the highest proportion of Indigenous people aged 18–24 did low intensity exercise in the previous week (34% or 22,700). Around a quarter (25% or 16,900) did moderate-intensity exercise and another quarter (25% or 16,900) did high intensity exercise. Around 15% (10,100) were sedentary.

Most young people in remote areas met physical activity guidelines

More than three-quarters (79% or 17,200) of Indigenous people aged 10–17 living in remote areas met the physical activity guideline on the previous day. Young Indigenous males (82% or 9,100) were more likely to meet the guideline than young females (76% or 8,000).

For those in remote areas, more than two-thirds (67% or 11,500) of those aged 18–24 met the physical activity guidelines. A further 19% (3,200) did less than 30 minutes of physical activity on the previous day and 14% (2,000) did no physical activity. As in non-remotes areas, young males in remote areas were more likely to meet physical activity guidelines (77% or 6,500) than young females (61% or 5,100) (Figure 4.5.3).

Figure 4.5.3: Proportion of Indigenous people aged 10–17 (left) and 18–24 (right) in remote areas by level of exercise over the previous day, 2012–13



Note: Excludes young people for whom physical and sedentary activity was not known.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

More than half played sport in the previous 12 months

In 2014–15, for Indigenous people aged 10–14, around 56% (42,300) played or trained for an organised sport in the previous 12 months. A higher proportion of young males in the group (63% or 24,300) played or trained for an organised sport in the time than young females (50% or 18,500).

Across remoteness areas, similar proportions of Indigenous people aged 10–14 played or trained for an organised sport in the previous 12 months in non-remote (57% or 34,900) and remote areas (55% or 7,700).

Across states and territories, the highest proportion of young Indigenous people who played or trained for an organised sport was in Victoria (71% or 3,700). The proportion was lowest in Queensland (50% or 11,200) (Figure 4.5.4).

Figure 4.5.4: Proportion of Indigenous people aged 10–14 who played or trained for an organised sport in previous 12 months, by state and territory, 2014–15



Note: Excludes young people for whom it was not known if they played sport in the previous 12 months.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

For Indigenous people aged 15–24, more than half (54% or 74,400) participated in organised sport or physical activities in the previous 12 months. Those in the 15 to 19 age group (62% or 45,600) were more likely to have participated in organised sport or physical activities than those aged 20–24 (45% or 29,100). A higher proportion of Indigenous males aged 15–24 (60% or 40, 800) participated than young females (49% or 34,000).

More than half of the young Indigenous people living in both non-remote areas (53% or 58,800) and remote areas (58% or 15,400) participated in organised sport or physical activities. Across states and territories, South Australia (65% or 4,900) had the highest participation in sport or physical activities and the Northern Territory (51% or 6,500) and Tasmania (51% or 2,600) had the lowest (Figure 4.5.5).

Figure 4.5.5: Proportion of Indigenous people aged 15–24 who participated in organised sport or physical activities in previous 12 months, by state and territory, 2014–15



Note: Excludes young people for whom it was not known if they played sport in the previous 12 months.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

4.6 Overweight and obesity

Overweight and obese young people are at a higher risk of being overweight or obese in adulthood. Being overweight or obese increases the risk of cardiovascular conditions, asthma, and type II diabetes, and may influence the psychological wellbeing of young people.

Box 4.6.1: Calculating body mass index (BMI)

BMI is calculated by dividing an individual's weight in kilograms by the square of the individual's height in metres (kg/m^2).

Classifications for those aged 18 and over

- **Obese** if BMI is 30 and over
- **Overweight** if BMI is 25.0 to 29.9
- **Normal** range if BMI is 18.5 to 24.9
- **Underweight** if BMI is less than 18.5.

Classifications for those aged under 18

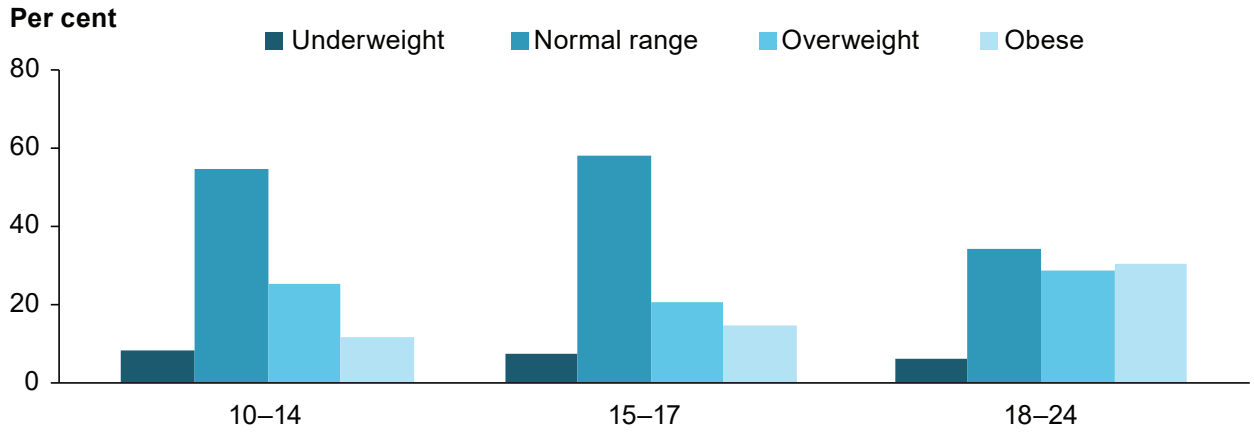
The formula used to calculate BMI is the same for young people, but the ABS uses different classifications for those aged 2 to 17. BMI classifications take into account an individual's sex and age, with the age-related cut-off points for the classifications changing every half-year (see ABS 2013 for the classification of BMI for children).

Most in normal weight range

In 2012–13, more than half of Indigenous people aged 10–14 (54% or 30,300) and 15–17 (58% or 18,500) were in the normal weight range, as assessed using the BMI cut-off points for children. A further 25% (14,100) of those aged 10–14 were overweight and 12% (6,500) were obese. For those aged 15–17, 21% (6,600) were overweight and 15% (4,700) were obese. Around 8% (4,600) of Indigenous people aged 10–14 and 7% (2,300) of those aged 15–17 were underweight (Figure 4.6.1).

Just over one-third (34% or 23,200) of Indigenous people aged 18–24 were in the normal weight range, 29% (19,400) were overweight and 30% (20,600) were obese. A further 6% (4,000) were underweight (Figure 4.6.1).

Figure 4.6.1: Young Indigenous people, body weight category, by age, 2012–13

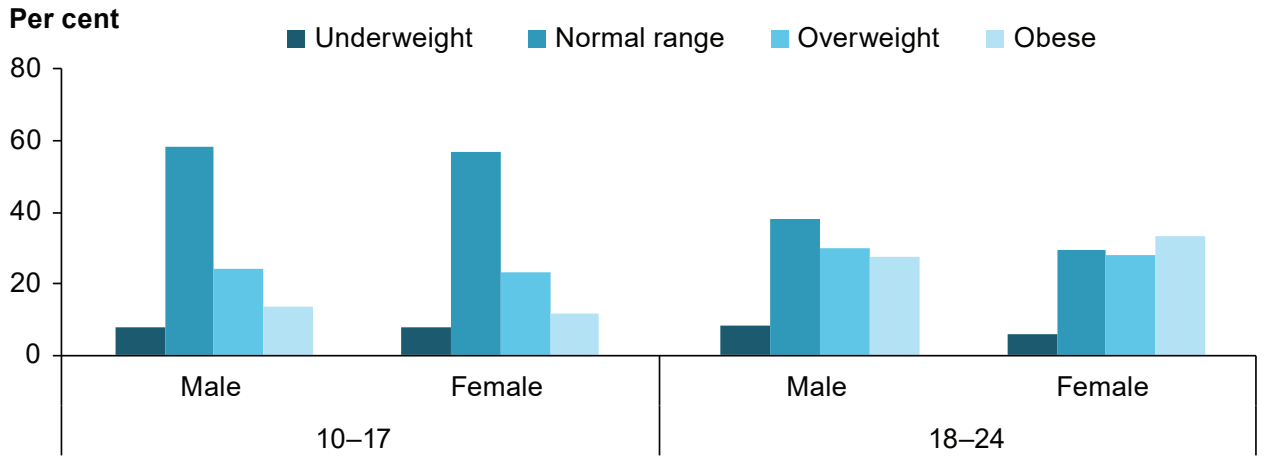


Note: Excludes young people for whom measurements were not taken due to refusal or other reasons.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

Similar proportions of young Indigenous males (58% or 25,800) and females (57% or 24,600) aged 10–17 were within the normal weight range. For those aged 18–24, males were more likely to be within the normal weight range (38% or 13,500) than females (30% or 9,500) (Figure 4.6.2).

Figure 4.6.2: Young Indigenous people, body weight category, by age group and sex, 2012–13



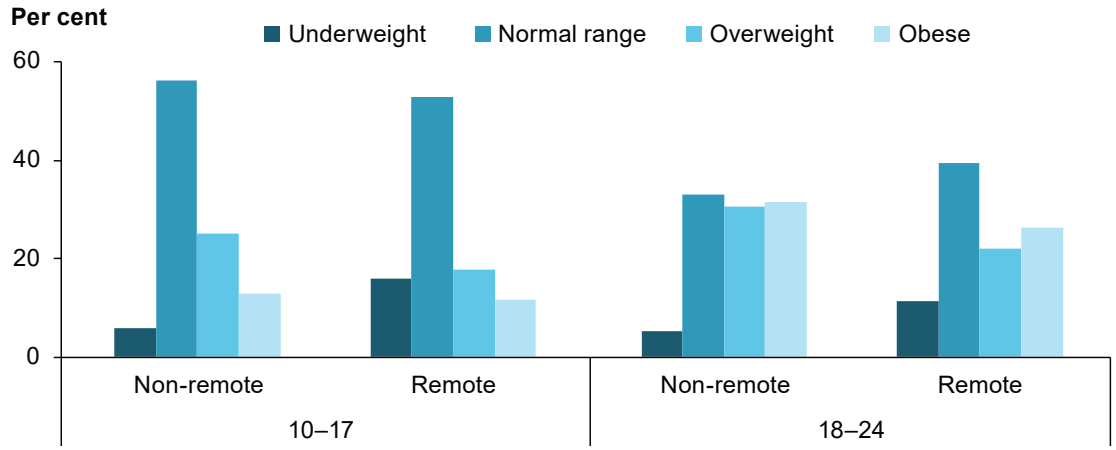
Note: Excludes young people for whom measurement were not taken due to refusal or other reasons.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

A slightly higher proportion of Indigenous people aged 10–17 in non-remote areas (56% or 39,900) were in the normal weight range than in remote areas (53% or 8,600). In this age group, a higher proportion of those living in non-remote areas were overweight (25% or 17,800) or obese (13% or 9,100) than those living in remote areas (18% or 2,900 and 12% or 1,900, respectively). In remote areas, a higher proportion of Indigenous people aged 10–17 were underweight than in non-remote areas (16% or 2,600 and 6% or 4,300, respectively) (Figure 4.6.3).

A higher proportion of Indigenous people aged 18–24 in remote areas were in the normal weight range (39% or 5,500) than those in non-remote areas (33% or 17,700). A higher proportion of those in non-remote areas were overweight (31% or 16,400) or obese (32% or 16,900) than those in remote areas (22% or 3,100 or 26% or 3,700). However, there was a higher proportion of underweight young people in remote areas (11% or 1,600) than in non-remote areas (5% or 2,900) (Figure 4.6.3).

Figure 4.6.3: Young Indigenous people by body weight category, age group and remoteness, 2012–13



Note: Excludes young people for whom measurements were not taken due to refusal or other reasons.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

Box 4.6.2: Knockout Health Challenge

The Knockout Health Challenge involves Aboriginal community–based teams from across NSW competing in an annual 16-week weight loss challenge. The aim of the challenge is to achieve weight loss and healthy living through increased physical activity and improved nutrition.

The Agency for Clinical Innovation and NSW Rugby League implement the challenge with support from the NSW Ministry of Health and the NSW Office of Preventative Health. In 2013, 586 people participated in 22 teams.

An evaluation of the program in 2013 found that participants who completed the challenge lost an average of 2.3 kilograms. Some 5 months after the challenge, average weight loss was 1.5kg. More than two-thirds (67%) of participants lost weight between the start of the challenge and the end of the challenge, and over half (55%) lost weight between the start of the challenge and 5 weeks after the challenge.

Source: ARTD Consultants 2013.

4.7 Sexual health

Sexual health refers to factors that affect sexual function and reproduction; it includes physical, mental and emotional factors. Sexual health is particularly important for young people as changes associated with puberty emerge and sexual behaviours develop. This section addresses young Indigenous people's sexual activity, contraceptive practices, and rates of selected sexually transmitted infections.

There are limited national data on the sexual activity of young Indigenous people. Data from the 2014 Sexual Health and Relationships Survey (Goanna Survey) provides self-reported information on the sexual behaviours of around 3,000 Indigenous people aged 16–29 (Ward et al. 2014). These data were collected at Indigenous community events in all jurisdictions, but may not be representative all young Indigenous people.

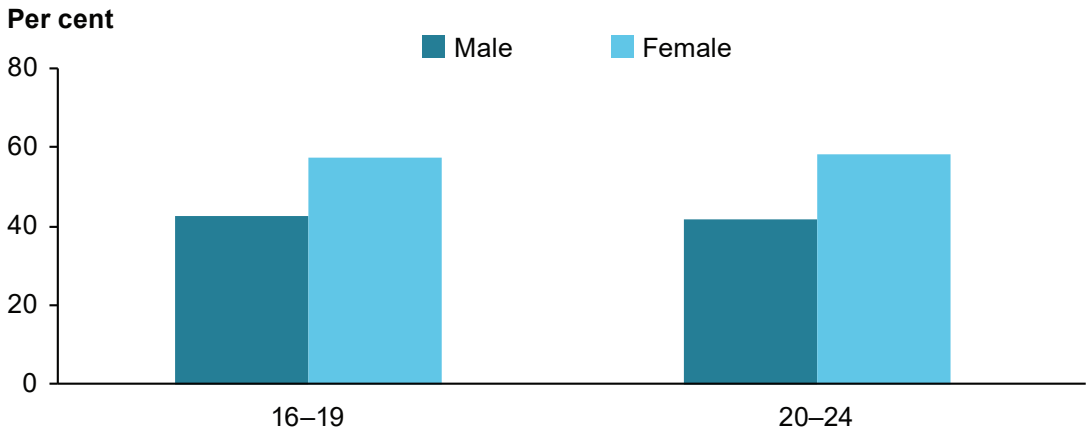
The survey found that older youth aged 20–24 were more likely to have ever had sex (87% or 783) compared with those aged 16–19 (69% or 871).

A majority of Indigenous people aged 16–24 who had ever had sexual intercourse reported sexual debuts at under 16 years of age (75% or 1,242). Across age groups, younger Indigenous people were more likely to report a sexual debut at a younger age than older youth. Around 85% (743) of Indigenous people aged 16–19 and 64% (499) of young people aged 20–24 reported a sexual debut before 16 years of age.

Around 2 in 5 Indigenous people aged 16–19 (42% or 367) and 20–24 (38% or 292) had, had 2 to 4 sexual partners in the past year.

A higher proportion of young Indigenous females than males across all age groups had, had sexual intercourse. Among Indigenous people aged 16–19, 57% of females and 43% of males reported they had had sexual intercourse. Among those aged 20–24, 58% of females and 42% of males reported they had had sexual intercourse (Figure 4.7.1).

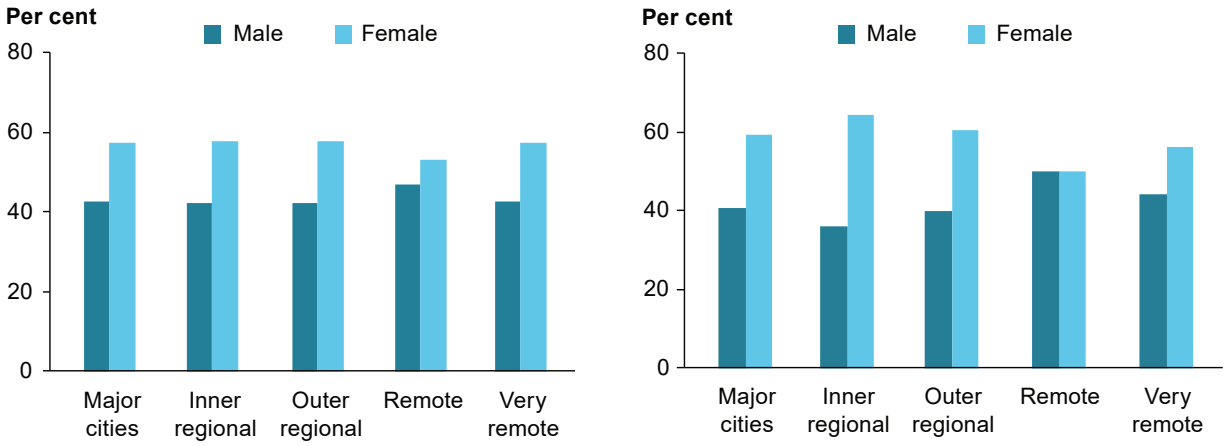
Figure 4.7.1: Proportion of young Indigenous people who had sexual intercourse in the previous year, by age group and sex, 2014



Source: Ward et al. 2014.

A similar pattern was evident across all remoteness areas with a higher proportion of young Indigenous females aged 16–19 and 20–24 reporting sexual intercourse compared with males of the same age group (Figure 4.7.2).

Figure 4.7.2: Proportion of Indigenous people aged 16–19 (left) and 20–24 (right) who had sexual intercourse in the previous year, by sex and remoteness, 2014



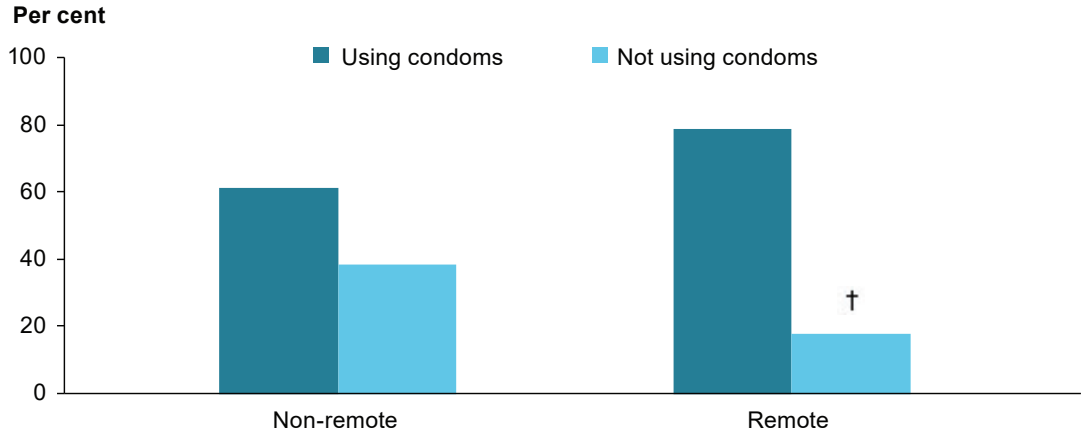
Source: Ward et al. 2014.

Most males use contraception

Data on young Indigenous people's contraceptive use was collected as part of the 2012–13 AATSIHS. Of the young Indigenous males aged 18–24 who reported ever using a condom (83% or 34,800), over half used condoms in current sexual activity (65% or 22,500), while 34% (11,900) did not.

A higher proportion of Indigenous males aged 18–24 in remote areas (79% or 18,300) than in non-remote areas (61% or 4,400) were using condoms in current sexual activity (Figure 4.7.3).

Figure 4.7.3: Indigenous males aged 18–24, by contraception use and remoteness, 2012–13



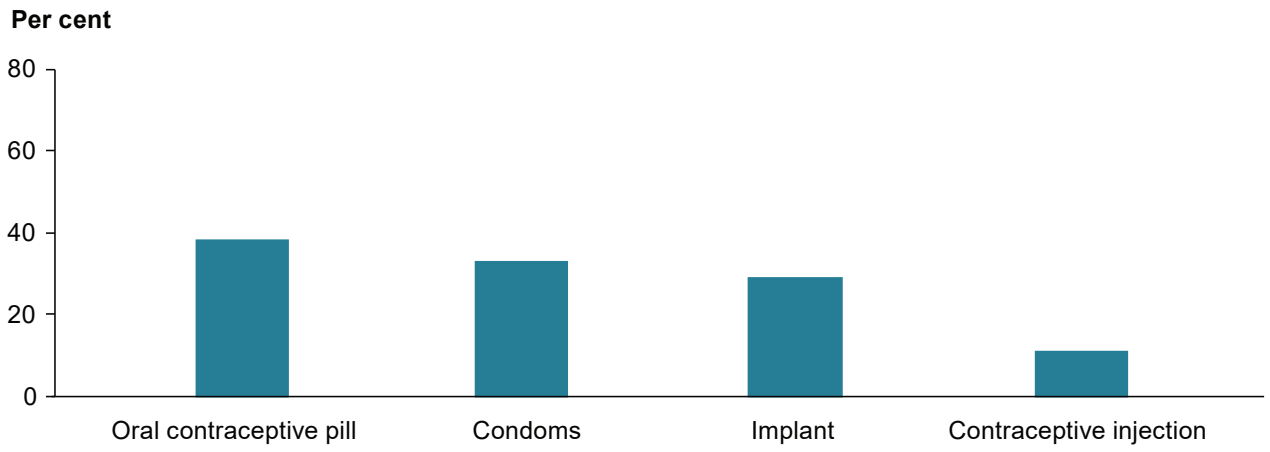
† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Note: Excludes young males for whom contraception use was not asked, and who have never used condoms.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

Of the young Indigenous females aged 18–24 who had ever taken oral contraceptives (49% or 20,300), the most common type of contraception currently used was the oral contraceptive pill (38% or 8,100), followed by condoms (33% or 7,000), implant (29% or 6,200) and contraceptive injection (11% or 2,400) (Figure 4.7.4).

Figure 4.7.4: Indigenous females aged 18–24 that used contraception by type of contraceptive used, 2012–13



Notes

1. Multiple responses item; sum of components may exceed total.
2. Includes 2% of young females that used other forms of contraception.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

The most common type of contraception used in non-remote areas for young females was the oral contraceptive pill (45% or 7,700). In remote areas, 1 in 2 young females used the implant (50% or 2,000).

4.8 How do young Indigenous people compare?

This report focuses on data about Indigenous youth so that, through the findings, their voice can be heard. Yet, there is also value in understanding what the data says about other groups. Some comparison data for key indicators for young non-Indigenous people and older Indigenous people are presented in Box 4.8.

Health risk factors are important predictors of health. Risky health behaviour in youth can lead to adverse health outcomes in the short-term and in later life.

More young Indigenous people were likely to not drink or drank but did not exceed short-term/single occasion alcohol risk than older Indigenous people or young non-Indigenous people.

However, a higher proportion of non-Indigenous people aged 15–24 than Indigenous people aged 15–24 or older Indigenous people had never smoked. Young non-Indigenous people were also more likely to be within the normal weight range than young Indigenous people or older Indigenous people.

Box 4.8: Health risk factors measures: comparison with other population groups

	Indigenous people under 25	Non-Indigenous people under 25	Indigenous people 25 and over
% did not drink, or drank but did not exceed short-term/ single occasion alcohol risk[(a)(b)]	65	33	67
% never smoked[(b)]	56	77	26
% within normal weight range[(b)]	34	58	22
% participated in sport/ physical recreation activities[(c)]	54	80	26

(a) For young non-Indigenous people totals includes 'did not consume alcohol in the previous 12 months' and 'never consumed alcohol'.

(b) For Indigenous and non-Indigenous people aged 18–24.

(c) For Indigenous and non-Indigenous people aged was 15–24. Young non-Indigenous people were asked if they were player or participant.

Sources: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey, 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder) and AIHWb 2017.



5

Wellbeing

The ages of 10 to 24 are, in general, some of the healthiest in a persons' life. This period, however, is also characterised by an interplay of physical, developmental, personal, and social changes that can present real and substantial challenges for young people. This chapter includes an overview of how young Indigenous people are faring on measures that relate broadly to wellbeing such as language, connection to culture and happiness. It also encompasses data on the major stressors faced by young Indigenous people, their experiences of unfair treatment, and psychological distress.

Box 5: Main data sources and key issues

Mission Australia's Youth Survey

- This national online survey was conducted by Mission Australia in 2017. Recruitment to the survey was undertaken by distributing an electronic link to secondary school principals across Australia, and to networks of other service providers.
- Of the 24,055 young Australians aged 15–19 who responded to the survey, 1,265 (5.3%) identified as Aboriginal and/or Torres Strait Islander (Bullot et al. 2017). This sample may not be representative of all young Indigenous people.

5.1 Language

Although English is the dominant language used in Australia, around 120 Indigenous languages are spoken throughout the country. Many Indigenous languages have been lost (there were around 250 distinct languages at the first significant European contact in the 18th century) and many of the languages spoken today are at risk of being lost as elders pass on (AIATSIS 2017). To young Indigenous people, language is not only a form of communication but also an integral part of belonging and identity (Standing Committee on Aboriginal and Torres Strait Islander Affairs 2012).

Around 1 in 10 speak an Indigenous language at home

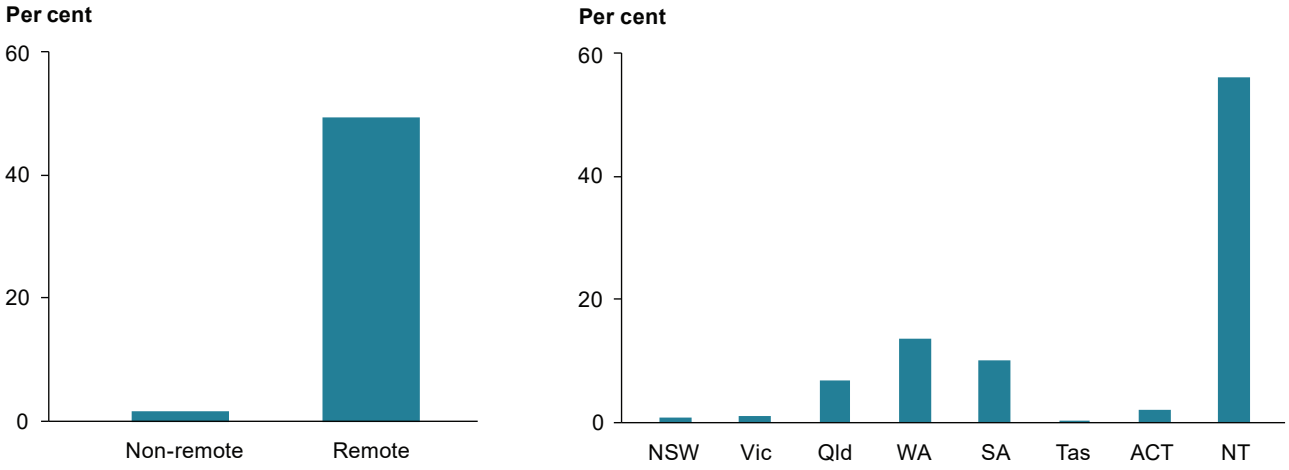
In 2016, for majority (89% or 166,099) of Indigenous people aged 10–24, English was the main language spoken at home. Around 1 in 10 young Indigenous people spoke an Indigenous language at home (10% or 18,336), roughly half of whom were male (50% or 9,243) and half of whom were female (50% or 9,099).

The proportion of young Indigenous people speaking mainly an Indigenous language at home increased slightly with age—7% (5,600) of those aged 10–14, 9% (6,800) of those aged 15–19 and 10% (6,900) of those aged 20–24.

Young Indigenous people living in remote areas (49% or 15,560) were more likely to speak mainly an Indigenous language at home than those in non-remote areas (2% or 2,741) (Figure 5.1.1).

Of all states and territories, the Northern Territory had the highest proportion of young Indigenous people speaking mainly an Indigenous language at home (56% or 10,226). The corresponding proportions for other states and territories were lower (Figure 5.1.1).

Figure 5.1.1: Proportion of Indigenous people aged 10–24 with an Australian Indigenous language as the main language spoken at home, by remoteness and state and territory, 2016



Note: Excludes young people for whom language spoken at home was not stated.

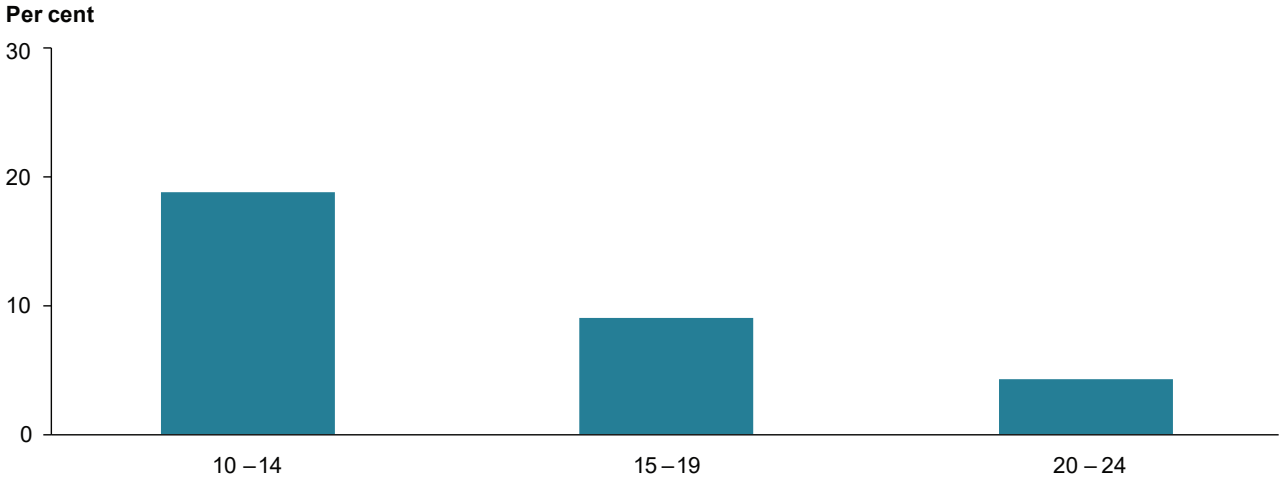
Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

The most common Indigenous languages spoken at home were Arnhem Land and Daily River regional languages (17% or 3,119), followed by Yolngu Matha (12% or 2,152), Torres Strait Islands languages (11% or 2, 079), Western Desert languages (11% or 1,972) and Arandic (7% or 1,292).

2 in 10 learning an Indigenous language

As part of the 2014–15 NATSISS, young Indigenous people were asked if they were learning an Indigenous language. The proportion of young people learning an Indigenous language decreased with age, with 19% (14,300) of those 10–14 learning an Indigenous language, followed by those aged 15–19 (9% or 6,600) and those aged 20–24 (4% or 2,800) (Figure 5.1.2). A slightly lower proportion of young Indigenous males (10% or 10,700) than females (12% or 12,800) were leaning an Indigenous language.

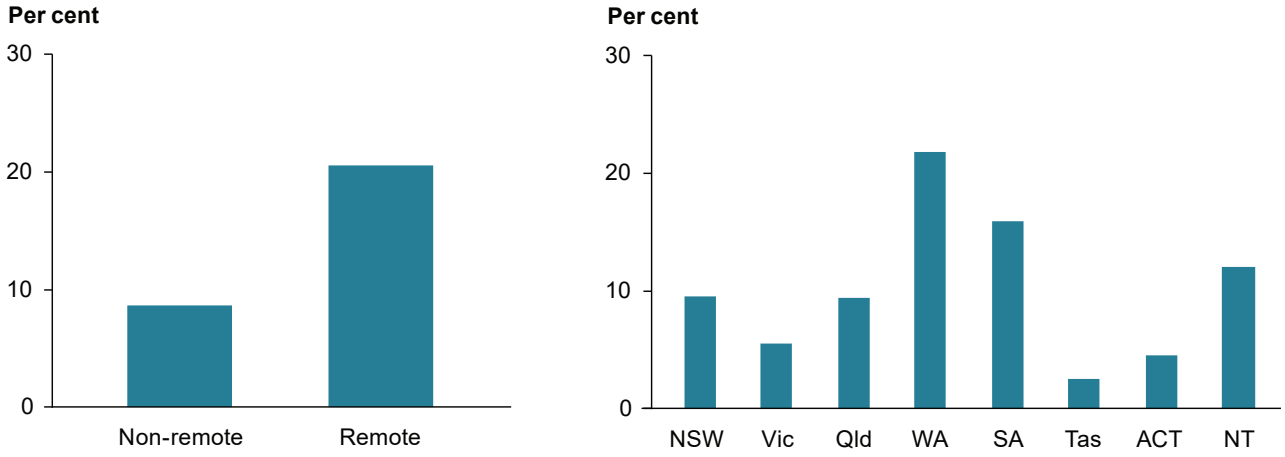
Figure 5.1.2: Proportion of young Indigenous people who were learning an Indigenous language, by age group, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

A higher proportion of young Indigenous people living in remote areas were learning an Indigenous language (21% or 8,400) than those in non-remote areas (9% or 15,100) (Figure 5.1.3). Across states and territories, Western Australia (22% or 5,900) had the highest proportion of young Indigenous people learning an Indigenous language, while the Australian Capital Territory (5% or 100) had the lowest proportion (Figure 5.1.3).

Figure 5.1.3: Proportion of Indigenous people aged 10–24 who were learning an Indigenous language, by remoteness and state and territory, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

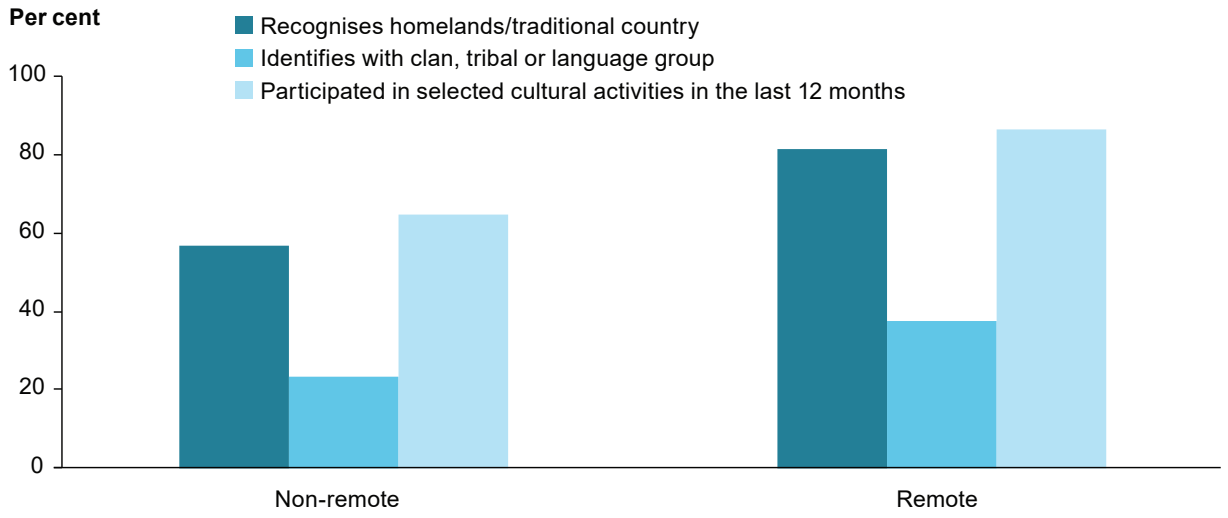
5.2 Culture

A strong connection to culture

A strong connection to culture and country has a central role in ensuring the good health of Indigenous Australians (DoH 2013). More than 6 in 10 Indigenous people aged 10 to 24 recognised their traditional homelands or traditional country (61% or 131,000) and over two thirds (69% or 146,800) were involved in selected cultural events (such as ceremonies, funerals or sorry business, and NAIDOC week activities) in the previous 12 months. Over half (53% or 113,000) identified with a clan, tribal or language group.

Similar proportions of young Indigenous males and females recognised homelands/traditional country (61% or 65,100 and 62% or 65,800, respectively). Young Indigenous males were more likely to report participating in selected cultural activities in the previous 12 months than females (73% or 79,100 and 64% or 67,800, respectively). Young Indigenous females were more likely to identify with a clan, tribal or language group (55% or 58,300 and 51% or 55,000, respectively). The proportion of young Indigenous people identifying with each of the theses cultural attributes measures was higher in remote areas than in non-remote areas (Figure 5.2.1).

Figure 5.2.1: Proportion of Indigenous people aged 10–24 with selected cultural attributes, by remoteness, 2014–15

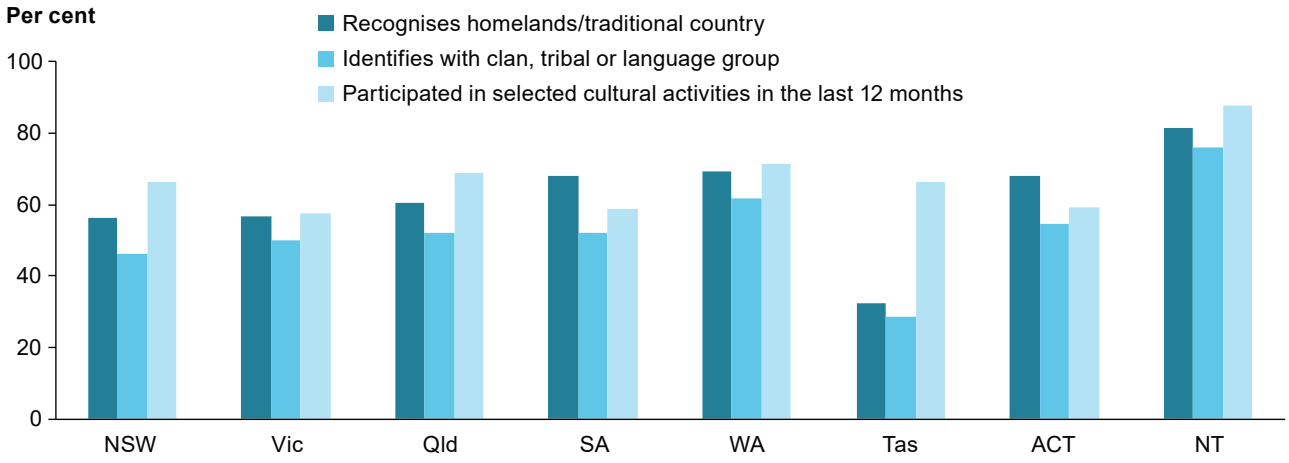


Note: Totals are not mutually exclusive.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Across states and territories, results were highest for young Indigenous people in the Northern Territory (Figure 5.2.2).

Figure 5.2.2: Proportion of Indigenous people aged 10–24 with selected cultural attributes by state and territory, 2014–15



Note: Totals are not mutually exclusive.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Box 5.2: Exploring links between culture, health and wellbeing

The Mayi Kuwayu study is a national longitudinal study of Aboriginal and Torres Strait Islander wellbeing. It was designed and is led by Aboriginal researchers and staff and the study team has collaborated with peak Indigenous organisations and Indigenous Australians. The study is currently being conducted, with data collection in February and June 2018.

The study involves surveying Indigenous people aged 16 and over. Around 200,000 surveys will be sent by mail around the country in the initial collection, with larger collection rounds to follow. Indigenous Australians will be asked about their connection to country, cultural practices, spirituality, language use, and other factors.

In addition to survey responses, the study involves linking hospital records, cancer records, Medicare services, Pharmaceutical Benefits Scheme records and mortality records. This linkage will allow for an analysis of how culture relates to health and wellbeing.

Source: Mayi Kuwayu study of Aboriginal and Torres Strait Islander Wellbeing, Australian National University.

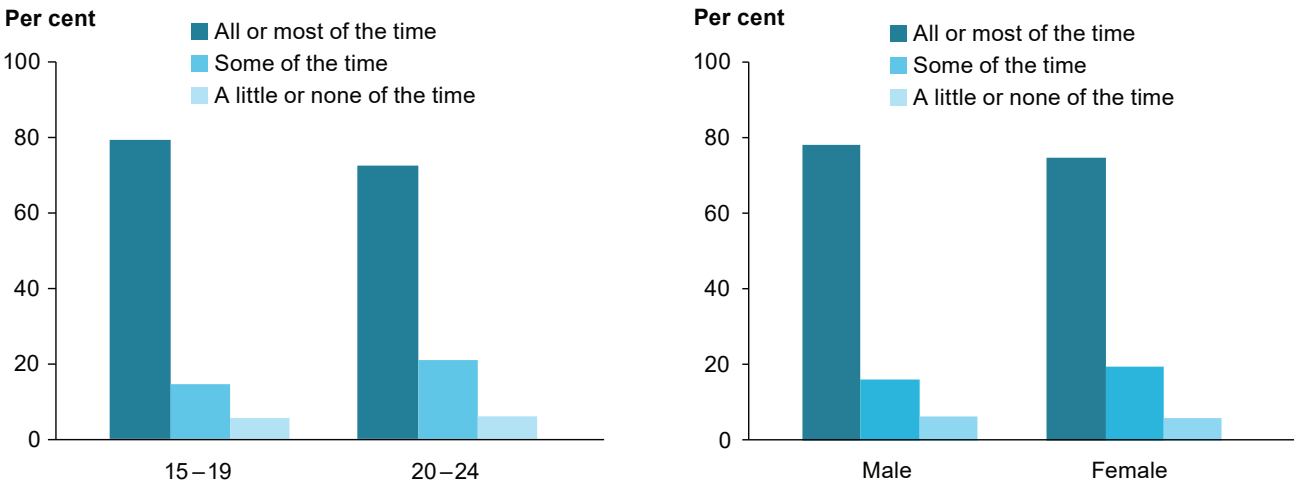
5.3 Happiness

Young Indigenous people are generally happy

As part of the NATSISS, young Indigenous people were asked to indicate how often they had felt happy in the previous 4 weeks. In 2014–15, 76% (104,500) of Indigenous people aged 15–24 reported they were happy all or most of the time, 18% (24,900) were happy some of the time and 6% (7,900) were happy a little or none of the time.

Around 79% of young Indigenous people, aged 15–19 (57,500) and 73% of those aged 20–24 (47,000) indicated they were happy all or most of the time (Figure 5.3.1). A slightly higher proportion of young Indigenous males (78% or 53,300) than females (74% or 51,200) were happy all or most the time (Figure 5.3.1).

Figure 5.3.1: Indigenous people aged 15–24, by reported frequency of happiness in the previous 4 weeks, age and sex, 2014–15



Note: Happiness was collected as a section of the K5 (see Box 5.8 for explanation) score.
Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

The proportion of Indigenous people aged 15–24 who were happy all or most of the time in the previous 4 weeks was slightly lower in non-remote areas (75% or 83,500) than in remote areas (78% or 20,400).

Across states and territories, New South Wales (80% or 35,200) and Queensland (79% or 30,900) had the highest proportions of young Indigenous people who were happy most or all of the time in the previous 4 weeks. Slightly lower proportions were observed for the Northern Territory (75% or 9,600), the Australian Capital Territory (73% or 1,100), Western Australia (73% or 12,200), and South Australia (72% or 5,400). Tasmania (69% or 3,500) and Victoria (67% or 6,900) had the lowest proportion of young Indigenous people who were happy most or all of the time in the previous 4 weeks.

5.4 Confidence, values, and looking to the future

Mission Australia's 2017 Youth Survey Report (Bullot et al. 2017) collected data on these topics from 1,265 young Indigenous people, but this may not be representative of the total young Indigenous population.

1 in 3 are extremely or very confident in achieving study/work goals

The Mission Australia survey found that more than one-third (37%) of Indigenous people aged 15–19 were either extremely or very confident in achieving their study/work goals. A higher proportion of males (41%) than females (32%) were extremely or very confident (Figure 5.4.1).

Figure 5.4.1: Indigenous people aged 15–19, by level of confidence in achieving study/work goals, and sex, 2017



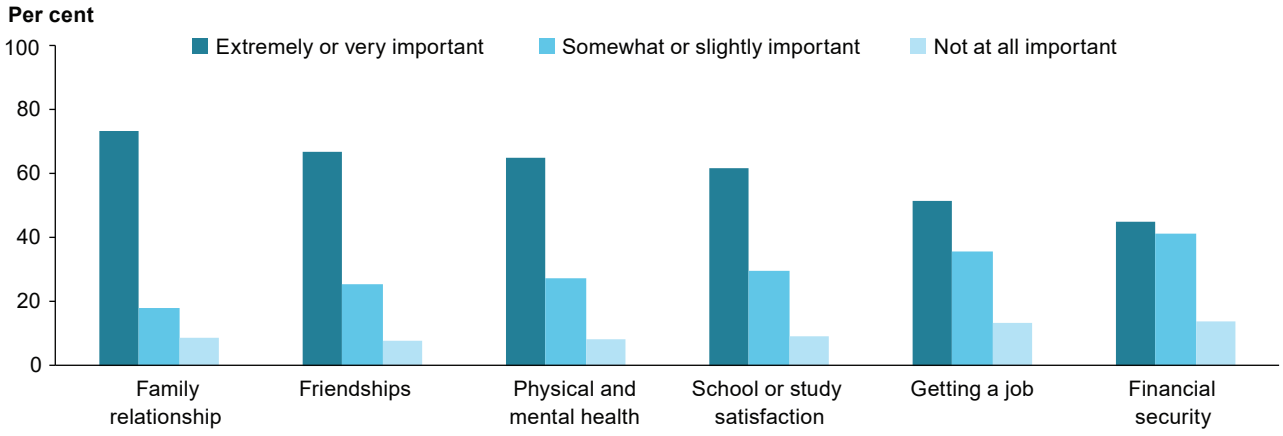
Source: Bullot et al. 2017.

Family relationships and friendships are most highly valued

The majority of young Indigenous people highly valued their relationships. Around 74% of them considered family relationships extremely or very important and 67% considered friendships extremely or very important.

Other areas Indigenous people aged 15–19 considered extremely or very important were physical and mental health (65%) and school or study satisfaction (62%). Around half of the group (51%) considered getting a job extremely or very important (Figure 5.4.2).

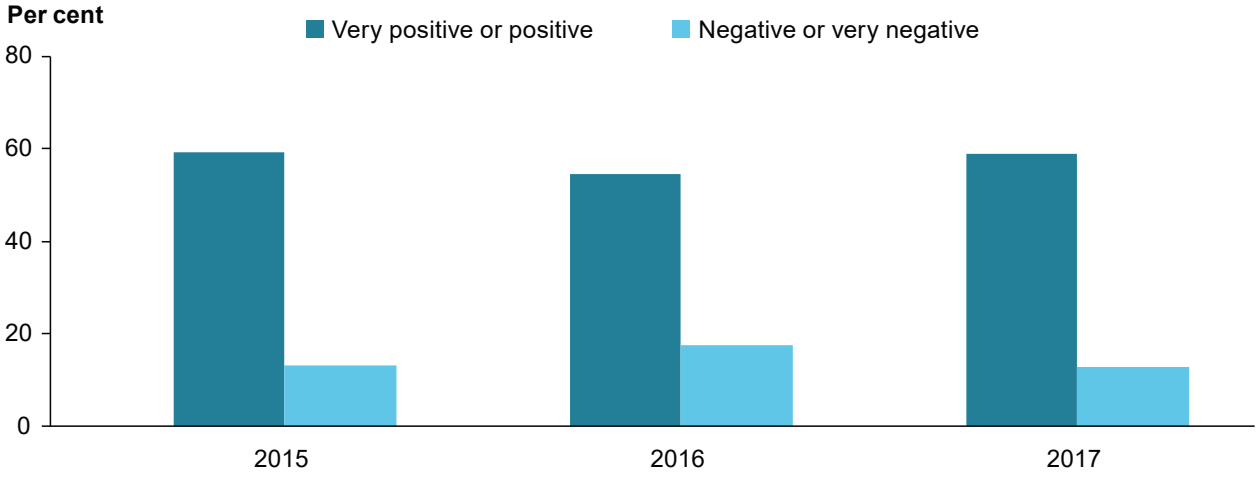
Figure 5.4.2: Indigenous people aged 15–19, by value ascribed to different domains, 2017



Source: Bullot et al. 2017.

In 2017, most (59%) young Indigenous people had very positive or positive feelings about the future. This result represented an increase on 2016 (54%) but was similar to 2015 (59%) (Figure 5.4.3).

Figure 5.4.3: Proportion of Indigenous people aged 15–19, by feelings about the future, 2015–2017



Note: Excludes neither positive nor negative responses.

Source: Bullot et al. 2017.

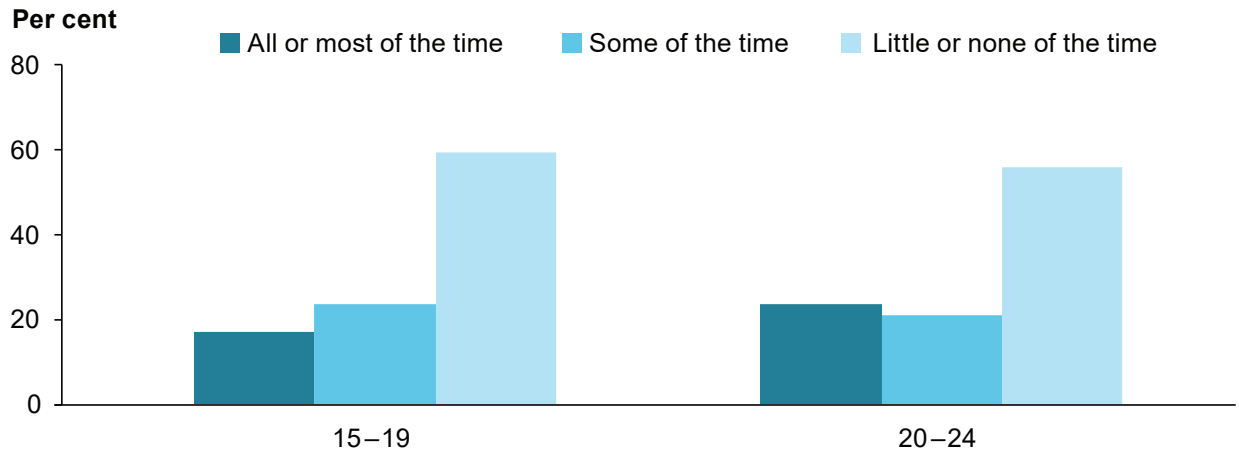
5.5 Having a say

3 in 5 feel they did not have a say on important issues within community

More than half of Indigenous people aged 15–24 (58% or 79,300) felt that they had a say on important issues within their communities either little or none of the time. A further 22% (30,600) reported having a say some of the time and 20% (27,200) reported having a say all or most of the time.

Analysis by age group shows that 17% (12,400) of youth aged 15–19 and 24% (15,300) of youth aged 20–24 felt they had a say all or most of the time on important issues within their community. Six in 10 (60% or 43,500) of those aged 15–19 and over half (56% or 36,300) of those aged 20–24 indicated that they felt they had a say only a little of the time or none of the time (Figure 5.5.1).

Figure 5.5.1: Indigenous people aged 15–24, by how often they felt able to have a say on important issues within their community and age group, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

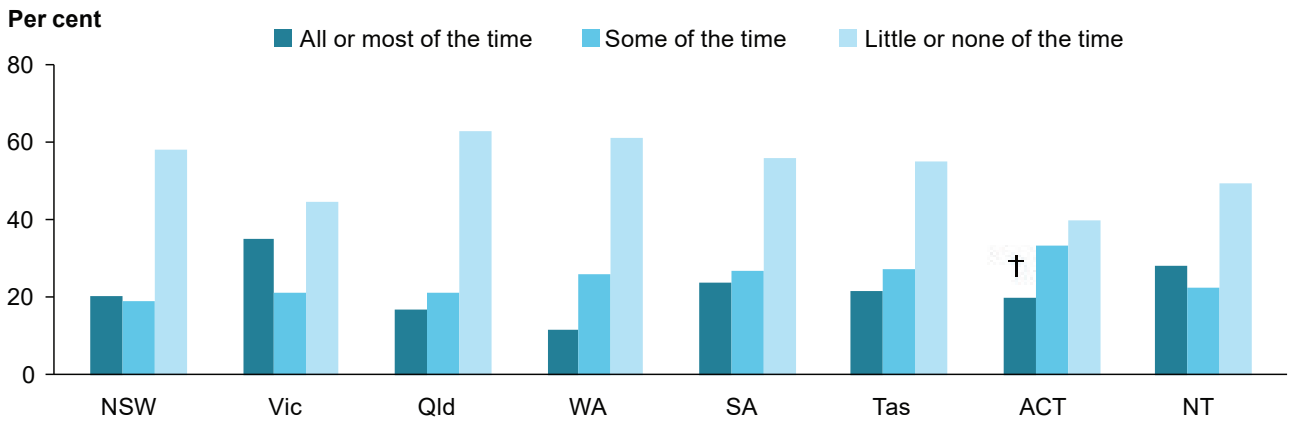
Similar proportions of males and females reported being able to have a say all or most of the time (19% or 12,900 and 21% or 14,100, respectively). More than half of both males and females reported not being able to have a say on important issues (57% or 39,200 and 58% or 39,700).

Youth in non-remote and remote areas reported similar assessments of whether they had a say on important community issues all or most of the time (20% or 22,700, and 18% or 4,700, respectively).

Around 22% (24,700) in both non-remote areas and remote areas (5,900) felt they had a say some of the time and 57% (63,600) in non-remote areas and 60% (15,900) in remote areas felt that they had a say little to none of the time.

Among states and territories, young Indigenous people living in Victoria were most likely to feel able to have a say all or most of the time (35% or 3,600), while in Western Australia they were least likely (12% or 2,000) (Figure 5.5.2).

Figure 5.5.2: Indigenous people aged 15–24, by how often they felt able to have a say within their community on important issues and by state and territory, 2014–15



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Cultural factors, such as an emphasis on respect for elders, may influence these findings. That is, young Indigenous people may feel that respected elders should take a leading role when it comes to having a say on important issues within their community.

Almost 3 in 4 feel they have a say on issues with family and friends

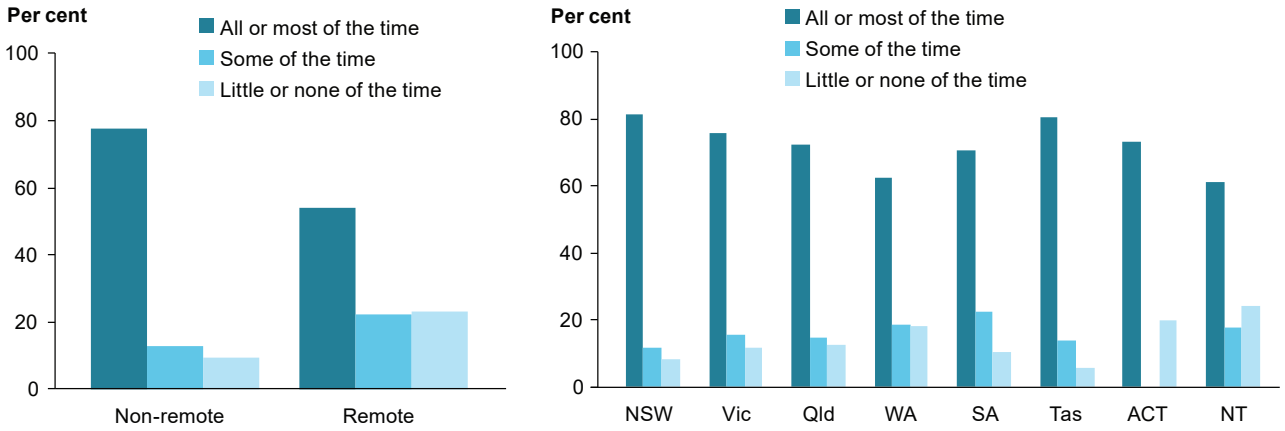
Nearly three-quarters (73% or 100,300) of Indigenous people aged 15–24 felt able to have a say on important issues with family and friends either all or most of the time. A further 15% (19,900) felt able to have a say some of the time and 12% (17,000) felt able to have a say a little or none of the time.

Around 76% (49,200) of Indigenous people aged 20–24 felt they had a say on important issues with family and friends all or most of the time. A lower proportion, 71% (51,600), of those aged 15–19 felt they had a say all or most of the time. A similar proportion of young Indigenous males (74% or 50,700) and females (72% or 49,800) felt able to have a say with family and friends on important issues all or most of the time.

The proportion of young Indigenous people who felt able to have a say on important issues with family and friends all or most of the time was higher in non-remote areas (78% or 85,900) than remote areas (54% or 14,300). The proportion who felt able to have a say only a little or none of the time was more than twice as high in remote areas (23% or 6,100) than in non-remote areas (9% or 10,400) (Figure 5.5.3).

Young Indigenous people living in New South Wales were most likely to feel able to have a say with friends and family all or most of the time (82% or 35,700). Young Indigenous people in the Northern Territory (61% or 7,800) and Western Australia (62% or 10,600) were least likely to feel able to have a say all or most of the time (Figure 5.5.3).

Figure 5.5.3: Indigenous people aged 15–24, by how often they felt able to have a say with family and friends on important issues, by remoteness and state and territory, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

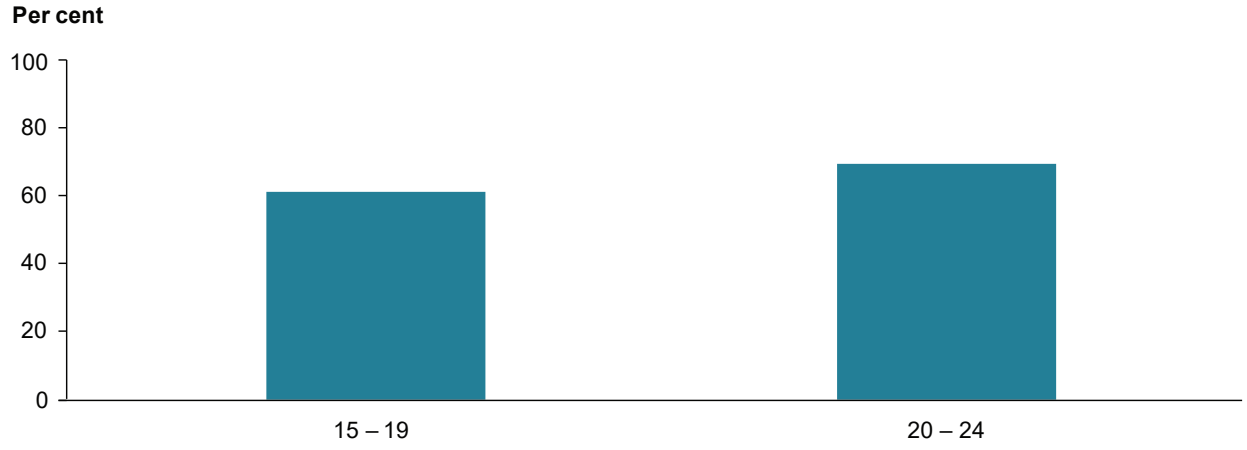
5.6 Stressors

Analysis of 2008 ABS data shows that exposure to life stressors is associated with psychological distress, poorer self-assessed health and higher rates of risky health behaviours such as daily smoking, binge drinking and illicit substance use (ABS 2011).

As part of the 2014–15 NATSISS, young Indigenous people were asked about selected stressors, that is, whether they, family members or friends had experienced 1 or more of a range of problems relating to health, family or work in the previous 12 months. The analysis in this section focuses on personal stressors only, meaning events that related to the self.

In 2014–15, almost two thirds of Indigenous people aged 15–24 had experienced 1 or more personal stressors in the previous 12 months (65% or 89,500). The proportion of young Indigenous people who had experienced a stressor increased with age. More than 6 in 10 (61% or 44,400) Indigenous people aged 15–19 experienced a stressor in the previous 12 months. This increased to 69% (44,900) for those aged 20–24 (Figure 5.6.1).

Figure 5.6.1: Proportion of Indigenous people aged 15–24 who personally experienced a stressor in the previous 12 months by age, 2014–15



Note: Excludes 'refusal' response.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

A higher proportion of young Indigenous females experienced a stressor in the previous 12 months (68% or 46,800) than males (62% or 42,600). Two-thirds (65% or 72,900) of those living in non-remote areas experienced a stressor in the previous 12 months compared with 63% (16,500) of young Indigenous people in remote areas.

Most young Indigenous people experienced 1 or 2 stressors in the previous year

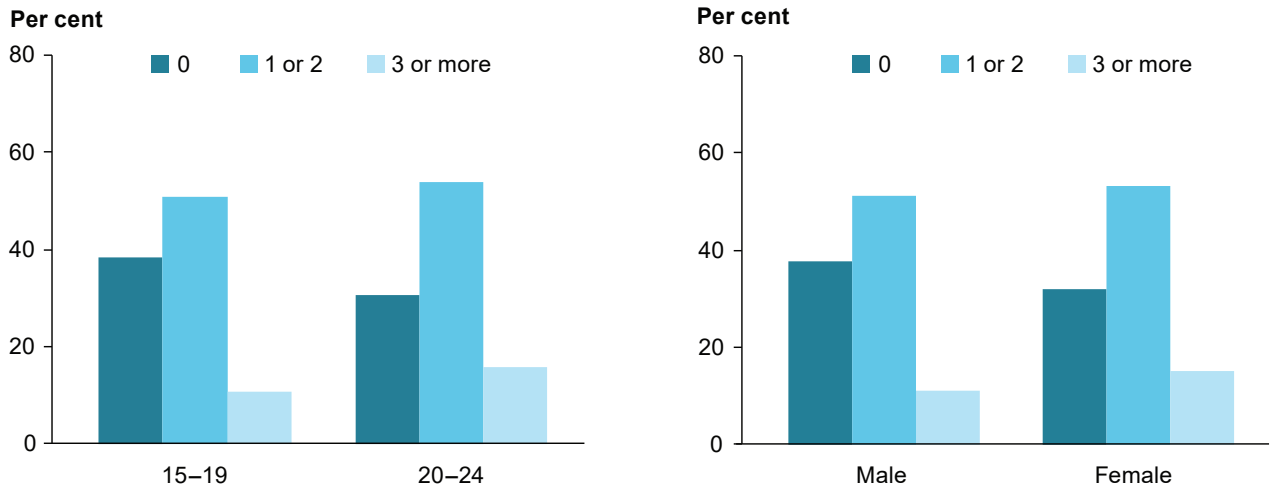
The experience of 3 or more stressors, or life events, is a commonly reported cut-off of interest in the research literature (Kikkawa 2014). Analysis of the Western Australian Aboriginal Child Health Survey, for example, found that, compared with children whose families had experienced 2 or fewer major life events over the previous 12 months, children whose families had experienced 3 to 6 major life events were 1.8 times as likely to develop clinically significant social and emotional difficulties. Children whose families had experienced 7 or more major life events were 5.5 times as likely to develop these difficulties (Zubrick et al. 2005).

Data from the 2014–15 NATSISS show that more than half (52% or 71,799) of Indigenous people aged 15–24 had experienced 1 or 2 stressors in the previous 12 months, 13% (17,981) reported experiencing 3 or more stressors, and the remainder reported experiencing no stressors.

There was evidence of an association between the number of stressors experienced by young Indigenous people and their level of psychological distress. Young people who experienced 3 or more stressors were more likely to report high psychological distress (60% or 10,779), than those who experienced 1 or 2 stressors (36% or 25,469) or no stressors (18% or 8,657).

The proportion of young Indigenous people who experienced 3 or more stressors increased with age. Around 11% (7,793) of those aged 15–19 and 16% (10,188) of those aged 20–24 experienced 3 or more stressors. A little more than half of young Indigenous males and females aged 15–24 experienced 1 or 2 stressors (51% or 35,299 and 53% or 36,500, respectively). More than 1 in 10 young Indigenous males and females (11% or 7,642 and 15% or 10,339) experienced 3 or more stressors (Figure 5.6.2).

Figure 5.6.2: Indigenous people aged 15–24 by number of stressors personally experienced in the previous 12 months, by age and sex, 2014–15

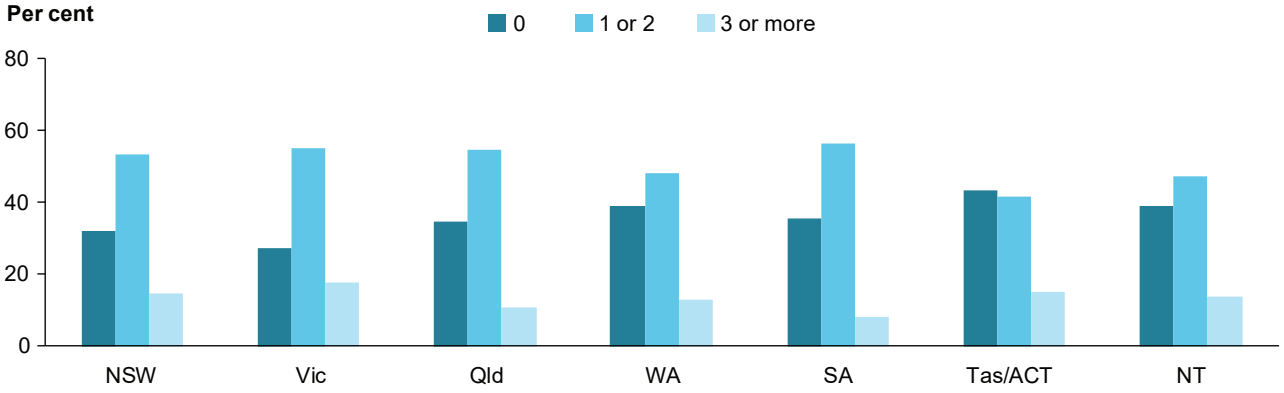


Note: Totals exclude 'refusal'.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using DataLab).

A similar proportion of Indigenous people aged 15–24 reported 1 or 2 stressors in non-remote (53% or 58,379) and remote (51% or 13,420) areas. Similar proportions also reported experiencing 3 or more stressors (13% or 14,893, and 12% or 3,088, respectively). Across states and territories, Victoria had the highest proportion of young Indigenous people who experienced 3 or more stressors (18% or 1,856) and South Australia had the lowest proportion (8% or 624) (Figure 5.6.3).

Figure 5.6.3: Indigenous people aged 15–24 by number of stressors personally experienced in the previous 12 months by state and territory, 2014–15



Note: Totals exclude 'refusal'.

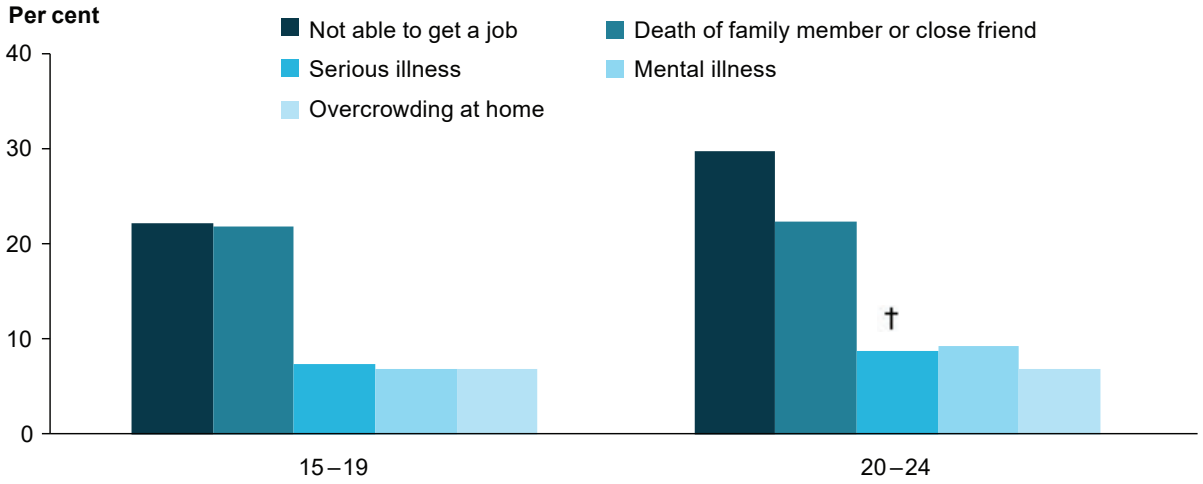
Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using DataLab).

Not being able to get a job a stressor for most

The most commonly reported life stressor personally experienced by all Indigenous people aged 15–24 was not being able to get a job (26% or 35,900). This was followed by the death of a family member or close friend (22% or 30,600), serious illness (8% or 11,600), mental illness (8% or 11,000) and overcrowding at home (7% or 9,300).

Across youth age groups, a higher proportion of Indigenous people aged 20–24 experienced not being able to get a job as a stressor (30% or 19,200) compared with those aged 15–19 (22% or 16,100). Those aged 20–24 were also more likely to experience mental illness (9% or 6,000) and serious illness (9% or 5,700) as life stressors, compared with those aged 15–19 (7% or 4,900 and 7% or 5,400) (Figure 5.6.4).

Figure 5.6.4: Young Indigenous people who experienced personal stressors, by most common types of stressor and age group, 2014–15



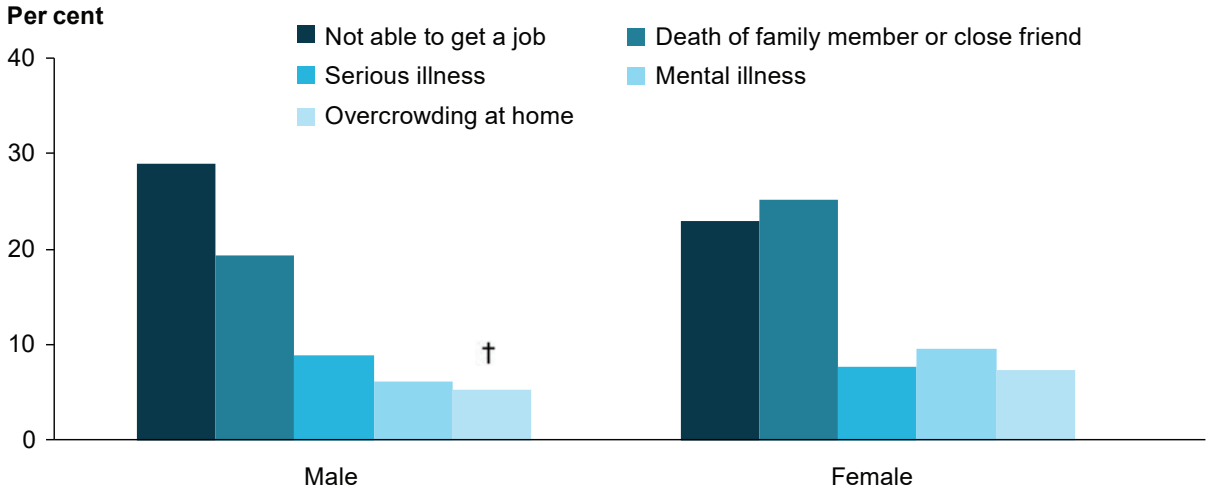
† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Note: Multiple responses item; sum of components may exceed totals.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Not being able to get a job was the most common stressor for both males and females (29% or 19,800 and 23% or 15,800, respectively), followed by the death of a family member or close friend (19% or 13,200 and 25% or 17,300, respectively). Females were more likely to experience mental illness as a stressor than males (10% or 6,600 and 6% or 4,200, respectively). Females were also slightly more likely to experience overcrowding at home as a stressor (7% or 5,100) than males (5% or 3,600) (Figure 5.6.5).

Figure 5.6.5: Indigenous people aged 15–24 who experienced personal stressors, by most common types of stressor and sex, 2014–15



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

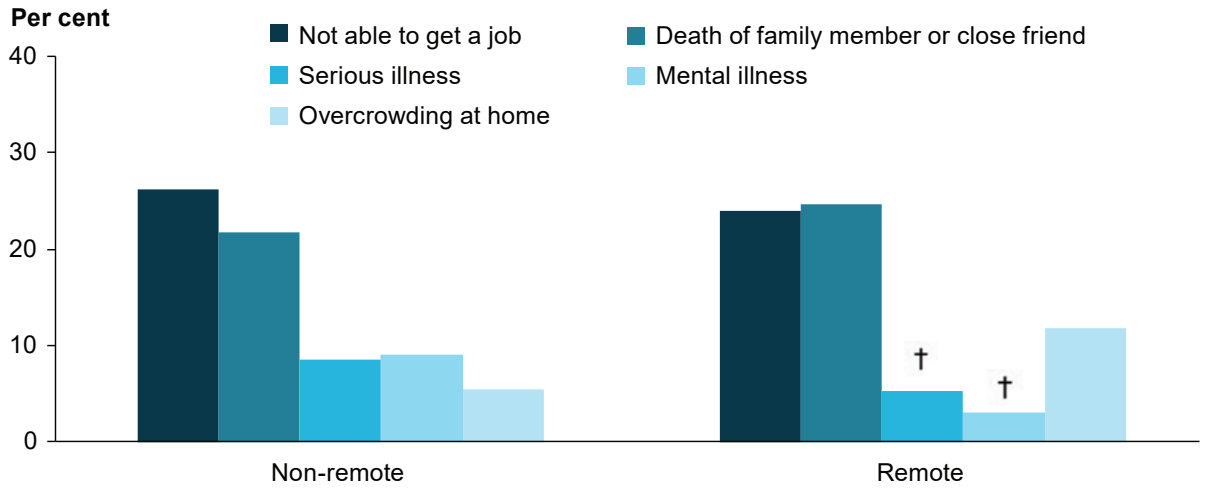
Note: Multiple responses item; sum of components may exceed totals.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Indigenous people aged 15–24 living in non-remote areas were slightly more likely to experience not being able to get a job as a stressor (26% or 29,200) than those living in remote areas (24% or 6,300). Those in non-remote areas were also more likely than those in remote areas to report experiencing mental illness (10,100 or 9% and 800 or 3%, respectively) and serious illness (9,600 or 9% and 1,400 or 5%, respectively) as stressors.

However, those in non-remote areas were less likely than those in remote areas to experience the stress of the death of a family member or close friend (22% or 24,200 and 25% or 6,500, respectively) and overcrowding at home (5% or 6,000 and 12% or 3,100, respectively) (Figure 5.6.6).

Figure 5.6.6: Indigenous people aged 15–24 who experienced personal stressors, by most common types of stressor and remoteness, 2014–15



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Note: Multiple responses item; sum of components may exceed total.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Around 4 in 10 were removed from natural family or had relatives removed

Removal from natural family can have a substantial impact on mental health and wellbeing. These effects can be intergenerational, affecting not only the health and wellbeing of those who experienced removal but also that of subsequent generations (Silburn et al 2006).

In 2014–15, 7% (9,000) of Indigenous people aged 15–24 had been removed from their natural families. When asked about relatives, more than one-third (38% or 45,400) had relatives who had been removed in the past, while 62% (73,600) had no relatives who had been removed.

There was a high degree of overlap between these 2 groups. Among those who had been removed, around 7,300 (6%) had also had relatives removed from their natural families. Great grandparents were the relatives who were most frequently removed (50% or 22,600) followed by aunties/uncles (19% or 8,800).

Similar proportions of Indigenous people aged 15–19 (8% and 5,400) and 20–24 (6% or 4,100) were removed from their natural families. Similar proportions of females (7% or 4,900) and males (6% or 4,400) who were removed from their natural families.

The proportions were similar across remoteness areas—7% (7,300) of those in non-remote areas and 6% (1,600) in remote areas. Of those who were removed, most (83% or 7,000) indicated they were able to see their relatives but did not use help from services to do so. Around 13% (1,100) reported using services to help contact relatives.

The proportion of young Indigenous people with high/very high psychological distress was higher among those removed from their natural families or relatives than those who had not been removed (49% and 32%, respectively).

Most young Indigenous people did not experience physical violence

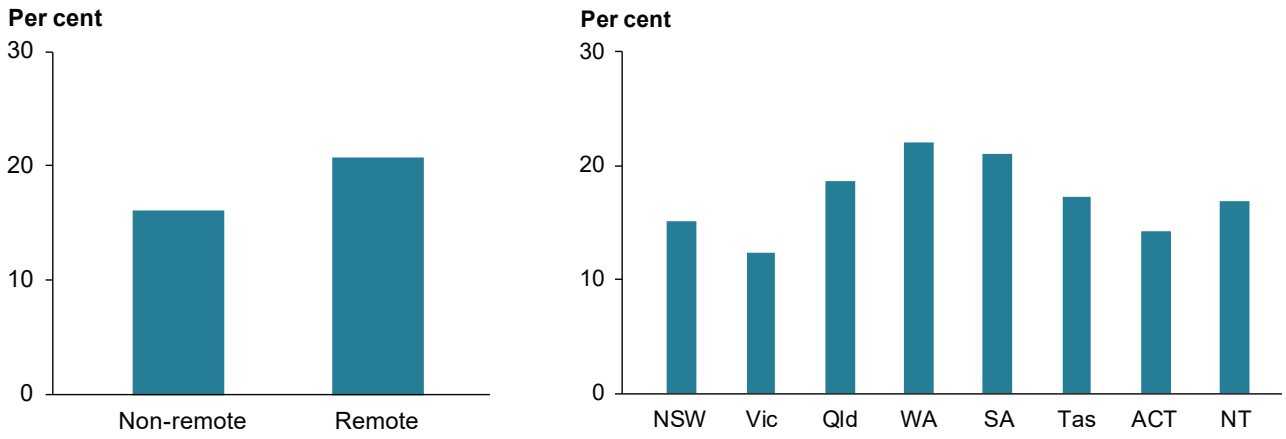
Around 8 in 10 (83% or 114,500) Indigenous people aged 15–24 had not experienced physical violence in the previous 12 months, while 17% (23,100) did experience violence in the previous 12 months.

Across age groups, a similar proportion of those aged 15–19 (82% or 60,000) and those aged 20–24 (84% or 10,600) had not experienced physical violence in the previous 12 months. Similar proportions of males (82% or 56,400) and females (85% or 58,200) had not experienced physical violence in the previous 12 months.

Experience of physical violence was higher in remote areas (21% or 5,500 aged 15–24) than in non-remote areas (16% or 17,800) (Figure 5.6.7).

Across all states and territories, the proportion of young Indigenous people who had experienced physical violence in the previous 12 months was highest in Western Australia (22% or 3,700) and lowest in Victoria (12% or 1,300) (Figure 5.6.7).

Figure 5.6.7: Proportion of Indigenous people aged 15–24 who had experienced physical violence in previous 12 months by remoteness and state and territory, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Around 1 in 10 (14% or 19,600) of all Indigenous people aged 15–24 had experienced physical violence from a person that was known to them. That is, from a current partner, previous partner, boyfriend, girlfriend or date, ex-boyfriend or ex-girlfriend, parent, sibling, other family member, or work colleague/fellow student or neighbour or another person.

The most common injuries received by the most recent physical violence incident were bruises (7% or 9,900) and scratches (3% or 4,300). Around 8% (11,600) reported not being physically injured or harmed in the most recent physical violence incident. Alcohol or other substances were involved in 10% (13,900) of the most recent incidents.

Of the Indigenous people aged 15–24 who had experienced violence in the previous 12 months, about 37% (8,600) did report the most recent physical violence to the police. Those aged 20–24 were more likely to report violence to the police (46% or 4,900) than those aged 15–19 (33% or 4,100). Females were slightly more likely to report recent experiences of violence to the police (41% or 4,300) than males (34% or 4,200).

5.7 Being treated unfairly

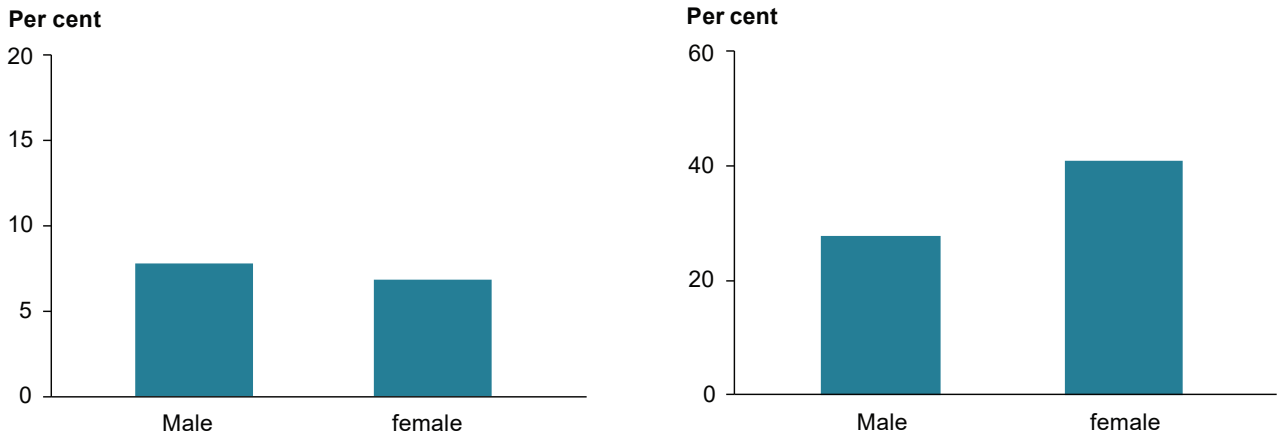
Most young Indigenous people were not treated unfairly

Around 7% (5,100) of Indigenous people aged 10–14 were treated unfairly at current school because they were Aboriginal and/or Torres Strait Islander. Similar proportions of males (8% or 2,800) and females (7% or 2,400) had unfair treatment in current school (Figure 5.7.1). Around 40% (2,800) of those aged 10–14 had progress in school affected by unfair treatment, while 60% (4,200) did not.

Across remoteness, similar proportions of those aged 10–14 in non-remote areas (6% or 8,100) and remote areas (5% or 1,500) were treated unfairly at current school for being Aboriginal and/or Torres Strait Islander.

Over 1 in 3 (34% or 44,800) Indigenous people aged 15–24 had unfair treatment in the previous 12 months because they were Aboriginal and/or Torres Strait Islander. Females (41% or 26,800) were more likely to have experienced unfair treatment than males (28% or 17,900) (Figure 5.7.1).

Figure 5.7.1: Proportion of Indigenous people who experienced unfair treatment aged 10–14 (left) and 15–24 (right) in the previous 12 months because Aboriginal and/or Torres Strait Islander by sex, 2014–15

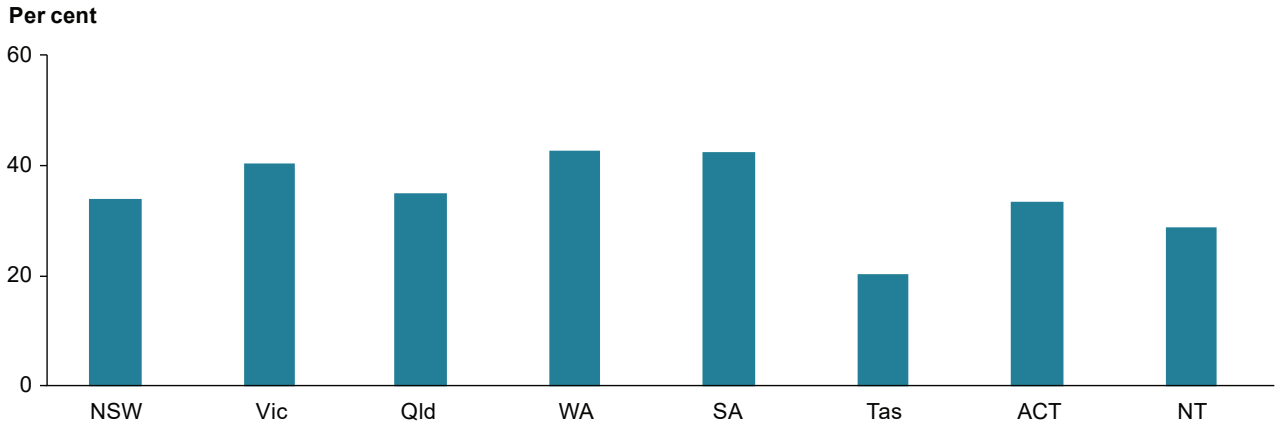


Note: Age group 10–14 reports being treated unfairly due to Indigenous status at school only.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Those aged 15–24 living in non-remote areas were slightly more likely to have had experienced unfair treatment (35% or 37,800) than in remote areas (30% or 20,800). Victoria had the highest proportion of those aged 15–24 who had experienced unfair treatment (40% or 4,000), while Tasmania had the lowest (20% or 1,000) (Figure 5.7.2).

Figure 5.7.2: Proportion of young Indigenous people who experienced unfair treatment aged 15–24 in the previous 12 months because Aboriginal and/or Torres Strait Islander and state and territory, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Box 5.7.1: Racism and links with ill health

A 2017 study, using data from the 2014 Victorian Population Health Survey, found that 15% of Aboriginal and/or Torres Strait Islanders had experienced racism in the preceding 12 months.

There was an association between experiences of racism and health outcomes:

- Victorian adults who experienced racism at least weekly were 4.9 times as likely to have high or very high psychological distress as those who did not.
- Victorian adults who experienced racism at least weekly were 2.5 times as likely to be in fair or poor health as those who did not.

Source: Department of Health and Human Services (Victoria), 2017.

Box 5.7.2: Racism and links with social and emotional wellbeing

In a cross-sectional study of 345 Aboriginal Australians aged 16–20, researchers investigated associations between self-reported racism and culturally appropriate measures of social and emotional wellbeing. Self-reported racism was experienced by 32% of the Aboriginal youth participants. Those who had experienced racism were:

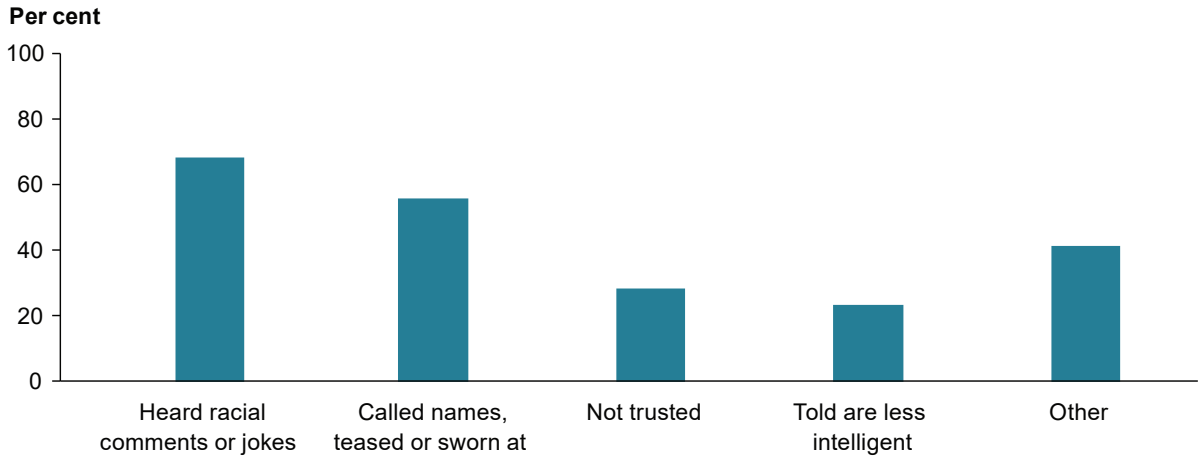
- 2.18 times as likely to report anxiety
- 2.16 times as likely to report depression
- 2.32 times as likely to be at risk of suicide
- 3.35 times as likely to be of overall poor mental health.

Source: Priest et al. 2011

More than 1 in 5 experienced racial comments or jokes

In 2014–15, for all Indigenous people aged 15–24 who experienced various types of unfair treatment in the previous 12 months, the most common form of unfair treatment was racial comments or jokes (69% or 20,300), followed by being called names, teased or sworn at (56% or 14,800) and not being trusted (29% or 4,800) (Figure 5.7.3).

Figure 5.7.3: Indigenous people aged 15–24 who experienced unfair treatment because Aboriginal and/or Torres Strait Islander, by most recent type of unfair treatment, 2014–15



Notes

1. Other unfair treatment includes: ignored or served last while accessing services or buying something; unfairly arrested or charged; left out, refused entry or told don't belong, spat at or had something thrown at; and any other experience that was unfair.
2. Includes only young people who have reported being treated unfairly.
3. Does not include young people who did not know if they had unfair treatment.
4. Multiple responses item; sum of components may exceed total.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Box 5.7.3: Call for police to collect racial profiling data

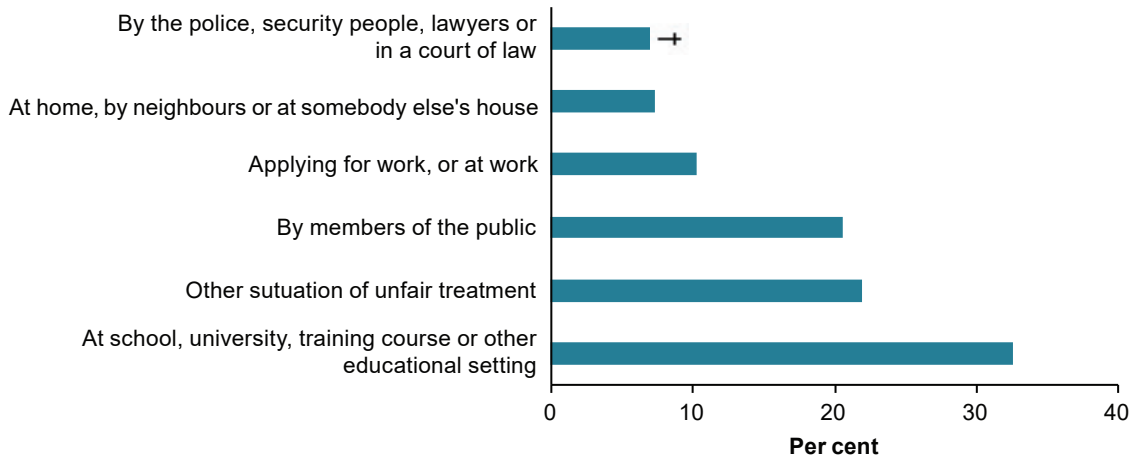
A 2017 report from the Police Stop Data Working Group includes the recommendation that Victoria Police collect additional data on all pedestrian and traffic stops, searches and directions to move on. Such data and 'officer-perceived' ethnicity could be supplied to an external agency in a de-identified format on a regular basis. By incorporating data from the Census and highway traffic use, it would be possible to develop a greater understanding of how rates for these police actions differed for various groups, including young Indigenous people.

Source: Police Stop Data Working Group 2017

Unfair treatment taking place in educational settings

When Indigenous people aged 15–24 were treated unfairly in the previous 12 months, it most commonly took place at school, university, or in another educational setting (33% or 14,600) (Figure 5.7.4).

Figure 5.7.4: Indigenous people aged 15–24 who experienced unfair treatment in the previous 12 months because Aboriginal and/or Torres Strait Islander, by most recent location of unfair treatment, 2014–15



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Notes

1. Other situation and does not know if had unfair treatment includes while doing any sporting, recreational or leisure activities; by doctors, nurses or other staff at hospitals or doctor's surgeries; when accessing government services; when seeking any other services; on the internet or telephone and any other situation.
2. Does not include young people who did not know if they had had unfair treatment.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Most young Indigenous people did not avoid situations due to past unfair treatment (88% or 121,700). A higher proportion of young Indigenous people in non-remote (37,200 or 34%) areas than remote areas (8,000 or 29%) reported unfair treatment in the previous 12 months.

5.8 Psychological distress

Psychological distress is a general term that captures unpleasant feelings or emotion experienced over a shorter period of time (Box 5.8). It is related to major stressors experienced, and over the longer term, can lead to mental health problems, which are, covered Chapter 7.

Box 5.8: Kessler Psychological Distress Scale

The Kessler psychological distress scale or K10 is a 10–item questionnaire designed to obtain a universal measure of distress based on questions about anxiety and depressive symptoms experienced in the previous 4 weeks. A shorter version of the K10, a subset of 5 questions known as the K5 adapted for Aboriginal and Torres Strait Islander respondents, was used (McNamara et al. 2014). Respondents were asked the following: *In the last 4 weeks*:

1. About how often did you feel nervous?
2. About how often did you feel without hope?
3. About how often did you feel restless or jumpy?
4. About how often did you feel everything was an effort?
5. About how often did you feel so sad that nothing could cheer you up?

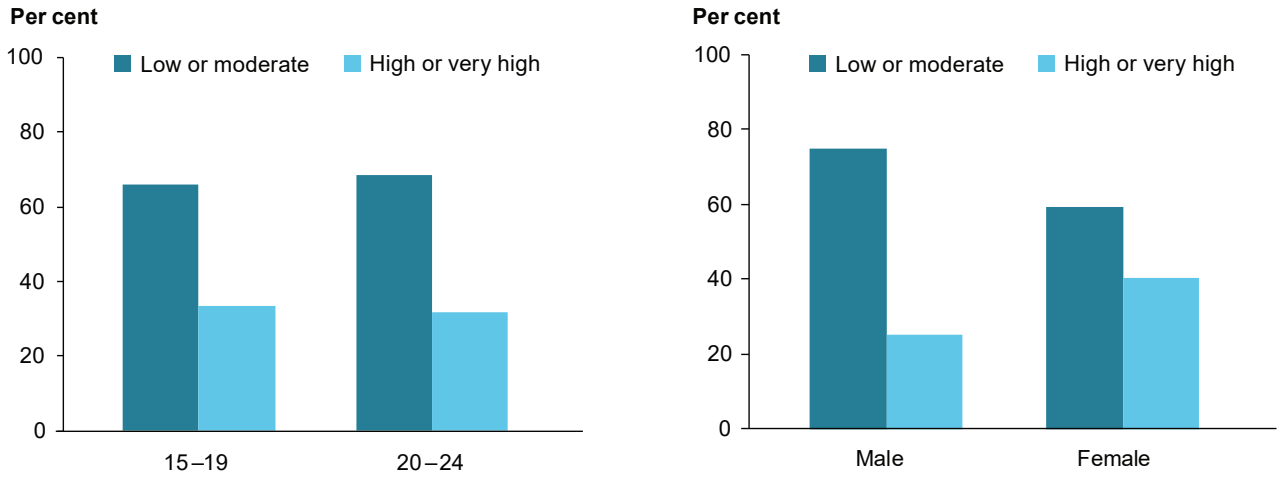
Response options range from 1 (none of the time) to 5 (all of the time). A total score of 5–11 is categorised as low/moderate distress, while 12–25 is categorised as high to very high distress.

Most have low to moderate levels of psychological distress

Most Indigenous people aged 15–24 reported low to moderate levels of psychological distress (67% or 90,900). However, a considerable proportion reported high to very high levels of psychological distress (33% or 44,700). A similar proportion of those aged 15–19 (34% or 24,100) and those aged 20–24 (32% or 20,500) reported high or very high psychological distress.

Across age groups, the proportion of youth who reported experiencing low or moderate psychological distress was similar in the 15–19 age group (66% or 47,400) and the 20–24 age group (69% or 44,200). A higher proportion of males (75% or 50,900) than females (59% or 40,400) experienced low or moderate levels of psychological distress (Figure 5.8.1).

Figure 5.8.1: Indigenous people aged 15–24 by level of psychological distress in the previous 4 weeks, by age group and sex, 2014–15

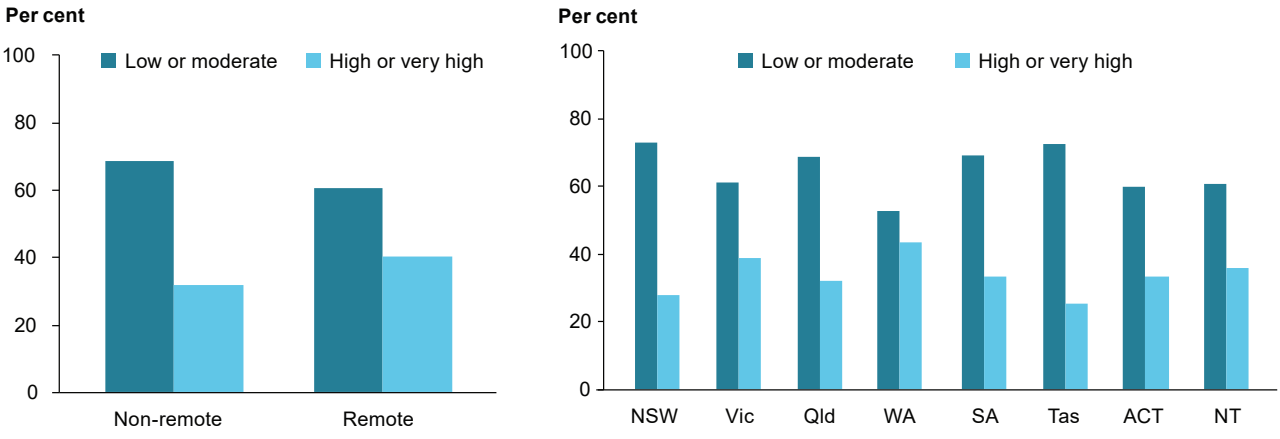


Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Indigenous people aged 15–24 in non-remote areas (69% or 75,700) were more likely to experience low or moderate psychological distress compared with those in remote areas (61% or 15,700). Those in remote areas were more likely to report high or very high psychological distress (40% or 10,400) compared with those in non-remote areas (32% or 35,000) (Figure 5.8.2).

Across states and territories, the proportion of young Indigenous people reporting high to very high psychological distress was highest in Western Australia (44% or 7,400) and Victoria (39% or 4,000) and lowest in Tasmania (26% or 1,300) and New South Wales (28% or 12,300) (Figure 5.8.2).

Figure 5.8.2: Indigenous people aged 15–24, by level of psychological distress in the previous 4 weeks, by remoteness and state and territory, 2014–15



Note: Excludes young people for whom K5 score was unable to be determined.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

5.9 How do young Indigenous people compare?

This report focuses on data about Indigenous youth so that, through the findings, their voice can be heard. Yet, there is also value in understanding what the data says about other groups. Some comparison data for key indicators on both young non-Indigenous people and older Indigenous people are therefore presented below.

Non-Indigenous people aged 15–24 were more likely to have a say with family and friends on important issues than young or older Indigenous people. More older Indigenous people felt like they had a say within their community on important issues than Indigenous or non-indigenous people aged 15–24.

Indigenous people aged 15–24 and older Indigenous people were more likely to experience personal stressors than young non-Indigenous people. Young non-Indigenous people were less likely to have high or very high psychological distress, than young Indigenous people or older Indigenous people.

Box 5.9: Wellbeing measures: comparison with other groups

	Indigenous people under 24	Non-Indigenous people under 24	Indigenous people over 25
% had a say with family and friends on important issues all or most of the time[(a)]	73	80	75
% had a say within the community on important issues all or most of the time[(a)]	20	20	28
% experienced personal stressors in the previous 12 months[(a)]	65	58	70
% 'High' or 'Very high' levels of psychological distress[(b)]	33	13	33

(a) For Indigenous and non-Indigenous people the age group used was 15–24.

(b) For Indigenous and non-Indigenous people the age group used was 18–24.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey and 2014 General Social Survey (using TableBuilder).



6

Health status and outcomes

Data presented in this chapter provide a higher-level overview of the health of young Indigenous people. The focus is on self-assessed health, the burden of disease and rates of disability, hospitalisation and mortality. These broad and important population health measures provide an indication of the extent and impact of ill health within a population. Each of these measures is recognised and used by the WHO (2014) to understand adolescent health.

Box 6: Main data sources and key issues

Australian Burden of Disease Study (ABDS)

- The AIHW Australian Burden of Disease Study 2011 provides estimates of the burden due to different diseases and injuries.
- The study uses a technique that assesses and compares the impact—the burden—of fatal and non-fatal diseases and injury on population groups. A component of the study assessed the disease burden for Aboriginal and Torres Strait Islander people.

National Hospital Morbidity Database (NHMD)

- The NHMD is a compilation of episode-level records from the admitted patient care data collections systems in Australian hospitals. The data for 2015–16 includes 37,603 hospitalisations for Indigenous persons aged 10–24, excluding those related to pregnancy and childbirth.
- There is some under-identification of Indigenous Australians in the NHMD, but data for all states and territories are considered to have adequate identification for statistical reporting from 2010–11 onwards. For time series data prior to this, data for 6 jurisdictions were used—New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory.

National Mortality Database (NMD)

- These data are collected in Australia by the registrars of births, deaths and marriages in each state and territory and compiled nationally by the ABS.
- The Indigenous status of the deceased is not always reported/recorded, or recorded correctly. Indigenous deaths data are reported for 5 jurisdictions determined to have adequate levels of Indigenous identification—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory.
- Due to the small number of deaths of young Indigenous people, recent data are presented for a 5-year period (2011–2015) to allow for reporting of cause of death by age and sex.

Note: For information on issues to consider for the NATSISS, see Box 3. See Appendix C for more information about all key data sources.

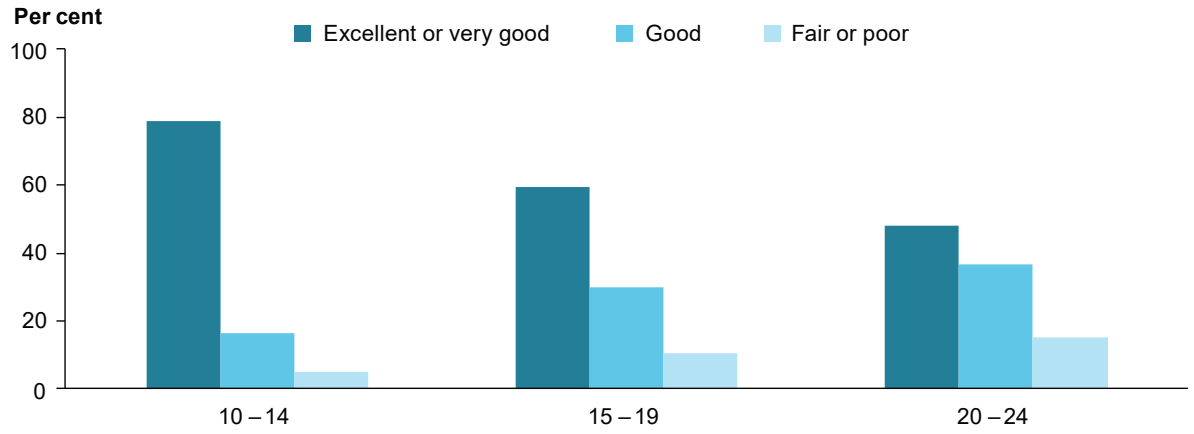
6.1 Self-assessed health status

Almost 2 in 3 report their health as very good or excellent

In 2014–15, the majority of Indigenous people aged 10–24 assessed their health as either 'excellent' or 'very good' (63% or 134,100). More than 1 in 4 reported their health as 'good' (27% or 57,700), and 1 in 10 reported their health as fair or poor (10% or 21,800).

Across age groups, proportions who rated their health as excellent or very good decreased with age from 79% (59,600) of those aged 10–14 to 60% (43,500) of those aged 15–19 and 48% (31,100) of those aged 20–24 (Figure 6.1.1). Similar proportions of young Indigenous males (64% or 68,500) and females (62% or 65,500) reported their health was 'excellent' or 'very good'.

Figure 6.1.1: Young Indigenous people by self-reported health status and age group, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

A slightly lower proportion of Indigenous people aged 10–24 reported excellent or very good health in non-remote areas (62% or 107,700) than in remote areas (65% or 26,300). In all states and territories, more than half of all young Indigenous people reported their health status as either 'excellent' or 'very good'. The highest proportion observed was for those in the Northern Territory (68% or 13,600) and the lowest was in the Australian Capital Territory (55% or 1,200) (Figure 6.1.2).

Figure 6.1.2: Proportion of Indigenous people aged 10–24, by self-reported health status and state and territory, 2014–15



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

6.2 Burden of disease

Burden of disease analysis quantifies the gap between a population's actual health and an ideal level of health in a given year. It measures both the burden of living with ill health and the burden of dying prematurely. It is a way of measuring the combined effect of the fatal and non-fatal impacts of diseases and injuries on a population. Burden of disease accounts for an individual's age at death and the severity of disease, in addition to counting deaths and disease prevalence (AIHW 2012).

Box 6.2: Burden of disease terms

DALY (disability-adjusted life years): The key measure used is the DALY, which measures years of healthy life lost, either through premature death, defined as dying before the ideal life span (YLL) or, equivalently, through living with ill health due to illness or injury (YLD).

Burden of disease (and injury): Refers to the quantified impact of a disease or injury on a population, using the disability-adjusted life year (DALY) measure.

Source: AIHW 2016

Suicide and self-inflicted injuries contributed most (3,913 DALYs or 13%) to the total burden of disease for Indigenous people aged 10–24. This was followed by anxiety disorders (2,411 DALYs or 8%), alcohol use disorders (2,210 DALYs or 7%), depressive disorders (2,007 DALYs or 7%) and road traffic injuries—motor vehicle occupants (1,905 DALYs or 6%).

There was some difference in the pattern for males and females. For example, suicide and self-inflicted injuries contributed the greatest burden for males (2,776 DALYs or 16%) but the third most for females (1,137 DALYs or 9%). Anxiety disorders contributed the greatest burden for females (1,514 DALYs or 11%) but the fourth most for males (895 DALYs or 5%), and road traffic injuries (1,280 DALYs or 8%) contributed third in the burden of disease for males, but sixth for females (625 DALYs or 5%). Tables 6.2.1, 6.2.2 and 6.2.3 present the top 10 specific diseases that contribute to the total burden of disease of Indigenous people aged 10–14, 15–19 and 20–24, respectively.

Asthma contributed the most to the total burden of disease for all Indigenous people aged 10–14 (599 DALYs or 10%) and for Indigenous females aged 10–14 (313 DALYs or 12%). Conduct disorder contributed the most to the total burden of disease for Indigenous males aged 10–14 (374 DALYs or 12%).

Table 6.2.1: Top 10 specific diseases contributing to total burden (DALYs; proportion of total) for males and females aged 10–14, 2011

Rank	Males	Females	Total
1	Conduct disorder (374; 12.2%)	Asthma (313; 11.6%)	Asthma (599; 10.4%)
2	Asthma (286; 9.4%)	Anxiety disorders (270; 10.0%)	Conduct disorder (598; 10.4%)
3	Anxiety disorders (271; 8.9%)	Depressive disorders (252; 9.3%)	Anxiety disorders (541; 9.4%)
4	Depressive disorders (206; 6.7%)	Conduct disorder (224; 8.3%)	Depressive disorders (458; 7.9%)
5	Suicide and self-inflicted injuries (181; 5.9%)	Suicide and self-inflicted injuries (206; 7.6%)	Suicide and self-inflicted injuries (387; 6.7%)
6	Autism spectrum disorders (146; 4.8%)	Acne (134; 4.9%)	Acne (233; 4.1%)
7	Attention deficit hyperactivity disorder (117; 3.8%)	Dental caries (113; 4.2%)	Dental caries (230; 4.0%)
8	Dental caries (117; 3.8%)	Upper respiratory conditions (76; 2.8%)	Autism spectrum disorders (174; 3.0%)
9	Acne (100; 3.3%)	Other musculoskeletal (69; 2.6%)	Attention deficit hyperactivity disorder (159; 2.8%)
10	Intellectual disability (96; 3.1%)	Other unintentional injuries (64; 2.4%)	Upper respiratory conditions (154; 2.7%)
	Top 10 (1,895; 61.9%)	**Top 10 (1,721; 63.7%)**	**Top 10 (3,534; 61.3%)**

Source: AIHW analysis of AIHW Burden of Disease Database 2011.

Suicide and self-inflicted injuries contributed the most to the total burden of disease for all Indigenous people aged 15–19 (1,918 DALYs or 15%). For males of this age group, this category accounted for the greatest burden (1,404 DALYs or 20%), followed by alcohol use disorders (753 DALYs or 10%) and road traffic injuries—motor vehicle occupants (554 DALYs or 8%). For females of this age group, the greatest burden was attributable to anxiety disorders (546 DALYs or 10%), followed by suicide and self-inflicted injuries (514 DALYs or 10%) and depressive disorders (471 DALYs or 9%).

Table 6.2.2: Top 10 specific diseases contributing to total burden (DALYs; proportion of total) for males and females aged 15–19, 2011

Rank	Males	Females	Total
1	Suicide and self-inflicted injuries (1,404; 19.6%)	Anxiety disorders (546; 10.3%)	Suicide and self-inflicted injuries (1,918; 15.4%)
2	Alcohol use disorders (753; 10.5%)	Suicide and self–inflicted injuries (514; 9.7%)	Alcohol use disorders (1,083; 8.7%)
3	Road traffic injuries—motor vehicle occupants (554; 7.7%)	Depressive disorders (471; 8.9%)	Road traffic injuries—motor vehicle occupants (968; 7.8%)
4	Anxiety disorders (334; 4.7%)	Road traffic injuries – motor vehicle occupants (414; 7.8%)	Anxiety disorders (880; 7.1%)
5	Depressive disorders (326; 4.5%)	Alcohol use disorders (330; 6.2%)	Depressive disorders (796; 6.4%)
6	Drug use disorders excluding alcohol (240; 3.3%)	Asthma (270; 5.1%)	Asthma (502; 4.0%)
7	Asthma (232; 3.2%)	Bipolar affective disorder (225; 4.2%)	Acne (366; 2.9%)
8	Schizophrenia (219; 3.1%)	Acne (170; 3.2%)	Bipolar affective disorder (351; 2.8%)
9	Conduct disorder (213; 3.0%)	Dental caries (153; 2.9%)	Drug use disorders excluding alcohol (333; 2.7)
10	Acne (196; 2.7%)	Other musculoskeletal (143; 2.7%)	Conduct disorder (332; 2.7%)
	Top 10 (4,469; 62.3%)	**Top 10 (3,234; 61.1%)**	**Top 10 (7,529; 60.4%)**

Source: AIHW analysis of AIHW Burden of Disease Database 2011.

Suicide and self-inflicted injuries also contributed the most to the total burden of disease for Indigenous people aged 20–24 (1,607 DALYs or 13%). For males in this age group, this category accounted for the greatest burden (1,190 DALYs or 17%), followed by alcohol use disorders (750 DALYs or 11%) and road and traffic injuries—motor vehicle occupants (634 DALYs or 9%). For Indigenous females aged 20–24, the greatest burden was attributable to anxiety disorders (698 DALYs or 13%), followed by depressive disorders (438 DALYs or 8%) and suicide and self-inflicted injuries (417 DALYs or 8%).

Table 6.2.3: Top 10 specific diseases contributing to total burden (DALYs; proportion of total) for Indigenous males and females aged 20–24, 2011

Rank	Males	Females	Total
1	Suicide and self-inflicted injuries (1,190; 17.3%)	Anxiety disorders (698; 13.0%)	Suicide and self–inflicted injuries (1,607; 13.1%)
2	Alcohol use disorders (750; 10.9%)	Depressive disorders (438; 8.2%)	Alcohol use disorders (1,092; 8.9%)
3	Road traffic injuries—motor vehicle occupants (634; 9.2%)	Suicide and self-inflicted injuries (417; 7.8%)	Anxiety disorders (990; 8.1%)
4	Homicide and violence (355; 5.1%)	Alcohol use disorders (342; 6.4%)	Road traffic injuries – motor vehicle occupants (786; 6.4%)
5	Depressive disorders (315; 4.6%)	Asthma (259; 4.8%)	Depressive disorders (753; 6.1%)
6	Anxiety disorders (293; 4.2%)	Other musculoskeletal (213; 4.0%)	Homicide and violence (525; 4.3%)
7	Other musculoskeletal (257; 3.7%)	Diabetes (207; 3.9%)	Other musculoskeletal (470; 3.8%)
8	Diabetes (240; 3.5%)	Bipolar affective disorder (190; 3.5%)	Asthma (459; 3.7%)
9	Schizophrenia (218; 3.2%)	Homicide and violence (171; 3.2%)	Diabetes (447; 3.6%)
10	Asthma (200; 2.9%)	Polycystic ovarian syndrome (165; 3.1%)	Schizophrenia (297; 2.4%)
	Top 10 (4,452; 64.5%)	**Top 10 (3,099; 57.8%)**	**Top 10 (7,426; 60.6%)**

Source: AIHW analysis of AIHW Burden of Disease Database 2011.

6.3 Disability

Box 6.3: Disability measurement

The 2014–15 NATSISS included self-reported data on disability; that is, those who reported having a disability or restrictive long-term health condition where a limitation, restriction, impairment, disease or disorder had lasted, or was expected to last for 6 months or more, and restricted everyday activities.

Disability status—is based on levels of activity limitations in the performance of 1 or more core activities such as self-care (eating, dressing, and toileting), mobility or communication. Classifications are profound, severe, moderate, mild and school/employment restriction only, and has no specific limitation or restriction, as determined by the highest level of limitation in any of these activities.

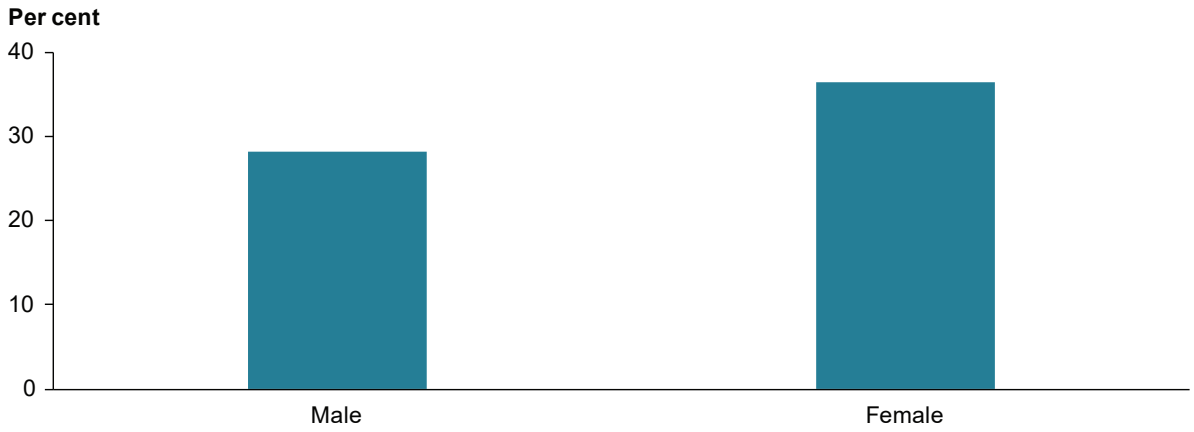
Disability type—includes sight, hearing or speech; physical; intellectual; psychological; head injury, stroke or brain damage. Individuals can have more than 1 type of disability.

Source: ABS 2017b.

Around 7 in 10 report no disability

In the 2014–15 NATSISS, 68% (93,400) of Indigenous people aged 15–24 had no disability, while 32% (44,300) had a disability. A similar proportion of young people across age groups had a disability—33% (23,700) aged 15–19, and 32% (20,500) aged 20–24. A higher proportion of females (37% or 25,100) than males (28% or 19,300) had a disability (Figure 6.3.1).

Figure 6.3.1: Proportion of young Indigenous people reporting a disability, by sex, 2014–15



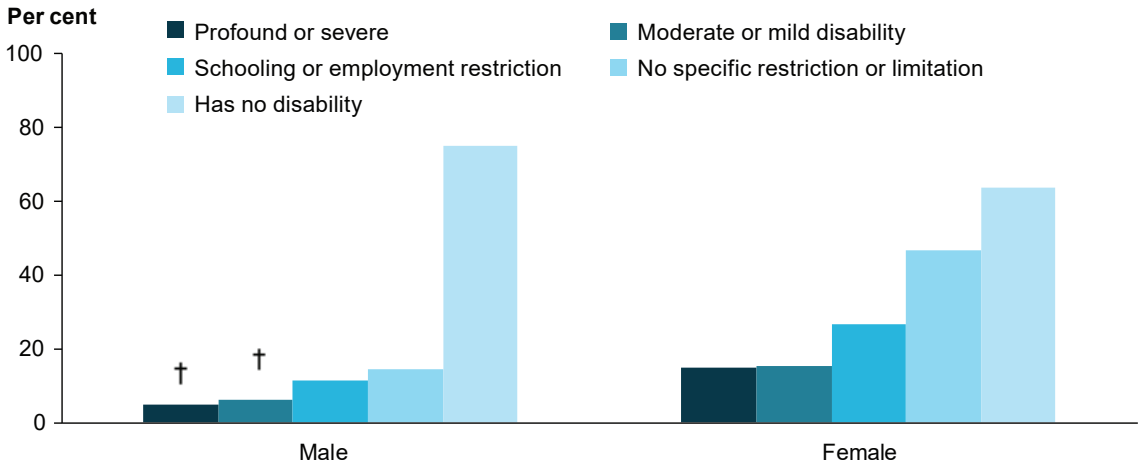
Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

A similar proportion of those aged 15–24 living in non-remote (32% or 36,000) and remote areas (31% or 8,200) had a disability.

Of all those aged 15–24, 5% (6,600) had a profound or severe core activity limitation, another 5% (7,400) had a moderate or mild core activity limitation, 8% (10,900) had a schooling or employment restriction and 14% (19,100) had no specific limitation or restriction status.

Similar proportions of males (5% or 3,200) and females (5% or 3,700) had a profound or severe core activity limitation. Similar proportions of males (6% or 3,900) and females (6% or 4,200) also had moderate or mild core activity limitation. While a higher proportion of males had a schooling or employment restriction (12% or 7,600) than females (4% or 3,000) (Figure 6.3.2).

Figure 6.3.2: Indigenous people aged 15–24 by disability status and sex, 2014–15



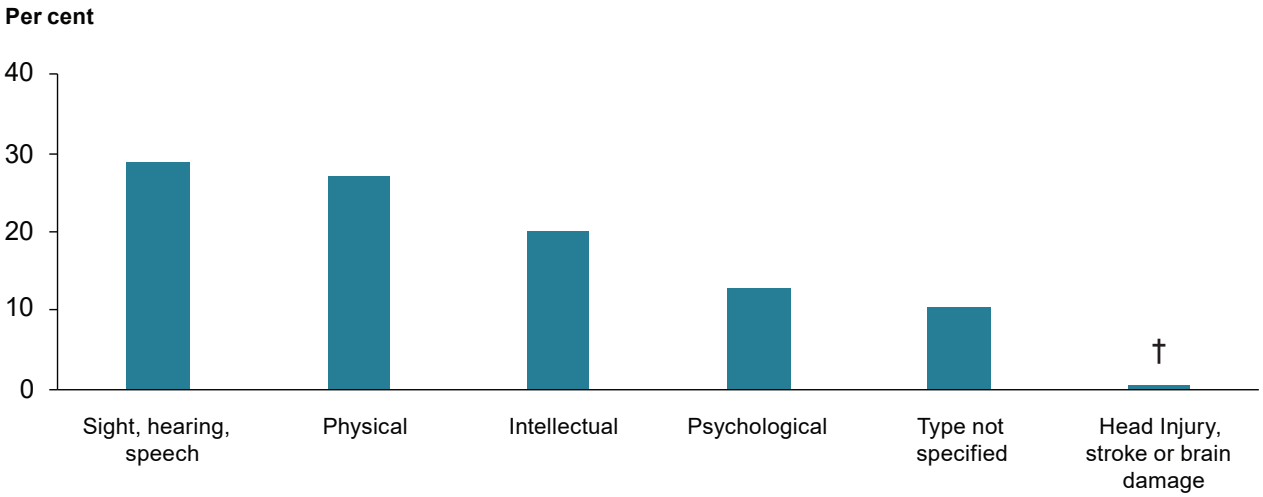
† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Sight, hearing or speech-related disability is most common

While the majority of young Indigenous people did not have a disability, the most common disability type among those who did was sight, hearing or speech-related disability (29% or 19,300), followed by physical disability (27% or 18,100), intellectual disability (20% or 13,500) and psychological disability (13% or 8,700) (Figure 6.3.3).

Figure 6.3.3: Indigenous people aged 15–24 by disability type, 2014–15



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Note: Individuals may have more than 1 disability type.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

6.4 Hospitalisations

Hospitalisations represent episodes of hospital care, rather than the number of individual people who were hospitalised. They provide a broad indication of the prevalence of particular conditions as well as access to and use of health services. In 2015–16, 48,914 hospitalisations were reported for Indigenous people aged 10 to 24 (214 per 1,000).

An important contributor to the number of hospitalisations for young Indigenous females was pregnancy and childbirth (excluded from Figure 6.4.2). In 2015–16, there were 11,311 hospitalisations with a principal diagnosis of pregnancy, childbirth and the puerperium for Indigenous people aged 10–24. This accounted for 23% of the 48,914 total hospitalisations over this period. Of all hospitalisations with a principal diagnosis of pregnancy, childbirth and the puerperium, just over half (51%) were for delivery, 45% were for other issues, 2% were for complications of labour and delivery, and 2% were for complications predominantly related to the puerperium.

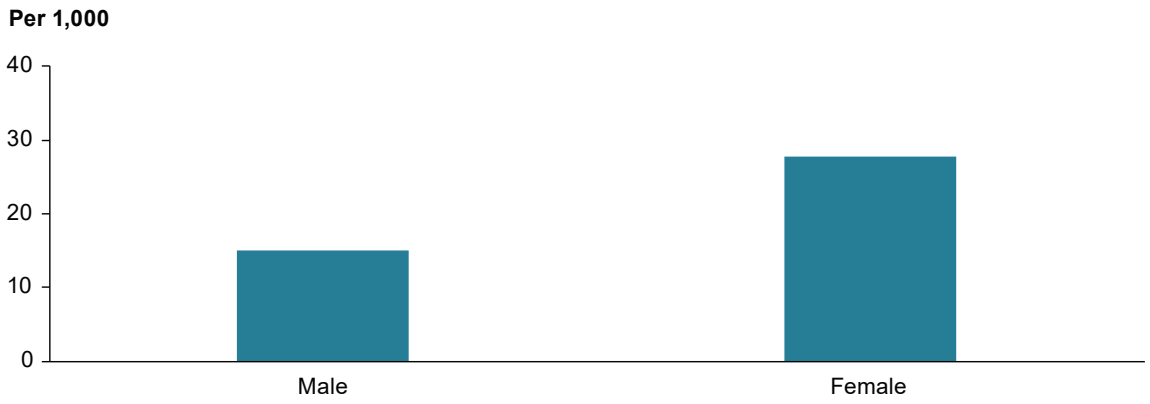
Excluding hospitalisations with a primary diagnosis of pregnancy, childbirth and the puerperium, in 2015–16 there were 37,603 hospitalisations of Indigenous people aged 10 to 24 (165 per 1,000).

Some hospitalisations could be prevented

Potentially preventable hospitalisations are conditions that could have been avoided through effective preventive measures, or through early diagnosis and treatment as part of primary health care. Between July 2013 and June 2015, Indigenous people aged 15–24 had a potentially preventable hospitalisation rate of 21 per 1,000.

The rate of potentially preventable hospitalisations for young Indigenous females (28 per 1,000) was almost twice that for males (15 per 1,000) (Figure 6.4.1). For both males and females of this age group, the Indigenous preventable hospitalisation rates were higher than the non-Indigenous rates (11 per 100,000)

Figure 6.4.1: Rate of potentially preventable hospitalisations for Indigenous people aged 15–24, by sex, 2013–2015



Source: AIHW 2017b.

Injury and poisoning the main reasons for hospitalisation across all youth age groups

Table 6.4 presents the main reasons for hospitalisation as a proportion of all hospitalisations, excluding hospitalisations due to pregnancy and childbirth. Across age groups, injury and poisoning accounted for the highest proportion of hospitalisations (23% or 1,917 hospitalisations for those aged 10–14; 25% or 3,118 for those aged 15–19, and 20% or 3,397 for those aged 20–24).

The top 5causes accounted for the majority of hospitalisations for all age groups, including 58% or 4,768 hospitalisations for those aged 10–14, 65% or 8,262 hospitalisations for those aged 15–19 and 71% or 11,809 hospitalisations for those aged 20–24.

Table 6.4: Hospitalisations for young Indigenous people as a proportion of all hospitalisations, by principal diagnosis and age group, 2015–16

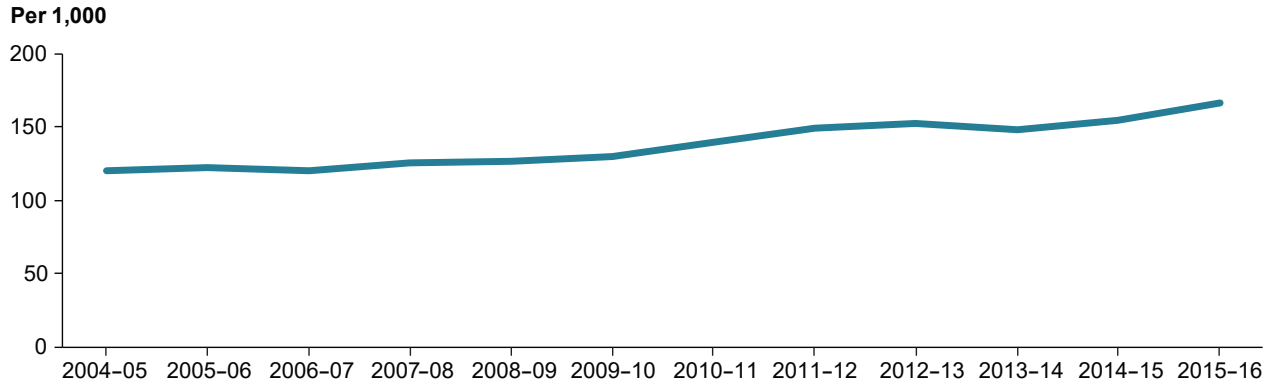
	Age group		
Rank	10–14	15–19	20–24
1	Injury and poisoning (23.3%)	Injury and poisoning (24.6%)	Injury and poisoning (20.4%)
2	Digestive diseases (10.6%)	Mental and behavioural disorders (13.8%)	Factors influencing health excluding dialysis (16.7%)
3	Respiratory diseases (9.6%)	Symptoms, signs and abnormal findings (10.8%)	Mental and behavioural disorders (14.0%)
4	Symptoms, signs and abnormal findings (7.9%)	Digestive diseases (9.0%)	Digestive diseases (10.0%)
5	Skin diseases (6.5%)	Respiratory diseases (7.1%)	Symptoms, signs and abnormal findings (9.6%)
	Top 5 (58.0%)	**Top 5 (65.3%)**	**Top 5 (70.8%)**

Source: AIHW analysis of National Hospital Morbidity Database.

The hospitalisation rate has increased over time

The rate of hospitalisations for Indigenous people aged 10 to 24 increased from 120 per 1,000 (20,143 hospitalisations) in 2004–05 to 166 per 1,000 (36,262 hospitalisations) in 2015–16 across New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined, excluding hospitalisation for pregnancy and childbirth (Figure 6.4.2).

Figure 6.4.2: Hospitalisations for Indigenous people aged 10–24, 2004–05 to 2015–16



Notes

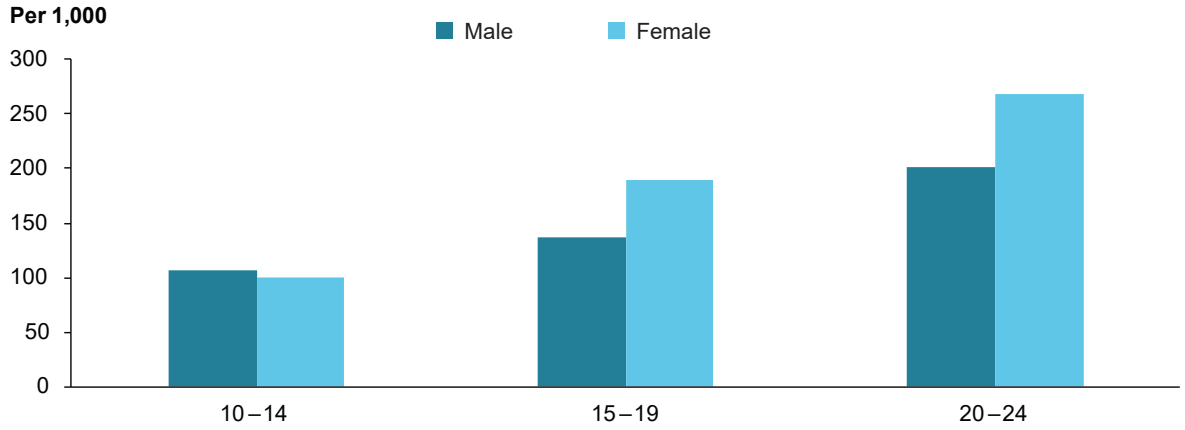
1. Data are for New South Wales, Victoria, Queensland, Western Australia, South Australia, and the Northern Territory.
2. Excludes separations for pregnancy, childbirth.

Source: AIHW analysis of National Hospital Morbidity Database.

Hospitalisations increase with age

More than 4 in 10 (44% or 16,715) hospitalisations for young Indigenous people were for those aged 20–24, while 34% (12,665) were for those aged 15–19 and around 22% (8,223) were for those aged 10–14. The hospitalisation rate was highest for both females (268 per 1,000 or 9,283) and males (201 per 1,000 or 7,432) in the 20–24 age group. For Indigenous people aged 10–24, females accounted for over half (54% or 20,423) of hospitalisations (Figure 6.4.3).

Figure 6.4.3: Hospitalisations for young Indigenous people, by age group, 2015–16

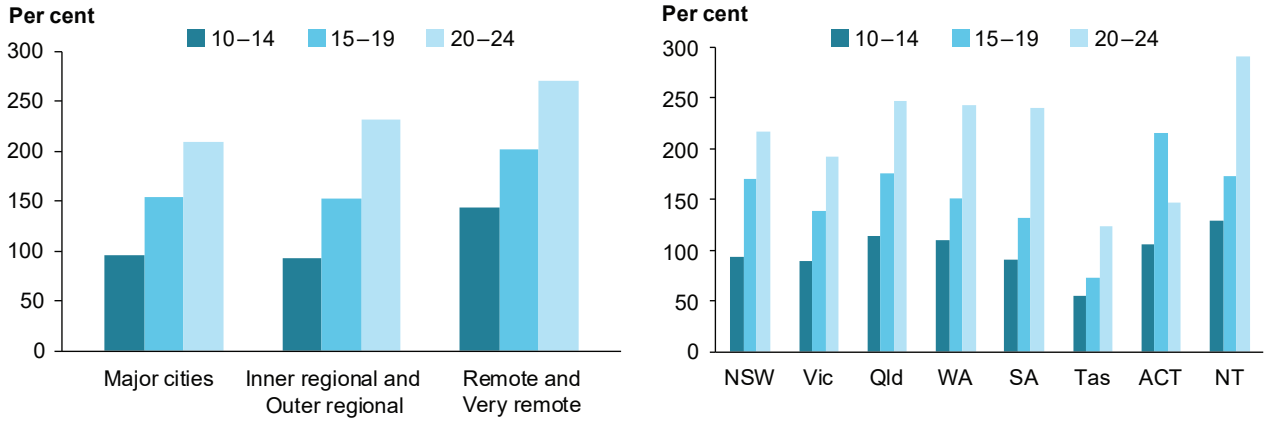


Source: AIHW analysis of National Hospital Morbidity Database.

Young Indigenous people in Remote and Very Remote areas (combined) had higher hospitalisation rates than those in other areas. Rates in Remote and Very remote areas were highest in the 20 to 24 age group (271 per 1,000 or 3,727) followed by the 15 to 19 age group (202 per 1,000 or 2,508) and the 10 to 14 age group (143 per 1,000 or 2,149) (Figure 6.4.4).

The rate of hospitalisations for Indigenous people aged 10–24 was highest in the Northern Territory (196 per 1,000 or 4,244) and lowest in Tasmania (83 per 1,000 or 675) (Figure 6.4.4).

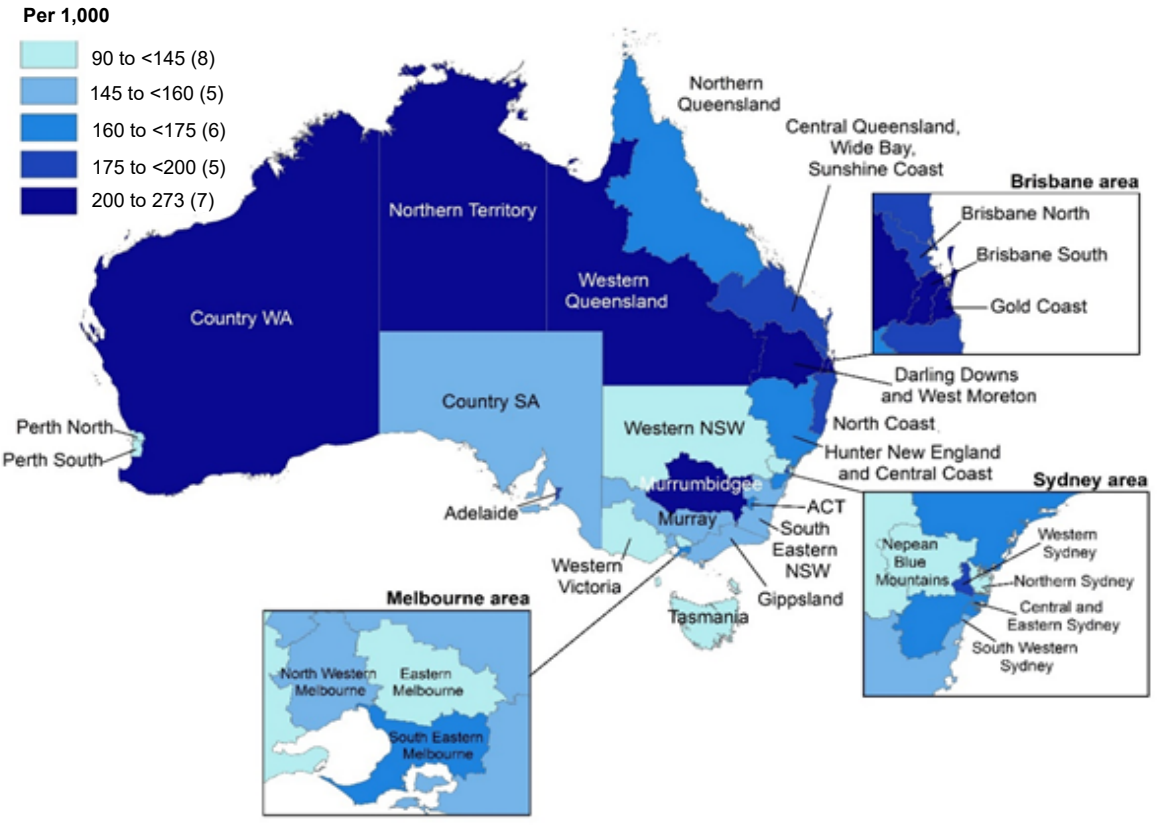
Figure 6.4.4: Hospitalisations for young Indigenous people, by age group, remoteness and state and territory, 2015–16



Source: AIHW analysis of National Hospital Morbidity Database.

Rates of hospitalisations for Indigenous people aged 10–24 also varied by Primary Health Network (PHN), being lowest in Tasmania (90 per 1,000 or 675) and highest in Western Queensland (271 per 1,000 or 959) (Figure 6.4.5 and Figure 6.4.6).

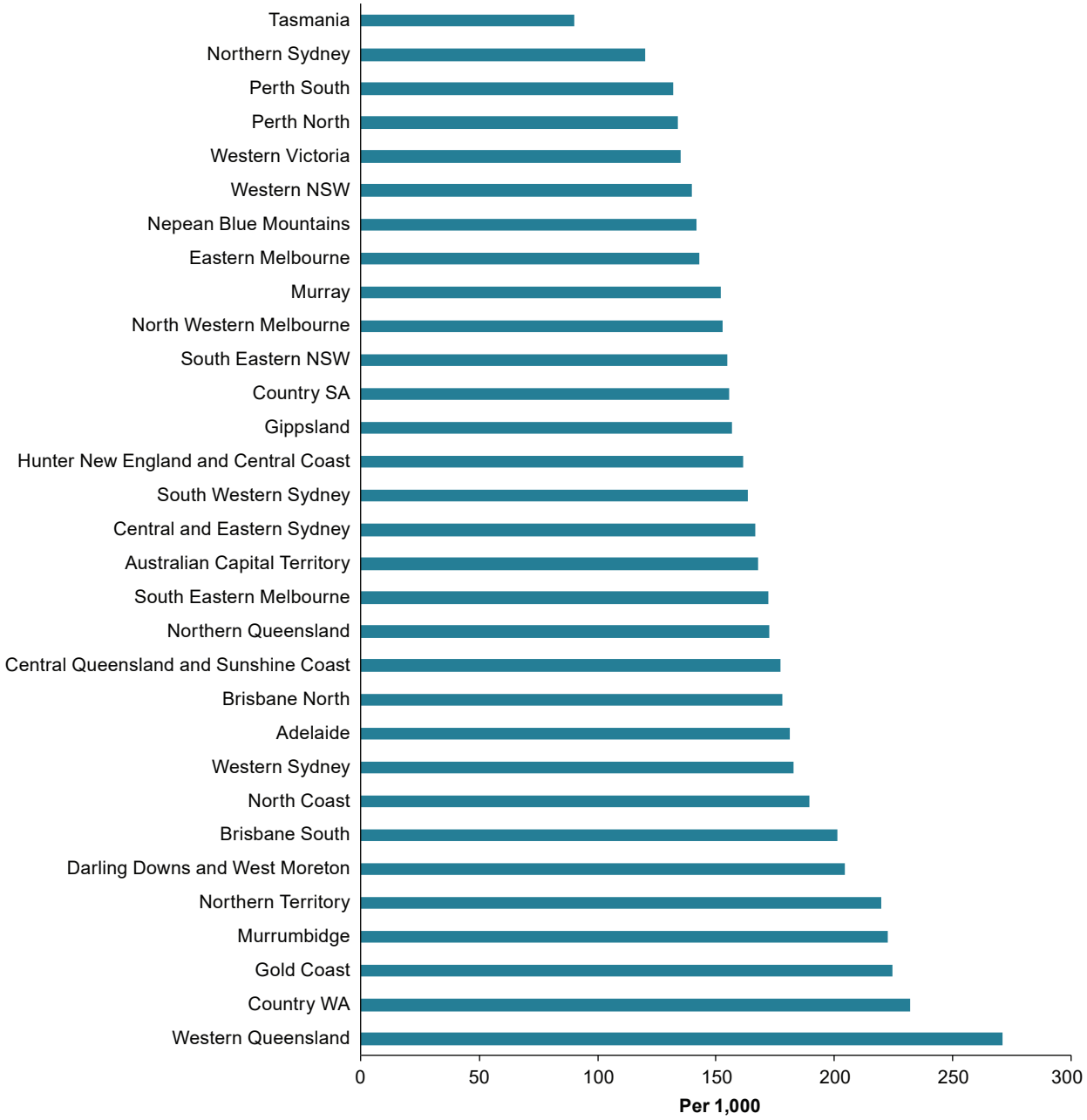
Figure 6.4.5: Map of hospitalisation rates for Indigenous people aged 10–24, by PHN, 2015–16



Note: Number in parentheses refers to the number of PHNs in the respective category.

Source: AIHW analysis of National Hospital Morbidity Database.

Figure 6.4.6: Hospitalisations for Indigenous people aged 10–24, by PHN, 2015–16



Source: AIHW analysis of National Hospital Morbidity Database.

6.5 Mortality

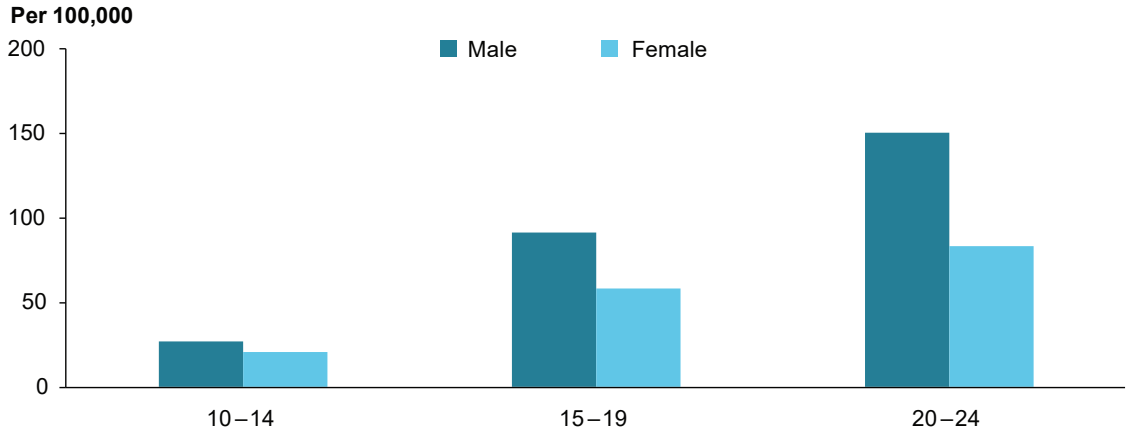
Mortality rates provide a measure of the overall health of a population. Understanding the leading causes of death provides an indication of the diseases and conditions that affect the health of a population, particularly when considered alongside the causes of ill health. Causes of death for young people differ from those for older people or the general population, due to differences in risk factors and behaviours, and the lower impact of chronic conditions that are still to emerge.

Around 700 deaths in 2011–2015

Mortality data for Indigenous Australians presented are restricted to 5 states and territories (New South Wales, Queensland, Western Australia, South Australia and the Northern Territory) where information on Indigenous status is considered of sufficient completeness for reporting. In the period 2011 to 2015, 674 deaths were recorded for Indigenous people aged 10–24 (70 per 100,000 population) in these states and territories.

The mortality rate increased with age, with those aged 10–14 having the lowest mortality rate of 24 per 100,000 (83 deaths), followed by the 15–19 age group (75 per 100,000 or 251 deaths) and the 20–24 age group (118 per 100,000 or 340 deaths). For the period 2011–2015, the mortality rate for males (86 per 100,000 or 428 deaths) was considerably higher than for females (52 per 100,000 or 246 deaths) (Figure 6.5.1).

Figure 6.5.1: Mortality rates for Indigenous people aged 10–24, by age group and sex, 2011–2015



Note: Data for NSW, Qld, WA, SA and NT combined.

Source: AIHW analysis of National Mortality Database.

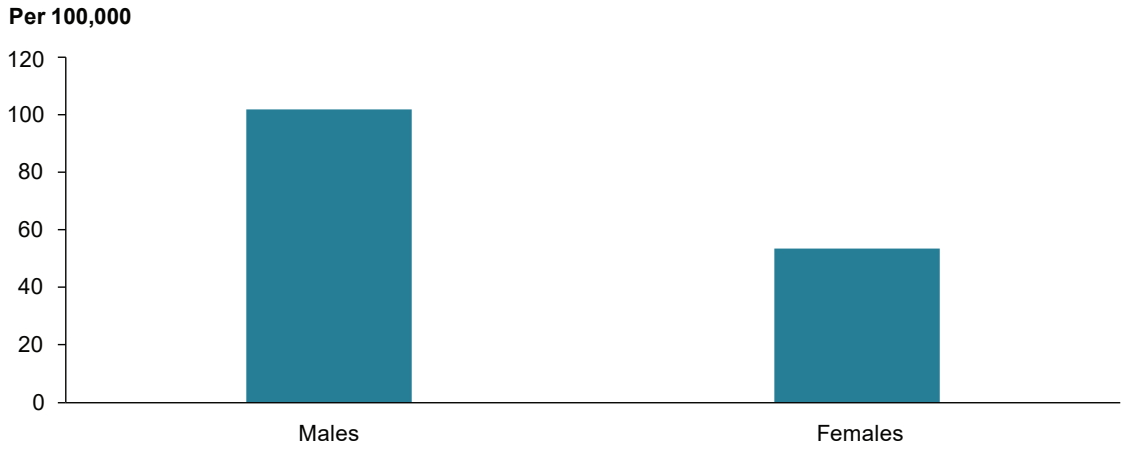
Avoidable mortality

Avoidable mortality refers to deaths that could have been avoided given timely and effective health care, including disease prevention and population health initiatives (Page et al, 2007; AIHW 2010).

In 2011–2015, there were an estimated 490 avoidable deaths among Indigenous people aged 15–24, representing 83% of Indigenous deaths for this age group. Suicide, transport accidents and assault, were the main causes of deaths for this age group, and all are classified as avoidable deaths.

Among avoidable deaths for 15–24 year olds, 327 deaths were of males (102 per 100,000) and 163 deaths were of females (54 per 100,000). For both males and females in this age group, the Indigenous avoidable mortality rate (38 per 100,000) was higher than the non-Indigenous rate (15 per 100,000) (Figure 6.5.2).

Figure 6.5.2: Rates of avoidable mortality for Indigenous people aged 15–24, by sex, 2011–2015



Note: Data for NSW, Qld, WA, SA and NT combined.

Source: AIHW 2017b.

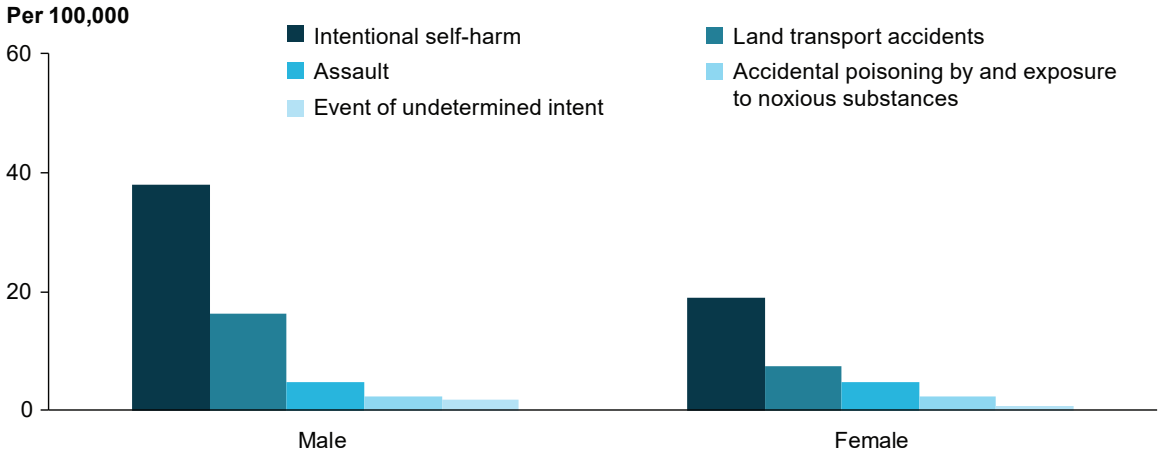
Suicide and transport accidents the leading causes of death

Injury and poisoning accounted for the majority of deaths among Indigenous people aged 10–24 in 2011–2015 (52 per 100,000 population or 505 deaths). This was followed by diseases of the circulatory system (4 per 100,000 or 36 deaths), the nervous system (3 per 100,000 or 30 deaths), and neoplasms (3 per 100,000 or 28 deaths).

Injury and poisoning deaths are classified as due to external causes. More than half (55%) of these deaths were due to intentional self-harm (29 per 100,000 or 278 deaths). The next most common causes were land transport accidents (12 per 100,000 or 115 deaths), assaults (5 per 100,000 or 45 deaths), accidental poisoning (2 per 100,000 or 22) and events of undetermined intent (1 per 100,000 or 13 deaths).

The intentional self-harm mortality rate was twice as high for males (38 per 100,000 or 188 deaths) as for females (19 per 100,000 or 90 deaths). This pattern was also evident for deaths due to land transport accidents, where the mortality rate was 16 per 100,000 (80 deaths) for males and 7 per 100,000 for females (35 deaths) (Figure 6.5.3).

Figure 6.5.3: Mortality rates for injury and poisoning for Indigenous people aged 10–24, by external causes of death, 2011–2015



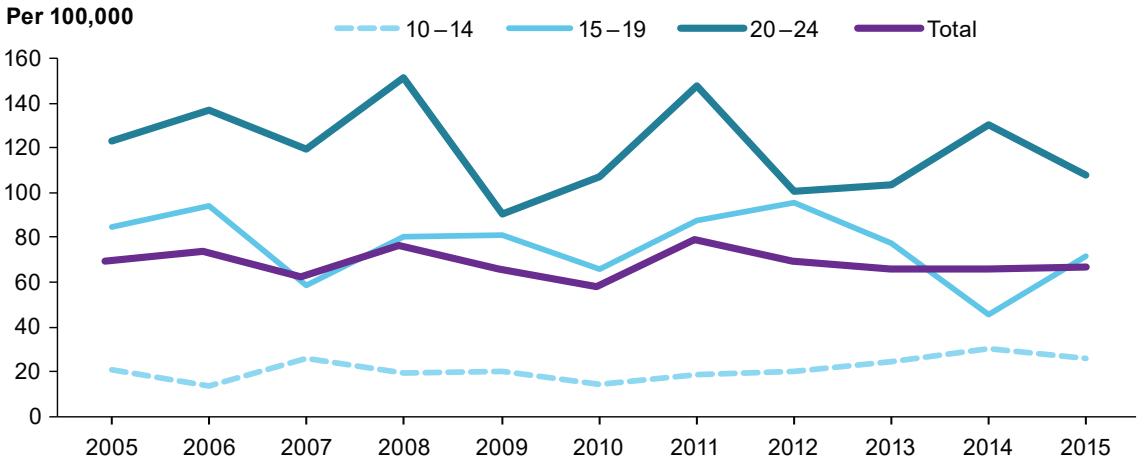
Note: Data for NSW, Qld, WA, SA and NT combined.

Source: AIHW analysis of National Mortality Database.

Trends in mortality

The mortality rate for young Indigenous people declined over the last 10 years, from 70 per 100,000 in 2005 to 67 per 100,000 in 2015. The highest mortality rate over this period was in 2011 (79 per 100,000), while the lowest was in 2010 (58 per 100,000). More recently, mortality rates have remained relatively stable, with 66 deaths per 100,000 in 2013 and 2014 and 67 deaths per 100,000 in 2015 (Figure 6.5.4).

Figure 6.5.4: Mortality rates of young Indigenous people by age group, 2005 to 2015



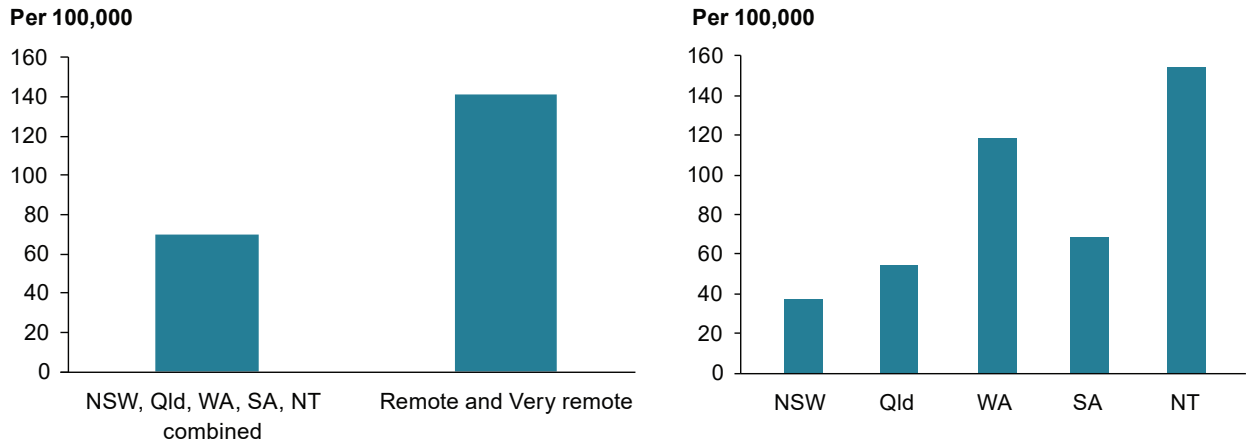
Note: Data for NSW, Qld, WA, SA and NT combined.

Source: AIHW analysis of National Mortality Database.

The mortality rate for Indigenous people aged 10–24 (142 per 100,000 or 294) in *Remote and Very remote* areas was more than twice the rate of the 5 reportable jurisdictions (New South Wales, Queensland, South Australia, Western Australia and the Northern Territory) combined (70 per 100,000 or 674) (Figure 6.5.5).

The Northern Territory had the highest mortality rate (155 per 100,000 or 164), followed by Western Australia (118 per 100,000 or 168), South Australia (69 per 100,000 or 42), Queensland (54 per 100,000 or 171) and New South Wales (37 per 100,000 or 129) (Figure 6.5.5).

Figure 6.5.5: Mortality rates of Indigenous people aged 10–24, by remoteness and state and territory, 2011–15



Note: 'Remote and Very remote areas' data from all jurisdictions, data for NSW, Qld, WA, SA and NT combined are for all remoteness areas.

Source: AIHW analysis of AIHW analysis of National Mortality Database.

6.6 How do young Indigenous Australians compare?

This report focuses on data about Indigenous youth so that, through the findings, their voice can be heard. Yet, there is also value in understanding how young Indigenous people compare to others, such as young non-Indigenous people and Indigenous older people. Some comparison data for the key health status and outcomes measures are presented below.

Young non-Indigenous people were more likely to self-rate their health as excellent or very good, compared with either young or older Indigenous people. A higher proportion of older Indigenous people had a disability than young Indigenous people or young non-Indigenous people. Young Indigenous people had higher rates of hospitalisation and mortality than young non-Indigenous people did.

Box 6.6: Health status and outcomes: comparison of Indigenous youth with other groups

	Indigenous people under 25	Non-Indigenous people under 25	Indigenous people 25 and over
% rated health as 'Excellent' or 'Very good'[(a)]	54	69	33
% with disability[(a)]	32	18	51
Hospitalisations per 1,000[(b)]	214	156	514
Mortality per 100,000[(b)(c)]	70	27	847

(a) For Indigenous and non-Indigenous people aged 15–24.

(b) For Indigenous and non-Indigenous people aged 10–24.

(c) Data for NSW, Qld, WA, SA, NT combined.

Sources: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder), National Hospital Morbidity Database and National Mortality Database.



7

Health conditions

This chapter includes more detailed information on the particular health conditions relevant to young Indigenous people. The conditions were selected because they are significant in terms of prevalence (such as asthma and mental health), severity (such as communicable diseases), and/or because they are concerning to observe in young people (such as diabetes). The impact of these diseases and conditions may be immediate, but it may also extend beyond youth as individuals progress through the life. Some acute conditions may contribute to the development of chronic conditions and decrease quality of life if left untreated (AIHW, 2016a).

Box 7: Main data sources and key issues

Rheumatic Heart Disease Program registers

- Data on the jurisdictional incidence of acute rheumatic fever and prevalence of rheumatic heart disease come from the Northern Territory, Queensland and Western Australian Rheumatic Heart Disease registers. It is not possible to compare these data directly as the registers are at different stages of establishment and coverage.

National Notifiable Diseases Surveillance System (NNDSS)

- NNDSS data includes only cases for which health care was sought, a test conducted and a diagnosis made, followed by a notification to health authorities. These represent only a proportion of the total cases occurring in the community. For sexually transmissible infections, for example, diagnoses are heavily influenced by testing patterns.
- The completeness of Indigenous identification in notifiable disease registries varies between the states and territories and by disease.

Note: For information on issues to consider for the AATSIHS see Box 4, and for the NHMD and the NMD see Box 6. See Appendix C for more information about all key data sources.

7.1 Prevalence of health conditions and injury

The chapter includes prevalence of different health conditions uses self-reported data from the 2012–13 AATSIHS. Additional hospitalisation and mortality data are included (Table 7.1).

4 in 10 do not have a current or long-term condition

Data from the 2012–13 AATSISHS indicate that just under 4 in 10 (77,000 or 38%) young Indigenous people reported no current or long-term health condition. Just over 6 in 10 (125,400 or 62%) had a long-term health condition; that is, conditions lasting or expected to last 6 months or more. The most prevalent long-term health conditions were respiratory diseases (36 per 100 population or 73,400) and eye and vision problems (20 per 100 population or 40,300).

The prevalence of short-term injury, that is, having been in an accident or been hurt in the previous 4 weeks, was 21 per 100 young Indigenous people (or 40,300).

Injury and poisoning was the most common cause of hospitalisation and mortality among young Indigenous people. Hospitalisations due to injury and poisoning occurred at a rate of 37 per 1,000 (8,432), which included hospitalisations due to intentional self-harm (5 per 1,000 population or 1,079). Mortality due to injury and poisoning occurred at a rate of 52 per 100,000 population (or 511), which included mortality due to intentional self-harm (29 per 100,000 or 278). Data on mental health are presented in Section 5.8.

Table 7.1: Top 10 health conditions for Indigenous people aged 10–24 by prevalence, hospitalisations and mortality

	Prevalence (self-report) 2012–13[a][b]			Hospitalisations (excluding dialysis) 2015–16[e]			Mortality 2011–2015[f]		
Rank	Long term health condition[a]/injury[b]	Number	Per 100 population	Principal diagnosis	Number	Per 1,000 population	Cause	Number	Per 100,000 population
1	Respiratory diseases	73,400	36.3	Injury and poisoning	8,432	36.9	Injury and poisoning	511	52.0
				Intentional self-harm	*1,079*	*4.7*	*Intentional self-harm*	*278*	*28.7*
2	Eye and vision problems	40,300	19.9	Mental/behavioural disorders	4,465	19.5	Diseases of the circulatory system	36	3.7
3	Signs and symptoms	22,900	11.3	Factors influencing health	4,183	18.3	Nervous system	30	3.1
	Injury (long-term)[c]	*3,800*	*1.9*						
4	Mental health conditions[d]	20,700	10.2	Digestive diseases	3,685	16.1	Neoplasms	28	2.9
5	Musculoskeletal diseases	17,900	8.8	Symptoms, signs & abnormal findings	3,618	15.8	Symptoms, signs & abnormal findings	14	1.4
6	Heart and circulatory conditions	16,800	8.3	Respiratory diseases	2,417	10.6	Endocrine, nutritional & metabolic	10	1.0
7	Ear and hearing problems	15,600	7.7	Genitourinary diseases	2,040	8.9	Respiratory diseases	9	0.9
8	Epilepsy, other nervous conditions	14,200	7.0	Skin diseases	2,034	8.9	Infections and parasitic diseases	8	0.8
9	Endocrine, other metabolic	10,100	5.0	Musculoskeletal	1,355	5.9	Genitourinary diseases	5	0.5
10	Digestive diseases	5,100	2.5	Infectious and parasitic diseases	1,025	4.5	..	..	..
	Other	14,800	7.3	Other	4,349	19.0	Other	23	2.4
Total	**With a health condition[a]**	**125,400**	**62.0**	**Total hospitalisations**	**37,603**	**164.5**	**Total deaths**	**674**	**69.6**
	Injury[b] (recent)	*43,200*	*21.3*	..	..	..	..	..	..

(a) Based on self-reported long-term health conditions, that is, conditions that had lasted, or were expected to last, for 6 months or more. A person may have more than 1 long-term health condition.

(b) Short-term injury where young people were asked as part of recent injuries, whether they have been in accidents or been hurt in previous 4 weeks.

(c) Injury (long-term) is a subset of 'signs and symptoms'. It includes fractures, sprains and strains, tear ligaments, muscle or tendon, internal organs, skin, knee, eye, joint, neck, burns and scalds, adverse effects of treatment and so forth.

(d) Includes only young people who experienced depression or felt depressed for 6 months or more.

(e) Excludes hospitalisations with a principal diagnosis of Pregnancy, childbirth (O00–O99) and dialysis; includes all other hospitalisations including principal diagnosis not stated.

(f) Data for NSW, Qld, WA, SA and NT combined.

Sources: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder), National Hospital Morbidity Database and National Mortality Database.



7.2 Respiratory health

A total of 73,400 (36 per 100) Indigenous people aged 10–24 had a respiratory condition or disease (Table 7.2) in 2012–13. Respiratory conditions were most common in those aged 20–24 (40%). However, hospitalisations for respiratory diseases were most common in the age group 15–19 (12 per 1,000 population), while the mortality rate was highest among those aged 20–24 (2 per 100,000) (Table 7.2).

Table 7.2: Indigenous people aged 10–24 with respiratory diseases, by age group

	Prevalence (self-report) 2012–13[a]		Hospitalisations 2015–16		Mortality 2011–2015[b]	
Age group (years)	Number	Per 100 population	Number	Per 1,000 population	Number	Per 100,000 population
10–14	23,600	31.6	792	10.0	n.p.	n.p.
15–19	27,600	39.3	902	11.6	n.p.	n.p.
20–24	22,800	39.7	723	10.1	5	1.7
Total 10–24	**73,400**	**36.3**	**2,417**	**10.6**	**9**	**0.9**

(a) Adjustment of estimates by the ABS, for the purpose of maintaining confidentiality, may result in the sum of components not equalling the total.

(b) Data for NSW, Qld, WA, SA and NT combined.

Sources: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder), National Hospital Morbidity Database 2015–16 and National Mortality Database 2011–2015.

Asthma an issue for 1 in 3

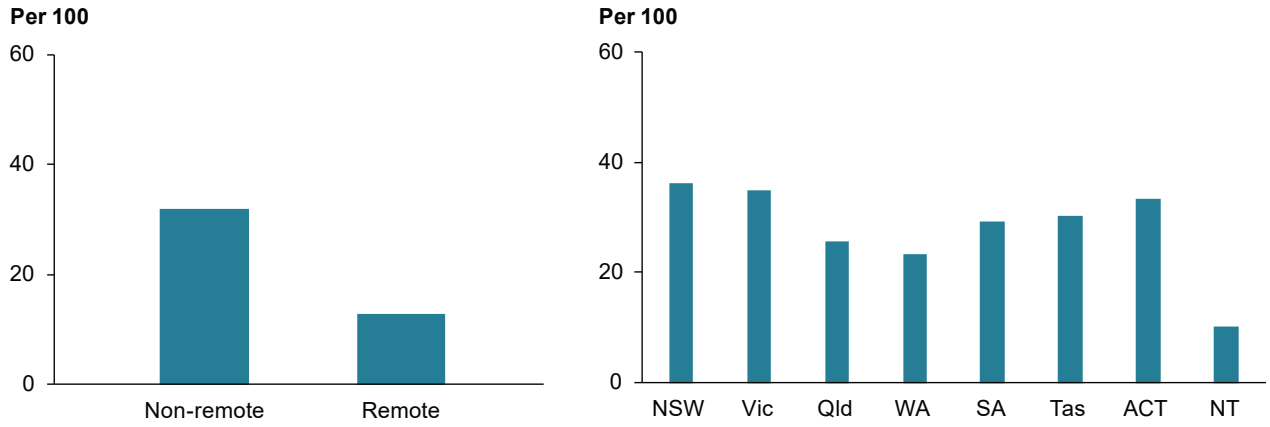
Asthma is a common chronic lung condition, which causes episodes of wheezing, breathlessness and chest tightness due to excessive narrowing of the airways. The rate of asthma was 28 per 100 (56,400) Indigenous people aged 10–24.

Older youth were more likely to have asthma. Rates of asthma were higher in those aged 15–19 (31 per 100 or 21,700) and those aged 20–24 (28 per 100 or 16,100) than those aged 10–14 (25 per 100 or 18,700).

The rate of asthma among young Indigenous males and females aged 10–24 was similar (28 per 100 or 28,900 and 28 per 100 or 28,000, respectively). However, in the 10–14 age group, a slightly higher proportion of young Indigenous males than females reported having asthma (28 per 100 or 10,800 and 22 per 100 or 7,900, respectively).

The rate of asthma among Indigenous people aged 10–24 was highest in non-remote areas (32 per 100 or 51,700) compared with remote areas (13 per 100 or 5,100) (Figure 7.2.1). Across states and territories, New South Wales (36 per 100 or 23,400) and Victoria (35 per 100 or 5,100) had the highest rates of asthma, while the Northern Territory had the lowest rate (10 per 100 or 2,000) (Figure 7.2.1).

Figure 7.2.1: Rate of Indigenous people aged 10–24 reporting asthma, by remoteness and state and territory, 2012–13



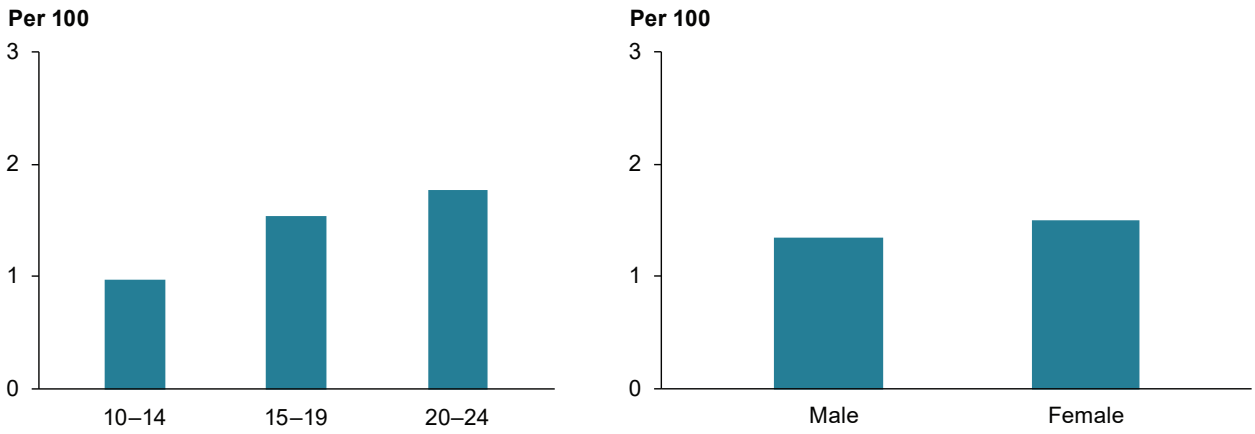
Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

Pneumonia responsible for over 300 hospitalisations annually

In 2015–16, 324 Indigenous people aged 10–24 were hospitalised for pneumonia. This equated to a rate of 1.4 per 1,000 young Indigenous people.

The rate was highest for those aged 20–24 (1.8 per 1,000 or 127), followed by those aged 15–19 (1.5 per 1,000 or 120) and those aged 10–14 (1.0 per 1,000 or 77). The hospitalisation rate for females (1.5 per 1,000 or 167) was slightly higher than the rate for males (1.3 per 1,000 or 157) (Figure 7.2.2).

Figure 7.2.2: Hospitalisation rate for Indigenous people aged 10–24 for pneumonia, by age group and sex, 2014–15



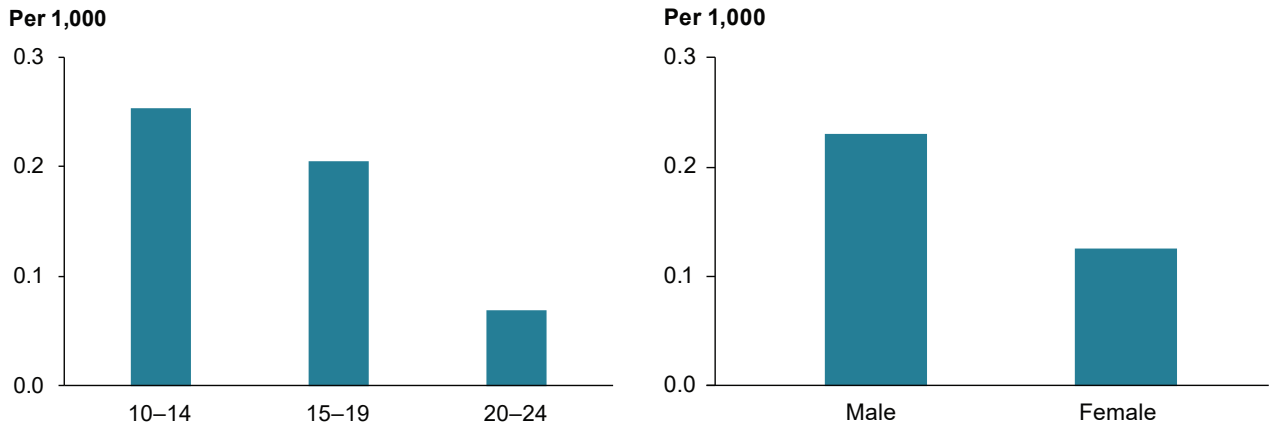
Source: AIHW analysis of National Hospital Morbidity Database.

Bronchiectasis hospitalisations higher for younger youth

A total of 41 Indigenous people aged 10–24 were hospitalised in 2015–16 for bronchiectasis. This equates to a rate of 0.2 per 1,000 young Indigenous people.

The hospitalisation rate for males (0.2 per 1,000 or 27) was around double that of females (0.1 per 1,000 or 14). Among youth age groups, the rate was highest for those aged 10–14 (0.3 per 1,000 or 20); followed by those aged 15–19 (0.2 per 1,000 or 16) and those aged 20–24 (0.1 per 1,000 or 5) (Figure 7.2.3).

Figure 7.2.3: Hospitalisation rate for Indigenous people aged 10–24 for bronchiectasis, by age group and sex, 2014–15



Source: AIHW analysis of National Hospital Morbidity Database.

7.3 Eye health

Vision is an important sense for communication, mobility and learning. Impaired vision can affect individuals' ability to engage fully in education, employment and social interaction (Chia et al 2004).

A total of 40,300 (20 per 100) Indigenous people aged 10–24 had an eye or sight condition, including short- or long-sightedness (Table 7.3). Eye or sight conditions were most common in those aged 15–19 (22 per 100 or 15,300) and 20–24 (23 per 100 or 13,000). Hospitalisations for eye diseases were most common in the 10–14 age group (0.8 per 1,000 population). There were no deaths attributable to diseases of the eye and adnexa between 2011 and 2015 (Table 7.3).

Table 7.3: Indigenous people aged 10–24 with eye/vision problems, by age group

	Prevalence (self-report) 2012–13[a]		Hospitalisations 2015–16		Mortality 2011–2015[b]	
Age group (years)	Number	Per 100 population	Number	Per 1,000 population	Number	Per 100,000 population
10–14	12,200	16.3	65	0.8	–	–
15–19	15,300	21.8	48	0.6	–	–
20–24	13,000	22.6	45	0.6	–	–
Total 10–24	**40,300**	**19.9**	**158**	**0.7**	**–**	**–**

(a) Adjustment of estimates by the ABS, for the purpose of maintaining confidentiality, may result in the sum of components not equalling the total.

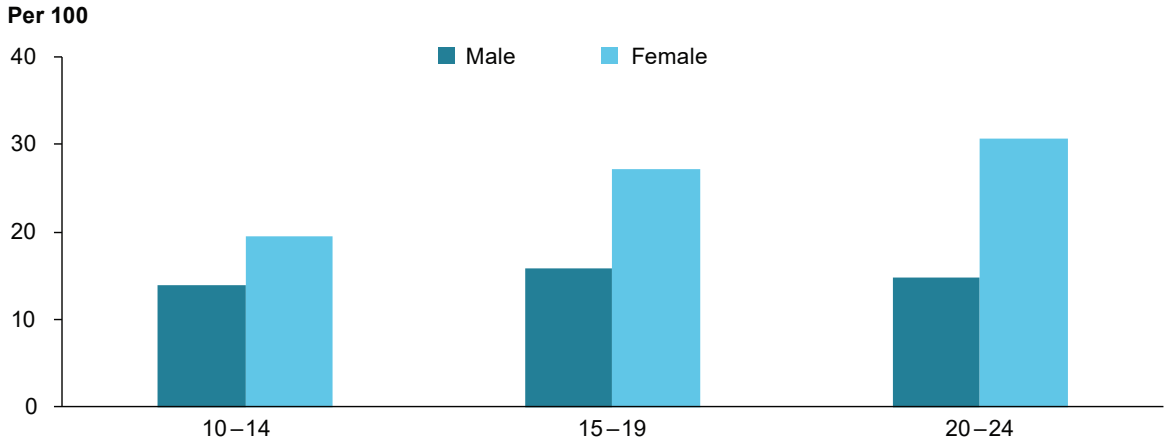
(b) Data for NSW, Qld, WA, SA and NT combined.

Note: Prevalence is self-reported eye or sight conditions. Hospitalisations and mortality are for diseases of the eye and adnexa.

Sources: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder), National Hospital Morbidity Database and National Mortality Database.

Young Indigenous females had higher rates of eye conditions than males (26 per 100 or 25,300 and 15 per 100 or 15,100, respectively). This pattern was evident across all age groups (Figure 7.3.1).

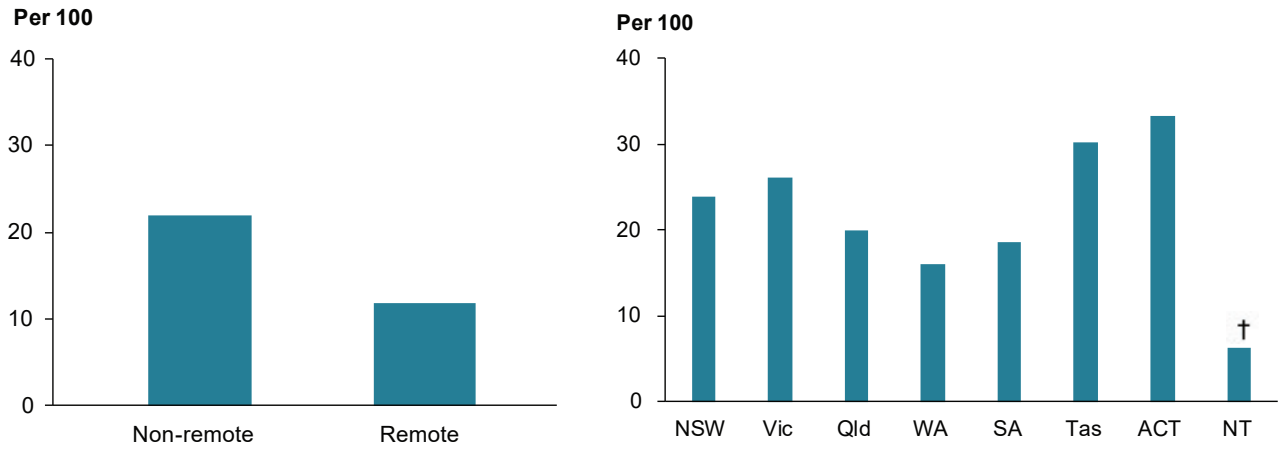
Figure 7.3.1: Rate of young Indigenous people reporting eye conditions, by age group and sex, 2012–13



Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

Young Indigenous people in non-remote areas (22 per 100 or 35,600) were more likely to have an eye condition than those in remote areas (12 per 100 or 4,700) (Figure 7.3.3). Across states and territories, the Australian Capital Territory (33 per 100 or 700) and Tasmania (30 per 100 or 2,300), had the highest. The lowest rate was in the Northern Territory (6 per 100 or 1,200) (Figure 7.3.2).

Figure 7.3.2: Rate of Indigenous people aged 10–24 reporting eye conditions, by remoteness and state and territory, 2012–13

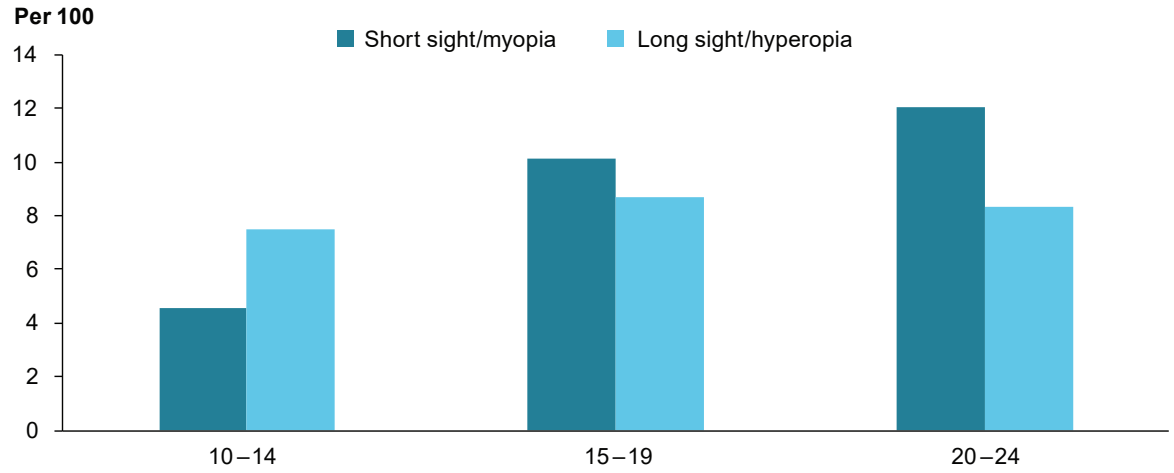


† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

The most common types of eye conditions for young Indigenous people were short-sightedness (8 per 100 or 17,100) and long-sightedness (8 per 100 or 16,600). Rates of these eye conditions varied by age. Short-sightedness increased with age: 5 per 100 (3,400) for the 10–14 age group, 10 per 100 (7,100) for the 15–19 age group and 12 per 100 (6,900) for the 20–24 age group. Long-sightedness was similar across the age groups: 8 per 100 (5,600) in the 10–14 age group, 9 per 100 (6,100 in the 15–19 age group, and 8 per 100 (4,800) in the 20–24 age group (Figure 7.3.3).

Figure 7.3.3: Rates of young Indigenous people with short sight/myopia and long sight/hyperopia by age group, 2012–13



Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

7.4 Injury and poisoning

Injury has a major but largely preventable impact on the health of young Indigenous Australians. It is one of the leading causes of hospitalisation among young people and can result in serious disability and long-term health conditions. It is also one of the major contributors to premature mortality in young people (AIHW, 2016a).

Around 43,200 (21 per 100 population) Indigenous people aged 10–24 had experienced an accident or had been hurt in the previous 4 weeks (Table 7.4). The rate of injury was similar across age groups. In contrast, hospitalisations for injury and poisoning were most common in the 20–24 age group (47 per 1,000 population). Mortality rates were also highest in the 20–24 age group (85 per 100,000) (Table 7.4).

Table 7.4: Indigenous people aged 10–24 with injury and poisoning conditions, by age group

	Prevalence (self-report) 2012–13[(a)(b)]		Hospitalisations 2015–16		Mortality 2011–2015[(c)]	
Age group (years)	Number	Per 100 population	Number	Per 1,000 population	Number	Per 100,000 population
10–14	16,000	21.4	1,917	24.2	63	18.2
15–19	15,000	21.4	3,118	40.1	202	60.5
20–24	12,100	21.1	3,397	47.4	246	85.2
Total 10–24	**43,200**	**21.3**	**8,432**	**36.9**	**511**	**52.1**

(a) Prevalence is for short-term injury, i.e. whether been in accidents or been hurt in the previous 4 weeks. There were an additional 3,800 young Indigenous people who reported injury as a long-term health condition, that is, one that lasted or was expected to last for 6 months or more.

(b) Adjustment of estimates by the ABS, for the purpose of maintaining confidentiality, may result in the sum of components not equalling the total.

(c) Data for NSW, Qld, WA, SA and NT combined.

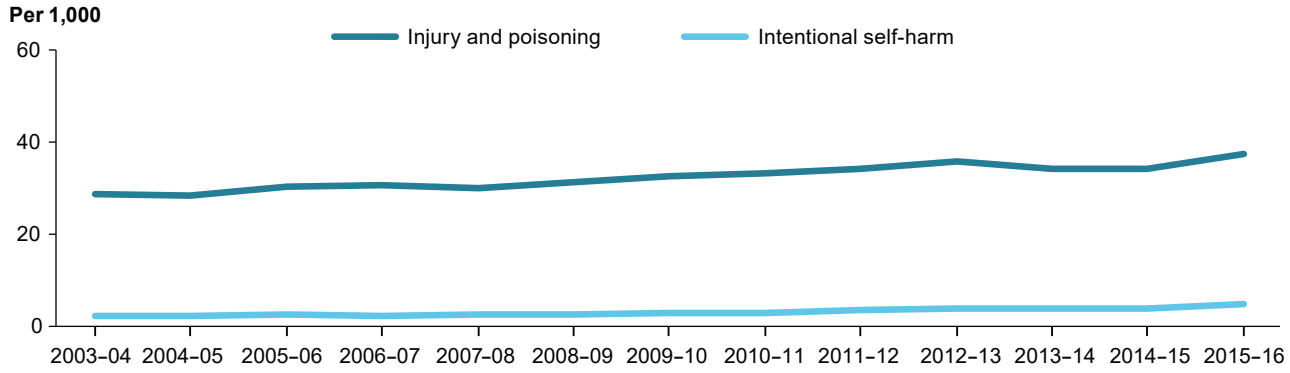
Sources: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder), National Hospital Morbidity Database and National Mortality Database.

Injury and poisoning main reason for hospitalisations

The rate of hospitalisations for injury and poisoning in 2015–16 was 38 per 1,000 (8,170) for Indigenous people aged 10–24. This rate increased with age, with the younger age group of 10–14 having the lowest rate of hospitalisations (24 per 1,000), followed by the 15–19 age group (40 per 1,000) and 20–24 age group (47 per 1,000).

Between 2003–04 and 2015–16, the rate of hospitalisations for injury and poisoning for Indigenous people aged 10 to 24 increased from 29 to 38 per 1,000. The rate of hospitalisations relating to intentional self-harm for Indigenous people aged 10–24 also increased over this period, rising from 2 to 5 per 1,000 (Figure 7.4.1).

Figure 7.4.1: Hospitalisations with a principal diagnosis of injury and poisoning and intentional self-harm for Indigenous people aged 10–24, 2003–04 to 2015–16



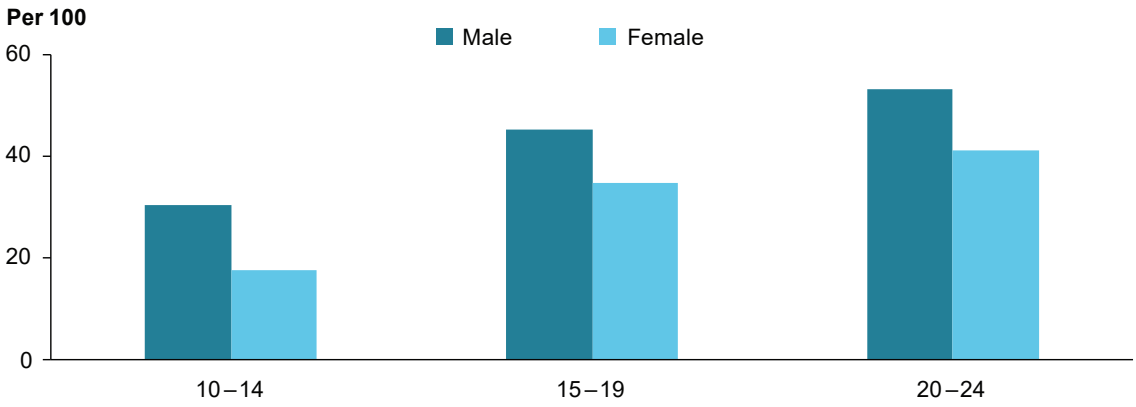
Notes

1. Hospitalisations for injury and poisoning (ICD-10-AM codes S00-T98) include all hospitalisations for this cause, and for this reason are not limited to those with an external cause.
2. Data are for New South Wales, Victoria, Queensland, Western Australia, South Australia, and the Northern Territory.

Source: AIHW analysis of National Hospital Morbidity Database.

In 2015–16, the rates of hospitalisation for injury and poisoning were higher among young Indigenous males than females (43 per 1,000 and 31 per 1,000, respectively). This pattern was evident across the 10–14, 15–19 and 20–24 age groups (Figure 7.4.2).

Figure 7.4.2: Hospitalisations with a principal diagnosis of injury and poisoning for Indigenous people aged 10–24 by sex, 2015–16



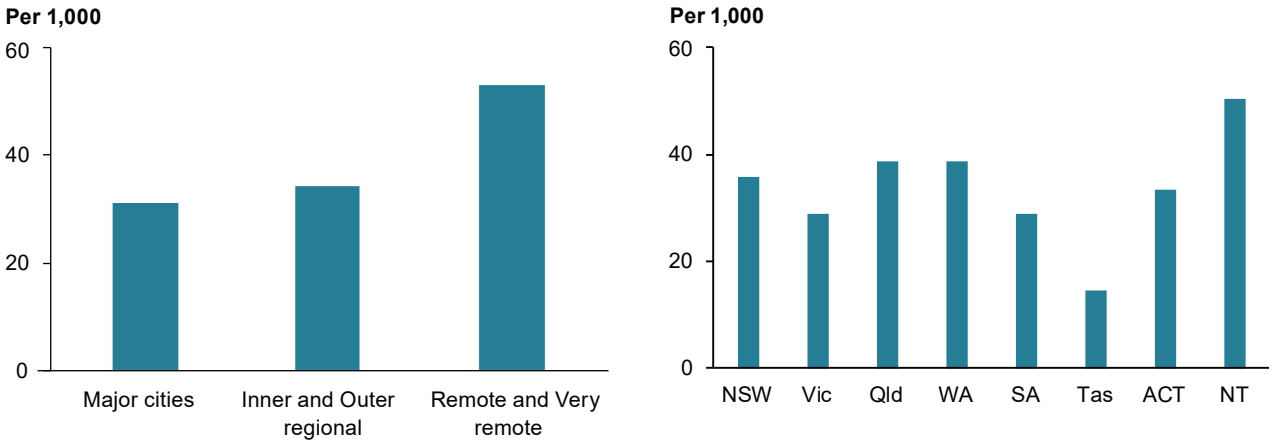
Note: Hospitalisations for injury and poisoning (ICD-10-AM codes S00-T98) include all hospitalisations for this cause, and for this reason are not limited to those with an external cause.

Source: AIHW analysis of National Hospital Morbidity Database.

Young Indigenous people in *Remote* and *Very remote* areas (combined) had a higher rate of hospitalisations for injury and poisoning (53 per 1,000 or 2,182) than those in *Inner* and *outer regional* areas (combined) (34 per 1,000 or 3,534), and *Major cities* (31 per 1,000 or 2,631) (Figure 7.4.3).

Across states and territories, the rate of hospitalisations for injury and poisoning was highest in the Northern Territory for Indigenous people aged 10–24 (50 per 1,000 or 1,095) and lowest in Tasmania (14 per 1,000 or 118) (Figure 7.4.3).

Figure 7.4.3: Hospitalisations with a principal diagnosis of injury and poisoning for Indigenous people aged 10–24, by remoteness and state and territory, 2015–16



Note: Hospitalisations for injury and poisoning (ICD-10-AM codes S00-T98) include all hospitalisations for this cause, and for this reason are not limited to those with an external cause.

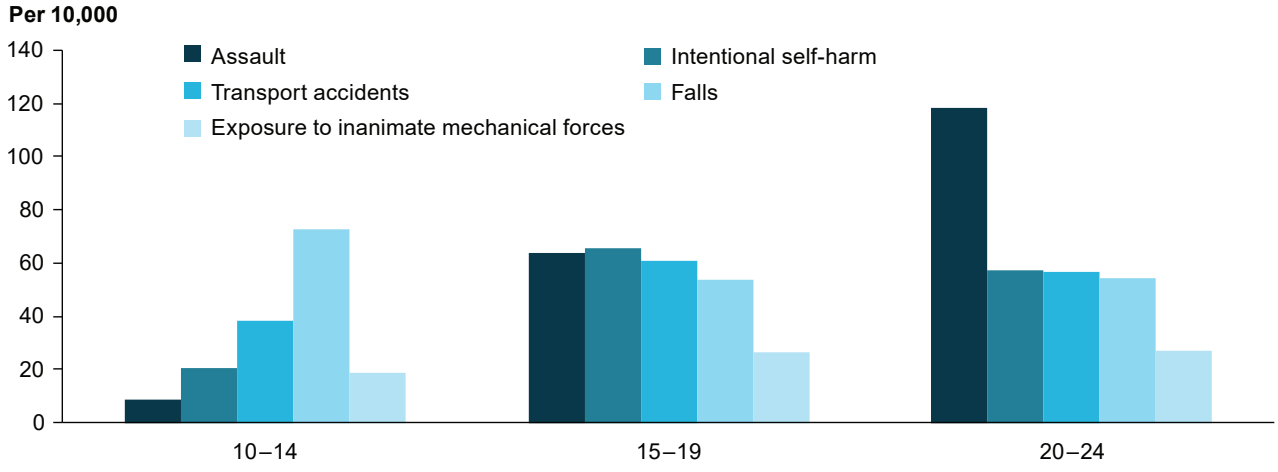
Source: AIHW analysis of National Hospital Morbidity Database.

Assault was the leading external cause of hospitalisation

Assault was the leading external cause of injury and poisoning hospitalisations for Indigenous people aged 10–24 (62 per 10,000); followed by falls (60 per 10,000), exposure to inanimate mechanical forces (56 per 10,000), transport accidents (52 per 10,000 population) and intentional self-harm (47 per 10,000).

Falls were the leading external cause of hospitalisations for Indigenous people aged 10–14 (73 per 10,000). For Indigenous people aged 15–19, intentional self-harm was the leading cause with a rate of 65 per 10,000 population while assault was the leading cause of injury-related hospitalisations for those aged 20–24 (118 per 10,000) (Figure 7.4.4).

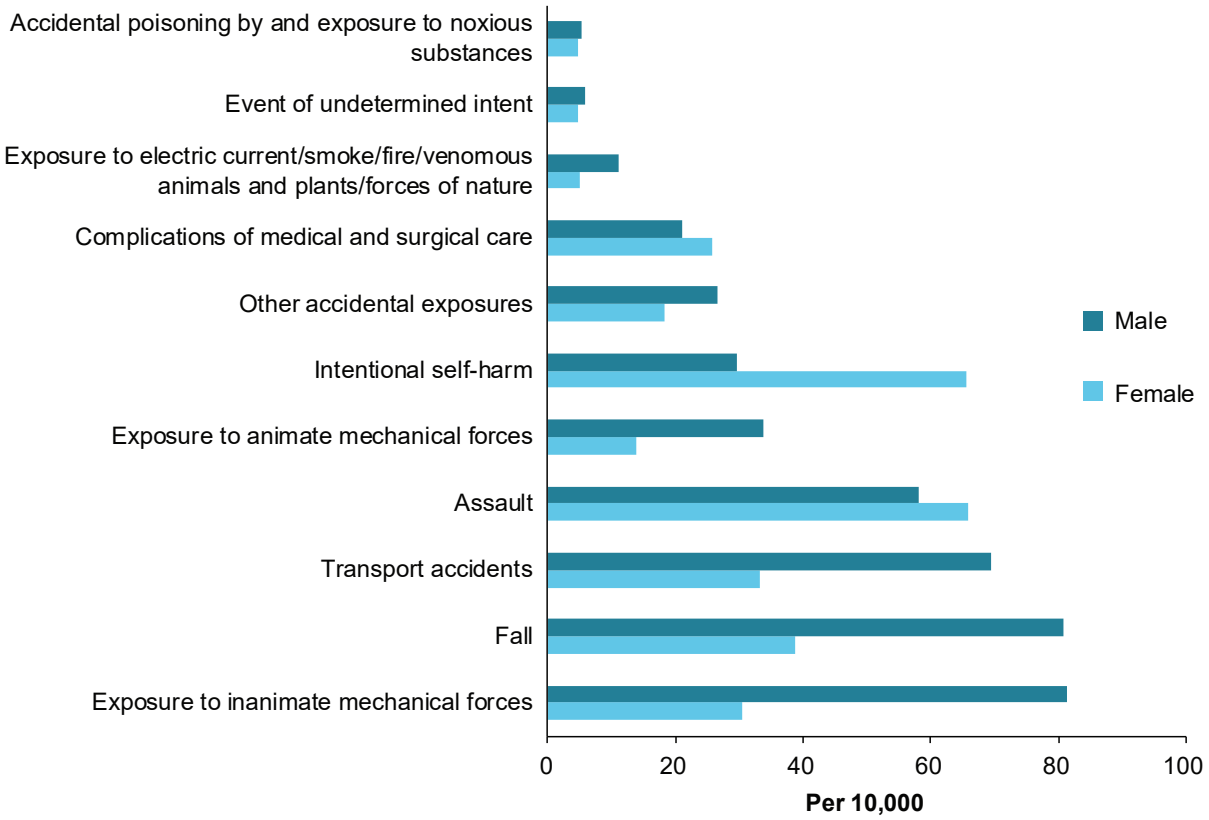
Figure 7.4.4: External causes of injury and poisoning hospitalisations for young Indigenous people, by cause and age group, 2015–16



Source: AIHW analysis of National Hospital Morbidity Database.

Rates of hospitalisations from exposure to inanimate mechanical forces, exposure to animate mechanical forces, exposure to electric current/smoke/fire/venomous animals and plants/forces of nature, transport accidents and falls were twice as high for males as for females. Males also had higher rates of hospitalisations for all other external causes, with the exception of assault, complications of medical and surgical care, and intentional self-harm. The rate of hospitalisation for intentional self-harm for young Indigenous females was more than twice the rate for young Indigenous males (66 per 10,000 and 30 per 10,000, respectively) (Figure 7.4.5).

Figure 7.4.5: External causes of injury and poisoning hospitalisations for Indigenous people aged 10–24, by cause and sex, 2015–16



Source: AIHW analysis of National Hospital Morbidity Database.

Sport-related external causes of injury and poisoning

Around 1,311 injury and poisoning hospitalisations (16% of all such hospitalisations) were related to a sporting activity— a rate of 6 per 1,000. More than 2 in 5 (45% or 593) of the injury and poisoning hospitalisations due to falls were related to engaging in a sporting activity.

Sport-related injury and poisoning hospitalisations varied with age, with higher rates for those aged 15–19 (503 or 6 per 1,000) and 10–14 (496 or 6 per 100,000) than for those aged 20–24 (312 or 4 per 1,000).

Cost of injury in Western Australia, 2016

Data were available for cost of injury resulting in hospitalisation for the Indigenous population in Western Australia in 2012. Note that this was not youth specific. Cost of injury increased with severity, with fatal injuries costing 424 million dollars, hospitalisations costing 157 million and emergency department attendance costing 161 million.

Source: Hendrie et al. 2016.

7.5 Mental health

The concept of mental health comes from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment. Mental health conditions include a wide range of disorders varying in severity. Its effect on individuals and families can be severe. For Indigenous people aged 10–24, mental health-related conditions (suicide and self-inflicted injuries, anxiety disorders, alcohol use disorders and depressive disorders) were the top 4 conditions contributing to their overall burden of disease (see Chapter 6).

There are limited population-level data on the mental health of young Indigenous people. This section reports on the available national data on self-reported long-term mental health conditions such as anxiety and depression, hospitalisations and mortality. While intentional self-harm is classified under injury and poisoning, it is also included in this section due to its strong relationship to mental health.

Box 7.5. Mental health data from NATSISS

- Collected data from Indigenous people aged 15–24.
- Respondents were asked if they had been told by a nurse or doctor that they had a mental health condition. Conditions included depression; anxiety; behavioural or emotional problems; and/or harmful use of, or dependence on drugs or alcohol.
- Only conditions that had lasted, or were likely to last, 6 months or more were included.

Data from the 2014–15 NATSISS show that 22% (30,600) of Indigenous people aged 15–24 reported a long-term mental health condition (Table 7.5.1). Young Indigenous people were hospitalised at a rate of around 20 per 1,000 for mental and behavioural disorders in 2015–16 and a rate of around 5 per 1,000 for intentional self-harm. Mortality due to intentional self-harm occurred at a rate of 29 per 100,000 for the period 2011–2015 (Table 7.5.1).

Table 7.5.1: Prevalence, hospitalisations and mortality for mental and behavioural disorders, and for self-harm, Indigenous people aged 10–24

Age group (years)	Prevalence (self-report) 2014–15[a][b]		Hospitalisations 2015–16		Mortality[c] 2011–2015	
	Number	Per 100 population	Number	Per 1,000 population	Number	Per 100,000 population
Mental and behavioural disorders						
10–14	n.a.	n.a.	380	4.8	—	—
15–19	14,700	20.1	1,742	22.4	—	—
20–24	15,700	24.2	2,343	32.7	—	—
Total	**30,600**	**22.2**	**4,465**	**19.5**	—	—
Intentional self-harm						
10–14	—	—	162	2.1	25	7.2
15–19	—	—	508	6.5	122	36.5
20–24	—	—	409	5.7	131	45.3
Total	—	—	**1,079**	**4.7**	**278**	**28.7**

(a) Prevalence is self-reported mental health problems that had lasted, or were likely to last, for 6 months or more.

(b) Adjustment of estimates by the ABS, for the purpose of maintaining confidentiality, may result in the sum of components not equalling the total.

(c) Data for NSW, Qld, WA, SA and NT combined.

Sources: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder), National Hospital Morbidity Database and National Mortality Database.

2 in 5 young Indigenous people suffer from mental health conditions

The proportion of young people reporting a mental health condition was lower for those aged 15–19 (20% or 14,700) than for those aged 20–24 (24% or 15,700) (Table 7.5.1). The proportion of young Indigenous people reporting a mental health condition was higher for females (28% or 19,000) than for males (17% or 11,800).

Young Indigenous people in non-remote areas were more than twice as likely to have a mental health condition (27,800 or 25%) than those living in remote areas (2,900 or 11%). Across states and territories, Victoria (3,400 or 33%) and Tasmania (1,700 or 33%) had the highest rate of Indigenous youth reporting mental health conditions. The lowest rate was in the Northern territory (12,800 or 9%).

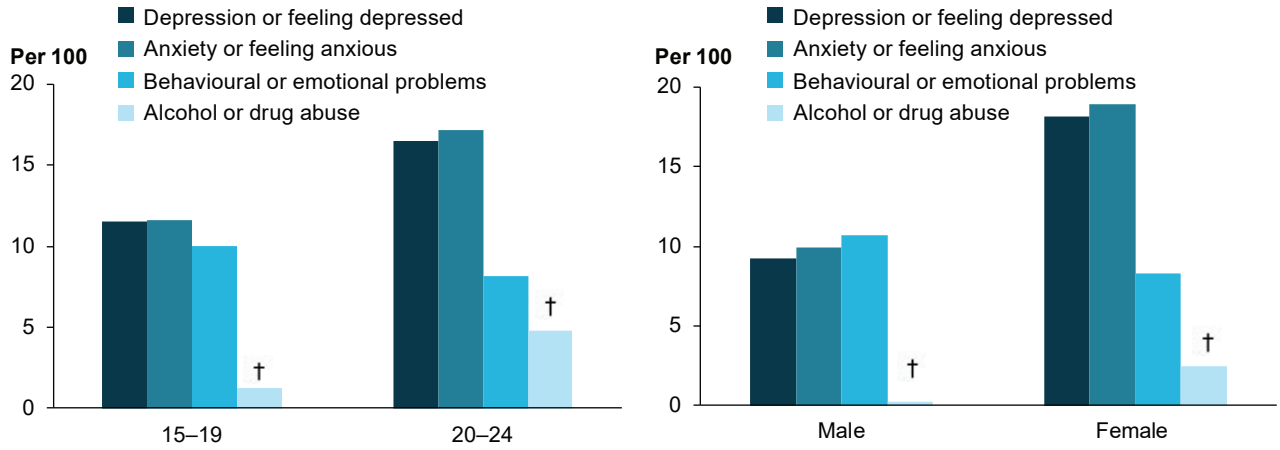
Anxiety was the most common self-reported long-term mental health condition

Anxiety or feeling anxious or nervous was the most commonly reported long-term mental health condition among Indigenous people aged 15–24 (14 per 100 or 19,500). This was followed by depression or feeling depressed (14 per 100 or 18,700), behavioural or emotional problems (9 per 100 or 12,600) and harmful use of, or dependence on, drugs or alcohol (3 per 100 or 3,800).

Those aged 15–19 (10%) experienced behavioural or emotional problems at a slightly higher rate than those aged 20–24 (8%). Those aged 20–24 (5%) were more likely to report the harmful use of, or dependence on drugs or alcohol than those aged 15–19 (1%) (Figure 7.5.1).

A higher rate of Indigenous females aged 15–24 (18% or 12,500) compared with males (9% or 6,300) had depression or were feeling depressed. Females were also more likely to report anxiety or feeling anxious (19% or 13,000) than males (10% or 6,800) (Figure 7.5.1).

Figure 7.5.1: Young Indigenous people, by type of long-term mental health condition, age group and sex, 2014–15.



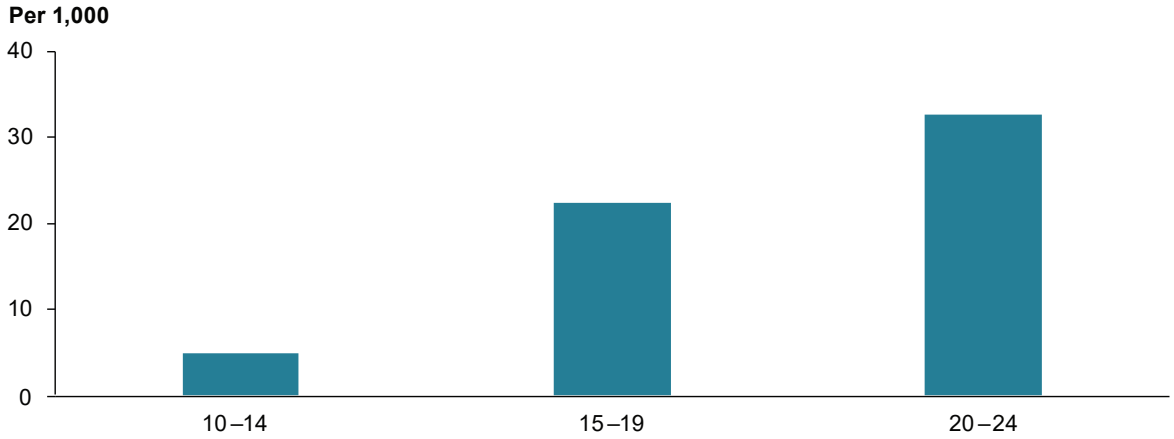
† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Higher rate of mental health hospitalisations for older youth

In 2015–16, there were 4,465 hospitalisations for mental and behavioural disorders for young Indigenous people. This represented a rate of 20 per 1,000. The rate was highest for those aged 20–24 (33 per 1,000 or 2,343), followed by those aged 15–19 (22 per 1,000 or 1,742) then those aged 10–14 (5 per 1,000 or 380) (Figure 7.5.2). The rate was similar for young Indigenous males (19 per 1,000 or 2,203) and females (20 per 1,000 or 2,262).

Figure 7.5.2: Hospitalisation rates of Indigenous people aged 10–24 due to mental and behavioural disorders, by age, 2015–16

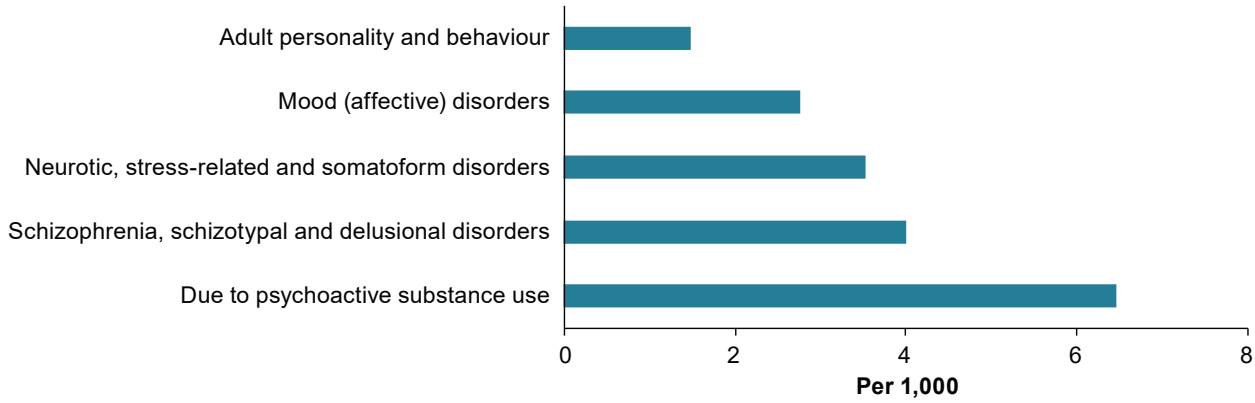


Source: AIHW analysis of National Hospital Morbidity Database.

The leading cause of hospitalisations for mental and behavioural disorders for Indigenous people aged 10–24 in 2015–16 was mental and behavioural disorders due to psychoactive substance use (7 per 1,000 or 1,476). This included hospitalisations due to alcohol related disorders, opioid-related disorders and cannabis-related disorders, among others.

The next highest rates were for schizophrenia, schizotypal and delusional disorders (4 per 1,000 or 915); neurotic, stress-related and somatoform disorders (4 per 1,000 or 804); mood (affective) disorders (3 per 1,000 or 630); and disorders of adult personality and behaviour (2 per 1,000 or 340). All other causes of mental and behavioural disorder hospitalisations occurred at a rate of less than 1 per 1,000 (Figure 7.5.3).

Figure 7.5.3: Top 5 causes of hospitalisation due to mental and behavioural disorders for Indigenous people aged 10–24, 2015–16



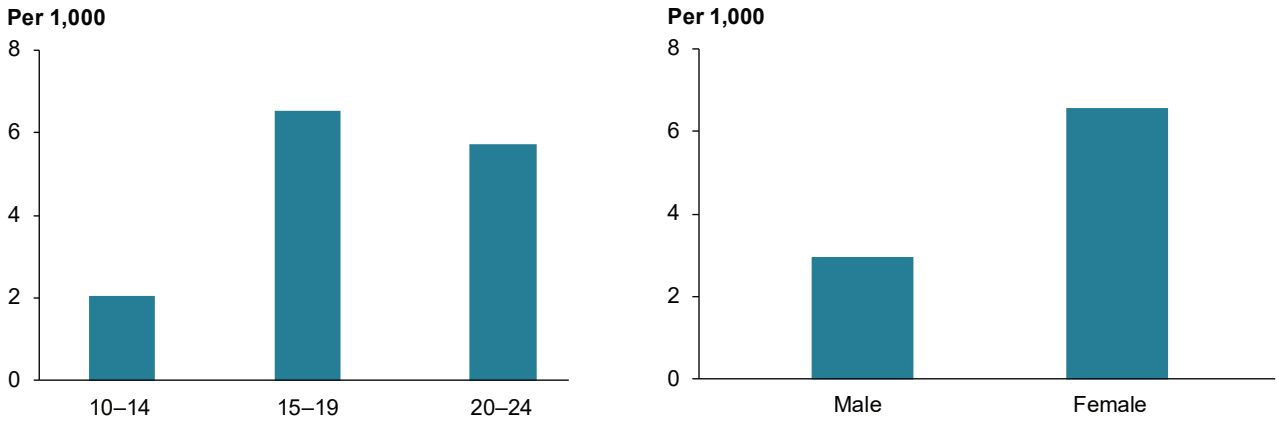
Note: Full codes are 'Mental and behavioural disorders due to psychoactive substance use', 'Schizophrenia, schizotypal and delusional disorders', 'Neurotic, stress-related and somatoform disorders', 'Mood (affective) disorders', and 'Disorders of adult personality and behaviour'.

Source: AIHW analysis of National Hospital Morbidity Database.

Hospitalisations due to intentional self-harm higher among females

In 2015–16, there were 1,079 hospitalisations (5 per 10,000 population) among Indigenous people aged 10–24 for intentional self-harm. The rate was higher among those aged 15–19 (7 per 1,000 population or 508) than those aged 20–24 (6 per 1,000 population or 409) and those aged 10–14 (2 per 1,000 population or 162) (Figure 7.5.4). The rate of hospitalisations due to intentional self-harm was higher among females (7 per 1,000 population or 731) than males (3 per 1,000 population or 348) (Figure 7.5.4).

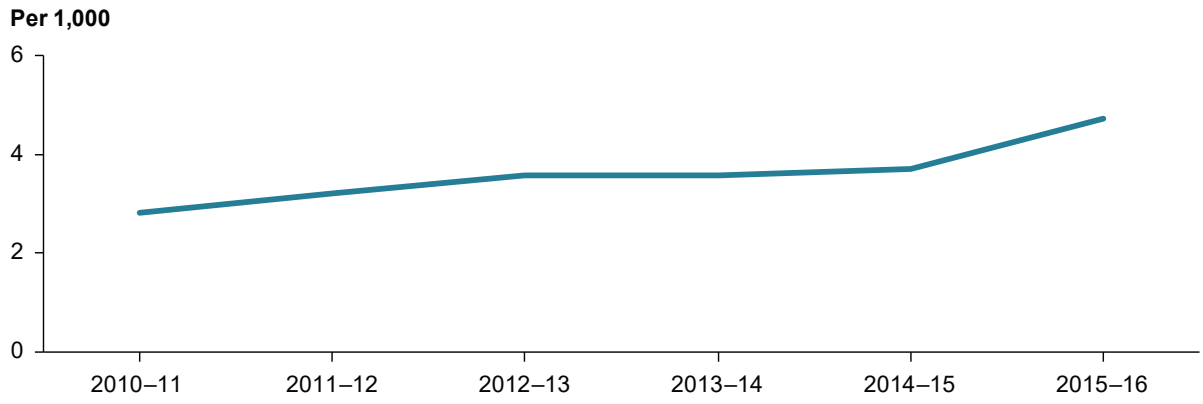
Figure 7.5.4: Hospitalisation rates of Indigenous people aged 10–24 due to intentional self-harm, by age and sex, 2015–16



Source: AIHW analysis of National Hospital Morbidity Database.

From 2010–11 to 2015–16, there was an increase in the number and rate of hospitalisations due to intentional self-harm for Indigenous people aged 10–24 from 3 per 1,000 (589) in 2010–11 to 5 per 1,000 (1,079) in 2015–16 (Figure 7.5.5). This may reflect the increasing prevalence of self-harm in the population, or greater access to and use of hospital services.

Figure 7.5.5: Hospitalisation rates of Indigenous people aged 10–24 due to intentional self-harm, 2010–11 to 2015–16

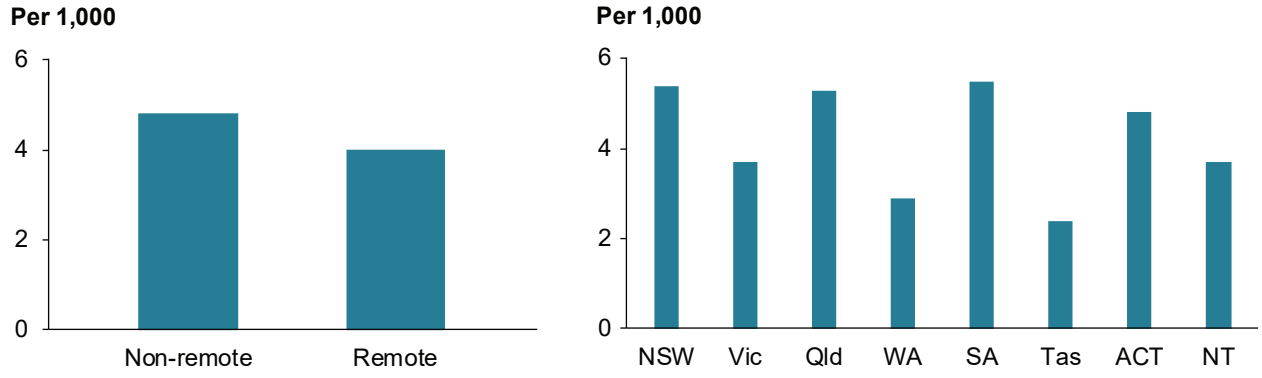


Source: AIHW analysis of National Hospital Morbidity Database.

Rates were slightly higher in non-remote areas (5 per 1,000 or 891) than in remote areas (4 per 1,000 or 166) (Figure 5.5.6).

Across states and territories, the rate was highest in New South Wales (5 per 1,000 or 388) and lowest in Tasmania (2 per 1,000 or 20) and Western Australia (2.9 per 1,000 or 84) (Figure 7.5.6).

Figure 7.5.6: Hospitalisation rates of Indigenous people aged 10–24 due to intentional self-harm, by state and territory and remoteness, 2015–16



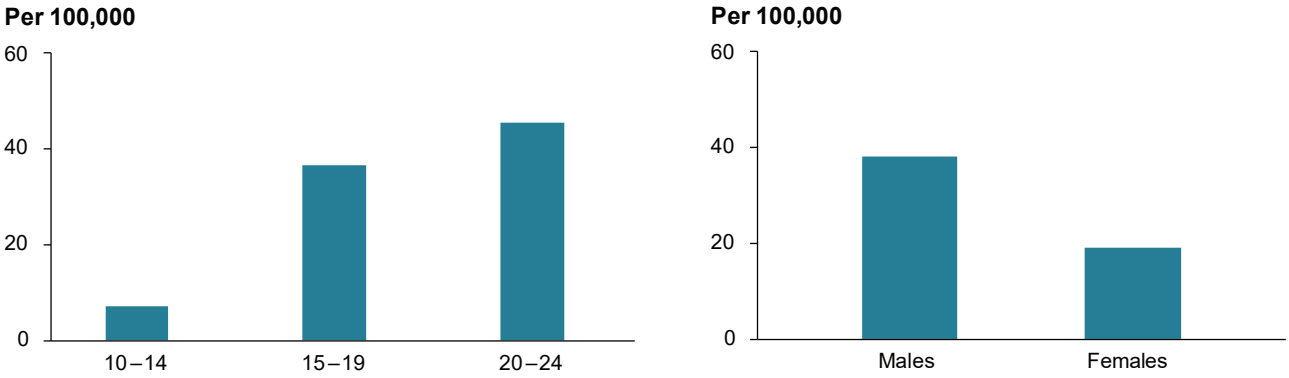
Source: AIHW analysis of National Hospital Morbidity Database.

Mortality due to intentional self-harm higher among males

In 2011–2015, there were 278 deaths (29 per 100,000) among Indigenous people aged 10–24 due to intentional self-harm in New South Wales, Queensland, Western Australia, South Australia, and the Northern Territory combined. Intentional self-harm deaths are classified under injury and poisoning as external causes of death, and therefore are not reported as deaths caused by mental health conditions. No deaths were attributed to mental and behavioural disorders.

The mortality rate for intentional self-harm increased with age. The rate for those aged 10–14 was 7 per 100,000 (25 deaths), for those aged 15–19 it was 37 per 100,000 (122 deaths), and for those aged 20–24 it was 45 per 100,000 (131 deaths). The rate was higher among males (38 per 100,000 or 188 deaths) than females (19 per 100,000 or 90 deaths) (Figure 7.5.7).

Figure 7.5.7: Mortality rates of Indigenous people aged 10–24 due to intentional self-harm, by age and sex, 2011–2015

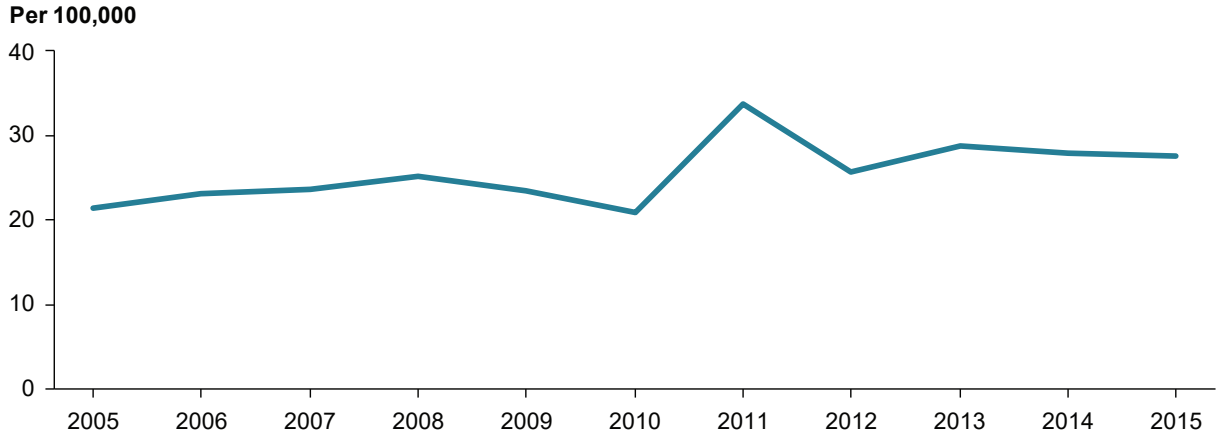


Note: Data for NSW, Qld, WA, SA and NT combined.

Source: AIHW analysis of National Mortality Database.

There was an increase in the number of deaths due to intentional self-harm between 2005 and 2015. Over this period, the number of deaths increased from 21 per 100,000 (34 deaths) to 28 per 100,000 (55 deaths), but peaked in 2011 when there were 34 per 100,000 or 63 deaths (Figure 7.5.8).

Figure 7.5.8: Mortality rates of Indigenous people aged 10–24 due to intentional self-harm, 2005 to 2015



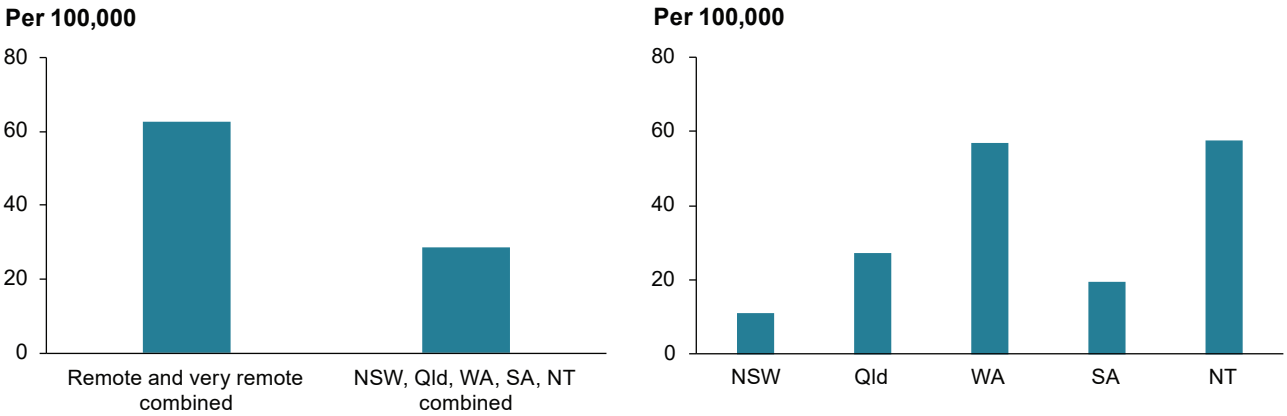
Note: Data for NSW, Qld, WA, SA and NT combined.

Source: AIHW analysis of National Mortality Database.

The mortality rate was twice as high in *Remote* and *Very remote* areas combined (63 per 100,000 or 130 deaths) compared with the total deaths in the 5 states for which data can be reported (29 per 100,000 or 278 deaths) (Figure 7.5.9).

Across states and territories, the rate was highest in the Northern Territory (58 per 100,000 or 61 deaths) and lowest in New South Wales (11 per 100,000 or 38 deaths) (Figure 7.5.9).

Figure 7.5.9: Mortality rates of Indigenous people aged 10–24 due to intentional self-harm, by state and territory and remoteness, 2011–15



Note: 'Remote and Very remote areas' data from all jurisdictions. Data from NSW, Qld, WA, SA and NT combined are all remoteness areas.

Source: AIHW analysis of National Mortality Database.

7.6 Circulatory health

Around 16,800 (8 per 100) Indigenous people aged 10–24 reported heart or circulatory conditions (Table 7.6). These conditions were most common among those aged 20–24 (16 per 100 or 9,300). Hospitalisations for circulatory diseases were most common in the 10–14 age group (4 per 1,000), while the 20–24 age group had the highest mortality rate (8 per 100,000) (Table 7.6).

Table 7.6: Indigenous people aged 10–24 with heart/circulatory diseases, by age group

	Prevalence (self-report) 2012–13[a]		Hospitalisations 2015–16		Mortality 2011–2015[b]	
Age group (years)	Number	Per 100 population	Number	Per 1,000 population	Number	Per 100,000 population
10–14	2,600	3.5	281	3.6	n.p.	0.9
15–19	5,700	8.2	175	2.2	9	2.7
20–24	9,300	15.9	243	3.4	24	8.3
Total	**16,800**	**8.3**	**699**	**3.1**	**36**	**3.7**

(a) Adjustment of estimates by the ABS, for the purpose of maintaining confidentiality, may result in the sum of components not equalling the total.

(b) Data for NSW, Qld, WA, SA and NT combined.

Sources: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder), National Hospital Morbidity Database and National Mortality Database.

Ischaemic heart disease

Ischaemic heart disease, or coronary heart disease, occurs due to a blockage in the blood vessels that supply blood to the heart muscle. The 2 main clinical forms of ischaemic heart disease are a heart attack, which is an acute life-threatening event and results from a complete blockage, and angina, which is a chronic condition and results from a temporary deficiency in the blood supply (AIHW 2015).

In 2011–2015, circulatory disease was the leading cause of death amongst all Indigenous Australians, accounting for almost one-quarter (24%) of all deaths. Ischaemic heart disease was the leading cause of Indigenous circulatory disease deaths, accounting for the majority (55%) of these deaths (AHMAC 2017).

Although typically a disease of adulthood, ischaemic heart disease has been identified as an emerging health issue for young Indigenous people (Azzopardi et al. 2017). In 2015–16, there were 6 hospitalisations of Indigenous people aged 10–24 for ischaemic heart disease. This equates to a rate of 0.03 per 1,000 population. For the period of 2011–2015, mortality rate for young Indigenous people due to the disease was <1 per 100,000 (n.p deaths).

Over 1,000 acute rheumatic fever cases

Acute rheumatic fever (ARF) is an illness caused by an inflammatory response to a bacterial infection with group A streptococcus. Rheumatic heart disease (RHD) is a complication of ARF (Box 7.6).

Box 7.6: Acute rheumatic fever and rheumatic heart disease

ARF is an inflammatory disease that is caused by an untreated group A streptococcal infection of the throat. The onset typically occurs 2 to 3 weeks after a throat infection (Webb et al. 2015). It has been suggested that streptococcal skin infections can also lead to ARF. Continuous episodes of ARF causes damage to the connective tissues in the body especially in the heart, joints, brain and skin. ARF is linked to poor environmental conditions such as poverty, poor hygiene, overcrowding and other characteristics of social and economic disadvantage (Webb, et al.).

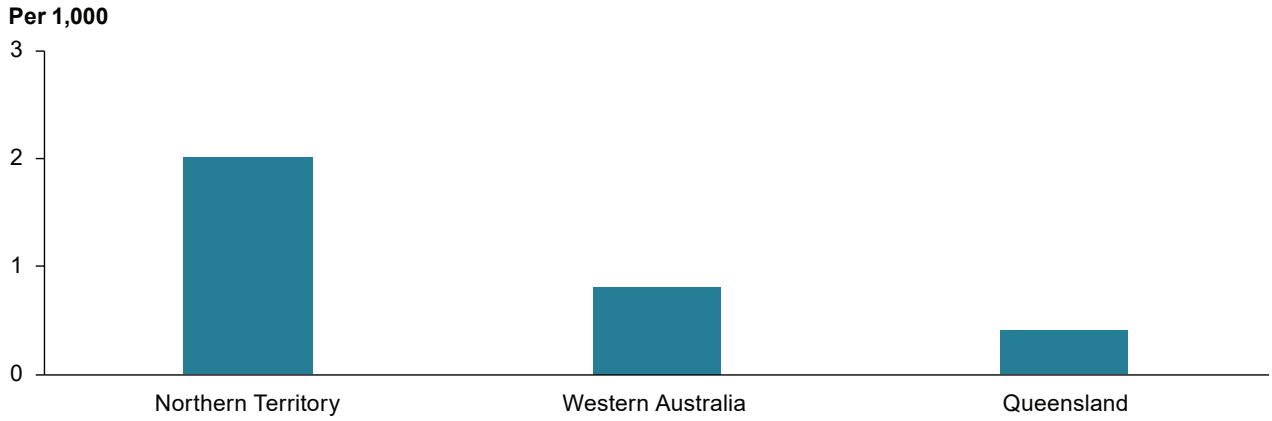
Severe episodes of ARF can lead to chronic RHD, a condition caused by the long-term damage to the heart muscles or heart valves, through repeated cases of ARF. RHD increases the risk of recurrent infections and further heart damage.

Both ARF and RHD are preventable causes of poor health. Despite being rare in developed nations where treatment and health services are accessible, and being almost entirely a disease of the elderly who acquired it as children more than 60 years ago, ARF and RHD are prevalent in Indigenous populations, particularly among young people (Parnaby & Carapetis, 2010). ARF and RHD incidence rates in the Northern Territory Indigenous population are among the highest rates reported worldwide (Field, 2004).

Between 2011 and 2015, a total of 1,132 ARF cases (new and recurrent cases) were registered in the Northern Territory, Western Australia, South Australia and Queensland for Indigenous people. Of the 1,096 ARF cases in the Northern Territory, Western Australia and Queensland, the majority occurred in children aged 0–14 (55% or 606) and Indigenous people aged 15–24 (26% or 284). South Australian data is limited to overall totals—age breakdowns are not yet available.

The incidence of ARF among the 15 to 24 age group was highest in the Northern Territory (2 per 1,000 population or 139), followed by Western Australia (0.8 per 1,000 population or 73) and Queensland (0.4 per 1,000 population or 72) (Figure 7.6.1).

Figure 7.6.1: Indigenous people aged 15–24 registered with ARF (new and recurrent), by state and territory, 2011–2015

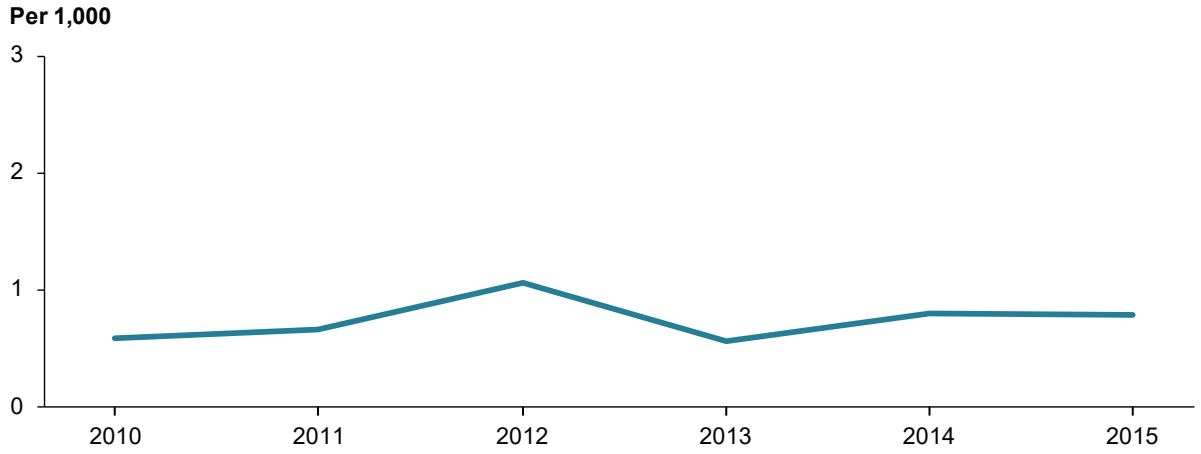


Note: Includes initial and recurrent cases for NT; and initial, recurrent and probable cases for WA and Qld. SA was unable to provide age-specific data.

Source: AIHW 2017b.

Between 2010 and 2015, the incidence of RHF (new and recurrent cases) increased slightly from 0.6 to 0.8 per 1,000 (Figure 7.6.2).

Figure 7.6.2: Indigenous people aged 15–24 registered with ARF (new and recurrent), 2010–2015



Note: Includes cases for NT and initial, recurrent and probable cases for WA and Qld. SA was unable to provide age-specific data.

Source: AIHW 2017b.

Higher rate of RHD in females in Northern Territory

In 2015, among Indigenous people aged 15–24, there were 9 cases of RHD per 1,000 (690 cases). In the Northern Territory, the rate for Indigenous males aged 15–24 was 18 per 1,000 population (128 cases) while for females it was 29 per 1,000 (195 cases). In Queensland, the RHD rate was 6 per 1,000 (126 cases) for males and 7 per 1,000 (138 cases) for females.

Although there were some yearly fluctuations, between 2010 and 2015 there was a decrease in new RHD registrations for Indigenous people aged 15 to 24 in Queensland (from 0.8 to 0.3 per 1,000 per population). In contrast, the rate in the Northern Territory remained mostly steady over the same period (1.4 to 1.6 per 1,000 population). Between 2011 and 2015 in Western Australia, the rate increased from 0.6 to 2 per 1,000.

Around 966 hospitalisations between 2010–11 and 2015–16

Over the period of 2010–11 to 2015–16, there were 966 hospitalisation with a principal diagnosis of ARF, a rate of 1 per 1,000 for Indigenous people aged 10–24. Additionally, there were 368 hospitalisations for RHD, a rate of 0.3 per 1,000.

7.7 Ear health

Good ear health is important for language acquisition and learning, and for the development of cognitive, emotional, and social skills. Working to reduce the prevalence of ear health conditions may facilitate the educational, social and employment successes of young Indigenous people (Burns & Thomson, 2013).

Around 15,600 (8 per 100) Indigenous people aged 10–24 had ear or hearing conditions in 2012–13. These problems were most common in those aged 20–24 (10 per 100). In 2015–16, hospitalisations for diseases of the ear were most common in the 10–14 age group (5 per 1,000 population) (Table 7.7).

Table 7.7: Indigenous people aged 10–24 ear/hearing problems, by age group

	Prevalence (self-report) 2012–13[a]		Hospitalisations 2015–16		Mortality 2011–2015[b]	
Age group (years)	Number	Per cent	Number	Per 1,000 population	Number	Per 100,000 population
10–14	5,000	6.7	380	4.8	n.p.	n.p.
15–19	4,400	6.3	123	1.6	–	–
20–24	5,800	9.9	69	1.0	–	–
Total 10–24	**15,600**	**7.7**	**572**	**2.5**	**n.p.**	**n.p.**

(a) Adjustment of estimates by the ABS, for the purpose of maintaining confidentiality, may result in the sum of components not equalling the total.

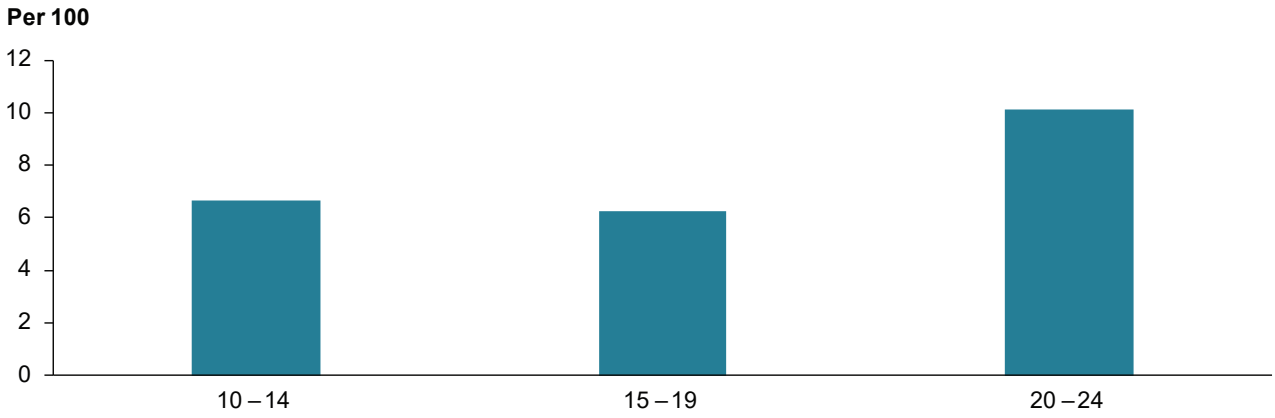
(b) Data for NSW, Qld, WA, SA and NT combined.

Sources: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder), National Hospital Morbidity Database and National Mortality Database.

Fewer than 1 in 10 report an ear condition

In 2012–13, fewer than 1 in 10 (8 per 100 or 15,600) Indigenous people aged 10–24 reported a hearing or ear condition. The rate of those with an ear condition was highest for those aged 20–24 (10 per 100 or 5,800) (Figure 7.7.1). The rates were similar for males and females (8 per 100 or 8,200 and 7 per 100 or 7,000, respectively).

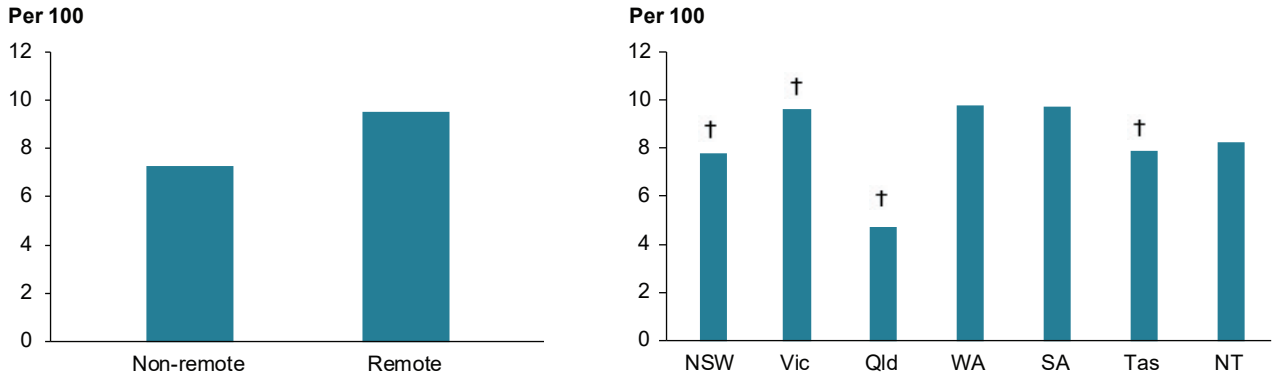
Figure 7.7.1: Rate of young Indigenous people with ear conditions, by age group, 2012–13



Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

Ear conditions were more likely to occur in remote areas (10 per 100 or 3,800) than in non-remote areas (7 per 100 or 11,800). Across states and territories, the rates were highest in Western Australia (10 per 100 or 2,500), South Australia (10 per 100 or 1,100) and Victoria (10 per 100 or 1,400), and lowest in Queensland (5 per 100 or 2,700) and the Australian Capital Territory (5 per 100 or 100) (Figure 7.7.2).

Figure 7.7.2: Rate of Indigenous people aged 10–24 reporting ear conditions, by remoteness and state and territory, 2012–13



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Note: ACT is not included as data had a high relative standard error, and was too unreliable for use.

AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

The most common ear condition among Indigenous people aged 10–24 was partial deafness and hearing loss (6 per 100 or 11,100). The rate of diseases of the middle ear and mastoid process, which include otitis media, among those aged 10–14 was 2 per 100 (1,600).

Box 7.7.1: Otitis Media

The most common type of ear disease is otitis media, involving an inflammation of the middle ear due to bacterial or viral pathogens. It is most common in early childhood (Jervis-Bardy et al. 2014). The main forms of the disease include acute otitis media, otitis media with effusion (OME), and chronic suppurative otitis media, which are respectively also known as bulging eardrum, glue ear, and running ear. If infection is left untreated, it can cause hearing loss. This can lead to delays in speech and language, and pose a threat to educational attainment and progression (Burns & Thomson 2013).

After adjusting for differences in the population age structure, the rate of otitis media in the Indigenous population was 2.4 times that of the non-Indigenous population (AHMAC 2017). In addition, Indigenous children tend to be affected by the condition earlier, more severely, and more frequently (Kong & Coates 2009).

Risk factors that have been associated with otitis media include allergies, lack of access to medical services, overcrowded housing, impoverished living conditions, and exposure to passive tobacco smoke (Kong & Coates 2009; Jacoby et al 2008).

Ear health improvement in the Northern Territory

The Child Health Check Initiative was introduced in July 2007 in the Northern Territory as part of the Northern Territory Emergency Response and included an expansion of hearing services (Box 7.7.2). Data in this section relates to hearing programs in the Northern Territory only.

Box 7.7.2: The Northern Territory Hearing Health Program

A component of the Northern Territory Child Health Check Initiative (CHCI) introduced in July 2017 was expanded to include hearing health specialist services. Since this period, the Australian Government has continued to fund various programs (broadly referred to as the Hearing Health Program). The Northern Territory Government has responsibility for delivering these programs.

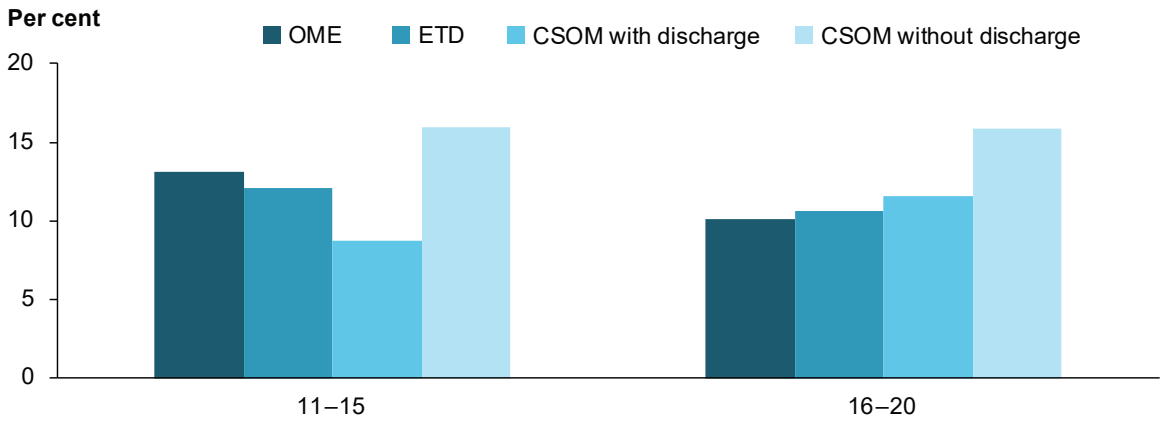
The Hearing Health Program is available to all Indigenous people aged under 21 in the Northern Territory. The program provides for health education, promotion and prevention, outreach audiology, ear, nose and throat (ENT) teleotology and Clinical Nurse Specialists (CNS). Entry to the program is generally through primary health care, from which referrals can be made to specialist services.

Source: AIHW 2017g.

There were 564 Indigenous people aged 11 to 20 who received an audiology, ENT or CNS service in 2016 as part of the Hearing Health Program in the Northern Territory. Of these 564 individuals, 256 (45%) of those aged 11–15 and 79 (42%) of those aged 16–20 were found to have at least 1 type of ear condition (Figure 7.7.3).

The most common ear condition was chronic suppurative otitis media (CSOM) without discharge (16% or 90 of those aged 11–15 and 16% or 30 of those aged 16–20) (Figure 7.7.3).

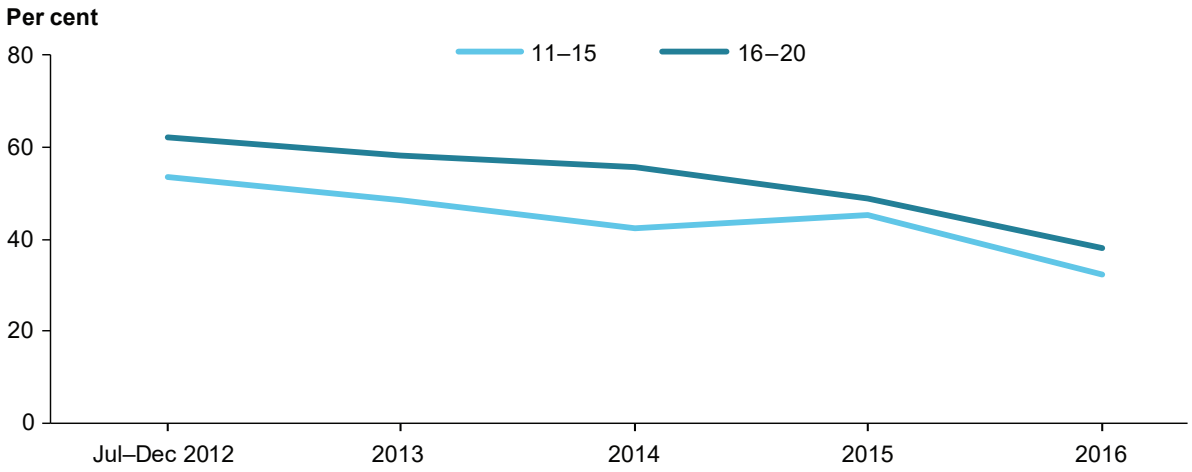
Figure 7.7.3: Proportion of young Indigenous people who received an audiology, ENT or CNS service and had an ear condition, by type of condition and age group, Northern Territory, 2016



Source: AIHW 2017h.

Between July–December 2012 and 2016, there was a decrease in the proportion of young Indigenous people with hearing loss among those who received outreach audiology service from 54% (60) to 32% (178) for those aged 11–15, and from 62% (23) to 38% (70) for those aged 16–20 (Figure 7.7.4).

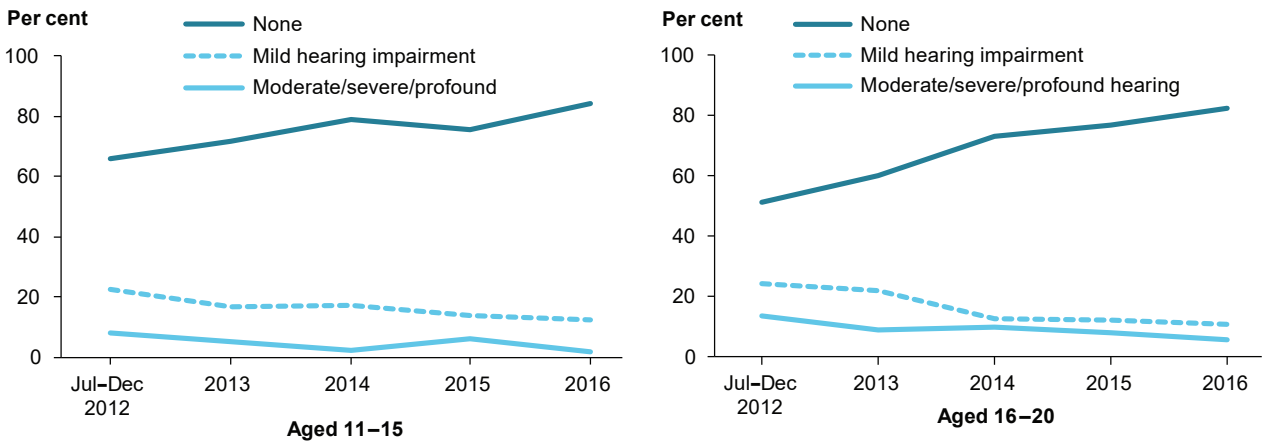
Figure 7.7.4: Proportion of young Indigenous people who received outreach audiology services and who had hearing loss, by age group, Northern Territory, July 2012 to 2016



Source: AIHW 2017h.

Over this period, there was a corresponding increase in the proportion who attended outreach audiology services and who had no hearing impairment. This proportion increased from 66% to 84% for those aged 11–15, and from 51% to 83% for those aged 16 to 20 (Figure 7.7.5).

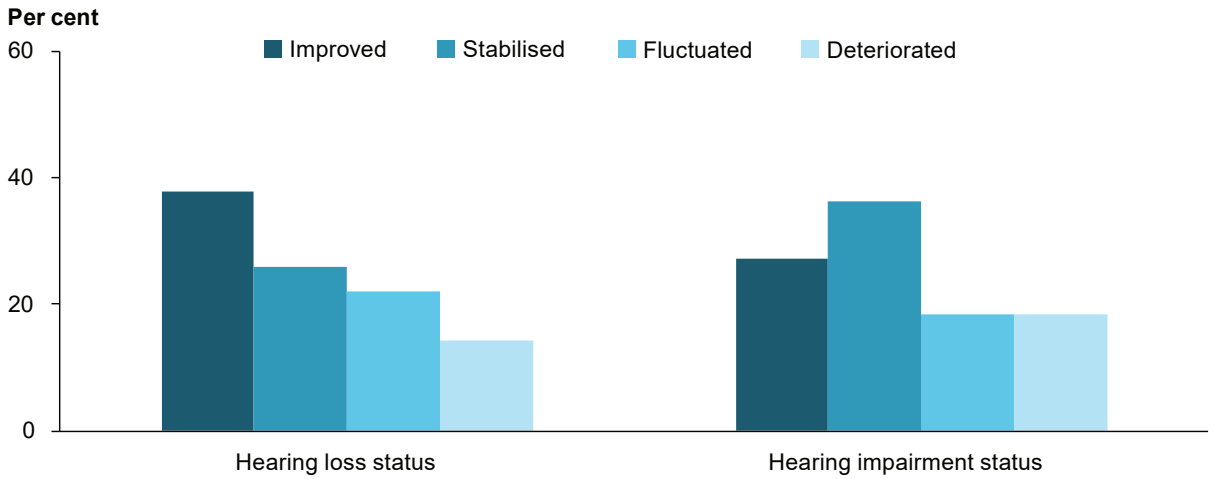
Figure 7.7.5: Indigenous people aged 11–15 and 16–20 who received outreach audiology services, by degree of hearing impairment, Northern Territory, July 2012 to 2016



Source: AIHW 2017h.

Between August 2007 and December 2016, 38% (83) of Indigenous people aged 11–15 who attended at least 3 outreach audiology services improved their hearing loss status while 27% (59) improved their hearing impairment status. An additional 26% (57) had stabilised hearing loss status and 36% (79) had stabilised hearing impairment status (Figure 7.7.6).

Figure 7.7.6: Indigenous people aged 11–15 who received audiology services by change in hearing loss/hearing impairment status, Northern Territory, August 2007 to December 2016



Note: Includes those who received at least 3 audiology outreach services.

Source: AIHW 2017h.

7.8 Endocrine health

Diabetes mellitus is the most common endocrine disorder. Diabetes is a chronic condition marked by high levels of glucose in the blood. It is caused by the inability to produce insulin (a hormone produced by the pancreas to control blood glucose levels), the insulin that is produced becoming less effective, or a mix of both factors (Box 7.8.1). This category also includes nutritional and other metabolic conditions.

Box 7.8.1: Type I, type II and gestational diabetes

Type I diabetes occurs when the auto-immune system mistakenly attacks and destroys the insulin-producing beta cells of the pancreas. When little to no insulin is released into the body, glucose (sugar) from food cannot be converted to energy, resulting in glucose build up. High glucose levels can lead to a range of complications including cardiovascular disease, nerve damage, poor eye health, and bone and joint problems (WHO, 2016). The onset of type 1 diabetes typically occurs in childhood or adolescence.

Type II diabetes occurs when the body cannot properly use the insulin that is released or does not make enough insulin, causing sugar to build up rather than be used as energy. Type II diabetes often develops in adulthood, but children and adolescents can also be affected.

Gestational diabetes is a temporary condition that occurs during pregnancy, where the placenta makes hormones that interfere with the action of insulin, leading to a build-up of sugar. In normal circumstances, the pancreas is able to make increased insulin to handle excess sugar levels. Gestational diabetes occurs when the body is unable to cope with the increased demand for insulin production (WHO, 2016).

Around 10,100 (5 per 100) Indigenous people aged 10–24 reported endocrine disorders including diabetes, disorders of the thyroid gland, high sugar levels or other related conditions (Table 7.8). These conditions were most common in those aged 20–24 (10 per 100). Hospitalisations for endocrine and related conditions were also most common in the 20–24 age group (4 per 1,000 population, and the mortality rate was highest in this age group (2 per 100,000) (Table 7.8).

Table 7.8: Indigenous people aged 10–24 with endocrine and related conditions, by age group

	Prevalence (self-report)[a] 2012–13		Hospitalisations 2015–16		Mortality[b] 2011–2015	
Age group (years)	Number	Per 100 population	Number	Per 1,000 population	Number	Per 100,000 population
10–14	1,300	1.7	248	3.1	n.p.	n.p.
15–19	3,400	4.9	294	3.8	n.p.	n.p.
20–24	5,600	9.6	318	4.4	6	2.1
Total 10–24	**10,100**	**5.0**	**860**	**3.8**	**10**	**1.0**

(a) Adjustment of estimates by the ABS, for the purpose of maintaining confidentiality, may result in the sum of components not equalling the total.

(b) Data for NSW, Qld, WA, SA and NT combined.

Note: Prevalence is self-reported endocrine (including diabetes and high sugar levels), nutritional and metabolic conditions. Hospitalisations and mortality are for endocrine, nutritional and metabolic diseases and disorders.

Sources: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder), National Hospital Morbidity Database and National Mortality Database.

In 2012–13, based on self-reported data from the AATSIHS, 0.5 per 100 (1,100) Indigenous people aged 10–24 had diabetes mellitus. These self-reported data are likely to underestimate the prevalence of diabetes, as many of those with the condition are not aware that they have it.

Box 7.8.2: Incidence of type 2 diabetes increasing in Indigenous and non-Indigenous children in Western Australia

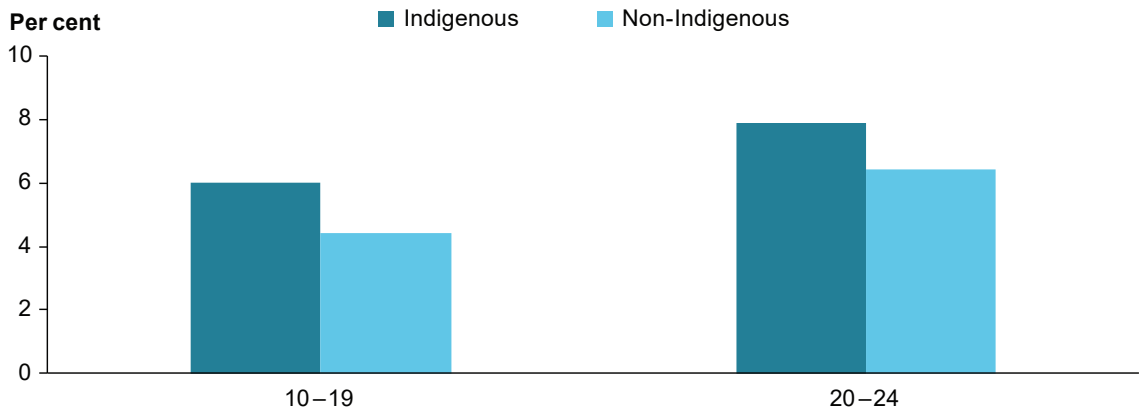
Using data from the Western Australian Children's Diabetes Database, researchers investigated the incidence of type 2 diabetes in children aged under 17. The evidence reveals a substantial increase in incidence rates. Between 1990 and 2012:

- The incidence of type II diabetes in Indigenous children increased from 4.5 to 31.1 per 100,000 person-years. The corresponding change in non-Indigenous children was from 0 to 1.4 per 100,000 person-years.
- The mean annual rate of increase in the incidence was 12.5% per year in Indigenous children and 10.9% per year in non-Indigenous children.

Source: Haynes et al 2016.

In 2016, 458 (8%) young Indigenous women, who gave birth and had gestational diabetes (Figure 7.8.1). Mothers aged 10–19 (112 or 7%) were slightly less likely to have given birth and have gestational diabetes than mothers aged 20–24 (346 or 9%).

Figure 7.8.1: Young women who gave birth and had gestational diabetes, by Indigenous status, and age group, 2016



Note: Data exclude Victoria, as data are not currently available.

Source: National Perinatal Data Collection.

7.9 Infectious diseases

Around 1,400 (1 per 100) Indigenous people aged 10–24 reported having an infectious or parasitic disease (Table 7.9). These diseases were most common in those aged 15–19 (1 per 100). Hospitalisations for infectious and parasitic diseases were most common in the 20–24 age group (6 per 1,000). The corresponding mortality rate was also highest in the 20–24 age group (2 per 100,000) (Table 7.9).

Table 7.9: Indigenous people aged 10–24 with infectious diseases, by age group

	Prevalence (self-report) 2012–13[a]		Hospitalisations 2015–16		Mortality 2011–2015[b]	
Age groups (years)	Number	Per 100 population	Number	Per 1,000 population	Number	Per 100,000 population
10–14	300	0.4	236	3.0	n.p.	n.p.
15–19	700	1.0	350	4.5	n.p.	n.p.
20–24	300	0.5	439	6.1	5	1.7
Total 10–24	**1,400**	**0.7**	**1,025**	**4.5**	**8**	**0.8**

(a) Adjustment of estimates by the ABS, for the purpose of maintaining confidentiality, may result in the sum of components not equalling the total.

(b) Data for NSW, Qld, WA, SA and NT combined.

Note: Prevalence is certain self-reported infectious conditions including tuberculosis, viral infections characterised by skin and mucous membrane lesions, viral hepatitis and other infectious and parasitic diseases. Hospitalisations and mortality are for infectious and parasitic diseases.

Sources: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder), National Hospital Morbidity Database and National Mortality Database.

Box 7.9: Vaccine preventable communicable diseases

Communicable diseases are caused by parasites, fungi, bacteria, or viruses, and can be transmitted from one individual to another. This transmission can occur through direct contact with an infected individual or indirectly through a vector (such as through the bite of an insect or consuming contaminated food or water) (Chief Medical Officer 2004).

Over the last century, considerable progress has been made in Australia to reduce the impact of communicable diseases on the health of the population. Improvements in sanitation, antibiotics, and vaccine advancements have all contributed to this progress (DoH 2014).

However, the complexity and diversity of communicable diseases means that they remain a significant public health challenge, particularly for Indigenous Australians (DoH 2014). Vaccination against bacterial and viral diseases reduces their incidence of their social and economic burden of these diseases on communities and is therefore an integral part of Australian and global communicable disease control strategy (Chief Medical Officer 2004).

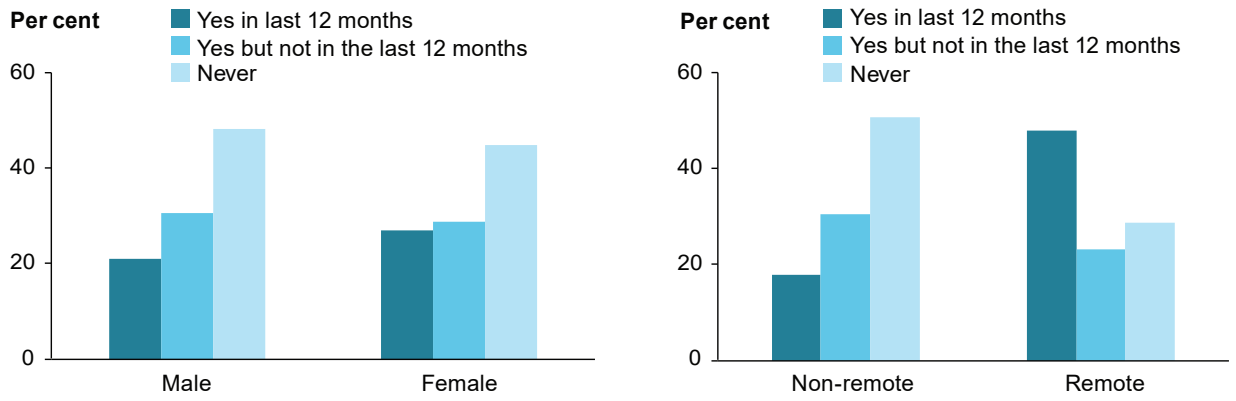
Around 1 in 2 have never had an influenza immunisation

Data from the 2012–13 AATSIHS shows that just under half (47% or 57,000) of Indigenous people aged 15–24 have never had an influenza vaccine. Around 24% (29,200) of Indigenous people aged 15–24 had an influenza vaccination in the previous 12 months; the remaining 29% (35,500) of young Indigenous people either had an influenza vaccine, but not in the previous 12 months or had an influenza vaccine but did not know if it was in the previous 12 months.

A higher proportion of females than males reported having had an influenza vaccination in the previous 12 months (27% or 16,100 and 21% or 13,000, respectively). Just under half of males and females aged 15–24 reported never having had an influenza vaccination (48% or 29,800 and 45% or 26,700, respectively) (Figure 7.9.1).

Young Indigenous people living in remote areas (48% or 11,800) were more than twice as likely to have had an influenza vaccination in the previous 12 months than those living in non-remote areas (18% or 17,700) (Figure 7.9.1).

Figure 7.9.1: Proportion of Indigenous people aged 15–24, by influenza vaccination status, by sex and remoteness, 2012–13



Note: Excludes young people for whom influenza vaccination status was not known.

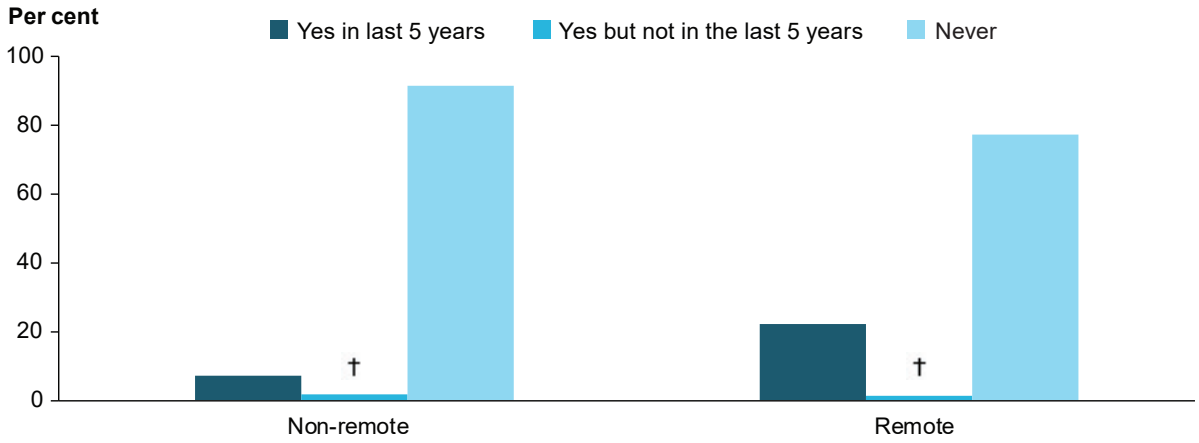
Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

The proportion of Indigenous people aged 15–24 who have never had a pneumococcus vaccination (88% or 100,400) was higher than for those who had been vaccinated in the last 5 years (10% or 11,700).

Almost 4 in 5 young Indigenous males and females aged 15–24 reported never having had a pneumococcus vaccination (88% or 50,800 and 88% or 49,700, respectively). Similar proportions of females (11% or 6,100) and males (10% or 5,500) had been vaccinated in the last 5 years.

The proportion of Indigenous people aged 15–24 who had never had a pneumococcus vaccination was higher in non-remote (91% or 83,500) than remote (77% or 17,400) areas. Those who had, had a pneumococcus vaccination in the last 5 years also differed by remoteness, with 22% (5,000) of those in remote areas and 7% (6,400) of those in non-remote areas reporting they had adopted this preventative health measure (Figure 7.9.2).

Figure 7.9.2: Proportion of Indigenous people aged 15–24, by pneumococcus vaccination status and remoteness, 2012–13



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Note: Excludes young people for whom pneumococcus vaccination status was not known.

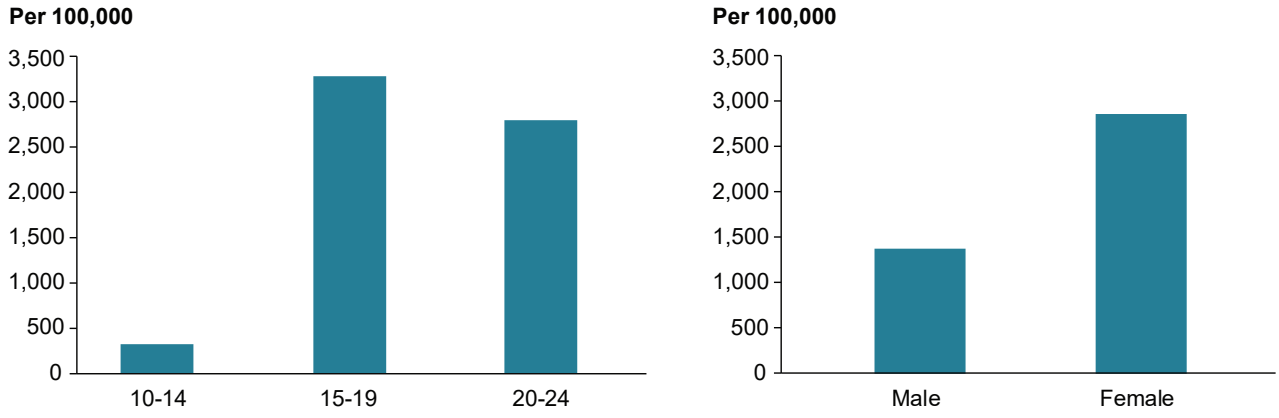
Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

Chlamydia notification rates highest among 15–19 age group

In 2016, there were 4,840 chlamydia notifications for Indigenous people aged 10–24 (2,103 per 100,000). The lowest rate was for the 10–14 age group (317 per 100,000 or 252 notifications), followed by the 20–24 age group (2,791 per 100,000 or 2,025 notifications) and 15–19 age group (3,282 per 100,000 or 2,536 notifications) (Figure 7.9.3).

The rate for chlamydia notifications for young Indigenous females (2,864 per 100,000 or 3,216 notifications) was twice as high as for males (1378 per 100,000 or 1,624 notifications) (Figure 7.9.3).

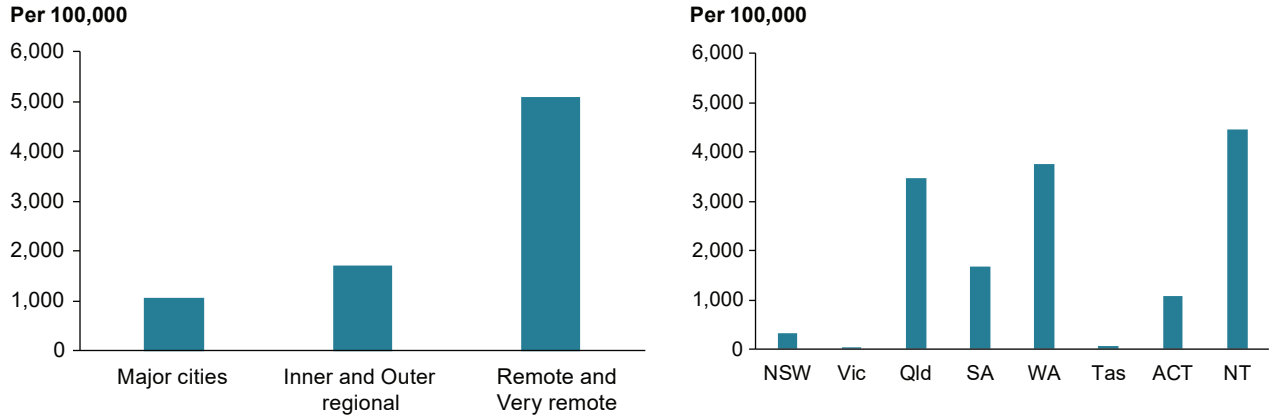
Figure 7.9.3: Notification rate of chlamydia in Indigenous people aged 10–24, 2016



Source: National Notifiable Disease Surveillance System 2016.

The highest rate of chlamydia notifications occurred in *Remote* and *Very remote* areas (5,088 per 100,000 or 2,091 notifications), followed by *Inner* and *Outer regional* areas (1,715 per 100,000 or 1,787 notifications) and *Major cities* (1,070 per 100,000 or 907 notifications). Across states and territories, the highest rate of notifications occurred in the Northern Territory (4,443 per 100,000 or 968 notifications) while Victoria (6 per 100,000 or n.p.) had the lowest (Figure 7.9.4).

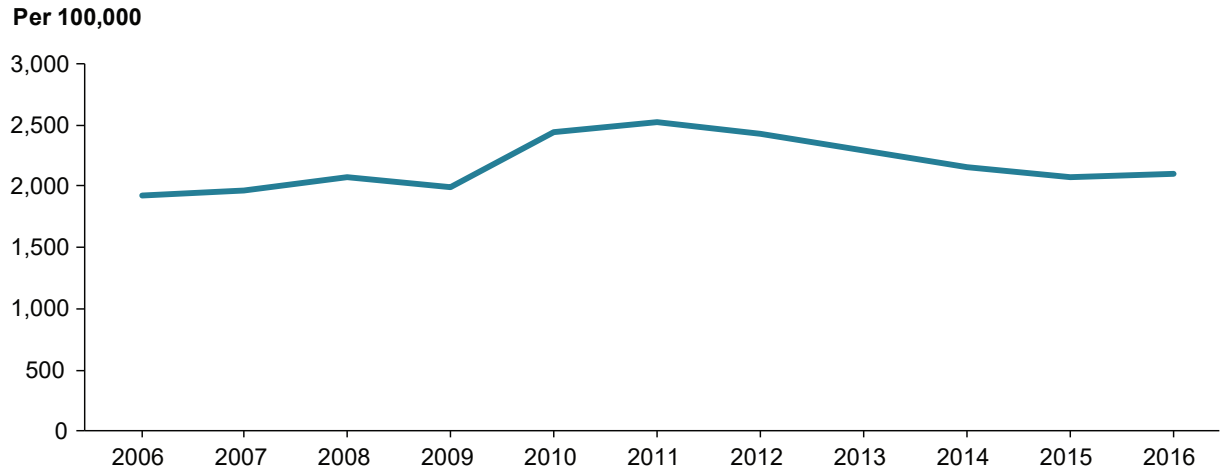
Figure 7.9.4: Notification rate and notifications of chlamydia in Indigenous people aged 10–24, by remoteness and state and territory, 2016



Source: National Notifiable Disease Surveillance System 2016.

Between 2006 and 2016, chlamydia notification rates increased among Indigenous people aged 10–24 from 1,922 per 100,000 (3,621 notifications) to 2,103 per 100,000 (4,840 notifications) (Figure 7.9.5).

Figure 7.9.5: Notification rate of chlamydia in Indigenous people aged 10–24, 2006–2016

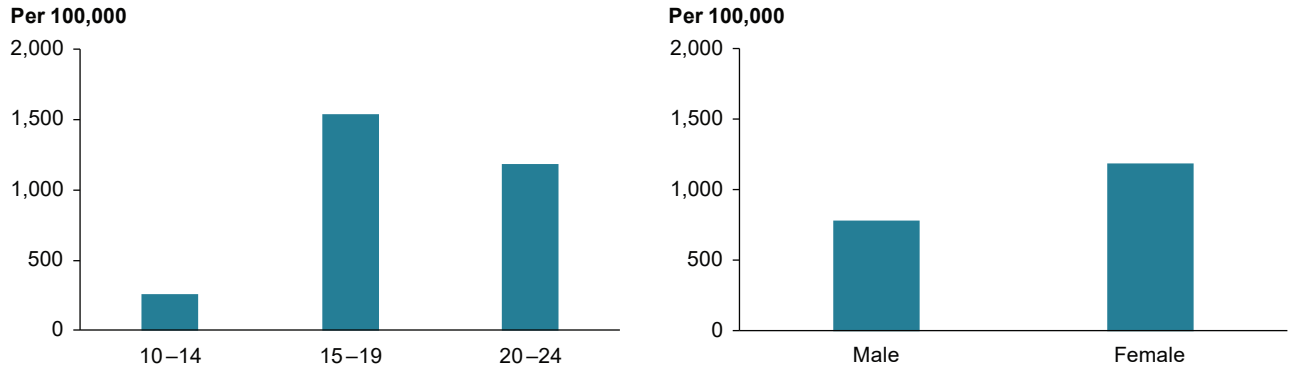


Source: National Notifiable Disease Surveillance System 2016.

Higher rate of gonorrhoea notifications in females

There were 2,267 gonorrhoea infection notifications for Indigenous people aged 10–24 in 2016 (a rate of 985 per 100,000). The 15–19 age group had the highest number of notifications (1,538 per 100,000 or 1,201 notifications), followed by the 20–24 age group (1,183 per 100,000 or 859 notifications) and the 10–14 age group (260 per 100,000 or 207 notifications). The number of notifications for gonorrhoea infection was higher for females aged 10–24 (1,191 per 100,000 or 1,337 notifications) than for males (787 per 100,000 or 927 notifications) (Figure 7.9.6).

Figure 7.9.6: Notification rate of gonorrhoea in Indigenous people aged 10-24 by age group and sex, 2016

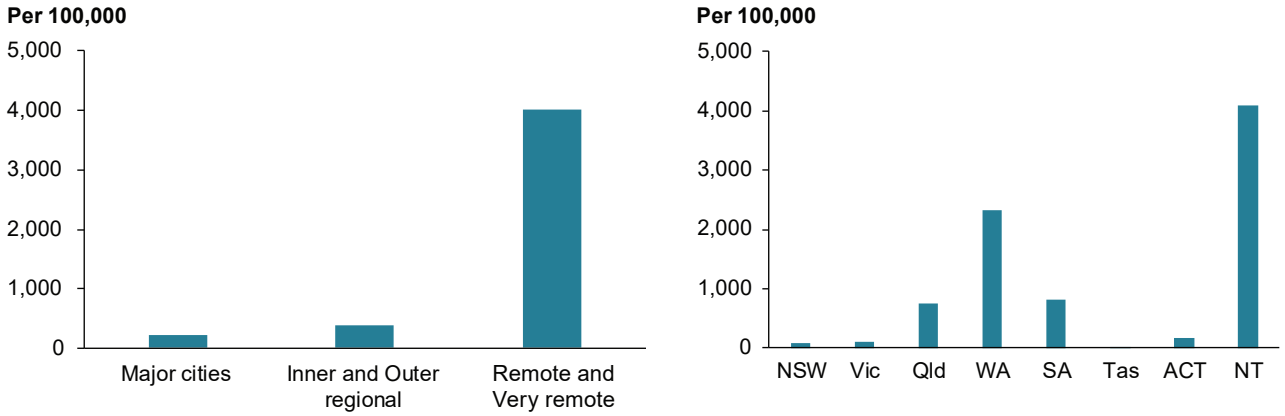


Source: National Notifiable Disease Surveillance System 2016.

Gonorrhoea infection notification rates were highest in *Remote* and *Very remote* areas (4,020 per 100,000 or 1,652 notifications), followed by *Inner* and *Outer regional* areas (388 per 100,000 or 404 notifications) and *Major cities* (234 per 100,000 or 198 notifications).

Across states and territories, the highest rate of notifications was in the Northern Territory (4,099 per 100,000 or 893 notifications), and the lowest was reported in Tasmania (12 per 100,000 or n.p notifications) (Figure 7.9.7).

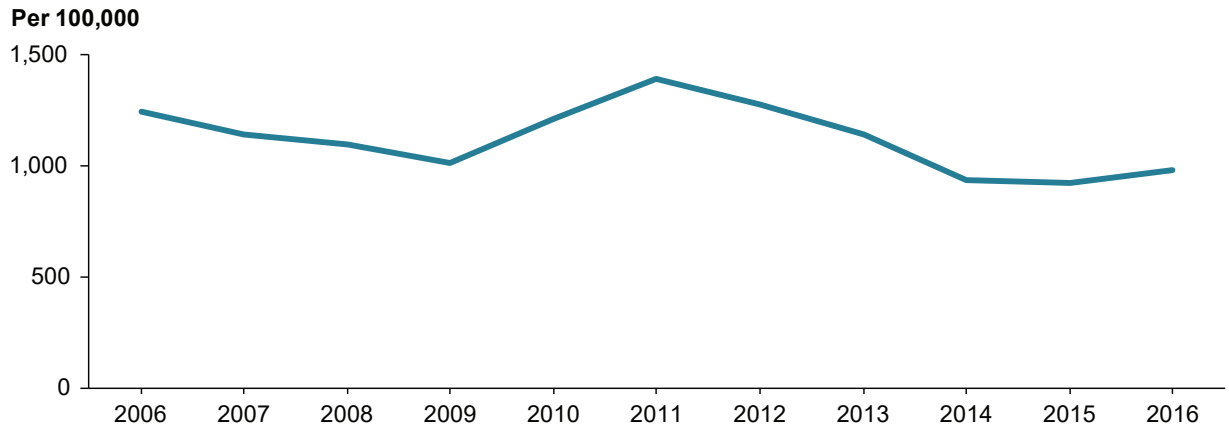
Figure 7.9.7: Notification rate of gonorrhoea in Indigenous people aged 10–24, by remoteness and state and territory, 2016



Source: National Notifiable Disease Surveillance System 2016.

Between 2006 and 2016, gonorrhoea infection notification rates decreased among Indigenous people aged 10–24 from 1,247 per 100,000 (2,349 notifications) to 985 per 100,000 (2,267 notifications) (Figure 7.9.8).

Figure 7.9.8: Notification rate of gonorrhoea in Indigenous people aged 10–24, 2006–2016

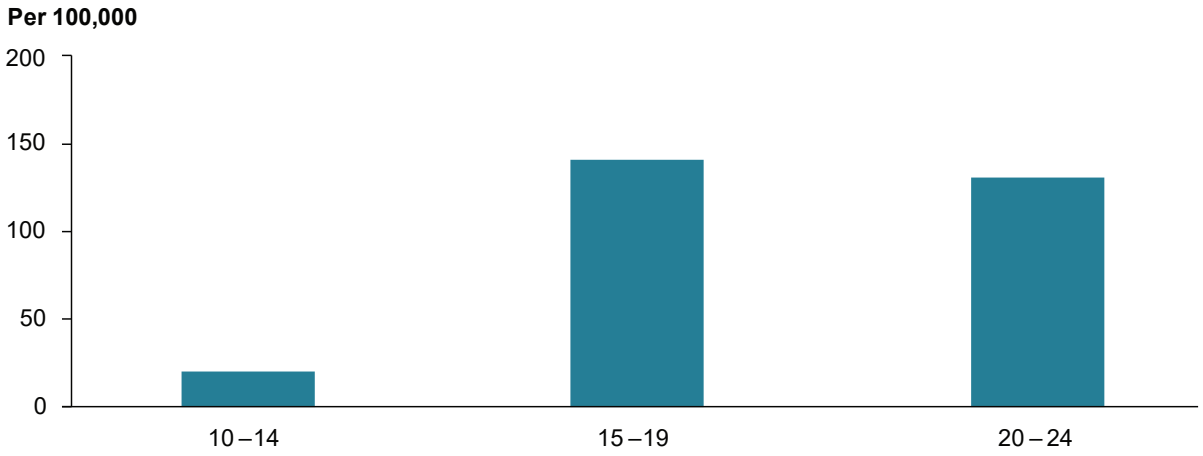


Source: National Notifiable Disease Surveillance System 2016.

Syphilis rates higher in more remote areas

In 2016, there were 221 notifications (96 per 100,000) of syphilis infections of less than 2 years' duration among Indigenous people aged 10–24. The highest notification rate was for the 15–19 age group (141 per 100,000 or 110 notifications), followed by the 20–24 age group (131 per 100,000 or 95 notifications) and 10–14 age group (20 per 100,000 or 16 notifications) (Figure 7.9.9).

Figure 7.9.9: Notification rate of syphilis (<2 years duration) in Indigenous people aged 10–24, 2016



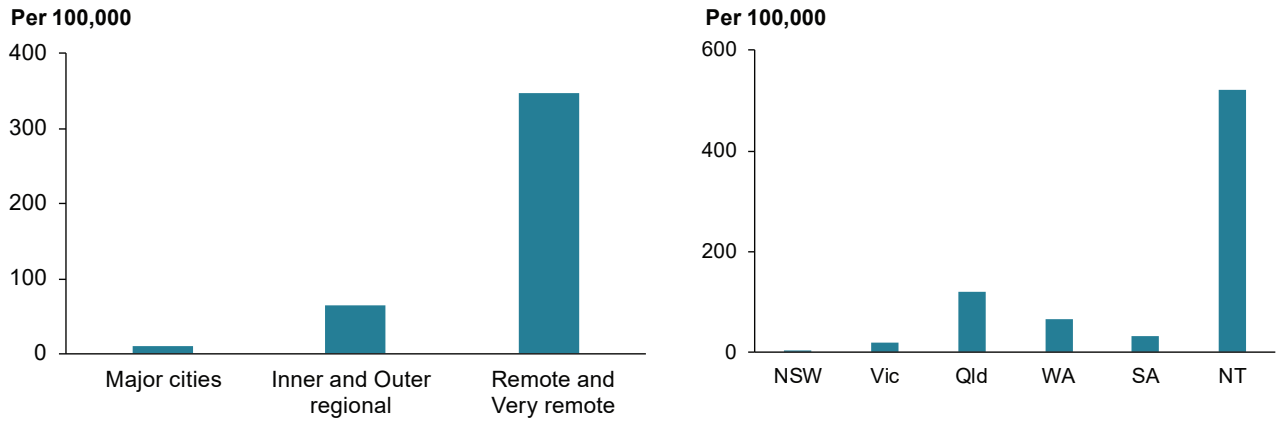
Source: National Notifiable Disease Surveillance System 2016.

The number of notifications for Indigenous females aged 10–24 was higher than the number of notifications for males (114 per 100,000 or 128 notifications and 79 per 100,000 or 93 notifications, respectively).

Across remoteness areas, the highest rate of syphilis infection of less than 2 years duration was in *Remote* and *Very remote* areas (348 per 100,000 or 143 notifications), followed by *Inner* and *Outer regional* areas (65 per 100,000 or 68) and *Major cities* (11 per 100,000 or 9 notifications) (Figure 7.9.10).

Half (51%) of the notifications for syphilis of less than 2 years duration were reported in the Northern Territory (519 per 100,000 or 113 notifications). Queensland had 80 notifications (111 per 100,000), Western Australia had 19 notifications (64 per 100,000), South Australia (31 per 100,000), Victoria (18 per 100,000) and New South Wales (3 per 100,000) all had less than 5 notifications. The Australian Capital Territory and Tasmania had no notifications in 2016 of syphilis of less than two years' duration (Figure 7.9.10).

Figure 7.9.10: Notification rate of syphilis (<2 years duration) in Indigenous people aged 10–24 by remoteness and state and territory, 2016

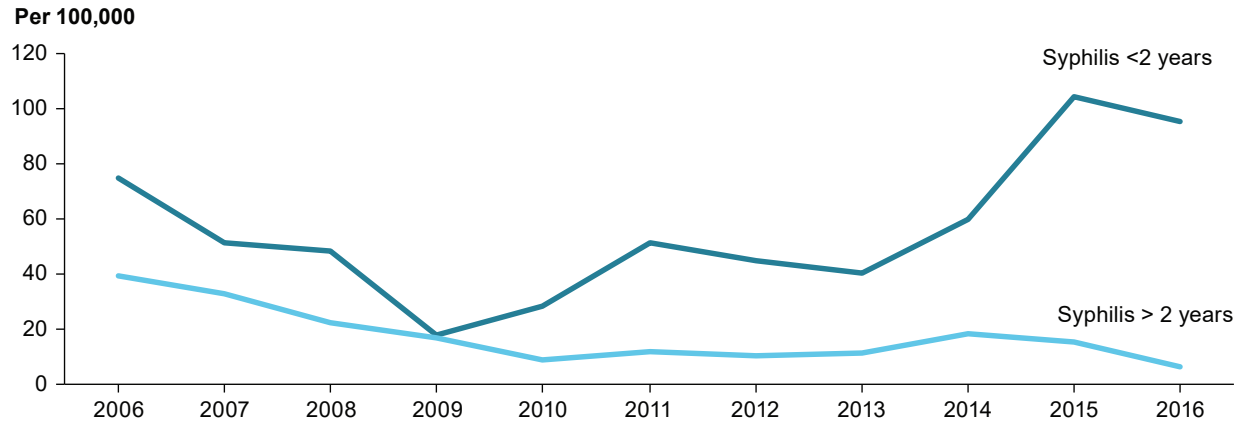


Source: National Notifiable Disease Surveillance System 2016.

There were 16 notifications in 2016 (7 per 100,000) of syphilis infections of more than 2 years' or unknown duration among Indigenous people aged 10–24. The numbers were equal for males and females (7 per 100,000 or 8 notifications).

Between 2006 and 2016, the rate of notifications for syphilis of less than 2 years duration increased from 75 per 100,000 (142 notifications) to 96 per 100,000 (221 notifications). Over the same period, the number of notifications for syphilis of more than 2 years' duration or unknown duration decreased from 40 per 100,000 (75 notifications) to 7 per 100,000 (16 notifications) (Figure 7.9.11).

Figure 7.9.11: Notification rate of syphilis <2 years duration and syphilis >2 years in Indigenous people aged 10–24, 2006–2016



Source: National Notifiable Disease Surveillance System 2016.

Rates of newly acquired hepatitis C have increased

A blood-borne virus (BBV) is a virus that is transmitted by blood or body fluids that contain blood. Blood-borne viruses may be transmitted if blood, semen or vaginal fluids pass from a person who is infected with the virus into the bloodstream of another person, commonly via a break in the skin or mucous membrane.

In 2016, there were no hepatitis A notifications for Indigenous people aged 10–24. There were 29 notified cases of unspecified hepatitis B and no notifications for newly acquired hepatitis B cases.

There were 96 notifications for newly acquired hepatitis C (a rate of 42 per 100,000) for Indigenous people aged 10–24 in 2016. The 20–24 age group had the highest number of notifications (95 per 100,000 or 69 notifications) followed by those aged 15–19 (35 per 100,000 or 27 notifications). There were more notifications of newly acquired hepatitis C for males (91 per 100,000 or 72 notifications) than females (21 per 100,000 or 24 notifications).

There were 213 notifications (93 per 100,000) for unspecified hepatitis C in 2016. The 20–24 age group had the highest number of notifications (238 per 100,000 or 173 notifications), followed by the 15–19 age group (47 per 100,000 or 37 notifications) and the 10–14 age group (4 per 100,000 or n.p. notifications). There were more unspecified Hepatitis C notifications for males (120 per 100,000 or 141 notifications) than females (64 per 100,000 or 72 notifications).

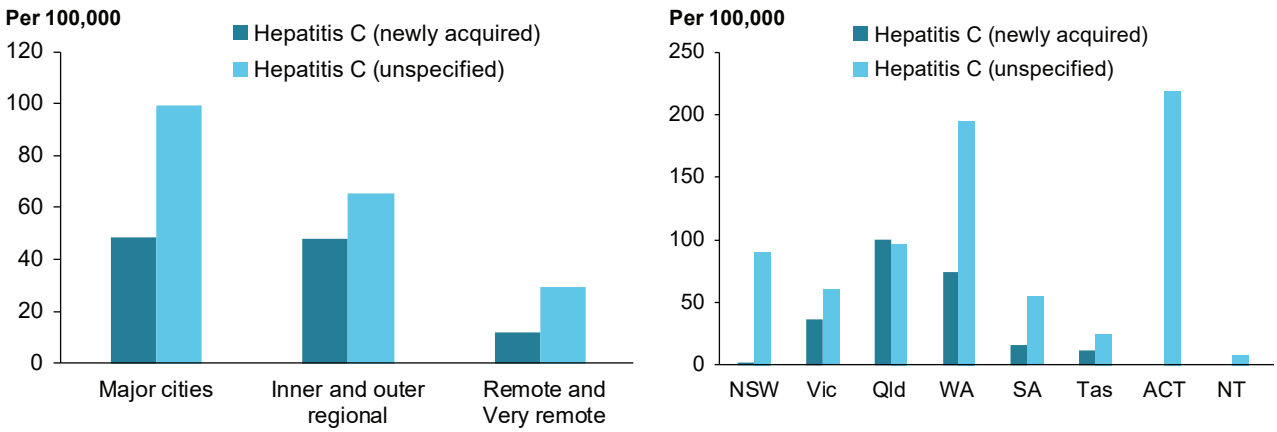
Notification rates were higher in non-remote areas than remote areas for newly acquired hepatitis C. The rate was similar in *Major cities* (48 per 100,000 or 41 notifications) and *Inner* and *Outer regional* areas (48 per 100,000 or 50 notifications), followed by *Remote* and *Very remote* areas (12 per 100,000 or n.p. notifications).

For unspecified hepatitis C, the notification rate for *Major cities* was 99 per 100,000 (84 notifications), followed by *Inner* and *Outer regional* areas (65 per 100,000 or 68 notifications) and *Remote* and *Very remote* areas (29 per 100,000 or 12 notifications) (Figure 7.9.12).

Across states and territories, the rate of notifications for newly acquired hepatitis C was highest in Queensland (100 per 100,000 or 67 notifications). The Australian Capital Territory and the Northern Territory had no corresponding notifications for newly acquired hepatitis C in 2016 (Figure 7.9.12).

The rate of notifications for unspecified hepatitis C was highest in the Australian Capital Territory (219 per 100,000 or n.p. notifications) and lowest in the Northern Territory (9 per 100,000 or n.p. notifications) (Figure 7.9.12).

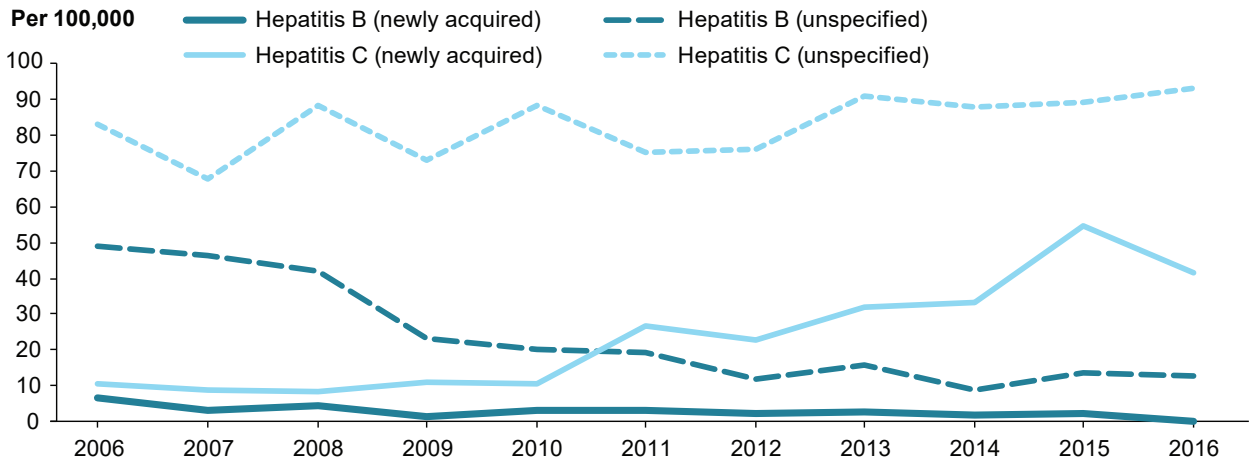
Figure 7.9.12: Notification rate and notifications of hepatitis C in Indigenous people aged 10–24 by remoteness, and state and territory, 2016



Source: National Notifiable Disease Surveillance System 2016.

Hepatitis C (unspecified) notification rates have increased over time, from 83 per 100,000 (157 notifications) in 2006 to 92 per 100,000 (213 notifications) in 2016. Similarly, notification rates for newly acquired Hepatitis C have increased over time, from 11 per 100,000 (20 notifications) in 2006 to 42 per 100,000 (96 notifications) in 2016. Hepatitis B (unspecified) notification rates have decreased over the same period, from 49 per 100,000 (92 notifications) to 13 per 100,000 (29 notifications) (Figure 7.9.13).

Figure 7.9.13: Notification rate and notification of hepatitis B, C in Indigenous people aged 10–24, 2006–2016



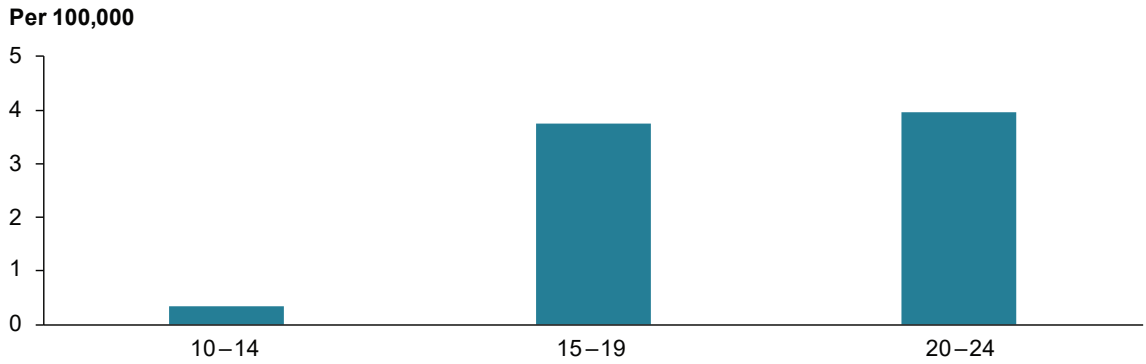
Source: National Notifiable Disease Surveillance System 2016.

Pelvic inflammatory disease

Pelvic inflammatory disease has been observed to occur frequently among Aboriginal women in central Australia but is often undiagnosed or inadequately treated. It is linked to the presence of chlamydia and gonorrhoea and may result in severe reproductive problems (Silver et al. 2012).

In 2015–16, there were 293 Indigenous females aged 10–24 who were hospitalised for pelvic inflammatory disease (3 per 1,000). Rates were highest among those aged 20–24 (4 per 1,000 or 137), followed by those aged 15–19 (4 per 1,000 or 143) and those aged 10–14 (<1 per 1,000 or 13) (Figure 7.9.14).

Figure 7.9.14: Hospitalisation rates for pelvic inflammatory disease for young Indigenous females aged 10–24 by age group, 2015–16



Source: AIHW analysis of National Hospital Morbidity Database.

7.10 Oral health

In addition to providing an indication of overall health, oral health quality may affect speech, the ability to chew food, appearance, and, as a consequence, the social life of young people. Decay, fillings and missing teeth are all important measures of oral health.

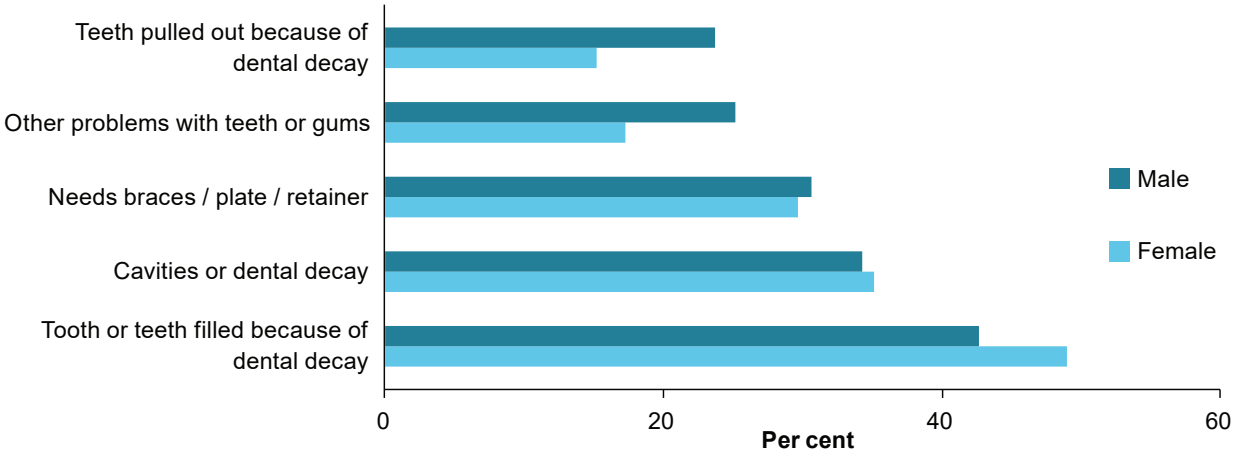
Dental decay an issue for Indigenous youth

Data from the 2014–15 NATSISS shows that the majority (61% or 44,800) of Indigenous people aged 10–14 did not have problems with their teeth. Just under 4 in 10 (39% or 28,900) had teeth or gum problems. Of the young Indigenous people that had teeth and gum problems, the most common problem was having a tooth or teeth filled because of dental decay (47% or 13,700), followed by cavities or dental decay (34% or 9,900) and having braces, a plate or a retainer (30% or 8,700).

Similar proportions of Indigenous males and females aged 10–14 did not have teeth or gums problems (61% or 22,700 and 61% or 22,100, respectively). Of the males and females that had teeth or gum problems, a higher proportion of females than males had a tooth or teeth filled because of dental decay (49% or 7,100 and 43% or 6,100, respectively).

Similar proportions of males and females had cavities or dental decay (35% or 5,100 and 34% or 4,900, respectively). For all other teeth and gum problems, there were a higher proportion of males than females experiencing the problem (Figure 7.10.1).

Figure 7.10.1: Proportion of Indigenous people aged 10–14 reporting teeth or gum problems, by type of problem and sex, 2014–15



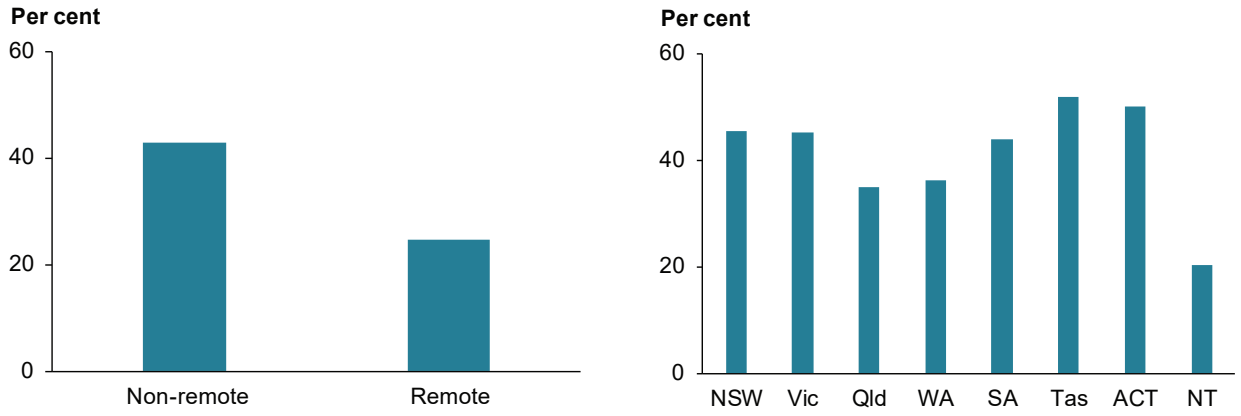
Note: Multiple responses item; sum of components may exceed total.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

The proportions of young Indigenous people with gum or teeth problems varied by remoteness, with 43% (25,700) of those aged 10–14 living in non-remote and 25% (3,400) in remote areas with a gum or teeth problem (Figure 7.10.2).

Across all states and territories, Tasmania (52% or 1,400) and the Australian Capital Territory (50% or 300) had the highest proportion of young Indigenous people who had teeth or gum problems. The Northern Territory had the lowest proportion (20% or 1,400) (Figure 7.10.2).

Figure 7.10.2: Proportion of Indigenous people aged 10–14 reporting teeth or gum problems, by remoteness and state and territory, 2014–15



Notes

1. *Remote* and *Very remote* include 'no usual address'.
2. Totals exclude 'not known if child has teeth problems' and 'doesn't have teeth'.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

7.11 Cancer

Around 1,200 (0.6 per 100) Indigenous people aged 10–24 reported having some form of cancer (neoplasms) (Table 7.11). Cancers were most common in those aged 15–19 (1 per 100 or 800). Hospitalisations for cancer were most common in the 20–24 age group (3 per 1,000 or 201). This age group also had the highest mortality rate (6 per 100,000 or 18) (Table 7.11).

Table 7.11: Indigenous people aged 10–24 with cancer (neoplasms), by age group

	Prevalence (self-report) 2012–13[a]		Hospitalisations 2015–16		Mortality 2011–2015[b]	
Age group (years)	Number	Per 100 population	Number	Per 1,000 population	Number	Per 100,000 population
10–14	—	—	189	2.4	n.p.	n.p.
15–19	800	1.2	161	2.1	9	2.7
20–24	500	0.9	201	2.8	18	6.2
Total 10–24	**1,200**	**0.6**	**551**	**2.4**	**28**	**2.9**

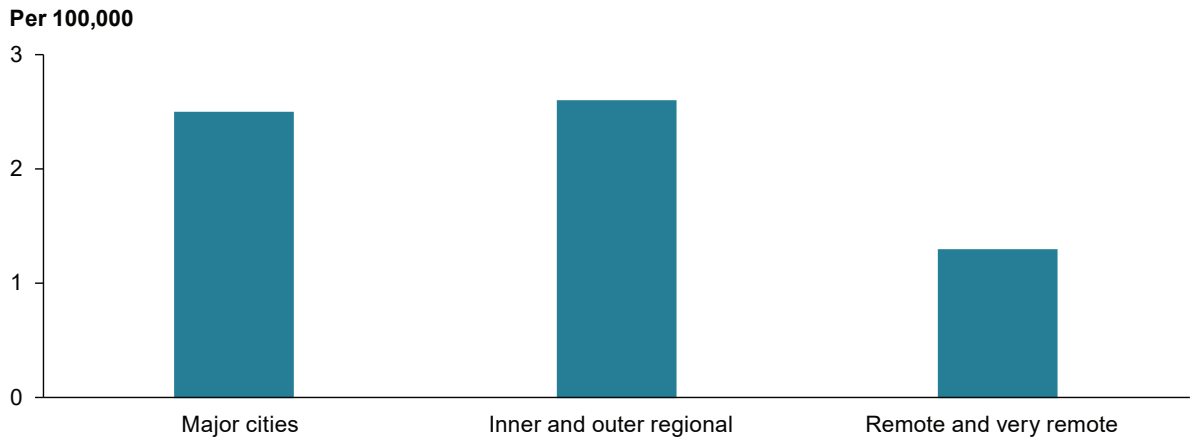
(a) Adjustment of estimates by the ABS, for the purpose of maintaining confidentiality, may result in the sum of components not equalling the total.

(b) Data for NSW, Qld, WA, SA and NT combined.

Sources: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBulider), National Hospital Morbidity Database and National Mortality Database.

The neoplasm hospitalisation rates for 2015–16 in *Remote* and *Very remote* areas combined (1.3 per 1,000 or 54) was around half that of *Inner regional* and *Outer regional* areas combined (2.6 per 1,000 or 273) and that of *Major cities* (2.5 per 1,000 or 214) (Figure 7.11.1).

Figure 7.11.1: Hospitalisation rates for neoplasms, Indigenous people aged 10–24 by remoteness, 2015–16



Source: AIHW analysis of National Hospital Morbidity Database.

Mortality rates for 2011–2015 were substantially higher in *Remote* and *Very remote* areas of Australia combined (5.1 per 100,000 or 11 deaths) than the combined total for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory (2.9 per 100,000 or 28 deaths).

7.12 How do young Indigenous people compare?

This report focuses on data about Indigenous youth so that, through the findings, their voice can be heard. Yet, there is also value in understanding what the data says about other groups. Some comparison data for key indicators on both young non-Indigenous people and older Indigenous people are therefore presented below.

Hospitalisation and mortality rates due to injury and poisoning were higher for older Indigenous people. Among young people, Indigenous youth had higher rates of hospitalisation and mortality due to injury and poisoning and long-term mental health conditions than non-Indigenous youth. Hospitalisation and mortality rates for intentional self-harm was similar for young Indigenous people and older Indigenous people.

Box 7.12: Health conditions measures: comparison with other groups

	Indigenous people under 25	Non-Indigenous people under 25	Indigenous people 25 and over
Hospitalisations for injury and poisoning per 1,000[(a)]	37	23	60
Mortality due to injury and poisoning per 100,000[(a)(b)]	52	18	87
Hospitalisations for intentional self-harm per 1,000[(a)]	5	2	5
Mortality due to intentional self-harm per 100,000[(a)(b)]	29	7	27
% with long-term mental health condition[(c)]	29	16	33

(a) For Indigenous and non-Indigenous people aged 10–24.

(b) Data for NSW, Qld, WA, SA and NT combined.

(c) For Indigenous and non-Indigenous people aged 15–24.

Sources: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder), National Hospital Morbidity Database, National Mortality Database and 2014 General Social Survey (using TableBuilder).



8

Health and welfare services

Health and welfare services play an important role in the promotion of general health and wellbeing, and in providing treatment, care and support in times of illness and need. It is crucial for young Indigenous people to have access to health and welfare services that meet their needs. A range of national data available that provides some information on young Indigenous people's access to these services.

Box 8: Main data sources and key issues

Alcohol and other Drug Treatment Services National Minimum Data Set

- The AODTS NMDS is an AIHW national collection of administrative data from government-funded alcohol and other drug treatment services. Data are based on closed treatment episodes and not number of clients.
- It includes information about the services; the clients who use these services; the types of drug problems for which treatment is sought; and the types of treatment provided.

The two client types in the AODTS NMDS are:

- Own drug use: clients who receives treatment or assistance concerning their own alcohol and/or other drug use.
- Others drug use: A client who receives support and/or assistance in relation to the alcohol and/or other drug use of another person.

Specialist Homelessness Services collection

- The SHS collection provides information about people who are either homeless or at risk of homelessness, and who are seeking services from specialist homelessness agencies. The data are provided to the AIHW monthly.
- The data collection includes basic socio-demographic information and the services required by and provided to each client, as well as the client circumstances before, during and after receiving support.

Child Protection National Minimum Data Set

- The CP NMDS is an AIHW annual collection of child protection administrative data from state and territory departments responsible for child protection and support services.
- It includes data notifications, investigations and substantiations; care and protection orders; funded out-of-home care services; and the characteristics of Australian children within the child protection system.

Juvenile Justice National Minimum Data Set

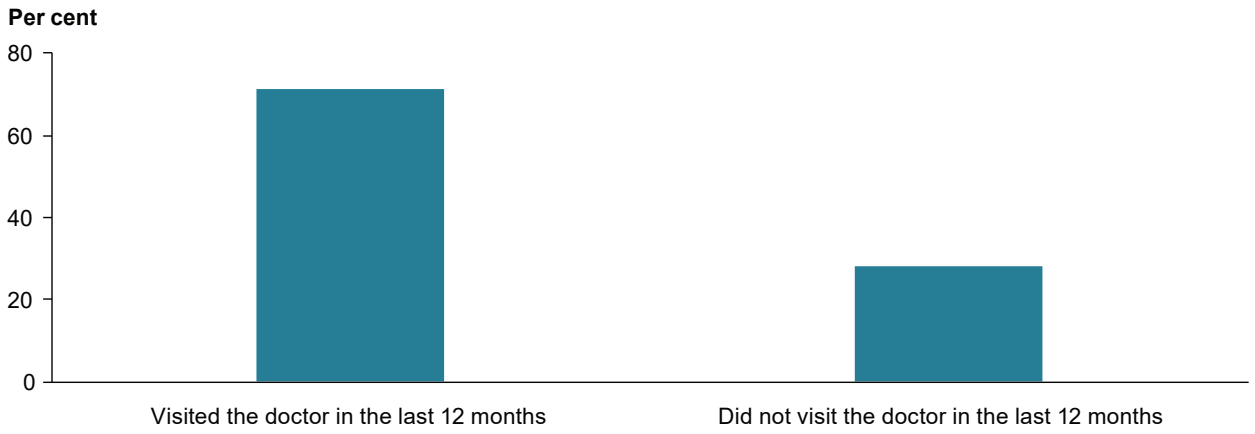
- The JJ NMDS is an AIHW annual collection of administrative information on young people under youth justice supervision in Australia. It contains data on all supervised orders (community-based and detention) relating to these young people.

8.1 Primary health care services

Primary healthcare, which includes general practitioners (GPs), Aboriginal health workers, dentists, nurses, allied health professionals and pharmacists, is the first point of contact with the health system for many young Indigenous people. Primary health care has an important role in the prevention and early treatment of disease and health conditions and lessens the load on the hospital system.

Data from the 2014–15 NATSISS shows that 71% (98,200) of Indigenous people aged 15–24 indicated that they had visited a doctor in the previous 12 months for their own health (Figure 8.1.1).

Figure 8.1.1: Indigenous people aged 15–24 by whether they had visited the doctor in the previous 12 months, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

The proportions of Indigenous people visiting a doctor were similar for those aged 15–19 and 20–24 (70% or 50,800 and 71% or 48,100, respectively). A higher proportion of females (79% or 54,500) had visited a doctor than males (63% or 43,600).

Indigenous people aged 15–24 living in non-remote areas (73% or 81,300) were more likely to have visited a doctor in the previous 12 months for their own health than those in remote areas (65% or 26,500).

Older youth more likely to visit GP

Medicare data shows that there was 945,143 (4,135 per 1,000) GP services were claimed for Indigenous people aged 10–24 in 2015–16. Those aged 20–24 (5,122 per 1,000) were more likely to claim GP services than those aged 15–19 (4,407 per 1,000) and those aged 10–14 (2,972 per 1,000). Indigenous people aged 20–24 (10 per 1,000) and 15–19 (7 per 1,000) had more complex consultations (that is, 'level C' consultations, being over 20 minutes in duration) than those aged 10–14 (3 per 1,000) (AIHW 2017b).

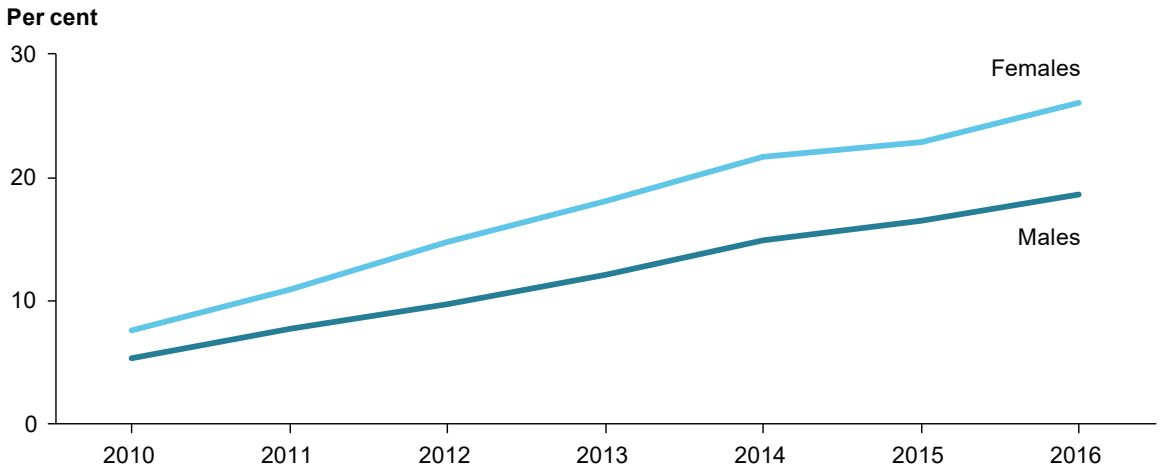
Indigenous-specific health services

The AIHW collects data from organisations funded to provide health care to Indigenous people, including Aboriginal Community Controlled Health Services, through the National Key Performance Indicators data collection. In June 2016, there were 117 of these organisations in remote areas and 124 in non-remote areas; 29,158 male and 21,339 female Indigenous, regular clients aged 15–24 attended these organisations.

All Indigenous people, regardless of age, are eligible for an annual Indigenous-specific health check (item 715 on the Medical Benefits Schedule). Providers of these checks assess the physical, psychological, and social wellbeing of patients. The checks encourage early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality (DoH, 2016).

In 2016, 33,411 health checks were provided to Indigenous people aged 15–24. Between 2010 and 2016, the proportion of Indigenous people aged 15–24 receiving these health checks increased from 6% to 22% (AIHW 2017i). A higher proportion of young Indigenous females (26%) than males (19%) had a health check in 2016 (Figure 8.1.2).

Figure 8.1.2: Indigenous people aged 15–24 who had an Indigenous health check (MBS item 715), by sex, 2010 to 2016



Note: Proportion calculated as the number of health checks provided divided by the Indigenous population of that age.

Source: Department of Human Services, Medicare data 2011–2016.

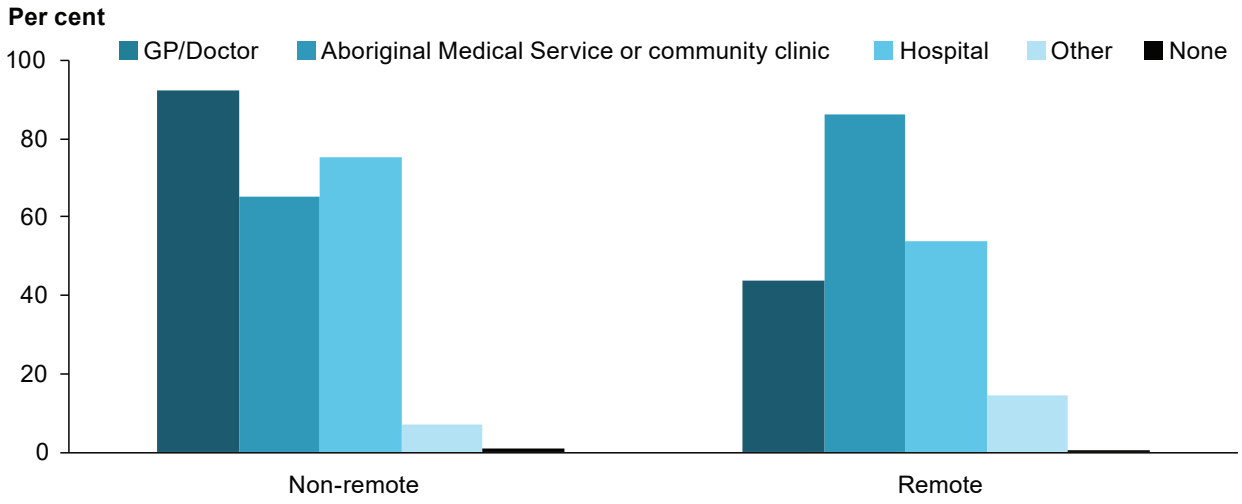
Remoteness disparities in doctor/GP availability

Data from the 2012–13 AATSIHS show that more than 8 in 10 Indigenous people aged 10–24 (83% or 167,700) had a GP/doctor in their local area. More than 7 in 10 (71% or 143,000) Indigenous people aged 10–24 had a hospital, around 69% (140,600) had an Aboriginal medical service or community clinic in their local area. Around 9% (16,800) had other health services and 1% (1,700) did not have a health service in their local area.

A higher proportion of Indigenous people aged 10–24 in non-remote areas (93% or 150,100) had access to a GP/doctor in their local area compared with those in remote areas (44% or 17,500). Similarly, young Indigenous people in non-remote areas (76% or 122,000) were also more likely to have access to hospital in their local area than those living in remote areas (54% or 21,400).

A higher proportion of young Indigenous people in remote areas had access to Aboriginal medical service or community clinic (86% or 34,300) compared with those living in non-remote areas (65% or 105,700) (Figure 8.1.3).

Figure 8.1.3: Indigenous people aged 10–24 by type of health service available in their local area, by remoteness, 2012–13



Note: Multiple responses item; sum of components may exceed total.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

Around half of Indigenous people aged 10–24 usually went to a doctor if they had a problem with their health (51% or 103,700). Another 25% (50,800) usually went to an Aboriginal medical service or community clinic. A further 17% (or 33,900) had no usual place to go and 1% (2,000) used other health services.

Young Indigenous people indicated that the main types of lifestyle issues discussed with their GP/health professional were eating healthy food or improving their diet (9% or 11,500) and reaching a healthy weight (9% or 11,300).

Access to health services

In the 2012–13 AATSIHS, 1 in 10 Indigenous people aged 10–24 (11% or 21,600) needed to go to the doctor in the previous 12 months, but did not go. Around, 5% (11,000) needed to go to hospital, but did not go; 7% (13,500) needed to go to a health professional (nurses, health workers), but did not go and 16% (33,300) needed to go to the dentist, but did not go.

Females were slightly more likely to not go to the doctor (12% or 11,500 and 10% or 10,000, respectively), hospital (6% or 6,000 and 5% or 4,900, respectively), and health professionals (8% or 7,900 or 6% or 5,900, respectively) and dentist (20% or 19,700 or 13% or 13,900, respectively) when they needed than males.

Those in non-remote areas were more likely than those in remote areas who needed to go to the doctor (12% or 19,200 or 6% or 2,500, respectively), hospital (6% or 9,300 or 5% or 1,800, respectively), other health professionals (8% or 12,800 and 3% or 1,200, respectively) or dentist (18% or 29,500 and 10% or 3,800, respectively) but did not go.

The most common reasons among those who did not go to the doctor but needed to, were deciding not to seek care (32% or 7,000), too busy (with work, personal or family) (28% or 6,100), waiting time was too long or not available at time required (21% or 4,500) and dislikes the service, professional, was afraid or embarrassed (19% or 4,000) and transport or distance (15% or 3,300). An additional 14% (3,000) did not go to doctor when needed due to cost.

The most common reasons that young Indigenous people did not go to the hospital but needed to was deciding not seek care (40% or 4,400), waiting time was too long or not available at the time required (25% or 2,800), dislikes the service, professional, was afraid or embarrassed (17% or 1,900) and transport or distance (13% or 1,400). The most common reason young Indigenous people did not go to other health professional (35% or 4,700) or a dentist (32% or 10,500) when they needed to was cost (Table 8.1).

Table 8.1: Indigenous people aged 10–24 who did not go to a health service when needed to, by type of service and reason, 2012–13

	Doctor		Hospital		Other health professionals		Dentist	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Decided not to seek care	7,000	32.4	4,400	40.0†	2,100	15.6	4,900	14.7
Too busy (including work, personal, family responsibilities)	6,100	28.2	2,200	20.0†	3,700	27.4†	9,300	27.9
Waiting time too long or not available at time required	4,500	20.8	2,800	25.5	2,200	16.3†	5,600	16.8
Dislikes (service/ professional, afraid, embarrassed)	4,000	18.5	1,900	17.3†	1,900	14.1†	7,500	22.5
Transport/distance	3,300	15.3†	1,400	12.7†	1,200	8.9†	3,400	10.2
Cost	3,000	13.9	n.p	n.p	4,700	34.8	10,500	31.5
Other reasons	4,600	21.3	1,800	16.4†	2,600	19.3†	6,900	20.7
Total who did not access health service	**21,600**	**100.0**	**11,000**	**100.0**	**13,500**	**100.0**	**33,300**	**100.0**

† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Note: Multiple responses item; sum of components may exceed total.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using Tablebuilder).

8.2 Mental health services

Mental health disorders contribute substantially to the disease burden for young Indigenous people (see Section 6.2), so access to mental health services is critically important. The Roadmap for National Mental Health Reform 2012–22 prioritises strategies that increase the availability of prevention and intervention activities appropriate for each person's life stage. The Roadmap also priorities strategies that increase the involvement of Aboriginal and Torres Strait Islander people in developing and implementing culturally appropriate mental health, social, and emotional wellbeing programs (COAG, 2012).

Community mental health care refers to government-funded and operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics. AIHW analysis of the National Community Mental Health Care Database shows that in 2014–15, there were 178,893 community mental health care service contacts for Indigenous people aged 15–24. This represented 23% of all service contacts. Of the 178,893 contacts, 59% were with males and 41% were with females (AIHW 2107b).

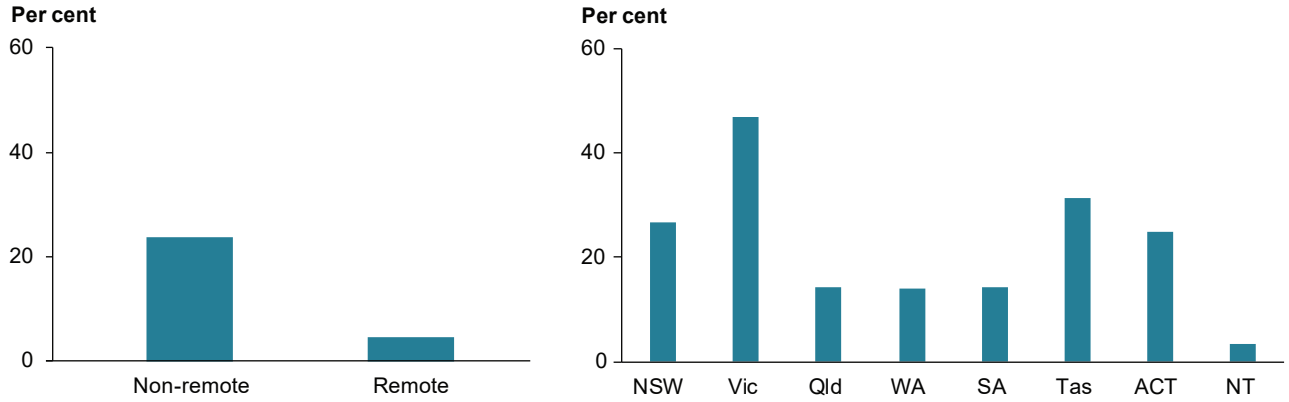
Use of health services for mental health

As part of the 2012–13 AATSIHS, Indigenous people aged 18 and over were asked about their use of health services for mental health conditions and whether they had attended counselling services. Around 1 in 5 (20% or 16,400) of those aged 18–24 had used mental health services, while 80% (66,900) had not. A higher proportion of females (9,300 or 23%) than males (7,700 or 18%) had used health services for mental health conditions.

A higher proportion of Indigenous people aged 18–24 in non-remote areas had used health services for mental health conditions (24% or 15,600) than those in remote areas (5% or 800).

Indigenous people aged 18–24 in Victoria (47% or 3,000) were more likely to use health services for mental health conditions than those in other states and territories. The Northern Territory had the lowest proportion who used health services for mental health conditions (4% or 300) (Figure 8.2.1).

Figure 8.2.1: Proportion of Indigenous people aged 18–24 who used health services for mental health conditions, by remoteness and state and territory, 2012–13



Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

In addition to this use of health services, around 15% (12,700) of young Indigenous people had attended a counselling service in the previous 12 months. Females aged 18–24 were twice as likely to have used such services than males (20% or 8,400 compared with 10% or 4,200).

Of all Indigenous people aged 18–24 who had experienced very high or high psychological distress, 77% (19,519) had not seen a health professional (AIHW 2017b).

8.3 Disability services

The purpose of the National Disability Insurance Scheme (NDIS) is to provide Australians aged 65 and under, who have permanent and significant disability, with the necessary support to participate in everyday life (NDIA 2016). Around 1 in 20 (5% or 1,001) participants with an approved NDIS plan who entered the NDIS in the second quarter of 2017–18 identified as Aboriginal and/or Torres Strait Islander. This is a similar proportion to that reported in previous quarters (5% or 5,605).

Box 8.3: The NDIS and NDIA

Background to the NDIS

In response to the Productivity Commission's final report on disability care and support (PC 2011), the Australian Government announced the introduction of the National Disability Insurance Scheme (NDIS) in July 2012, the NDIS will reach full Scheme in 2020 and provide NDIS funded services to around 460,000 people nationally (including approx. 28,000 Indigenous Australians).

From the 1 July 2013, disability support services users began transitioning to the NDIS. This transfer is occurring progressively under the administration of the National Disability Insurance Agency (NDIA). The NDIA collects data on the NDIS and publishes it on its website.

The NDIS is based on an insurance model. Individuals seeking access are assessed on a common set of criteria and eligible individuals then receive a package of funding to purchase the support identified in their individualised plan.

Transition from the NDA to NDIS

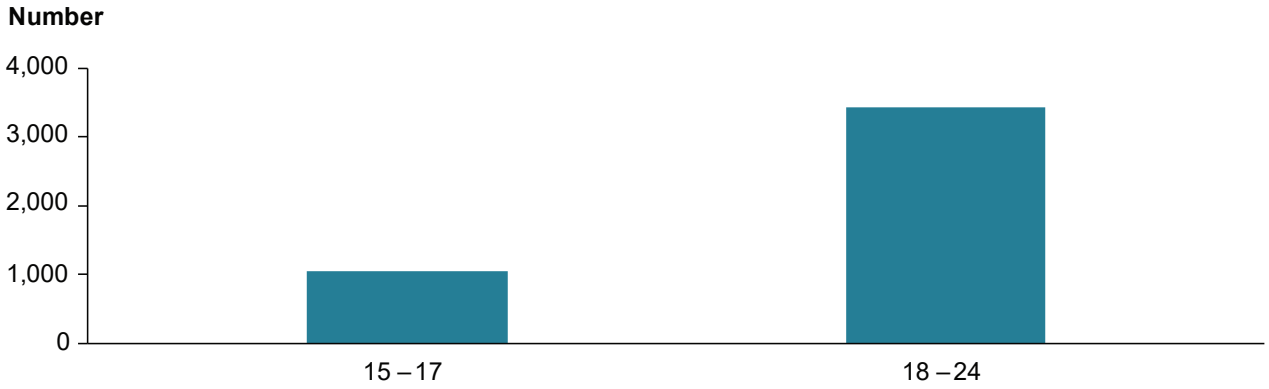
Iterations of the National Disability Agreement (NDA) have governed the provision of disability support services provision in Australia since 1991. The NDIS is expected eventually to largely replace disability service provision under the NDA eventually. The process of transitioning eligible individuals from the NDA to the NDIS is being done in accordance with the timeframes agreed bilaterally between the Commonwealth and individual jurisdictions.

Information on the use of NDA services is collected in the Disability Services (DS) NMDS. Individuals who have transitioned to the NDIS (that is, have an approved plan and have funding made available through the NDIA) are excluded from the DS NMDS from the date of their transition.

Source: AIHW 2017j.

In 2015–16, 4,473 Indigenous people aged 15–24 who used disability support services, as registered in the Disability Services National Minimum Data Set. Of these 4,473 users, 1,047 were aged 15–17 and 3,426 were aged 18–24 (Figure 8.3.1).

Figure 8.3.1: Number of young Indigenous disability support service users by age, 2015–16



Note: The Australian Capital Territory Government did not collect DS NMDS data in 2015–16.

Source: AIHW 2017j.

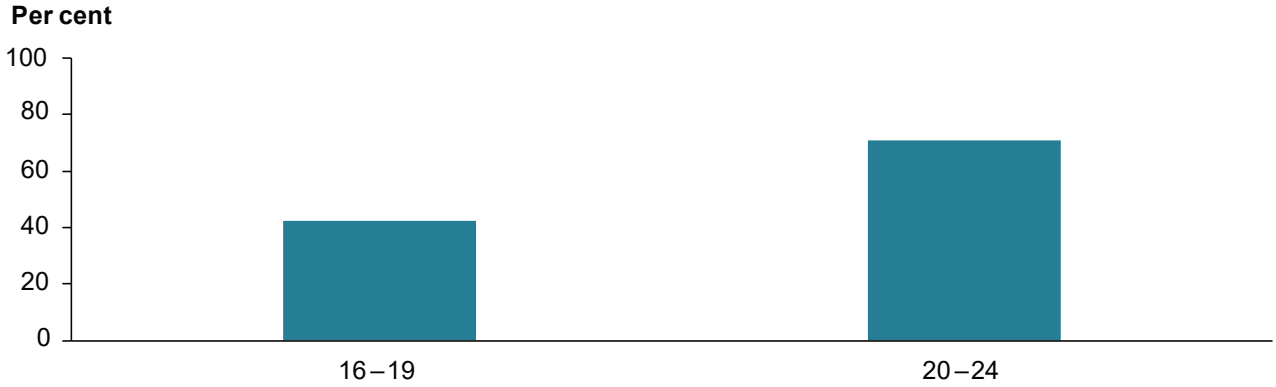
8.4 Sexual health services

In addition to data on young Indigenous people's sexual health, the Goanna Survey collected data on their use of sexual health services (Ward et al. 2014). The survey was conducted between 2011 and 2013 and included 2,877 Indigenous people aged 16–29 recruited from 40 Aboriginal and Torres Strait Islander community events in all states and territories, and may not be representative of all young Indigenous people.

Sexually transmitted infections

Over half of Indigenous people aged 16–24 surveyed reported ever being tested for STIs (54% or 1,170). The older age group were more likely to have been tested for STIs: 71% (637) of those aged 20–24 and 42% (533) of those aged 16–19 (Figure 8.4.1).

Figure 8.4.1: Proportion of Indigenous people aged 16–24 who had been tested for STIs, by age group, 2014



Note: Ever tested for STIs include 'yes last year' and 'yes over a year ago'.

Source: Ward et al. 2014.

Almost half of young Indigenous people who were tested reported that an Aboriginal Medical Service (48% or 563) was the location for their most recent STI testing.

Of the young Indigenous people who were tested, 22% (254) were diagnosed with an STI. Over half of those tested received a diagnosis of chlamydia (56% or 141), and lower proportions received a diagnosis of gonorrhoea (9% or 24) or (6% or 14) syphilis.

Among Indigenous people aged 16–24, 44% (943) reported that they had ever been tested for HIV and around 32% (700) aged 16–24 reported ever having been tested for hepatitis C.

8.5 Cancer screening services

Population-based screening services focus on reducing illness and death through the early detection of disease and identification in pre-disease stages. In Australia, free national screening programs for cervical cancer, breast cancer and bowel cancer are available even for individuals with no apparent symptoms.

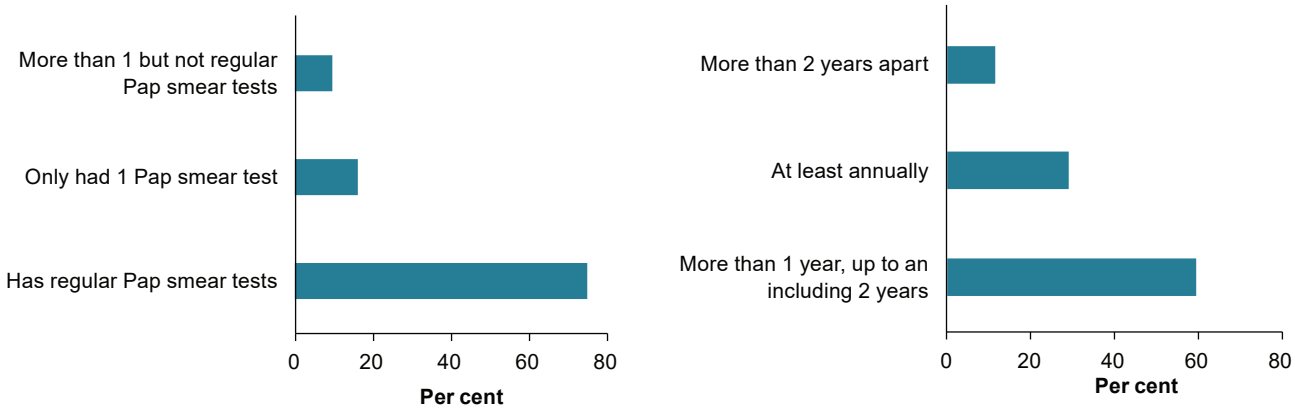
More than half have had a Pap test

In November 2017, the Cervical Screening Test replaced the Pap test as the method of screening for changes that can lead to cervical cancer. The 2-yearly Pap test for females aged 18 to 69 was replaced with a 5-yearly human papillomavirus test for females aged 25 to 74. Data on numbers having the Cervical Screening Test are not yet available, but some data are available on Pap tests.

In 2012–13, more than 4 in 5 (85%) young Indigenous females aged 20–24 had heard of a Pap smear test and 65% (18,800) had had a Pap smear. Of those who ever had a Pap smear test, 75% (14,100) had regular Pap smear tests, 16% (or 3,000) only ever had 1 test, and 10% (1,800) had irregular tests.

Among those aged 20–24 who had regular Pap smear tests, 60% (8,400) had had more than 1 in the previous 2 years, 29% (4,100) had had at least 1 test annually, and 11% (1,600) had had tests more than 2 years apart (Figure 8.5.1).

Figure 8.5.1: Proportion of young Indigenous females aged 20–24, by number and frequency of Pap smear tests, 2012–13



Note: Number of Pap smear tests was asked only of females who reported ever having a Pap smear. Frequency of Pap smear tests was asked only of females who reported having regular Pap smear tests.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

Across states and territories, the proportion of Indigenous females aged 20–24 who had ever had a Pap smear test was highest in New South Wales (74% or 6,000) and lowest in Queensland (51% or 4,000) (Figure 8.5.2).

Figure 8.5.2: Proportion of Indigenous females aged 20–24 who had ever had a Pap smear test, by state and territory, 2012–13



Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

A higher proportion of Indigenous females aged 20–24 in non-remote areas had had a Pap smear than those in remote areas (68% or 15,300 and 58% or 3,700, respectively). Similar proportions of women in non-remote areas (75% or 11,400) and remote areas (73% or 2,700) who had had a Pap smear indicated they were tested regularly.

Among Indigenous women aged 20–24 who had regular tests, 25% (2,800) of those in non-remote areas and 44% (1,200) in remote areas indicated they had a test annually. A further 64% (7,300) of females in non-remote areas had one every 2 years, while 44% (1,200) of females in remote areas had one every 2 years.

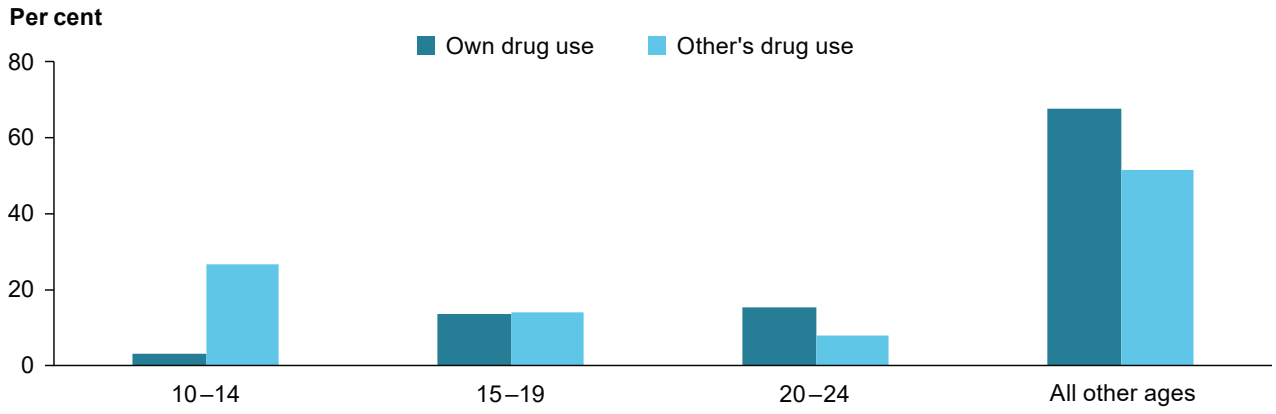
8.6 Alcohol and other drug treatment services

Analysis of the Alcohol and Other Drugs Treatment Services (AODTS) NMDS for 2015–16 shows that there were 9,326 closed treatment episodes for Indigenous clients aged 10–24 in Australia, around one-third (33%) of all closed treatment episodes for Indigenous clients . Most (8,820 or 95%) episodes for young Indigenous people related to their own drug use.

There were fewer episodes relating to own drug use for young Indigenous people in the 10–14 age group (902) than in the 15–19 (3,745) and 20–24 (4,173) age groups. As a proportion of all episodes relating to own drug use for Indigenous clients aged 10–24, those aged 10–14 represented 10%, those aged 15–19 represented 43% and those aged 20–24 represented 47%. The inverse pattern was evident for episodes relating to others' drug use, with the number of episodes being highest at the 10–14 age group (278), followed by the 15–19 (145) and 20–24 (83) age groups. As a proportion of all episodes for Indigenous clients relating to others' drug use for those aged 10–24, those aged 10–14 represented 55%, those aged 15–19 represented 29% and those aged 20–24 represented 16%.

Of all the closed treatment episodes for Indigenous clients across Australia, Indigenous people aged 10–24 accounted for almost a third (32% or 8,820) of the Indigenous clients who sought treatment for their own drug use. They also accounted for around a half (48% or 506) of treatment episodes for Indigenous clients where treatment was sought for another's drug use (Figure 8.6.1).

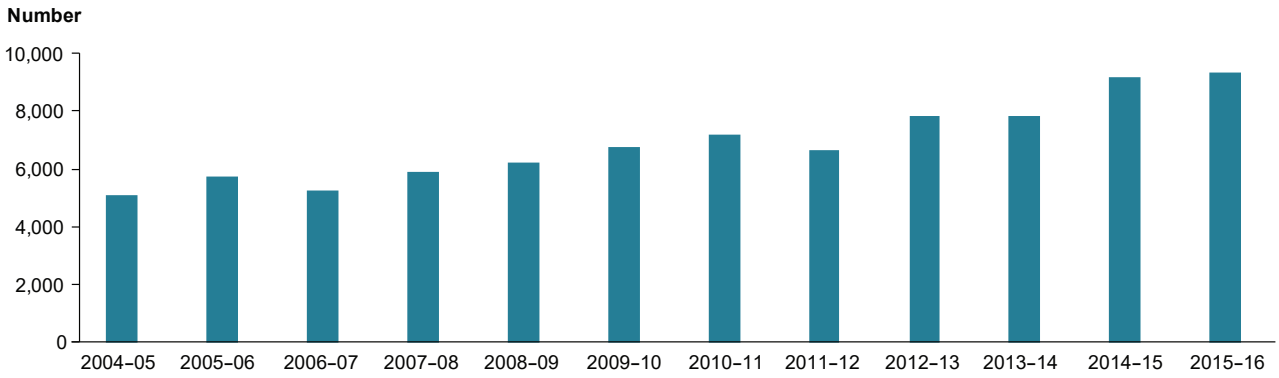
Figure 8.6.1: Distribution of closed treatment episodes for Indigenous clients seeking treatment for their own and others' drug use, by age group, Australia, 2015–16



Source: AODTS NMDS.

From 2004–05 to 2015–16, the number of closed episodes provided to Indigenous clients aged 10–24 increased from 5,108 to 9,326 (Figure 8.6.2). Over the same period, the proportion of total closed episodes that were for Indigenous clients aged 10–24 increased from 12% to 17% (Figure 8.6.2).

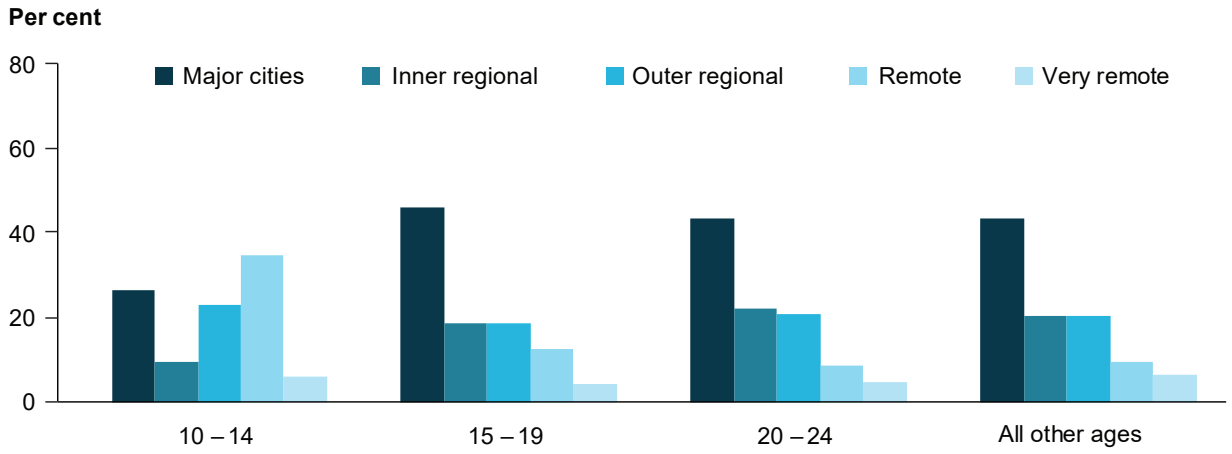
Figure 8.6.2: Number of closed treatment episodes for young Indigenous clients aged 10–24, 2004–05 to 2015–16



Source: AODTS NMDS.

In 2015–16, the proportion of closed episodes provided to Indigenous clients varied with remoteness area. For Indigenous people aged 10–14, the highest proportion of closed episodes were for treatment agencies located in *Remote* areas (35% or 411), but for those aged 15–19 and 20–24, closed episodes were more commonly recorded in *Major cities* (46% or 1,799 and 43% or 1,844, respectively) (Figure 8.6.3).

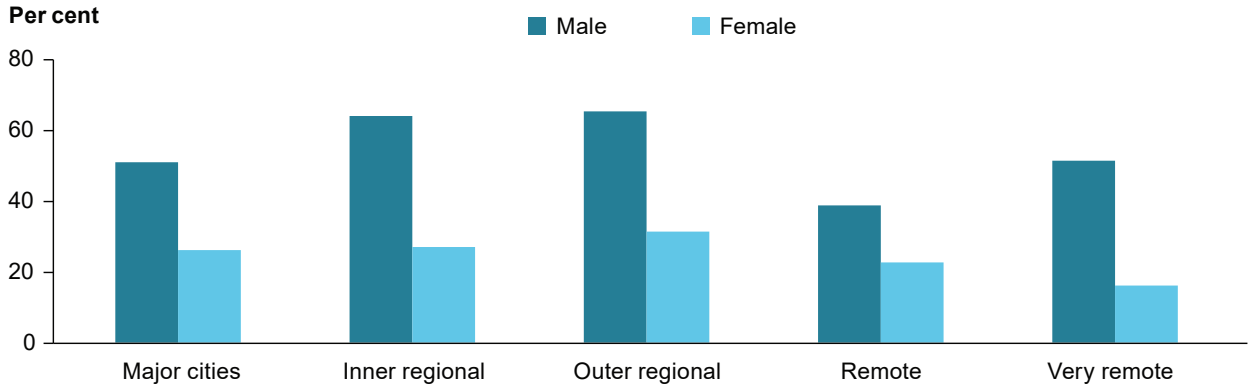
Figure 8.6.3: Closed treatment episodes for Indigenous clients, by age group and remoteness area of treatment agency, Australia, 2015–16



Source: AODTS NMDS.

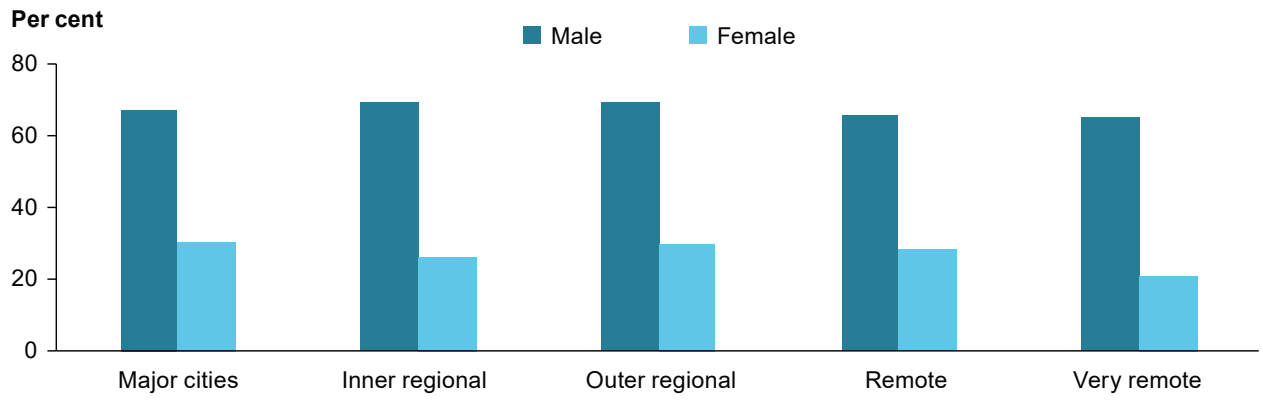
For those aged 10–14, 15–19 and 20–24, a higher proportion of closed treatment episodes for Indigenous clients relating to seeking treatment for their own drug use were for males than females across all remoteness areas. Across age groups, for those aged 10–14, the highest proportion of closed treatment episodes for male clients was in *Outer regional* areas (65% or 177) (Figure 8.6.4), while for those aged 15–19 it was in *Outer regional* areas (69% or 503) (Figure 8.6.5) and *Remote* areas (77% or 276) for those aged 20–24 (Figure 8.6.6).

Figure 8.6.4: Proportion of closed treatment episodes within each remoteness area by sex, Indigenous clients aged 10–14 seeking treatment for own drug use, 2015–16



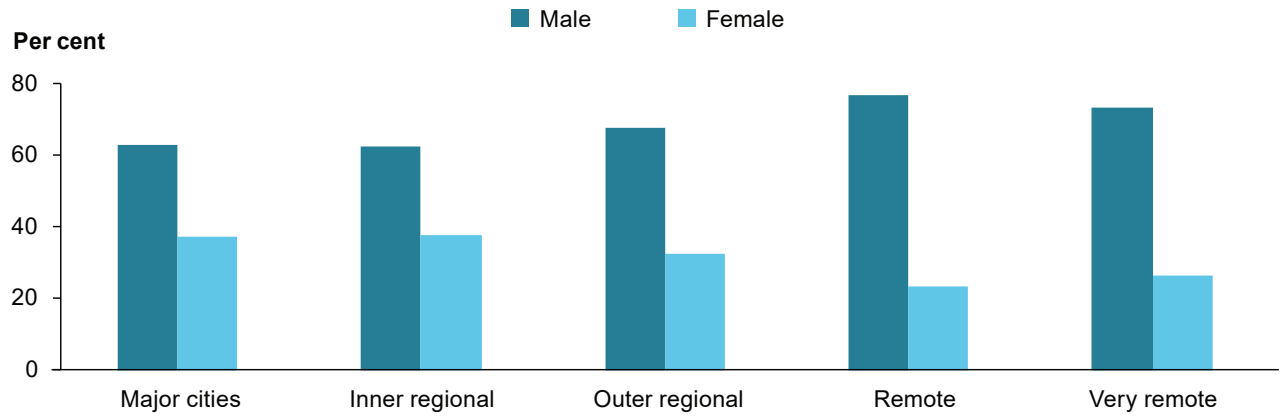
Source: AODTS NMDS.

Figure 8.6.5: Proportion of closed treatment episodes within each remoteness area by sex, Indigenous clients aged 15–19 seeking treatment for own drug use, 2015–16



Source: AODTS NMDS.

Figure 8.6.6: Proportion of closed treatment episodes within each remoteness area by sex, Indigenous clients aged 20–24 seeking treatment for own drug use, 2015–16

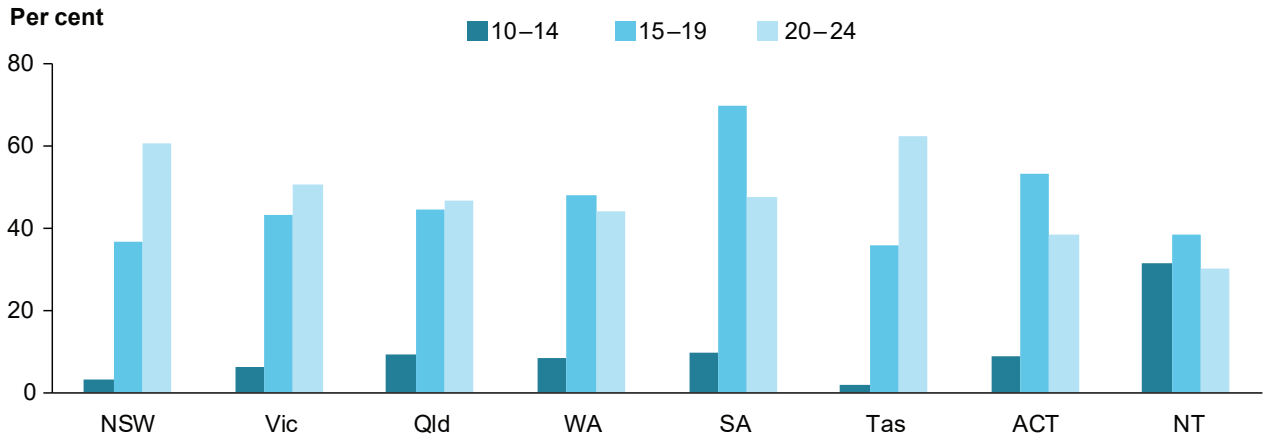


Source: AODTS NMDS.

In New South Wales, Victoria, Queensland, and Tasmania, Indigenous people aged 20–24 represented a greater proportion of all Indigenous youth clients seeking treatment for their own drug use than those aged 10–14 or 15–19.

In Western Australia, the Australian Capital Territory and the Northern Territory, those aged 15–19 represented a greater proportion of all Indigenous youth clients seeking treatment for their own drug use (Figure 8.6.7).

Figure 8.6.7: Proportion of closed treatment episodes for young Indigenous people seeking treatment for own drug use within each state and territory, by age group, 2015–16



Note: The data in NSW may be under-reported.

Source: AODTS NMDS.

8.7 Homelessness services

Specialist homelessness agencies across Australia fund non-government organisations to deliver services to support people who are either experiencing homelessness or at risk of becoming homeless. Both accommodation and support services may be provided.

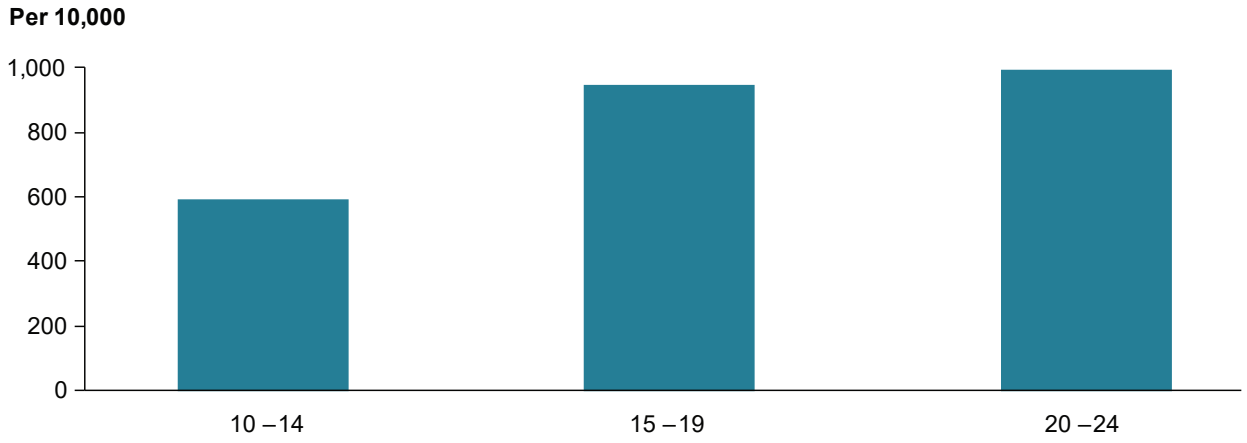
Box 8.7: Key terms in the Specialist Homelessness Services Collection (SHSC)

The SHSC distinguishes between clients who are experiencing homelessness and those who are at risk of homelessness:

- Clients are assumed 'homeless' if they are living without shelter, in improvised or inadequate accommodation; staying in short-term temporary accommodation; or living in a house, townhouse or flat with relatives for free or couch surfing or with no tenure. The definition of homelessness used in the SHSC aligns with the ABS definition, except that it does not cover people living in severely crowded dwellings.
- Clients are assumed to be 'at risk of homelessness' if they have sought assistance from a homelessness agency but do not fall into a homeless category—that is, they are living in social housing, private or other housing, or an institutional setting.

Overall, 19,583 (840 per 10,000) Indigenous people aged 10–24 were clients of a SHS in 2016–17. The rate was higher for older youth—995 per 10,000 in the 20–24 age group. The rate for the 15–19 age group was 945 per 10,000 (7,376) for the 10–14 age group 594 per 10,000 (4,772) (Figure 8.7.1).

Figure 8.7.1: Rate of young Indigenous people who were Specialist Homelessness Services clients, by age group, 2016–17



Source: Specialist Homelessness Services collection.

Indigenous females aged 10–24 were almost twice as likely to present as clients to SHS (323 per 10,000 or 12,273) as males (192 per 10,000 or 7,309).

In 2016–17, Victoria had the highest rate of all states and territories of young Indigenous people who were SHS clients (2,460 or 1,481 per 10,000). Rates were lower in the Australian Capital Territory (249 or 1,093 per 10,000), South Australia (1,375 or 1,087 per 10,000), New South Wales (7,241 or 1,015 per 10,000), the Northern Territory (1,927 or 888 per 10,000), Western Australia (2,370 or 805 per 10,000), Queensland (3,772 or 569 per 10,000) and Tasmania (401 or 490 per 10,000) (Figure 8.7.2).

Figure 8.7.2: Rate of young Indigenous people who were Specialist Homelessness Services clients by state and territory, 2016–17

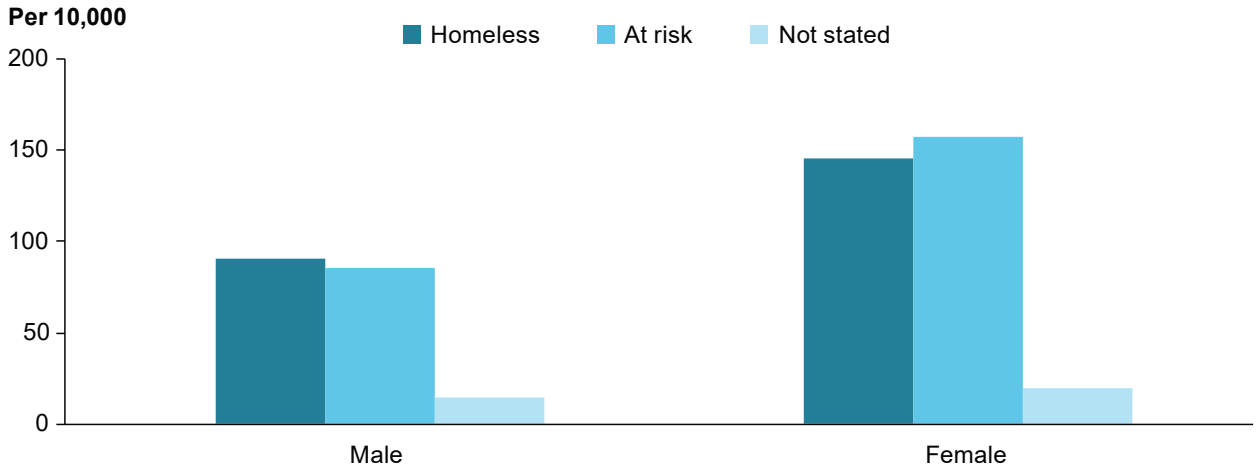


Source: Specialist homelessness services collection.

2 in 5 presented to SHS as homeless

Around 397 per 10,000 (9,262) Indigenous people aged 10–24 were at risk of homelessness, and 386 per 10,000 (8,996) were homeless on presentation to a SHS. For 57 per 10,000 (1,324), the homelessness status could not be determined. Females were more likely to present at a SHS as at risk of homelessness (158 per 10,000 or 5,988) or as homeless (146 per 10,000 or 5,527) than young males (Figure 8.7.3).

Figure 8.7.3: Rate of young Indigenous people who were Specialist Homelessness Services clients, by presentation status and sex, 2016–17



Source: Specialist homelessness services collection.

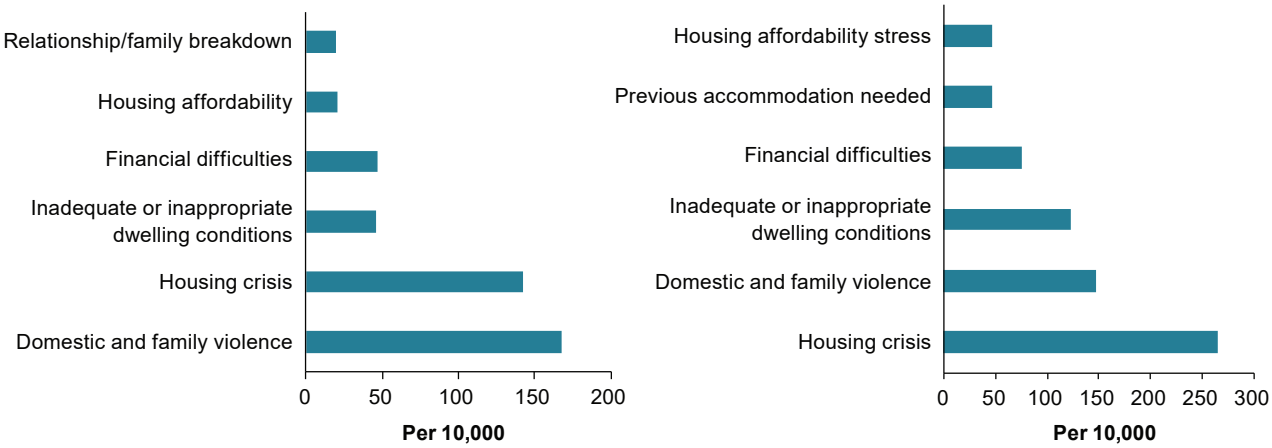
Those aged 20–24 were more likely to present as homeless (492 per 10,000 or 3,673) than those aged 10–14 (204 per 10,000 or 1,636), or those aged 15–19 (472 per 10,000 or 3,686). Rates of Indigenous people who presented to SHS at risk of homelessness were also higher for those aged 20–24 (471 per 10,000 or 3,519) than those aged 10–14 (285 per 10,000 or 2,288) or those aged 15–19 (443 per 10,000 or 3,455).

Domestic and family violence the main reason younger youth are seeking help

For Indigenous people aged 10–14, the most common reason for accessing specialist homelessness services was domestic and family violence (1,353 or 168 per 10,000). This was followed by a housing crisis (1,145 or 142 per 10,000), financial difficulty (375 or 47 per 10,000), inadequate or inappropriate dwelling conditions (371 or 46 per 10,000) and housing affordability stress (166 or 21 per 10,000) (Figure 8.7.4).

For Indigenous people aged 15–24, the main reasons for seeking support was a housing crisis (4,044 or 265 per 10,000). This was followed by domestic and family violence (2,247 or 147 per 10,000), inadequate or inappropriate dwelling conditions (1,876 or 123 per 10,000), financial difficulty (1,159 or 76 per 10,000) and housing affordability (712 or 47 per 10,000) (Figure 8.7.4).

Figure 8.7.4: Indigenous people aged 10–14 (left) and 15–24 (right) who were Specialist Homelessness Services clients, by reason for service use and age group, 2016–17



Source: Specialist Homelessness Services collection.

8.8 Child protection and out-of-home care

In Australia, state and territory governments have responsibility for statutory child protection and each jurisdiction has its own legislation, policies and practices regarding child protection (AIHW 2017d). Indigenous Australians' experience with child welfare policies has historically been traumatic. This history includes the policy of forcible removal of children known as the Stolen Generations (HREOC 1997).

Between 1 July 2014 and 30 June 2016 indicates that young Indigenous Australians aged 10–16 were 16 times as likely as non-Indigenous Australians of this age group to be both in the child protection system and under youth justice supervision (AIHW 2017e).

Box 8.8: Care and protection orders and out-of-home care

Care and protection orders

Care and protection orders are legal orders or arrangements that give child protection departments some responsibility for a child's welfare.

Out-of-home care

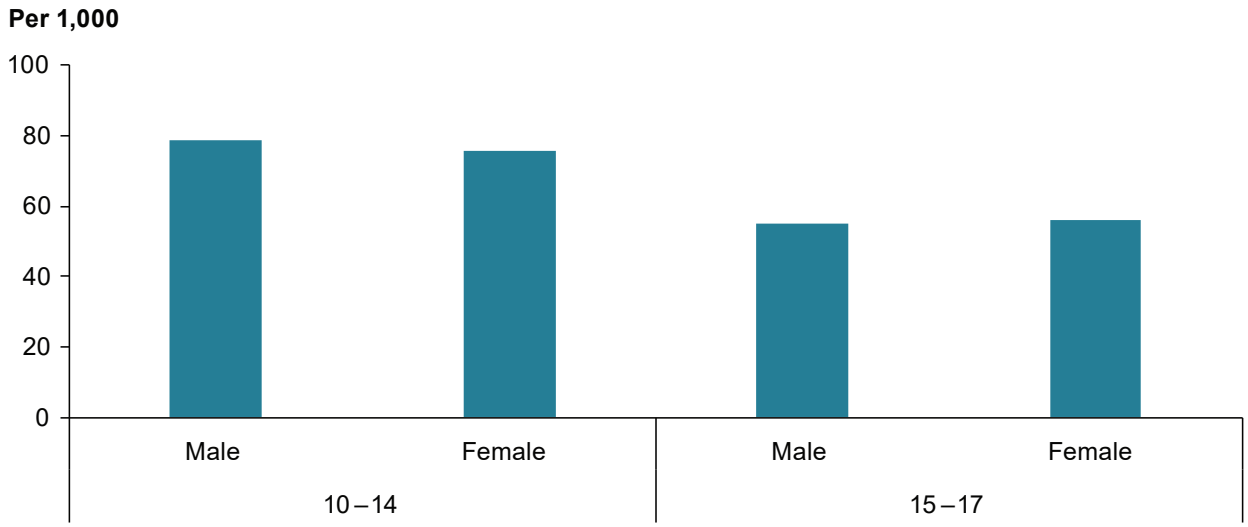
Children may be placed in out-of-home care when parents are unable to provide adequate care, children require a more protective environment or alternative accommodation is needed during family conflict. This is overnight care for children aged 0–17 where the department makes or offers a financial payment to the carer. Consistent with the principle of keeping children with their families, out-of-home care is considered an intervention of last resort. It is possible for children and young people to be involved in both of these components at the same time.

Source: AIHW 2017e.

Almost 9,000 young Indigenous people on care and protection orders

At June 30 2017, there were 4,545 Indigenous males and 4,278 Indigenous females aged 10–17 on care and protection orders. For those aged 10–14, the Indigenous male rate (79 per 1,000 or 3,227) exceeded the Indigenous female rate (76 per 1,000 or 2,985), while rates for those aged 15–17 were similar—the Indigenous female rate was 56 per 1,000 (1,293) and the Indigenous male rate was 55 per 1,000 (1,318) (Figure 8.8.1).

Figure 8.8.1: Young Indigenous people on care and protection orders, by age group and sex, 30 June 2017



Source: ABS 2014a, AIHW Child Protection Collection.

The rate of Indigenous males aged 10–14 on care and protection orders was highest in the Australian Capital Territory (152 per 1,000 or 48) and lowest in the Northern Territory (40 per 1,000 or 160) at 30 June 2017. Rates for Indigenous females aged 10–14 were highest in Victoria (118 per 1,000 or 318) and lowest in the Northern Territory (36 per 1,000 or 131) (Figure 8.8.2).

Figure 8.8.2: Indigenous people aged 10–14 on care and protection orders, by sex and state and territory, 30 June 2017



Source: ABS 2014a, AIHW Child Protection Collection.

For Indigenous people aged 15–17, Victoria had the highest rate of males (75 per 1,000 population or 131) and females (78 per 1,000 population or 129) on care and protection orders. The lowest rates for males and females were in Tasmania (28 per 1,000 or 26 and 31 per 1,000 or 25, respectively) (Figure 8.8.3).

Figure 8.8.3: Indigenous people aged 15–17 on care and protection orders, by sex and state and territory, 30 June 2017



Source: ABS 2014a, AIHW Child Protection Collection.

Out-of-home care rates lowest in Very remote areas

At 30 June 2017, there were 7,721 Indigenous people aged 10–17 in out-of-home care. The rate of males in out-of-home care slightly exceeded that of females (62 per 1,000 or 3,989 and 60 per 1,000 or 3,732, respectively).

Rates for males aged 10–17 in out-of-home care were highest in the Australian Capital Territory (106 per 1,000 or 56), whereas rates for females were highest in Victoria (96 per 1,000 or 420). Tasmania had the lowest rates for males (36 per 1,000 or 87) and females (31 per 1,000 or 68) (Figure 8.8.4).

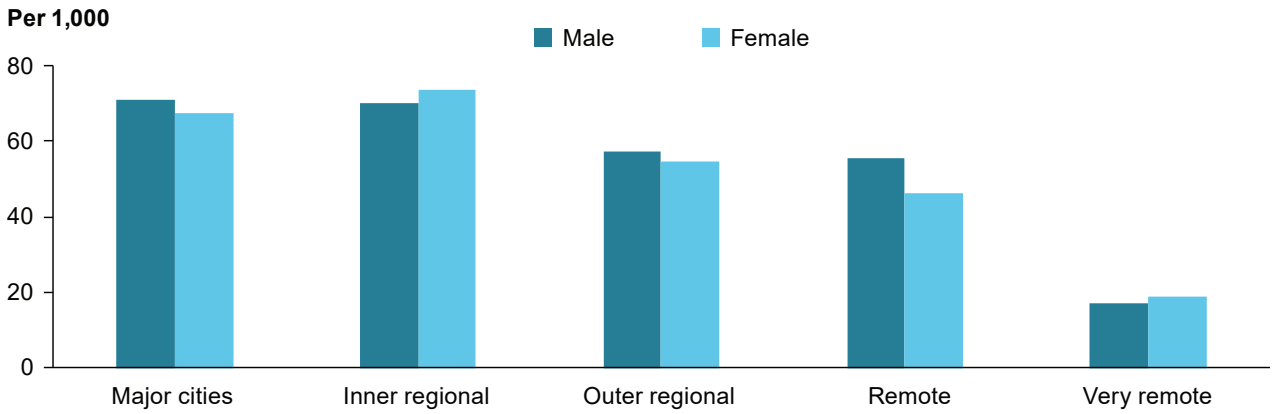
Figure 8.8.4: Indigenous people aged 10–17 in out-of-home care, by state and territory and sex, 30 June 2017



Source: ABS 2014a, AIHW Child Protection Collection.

Across remoteness areas, the lowest rates of young Indigenous males and females in out-of-home care were in *Very remote* areas (17 per 1,000 or 125 and 19 per 1,000 or 130, respectively). *Inner regional* areas had the highest rate for females (74 per 1,000 or 1,099), while *Major cities* had the highest rate for males (71 per 1,000 or 1,635) (Figure 8.8.5).

Figure 8.8.5: Indigenous people aged 10–17 in out-of-home care, by remoteness and sex, 30 June 2017



Source: ABS 2014a, 2014b, AIHW Child Protection Collection.

8.9 Contact with the justice system

Indigenous youth are disproportionally represented in contacts with the justice system. On an average day in 2016–17, around 50% of those under youth justice supervision were Indigenous (but Indigenous youth comprised of 5% of the population aged 10–17). This disproportional representation affects individuals' own health as well as the social and emotional wellbeing of families and communities (AHMAC 2017). Higher rates of contact with the criminal justice system are correlated with other social determinants of health, such as poverty, unemployment and low levels of education, as well as behavioural factors such as substance use and stressful life events, and health outcomes such as psychological distress and mental health issues (AMA 2015).

Table 8.9: Types of youth justice supervision

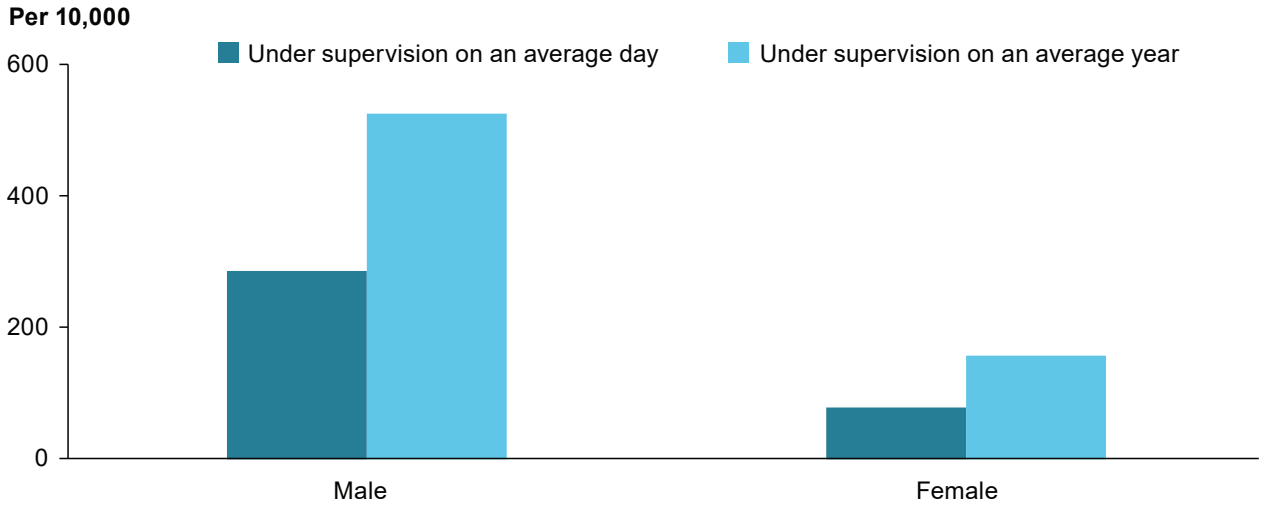
	Community-based	Detention
Unsentenced supervision	Home detention bail: supervised or conditional bail	Remanded in custody (can be police or court referred)
Sentenced supervision	Parole or supervised release, probation or similar suspended detention	Sentenced to detention

Source: AIHW 2017f.

Over 4,000 young Indigenous people under youth justice supervision during the year

In 2016–17, there were 1,852 Indigenous males aged 10–17 under youth justice supervision on an average day (286 per 10,000) and 3,389 during the entire year (524 per 10,000). These numbers and rates were considerably higher than those for Indigenous females aged 10–17. During the same period, there were 487 Indigenous females aged 10–17 under youth justice supervision on an average day (78 per 10,000) and 976 during the entire year (157 per 10,000) (Figure 8.9.1).

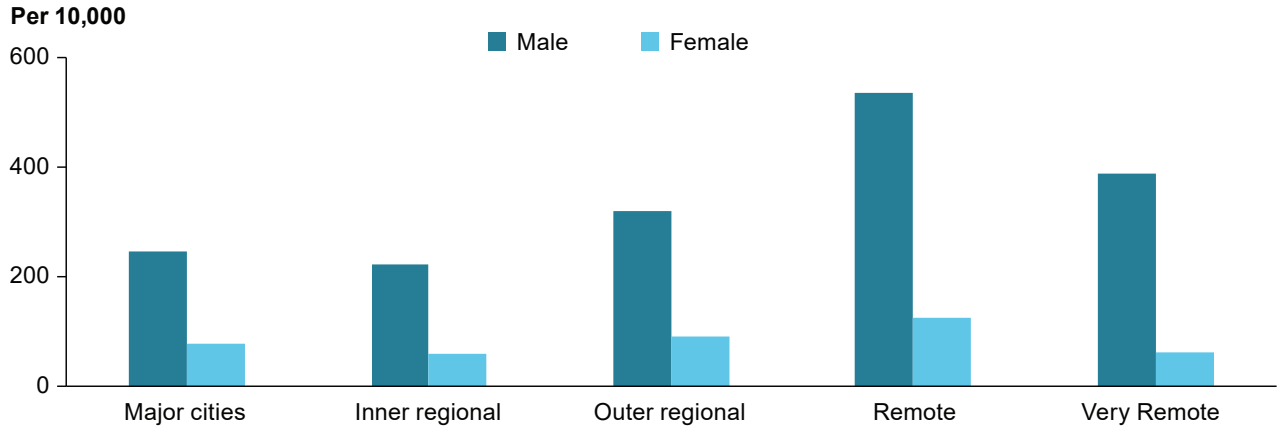
Figure 8.9.1: Indigenous children aged 10–17 under youth justice supervision, by sex, 2016–17



Source: AIHW Juvenile Justice National Minimum Data Set.

Across all remoteness areas, rates of Indigenous males aged 10–17 under youth justice supervision exceeded those of females both on an average day and during the year. Rates on an average day were highest in *Remote* areas for males and females (536 per 10,000 or 158 and 125 per 10,000 or 37, respectively) and lowest in *Inner regional* areas (222 per 10,000 or 341 and 60 per 10,000 or 89, respectively) (Figure 8.9.2).

Figure 8.9.2: Indigenous children aged 10–17 under youth justice supervision on an average day, by sex and remoteness, 2016–17

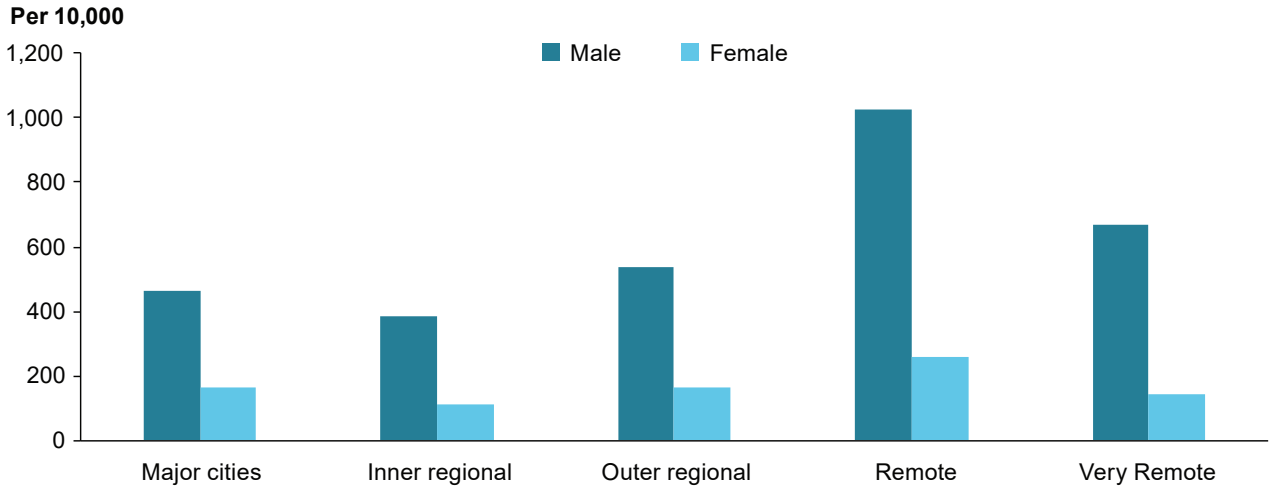


Note: Excludes data from the Northern Territory, as geographical information was not available.

Source: AIHW Juvenile Justice National Minimum Data Set.

Similarly to rates for an average day, rates of supervision during the year were highest for males (1,027 per 10,000 or 303) and females (259 per 10,000 or 77) in *Remote* areas and lowest in *Inner regional* areas (383 per 10,000 or 588 and 110 per 10,000 or 163, respectively) (Figure 8.9.3).

Figure 8.9.3: Indigenous children aged 10–17 under youth justice supervision during the year, by sex and remoteness, 2016–17



Note: Excludes data from the Northern Territory, as geographical information was not available.

Source: AIHW Juvenile Justice National Minimum Data Set.

Rates for youth justice supervision lowest in Tasmania

Across all states and territories, supervision rates for males on an average day were highest in Western Australia (507 per 10,000 or 410), whereas rates for females were highest in the Australian Capital Territory (116 per 10,000 or 6). Rates for both males (95 per 10,000 or 23) and females (20 per 10,000 or 4) were lowest in Tasmania (Figure 8.9.4).

Figure 8.9.4: Indigenous children aged 10–17 under youth justice supervision on an average day, by sex and state and territory, 2016–17

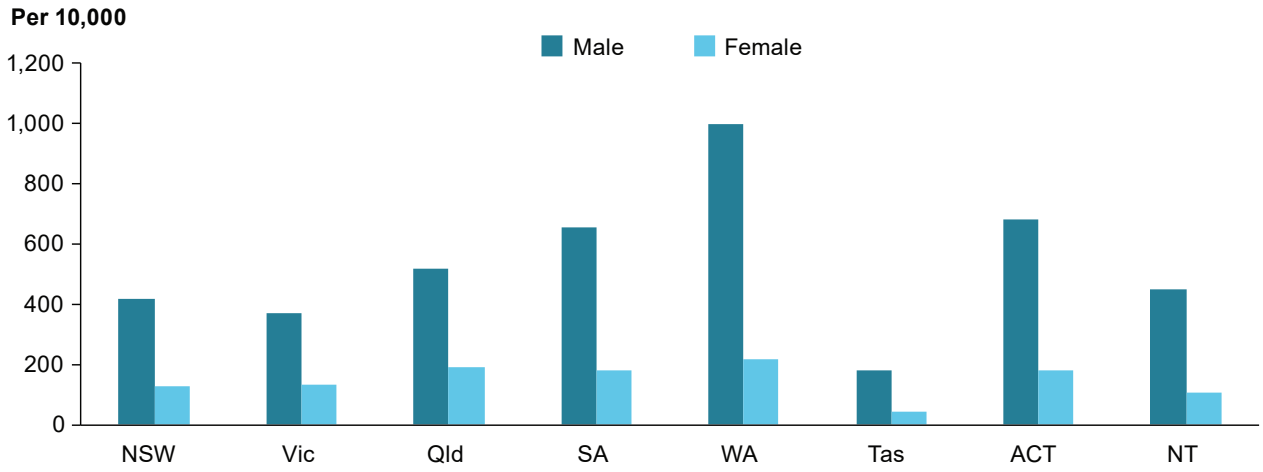


Note: Excludes data from the Northern Territory, as geographical information was not available.

Source: AIHW Juvenile Justice National Minimum Data Set.

Supervision rates during the year were highest for males and females in Western Australia (996 per 10,000 or 805 and 220 per 10,000 or 183, respectively) and lowest in Tasmania (179 per 10,000 or 43 and 42 per 10,000 or 9, respectively) (Figure 8.9.5).

Figure 8.9.5: Indigenous children aged 10–17 under youth justice supervision during the year, by sex and state and territory, 2016–17



Note: Excludes data from the Northern Territory, as geographical information was not available.

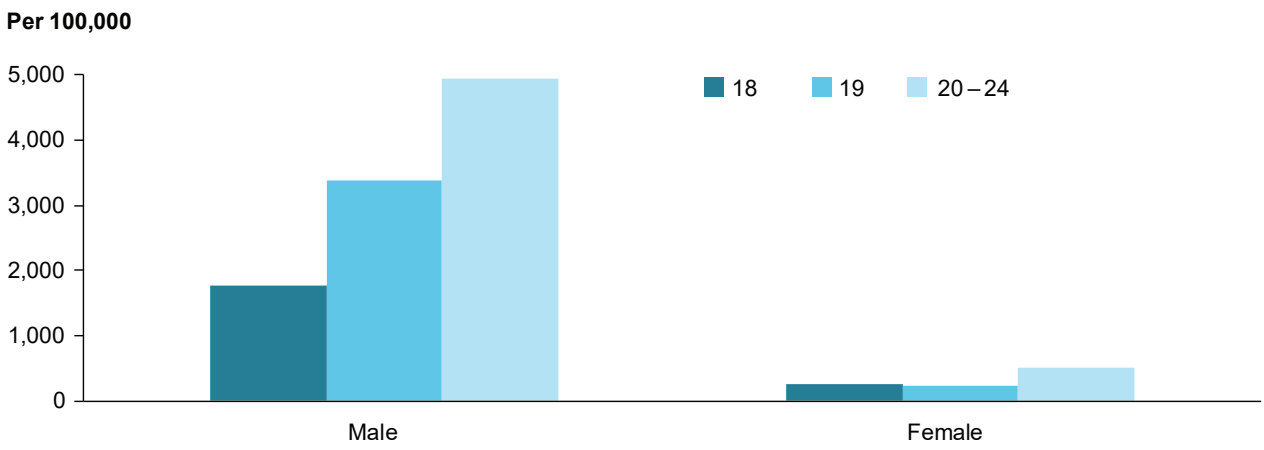
Source: AIHW Juvenile Justice National Minimum Data Set.

Imprisonment rates higher for young Indigenous males

In 2017, 22% (2,521) of the total Indigenous prison population, and 6% of the total prison population, comprised of Indigenous people aged 18–24. Imprisonment rates increased with age, rising from 981 per 100,000 (152) for those aged 18, to 1,839 per 100,000 (286) for those aged 19, and 2,789 per 100,000 (2,083) for those aged 20–24.

Rates of imprisonment were higher for males than females. For males the rates were 1,768 per 100,000 (138) for those aged 18; 3,372 per 100,000 (270) for those aged 19; and 4,941 per 100,000 (1,903) for those aged 20–24. For Indigenous females, the corresponding rates were 247 per 100,000 (19) for those aged 18; 225 per 100,000 (17) for those aged 19; and 498 per 100,000 (180) for those aged 20–24 (Figure 8.9.6).

Figure 8.9.6: Rate of imprisonment for young Indigenous people by age group and sex, 2017



Source: ABS 2017c.

8.10 Accessing services

1 in 3 in remote areas lacked access to public transport

Transport provides young people with a way to get to health and welfare services. Having transport options available helps young people to connect with family and friends, attend education and employment, and extends options for housing and other facilities.

The majority of Indigenous people aged 15–24 had public transport available in their local area (80% or 108,100).

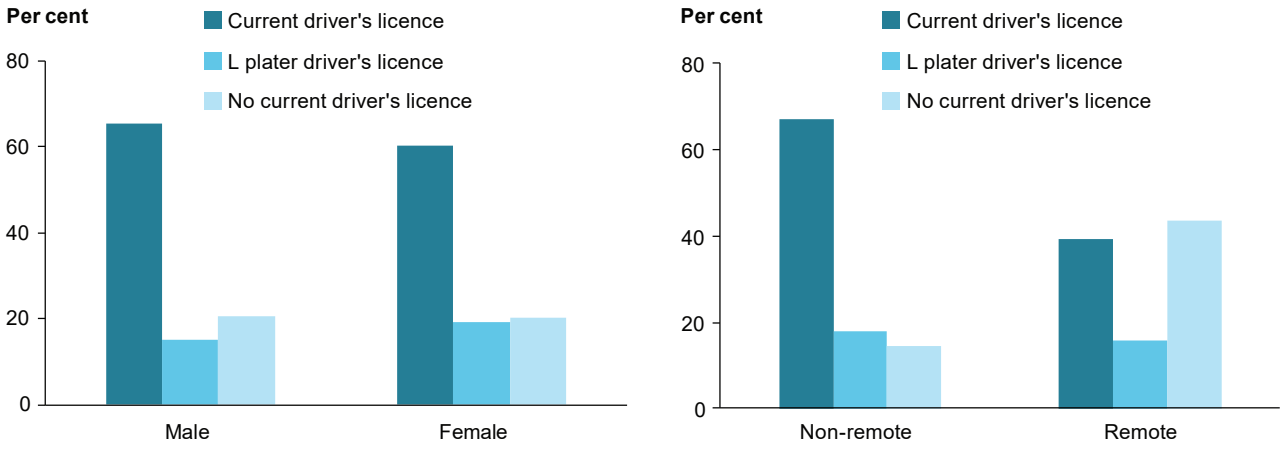
There was a marked disparity by remoteness in the availability of local public transport. In non-remote areas, 91% (99,200) of young Indigenous people had access to local public transport, whereas around 1 in 3 (35% or 9,100) of those in remote areas had local public transport available.

6 in 10 held a current driver's licence

In 2014–15, most Indigenous people aged 18–24 held some form of driver's licence. More than 6 in 10 (62% or 47,500) held a current driver's licence and 18% (13,400) held an L plater driver's licence. A higher proportion of young Indigenous males than females held a current driver's licence (65% or 25,000 and 60% or 23,100, respectively) (Figure 8.10.1).

The proportion of young Indigenous people holding a driver's licence was higher in non-remote areas (67% or 41,500) than in remote areas (39% or 5,700).

Figure 8.10.1: Proportion of Indigenous people aged 18–24 who hold a driver's licence, by sex and remoteness, 2014–15



Notes

1. 'Current drivers licence' 'No current drivers licence' and 'L plater driver's licence' is for those aged 18–24. Also, only includes individuals who could access a car when they wanted to or knew how to drive and were not housebound.
2. Data are not mutually exclusive.

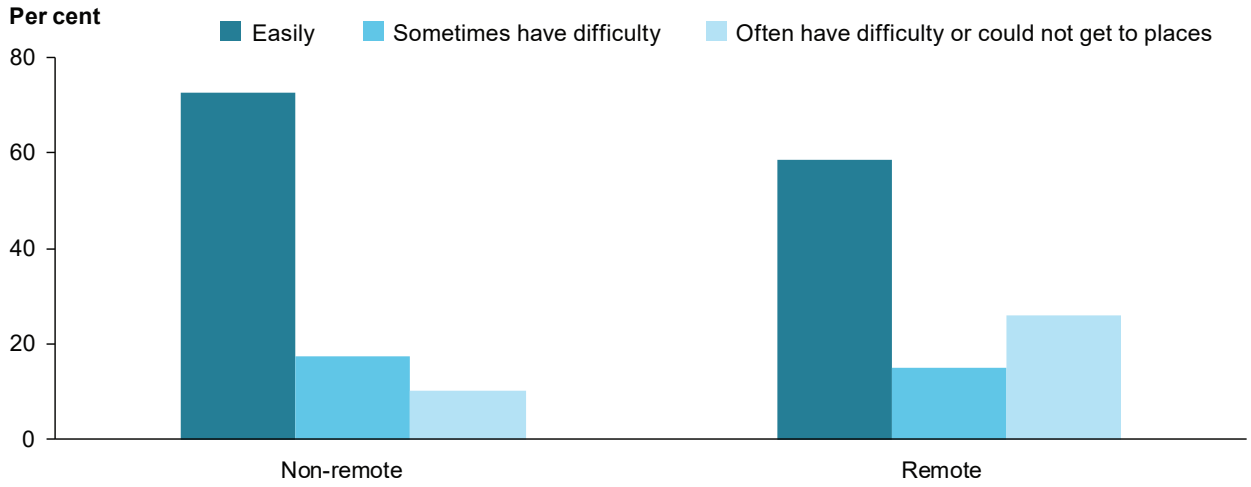
Source: 2014–15 AIHW analysis of National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

Most found it easy to get to places

Most Indigenous people aged 15–24 found it easy to get to the places they needed to (70% or 96,000). A further 17% (23,200) sometimes had difficulty doing so, and 13% (617,800) often found it difficult or could not get to places they needed to.

A higher proportion of young Indigenous people living in non-remote areas could easily get to the places they needed to (73% or 80,600) than those living in remote areas (59% or 15,300). Over 1 in 4 (26% or 6,800) young Indigenous people living in remote areas often had difficulty or could not get to the places needed, while 1 in 10 (10% or 11,200) of those living in non-remote areas had difficulty or could not get to the places they needed to (Figure 8.10.2).

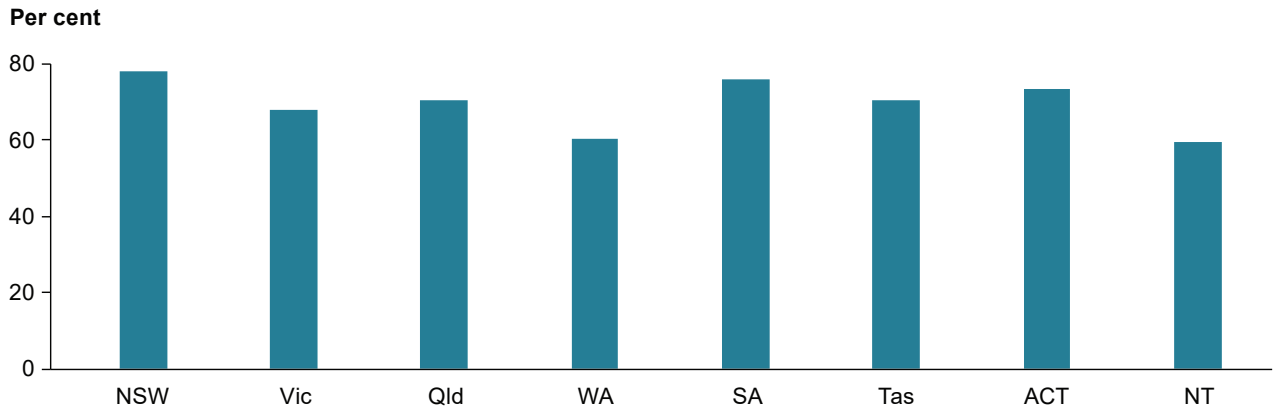
Figure 8.10.2: Proportion of Indigenous people aged 15–24, by difficulty accessing transport to get to places needed and remoteness, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

New South Wales had the highest proportion of Indigenous people aged 15–24,who could easily get to places they needed to (78% or 34,400) while the Northern Territory had the lowest proportion (59% or 7,600) (Figure 8.10.3).

Figure 8.10.3: Proportion of Indigenous people aged 15–24 who could easily access transport to places needed, by state and territory, 2014–15



Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

8.11 How do young Indigenous people compare?

This report focuses on data about Indigenous youth so that, through the findings, their voice can be heard. Yet, there is also value in understanding what the data says about other groups. Some comparison data for key indicators on both young non-Indigenous people and older Indigenous people are therefore presented below.

Older Indigenous people had a higher rate of MBS items claimed for GP services than young Indigenous people or young non-Indigenous people. A similar pattern was evident for rates of homelessness services use and in the use of mental health services.

Older Indigenous people were more likely to indicate they could easily get to places they needed to go via transport. Young Indigenous people had higher rates of MBS items claimed for GP services and homelessness service used than young non-Indigenous people did, but similar proportions indicated they used mental health services and could easily get to places they needed to via transport.

Box 8.11: Health and welfare services measures: comparison with other groups

	Indigenous people under 25	Non-Indigenous people under 25	Indigenous people over 25
MBS claims for GP services per 1,000[(a)]	4,135	3,665	7,219
Use of homelessness services per 10,000[(a)]	840	117	847
% who used mental health services[(b)]	20	18	28
% could easily get to places needed through transport[(c)]	70	71	78

(a) For Indigenous and non-Indigenous people aged 10–24.

(b) For Indigenous and non-Indigenous people aged 18–24.

(c) For Indigenous and non-Indigenous people aged 15–24.

Sources: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey, 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder), AIHW 2017b and Specialist homelessness services collection.



9

Young Torres Strait Islander people

Data in this chapter relate specifically to the almost 18,000 young Indigenous people who identify as being of Torres Strait Islander origin. The Torres Strait is a region located between Australia's Cape York Peninsula and Papua New Guinea, but Torres Strait Islanders reside in all states and territories across Australia. The Torres Strait region has a distinct history and culture. There is diversity of language and traditions both between Torres Strait Islander people and other Indigenous peoples and between Torres Strait Islander communities (PC 2016).

This chapter includes information on the geographic location, health outcomes, social determinants, health risk factors and access to primary health care for young Torres Strait Islanders. Throughout the chapter, the term 'Torres Strait Islander' is used to refer to those who identify either as Torres Strait Islander only or as both Aboriginal and Torres Strait Islander.

Box 9: Main data sources and key issues

- The main ABS data sources used for information on young Torres Strait Islanders were the Census of Population and Housing, National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and the Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS).
- The NATSISS and AATSIHS are sample surveys and due to the small population size, many of the estimates are subject to sampling error. Those with a relative standard error over 25% are noted.
- Estimates with a relative standard error of 25% to 50% should be used with caution and those with a relative standard error greater than 50% are considered too unreliable for general use.
- The data on Torres Strait Islanders includes those who identify as Torres Strait Islander only and those who identify as both Torres Strait Islander and Aboriginal.
- There is some under-identification of Torres Strait Islander Australians in the NHMD, for Torres Strait Islander Australians, at state and territory level, use of data for sub-categories should be untaken only with extreme caution given the small numbers involved for some of the categories and because the quality of the data for the individual categories is not known. For this reason hospitalisation at state and territory level has been excluded.

Note: For information on issues to consider for the NATSISS, see Box 3, for the AATSIHS see Box 4, for more on NHMD and NMD see Box 6. See Appendix C for more information about all key data sources.

9.1 Population profile

Torres Strait Islanders are a small but significant part of the youth population

In 2016, there were 21,735 Torres Strait Islander people aged 10–24 in Australia. Young Torres Strait Islander people made up 9% of the total young Indigenous population and 0.5% of the total Australian youth population. These proportions were similar across youth age groups and for both males and females (Table 9.1).

Of the 21,735 young Torres Strait Islander people, 52% (11,331) identified as Torres Strait Islander only and 48% (10,404) identified as being both Aboriginal and Torres Strait Islander.

Table 9.1: Young Torres Strait Islander by age group, 2016

	Number			% of total Indigenous population[(a)]			% of Australian population		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
10–14	3,861	3,973	7,834	8.7	9.4	9.0	0.5	0.6	0.5
15–19	3,790	3,535	7,325	9.1	8.9	9.0	0.5	0.5	0.5
20–24	3,483	3,093	6,576	9.1	8.6	9.0	0.4	0.4	0.4
Total 10–24	**11,134**	**10,601**	**21,735**	**9.0**	**9.0**	**9.0**	**0.5**	**0.5**	**0.5**

(a) Includes Aboriginal and/or Torres Strait Islander people.

Source: AIHW analysis of ABS 2018.

9.2 Geographic location

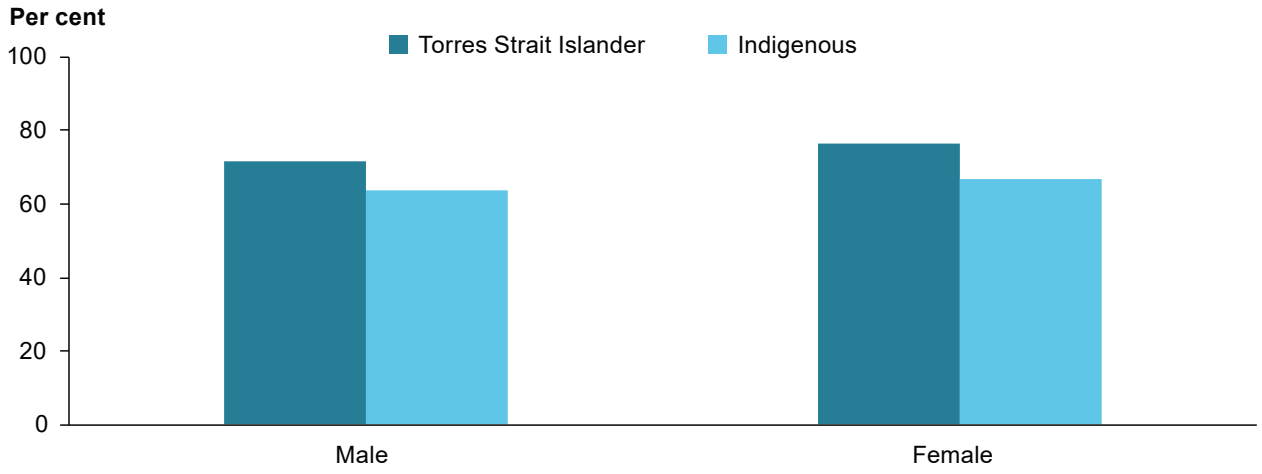
The Torres Strait Islands, defined at the ABS Statistical Area 2 level, are categorised as being *Very remote*. Of the 21,735 young Torres Strait people aged 10–24, 2,518 (12%) lived in Torres Strait regions. Around 92% (20,056) of young Torres Strait Islander people lived in Queensland, while around 8% (1,679) lived in other jurisdictions.

9.3 Social determinants

The majority have a Year 12 or equivalent school attainment level

Around 74% of Torres Strait Islander people aged 20–24 held a Year 12 or equivalent attainment. Slightly higher proportion of females held a Year 12 or equivalent attainment (76%) than males (72%) (Figure 9.3.1).

Figure 9.3.1: Proportion of young people aged 20–24 with year 12 or equivalent attainment by Indigenous status and sex, 2016

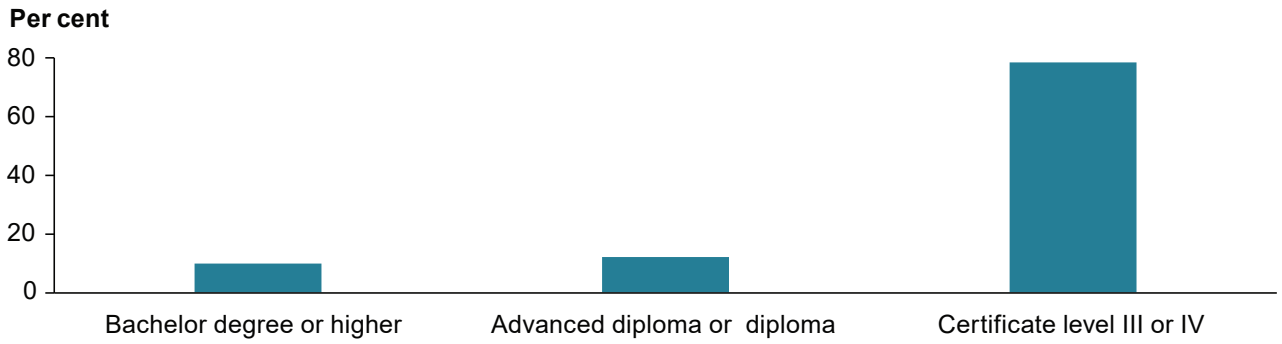


Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

Around 3 in 10 Torres Strait Islander people aged 20–24 (29%) had highest qualification attainment at the post-school level, while 71% did not.

Among those with post-school qualifications, the majority (78%) had attained Certificate III or IV level, followed by advanced diploma or diploma level (12% or 156) and bachelor degree level or higher (10% or 125) (Figure 9.3.2).

Figure 9.3.2: Torres Strait Islander people aged 20–24 with post school qualifications, by highest post-school level of attainment, 2016



Notes

1. Bachelor degree level or higher includes 'graduate diploma or graduate certificate level' and 'postgraduate degree level'.
2. There were no young Torres Strait Islander young people with a Certificate I or II as highest educational attainment.

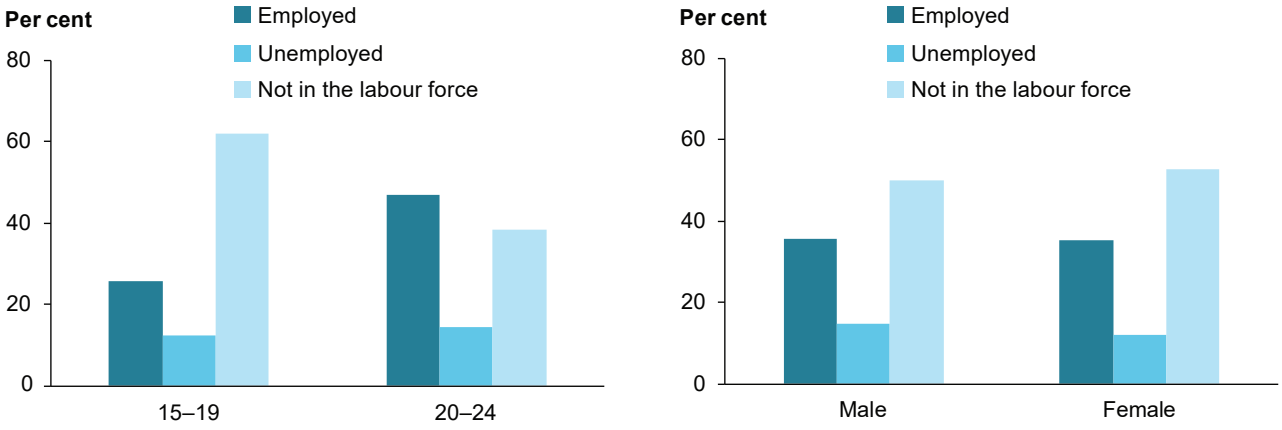
Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

Almost half are in the labour force

Over 1 in 3 (35% or 3,827) young Torres Strait Islanders aged 15–24 were employed and 13% (1,448) were unemployed. This meant that around 49% (5,277) of Torres Strait Islander youth aged 15–24 were in the labour force. The proportion who were employed increased with age, with 26% (1,514) of those aged 15–19 employed compared with 47% (2,314) of those aged 20–24 (Figure 9.3.3).

Similar proportions of males (36% or 2,005) and females (35% or 1,829) aged 15–24 were employed. A slightly higher proportion of males (15% or 829) than females (12% or 624) in this age group were unemployed (Figure 9.3.3).

Figure 9.3.3: Torres Strait Islander people aged 15–24, by labour force status, age group and sex, 2016



Note: Excludes young people for whom employment status was not stated.

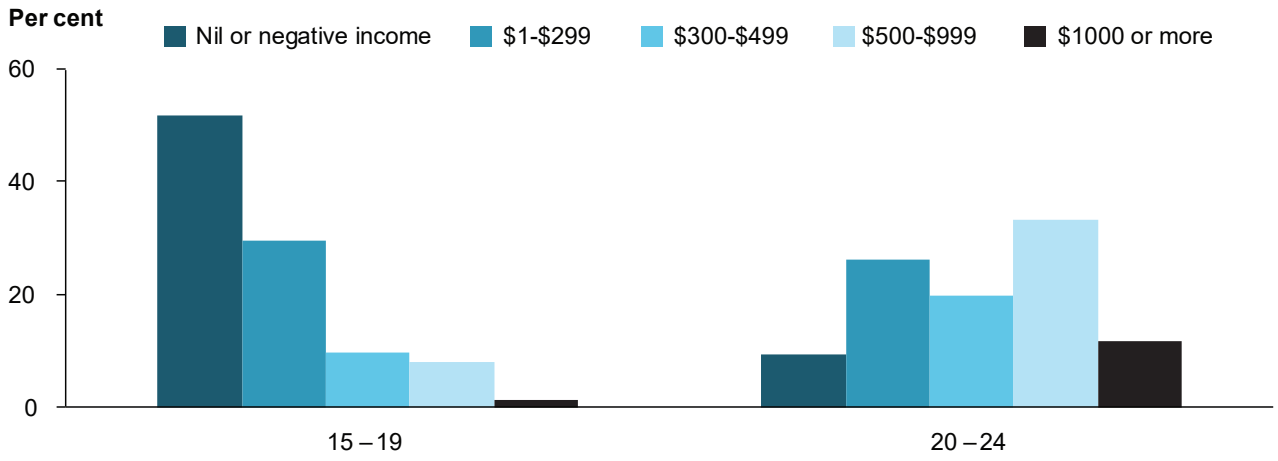
Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

Around 39% (2,947) of young Torres Strait Islander people were fully engaged in full-time work, full-time study or combining work and study, while 19% (1,405) were partially engaged in part-time work or part-time study, and 2 in 5 (43% or 3,259) were not in education, training or employment.

More females than males had a weekly income

Half of Torres Strait Islander people aged 15–19 were most likely to have no income (52% or 2,747), while the most common weekly income bracket for those aged 20–24 was $500-$999 (33% or 1,515) (Figure 9.3.4).

Figure 9.3.4: Torres Strait Islander people aged 15–24, by weekly income and age group, 2016

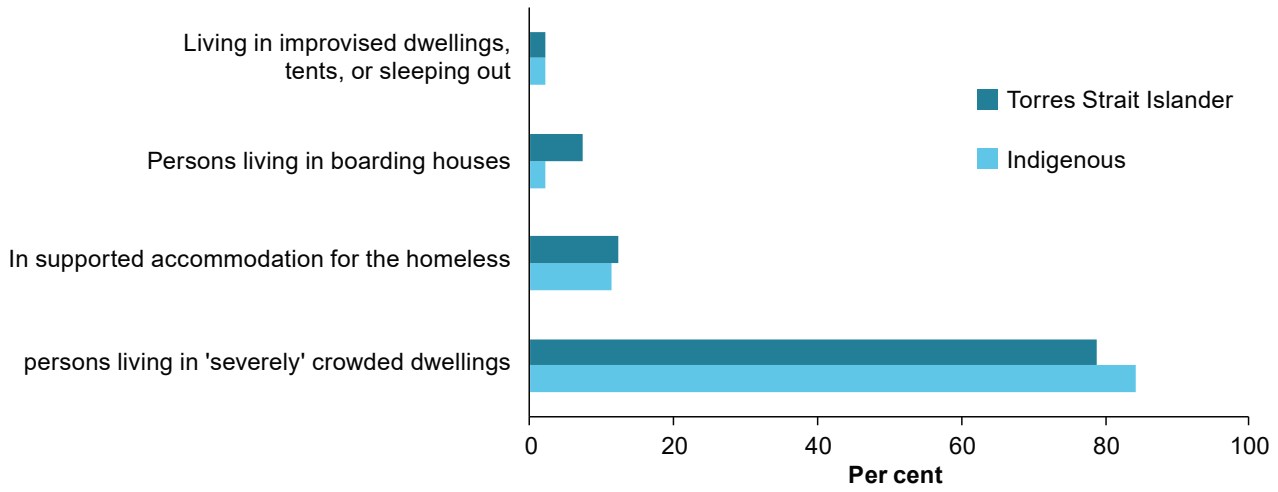


Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

Most not living in overcrowded housing

On the 2016 Census night, of all the Torres Strait Islander people aged 10–24, 3% (451) were homeless, similar to the overall Indigenous population (4% or 6,680). The most common type of homelessness for young Torres Strait Islander people was living in severely overcrowded dwellings (79% or 355) (Figure 9.3.5)

Figure 9.3.5: Young people aged 10–24, by type of homelessness and Indigenous status, 2016



Source: AIHW analysis of ABS 2016 Census (using TableBuilder).

9.4 Health risk factors

More than half do not drink, smoke or use substances

In 2014–15, more than half (56% or 7,800) of Torres Strait Islander people aged 15–24 had not consumed alcohol in the previous 2 weeks, or consumed alcohol 1 day a year or less. Similarly, more than half had never smoked (54% or 7,600) and had never used substances (58% or 7,200) in the previous 12 months (Table 9.4).

Table 9.4: Health behaviours of Torres Strait Islander and Indigenous people aged 15–24, 2014–15

	Torres Strait Islander		Indigenous	
	Number	Per cent	Number	Per cent
Alcohol consumption				
Did not exceed guidelines for single occasion risk	1,900	13.7†	16,000	11.6
Exceeded guidelines for single occasion risk	4,100	29.5†	36,300	26.4
Has not consumed alcohol in the previous 2 weeks/ drinks one day a year or less	7,800	56.1	83,800	60.9
Smoking				
Current daily smoker	4,200	30.0	42,300	30.7
Never smoked	7,600	54.3	77,200	56.1
Substance use				
Has used substances in the previous 12 months	5,500	44.4†	40,700	32.5
Has not used substances in the previous 12 months	7,200	58.1	82,600	66.6

† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: AIHW analysis of 2014–15 National Aboriginal and Torres Strait Islander Social Survey (using TableBuilder).

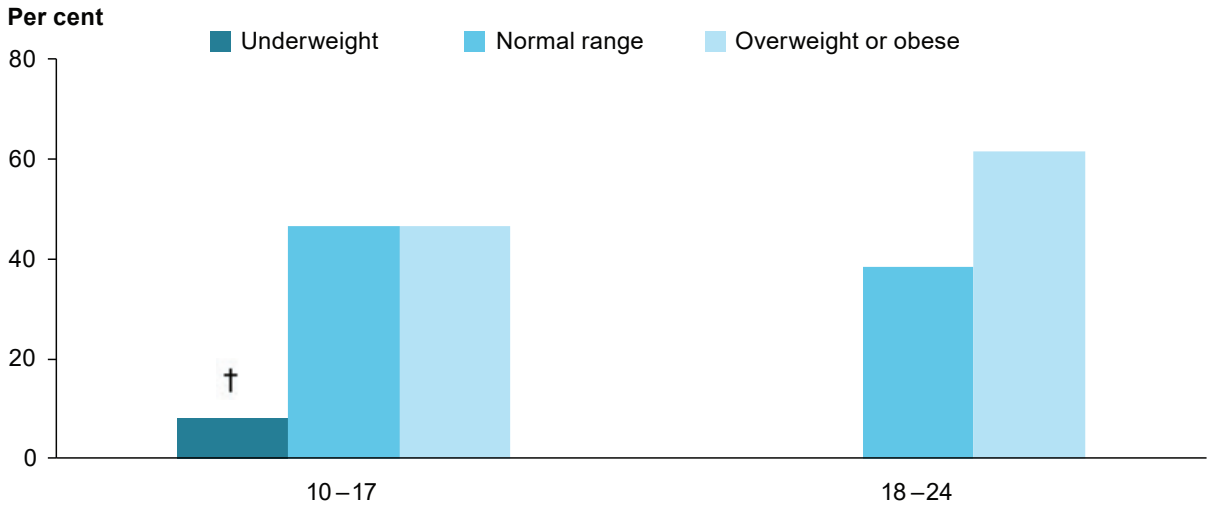
More than half met the fruit intake guidelines

More than half of young Torres Strait Islander people met the recommended fruit intake guidelines (59% or 12,800). Further details of nutritional guidelines can be found in the online tables: they are not included here due to data quality.

Younger age group more likely to be in normal weight range

Around 47% (3,500) of Torres Strait Islander people aged 10–17 and 39% (2,700) of those aged 18–24 were in the normal weight range. Those aged 18–24 were more likely to be overweight or obese (61% or 4,300) than those aged 10–17 (47% or 3,500) (Figure 9.4.1).

Figure 9.4.1: Young Torres Strait Islander people by body weight category and age group, 2012–13



† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder).

9.5 Health status and outcomes

The majority report excellent or very good health

Most young Torres Strait Islander people self-reported their health as excellent or very good (58% or 12,600) and a further 30% (6,400) reported their health as good. A clear difference by sex was evident, with just under half (48% or 5,300) of males but two-thirds (68% or 7,000) of females reporting excellent or very good health. Most Torres Strait Islander people aged 15–24 reported low or moderate psychological distress (64% or 9,000).

No disability or long-term condition for 1 in 2

Most Torres Strait Islander people aged 15–24 did not have a disability (74% or 10,400), while 22% (3,100) reported a disability. Around 54% (7,500) did not have a long-term health condition, while 43% (6,000) did have a long-term condition.

Self-reported data on the prevalence of long-term health conditions for Torres Strait Islander youth is available from the 2012–13 AATSIHS. Hospitalisation and mortality data, which provide a somewhat different picture, are also included in the following table.

Table 9.5: Top health 10 conditions for Torres Strait Islander people aged 10–24 by prevalence, hospitalisations and mortality

	Prevalence (self-report) 2012–13[a][b]			Hospitalisations[c] 2015–16			Mortality[e] 2011–2015		
Rank	Health condition	Number	Per 100 population	Principal diagnosis	Number	Per 1,000 population	Cause	Number	Per 100,000 population
1	Respiratory diseases	5,300	28.1	Injury and poisoning	733	40.8	Injury and poisoning	32	193.5
				Intentional self-harm	*89*		*Intentional self-harm*	*6*	*36.0*
2	Eye and vision problems	4,000	21.3	Factors influencing health status excluding dialysis	567	31.6	Nervous system	n.p.	n.p.
3	Heart and circulatory conditions	2,100	11.2†	Digestive diseases	367	20.4	Endocrine, nutritional & metabolic	n.p.	n.p.
4	Ear and hearing problems	1,900	10.1†	Mental/behavioural disorders	357	19.9	Symptoms, signs & abnormal findings	n.p.	n.p.
5	Signs and symptoms (including Injury long-term)	1,800	9.6	Symptoms, signs and abnormal findings	339	18.9	Infections and parasitic diseases	n.p	n.p.
6	Musculoskeletal diseases	1,800	9.6†	Respiratory diseases	221	12.3			
7	Mood (affective) problems	1,700	9.4†	Genitourinary diseases	160	8.9			
8	Endocrine, other metabolic	1,000	5.3†	Skin diseases	156	8.7			
9				Musculoskeletal	123	6.8			
10				Infectious and parasitic diseases	98	5.5			
Total	**Total health conditions**	**10,300**	**54.8**	**Total hospitalisations**	**4,542**	**252.8**	**Total mortality**	**43**	**49.0**
	Injury (short-term)[d]	*3,200*	*17*						

† Estimate has a relative standard error of 25% to 50% and should be used with caution.

Note: Prevalence data is subject to adjustments of estimates by the ABS, for the purpose of maintaining confidentiality and may result in the sums not equalling to the total.

(a) Based on long-term health conditions; That is, conditions that have lasted or are expected to last for 6 months or more.

(b) A person may have more than 1 long-term health condition.

(c) Excludes hospitalisations with a principal diagnosis of Pregnancy, childbirth (O00–O99) and not stated.

(d) Short-term injury where young people were asked as part of recent injuries, whether they had been in accidents or been hurt in the previous 4 weeks.

(e) Data for NSW, Qld, WA, SA and NT combined.

Source: AIHW analysis of 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (using TableBuilder), National Hospital Morbidity Database and National Mortality Database.

Around 45% (8,500) of young Torres Strait Islander people did not have a current or long-term health condition. In 2012–13, the most prevalent self-reported health conditions for Torres Strait Islander youth were respiratory diseases (28 per 100 or 5,300), eye and vision problems (21 per 100 or 4,000), heart and circulatory conditions (11 per 100 or 2,100) and ear and hearing problems (10 per 100 or 1,900).

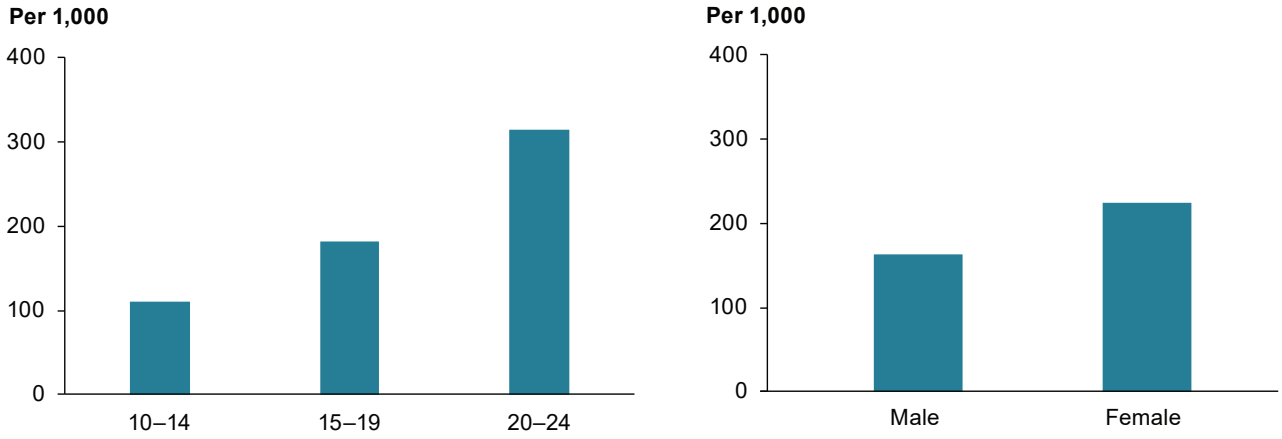
Hospitalisation rates increased with age

In 2015–16, there were 3,470 (193 per 1,000) hospitalisations (excluding the 1,072 or 24% hospitalisations for pregnancy and childbirth). The rate for young Torres Strait Islander people was higher than for total young Indigenous people (165 per 1,000).

Hospitalisation rates increased with age—young Torres Strait Islander people aged 10–14 had a rate of 110 per 1,000 population (729), those aged 15–19 had a rate of 181 per 1,000 population (1,118) and those aged 20–24 had a rate of 314 per 1,000 population (1,623) (Figure 9.5.1).

The rate of hospitalisations was higher for young Torres Strait Islander females (225 per 1,000 population or 1,973) than for males (163 per 1,000 population or 1,497) (Figure 9.5.1).

Figure 9.5.1: Hospitalisations for young Torres Strait Islander people, by age group and sex, 2015–16



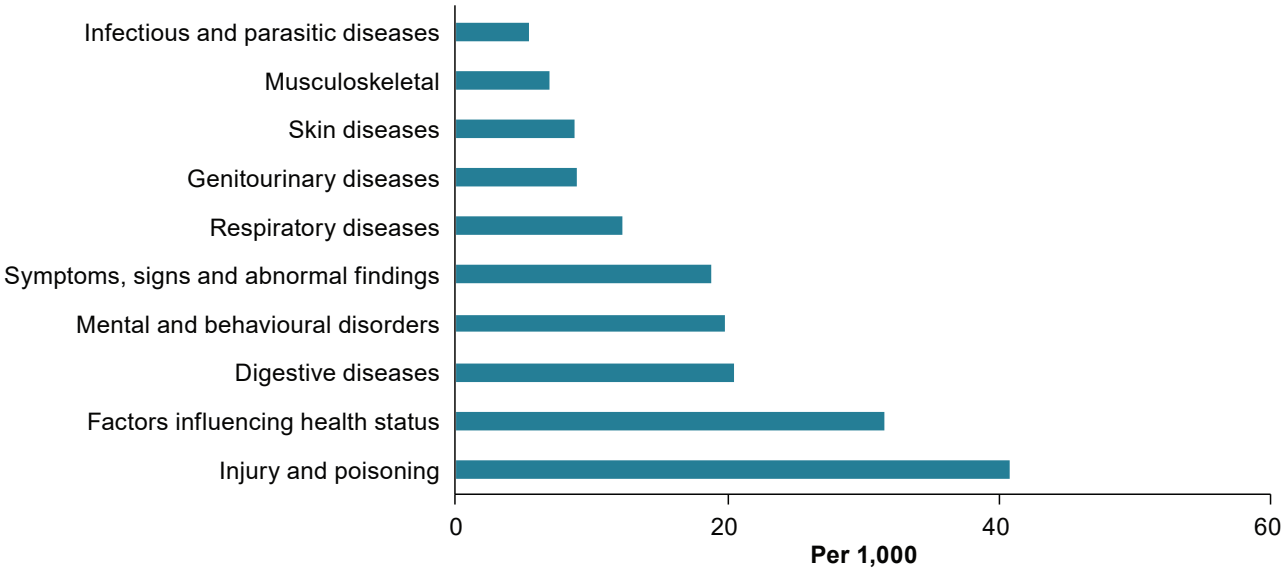
Note: Excludes hospitalisation of childbirth and pregnancy.

Source: AIHW analysis of National Hospital Morbidity Database.

Across remoteness areas, *Major cities* had the highest hospitalisation rate for Torres Strait Islander people aged 10–24 (221 per 1,000 or 1,065), followed by *Outer regional* areas (213 per 1,000 or 1,234), *Inner regional* areas (204 per 1,000 or 653), *Remote* areas (184 per 1,000 or 120) and *Very remote* areas (111 per 1,000 or 378).

The most common reason for hospitalisation (excluding pregnancy and childbirth) was injury or poisoning (41 per 1,000 or 733), followed by factors influencing health status (including examinations and procedures) (32 per 1,000 or 567), digestive diseases (20 per 1,000 or 367), mental and behavioural disorders (20 per 1,000 or 357), and symptoms, signs and abnormal findings (19 per 1,000 or 339) (Figure 9.5.2).

Figure 9.5.2: Hospitalisations for young Torres Strait Islander people, by main cause, 2015–16



Note: 'Factors influencing health status' excludes dialysis.

Source: AIHW analysis of National Hospital Morbidity Database.

The most common external causes of injury and poisoning were falls (8 per 1,000 or 141), transport accidents (6 per 1,000 or 107), assault (6 per 1,000 or 101), exposure to inanimate mechanical forces (6 per 1,000 or 99) and intentional self-harm (5 per 1,000 or 89).

Most young people visited the doctor

The majority of Torres Strait Islander people aged 10–24 had visited a doctor in the previous 12 months (79% or 11,100). Data from the 2012–13 AATSIHS shows that 75% (14,100) reported access to hospitals, and 52% (9,800) reported access to an Aboriginal Medical Service in their local area.

More than half (52% or 9,700) of young Torres Strait Islander people reported that they visited a doctor when they encountered a health problem. Almost 1 in 5 (17% or 3,100) reported attending an Aboriginal Medical Service, 9% (1,700) visited a community clinic and 7% (1,300) went to a hospital. A further 16% (3,000) reported not having a usual place to attend when encountering health problems.

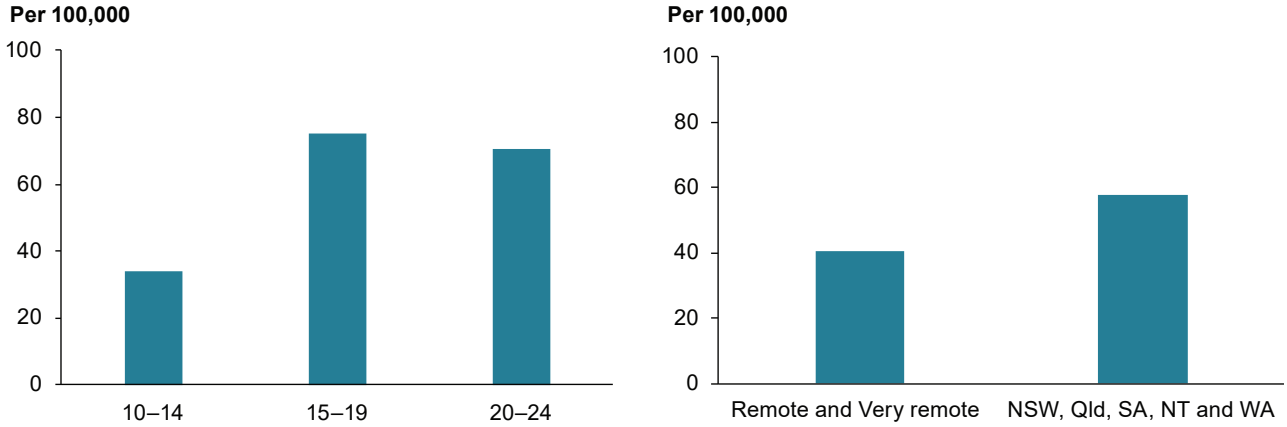
Mortality rate for males twice that of females

In 2011–2015, there were 43 deaths (58 per 100,000) among Torres Strait Islander people aged 10–24 in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined. Among these, those aged 15–19 had the highest mortality rate (75 per 100,000 or 19 deaths), followed by those aged 20–24 (71 per 100,000 or 14 deaths) and those aged 10–14 (34 per 100,000 or 10 deaths) (Figure 9.5.4).

The mortality rate for males (78 per 100,000 or 29 deaths) was almost twice that for females (39 per 100,000 or 14 deaths).

The mortality rate in *Remote* and *Very remote* areas combined was 41 per 100,000 (8 deaths), slightly lower than the rate for the 5 jurisdictions for which data can be reported (58 per 100,000 or 43 deaths) (Figure 9.5.4).

Figure 9.5.3: Mortality rates for young Torres Strait Islander people, by age group and remoteness, 2011–2015

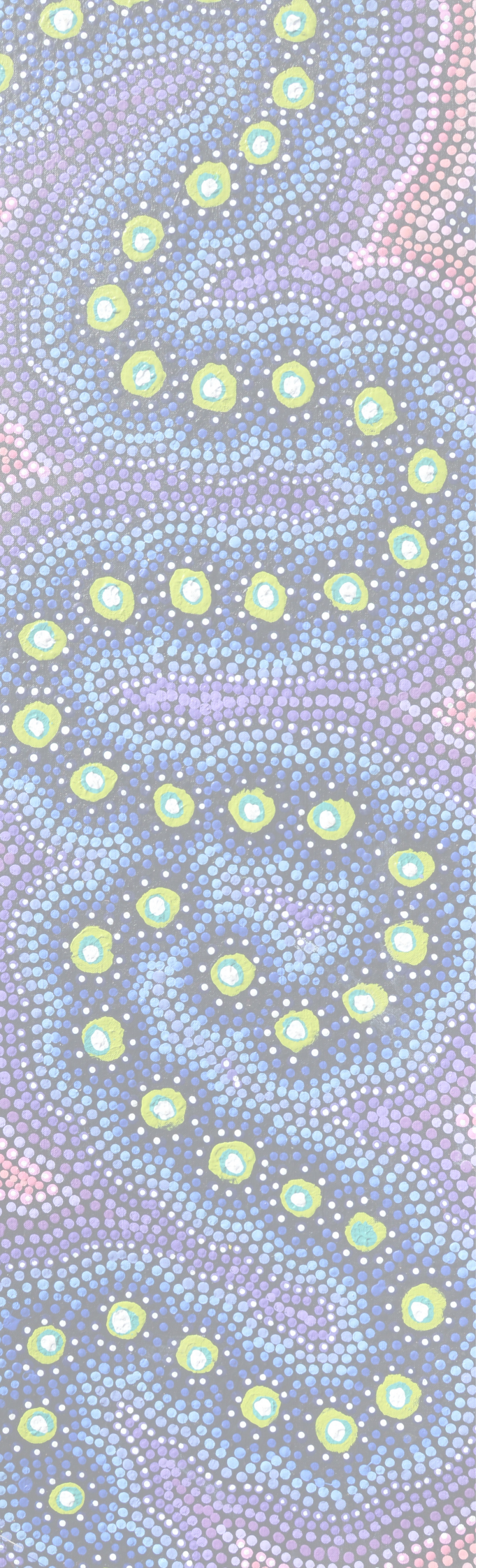


Note: 'Remote and Very remote areas' data from all jurisdictions, data for NSW, Qld, WA, SA and NT combined are for all remoteness areas.

Source: AIHW analysis of National Mortality Database.

Among states and territories, the mortality rate was highest in the Northern Territory (117 per 100,000 or 4), followed by Queensland (60 per 100,000 or 32), South Australia (52 per 100,000, number of deaths n.p.) and New South Wales (51 per 100,000 or 6 deaths).

External causes were the most common cause of death (43 per 100,000 or 32 deaths), followed by endocrine, nutritional and metabolic diseases (4 per 100,000 or 3 deaths) and nervous system diseases (4 per 100,000 or 3 deaths). Among those aged 10–24, 6 deaths (8 per 100,000) were attributed to self-harm.



Appendix A

Indicator Framework

Table A: Indicator framework

Measures	Indicator (Framework from which the indicator was derived)
	Social determinants
Education	Proportion of young people in Year 5 (9–10 years old), Year 7 (12–13 years old), Year 9 (14–15 years old) achieving at or above the national minimum standards for literacy and numeracy (NYIF, HPF)
	Year 12 retention rate among 20–24 year olds (NYIF,HPF)
Employment	Proportion of young Indigenous people in the labour force aged 15–24 (NYIF)
	Proportion of young people aged 15–24 who are not in employment, education or training (NEET) (NYIF)
	Proportion of 20–24 year olds employed in the health workforce
Income	Proportion of young people aged 15–24 receiving government income support (NYIF)
	Proportion of young people aged 10–24 living in families that are unable to raise $2000 in a week (HPF)
Housing	Proportion of young people aged 15–24 who lived in overcrowded housing (NYIF)
	Proportion of young people aged 15–24 who have experienced homelessness
Social support	Proportion of young people aged 15–24 with everyday contact with friends or family
	Proportion of young people aged 10–24 that could easily access transport (HPF)
	Proportion of young people aged 10–24 with internet access at home
	Health risk factors
Alcohol	Proportion of young people aged 15–24 who did not drink alcohol in the previous 12 months (NYIF, HPF)
Smoking	Proportion of young people aged 15–24 who have never smoked, are occasional smokers, current daily smokers or who have never smoked (NYIF, HPF)
Substance use	Proportion of young people aged 15–24 who have not used illicit substances in the previous 12 months (NYIF, HPF)
Diet	Proportion of young people aged 10–24 meeting Australian Dietary Guidelines (NYIF, HPF)
Physical activity	Proportion of young people aged 10–24 meeting National Physical Activity Guidelines (NYIF, HPF)
Overweight and obese	Proportion of young people aged 10–24 who are overweight or obese (NYIF, HPF)
Sexual health	Proportion of young males aged 18–24 who were using condoms (NYIF)
	Proportion of young females aged 18–24 who used a form of contraception (NYIF)
	Wellbeing
Language	Proportion of young people aged 10–24 learning an Indigenous language
Culture	Proportion of young people aged 10–24 that identify with a clan, tribal or language group (HPF)
Happiness	Proportion of young people aged 15–24 who were happy all or most of the time in the previous 4 weeks
Having a say	Proportion of young people aged 15–24 who felt able to have a say on important issues within their community all of the time or most of the time

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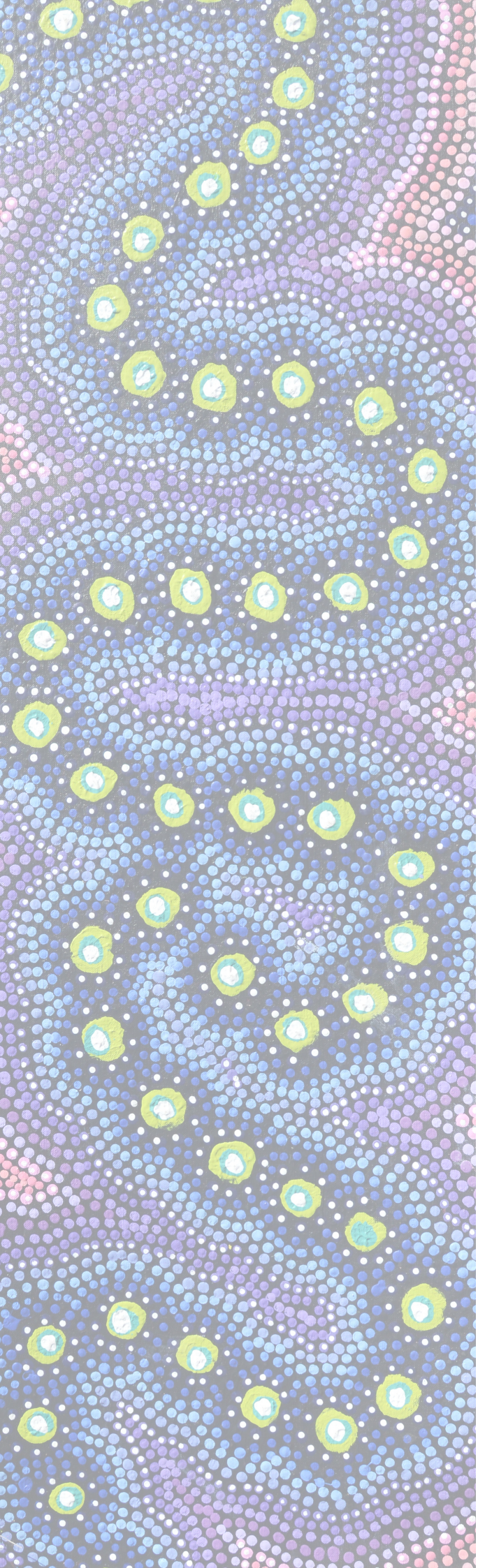
Table A (continued): Indicator framework

Measures	Indicator (Framework from which the indicator was derived)
	Wellbeing
Major stressors	Proportion of young people aged 15–24 who personally experienced a stressor in the previous 12 months
	Proportion of young people aged 15–24 who have been removed or family members have been removed (HPF)
	Proportion of young people aged 15–24 who experienced physical violence in the previous 12 months (NYIF)
Unfair treatment	Proportion of young people aged 10–24 who experienced unfair treatment in the previous 12 months because they were Aboriginal and/or Torres Strait Islander
Mental health	Proportion of young people aged 15–24 having high or very high levels of psychological distress as measured by the K5 (NYIF)
	Rate of young people aged 10–24 reporting mental health conditions (NYIF)
	Rate of deaths due to intentional self-harm for young people aged 10–24
	Health outcomes
Health status	Proportion of young people aged 10–24 with self-rated health status as excellent, very good or good (NYIF, HPF)
Burden of disease	Leading conditions contributing to the total burden of disease for young people aged 10–24
Disability	Proportion of young people aged 15–24 reporting a disability (HPF)
Hospitalisations	Rate of hospitalisations of young people aged 10–24 from all causes (HPF)
	Leading causes of hospitalisations among young people aged 10–24 (NYIF)
Mortality	Mortality rate among young people aged 10–24 from all causes of death (NYIF, HPF)
	Leading causes of mortality among young people aged 10–24 (HPF)
Health conditions	Most prevalent long-term health conditions for young people aged 10–24
	Proportion of young people reporting respiratory health problems, including asthma, among those aged 10–24 (NYIF, HPF)
	Proportion of young people reporting eye /sight problems among those aged 10–24 (HPF)
	Proportion of young people reporting injury and poisoning conditions among those aged 10–24 (NYIF, HPF)
	Proportion of young people reporting circulatory health problems among those aged 10–24 (HPF)
	Incidence rate of acute rheumatic fever among young people aged 10–24 (HPF)
	Proportion of young people reporting ear/hearing problems among those aged 10–24 (HPF)
	Proportion of young people reporting endocrine health problems among those aged 10–24
	Proportion of young people reporting infectious diseases among those aged 10–24
	Sexually transmissible infection (chlamydia, gonorrhoea infection, infectious syphilis) notification rates among those aged 10–24 (NYIF, HPF)
	Hepatitis A, B and C notification rates among young people aged 10–24 (NYIF, HPF)
	Proportion of young people reporting teeth or gum problems among those aged 10–14 (NYIF, HPF)
	Proportion of young people reporting cancer among those aged 10–24 (HPF)

continued

Table A (continued): Indicator framework

Measures	Indicator (Framework from which the indicator was derived)
	Health and welfare services
Primary health care services	Rate of young people aged 15–24 had visited a GP (Medicare) in the previous 12 months Proportion of young people aged 15–24 who had an Indigenous health check (MBS item 715) Proportion of young people aged 15–24 who had access a primary healthcare provider in the previous 12 months (HPF)
Mental health services	Proportion of young people aged 18–24 who used health services for a mental health condition (HPF)
Disability services	Number of young people aged 15–24 registered as disability support service users
Sexual health services	Proportion of young people aged 16–24 who have been tested for STIs, HIV and Hepatitis C
Screening	Proportion of young females aged 20–24 who have had cervical cancer screening (Pap smear) (NYIF)
Alcohol and other drugs services	Closed treatment episodes for young people aged 10–24 (HPF)
Homelessness services	Rate of young people who are specialist homelessness services clients (NYIF)
Child protection and out-of-home care	Rate of young people aged 10 –17 who are subject of care and protection orders (NYIF) Rate of young people aged 10–17 in out-of-home care (NYIF)
Contact with the justice system	Rate of young people aged 10–24 under juvenile justice supervision (NYIF) Rate of imprisonment of young people aged 18–24 (NYIF)
Accessing services	Proportion of young people aged 15–24 with access to public transport in their local area



Appendix B

Non-Indigenous comparisons

Table B: Indigenous and non-Indigenous comparisons for key data points

Category	Indicator or measure	Indigenous	Non-Indigenous
	Social determinants and health risk factors		
Education	Proportion of people aged 20–24 who have completed year 12 or equivalent (%)[a]	65	89
	Proportion of people in year 5, year 7 and year 9 achieving at or above the national minimum standards for literacy and numeracy (%)[b]		
	Year 5 (9–10 years old)		
	Reading	76	95
	Writing	69	93
	Spelling	78	95
	Grammar and punctuation	70	94
	Numeracy	80	96
	Year 7 (12–13 years old)		
	Reading	74	95
	Writing	60	70
	Spelling	77	94
	Grammar and punctuation	69	94
	Numeracy	80	96
	Year 9 (14–15 years old)		
	Reading	71	91
	Writing	49	84
	Spelling	71	92
	Grammar and punctuation	62	91
	Numeracy	84	97
Employment	Proportion of people aged 20–24 who are NEET	42	13
Housing	Homelessness rate for people aged 10–24 (per 100)	4	0.4
Smoking	Proportion of people aged 18–24 who (%)[c][d]		
	Have never smoked	46	70
	Current daily smokers	37	14
Alcohol	Proportion aged 18–24 who did not drink in the previous 2 weeks, or drank but did not exceed single occasion alcohol risk (%)[c][d]	65	33

continued

Table B (continued): Indigenous and non-Indigenous comparisons for key data points

Category	Indicator or measure	Indigenous	Non-Indigenous
	Health and wellbeing outcomes		
Health status	Proportion of people aged 15–24 with self-rated health status as 'Excellent' or 'Very good' (%)[c]	54	69
Hospitalisations	Hospitalisation rate for people aged 10–24 (per 1,000)	214	155
	Leading causes of hospitalisations in people aged 10–24 (per 1,000)[e]		
	Injury and poisoning	37	23
	Intentional self-harm	*5*	*2*
	Mental and behavioural disorders	20	12
	Factors influencing health status (excluding dialysis)	18	10
	Digestive disease	16	27
	Symptoms signs and abnormal findings	16	13
Psychological distress	Proportion of people aged 18–24 with high or very high levels of psychological distress (%)[c][f]	33	13
Mortality	Mortality rate for people aged 10–24, all causes of death (per 100,000)[g]	70	27
	Leading causes of death among people aged 10–24 (per 100,000)		
	Injury and poisoning	52	18
	Intentional self-harm	*29*	*7*
	Diseases of the circulatory system	4	1
	Nervous system	3	2
	Neoplasms	3	3
	Symptoms signs and abnormal findings	1	<1
	Services		
Primary health care services	Rate of MBS claims for GP services for people aged 15–24 in the previous 12 months (per 1,000)[h]	4,135	3,665
Mental health services	Proportion of people aged 15–24 using mental health services (%)[c][i]	20	18
Alcohol and other drugs services	Rate of alcohol and drug services treatment episodes of young people aged 14–24 (%)[j]	33	25
Homelessness services	Rate of people aged 10–24 who used specialist homelessness services[k]	840	117

continued

Table B (continued): Indigenous and non-Indigenous comparisons for key data points

Sources:

(a) AIHW analysis of ABS Census, 2016.

(b) ACARA 2016.

(c) AIHW analysis of National Aboriginal and Torres Strait Islander Social Survey, 2014–15 (TableBuilder).

(d) AIHW analysis of the National Health Survey, 2014–15 (TableBuilder).

(e) AIHW analysis General Social Survey, 2014 (TableBuilder).

(f) AIHW analysis of National Hospital Morbidity Database.

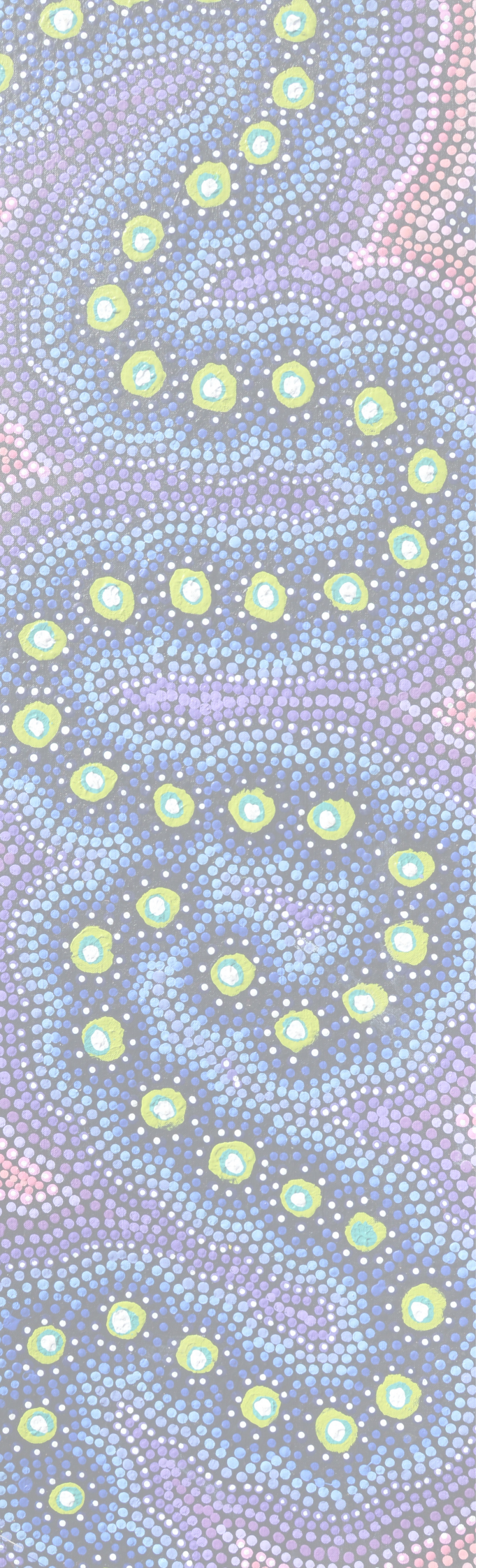
(g) AIHW analysis of National Mortality Database.

(h) AIHW analysis of Medicare data.

(i) AIHW 2017 HPF.

(j) AIHW analysis of AODTS NMDS.

(k) AIHW Specialist homelessness services, 2016–17.



Appendix C

Key data sources

Data in this report come from administrative data sets and surveys, both of which have limitations to their use in understanding the health and wellbeing of Indigenous youth. Administrative data sets have excellent coverage of the relevant population but the information gathered is often a by-product of service provision rather than purposely aligned with specific research questions. Survey data are designed with specific research questions in mind and may therefore provide insight that administrative data cannot. Survey data are however, collected from only a segment of the population and for this reason results are subject to sampling error. Information about the strengths and weaknesses of key data sources used in this report is provided below.

ABS surveys

This report incorporates data from ABS surveys using its TableBuilder© product. The ABS notes that TableBuilder© estimates have been rounded and that discrepancies may occur between sums of the component items and totals. This is due to cells in tables being randomly adjusted to avoid the release of confidential data.

Where relevant, and consistent with ABS reporting, survey estimates presented in this report that have large relative standard errors have been footnoted (see supplementary tables) to indicate this and note that the data should be used with caution or are generally considered too unreliable for use.

2012–13 Australian Aboriginal and Torres Strait Islander Health Survey

The 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) included a sample of 12,000 Indigenous Australians for the core sample and sub-samples for various components of the survey such as voluntary biomedical data for adults. The AATSIHS sample was specifically designed to select a representative sample of Indigenous Australians and therefore overcome the problem inherent in most national surveys (that is, small and unrepresentative Indigenous samples).

Responses provided as part of the AATSIHS, such as dietary behaviour, body mass, smoking and physical activity, are self-reported. As such, estimates may differ from true population values. Interviews were conducted with Indigenous persons aged 15–17 themselves when parent or guardian consent was provided. For those aged 14 or younger, proxy interviews were conducted. Where possible, the proxy was the individual's parent or guardian but otherwise the proxy was a close relative or other household member with responsibility for the child.

To infer results for the total in–scope population, a population weighting was applied by the ABS to produce AATSIHS estimates. The ABS provides the relative standard error (RSE) for the estimates it produces based on AATSIHS data. The RSE is a measure of sampling error (the expected random difference between the sample estimate and the true value) for a given estimate. Supplementary tables for this report include notes provided by the ABS to indicate where the RSE for an estimate warrants interpretation with caution or where the estimate maybe unreliable.

ABS Data quality:
<http://www.abs.gov.au/ausstats/abs@.nsf/PrimaryMainFeatures/4727.0.55.002?OpenDocument>.

2014–15 National Aboriginal and Torres Strait Islander Social Survey

The NATSISS is specifically designed to select a representative sample of Indigenous Australians. It is conducted in all states and territories and includes Remote and Non-remote areas.

For the 2014–15 survey 8,235 dwellings were approached for an interview as part of NATSISS collection processes. Around 80% of these responded fully or adequately (meaning at least 1 person completed their interview). A total of 6,661 dwellings were sampled and 11,178 interviews were completed. The ABS estimates a 6% under coverage of Indigenous persons in scope for the NATSISS. Enumeration was not used, but the final sample was weighted to population benchmarks to account for these exclusions.

Up to 3 randomly selected Indigenous Australians were chosen from selected households to participate in the survey. As part of NATSISS data collection, personal interviews were conducted with selected Indigenous persons aged 15 and over. For those aged 15–17, permission from a parent or guardian was required. For those aged under 15, proxy interviews were used. Parents or guardians were the preferred proxies. If they were not available, other close relatives or household members were used as proxies. Information recorded in this survey is 'as reported' by respondents, and therefore may differ from information available from other sources or collected using different methodologies.

As with other surveys, the NATSISS is subject to sampling and non-sampling errors. The ABS provides the relative standard error (RSE) for the estimates it produces based on NATSISS data. The RSE is a measure of sampling error (the expected random difference between the sample estimate and the true value) for a given estimate. Supplementary tables for this report include notes provided by the ABS to indicate where the RSE for an estimate warrants interpretation with caution or where the estimate may be unreliable.

ABS data quality:
<http://www.abs.gov.au/ausstats/abs@.nsf/PrimaryMainFeatures/4720.0?OpenDocument>.

2016 Census of Population and Housing

The Census uses the standard Indigenous status question and it is asked for each household member. There are 4 principal sources of error in Census data: respondent error, processing error, partial response and undercount. Quality management of the Census program aims to reduce error as much as possible, and to provide a measure of the remaining error to data users, to allow them to use the data in an informed way.

One household member on behalf of others may complete the Census form. Incorrect answers can be introduced to the Census form if the respondent does not understand the question or does not know the correct information about other household members. Many of these errors remain in the final data.

When completing their Census form, some people do not answer all the questions that apply to them. In these instances, a 'not stated' code is allocated during processing, with the exception of non-response to age, sex, marital status and place of usual residence. These variables are needed for population estimates, so they are imputed using other information on the Census form, as well as information from the previous Census.

Australian standard classifications were used, where available and appropriate, to provide data comparability across statistical collections. These include, for example, standards for occupation and geographic areas.

Administrative data sources

This report includes data from various national administrative data collections. The quality of the Indigenous data varies across these collections. Indigenous identification is, however, generally more complete in *Remote* and *Very remote* areas.

National Hospital Morbidity Database

Data about hospitalisations were extracted from the AIHW NHMD, which is a compilation of episode-level records from admitted patient care data collection systems in Australian hospitals in each state and territory. The NHMD is based on data provided to the AIHW by state and territory health authorities for the national minimum data set (NMDS) for admitted patient care. The AIHW collects and reports the NHMD under the auspices of the Australian Health Ministers' Advisory Council, through the National Health Information Agreement. The NHMD contains episode-level records from admitted patient morbidity data collection systems in Australian public and private hospitals and includes administrative, demographic and clinical data. Data are based on financial years.

Data are a count of hospitalisations (episodes of admitted patient care, which can be a total hospital stay, or a portion of a hospital stay that begins or ends in a change of type of care) and not patients. Patients who separated from hospital more than once in the year will be counted more than once in the data set. The number and pattern of hospitalisations can be affected by differing admission practices among the jurisdictions and from year to year, and differing levels and patterns of service delivery.

Data on diagnoses are recorded using the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD–10–AM, 9th edition). Information on procedures was recorded using the Australian Classification of Health Interventions.

NHMD data presented by state and territory and remoteness area in this report are based on the patient's place of usual residence. For analyses by remoteness area, the NHMD data for 2012–13 onwards were classified according to the Australian Statistical Geography Standard; earlier years were classified according to the Australian Standard Geographical Classification.

There is some under-identification of Indigenous Australians in the NHMD, but NHMD data for all states and territories are considered to have adequate Indigenous identification from 2010–11 onwards. Changes in the accuracy of Indigenous identification in hospital records will result in changes in the reported number of hospitalisations for Indigenous Australians. Caution should be used when interpreting changes over time, as it is not possible to ascertain whether a change in reported hospitalisations is due to changes in the accuracy of Indigenous identification and/or real changes in the rates at which Indigenous Australians were hospitalised. An increase in hospitalisation rates for a particular population might also reflect higher use of admitted patient hospital services—as opposed to other forms of health care—rather than a worsening of health.

Rehabilitation care principal diagnosis

Changes to the Australian Coding Standard for Rehabilitation (ACS 2014), introduced from 1 July 2015 in the 9th edition of ICD–10–AM, mean that Z50.—Care involving the use of rehabilitation procedures (which was previously required to be coded as the principal diagnosis) is now an 'Unacceptable principal diagnosis'. The change to the ACS means that the 'reason' for rehabilitation will now be identified using the principal diagnosis (rather than as the first additional diagnosis). Therefore, between 2014–15 and 2015–16, there were increases in principal diagnoses reported for *S00–T98 Injury, poisoning* and certain other consequences of external causes.

External causes

The external cause classification (Chapter 20 of ICD-10-AM) is hierarchical, consisting of 397 3-character categories (including place of occurrence and activity when injured). In this report, the first reported external cause was used.

A data quality statement for the NHMD is available at <http://meteor.aihw.gov.au/content/index.phtml/itemId/611030>.

National Mortality Database

The AIHW National Mortality Database (NMD) contains information provided by the registries of births, deaths and marriages and the National Coronial Information System (coded by the ABS), for deaths from 1964 to 2016. Registration of deaths is the responsibility of each state and territory's registry of births, deaths and marriages. These data are then collated and coded by the ABS and are maintained at the AIHW in the NMD.

Almost all deaths are recorded; however, the Indigenous status of the deceased is not always reported/recorded or recorded correctly. This means that Indigenous deaths are often an underestimate of the deaths occurring in the Indigenous population.

In this report, mortality data are reported for 5 states and territories combined—New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. Other states and territories have a small number of Indigenous deaths, and identification of Indigenous deaths in their death registration systems is relatively poor, making the data less reliable. The AIHW considers the quality of Indigenous identification in mortality data for the 5 states and territories to be adequate from 1998; thus trend data are shown in this report from that year onwards.

Due to the small number of Indigenous youth deaths, mortality data for the most recent period are presented in the 5–year period 2011–2015 to allow for reporting of cause of death data by age and sex. Deaths registered in 2013 and earlier are based on final version of cause of death data, while those from 2014 and 2015 are based on revised and preliminary data, respectively. Revised and preliminary data are subject to further revision by the Australian Bureau of Statistics (ABS). In this report, mortality data are based on the year of registration of the death.

The data quality statements underpinning the AIHW NMD can be found on the following ABS internet pages:

- ABS quality declaration summary for Deaths, Australia (ABS cat. no. 3302.0) <http://www.abs.gov.au/ausstats/abs%40.nsf/mf/3302.0>.
- ABS quality declaration summary for Causes of death, Australia (ABS cat. no. 3303.0) <http://www.abs.gov.au/ausstats/abs%40.nsf/mf/3303.0>.

For more information on the AIHW NMD, see *Deaths data at AIHW* <https://www.aihw.gov.au/about-our-data/how-we-use-our-data/deaths-data>.

National Perinatal Data Collection

The National Perinatal Data Collection (NPDC) 2016 is a national population-based cross-sectional collection of data on pregnancy and childbirth. The data are based on births reported to the perinatal data collection in each state and territory in Australia. Midwives and other birth attendants complete notification forms for each birth using information obtained from mothers and from hospital or other records. A standard de-identified extract is provided to the AIHW annually.

In this report, per cents based on denominators of less than 100 have been suppressed for reliability reasons. Per cent values are calculated after excluding records with missing values and so care must be taken when interpreting percentages. Due to differences in definitions and methods used for data collection, care must be taken when comparing across jurisdictions.

A data quality statement for the NPDC is available at <http://meteor.aihw.gov.au/content/index.phtml/itemId/693978>.

Child Protection National Minimum Data Set

The Child Protection National Minimum Data Set (2015–16) pertains to all children who were involved in any component of the child protection system throughout Australia in 2015–16. Children and young people are defined as those aged less than 18 years, including unborn children in jurisdictions where they are covered under the child protection legislation.

The data relate to notifications, investigations and substantiations, children on care and protection orders, living arrangements for children under care (including children in funded out-of-home care and/or on orders), carers who were authorised to provide home-based out-of-home care placements, National Out-of-Home Care Standards (i.e. children and young people aged 0–17 years whose care arrangements were ordered through the Children's Court, where parental responsibility for the child or young person was transferred to the Minister/Chief Executive), and siblings.

Juvenile Justice National Minimum Data Set

The Juvenile Justice National Minimum Data Set 2015–16 (JJ NMDS) contains information on young people in Australia who were supervised by youth justice agencies because they were alleged or proven to have committed an offence. The JJ NMDS is the only national collection of youth justice data.

The AIHW compiles the JJ NMDS each year using data extracted from the administrative systems of the state and territory departments responsible for youth justice.

There are a number of data quality and coverage limitations specific to each state and territory. The Northern Territory did not provide JJ NMDS data for 2008–09 to 2015–16. Estimates for the Northern Territory are used in the calculation of national totals for 2008–09 to 2010–11. Additional information on how these totals are calculated is available at <http://www.aihw.gov.au/youth-justice/data-quality/>.

South Australian data may vary from that reported in previous years due to improvements in data quality and assurance. In Tasmania, data are available only from 2006–07 onwards. In the Australian Capital Territory, data prior to 2003–04 are not available, and data for 2003–04 to 2007–08 are available only in JJ NMDS 2007 format. In New South Wales, data on young people in the Kariong Juvenile Correctional Centre between November 2004 and May 2015 are not included.

Alcohol and other Drug Treatment Services National Minimum Data Set

The AODTS NMDS is an AIHW national collection of administrative data from government-funded alcohol and other drug treatment services. It includes information about the services; the clients who use these services; the drugs for which treatment is sought, and the types of treatment provided. The data are based on closed episodes of treatment (not number of clients) provided to clients by alcohol and other drug treatment services.

In NSW, there were a number of data collection systems in use and development during this period (2012–13 to 2015–16). The New South Wales Minimum Data Set was collected by the systems from which the collection of the AODTS NMDS was provided to the AIHW. New South Wales developed a Drug and Alcohol State Baseline Build Information System for use by government agencies. Note that not all NSW government agencies and Local Health Districts LHDs) will migrate to the new system. During the 2014–15 and 2015–16 collection cycles, a number of NSW LHDs migrated to this system, leaving a small number of LHDs still to migrate. There was some difficulty reporting data due to ongoing implementation. The data in NSW may be under-reported for 2014–15 and 2015–16.

Indigenous people are under-represented in the AODTS NMDS. The Australian Government funds Indigenous specific organisations to provide substance-use services primarily to Indigenous Australians. These services are in scope for the AODTS NMDS; however, most do not contribute to the data collection as they currently provide data to the Online Services Report (OSR) data collection. The OSR and AODTS NMDS have different collection purposes, scope and counting rules.

National Notifiable Disease Surveillance System data

The NNDSS data includes only cases for which health care was sought, a test conducted and a diagnosis made, followed by a notification to health authorities. There are over 70 notifiable diseases in Australia. The data provided were extracted from the NNDSS on 13 February 2018. Due to the dynamic nature of the NNDSS, data in this extract are subject to retrospective revision and may vary from data reported in published NNDSS reports and reports of notification data by states and territories.

These notification data represent only a proportion of the total cases occurring in the community, that is, only those cases for which health care was sought, a test conducted and a diagnosis made, followed by a notification to health authorities. The degree of under-representation of all cases is unknown and is most likely variable by disease and state and territory.

Indigenous status is usually obtained from medical notification and completeness varies by disease and by state and territory. This reflects differences in notification requirements (i.e. depending on the state and territory, some diseases are primarily or completely notified by pathology laboratories rather than clinicians) and the fact that it is not possible to follow–up all cases for diseases with a large volume of notifications and/or not requiring specific case–based public health action.

In Tasmania, laboratory notifications do not have information on Indigenous status, so on initial reporting the default category is “not stated”. When enhanced data questionnaires are returned, this field may be updated. If the clinician has ticked indigenous status as unknown the indigenous status remains as “not stated”.

In Victoria, about 70% of the total hepatitis B and C notifications comes from laboratories only—Indigenous status is not a legislated data field by laboratories. All newly acquired cases are followed up for newly acquired hepatitis B and C, and Indigenous status is completed for approximately 80% of the cases.

Specialist Homelessness Services Collection

The SHSC data cubes were used for this report; they are a subset of the confidentialised and weighted SHSC dataset. The data cubes currently contain SHSC data for the 2011–12 to 2016–17 financial years. The data are split into a series of 4 cubes to ensure that client confidentiality is retained in accordance with legislation and agreements supporting the data collection, while at the same time maximising functionality for cube users.

The counting unit for these data cubes is weighted clients. The SHSC collects data about support periods and certain information captured about the client is used to construct a statistical linkage key that brings together all data about each client (who could have multiple support periods) and their outcomes. To maintain confidentiality, age is not published (n.p.) for some clients in all 4 data cubes. While client totals will match those in the SHSC annual report supplementary tables, totals for individual age groups may not match due to this suppression.

All client counts are weighted using a client weight. The use of client weights adjusts for agency non-response and data error in the statistical linkage key. The applied weighting methodology results in estimated client figures that are not whole numbers. As a result, all counts are rounded to the nearest whole number and client numbers in separate components may not add to the total due to rounding errors.

Glossary

Aboriginal or Torres Strait Islander: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander. See also **Indigenous**.

administrative data collection: A data set that results from the information collected for the purposes of delivering a service or paying the provider of the service. This type of collection is usually complete (that is, all in-scope events are collected), but it may not be fully suitable for population-level analysis because the data are collected primarily for an administrative purpose. An example is the Alcohol and Other Drug Treatment Services National Minimum Data Set.

admitted patient: A patient who undergoes a hospital's formal admission process.

asthma: A common, chronic inflammatory disease of the air passages that presents as episodes of wheezing, breathlessness and chest tightness due to widespread narrowing of the airways and obstruction of airflow. The symptoms may reverse without treatment, but often treatment is required. Different medications can prevent the episodes or relieve them.

Australian Statistical Geography Standard (ASGS): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGS replaced the Australian Standard Geographical Classification (ASGC) in July 2011.

body mass index (BMI): The most commonly used method of assessing whether a person is of normal weight, underweight, overweight or obese. It is calculated by dividing the person's weight (in kilograms) by their height (in metres) squared.

burden of disease and injury: Term referring to the quantified impact of a disease or injury on an individual or population, using the disability-adjusted life year (DALY) measure.

cancer: Cancer, also called malignancy, is a term for diseases in which abnormal cells divide without control and can invade nearby tissues. Cancer cells can also spread to other parts of the body through the blood and lymph systems.

cardiovascular disease: Any disease of the circulatory system, namely the heart (cardio) or blood vessels (vascular). Includes heart attack, angina, stroke and peripheral vascular disease. Also known as circulatory disease.

care type: The care type defines the overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care).

care and protection orders: Legal orders or arrangements that give child protection departments some responsibility for a child's welfare. The level of responsibility varies with the type of order or arrangement. These orders include guardianship and custody orders, third-party parental responsibility orders, supervisory orders, interim and temporary orders, and other administrative arrangements.

cause of death: The causes of death entered on the Medical Certificate of Cause of Death are all diseases, morbid conditions or injuries that either resulted in or contributed to death, and the circumstances of the accident or violence that produced any such injuries. Causes of death are commonly reported by the underlying cause of death.

chlamydia: The most common sexually transmissible infection in Australia, caused by the bacterium *Chlamydia trachomatis*.

clan, tribal group or language group: A group of Aboriginal and/or Torres Strait Islander people who share a common language and/or clan or tribal membership.

communicable diseases (infectious diseases): Diseases or illnesses due to infectious organisms or their toxic products. Communication may occur directly or indirectly through contact with other humans, animals or other environments that harbour the organism.

DALY: See **disability-adjusted life year**.

diabetes (diabetes mellitus): A chronic condition in which the body cannot properly use its main energy source, the sugar glucose. This is due to a relative or absolute deficiency in insulin, a hormone that is produced by the pancreas and helps glucose enter the body's cells from the bloodstream and then be processed by them. Diabetes is marked by an abnormal build–up of glucose in the blood, and it can have serious short-and long-term effects.

disability: An umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation. Disability is a multidimensional concept, and is considered as an interaction between health conditions and the environment.

disability-adjusted life year (DALY): A year of healthy life lost, either through premature death or equivalently through living with disability due to illness or injury. It is the basic unit used in burden of disease and injury estimates.

disease: A physical or mental disturbance involving symptoms (such as pain or feeling unwell), dysfunction or tissue damage, especially if these symptoms and signs form a recognisable clinical pattern.

dwelling: A structure or a discrete space within a structure intended for people to live in, or where a person or group of people live. Thus, a structure that people live in is a dwelling regardless of its intended purpose, but a vacant structure is only a dwelling if intended for human residence. A dwelling may include 1 or more rooms used as an office or workshop, provided the dwelling is in residential use.

estimated resident population (ERP): The official Australian Bureau of Statistics estimate of the Australian population. The ERP is derived from the 5-yearly Census counts, and is updated quarterly between censuses.

external cause: The environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.

hospitalisation: Synonymous with separation; that is, an episode of hospital care that starts with the formal admission process and ends with the formal separation process. An episode of care can be completed by the patients being discharged, transferred to another hospital or care facility, or dying, or by a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation).

household: A group of 2 or more related or unrelated people who usually reside in the same dwelling, and who make common provision for food or other essentials for living. Or a single person living in a dwelling who makes provision for his or her own food and other essentials for living, without combining with any other person.

HPV (human papillomavirus): The virus that causes genital warts and which is linked in some cases to the development of more serious cervical cell abnormalities.

immunisation: Inducing immunity against infection by the use of an antigen to stimulate the body to produce its own antibodies. See vaccination.

incidence: The number of new cases (of an illness or event, and so on) occurring during a given period. Compare with **prevalence**.

Indigenous: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander. See also **Aboriginal or Torres Strait Islander**.

Indigenous household: One which contains one or more Indigenous Australians.

Indigenous status: Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin.

influenza (flu): An acute contagious viral respiratory infection marked by fevers, muscle aches, headache, cough and sore throat.

Kessler-5: A measure of psychological distress which is based on responses to a subset of 5 questions from the full Kessler Psychological Distress Scale, which has 10 questions. A high score indicates that the person may be experiencing feelings of anxiety or depression on a regular basis, whereas a low score indicates that the person is experiencing these feelings less frequently or not at all.

life course: The life course is a series of life stages that people are normally expected to pass through as they progress from birth to death.

life expectancy: An indication of how long a person can expect to live, depending on the age they have already reached. Technically, it is the number of years of life remaining to a person at a particular age if death rates do not change. The most commonly used measure is life expectancy at birth.

lifetime risk (alcohol): Defined as the accumulated risk from drinking either on many drinking occasions, or on a regular (for example, daily) basis over a lifetime. The lifetime risk of harm from alcohol-related disease or injury increases with the amount consumed.

Medicare: A national, government-funded scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care. The Medicare Benefits Schedule (MBS) is the listing of the Medicare services subsidised by the Australian Government. The schedule is part of the wider Medicare Benefits Scheme (Medicare).

mental illness: Disturbances of mood or thought that can affect behaviour and distress the person or those around them, so the person has trouble functioning normally. They include anxiety disorders, depression and schizophrenia.

morbidity: Refers to ill health in an individual and to levels of ill health in a population or group.

mortality: Death.

non-Indigenous: People who have declared they are not of Aboriginal or Torres Strait Islander descent.

out-of-home care: Alternative overnight accommodation for children and young people aged under 18 who are unable to live with their parents, where the child protection department makes (or offers) a financial payment. Children in out-of-home care can be placed in a variety of living arrangements, including foster care, relative/kinship care and residential care.

prevalence: The number or proportion (of cases, instances, and so forth) in a population at a given time. Compare with incidence.

principal diagnosis: The diagnosis established after study to be chiefly responsible for occasioning an episode of patient care (hospitalisation), an episode of residential care or an attendance at the health care establishment.

rate: A rate is one number (the numerator) divided by another number (the denominator).The numerator is commonly the number of events in a specified time. The denominator is the population 'at risk' of the event. Rates (crude, age-specific and age-standardised) are generally multiplied by a number such as 100,000 to create whole numbers.

rheumatic fever: An acute, serious disease that affects mainly children and young adults and can damage the heart valves, the heart muscle and its lining, the joints and the brain. Is brought on by a reaction to a throat infection by a particular bacterium. Now very rare in the non–Indigenous population, it is still at unacceptably high levels among Indigenous Australians living in remote areas. See **rheumatic heart disease**.

rheumatic heart disease: Chronic disease from damaged heart valves caused by earlier attack(s) of rheumatic fever.

separation: The formal process where a hospital records the completion of an episode of treatment and/or care for an admitted patient. In this report, described by the term **hospitalisation**.

sexually transmissible infection: An infectious disease that can be passed to another person by sexual contact. Notable examples include chlamydia and gonorrhoea.

single occasion risk (alcohol): A single occasion is defined as a sequence of drinks taken without the blood alcohol concentration reaching zero in between. The risk of an alcohol-related injury arising from a single occasion of drinking increases with the amount consumed.

social determinants of health: The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

Torres Strait Islander: A person of Torres Strait Islander descent who identifies as a Torres Strait Islander and is accepted as such by the community in which he or she lives.

vaccination: The process of administering a vaccine to a person to produce immunity against infection. See **immunisation**.

vector: An insect or other organism that transmits infectious micro-organisms from animal to human or human to human.

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The Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018 report provides comprehensive data on the health and wellbeing of Indigenous people aged 10–24. Information on health and wellbeing outcomes, health determinants, risk factors, and health and welfare service use for Indigenous youth are included. Data are disaggregated by age group, sex, state and territory and remoteness areas, as well as trend information. The report also examines differences between young Indigenous and non-Indigenous people on key health and wellbeing measures.

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