

The state of Victoria's children report 2011

A report on how children and young
people in rural and regional Victoria
are faring



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Cover artwork by Ethan, Grade 4
Maiden Gully Primary School

Ministerial foreword

Victoria's rural and regional communities are great places for children to develop and grow.

Children and young people in rural and regional Victoria enjoy high levels of community support and participation, particularly when it comes to volunteering, sport and other activities.

At the same time, rural and regional children face a range of social, economic and environmental challenges which may impact on their health, wellbeing, learning and development.

This report brings together the most recently available data from Victorian government departments and other relevant research to document how rural and regional children and young people are faring. It also notes key policies, programs and initiatives that are already on the right track in supporting children, young people and their families across Victoria.

This data and research will be a valuable resource for guiding future policy development across all levels of government and will assist service providers, non government organisations and communities in the development of effective and practical responses to issues identified.

This is the first time that information has been compiled and analysed in this way and I have no doubt that this report will assist in what must be our constant endeavour, the welfare of all of our children.



Hon Wendy Lovell, MLC
Minister for Children and
Early Childhood Development

Acknowledgements

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We are grateful to the Project Steering Group for their guidance, including members from across Victorian government and colleagues from the Youth Affairs Council of Victoria (YACVic), the Municipal Association of Victoria (MAV) and the Centre for Multicultural Youth (CMY).

We are particularly grateful to the children and young people who shared their experiences of living in rural and regional Victoria through creative responses, including the artwork that illustrates the report. We would also like to thank their teachers and parents for their support of these creative projects. We were unable to publish all the work that we received but were immensely impressed by the quality of the contributions.

Our thanks also go to our colleagues in government and in the Victorian community who provided examples of good practice and community achievements for inclusion in the report.

The development and production of the report was led by the Research and Analysis Division in the Department of Education and Early Childhood Development.

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Executive summary

Introduction

This state of Victoria's children report presents the first consolidated discussion of outcomes for children, young people and their families living in rural and regional Victoria. It builds on previous reports to enable a more thorough investigation of strengths and challenges in regional Victoria, and provides government and the community with a sound basis for future action.

Rural and regional Victoria has major advantages associated with strong communities, community connectedness, participation and engagement and high levels of social capital. However, at the same time, it faces a range of social, economic and environmental challenges, which impact on outcomes for children, young people and their families.

This report brings together data and evidence from a breadth of robust sources, providing a statistical view on how rural and regional children and young people are faring against key indicators of health, safety, development, learning and wellbeing. It aims to:

- identify how outcomes for children and young people differ *between* rural and regional and metropolitan Victoria, and *within* rural and regional Victoria
- explore factors that may be influencing observed disparities in outcomes for children and young people
- understand *whether* and *how* rural and regional children and young people may be *disproportionately* affected by poorer outcomes, when compared with their metropolitan peers.

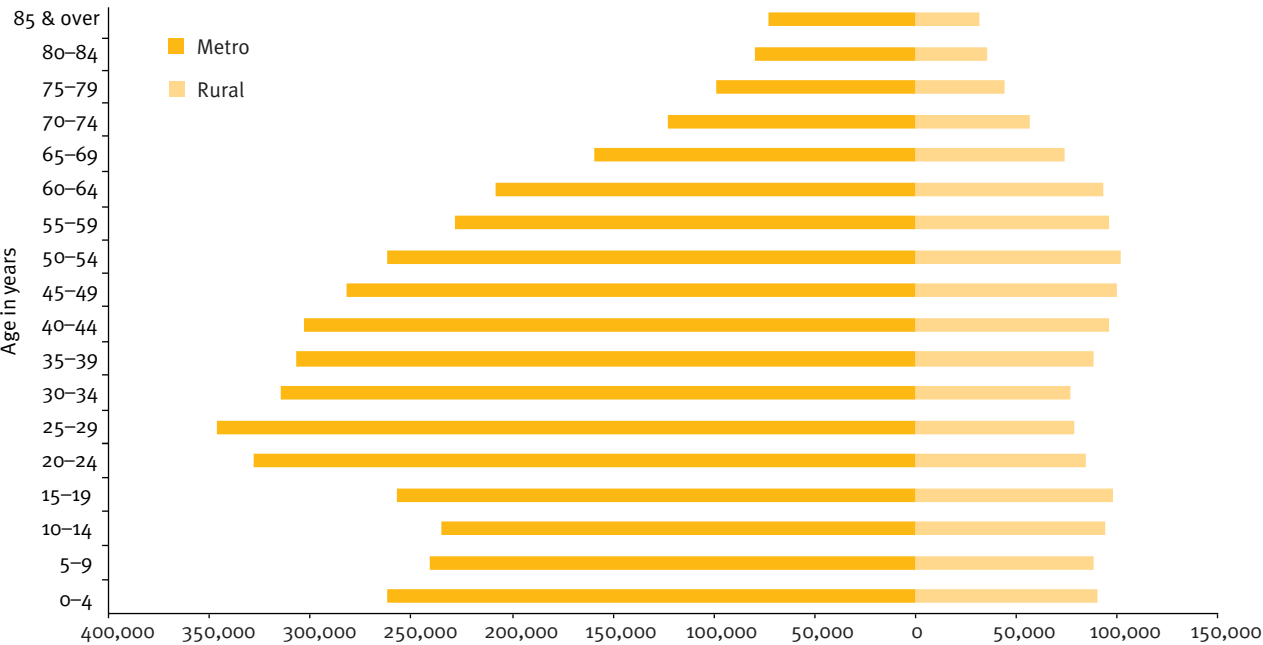
Key government commitments and programs are presented as relevant to the discussion throughout the report and local examples of good practice and community achievements are also included. The report follows on from and progresses the Victorian Government's commitment, in its response to the *2011 Inquiry into disadvantage and inequity in rural and regional Victoria*, to ensuring that 'all Victorians have the same access to opportunities, regardless of where they live' (Victorian Government 2011a). It further represents an example of the Government's commitment, as outlined in the *2011 Victorian Families Statement*, to use measurable benchmarks to 'indicate where we are changing and where we need to do more' (Victorian Government 2011b).

Rural and regional Victoria – social and demographic context

Nearly 30% of Victoria's children and young people (aged 0–17 years) live in rural and regional Victoria and just over 70% live in metropolitan Victoria (ABS Estimated Resident Population, 30 June 2010). Across rural and regional Victoria, most of the children and young people live in the Barwon South Western Region (25.2% of all children and young people in rural and regional Victoria), followed by Loddon Mallee Region (22.5%).

Rural and regional Victoria has a lower proportion of young adults in the population than metropolitan Victoria, reflecting a pattern of young adults moving to metropolitan areas for education and employment (Figure E1).

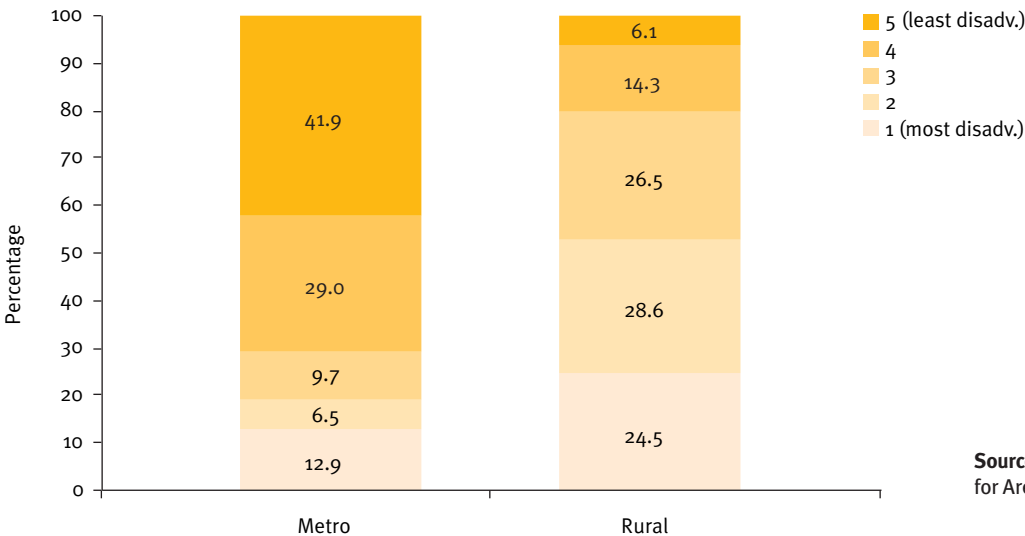
Figure E1: Estimated resident population, by age group and region type, Victoria, 30 June 2011



Source: ABS Estimated Resident Population, 30 June 2011. Note: ERP data for 2011 is based on preliminary ABS estimates.

Rural and regional Victoria experiences relatively higher rates of socioeconomic disadvantage when compared with metropolitan Victoria, as highlighted through the Socioeconomic Index for Area (SEIFA) Index of Relative Socioeconomic Disadvantage (IRSED) (Figure E2) and through measures of household income, parental education and financial hardship.

Figure E2: Distribution of Victorian LGAs by SEIFA Quintiles of Index of Relative Socioeconomic Disadvantage, by region type, Victoria, 2006



Source: ABS Socioeconomic Indexes for Areas (SEIFA), 2006.

When compared to metropolitan Victoria, rural and regional Victoria also has a higher representation of population groups that are known to experience higher levels of disadvantage, including Aboriginal and Torres Strait Islanders, one-parent families and people with a disability. A higher proportion of children (up to 12 years) in rural and regional Victoria also have a special health care need.⁴

Families with a language background other than English are under-represented in rural and regional Victoria; and, while rural and regional Victoria has several areas of major settlement of refugee populations, the majority of children and young people of a refugee background in Victoria are living in metropolitan regions.

In relation to housing, one-parent families in Victoria are much more likely than couple families to be in rented accommodation (as opposed to owning or purchasing their own home); and this disparity is particularly more pronounced in rural and regional Victoria. One-parent families in Victoria are also more likely than couple families to be in housing stress (spending more than 30% of their income on housing). However, overall, families in rural and regional Victoria are less likely than those in metropolitan Victoria to be in more severe housing stress.

Recent changes impacting on the socioeconomic disadvantage of rural and regional Victoria need to be acknowledged and are discussed in more detail in Section 2 of the report. These changes include economic restructuring, shifting population composition and rising house prices.

Although the report discusses rural and regional Victoria as a whole, variation between regions (using the five DEECD rural and regional boundaries) is also addressed as relevant to the discussion throughout the report. This confirms that there is no single region within rural and regional Victoria faring poorly on all measures; each region displays particular strengths and faces slightly different challenges.

It should be noted that the data analysis using DEECD rural and regional boundaries does not address variation within regions. Moreover, more remote areas are considered in conjunction with some of the larger regional towns in the data analysis. To address these data gaps, a variation of the ABS Accessibility/Remoteness Index of Australia (or ARIA classification) was also used throughout the report to examine the impact of increasing distance from large cities or regional centres on child and family outcomes. (This methodology is further described in the online Technical Appendix.)

Importantly, rural and regional Victoria is not a homogenous area, but can be characterised by its diversity. This means that there will be differences in the experiences and outcomes of children and young people that are influenced by location factors, such as levels of remoteness, access to transport and key services, together with socioeconomic factors, such as household income.

Key findings

Evidence presented in this report shows that, while most children and young people in rural and regional Victoria are faring well, there are disparities in outcomes between rural and regional and metropolitan children. The report itself is structured around related outcomes for children, young people, their families and the community. However, these key findings draw together the emerging strengths and challenges from across the report over the developmental trajectory.

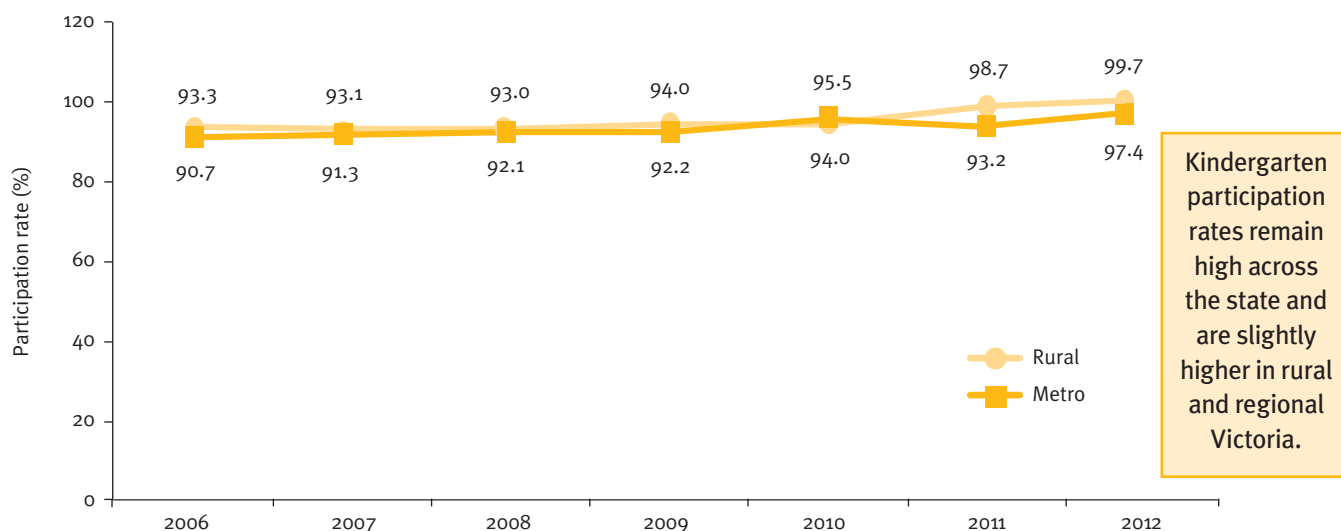
Community strengths

While rural and regional Victoria faces challenges associated with recent social and economic changes, it has major strengths associated with high levels of community engagement, connectedness and support. These together with high levels of participation in community, cultural and recreational activities, and volunteering or offering community service, act as important protective factors for children and young people.

Health and development in the early years

Immunisation rates are higher for children in rural Victoria and children are more likely to be physically active than their metropolitan counterparts.

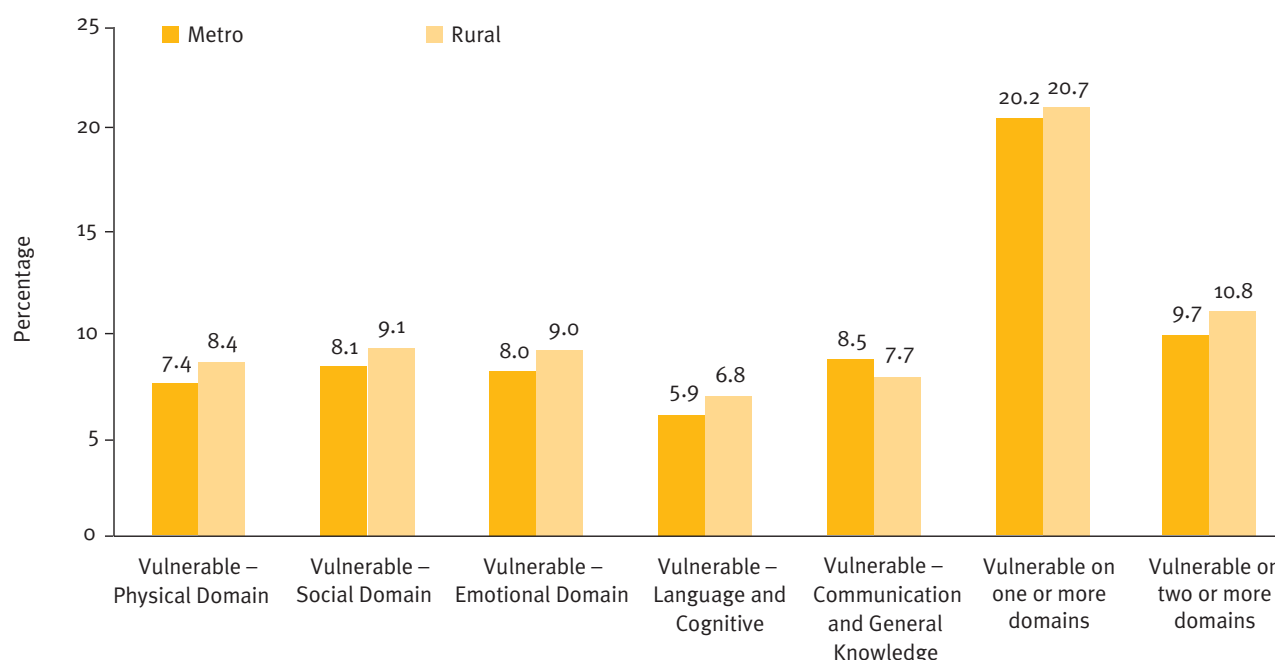
Figure E3: Kindergarten participation rates, by region type, Victoria, 2006–12



Source: DEECD Annual confirmed kindergarten data collection.

- Participation at Victoria's Maternal and Child Health (MCH) service is also high across the state and general participation rates are higher in rural and regional Victoria, with notably higher participation in the 3½ year key ages and stages visit.
- Oral health is a notable concern for children in rural and regional Victoria, who are more likely than their peers in metropolitan Victoria to have poor oral health status, with higher rates of teeth extractions, fillings, and hospital treatments under general anaesthetic.
- The rate of hospitalisations due to tooth decay among children is higher in rural and regional Victoria compared with metropolitan Victoria, although there has been a decrease in these hospitalisations among children aged 0–4 years in rural and regional Victoria over the last six years.
- There is no notable difference in oral health behaviours that appears to be driving the disparity in oral health outcomes, although fluoridation and increased consumption of sugary drinks may provide partial explanations.

Figure E4: Percentage of children who are developmentally vulnerable, by region type, Victoria, 2009



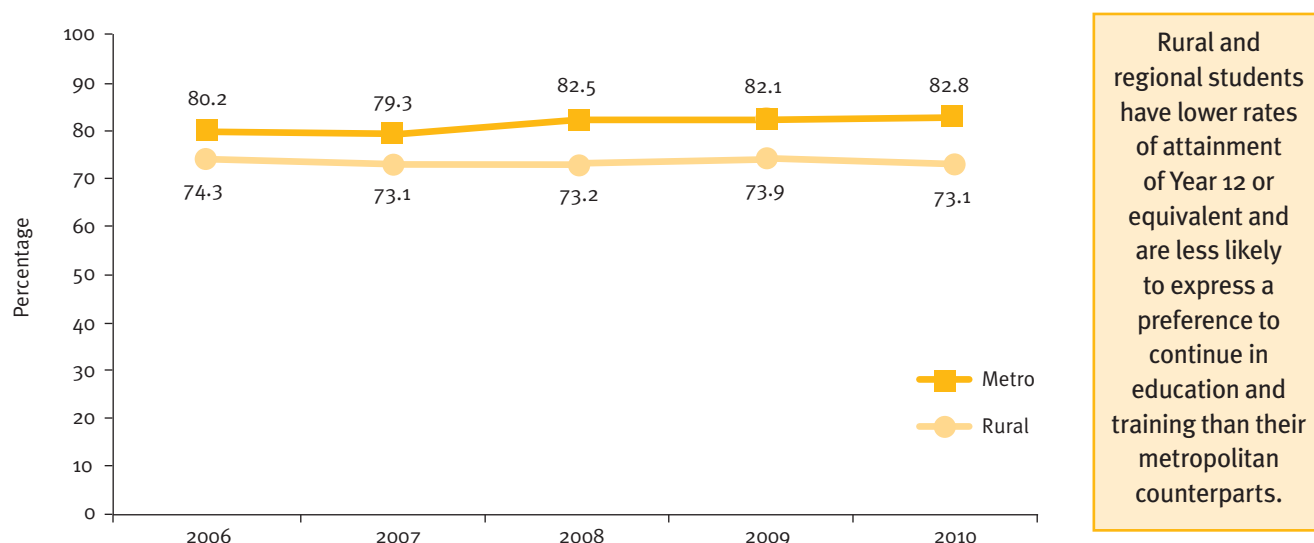
Source: Australian Early Development Index 2009, DEECD.

- Measures of parental concern about their child's speech and language at school entry show higher rates of concern among rural and regional parents as compared to those in metropolitan Victoria.
- in rural and regional Victoria are at a higher risk of emotional and behavioural problems at school entry than those in metropolitan Victoria, with the difference most notable in relation to 'conduct problems' and 'hyperactivity'. This difference is also reflected in higher rates of parental concern about their child's behaviour at school entry in rural and regional Victoria.

Educational engagement, achievement and pathways

- Participation rates in Victoria's universal early years services platform are high statewide, and kindergarten participation rates are higher for children in rural and regional Victoria.
- For children and young people in rural and regional Victoria, absence rates are higher in primary and secondary school as compared to those in metropolitan Victoria, with the difference becoming more pronounced in secondary school.
- Reported levels of school connectedness, student motivation, school enjoyment and interest in school subjects are all slightly lower for secondary school students in rural and regional Victoria.
- While overall rates of literacy and numeracy are high in Victoria, the percentage of students meeting national minimum standards on NAPLAN domains of reading, writing and numeracy is slightly lower in rural and regional Victoria in each school year level when compared to those in metropolitan Victoria.

Figure E5: Year 12 or equivalent attainment rates at age 19, by region type, Victoria, 2006–10

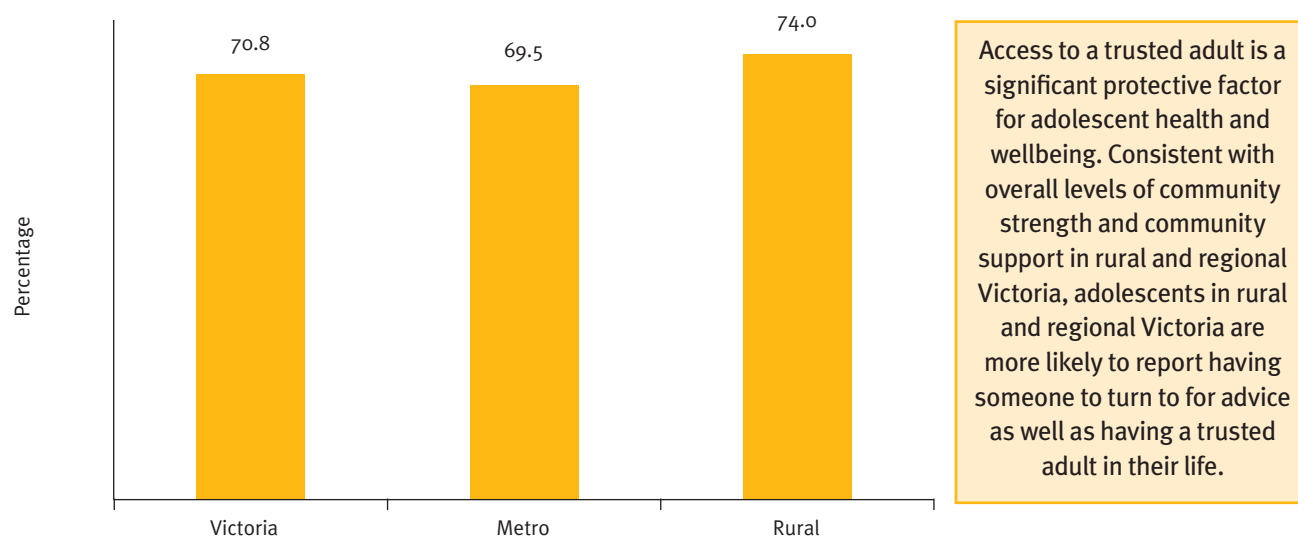


Source: VCAA and Skills Victoria administrative data; Estimated Resident Population 2006–2010, ABS.

- Year 12 completers from rural and regional Victoria make fewer transitions to bachelor degree and to upper level vocational training (VT) than metropolitan Year 12 completers, and they are much more likely to defer a university place than those in metropolitan Victoria.
- Rural and regional Year 12 completers are more likely to transition to entry level VT, apprenticeships, traineeships and the labour market than those in metropolitan Victoria.
- Early leavers from rural and regional Victoria make more positive transitions than those in metropolitan Victoria, with higher percentages in further education and training and lower percentages not working, not studying and looking for work.
- Detailed analysis of government school learning data (adjusted for measures of student disadvantage) suggest that the relative socioeconomic disadvantage of rural and regional Victoria is a key factor in explaining the learning outcomes that are observed in the report. This finding reflects, and is consistent with, a body of existing evidence which identifies a strong relationship between parental occupation (and level of education completed) and children's educational achievement (Australian Curriculum Assessment and Reporting Authority 2012).

Adolescent wellbeing and health behaviours

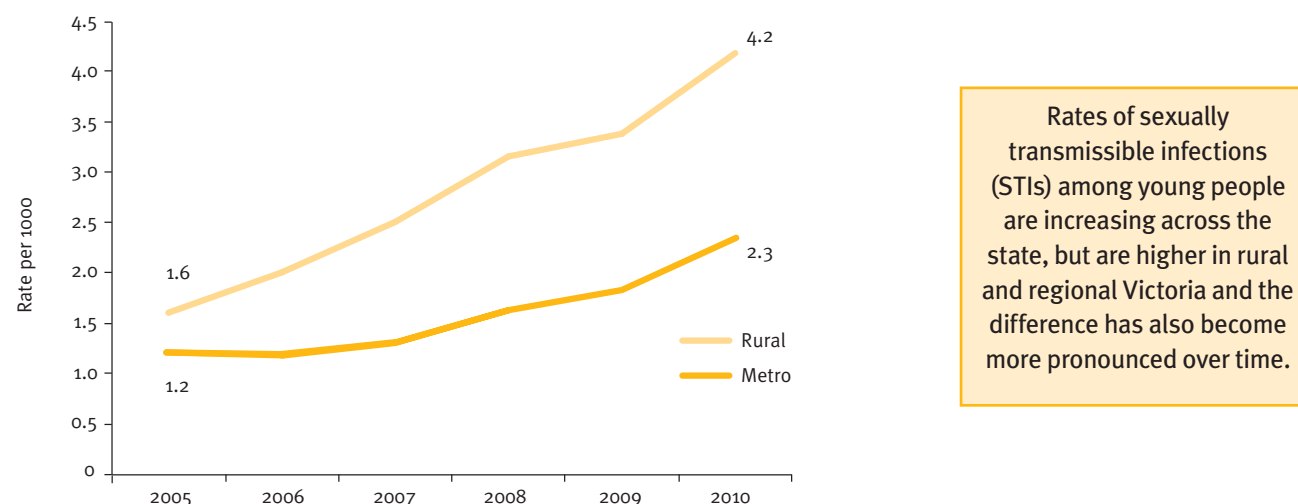
Figure E6: Young people reporting that they have a trusted adult in their life, Victoria, 2009



Source: HOWRU 2009, DEECD.

- Despite these high rates of social support, there are some concerning findings about the health behaviours of adolescents in rural and regional Victoria.
- Young people in rural and regional Victoria are more likely to be sexually active (aged 15–17 years) than metropolitan young people.

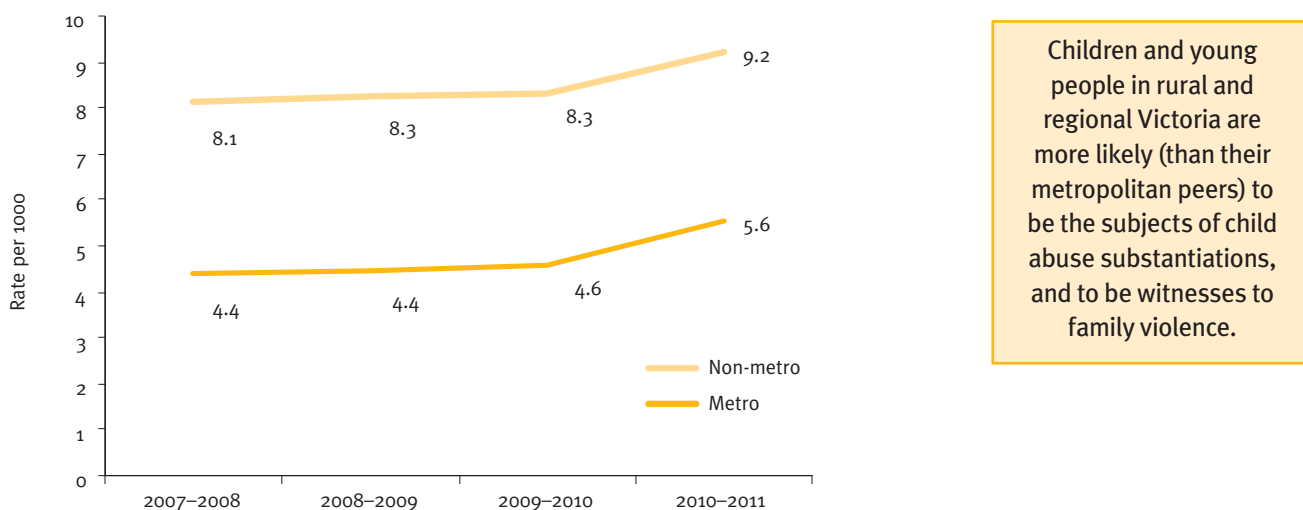
Figure E7: Rate of sexually transmissible infections in 12–17 year-olds (per 1000), by region type, Victoria, 2005–10



Source: The Notifiable Infectious Disease Surveillance System 2005–2010, DoH; Estimated Resident Population 2005–2010, ABS.

- The teenage birth rate is also higher in rural and regional than in metropolitan Victoria.
- Young people in rural and regional Victoria are more likely to report drinking alcohol and binge drinking than those in metropolitan Victoria. They also report easier access to alcohol as compared to adolescents in metropolitan Victoria.
- There were no notable differences in reported smoking rates by adolescents in rural and regional Victoria and those in metropolitan Victoria, though variation between regions was marked in rural and regional Victoria.
- In relation to adolescent mental health, overall levels of psychological wellbeing are high and similar when comparing rural and regional Victoria to metropolitan Victoria.
- Furthermore, there is no visible disparity in relation to levels of psychological distress. However, there are considerable variations in levels of adolescent psychological distress in between regions in rural and regional Victoria, with a similar pattern observed as to the regional variation in behavioural and emotional difficulties in early childhood.
- Safety in the home and the community
- Rates of children and young people on Care and Protection Orders or in out-of-home care are higher in rural and regional Victoria.
- Children in out-of-home care in rural and regional Victoria are less likely to be placed with a relative than those children in metropolitan Victoria in out-of-home care. However, Aboriginal children in out-of-home care in rural and regional Victoria are more likely to be placed in accordance to the Aboriginal child placement principle than Aboriginal children in out-of-home care in metropolitan Victoria.
- While relatively few children and young people are involved in crime, children and young people in rural and regional Victoria are more likely than those in metropolitan Victoria to be victims of crime and involved in criminal activities. This stands in marked contrast to the picture for overall crime among the total population (all ages), where rates are higher in metropolitan areas.
- Despite higher rates of children and young person as victims of crime and as offenders in rural and regional Victoria, there is no difference between rural and metropolitan Victoria in the overall rates of perceived neighbourhood safety (as reported by parents of young children and by young people themselves).
- Hospitalisation rates for injury and poisoning among children and young people are higher in rural and regional than in metropolitan Victoria and are lowest in major cities, with the rate increasing progressively with levels of remoteness.

Figure E8: Rate of child abuse substantiations of children aged 10–17 years (per 1000 population), by region type, Victoria, 2007–08 to 2010–11

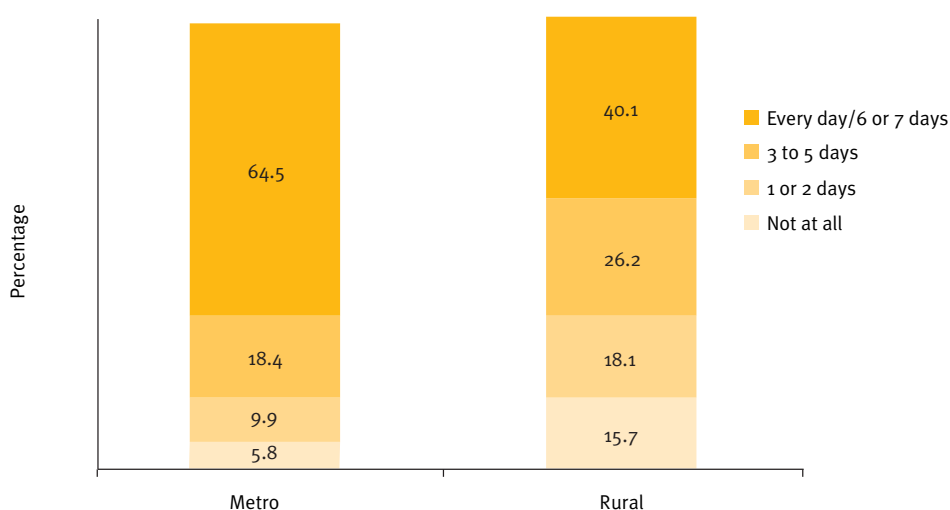


Source: Client Relationship Information System 2007–08 to 2010–11, DoH (unpublished); Estimated Resident Population 2005–2009, ABS.

Family environment

- Parental health behaviours known to influence child outcomes (smoking and alcohol consumption in pregnancy, nutrition and physical activity levels) are comparable across rural and regional Victoria and metropolitan Victoria.
- Breastfeeding rates are slightly lower in rural and regional Victoria.

Figure E9: Reported frequency of parents reading to their children aged under 1 year, by region type, Victoria, 2009



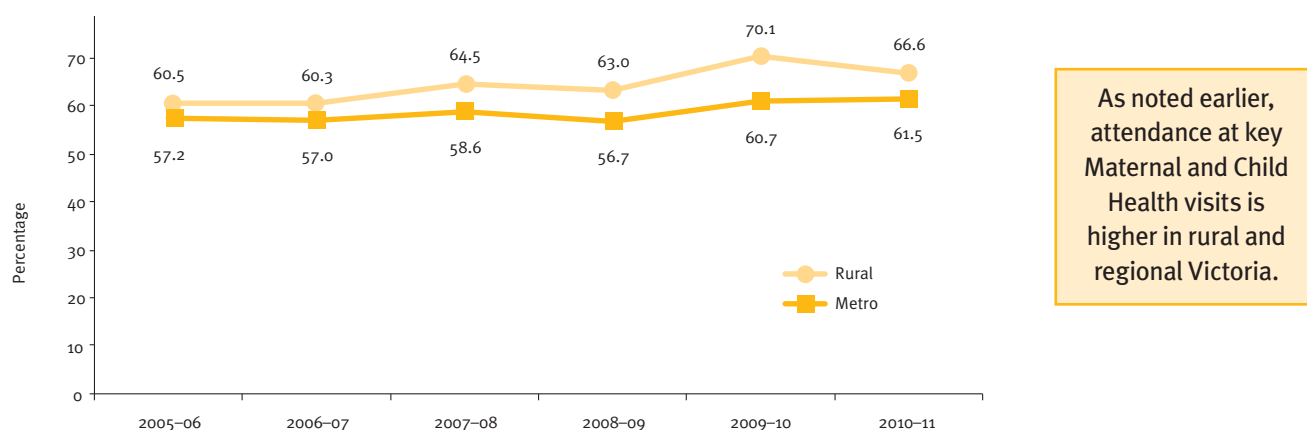
Source: VCHWS 2009, DEECD.

Social support levels are high in rural and regional Victoria and there is no notable difference in family functioning between families in rural and regional Victoria and metropolitan Victoria. However, parents of children at school entry in rural and regional Victoria are more likely to report experiencing high levels of family stress (including alcohol or drug-related problems and history of mental illness).

Services and community facilities

- Findings confirm the community strength of rural and regional Victoria, with high levels of community engagement, connectedness and support, together with opportunities for participation in community, cultural and recreational activities (parents) and volunteering or offering community service (young people).
- Rural and regional Victorians report more limited access to recreational facilities, basic services and transport than metropolitan Victorians.
- Young people in rural and regional Victoria are more likely to report that lack of transport makes it difficult for them to work, study, see a doctor or socialise as compared to young people in metropolitan Victoria.

Figure E10: Children attending the 3½ years key ages and stages visit, by region type, Victoria, 2005–06 to 2010–11



Source: DEECD Online MCH annual reports 2005–06 to 2010–11.

- Rural and regional children are also more likely than their metropolitan counterparts to be accessing primary school nursing assessments at school entry.
- Parents in rural and regional areas are less likely than metropolitan parents to be using child care services; and there is a much lower proportion of kindergarten enrolments in a long-day-care setting in rural and regional Victoria as compared to metropolitan Victoria.
- Consistent with higher levels of socioeconomic disadvantage observed in rural and regional Victoria, a higher proportion of kindergarten placements attract a fee subsidy than in metropolitan Victoria.
- Young people's reported access to physical, dental and mental health services does not differ significantly between rural and regional and metropolitan locations.
- Issues of cost (and of low income), as barriers to service access, are vital to consider at a local level, together with issues of transport, appropriateness and availability of services, lack of anonymity (for service users), and local patterns of staff recruitment and retention.

Outcomes for Aboriginal children in rural and regional Victoria

While the report does not aim to replicate previously published comparative data on outcomes for Aboriginal and non-Aboriginal children, analysis was undertaken for selected areas to determine whether there were disparities in outcomes for Aboriginal children and young people in rural and regional Victoria as compared to Aboriginal children and young people in metropolitan Victoria.

In general, similar patterns of differences in outcomes between rural and regional Victoria and metropolitan Victoria were observed for Aboriginal children and young people as were observed for the whole population. However, for some of the outcomes that were analysed, the disparity or gap between Aboriginal and non-Aboriginal outcomes was also more marked in rural and regional than in metropolitan Victoria. For example, this was found for educational attainment as measured through NAPLAN and for children at school entry with parents reporting concern about their behaviour. It is possible that this finding may reflect greater levels of disadvantage in the Aboriginal population in rural and regional Victoria than in metropolitan Victoria. However, as analysis of Aboriginal data was limited to selected outcome areas and data sets (detailed in the online Technical Appendix), this finding should be interpreted with caution. Further analysis of

a wider range of datasets, including more detailed analysis of trends over time, would be needed to confirm whether the disparity between Aboriginal and non-Aboriginal outcomes is consistently more marked in rural and regional Victoria than in metropolitan Victoria.

Role of socioeconomic disadvantage

Where data allowed, analysis was conducted to investigate the contribution of disadvantage to the poorer outcomes that were observed for children and young people in rural and regional Victoria. Findings show that living in rural and regional Victoria does not appear to increase the overall likelihood of disadvantaged children having poorer outcomes, because when we adjust for the impact of disadvantage observed disparities in outcomes are lessened. This suggests that (for the analysed indicators) geographical location is not a principal factor, on its own, in predicting poorer outcomes among disadvantaged rural and regional children. Rather, higher rates of relative disadvantage may underpin some of the observed disparities.

Emerging concerns and challenges

Analysis suggests that the relatively poorer outcomes of children and young people in rural and regional Victoria on some indicators are associated with inter-related factors, including socioeconomic disadvantage, family risk factors, employment and local service access issues.

Factors such as disability, family violence, substance misuse and mental illness can contribute to disadvantage. Furthermore, in some cases families experience multiple risk factors, which impact adversely on their ability to participate in the community. Data gaps currently limit the amount of information we have on the prevalence of compound disadvantage and multiple risk factors in families and for children and young people.

Next steps

This report raises a number of questions and draws attention to data gaps, providing a basis for future research, analysis and data development.

This is the first time information on outcomes for children, young people and families in rural and regional Victoria has been brought together and analysed in this way. The report findings present valuable new insights to shape future planning for children, young people and their families in rural and regional Victoria. It is clear there is already good alignment between government initiatives and current programs, and some of the emerging challenges described in this report, but there is still room for improvement.

It will be important to engage with regions and communities on the findings and what they mean in a local context in order to realise the full potential of this report. Victorian government departments are committed to working with regions through established networks and forums to disseminate these data. They support the use of this evidence to inform local planning and community responses.

Technical note

The report structure, approach and methodology are set out in more detail in Section 1, with some additional analytic techniques further described in the online Technical Appendix. The report draws on the Victorian Child and Adolescent Outcomes Framework to present the most important aspects of children and young people's health, safety, learning, development and wellbeing.² This framework is further described in Section 1 and in the online Technical Appendix.

As noted earlier, the report brings together data and evidence from a variety of sources. The source of each data item is detailed in the body of each chapter. All surveys used in this report, developed by child and adolescent experts, incorporate questions and scales with national and international validity to measure key indicators. Statistical rigour has also been applied to the sampling methodology, to weighting of survey results and to analysis and reporting of findings. Some of the key sources used are listed below:

- Australian Bureau of Statistics (ABS) data, including findings from the ABS 2006 and 2011 Census of Population and Housing where updated data are available, together with ABS (2011) Estimated Residential Population (ERP)
- National Centre for Social and Economic Modelling (NATSEM) Child Social Exclusion (CSE) Index (2012)
- Australian Early Development Index (AEDI) (2009)
- School Entrant Health Questionnaire (SEHQ) (2009–11)
- Victorian Child Health and Wellbeing Survey (VCHWS) (2009)
- Victorian Adolescent Health and Wellbeing Survey (termed 'HOWRU') (2009)
- Victorian Population Health Survey (VPHS) (2007 and 2008)
- DEECD 'On Track' Survey (2008–12)
- DEECD Attitudes to School Survey (2006–11)
- National Report on Schooling in Australia (NAPLAN) (2011)
- Victorian Admitted Episodes Dataset (2009–10)
- Client Relationship Information System (CRIS) data (2010–11)
- Law Enforcement Assistance Program (LEAP) data (2010–11).



‘This is a drawing of the street
and houses where I live.’

Artwork by Lauren, Grade 4
Cowes Primary School
Title: Cowes



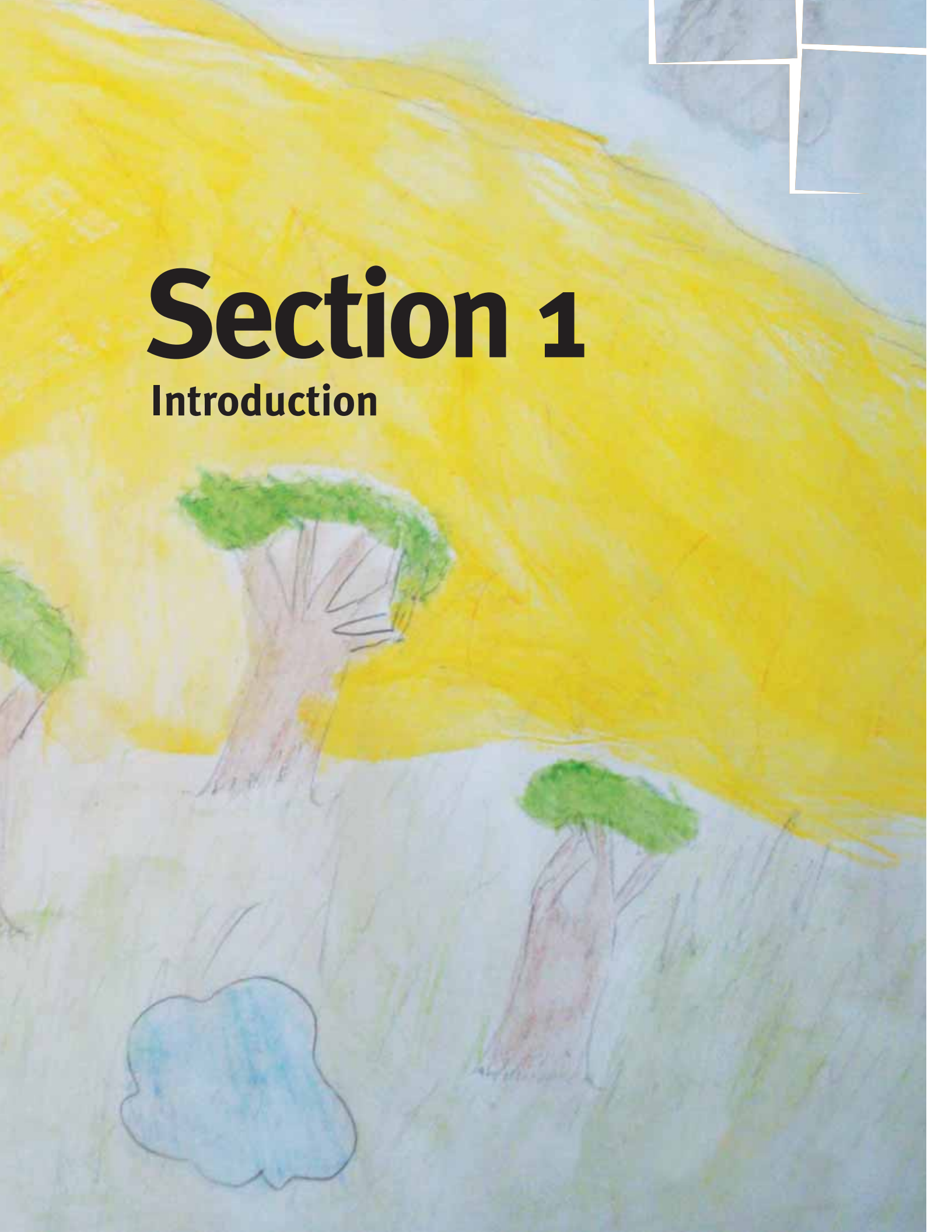
*What's special / the best thing about
where you live?*

You can explore and discover things
that you can't see in the city.'

Artwork by Joseph, Grade 4
Maiden Gully Primary School
Title: The Bush

Section 1

Introduction



1. Victorian child and adolescent outcomes framework

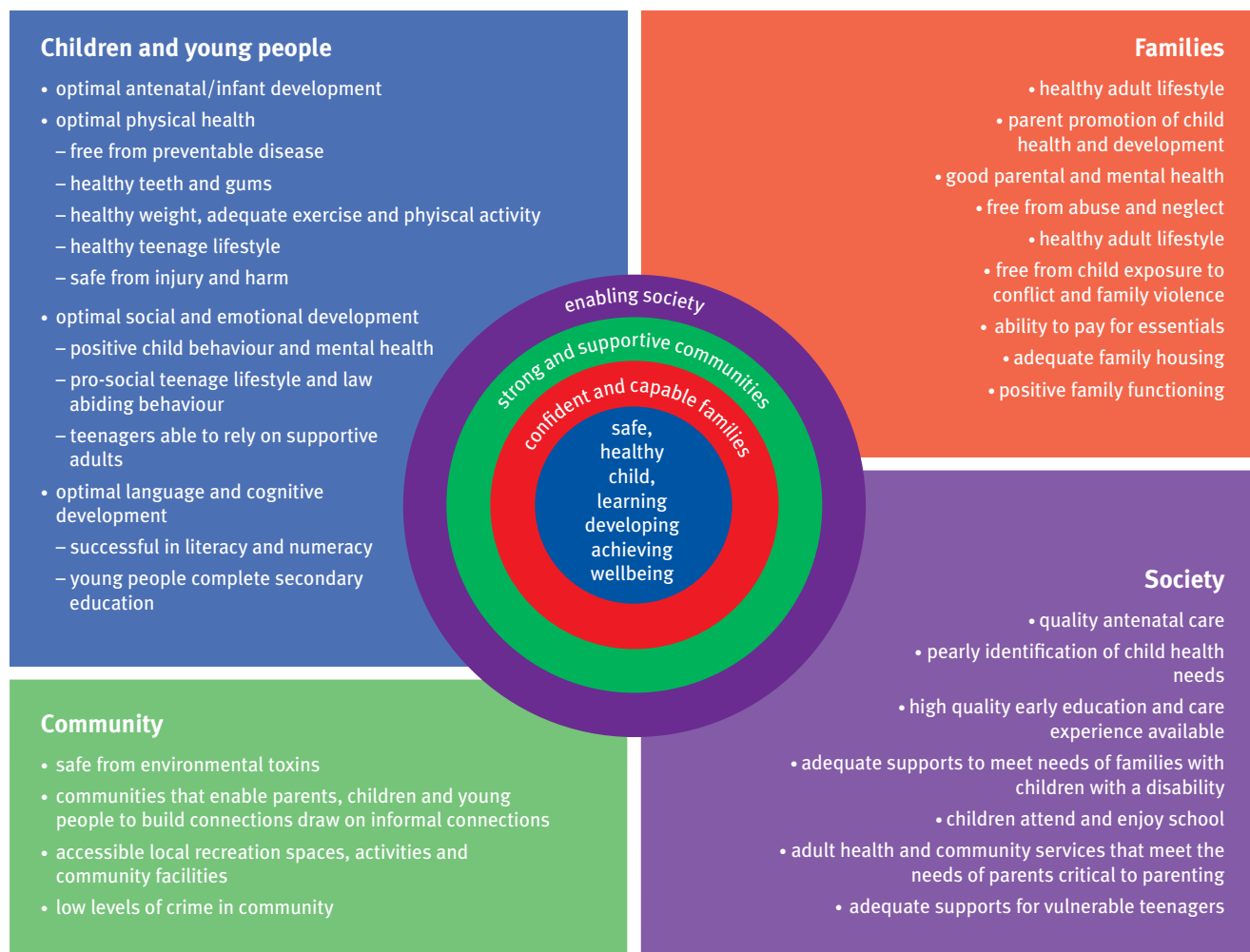
1.1 VCAMS Outcomes framework

The Victorian Government monitors, measures and reports on how children and young people are faring against the Victorian Child and Adolescent Outcomes Framework. This framework is based on 35 measurable aspects, known as ‘outcomes’ of children’s health, wellbeing, development, learning and safety.

These 35 outcomes were chosen because they are known to be of importance to children; are relevant to all or most children; are likely to respond to programs of intervention; and are appropriate for government intervention and support.

The outcomes framework, which is illustrated in Figure 1.1, adopts an ecological approach centred upon the child or young person, whose outcomes are influenced by family factors and by broader community and society factors, such as access to services and adequate supports.

Figure 1.1: Figure 1.1: The Victorian Child and Adolescent Outcomes Framework



1.2 Report scope, approach and methodology

Age focus

In line with the Victorian Child and Adolescent Outcomes Framework, the report focuses on outcomes for children and young people aged 0–17 years. Some data on the 18–24 year age group are included in relation to a key area of importance rural and regional young people; namely, post-school transitions to the labour market and to education and training.

Children, young people and their families

The report focuses principally on how children and young people are faring. However, also in line with the outcomes framework, it is recognised that the experiences of children and young people are inextricably linked with those of their families and households, and family factors are addressed where these are known to influence child outcomes.

Methodology

The data sources used in this report are listed in the Executive Summary. The online Technical Appendix gives details about them, as well as further information on geographic boundaries and measures of disadvantage.

Analytical themes for inclusion in the report

This report focuses principally on areas where there are identified disparities in outcomes between children and young people in rural and regional and metropolitan Victoria, as identified by initial analysis and in the 2010 SOVC report (DEECD 2012). Attention is also given to outcome areas where there is little or no disparity in outcomes between rural and regional and metropolitan Victoria, and where there are notable disparities between DEECD regions.

Box 1.1: Terminology used in presentation of data

- *ARIA analysis* refers to analysis using the ABS Accessibility/Remoteness Index of Australia (ARIA) + classification
- *metropolitan* Victoria refers to the following DEECD regions: Western, Southern, Eastern and Northern Metropolitan regions
- *region type* refers to rural or metropolitan Victoria
- *regional variation* refers to differences found between outcomes in individual DEECD regions
- *rural Victoria* refers to the following rural and regional DEECD regions: Barwon South Western, Gippsland, Hume, Loddon Mallee and Grampians regions
- *rurality* refers to living in rural Victoria, as defined above.



What would you like to change about where you live? What would make it even better?

'It produces food for us to eat which we eat daily which helps us to grow.'

Artwork by Peta, Grade 4
Maiden Gully Primary School
Title: More farms

Section 2

Unique Context of Rural
and Regional Victoria



2. Unique context of rural and regional Victoria



Artwork by April, Grade 4
Maiden Gully Primary School
Title: Bigger houses

2.1 Introducing Victoria's rural and regional (termed 'rural') population

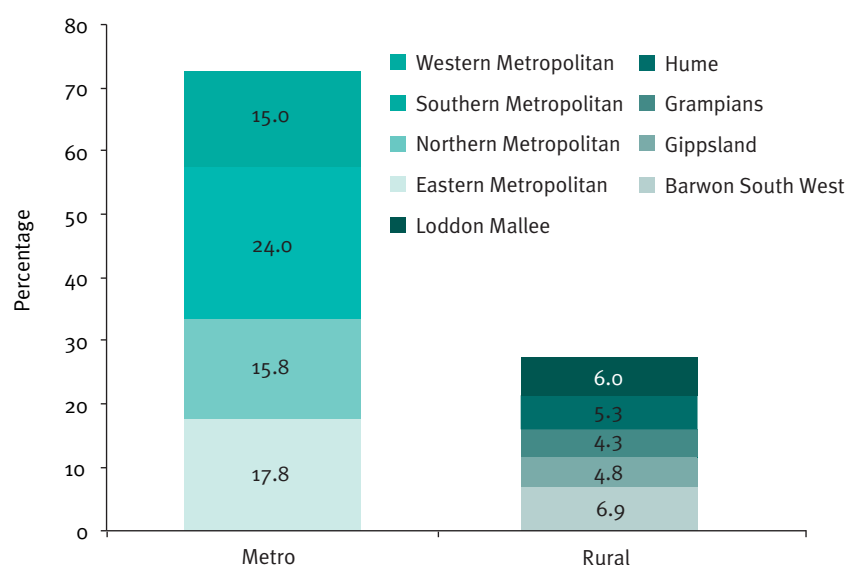
As at June 2011, the estimated population of Victoria was 5,534,526, with just over a quarter of the population (25.8% or 1,425,985) living in rural Victoria, and the majority (74.2% or 4,108,541) residing in metropolitan Victoria.

There were 1,218,302 children and young people (aged 0–17 years) in Victoria. Nearly 30% (27.4% or 333,331) of these were living in rural Victoria and just over 70% (72.6% or 884,971) were living in metropolitan Victoria.

Geographical distribution of Victoria's children and young people

Figure 2.1 shows the distribution of children and young people across the Victorian DEECD regions. Within rural Victoria, the greatest proportion of children and young people live in the Barwon South Western Region (6.9%) followed by Loddon Mallee (6.0%).

Figure 2.1: Distribution of population of children and young people aged 0–17 years, across DEECD regions, Victoria, 30 June 2011



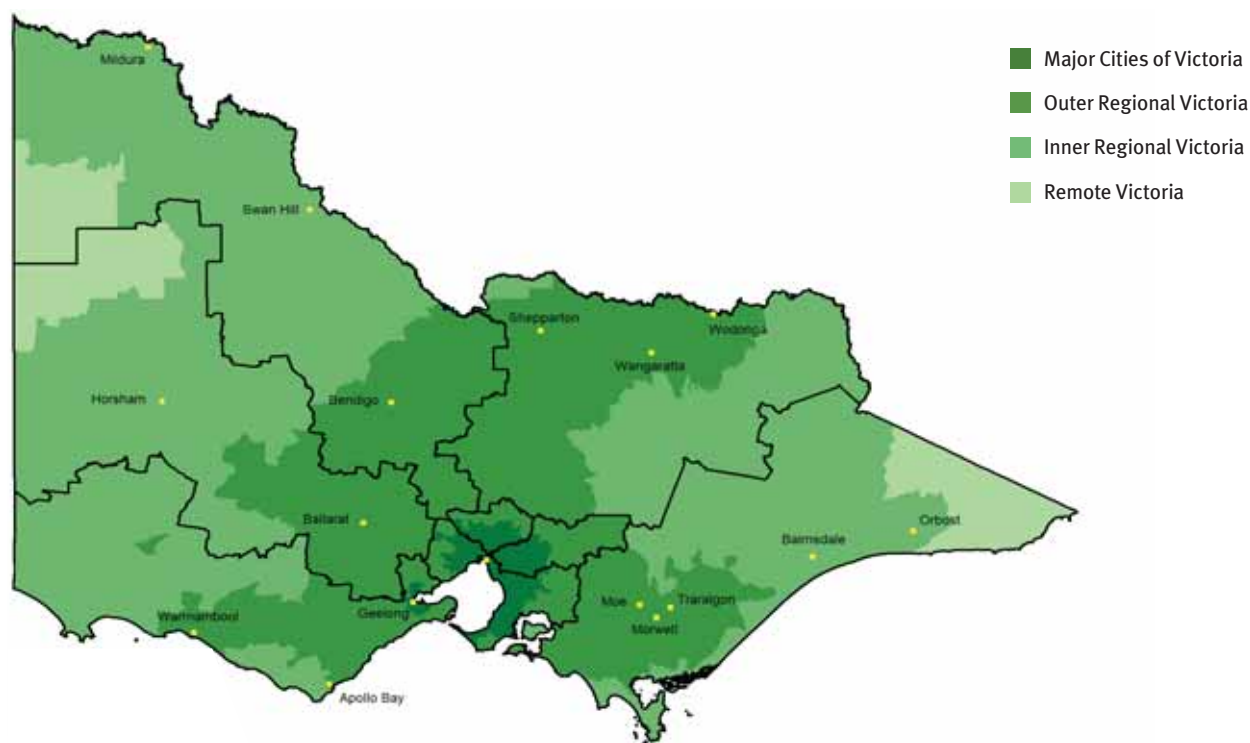
Source: ABS Estimated Resident Population, 30 June 2011.

Note: ERP data for 2011 is based on preliminary ABS estimates.

Distribution of children and young people across Victoria by ARIA classification

Around three-quarters of Victoria's children and young people (74.0%) live in 'major cities' as defined by the ARIA classification (described in Section 1 and shown in Figure 2.2). Around one-fifth (21.2%) live in inner regional areas, and outer regional and remote areas account together for just 4.8% of the Victorian population of children and young people.

Figure 2.2: Distribution of population of children and young people aged 0–17 years, by ARIA classification, Victoria, 2011



Source: Estimated Resident Population, 30 June 2011; DEECD analysis by ARIA.

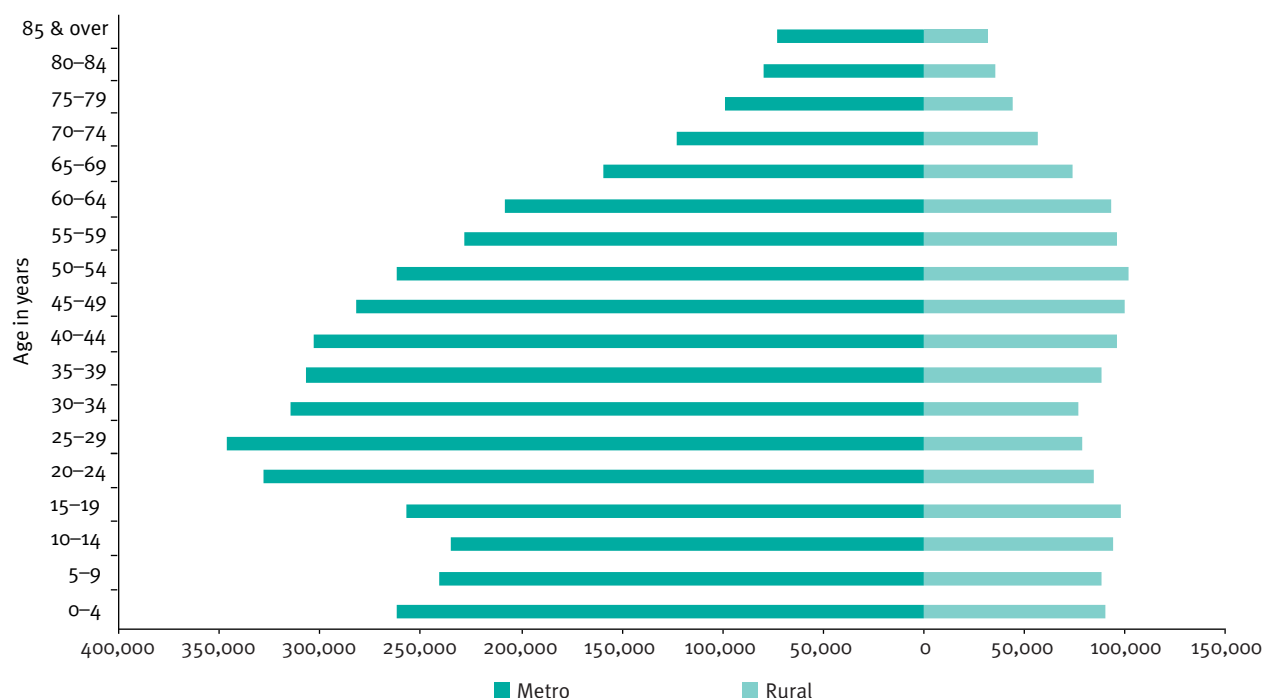
Note: ERP data for 2011 is based on preliminary ABS estimates.

Patterns of population change: the youth gap

Relative population growth between rural and metropolitan Victoria has fluctuated over recent decades. However, while the population of rural Victoria has grown overall, Melbourne has grown faster than rural Victoria between every Census period since 1986–91 (DPCD 2010, p. 3). In rural Victoria, towns and regional cities have experienced higher rates of growth than rural areas (outside of towns and cities) (1996–2006), reflecting population changes associated with patterns of economic restructuring (DPCD 2010; DPCD 2011) (see Box 2.1).

As the Department of Planning and Community Development (DPCD) describes, there have been clear patterns of age-specific movement among young people in rural Victoria, with teenagers moving to regional centres (commonly for education) and young adults moving to Melbourne for education and employment (DPCD 2010, p. 8). The relatively lower proportion of young adults in rural Victoria than in metropolitan Victoria is shown in Figure 2.3.

Figure 2.3: Estimated resident population, by age group and region type, Victoria, 30 June 2011



Source: ABS Estimated Resident Population, 30 June 2011.

Note: ERP data for 2011 is based on preliminary ABS estimates.

Box 2.1: Population growth in Victoria

Between 2011 and 2031, the population of rural Victoria is expected to grow from 1.5 million to 1.9 million, representing an average annual growth rate of 1.2%. Melbourne's population is expected to grow from 4.1 to 5.4 million over the same period, an average annual growth rate of 1.3% (DPCD 2012a).

2.2 Socioeconomic disadvantage in rural Victoria

Unemployment rates in rural Victoria are similar to those in metropolitan Victoria, and average annual employment growth has been stronger in rural Victoria compared with metropolitan Victoria over the five years 2010–11 (ABS data reported in Department of Treasury and Finance 2012). However, the evidence suggests that rural Victoria is relatively socioeconomically disadvantaged on a range of measures when compared with metropolitan Melbourne.

Box 2.2: Important note

While the evidence suggests that rural Victoria is relatively socioeconomically disadvantaged when compared with metropolitan Victoria, the total number of children and young people who are affected by socioeconomic disadvantage is smaller in rural than in metropolitan Victoria.

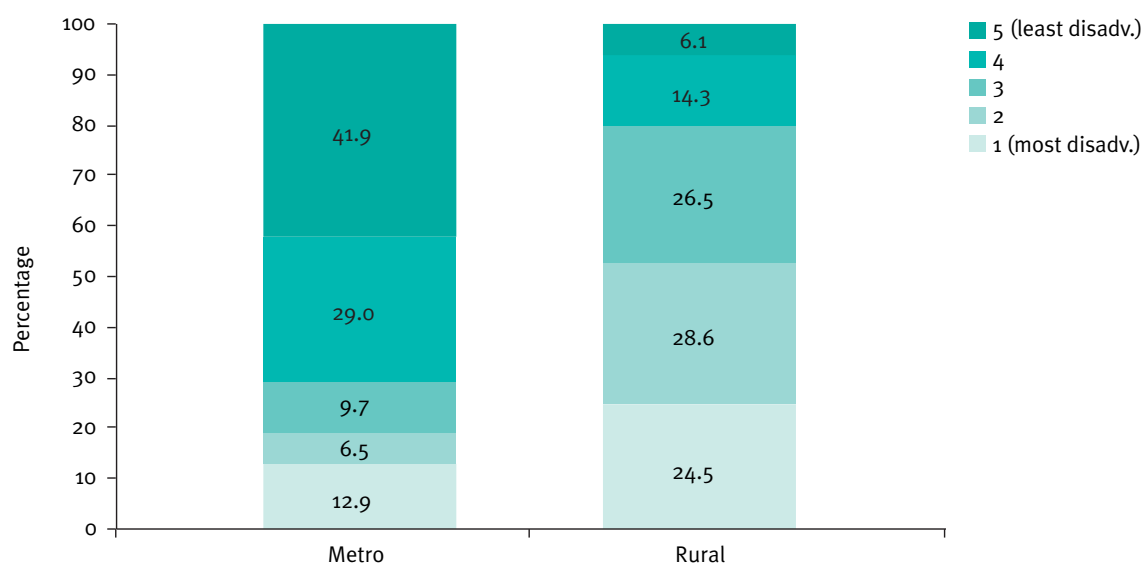
Measures of disadvantage

SEIFA Index of Relative Socioeconomic Disadvantage

The Socioeconomic Indexes for Areas (SEIFA) Index of Relative Socioeconomic Disadvantage (IRSED) is derived from the attributes of a small geographic area, including low income, low educational attainment, jobs in relatively unskilled occupations, high unemployment and other indicators of disadvantage. Areas can be grouped into quintiles based on their IRSED score to provide categories based on level of disadvantage, with quintile one being the most disadvantaged and quintile five the least (DEECD 2012, p. 38).

As Figure 2.4 shows, 70.9 per cent of the local government areas (LGAs) within metropolitan Victoria are ranked in the top two (least disadvantaged) SEIFA quintiles, whereas more than half (53.1%) of the LGAs in rural Victoria are ranked in the bottom two (most disadvantaged) SEIFA quintiles.

Figure 2.4: Distribution of Victorian LGAs by SEIFA Quintiles of Index of Relative Socioeconomic Disadvantage, by region type, Victoria, 2006



Source: ABS Socioeconomic Indexes for Areas (SEIFA), 2006.

Child Social Exclusion Index

The Child Social Exclusion (CSE) Index, developed by the National Centre for Social and Economic Modelling (NATSEM) at the University of Canberra, is an age-specific calculation for children who are at risk of social exclusion in Statistical Local Areas (SLAs). The measurement is based on a range of factors that are related to disadvantage and poor outcomes, and include socioeconomic and education factors, community connectedness, housing costs and overcrowding and health service access.³

Unlike the SEIFA (which is derived from the attributes of all households in a small geographic area), the CSE has the advantage of being child focused and developed specifically for measuring child disadvantage.

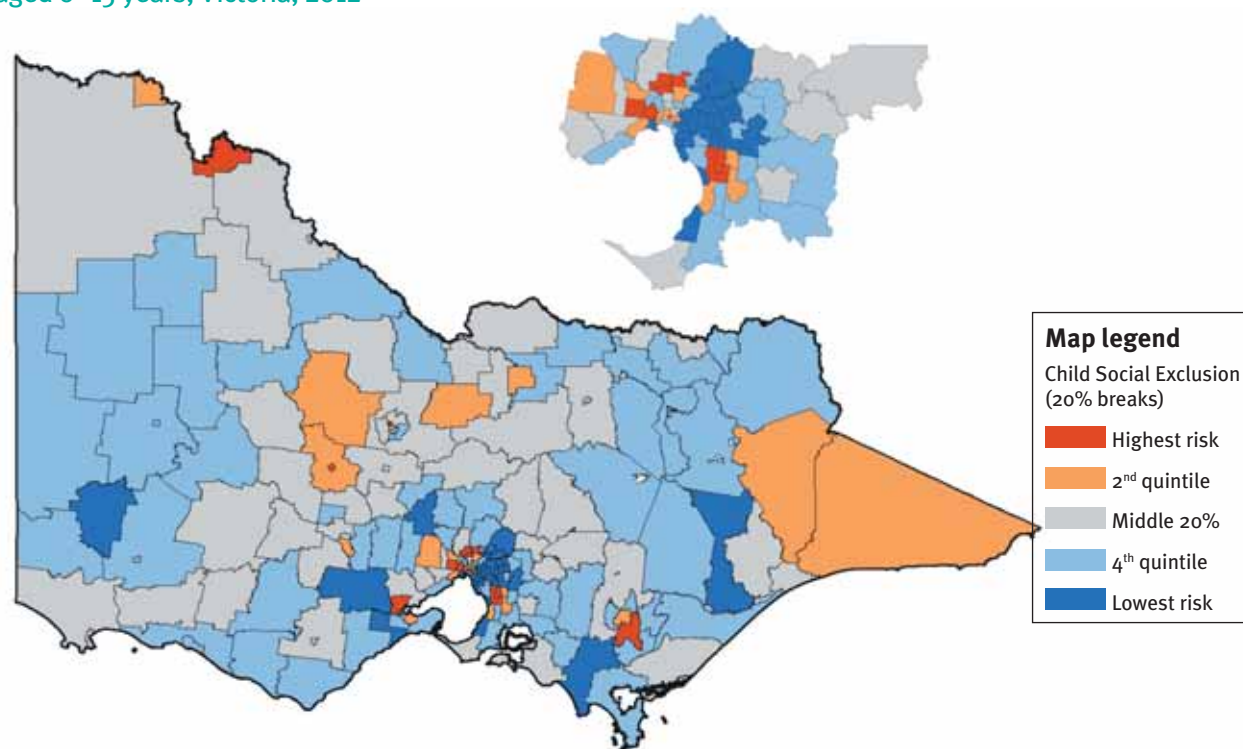
The CSE Index includes five quintile groups. These groups are derived by ranking SLAs by their social exclusion index value and dividing them into child population weighted quintiles of social exclusion.⁴ The lowest quintile represents SLAs with the highest risk of social exclusion (the most disadvantaged) and the highest quintile represents SLAs with the lowest risk of social exclusion (the most advantaged) (McNamara et al. 2008).

A total of 13 Statistical Local Areas (SLAs) in Victoria are classified in quintile one (areas of most disadvantage) for children aged 0–15 years. Five of these are located in rural Victoria.⁵

A total of 37 SLAs in Victoria are classified in quintile five (areas of most advantage). Just seven of these are located in rural Victoria,⁶ and the majority (30) are in metropolitan Victoria (NATSEM 2012 data accessed via: www.natsem.canberra.edu.au/maps/AUST_CSE/VIC/atlas.html).

The spatial distribution of children across Victoria, by CSE quintile rankings, is shown in Figure 2.5.

Figure 2.5: Spatial distribution of Child Social Exclusion Index quintile rankings, for children and young people aged 0–15 years, Victoria, 2012



Source: DEECD graph based on NATSEM 2012, University of Canberra data, accessed via www.natsem.canberra.edu.au/maps/AUST_CSE/VIC/atlas.html

The CSE Index also includes a ‘distance from the mean classification’. This allows for identification of areas where, while there may not be large *numbers* of children at risk of social exclusion, there are very high *proportions* of children living in families where there is a high risk of social exclusion (e.g. families where no adult is in paid employment or in the bottom income quintile, or where no adult has completed Year 12) (NATSEM 2012).

The ‘distance from mean’ classification comprises four groups, ranked from ‘highest risk’ (more than one standard deviation above the mean) to ‘lowest risk’ (equal to or more than one standard deviation below the mean). Using this classification, two SLAs in Victoria are ranked in the ‘highest risk’ group.⁷ A total of 28 SLAs in Victoria are classified as ‘lowest risk’ of child social exclusion. Five of these are in rural Victoria⁸ and the majority (23) are in metropolitan Victoria (NATSEM 2012 data available at www.natsem.canberra.edu.au/maps/AUST_CSE/VIC/atlas.html).

Income

According to the ABS 2011 Census, median weekly family income among households with children (0–17 years) is lower in rural Victoria (\$1347) compared with metropolitan Victoria (\$1670).

Financial hardship

Analysis of the 2009 Victorian Child Health and Wellbeing Survey (VCHWS) also shows that, while the vast majority of Victorian families do not experience financial hardship, children in rural Victoria are more likely to have families reporting that they ran out of food and couldn't afford to buy more (6.6% rural compared with 4.2% metropolitan).

2.3 Socioeconomic disadvantage and population groups

When compared with metropolitan Victoria, rural Victoria also has a higher representation of key population groups that are known to experience higher levels of socioeconomic disadvantage, including Aboriginal and Torres Strait Islanders, one-parent families and people with a disability.

Box 2.3: Population cohorts experiencing disadvantage

Socioeconomic disadvantage is commonly geographically concentrated and particular population groups are commonly over-represented among those who are disadvantaged. These groups include aged persons, public housing renters, Aboriginal and Torres Strait Islanders, one-parent families, people with non-English speaking backgrounds, the unemployed, private renters, and people with a disability (Australian Government 2009; Saunders & Wong 2009).

Aboriginal population in rural Victoria

According to the ABS Census of Population and Housing 2006, there are 33,517 Aboriginal people in Victoria,⁹ of whom 13,206 are children and young people (0–17 years). Just over half (52.5%) of Victoria's Aboriginal population live in rural Victoria, compared with just 26.8% of the non-Aboriginal population; and 55.8% of Victoria's Aboriginal children and young people live in rural Victoria, compared with just 27.9% of the 0–17 years population in Victoria as a whole.

Box 2.4: Socioeconomic disadvantage and Victoria's Aboriginal population

Key findings included in the Department of Health *Victorian Population Health Survey 2008: Supplementary Report* show that Aboriginal adults are significantly socioeconomically disadvantaged when compared with non-Aboriginal Victorian adults, with lower total annual household incomes, lower levels of educational attainment and higher rates of unemployment (Department of Health 2011a). The report also finds that, while there were no statistically significant differences in reported income between Aboriginals in rural and metropolitan Victoria, the proportion reporting incomes greater than \$80,000 in urban Victoria was almost double that of those in rural Victoria (Department of Health 2011a, p. 26).

The 2009 SOVC report, which focuses on how Aboriginal children and young people in Victoria are faring, observes that, 'while there are clear areas of strength for many Aboriginal children and young people, the compounding effects of multiple stressors and disadvantage (whether through major life events, lack of economic resources or diminished health and wellbeing for an individual or within a family) increase the risk of poorer short-term and possible long-term outcomes' (DEECD 2010, p. 3).

One-parent families

In rural Victoria 20.1% of families with children aged 0–17 years are one-parent families (compared with 18.7% in metropolitan Victoria); and Table 2.1 highlights that median weekly income is lower in one-parent families (and even lower among one-parent families in rural Victoria).

Table 2.1: Median weekly family income, by region type, Victoria, 2011

| Region type | Metropolitan | Rural |
|--------------------------------------|--------------|-------|
| Couple family with children | 1,924 | 1,629 |
| One-parent family | 690 | 607 |
| Total couple and one-parent families | 1,670 | 1,347 |

Source: Census of Population and Housing 2011, ABS.

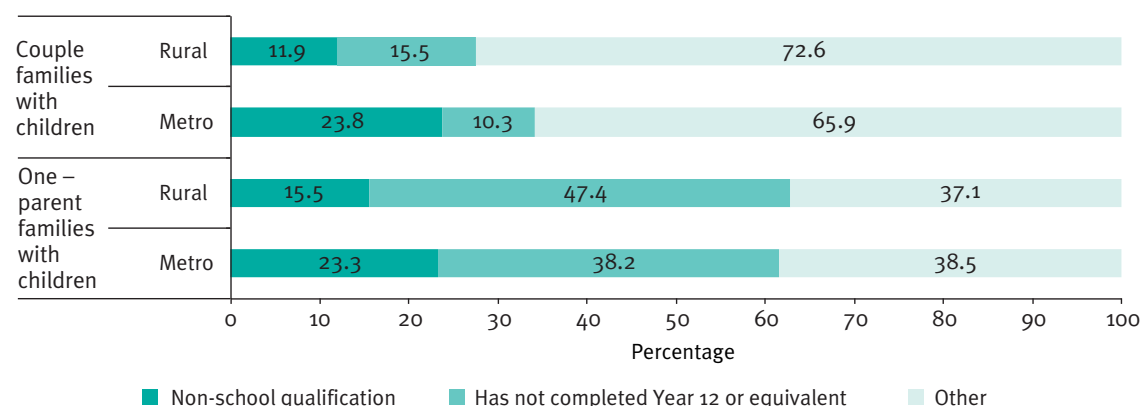
Unemployment

Unemployment can be a major cause of income poverty, as well as having long-term effects on children's development, educational progress and employment prospects (McLelland in DEECD 2009b). ABS 2006 Census data show that while there are no marked differences, by region type, in the labour force status of couple families in Victoria, one-parent families are more likely than couple families to be unemployed or not in the labour force (NILF). One-parent families in rural Victoria are also more likely than those families in metropolitan Victoria to be unemployed (8.6% of one-parent families in rural Victoria are unemployed compared with 7.1% in metropolitan Victoria).

Parental education

Parental education levels are also linked to income and employment. Parents in rural Victoria are less likely than parents in metropolitan Victoria to have completed Year 12 or to have attained a non-school qualification. One-parent families in rural Victoria are less likely than one-parent families in metropolitan Victoria to have done so (Figure 2.6).

Figure 2.6: Highest educational attainment of couple and one-parent families with at least one child aged 0–17 years, by region type, Victoria, 2006



Source: Census of Population and Housing 2006, Customised Data Report, ABS.

Children with a disability

According to the ABS 2006 Census, the proportion of children with a need for assistance with core activities¹⁰ is higher in rural than in metropolitan Victoria (1.9% of rural children and young people aged 0–17 years were found to have a need for assistance with core activities, compared with 1.5% in metropolitan Victoria).

This Census data is broadly supported by 2011 School Entrant Health Questionnaire (SEHQ) findings, which show that 4.7% of children at school entry in rural Victoria had parents who reported that their child had an intellectual disability, developmental delay or learning disability, compared with 3.9% of children in metropolitan Victoria.

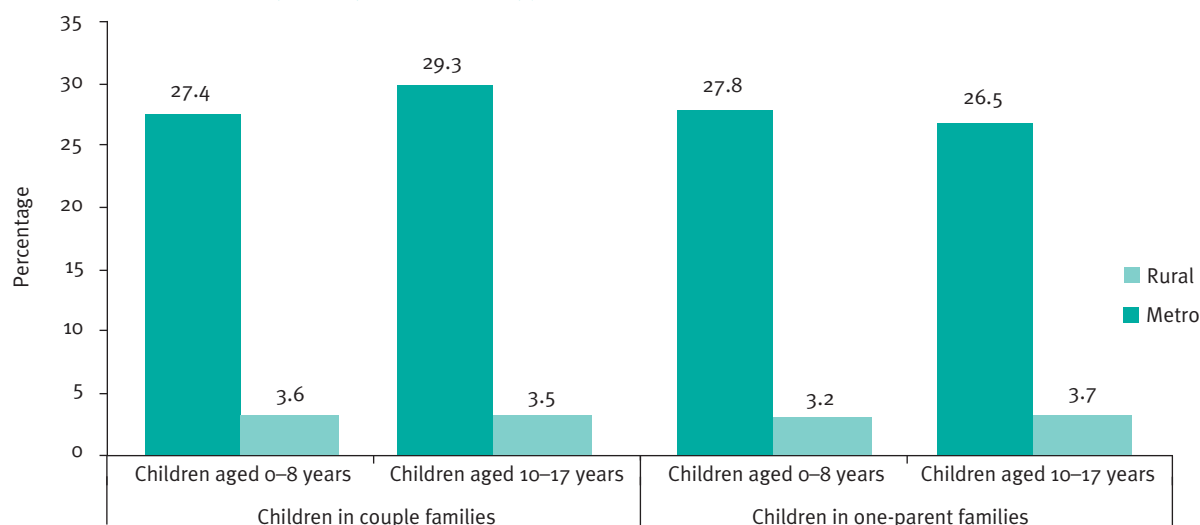
Children with special care needs

VCHWS data indicate that 16.8% of rural children up to 12 years have special health care needs¹¹ (compared with 13.5% in metropolitan Victoria). While the Victorian Adolescent Health and Wellbeing Survey (termed HOWRU) shows only a small difference by region type in the proportion of young people with special health care needs (14.8% in metropolitan Victoria and 15.5% in rural Victoria), there is marked regional variation (detailed under *regional variation*).

Children and young people from CALD backgrounds

People with non-English speaking backgrounds are also known to experience higher levels of disadvantage (DPCD 2011). However, as Figure 2.7 shows, children and young people in rural Victoria are much less likely than children and young people in metropolitan Victoria to be living in families where parents speak a language other than English at home.

Figure 2.7: Percentage of children and young people living in families where parents speak a language other than English at home, by family and region type, Victoria, 2006



Source: 2006 Census of Population and Housing.

Refugee children and young people

Increasing priority has been given to the settlement of people from refugee backgrounds in rural Victoria since 2008, and it has several areas of major settlement of refugee populations. Nevertheless, the majority of children and young people of a refugee background in Victoria are living in metropolitan regions, primarily in Melbourne's outer suburbs (DEECD 2011).

Regional variation: socioeconomic disadvantage and population groups

Within rural Victoria, median family income is highest in Barwon South Western region (\$1447) and lowest in Hume (\$1301 dollars), Loddon Mallee and Gippsland (both \$1306).

The highest percentage of children with families reporting financial hardship is found in Loddon Mallee and Gippsland (VCHWS 2009), the regions that also have the highest proportions of one-parent families (25.7% and 24.6%, respectively).

Loddon Mallee has the highest proportion of Aboriginal children and young people (29.7%), followed by Hume (23.3%) and Gippsland (19.6%).

The highest percentage of parents reporting that their child had an intellectual disability, developmental delay or learning disability was in Gippsland (5.7%) (2011 SEHQ). Loddon Mallee has the greatest proportion of children (19.3%) and adolescents (17.5%) with special health care needs (VCHWS 2009; HOWRU 2009).

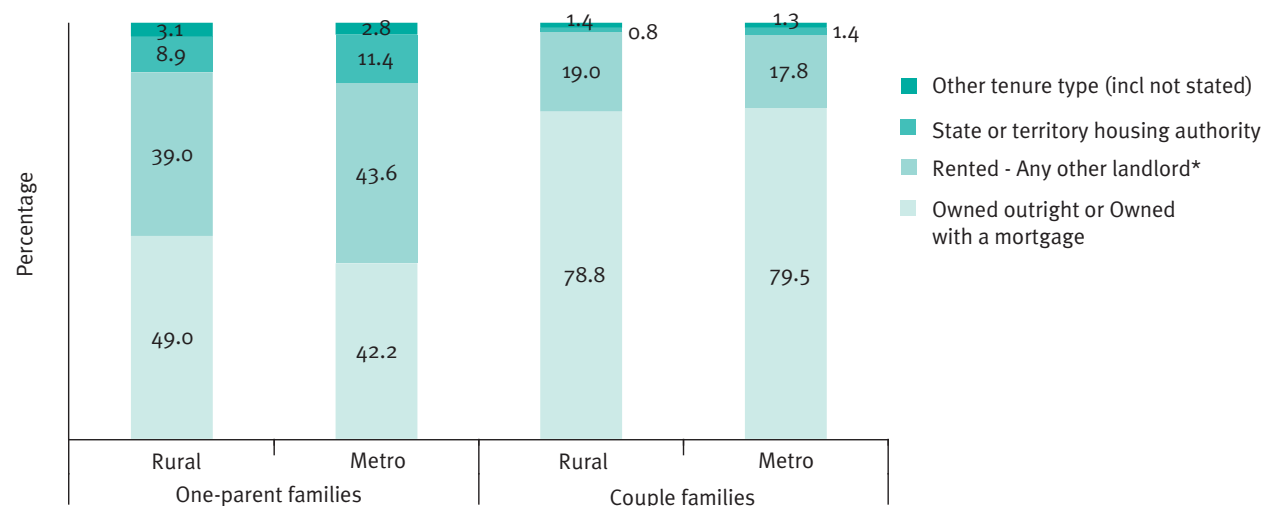
2.4 Housing

Stable, secure, well-located and affordable housing has a key role to play in promoting the wellbeing of children and in helping people to move out of poverty (DEECD 2009b; Rowe & Savelsberg 2010).

There has been considerable change in rural Australian housing markets since 2000, with rapid house price rises, a lack of affordable rental housing, and consequent inability of low-income earners to access affordable housing and move into home ownership (Australian Housing and Urban Research Institute 2012). One factor that may be impacting on this is a shortage of affordable housing in metropolitan areas, leading to people on low incomes moving to rural areas in search of cheaper accommodation.

Figure 2.8 shows one-parent families in Victoria are much more likely than couple families to be in rented accommodation; and this disparity is more evident in rural Victoria, where 43.6% of one-parent families are renting privately (compared with 39.0% of one-parent families in metropolitan Victoria) and 11.4% are renting from the state authority (compared with 8.9% in metropolitan Victoria).

Figure 2.8: Housing tenure for families with at least one child aged 0–17 years, by family and region type, Victoria, 2011



Source: 2011 Census of Population and Housing; ABS customised data report; DEECD analysis.

* Also includes landlord not stated.

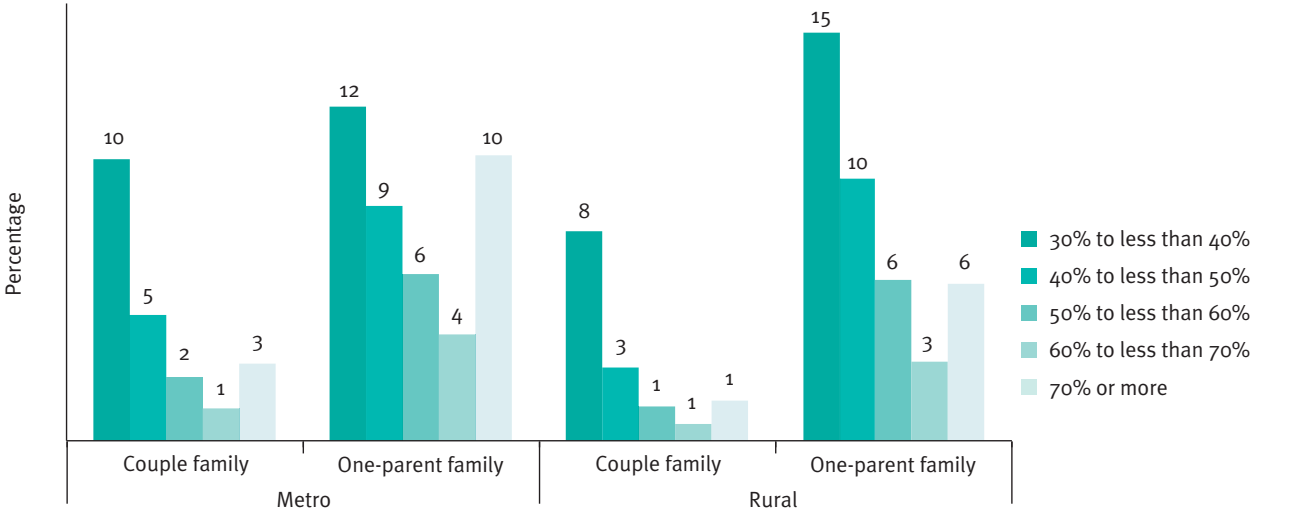
Income spent on housing

In general, the lower the household income, the higher the percentage of income that is spent on housing costs. Households that spend more than 30% of their incomes are considered to be in housing stress, with one-parent families and low-income families with children being the most likely to experience this (Gabriel et al. 2005).

Analysis of ABS 2011 Census data shows that one-parent families in Victoria are much more likely than couple families to be in housing stress, with similar proportions of one-parent families experiencing this in rural (40%) and metropolitan (41%) Victoria. Couple families in metropolitan Victoria are more likely than those in rural Victoria to experience housing stress (21% of couple families in metropolitan Victoria experience housing stress, compared with 14% of couple families in rural Victoria).

Figure 2.9 provides more detailed information about the percentage of income that is spent on housing by families in Victoria who are in housing stress. This highlights that, overall, families in rural Victoria are less likely than those in metropolitan Victoria to be in more severe housing stress.

Figure 2.9: Percentage of income spent on housing among families in housing stress, by family and region type, Victoria, 2011



Source: 2011 Census of Population and Housing; ABS customised data report; DEECD analysis.

Box 2.5: Changes impacting on disadvantage in rural/regional Victoria ¹²

Economic restructuring: resulting in decreased economic opportunities for some residents

The main industries in which regional Victorians were employed in the 1980s – agriculture, forestry, fishing and manufacturing sector – have declined, whereas the retail trade, accommodation, construction and healthcare and social assistance sectors have increased in the last decade. The agricultural industry is evolving from a base of small, family-held landholdings open to low-skilled labour towards larger corporate holdings requiring more highly skilled labour. The labour skills available in regional Victoria do not necessarily match the requirements of a restructuring economy. Almost 20% of workers in regional Victoria are unskilled.

Shifting population compositions resulting in the need for services and businesses to restructure

Population shifts have been experienced along with this economic restructuring. Some areas have experienced declines in population as they no longer offer the same level of employment opportunities for young people and unskilled labour as they have in the past. Ageing populations are evident in the wake of these shifts. Other regional areas have experienced growth due to shifts of population from other areas due to their attractiveness as service towns or cheaper housing for downshifter or commuters. The changing population composition creates new patterns of demands or pressure on services in towns – whether for new services, increased demand for existing services or lack of demand with population decline. Attracting service workers and skilled workers can also be a problem for regional Victoria.

Rising house prices leading to some populations becoming concentrated in low service areas

Since the mid-1990s housing prices have been rising in Melbourne and in regional centres. This has affected those segments of the population with limited income to spend on housing, therefore constrained to live in low-service areas, despite need. These groups include people who move to low-service areas for housing affordability (including metropolitan ‘migrants’ on low incomes) and local residents who cannot move to high-service areas when they need to (the aged, disabled, those wanting to enter the labour market) because of lack of affordability in those areas (Barr 2009; DPCD 2011).

Further information about Victoria’s economy, including the number and distribution of businesses, industry and the workforce in Melbourne and regional Victoria, is available in the *Industry Atlas of Victoria* at <http://www.dbi.vic.gov.au/research-reports/industry-atlas-of-victoria>

2.5 Diversity, community strength and social capital

While rural Victoria is socioeconomically disadvantaged in comparison to metropolitan Victoria, it has major advantages associated with strong communities, community connectedness and engagement. These advantages of social capital, identified through Victorian Community Indicators Survey data, are widely recognised in rural health literature, both in Australia (AIHW 2008; Bourke et al. 2010a) and internationally.

Rural parents responding to the 2008 Victorian Population Health Survey (VPHS) were significantly more likely than metropolitan parents to report that their neighbourhoods offered opportunities for participation in community, cultural and recreational activities (69.4% rural versus 55.9% metropolitan parents). Furthermore, the vast majority of rural parents reported that they can turn to one another for support at times of crisis (98.6%), or to help with problems (97.5%) (2009 VCHWS).

These views are echoed by young rural Victorians (2009 HOWRU), who are more likely than their metropolitan peers to believe that they can help decide about activities in their neighbourhoods (50.1% compared with 45.9%), and are more likely to report that there are opportunities to be involved in voluntary activities (66.7% compared with 61.3%). A greater proportion of those in rural than metropolitan areas also stated that they had a trusted adult in their life (74% compared with 69.5%).

The community strengths of rural Victoria are discussed in more depth in Section 7 of the report.

The Victorian Government's response (Victorian Government 2011a) to the recent *Parliamentary Inquiry into the Extent and Nature of Disadvantage and Inequity in Rural/regional Victoria* (Parliament of Victoria 2010) reiterates its commitment to ensuring all Victorians have the same access to opportunities, no matter where they live (Victorian Government 2011a). It recognises the diversity of rural Victoria and its experience. It also acknowledges the advantages rural Victorians have in living in strong communities, with high rates of volunteering and close community connectedness.

The *Regional Growth Fund* demonstrates the Government's commitment to delivering an improved quality of life, new opportunities and increased prosperity to rural Victoria.

The Victorian Health Priorities Framework 2012–2022 (released May 2011) provides the blueprint for the planning and development priorities for the Victorian healthcare system for the coming decade (Department of Health 2011b). The framework provides the foundation for the *Victorian Rural and Regional Health Plan 2012–2022* (Department of Health 2011c). It has been applied to the rural/regional health system to drive the development of key actions that will deliver services in rural Victoria that are more responsive to people's needs and rigorously informed and informative.

Koolin Balit (Department of Health 2011d) sets out the Victorian Government's strategic directions for Aboriginal health for 2012–22. It provides an integrated, whole-of-life framework for making a significant and measurable impact on improving the length and quality of the lives of Aboriginal Victorians.

The *Victorian Aboriginal Affairs Framework 2013–18* (VAAF) (Department of Planning and Community Development 2012b) brings together Government and Aboriginal community commitments and efforts to create a better future for Victoria's Aboriginal population. The VAAF focuses effort and resources on six Strategic Action Areas that are central to closing the gap in Aboriginal disadvantage.

The *2011 Victorian Families Statement* (Victorian Government 2011b) recognises the differences in life circumstances experienced by families in rural Victoria and metropolitan Melbourne and reiterates the Government's position that *services and opportunities should not depend on where we live*.

The *2012–13 Budget* confirms the Government's commitment to providing strong, responsive frontline services to families. This commitment, together with the focus on strengthening the economy, will help Victorian families to meet their full potential.

Box 2.6: Advancing Country Towns program

The Victorian Government's \$9.4 million Advancing Country Towns place-based program commenced in June 2011 to create new opportunities and improve quality of life in nine small regional and rural townships. The program responds to the challenges associated with rapid change and complex and entrenched disadvantage that limits access to services and economic participation.

The program objectives are to:

- improve investment and service coordination and integration to more efficiently meet identified local priorities
- improve access to education, skills and training and employment
- identify economic development opportunities
- increase the capacity of regional communities to participate in decision-making and priority-setting activities.

Each project site identified a set of local priority areas to focus effort and investment. The program has used the Department of Treasury and Finance's (DTF) Investment Management Standard to confirm local priorities. This approach involves three facilitated workshops with local and regional decision-makers to identify local problems and the benefits to be achieved. The approach is recognised across government as a proven methodology for making funding and investment decisions.

In Benalla, the Advancing Country Towns program identified four problems. An early years issue, that vulnerable families were not getting the collaborative ongoing support they need to give their children a fair start, was prioritised as needing almost half the project's effort and investment. This was in response to local people recognising the importance of providing a strong foundation for their children to be ready for school. International research indicates that early years skills form the basis for the life skills needed in later life, so ensuring that people can participate in the kind of economic opportunities this program will create in the future.

To address this problem, the project is piloting the internationally successful Parents Early Education Partnership (PEEP) program, which supports parents and carers as the child's earliest and most significant educators. Where possible, the program works with parents, from before the birth of their child, to improve outcomes for children. PEEP programs will be delivered in a local shop front, playgroups, preschools and family homes. Benalla's Tomorrow: Today Foundation, a locally run philanthropic organisation, will pilot PEEP in partnership with DEECD.

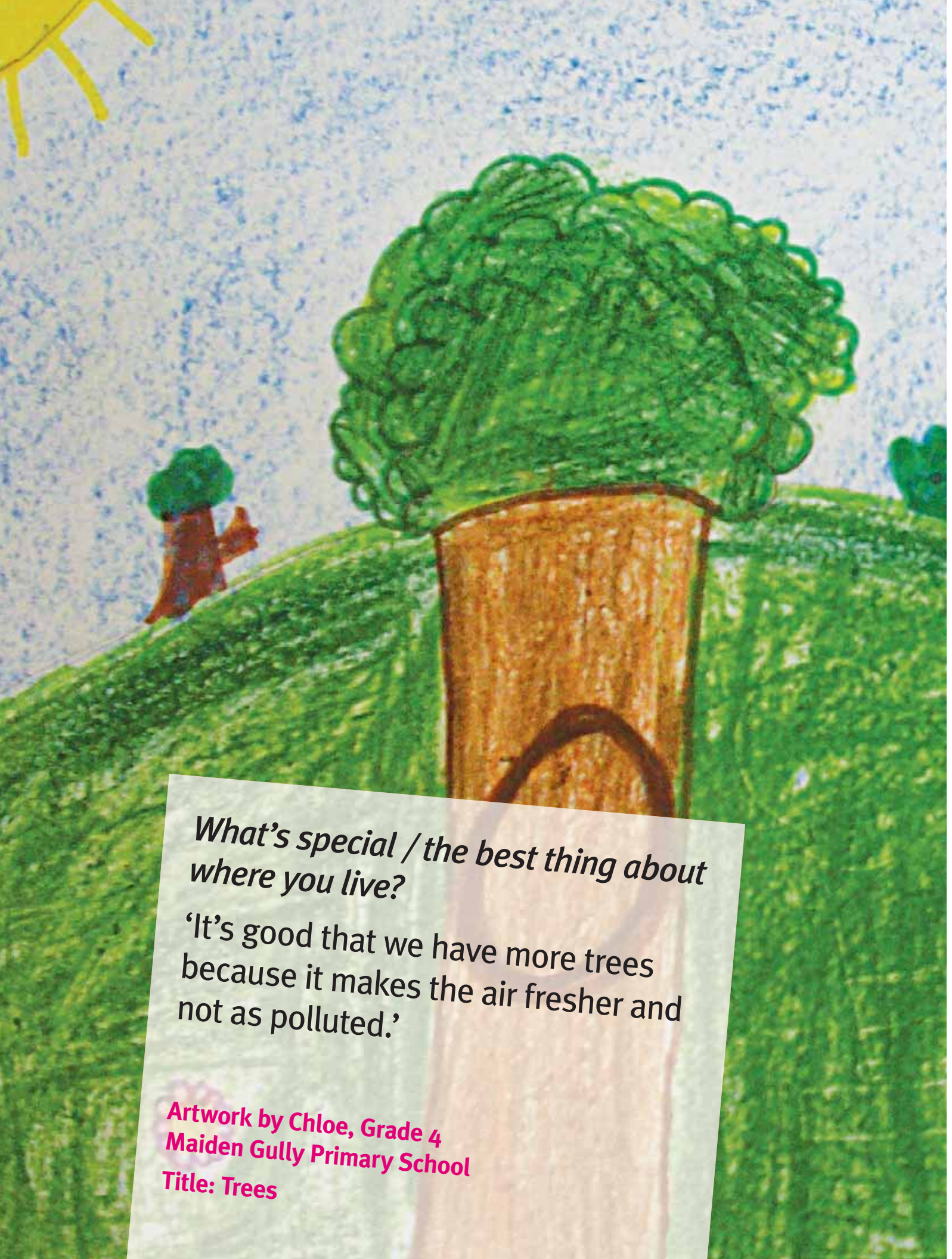
The use of the DTF Investment Management Standard to confirm priorities has led to an agreed set of key performance indicators, measures and targets to monitor and evaluate program outcomes. The benefits of using this proven methodology has meant government departments have come together around an agreed framework and been involved in local activities to improve outcomes for children in this regional town.



*What's special / the best thing
about where you live?*

*'You can go camping and you
can play outside.'*

Artwork by Toby, Grade 3
Maiden Gully Primary School
Title: A nice summer day



*What's special / the best thing about
where you live?*

*'It's good that we have more trees
because it makes the air fresher and
not as polluted.'*

**Artwork by Chloe, Grade 4
Maiden Gully Primary School
Title: Trees**

A child's drawing of a landscape. The sky is blue with three small, dark, curved marks. The hills are green with white lines representing grass. A green tree is on the left. A girl with brown hair, wearing a purple shirt and blue pants, is standing in the foreground. A brown bench is on the right.

Section 3

Health and Wellbeing

3. Health and Wellbeing



Artwork by Laura, Grade 3
Maiden Gully Primary School
Title: A day camping

3.1 General physical health

Immunisations

Early years

The Australian Childhood Immunisation Register provides information about vaccine coverage at the three key milestones of 12 months, 24 months and 6 years of age. Children are routinely immunised against hepatitis B, rotavirus, diphtheria, tetanus, pertussis (whooping cough), polio, pneumococcal disease, haemophilus influenza type B (Hib), measles, mumps, rubella, meningococcal C and varicella (chicken pox).

This information shows that higher proportions of children in rural Victoria are fully immunised¹³ than in metropolitan Victoria, with no marked regional variations (2010–11). This has been true for all three of the above age cohorts since 2002–03.

Secondary school

Secondary school children are immunised in Year 7 (against hepatitis B, chickenpox and human papillomavirus)¹⁴ and in Year 10 (against diphtheria, tetanus and pertussis).¹⁵ Children are more likely to be fully vaccinated (Years 7 and 10) in rural Victoria than in metropolitan Victoria (Table 3.1).

Table 3.1: Percentage of fully vaccinated children in Years 7 and 10, by region type and vaccination, Victoria, 2009

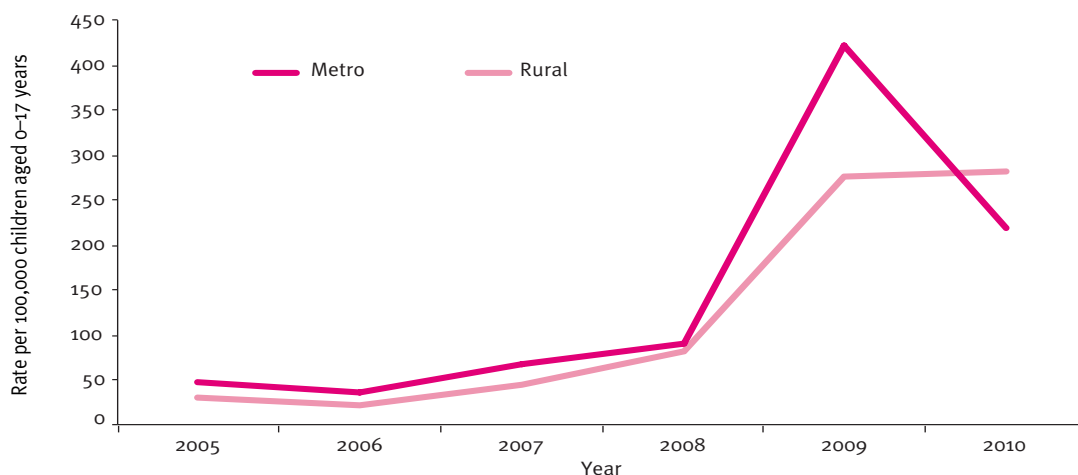
| Rural type | Boostrix | Hepatitis B | HPV-Gardasil | Varilrix |
|--------------|----------|-------------|--------------|----------|
| Rural | 79.2 | 77.4 | 75.9 | 71.6 |
| Metropolitan | 71.5 | 73.6 | 71.5 | 72.5 |

Source: School Immunisation Program, 2009, DEECD.

Vaccine preventable diseases notifications

The rate of vaccine preventable diseases (VPD) notifications in children and young people aged 0–17 years increased markedly from 2008–09 and has since declined.¹⁶ The rate is lower in rural Victoria compared with metropolitan Victoria (2005–09), although this pattern reverses in 2010 (Figure 3.1)

Figure 3.1: Rate of notifications of vaccine preventable diseases (VPD) in children and young people aged 0–17 years (per 100,000), by region type, Victoria, 2005–10



Source: Notifiable Infectious Disease Surveillance System 2005–2010, DoH (unpublished).

Inner regional Victoria has the highest rate of VPD notifications, while rates are lowest in major cities. From 2005 to 2009, the rate of VPD notifications was highest in Gippsland region.

Asthma

Asthma is the primary cause of disease burden for Victoria children, accounting for approximately one-fifth of the total disease burden (DHS 2005). There are no significant differences in the proportions of children and young people in rural and metropolitan Victoria who have it. Though there is considerable regional variation, most notably among children, with rates ranging from 8% of children with asthma in the Northern Metropolitan Region to 15.9% in the Grampians Region. There are also marked regional variations in the proportions of children and young people who have a written asthma plan.

Child vision

In the School Entrant Health Questionnaire (SEHQ) parents of Victorian children are asked if they have concerns about their child's vision. Levels of reported parental concern about child vision have declined in Victoria since 2009 and are higher in 2011 in metropolitan Victoria than in rural Victoria (8.6% of parents reporting concerns compared with 6.7% in rural Victoria).

Regional variation

In rural Victoria the highest level of reported concern about child vision is in Loddon Mallee (7.7%) and the lowest is in Barwon South Western Region (6.0%).

Aboriginal children

Aboriginal children are more likely than non-Aboriginal children to have parents who are concerned about their child's vision (Table 3.2). Similar proportions of Aboriginal children have parents who express concerns in rural and metropolitan Victoria (10.0% and 9.7% respectively). The gap between the percentages of Aboriginal and non-Aboriginal children (who have parents expressing concerns) is slightly larger in rural (3.2%) than in metropolitan Victoria (1%).

Table 3.2: Percentage of children at school entry whose parents are concerned about their vision, by region type and Aboriginal status, Victoria, 2011

| Rural type | Aboriginal | Non-Aboriginal |
|--------------|------------|----------------|
| Rural | 10.0 | 6.8 |
| Metropolitan | 9.7 | 8.7 |

Source: SEHQ 2011, DEECD.

Key policy directions relating to general physical health

- Victorian Government Prevention Community Model – National Partnership Agreement on Preventive Health (2008)
- *Victorian Public Health and Wellbeing Plan 2011–15* (2011)
- *Victorian Health Priorities Framework 2012–2022*
- *Victorian Rural and Regional Health Plan 2012-2022*
- Victorian Health Promotion for Children and Young People Policy
- Community Health Services Child Health teams

Programs in place

- Maternal and Child Health (MCH) Services and Enhanced MCH
- anaphylaxis management in schools
- hepatitis B vaccination for babies
- human papillomavirus vaccination (Year 7)

3.2 Oral health

Parental concerns about their children's oral health

SEHQ data for 2011 show that similar proportions of rural and metropolitan parents report having concerns about their children's oral health (14.7% of rural parents reported concerns, compared with 14.5% of metropolitan parents). This pattern differs, however, from that observed in 2009 and 2010, when parents in rural Victoria were more likely to report concerns than parents in metropolitan Victoria (Table 3.3).

Table 3.3: Percentage of children at school entry whose parents reported concern about their oral health, by region type, Victoria, 2009–11

| Rural type | 2009 | 2010 | 2011 |
|--------------|------|------|------|
| Rural | 17.5 | 13.7 | 14.7 |
| Metropolitan | 15.7 | 12.1 | 14.5 |

Source: SEHQ 2009–11, DEECD.

Aboriginal children

Aboriginal children are more likely than non-Aboriginal children to have parents reporting concerns about their children's oral health. This difference (between outcomes for Aboriginal and non-Aboriginal children) is slightly more evident in rural, compared with metropolitan Victoria (Table 3.4).

Table 3.4: Percentage of children at school entry whose parents reported concern about their oral health, by region type and Aboriginal status, Victoria, 2011

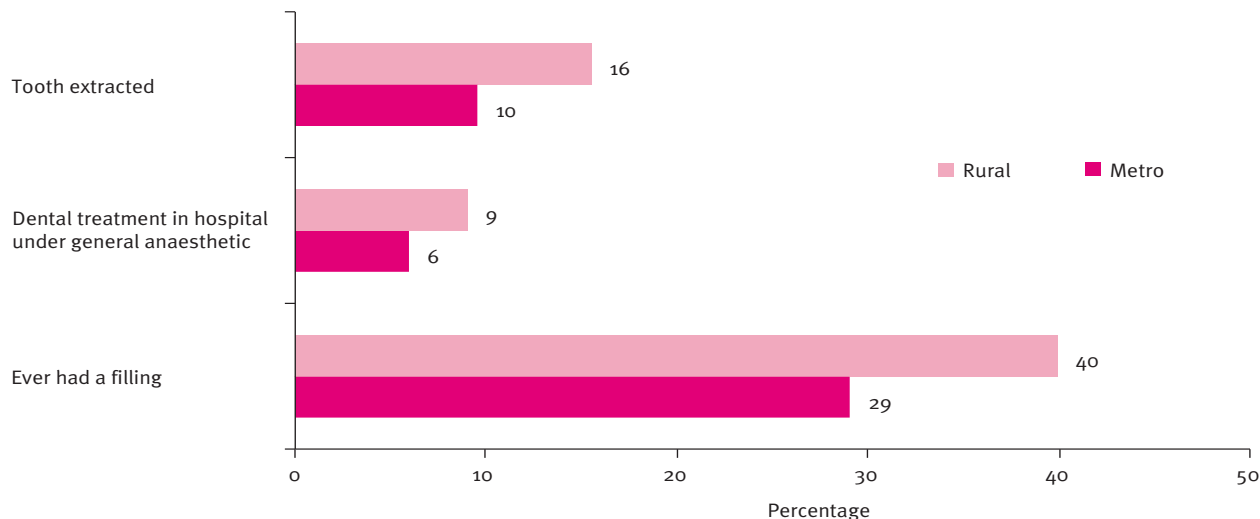
| Rural type | Aboriginal | Non-Aboriginal | % difference |
|--------------|------------|----------------|--------------|
| Rural | 21.8 | 14.8 | 7.0 |
| Metropolitan | 20.1 | 14.8 | 5.3 |

Source: SEHQ 2011, DEECD.

Oral health status and treatments

The 2009 VCHWS indicates that over a quarter (27.3 per cent) of all 5–12 year-old Victorian children have experienced a toothache at some stage, with a much higher proportion in rural Victoria (35.2 per cent in rural versus 24.1 per cent in metropolitan Victoria). Tooth fillings, tooth extractions and hospital dental treatment also occur more frequently in children from rural Victoria (Figure 3.2).

Figure 3.2: Reported dental treatments in children up to 12 years of age, by region type, Victoria, 2009



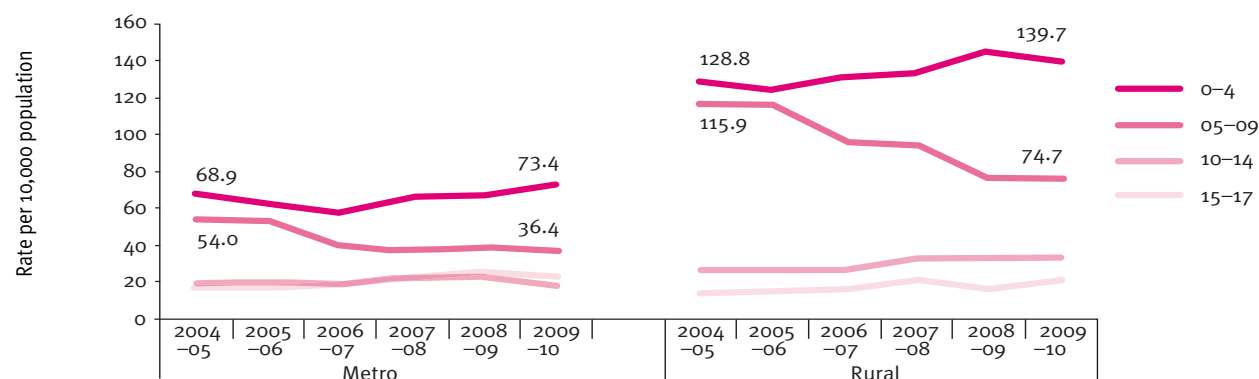
Source: VCHWS 2009, DEECD.

Hospitalisations due to dental decay

Admissions to hospital for tooth decay and related causes are preventable, since appropriate health care should remove the need for hospital-based treatment of dental problems. However, dental caries (decay and crumbling of a tooth) is a leading cause of hospitalisation among children and young people aged 0–17 in rural Victoria;¹⁷ and, as Figure 3.3 shows, the rate (per 10,000 population) of hospitalisations due to dental decay is much higher in rural than metropolitan Victoria for children in the 0–4 and 5–9 year age group.

While rates of dental decay hospital separations have shown marked declines in the 0–4 year age group (2004–05 to 2009–10), they have increased among 5–9 year-olds (Figure 3.3).

Figure 3.3: Rate of hospital separations due to tooth decay (dental caries and related causes) in children and young people aged 0–17 years (per 10,000), by age group and region type, Victoria, 2004–05 to 2009–10



Source: Victorian Admitted Episodes Data (both public and private hospitals) 2004–05 to 2009–10, DoH; Estimated Resident Population 30 July 2010, ABS.

Regional variation

The highest percentages of children with parents reporting concerns about their child’s oral health in rural Victoria were in Gippsland (15.5%) and Hume (15.1%) regions (2011 SEHQ).¹⁸

The highest reported rates of fillings were in Barwon South Western (43.6%) and the Grampians (40.7%), and the highest rates of extractions were in Barwon South Western (17.9%) and Hume (16.2%) (2009 VCHWS). Grampians consistently had the highest rates of dental decay hospitalisations for children aged 0–4 and 5–9 years. Within rural Victoria, rates were lowest at age 0–4 years in Barwon South Western Region and at 5–9 years in Hume.

VCHWS dental treatment data highlights that outcomes are generally poorer for children living in inner regional Victoria and better for those in major cities, although similar percentages of children in inner (8.4%) and outer regional Victoria (9.9%) have had dental treatment in hospital under general anaesthetic.

The poorer oral health outcomes of children in inner regional Victoria are marked for tooth extractions and fillings.

Possible explanation for the poorer oral health outcomes in rural Victoria

Possible explanations for the poorer oral health outcomes in rural Victoria include the extent of water fluoridation, oral health behaviours (tooth brushing), poor dietary habits (including sugary drink consumption) and access to and use of dental services, including barriers associated with cost.

Fluoridation

DEECD analysis of both DHS postcode fluoridation data and data from the 2009 VCHWS highlights that children in areas with no or partial water fluoridation are more likely to have fillings than those in fluoridated areas. Of children who were living in areas with no or partial fluoridation, 39.8% had had a filling, compared with 30.8% of children living in fluoridated areas.

Sugary drink consumption

Excessive consumption of sugary drinks is associated with poor oral health, particularly tooth decay (DoH 2012). The 2009 VCHWS shows that children in rural areas are more likely than those in metropolitan areas to be having a sugary drink daily, with 48.5% of children (aged 1–12 years) in rural Victoria consuming at least one cup of sugary drink⁴⁹ daily (compared with 42.7% in metropolitan Victoria).²⁰

Further analysis of VCHWS data also indicates a consistent pattern of associations between measures of socioeconomic disadvantage and the likelihood of a child (aged 1–12 years) in Victoria consuming sugary drinks daily. This association is stronger in rural than in metropolitan Victoria for income-based indicators (child listed on a health care card, household income is less than \$40,000);²¹ and strongest in metropolitan than in rural Victoria for ‘most disadvantaged SEIFA quintile’ and ‘single-parent family’.²²

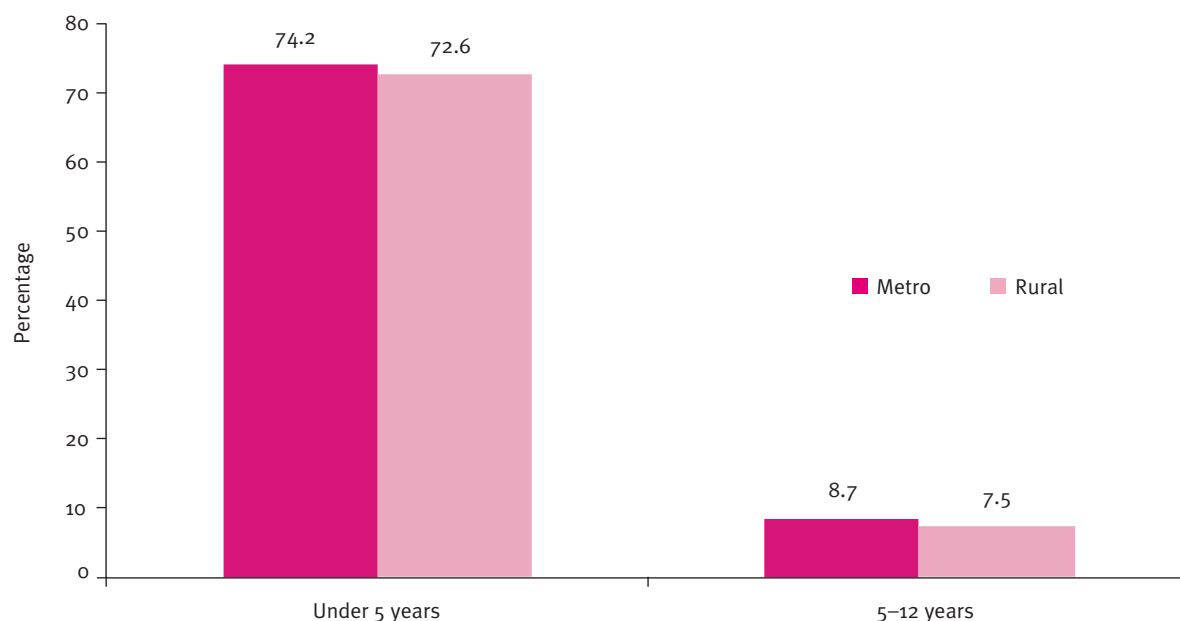
Oral health behaviours

There are no notable differences in tooth-brushing behaviours between children and young people in rural areas and those in metropolitan areas, with around 60% of children and 68% of young people reported to be brushing their teeth at least twice a day.

Access to and use of dental services

As Figure 3.4 shows, the 2009 VCHWS also finds no notable region type differences in i) the percentages of children who have never been to a dentist or ii) young people’s reported access to and use of dental services. However, as is noted in the following sections, there are disparities in reported access to dental services for Aboriginal children and ii) regional variation in young people’s reported access to dental services.

Figure 3.4: Percentage of children who have never been to a dentist, by age group and region type, Victoria, 2009



Source: VCHWS 2009, DEECD.

Parents' report data from the 2011 SEHQ show that 52.1% of children entering primary school in rural Victoria had attended a dentist, compared with 46.3% of children in metropolitan Victoria.

Aboriginal children at school entry are less likely to have visited a dentist than non-Aboriginal children (Table 3.5). However, Aboriginal children in rural Victoria are slightly more likely than Aboriginal children in metropolitan Victoria to have visited a dentist (41.2% and 37.6%, respectively) and the difference between Aboriginal and non-Aboriginal dentist attendance is only slightly more evident in rural (12.6%) than in metropolitan Victoria (10.3%).

Table 3.5: Percentage of children at school entry who have visited a dentist, by Aboriginal status and region type, Victoria, 2011

| Rural type | Aboriginal | Non-Aboriginal |
|--------------|------------|----------------|
| Rural | 41.2 | 53.8 |
| Metropolitan | 37.6 | 47.3 |

Source: SEHQ 2011, DEECD.

Cost as a barrier to access

Cost is often cited as a significant reason for the delay or avoidance of dental care. It is mainly concession card holders, those who are uninsured and those who only go when dental issues arise who tend to delay or avoid recommended treatment (Richardson & Richardson 2011). Analysis presented in the 2007 DHS plan 'Improving Victoria's oral health' concludes that access to fluoridated water and the proportion of households living in poverty are significant predictors of regional differences in dental Ambulatory Care Sensitive Condition (ACSC)²³ admission rates (DHS 2007).

Analysis of 2009 VCHWS data carried out for this report found that there was evidence in Victoria of a significant association between socioeconomic disadvantage (as measured through a range of disadvantage indicators) and the chances of a child (aged 1–12 years) having had a tooth filling. Generally, there was a slightly higher risk in metropolitan than in rural Victoria.²⁴ 'Being from the most disadvantaged SEIFA quintile' was not associated with an increased likelihood of a child having a tooth filling in either rural or metropolitan Victoria. However, 'being from a low income household' increased the likelihood of a child having a tooth filling by 34% in rural Victoria, with no increased likelihood for metropolitan Victoria (for detailed findings, see online Technical Appendix).

Regional variation

There is considerable regional variation in the percentages of children aged under 12 years who consume at least cup of sugary drink daily, ranging from 36.9% in Eastern Metropolitan Region to 50.4% in the Grampians.

Young people in the Grampians are also the least likely to report brushing their teeth at least twice a day (63.3%). (Young people in Hume were the most likely to report this.)

Although Grampians has the lowest percentage of children aged under 5 years who have never been to a dentist (69.5%), it also has the highest percentage of children aged 5–12 years who have never been to a dentist (11.5%). Barwon South Western Region has the lowest percentage of children aged 5–12 years who have never been to a dentist (3.3%).

Young people in the Grampians are less likely to say that they can access dental services and to report visiting a dentist regularly (once or more times a year), and more likely to visit a dentist for a dental problem rather than a check-up (2009 HOWRU).

Key policy directions relating to oral health for children and young people

- WHO, *Global Policy for Improvement of Oral Health* (2007)
- Australian Government, *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2004–2013* (2004)
- *Improving Victoria's Oral Health* (2007)
- *Victorian Public Health and Wellbeing Plan 2011–2015* (2011)
- *Victorian Oral Health Promotion Plan 2012–2017* (under development)
- *Koolin Balit: The Victorian Government's strategic directions for Aboriginal health 2012–2022* (2012)

Victorian government commitments and initiatives

- *Healthy Families, Healthy Smiles* – Early Intervention Oral Hygiene and Health Program (\$4m over four years from 2012)
- mobile dental units, to deliver improved dental services in rural/regional areas.
- Dental employment program, focusing on areas of highest workforce shortages (usually rural)
- Health and Education Assessments for Children in Residential Care

Programs in place

- Water fluoridation
- Evidence-based Oral Health Promotion Resource
- Dental Employment Program, Rural Dental Practitioners and Mobile Dental Units
- La Trobe University Dental School in Bendigo
- Dental program targeted to areas of high needs
- Oral Health Capacity Building
- Oral Health Component – MCH strategy
- *Smiles 4 Miles*
- Victorian Prevention and Health Promotion Achievement Program

3.3 Nutrition, physical activity and healthy weight

Childhood and adolescence are critical periods for the development of overweight and obesity, and obesity in early life is of particular concern because it has both short- and long-term health consequences and can impact on children and young people's psychosocial development (DEECD 2009b, p. 46). As is noted in the 2010 SOVC, 'establishing patterns of good eating and physical activity in childhood helps ensure that children and young people maintain a healthy body weight until they reach adulthood, thus providing the best start for optimum physical and mental development' (DEECD 2012, p. 49).

Overweight and obesity: prevalence in early childhood and in children and young people

Estimates of overweight and obesity among Victorian children and young people, based on national survey data, suggest that around 19.2%* are overweight and 6.1% obese (NHS 2007–08). Reliable data are limited on the prevalence of overweight and obesity in children and young people in rural Victoria.

Recent studies highlight that the prevalence of obesity and overweight appears to be associated with two factors that are linked more notably to rural than to metropolitan Victoria: higher levels of socioeconomic disadvantage (Nichols et al. 2010; National Secondary Students' Diet and Activity (NaSSDA) Survey 2009–10) and geographical remoteness (NHS 2007–08). However, research has found no associations between children's body mass index (BMI) and location (rural or metropolitan), after controlling for socioeconomic status (Aucote & Cooper 2009).

* Figure amended from first release

Nutrition

Eating sufficient quantities of fruit and vegetables and limiting the consumption of high-sugar, high-salt and high-fat foods are important for a healthy diet and the maintenance of healthy weight (DEECD 2012).

Fruit and vegetable consumption

Analysis of Victorian survey data shows that only a small proportion of children and young people meet the National Health and Medical Research Council (NHMRC) recommended guidelines for fruit and vegetable consumption (Box 3.1).

Box 3.1: NHMRC recommendations for daily fruit and vegetable consumption

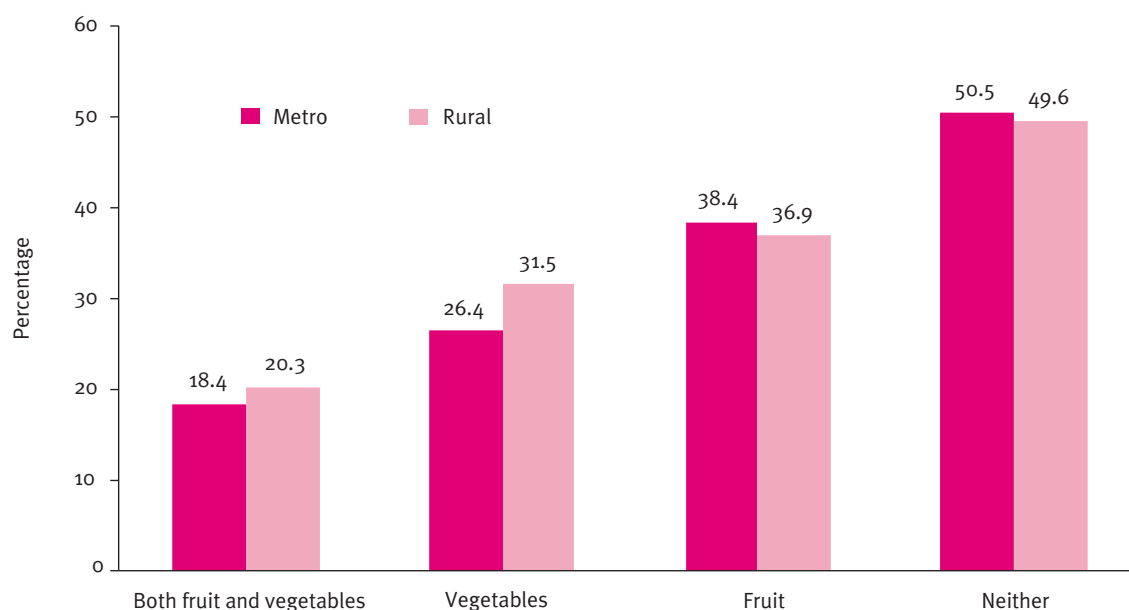
- For children aged 4–7 years: one serve of fruit and two serves of vegetables
- For children aged 8–11 years: one serve of fruit and three serves of vegetables
- For young people aged 12–18: three serves of fruit and four serves of vegetables.

(NHMRC 2003b).²⁵

There is no significant difference in intake of fruit and vegetables between children in rural and in metropolitan Victoria, with just over one-third of children meeting recommended consumption levels for both fruit and vegetables (34.5% rural versus 34.8% metropolitan). Around one in 12 children meet neither of the recommended intake levels (7.6% rural versus 7.7% metropolitan).

Young people (aged 12–17 years) are much less likely than children to meet recommended levels of fruit and vegetable consumption, with 50.5% in metropolitan Victoria and 49.6% in rural Victoria meeting neither of the recommended intake levels (Figure 3.5). However, young people in rural Victoria are more likely than young people in metropolitan Victoria to meet the recommendations for vegetable consumption (31.5% compared to 26.4%).

Figure 3.5: Percentage of 12–17 year-olds meeting recommended intake of fruit and vegetables, by region type, Victoria, 2009



Source: HOWRU 2009, DEECD.

Socioeconomic status

Analysis of 2009 VCHWS data also identifies that children living in families with a low income (less than \$40,000) in rural Victoria have an increased likelihood of not meeting recommended intake levels for fruit (for detailed findings, see online Technical Appendix).

Takeaway food consumption

Similar proportions of children (aged 1–12 years) in rural and metropolitan Victoria were reported to consume takeaway foods (6.2% of children in rural areas and 7.1% in metropolitan areas consumed these foods five times a month or more; while 13.2% of children in rural areas rarely or never consumed these foods, compared with 13.3% in metropolitan Victoria). Children in rural areas were more likely, however, to consume fried potato products.²⁶

Sugary drinks

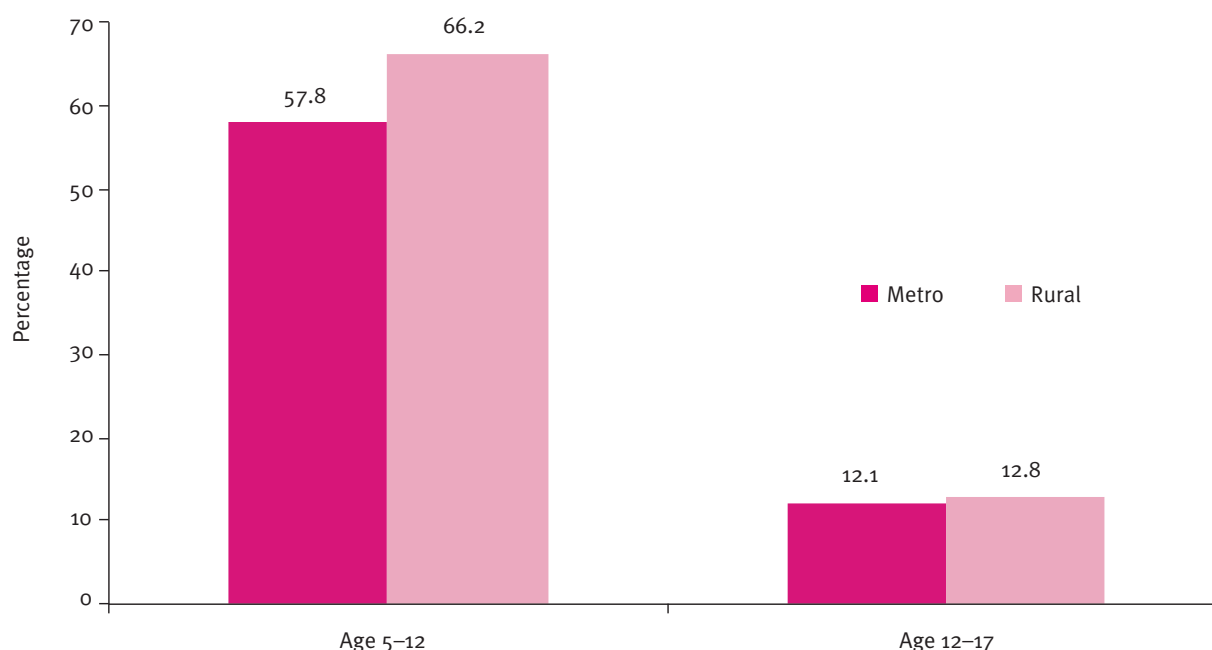
As noted in the discussion of oral health, the 2009 VCHWS shows that children in rural areas are more likely than those in metropolitan areas to be having a sugary drink daily. Excessive consumption of sugary drinks is associated with weight gain and obesity in childhood (Whitaker 2003), as well as poor oral health (Gussy et al. 2006).

Physical activity

The Australian Government recommends that children and young people aged 5–18 years should have at least one hour of moderate-to-vigorous physical activity every day and should not spend more than two hours a day using electronic media for entertainment (Australian Government 2004a; 2004b).

Children in rural areas are more likely than children in metropolitan areas to meet recommended levels of physical activity. There is no difference by region type in the percentages of young people meeting recommendations. There is a marked decline with age across Victoria in levels of physical activity (Figure 3.6).

Figure 3.6: Percentages of children and young people meeting daily recommended levels of physical activity, by age group and region type, Victoria, 2009



Box 3.2: Relationship between children's physical activity and the physical environment

A review of 33 studies of the relationship between children's participation in physical activity (aged 3–18 years) and the physical environment (perceived and objectively measured) found that children's participation in physical activity was positively associated with recreational and transport infrastructure (access to recreational facilities and schools, and presence of sidewalks and access to public transport). At the same time, key aspects of transport infrastructure (number of roads/traffic density and speed) and local conditions (crime, area deprivation) were negatively associated with physical activity (Davison & Lawson 2006).

Use of electronic media

High levels of sedentary activity, as measured through time spent in using electronic media, can link with lower levels of physical activity and, in turn, with overweight and obesity, although the evidence to support this pattern of association is not conclusive (Aucote & Cooper 2009). Recent evidence also suggests that increased sedentary behaviours may be associated with unfavourable health outcomes, independent of physical activity levels (Tremblay et al. 2011).

There are no notable differences in the proportions of children in rural Victoria (21.7%) and metropolitan Victoria (18.8%) who use electronic media for more than two hours per day. However, young people in rural Victoria are less likely than young people in metropolitan Victoria to use electronic media for more than two hours per day (60% of young people in metropolitan areas do so, compared with 55.7% in rural Victoria).

Regional variation

There is considerable regional variation in physical activity levels, with percentages of children who meet recommended levels of physical activity ranging from 55.3% in Northern Metropolitan Region to 70.4% in Gippsland; and percentages of young people meeting physical activity recommendations ranging from 9% in Grampians to 14.8% in Barwon South Western Region.

Percentages of children (aged 5–12 years) who use electronic media for more than two hours per day (on average) range from 14.2% in Northern Metropolitan Region to 26% in Loddon Mallee; and percentages of young people who usually use electronic media for more than two hours per day range from 51.6% in Hume to 61.9% in Northern Metropolitan Region.

Key policy directions relating to physical activity and healthy weight

- Victoria's Prevention Community Model has funded 12 local prevention areas, consisting of 14 LGAs and community health agencies
- Victorian Government Prevention Community Model – National Partnership Agreement on Preventive Health (2008)
- *NHMRC Dietary Guidelines for Children and Adolescents* (in preparation)
- *Victorian Public Health and Wellbeing Plan 2011–15* (2011)
- Victorian Health Promotion for Children and Young People Policy
- *Victorian Aboriginal Nutrition & Physical Activity Strategy 2009–2014* (2009)

Programs in place

- Victoria's Prevention Community Model has funded 12 local prevention areas, consisting of 14 LGAs and community health agencies
- Victorian Prevention and Health Promotion Achievement Program
- Victorian Healthy Eating Advisory Service
- Healthy Eating and Food Literacy in Secondary Schools in the Prevention Community Model

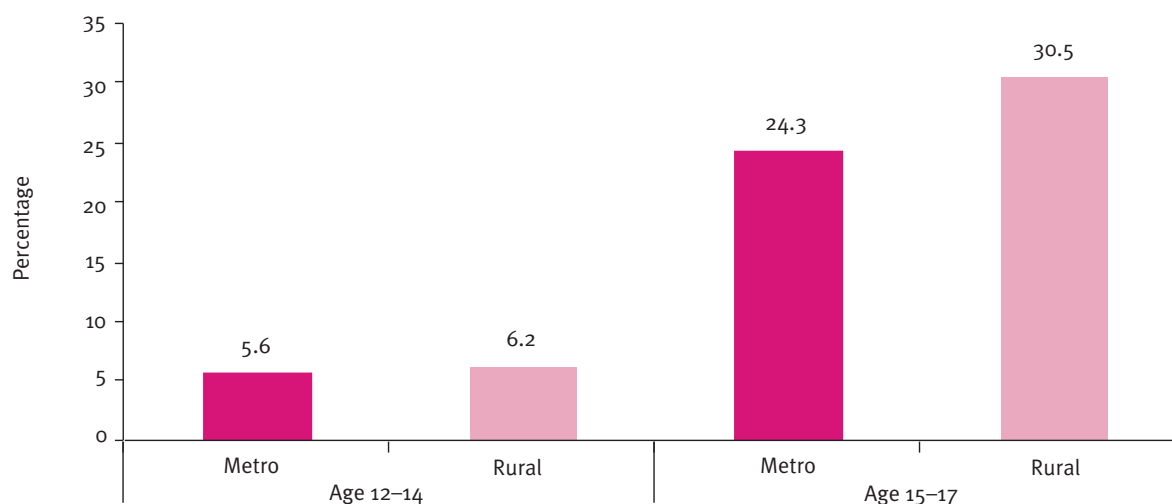
3.4 Sexual and reproductive health

Sexual activity

Many young people have sexual experiences at a younger age than their first engagement in sexual intercourse. However, intercourse before the age of 16 years is associated with lower use of contraception, more sexual partners, a higher risk of sexually transmitted infections (STIs) and teenage pregnancy; consequently, early sexual activity can be viewed as a ‘problem behaviour’ for young people (Family Planning Victoria et al. 2005).

Young people in rural Victoria are much more likely to report having had sexual intercourse than young people in metropolitan areas. The percentages of young people who report having had intercourse are shown by age in Figure 3.7.

Figure 3.7: Percentages of young people who have had sexual intercourse, by age group and region type, Victoria, 2009



Source: HOWRU 2009, DEECD.

Box 3.3: Sexual attraction and sexual identities among young people

Information from a 2008 national survey of secondary school students (Smith et al. 2009) suggests that the majority of young people (91%) are attracted to the opposite sex, with 6% attracted to both males and females, 1% report same-sex attraction, and around 2% of young people are unsure of their sexual identity.

A 2010 national survey of same-sex attracted and gender-questioning (SSAGQ) young people found that, when compared with their heterosexual peers, young SSAGQ people are less likely to use a condom, twice as likely to become pregnant and more likely to contract a sexually transmitted infection (STI). Young SSAGQ people in rural and remote areas experience particular concerns relating to isolation, discrimination and lack of appropriate services and supports (Hillier et al. 2010).

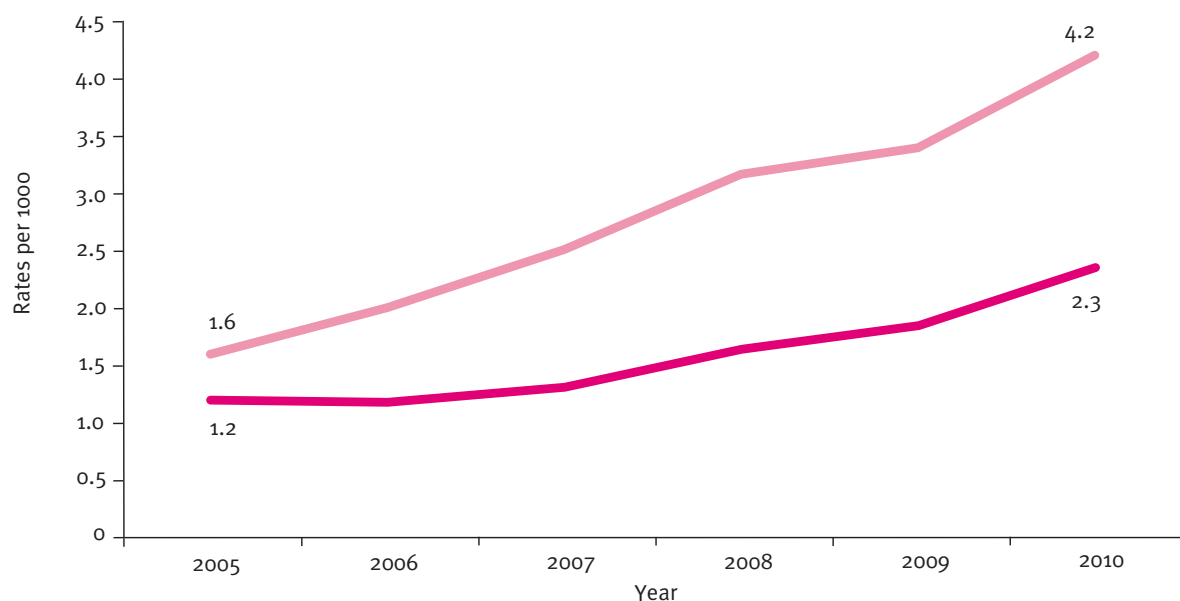
Contraception use

Sexually active young people in rural Victoria are more likely to use contraception (68.2%) than sexually active young people in metropolitan Victoria (58.4%). Condoms (which can provide protection against STIs when consistently used) and the contraceptive pill are the most commonly used types of contraception.

Sexually transmissible infections

Contracting a STI can have adverse effects on sexual and reproductive health, including the development of cervical cancer, infertility and recurrent pain (DEECD 2012, p. 130). Rates of STIs in young people are increasing (2005–10). They are higher for young people in rural Victoria than metropolitan Victoria, and this difference has become more pronounced over time (Figure 3.8). The highest and fastest growing rates are for chlamydia.

Figure 3.8: Rate of sexually transmissible infections in 12–17 year-olds (per 1000), by region type, Victoria, 2005–10

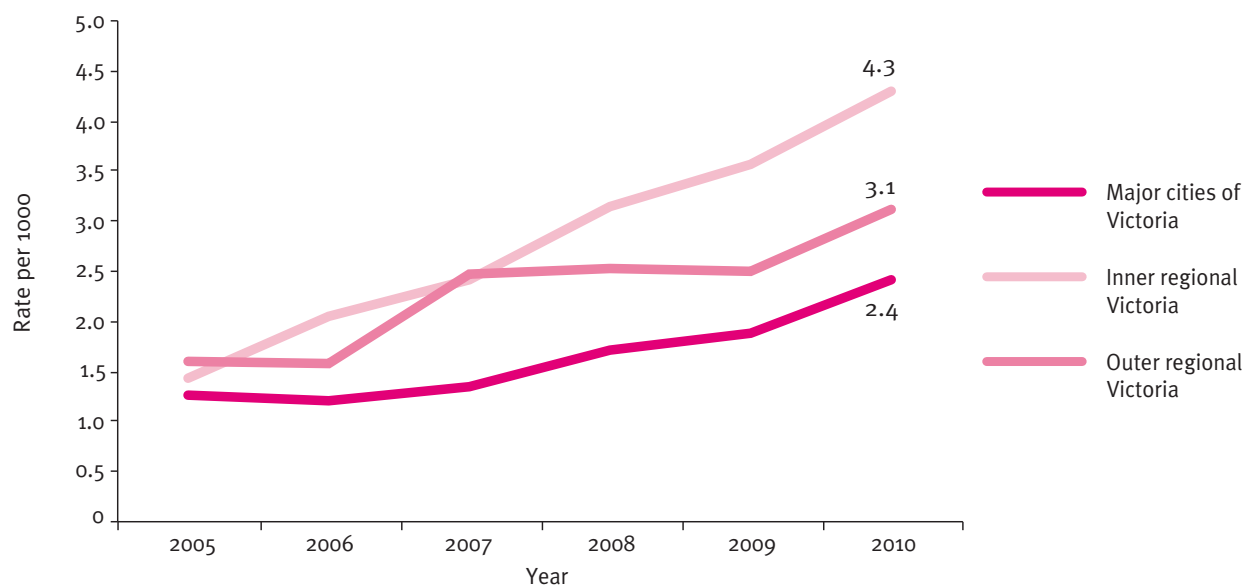


Source: The Notifiable Infectious Disease Surveillance System 2005–2010, DoH; Estimated Resident Population 2005–2010, ABS.

Regional variation

Inner regional Victoria has the highest rates of STIs and rates of STIs are increasing notably in inner regional areas (Figure 3.9).

Figure 3.9: Rate of sexually transmissible infections for 12–17 year-olds (per 1000), by ARIA classification, Victoria, 2005–10



Source: The Notifiable Infectious Disease Surveillance System 2005–2010, DoH; Estimated Resident Population 2005–2010, ABS.

Teenage births

Being a young parent (under 20 years) is associated with an increased risk of poor social, economic and health outcomes, although not all teenage conceptions are unplanned or unwanted and not all teenage pregnancies lead to poorer outcomes.

Based on the latest available data (2008), the teenage birth rate (per 1000 women) is two times higher for young women aged 15–19 years in rural Victoria (at 16.7) than in metropolitan Victoria (at 7.6). This pattern has been consistent since 2003.

Regional variation

Among young people aged 15–17, those in Barwon South Western and the Grampians regions are the most likely to have had sexual intercourse. The highest rates of contraception use are in Hume (78.5%) and the lowest in Western Metropolitan Region (54.4%).

The highest rates of STIs are in Barwon South Western Region (where levels of sexual activity are also highest) and rates in Loddon Mallee are also notably high. The lowest rates are in Eastern Metropolitan Region. In rural Victoria, the lowest rates are in the Grampians.

Over the past six years, the region with the highest teenage birth rate is Loddon Mallee, while the lowest teenage birth rate is in Eastern Metropolitan Region.

Key policy directions: sexual and reproductive health

- National Sexual Transmitted Infections Campaign
- *Victorian Public Health and Wellbeing Plan 2011–2015* (2011)

Programs in place

- human papillomavirus (HPV) and hepatitis B vaccination for children in Year 7
- Whole-of-school community-based sexuality education: *Catching On* (in secondary schools) and *Catching on Early* (in primary schools)
- School Nurses in Secondary Schools and Student Welfare Coordinators (SWCs)
- A range of pilot programs funded by Department of Health address STI rates and healthy sexuality, particularly in rural areas, within the context of five different local and national strategies for blood-borne viruses (BBV) and STI strategies.
- Rural Sexually Transmitted Diseases Clinical Services
- Centre for Excellence in Rural Sexual Health, Shepparton (extending from Hume to Loddon Mallee region)
- Family Planning Victoria – programs and services in rural/regional areas
- Undergraduate teacher training units for sexuality education being developed by Deakin University (funded by the Department of Health)
- Various programs specifically aimed at Indigenous children under the framework of the Indigenous Early Childhood Development National Partnership
- Hepatitis Victoria run projects for young people at risk of hepatitis C in regional and rural areas
- Multicultural Health and Support Service runs youth outreach programs in rural areas
- Positive Speakers Bureau (HIV-positive people talking about their experiences (e.g. stigma, etc.) has a specific regional and rural program that includes some young HIV-positive people
- In Loddon Mallee, the Country Awareness Network (CAN) promotes awareness about sexual health and safer sex practices

Box 3.4: Geelong Adolescent Sexuality Project (GASP)

GASP has been active in the City of Greater Geelong local government for 16 years, with a part-time position funded for much of this time. It currently also receives Victorian government funding through the Suicide Prevention Initiative from the Department of Health, which started in January 2011. This funding allows for significant expansion of the project, with two extra full-time staff employed.

The project acknowledges the pervasive homophobia in the community and resultant widespread abuse and neglect of same-sex attracted and gender-questioning (SSAGQ) young people that put them at risk. This project works with the communities and services relevant to young people to provide respectful, safe environments and to improve the health and wellbeing of SSAGQ young people, aged 10–25 in the Geelong area.

The prevention component develops/builds on existing community projects and programs that seek to promote community education and awareness-raising for the SSAGQ and the broader community. These projects will engage young people in the planning and implementation of these activities and strengthen social networks for young SSAQG people.

The early intervention component seeks to identify SSAGQ young people who are at risk of suicide or self-harm, or who are experiencing emotional distress, and to intervene early to provide pathways to support and services. The project will have capacity to support both the young person and their family/support network.

It is anticipated that the project will enhance the local services through capacity building. The provision of expert training and secondary consultation advice is crucial for local health, education and social support services. Training will assist services to early identify at risk SSAGQ young people, appropriately assess need and provide a sensitive response.

3.5 Substance use

Many young people begin experimenting with substances that can cause health problems during adolescence. For the majority, this does not develop into a pattern of addiction and risk-taking behaviour. However, for a minority who engage in chronic or multiple substance use there may be serious health consequences (AIHW 2007; Pitam et al. 2003, in DEECD 2008).

Research suggests that risky alcohol consumption in Australia increases with remoteness, including among teenagers and young adults (Cooper-Stanbury & Nargis 2009 and Livingston, Laslett et al. 2008, references cited in Coomber et al. 2011). Evidence also suggests that people living in regional and remote areas of Australia tend to engage more heavily in smoking (AIHW 2012).

Alcohol

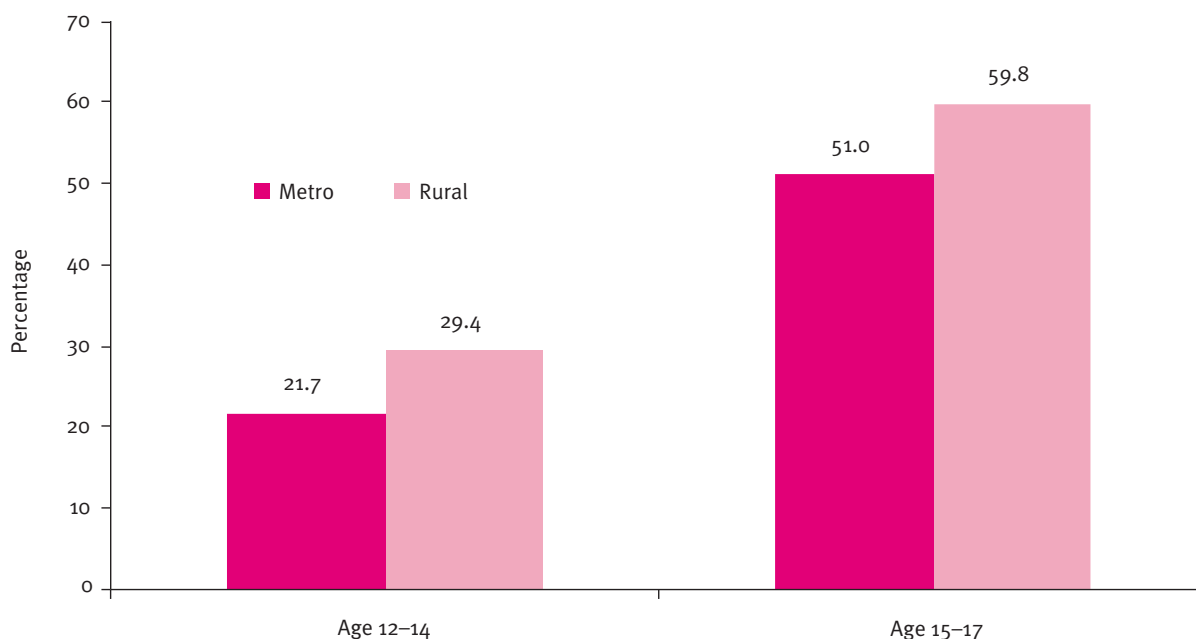
Alcohol consumption

Early initiation of alcohol consumption is associated with more frequent use and higher alcohol consumption in adolescence, and thereby with greater exposure to risky behaviour in adolescence and adulthood (NHMRC 2009, p. 58).

Around half of young people aged 12–14 in Victoria report that they have ever consumed alcohol,²⁷ compared with around three-quarters of 15–17 year-olds. Young people in rural Victoria are more likely to report having ever consumed alcohol than their peers in metropolitan Victoria.

Among those young people who reported that they had ever drunk alcohol, young people in rural Victoria were more likely to have drunk alcohol in the last month (45.1%) compared with young people in metropolitan Victoria (36.6%), with differences apparent in both age groups (Figure 3.10).

Figure 3.10: Young people who have consumed alcohol in the last 30 days, by age group and region type, Victoria, 2009

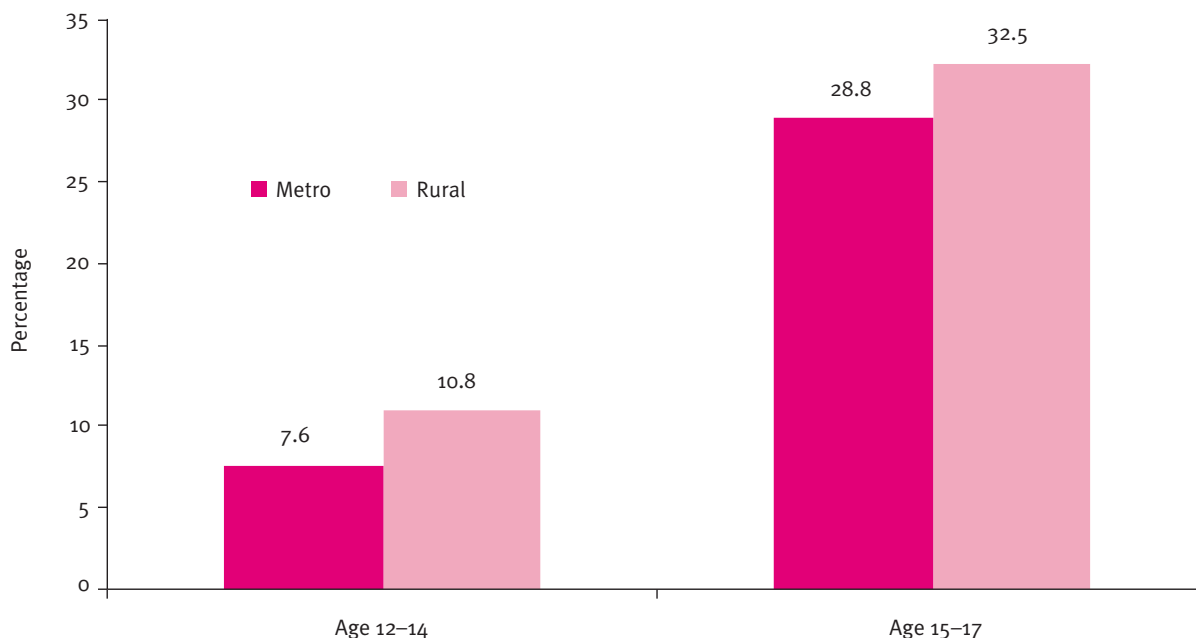


Source: HOWRU 2009, DEECD.

Binge drinking

Binge drinking (defined as having five or more drinks in a row) places young people at heightened risk of accidental injury, unwanted or unsafe sexual encounters, violence and drug use. Young people aged 12–14 (who have ever drank) in rural Victoria are also more likely than those in metropolitan Victoria to have reported binge drinking in the last two weeks (Figure 3.11).

Figure 3.11: Young people who report binge drinking in the last two weeks, by age group and region type, Victoria, 2009



Source: HOWRU 2009, DEECD.

Box 3.5: Young people's views about alcohol in rural and metropolitan Victoria

Victorian results from the Australian Secondary Students' Alcohol and Drug (ASSAaD) Survey 2008 show that rural young people were more likely than their metropolitan peers to think that 'getting drunk every now and then is not a problem' (52% compared with 45%); 'having a few drinks is one of the best ways to relax' (40% compared with 32%); 'drinking is a good way of getting to know others' (44% compared with 33%) (ASSAaD Survey 2008 and Victorian Department of Health (2009), references cited in DEECD 2012).

Access to alcohol

Among young people who had ever had a drink, young people in rural Victoria were less likely to have purchased alcohol (7.1% in rural areas compared with 9.5% in metropolitan areas); and were more likely to have got their last drink ('if they didn't buy it') from their parents (36.65% in rural areas, compared with 31.8% in metropolitan areas). Young people in rural Victoria were also more likely (than those in metropolitan areas) to indicate that it is easy ('sort of easy'/'very easy') to obtain alcohol (59.2% of young people in rural Victoria reported this, compared with 53.3% in metropolitan Victoria).

Regional variation

The highest percentage of young people (aged 12–14) drinking in the last 30 days was in Barwon South Western Region (34.9%) and the Grampians (31.7%); and the highest percentage among 15–17 year-olds was in Loddon Mallee (62.8%) and Barwon South Western (62.4%).

Regions with the highest levels of reported drinking in the last 30 days are also those with the highest level of reported binge drinking: Barwon South Western (26.7%) and Loddon Mallee (23.4%). The highest percentages of young people reporting that it was ‘easy’/‘very easy to obtain’ alcohol were in Gippsland (61.7%), Loddon Mallee (60.4%) and Barwon South Western (60.1%).

In rural Victoria, Hume and Gippsland had the lowest overall rates of alcohol consumption among young people (both age groups and measures). The highest levels of alcohol consumption (as measured by use on the past 30 days) were in outer regional Victoria and the lowest level in major cities (for both age groups), although there was no significant difference between outer and inner regional use.

Box 3.6: Factors influencing young people’s health behaviours in rural Victoria

In a recent qualitative study, interviews about teenage health behaviours and the factors influencing these behaviours were conducted with 19 young people, 11 parents and 10 key informants from a small rural Victorian community.

The young people who were interviewed ate both healthy and unhealthy foods, most participated in physical activity, few smoked and most drank alcohol.

The study found that community level factors (such as community norms, peers, access issues and geographic isolation) had a strong influence on health behaviours, particularly alcohol consumption. Smoking was influenced by social engagement in the community, as well as by national media health campaigns. Behaviours around diet and exercise were influenced by access and availability, convenience, family, peers, together with local and non-local cultural influences.

The researchers conclude that aspects of the rural context, including less access to and choice of facilities and services, lower incomes, and lack of transport impact significantly on young people’s health behaviours, together with community social norms. They observe that a greater focus is needed on the role and importance of the local contexts in shaping health decisions of young rural people (Bourke et al. 2009).

Cigarette smoking

Cigarette smoking in young people has a range of immediate adverse health impacts, and where young people become long-term smokers they are at increased risk of smoking-related cancers and other illnesses (DEECD 2012). Young people in rural Victoria (aged 15–17 years) are less likely than those in metropolitan Victoria to have ever smoked cigarettes, although the percentages of 12–14 year-olds who have ever smoked are similar in both locations (Table 3.6).

Table 3.6: Young people who have ever smoked cigarettes, by age group and region type, Victoria, 2009

| Rural type | 12–14 years old | 15–17 years old |
|--------------|-----------------|-----------------|
| Rural | 15.1 | 33.8 |
| Metropolitan | 12.8 | 38.3 |

Source: HOWRU 2009, DEECD.

Among those young people who have ever smoked cigarettes, there is very little difference by region type in the percentage who have smoked cigarettes in the last 30 days (19.1% of young people in rural Victoria versus 20.2% in metropolitan Victoria).

Illegal drug use

There is no difference by region type in the proportion of young people who have sniffed glue or chromed²⁸, ever used marijuana or other illegal drugs.

Regional variation

There is considerable variation across the DEECD regions for smoking and illegal drug use.

Barwon South Western Region has the highest proportion of young people who have smoked cigarettes within the last 30 days (24.3%), followed by Western Metropolitan Region (23.3%) and Loddon Mallee (23.1%). Gippsland has the lowest proportion (13.8%).

Western Metropolitan Region has the highest proportion of young people who report ever having used marijuana or other illegal drugs (12.3%). Within rural Victoria, the percentage of young people who report ever having used marijuana or other illegal drugs is highest in Barwon South Western (11.1%) and Loddon Mallee (10.8%) regions and lowest in Grampians 5.6%.

The highest percentage of young people reporting sniffing glue or chroming is in Loddon Mallee (10.5%) and the lowest is in Gippsland (6.3%).

The highest percentage of young people who report ever having used marijuana or other illegal drugs is in major cities, and the percentage is lowest in outer regional Victoria.

Key policy directions: substance use

- WHO, Global Strategy to Reduce the Harmful Use of Alcohol (2010)
- NHMRC, Australian Guidelines to Reduce Health Risks from Drinking Alcohol (2009)
- National Drug Strategy: 2010–2015 (2011)
- Taking Preventative Action – the Government’s response to the report of the National Preventative Health Taskforce (2010)
- Victorian Public Health and Wellbeing Plan 2011–2015 (2011) (under development)
- New Directions for alcohol and drug treatment services: A roadmap (2012) Victorian Alcohol Action Plan 2008–2013 (2008)
- Koori Alcohol Action Plan 2010–2020 (2010)

Victorian government commitments and initiatives

- ban on the sale, display and supply of cannabis bongs
- banned synthetic cannabinoids and increased penalties for traffickers
- passed legislation to ensure that emerging drugs can be quickly banned
- Funded the Step Back, Think program to continue its work in tackling alcohol-fuelled violence
- legislated ‘tip out’ powers for police
- introduced legislation enabling tough new penalties for drunken, loutish and threatening behaviour
- extended the freeze on new late-night liquor licenses in inner Melbourne and surrounding municipalities
- introduced legislation for new offences to deal with drunks hanging around licensed premises after being refused entry or required to leave
- legislated new powers to licensees and police officers to bar troublesome patrons from entering or remaining in a venue for a set period of time
- provided funding for emergency departments in hospitals to improve the response to people affected by alcohol and drugs.

Programs in place

- Youth Support and Advocacy Service (YSAS)
- Victorian Early Intervention Pilot Program
- Comprehensive P–12 drug education curriculum and policy support to all schools
- Student Support Services Officers
- Primary School Nurses and Secondary School Nurses
- Primary Welfare Officers and Student Welfare Coordinators
- School Focused Youth Service
- regulatory measures under the Tobacco Act 1987, in particular bans on:
 - sale of tobacco products to minors, and associated cigarette sales, enforced via a to minors’ test-purchase program run by local government (involving random testing of retailers’ practices)
 - retail display of cigarettes, aiming to discourage smoking and prevent the uptake of smoking, especially by children and young people
 - smoking at underage dance parties/events
- promotion of smoking reduction strategies by health and early childhood practitioners
- drug education professional learning for primary and secondary teachers
- Alcohol and Drug Diversion Programs coordinated by Victoria Police also include the Illicit Drug Diversion Initiative
- Police Cautioning Program – early diversion process
- Police Cautioning & Youth Diversion Project (Koorie) (a Victoria Police and Victorian Aboriginal Legal Service (VALS) project)
- Youth Support Service Program – early intervention and referral service by DHS for identified at-risk young people

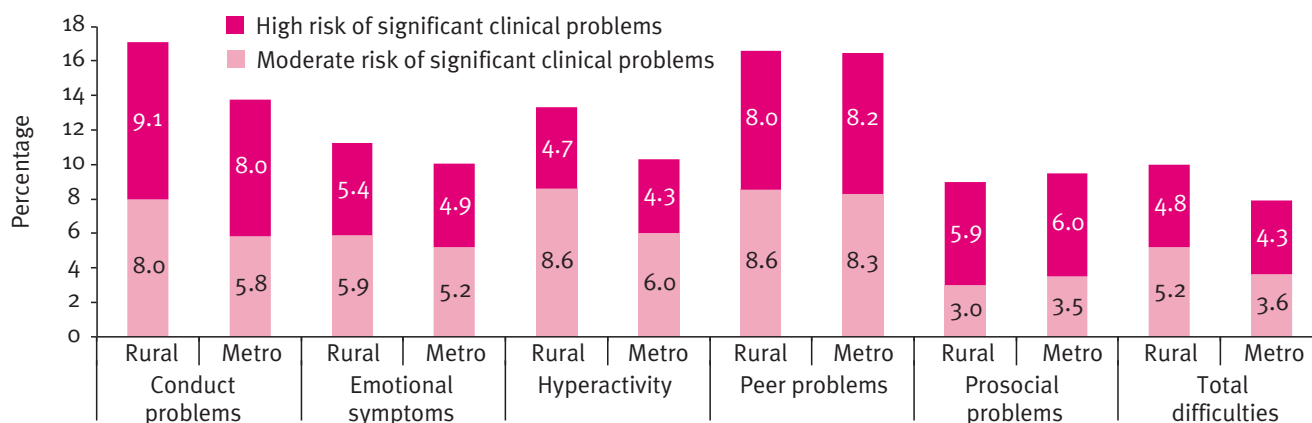
3.6 Emotional and mental health

Mental health is defined by the World Health Organisation (WHO) as ‘a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community’ (WHO 2010). Mental health sets the stage for young people’s wellbeing and development. Mental health problems or disorders can seriously affect the capacity of children and young people to participate fully in school, social and community networks.

Mental health in early childhood

The Strengths and Difficulties Questionnaire (SDQ) is used, as part of the School Entrant Health Questionnaire (SEHQ), to assess different aspects of child behaviours at the beginning of primary school, including prosocial behaviour, hyperactivity, emotional symptoms, peer problems and conduct problems. Figure 3.12 shows that children in rural areas are more likely (than metropolitan children) to be at risk of significant clinical problems across three (out of the five) SDQ scales.

Figure 3.12: Percentage of children with a moderate and high risk of significant clinical problems, by region type, Victoria, 2011



Source: SEHQ 2011, DEECD.

Parental concern about child health behaviour

There is considerable concurrence between the SDQ findings and parents' ratings of concern with their child's behaviour at school entry. Of parents reported having one or more concerns about their child's behaviour, 16.0% of rural parents did so, compared with 14.1% of metropolitan ones.

ARIA analysis finds that a slightly lower percentage of parents in major cities report having concerns about their child's behaviour (14.1%) than parents in other locations (inner regional and outer regional – both 16%, remote 16.1%).²⁹

Aboriginal children

Aboriginal children in rural Victoria are more likely than Aboriginal children in metropolitan Victoria to have parents reporting concerns about their child's behaviour on starting school (28.6% of Aboriginal children in rural Victoria, compared with 24.2% of Aboriginal children in metropolitan Victoria) (see Table 3.7).

Table 3.7: Percentage of children at school entry whose parents are concerned about their behaviour, by region type and Aboriginal status, Victoria, 2011

| Region type | Aboriginal | Non-Aboriginal | % difference |
|--------------|------------|----------------|--------------|
| Rural | 28.6 | 15.9 | 12.7 |
| Metropolitan | 24.2 | 14.4 | 9.8 |

Source: SEHQ 2011, DEECD.

Regional variation

Gippsland has the highest percentage of children at risk of significant emotional and behavioural problems, with a total difficulties score of 6.6%, while Eastern Metropolitan Region has the lowest percentage (2.9%). Gippsland also had the highest percentage of parents reporting concern (17.5%) with their child's behaviour and Eastern Metropolitan Region the lowest (13.4%).

In rural Victoria, Barwon South Western Region has the lowest total difficulties score (4.3%), as well as the lowest percentage of parents reporting concern with their child's behaviour (14.8%).

SDQ and socioeconomic disadvantage

Additional SEHQ analysis,³⁰ focusing on the impacts of measures of socioeconomic disadvantage, found that, overall, across Victoria, the likelihood of a child scoring 'of concern' on at least one domain increased with the following measures of disadvantage: 'being on a health care card', 'being in a one-parent family', 'mother not completed secondary school' and 'being from the most disadvantaged SEIFA quintile'.

'Being on a health care card' was associated with the greatest likelihood of poorer SDQ outcomes, when compared with the other measures of disadvantage; and it was notably more likely to be associated with poorer outcomes than 'being from the most disadvantaged SEIFA quintile'.³¹ 'Being on a health care card' was also associated with a greater likelihood of poorer outcomes in rural than in metropolitan Victoria.³² Detailed findings are provided in the online Technical Appendix.

Mental health of young people (12–17 years)

Box 3.7: Adolescent mental health services in Victoria

As part of the Specialist Mental Health service system, there are 13 child and adolescent services (CAMHS), Orygen Youth Health and an increasing number of youth services statewide. As part of ongoing reform and service improvement endeavours, CAMHS and Adult Mental Health Service (MHS) together deliver a new 0–25 age response – Child and Youth Mental Health Services (CYMHS) – which aims to provide seamless care across this important age range. Two streams, services for children (0–14) and young people (12–25), are being configured. Further information on the location of specialist mental health services is available at <http://www.health.vic.gov.au/mentalhealth/services/child/index.htm>

The transitions from childhood to adolescence and from adolescence to adulthood mark important periods of life change and increased vulnerability to mental health problems or disorders. More than 75% of all severe mental health and substance-use problems begin before the age of 25 (DEECD 2012).

The HOWRU 2009 survey shows that over three-quarters of Victorian young people (77%) are satisfied with the quality of their lives, with no difference between rural and metropolitan Victoria. There are also no significant differences between rural and metropolitan Victoria, or in ARIA analysis, in i) the proportion of young people high levels of emotional wellbeing (61% of young people)³³ or ii) the proportion of young people who report experiencing high levels of psychological distress (12.3% of young people in rural and 13.3% in metropolitan Victoria) (further details of this measure are provided in Box 3.8).

Regional variation

There is considerable regional variation in rural Victoria, however, in the proportions of young people experiencing high levels of psychological distress. Percentages range from 8.8% of young people in Grampians to 16.1% in Loddon Mallee.

Box 3.8: Measurement of psychological distress

Psychological distress is measured using the Kessler 10 scale (Kessler et al. 2002). People completing surveys are asked about a range of negative emotions they may have experienced over the past month. The Kessler 10 scale does not provide a diagnostic tool to determine if someone has a particular mental disorder. There is a strong association, nevertheless, between very high scores on the scale and the current diagnosis of mental health issues, in particular depressive symptoms.

Body image and eating disorders

Having a positive body image is an important aspect of health social and emotional wellbeing and poor body image can contribute to poor self-esteem, negative moods, unhealthy weight and diet behaviours and social isolation (DEECD 2012).³⁴

HOWRU 2009 survey analysis reported in SOVC 2011 shows that females, in particular, have high levels of concern about gaining weight or becoming fat, with levels of reported concern increasing with age (DEECD 2012). Around 40% of young females report that they are very or extremely concerned about gaining weight or becoming fat. However, region type analysis shows no difference in the proportions of young females reporting this in rural and metropolitan Victoria (41.1% in both).

Poor body image can be a risk factor for development of eating disorders, the most common of which are anorexia nervosa and bulimia nervosa. HOWRU survey data indicate that a small proportion (2.4%) of young people in Victoria have an eating disorder. There is no difference observed by region type, although ARIA analysis finds a higher proportion of young people with an eating disorder in major cities (2.7%) than in outer regional Victoria (0.5%).

Bullying

Bullying includes physical and emotional violence, deliberate exclusion and rumour spreading. It is known to impact on children's mental health status, including increasing the risk of depression. Around one-in-five (19.4%) children in the VCHWS have experienced bullying (parents' report) and 43.7% of young people in HOWRU report this.

Children in major cities are more likely (when compared with children in inner regional Victoria) to have parents who report that it is 'not true' that their child has been bullied. Young people in inner regional Victoria are more likely to report being bullied than those in major cities.

Victorian government school students are also asked if they have been bullied at school, in the 2011 DEECD Attitudes to School Survey 2006–11.³⁵ Findings from this survey show that student rate their safety highly overall,³⁶ and ratings have improved between 2006 and 2011. However, rural students give slightly lower ratings of their safety than metropolitan students, most notably in Years 7–9 (Figure 3.13).

Figure 3.13: Student ratings of their safety, by school year level and region type, Victoria, 2006–11



Source: Attitudes to School Survey 2006–2011, DEECD.

Young people's access to mental health services

Research identifies a range of barriers to seeking help for mental health problems for young people in rural areas. These barriers include lack of anonymity, stigma and a culture of self-reliance, together with lack of transport and a lack of qualified local mental health professionals and services (Hernan et al. 2010; see also Box 3.9).

In the HOWRU 2009 survey, young people who have used mental health services were asked whether they feel that they can access mental health services when needed. Around 70% of young people reported that they could access these services if needed, with no difference by region type.

Regional variation

There was marked regional variation in rural Victoria, however, with young people in Hume being the most likely to report that they could access services (79.7%) and those in Gippsland the least likely to report this (58.9%).

Box 3.9: Barriers to seeking help for mental health issues

A qualitative study of 52 Years 9 and 10 students from rural Victoria (attending schools in areas of ‘significantly restricted accessibility to services, goods and social interaction for residents’) found that lack of accessible transport was a key barrier to seeking help for mental health issues. Other factors related to stigma include self-stigma about having to access help and experiencing social stigma from others in the community.

The social visibility of people in rural areas is high and anonymity much less, which impacts negatively on young people’s willingness to seek help with mental health issues. The study suggests that ‘rural young people live in a culture that values individuals taking care of themselves and that this may mean that external help is resented or avoided’ (Francis et al. 2006, p. 47).

Psychiatric hospitalisations

Victoria has low rates of psychiatric hospitalisation compared with other Australian jurisdictions, and mental health policy emphasises a community-based approach, focusing on the use of community, outreach and youth intervention services. Only a small minority of young people with mental health concerns are hospitalised. In interpreting psychiatric hospitalisations data it is important to note that these rates are not a direct measure of the level of mental health problems in a community; rather, hospitalisation rates can sometimes reflect local access to hospitals and be higher in areas where access is easier.

Box 3.10: Location of mental health service inpatient beds for adolescents and children

Metropolitan Victoria

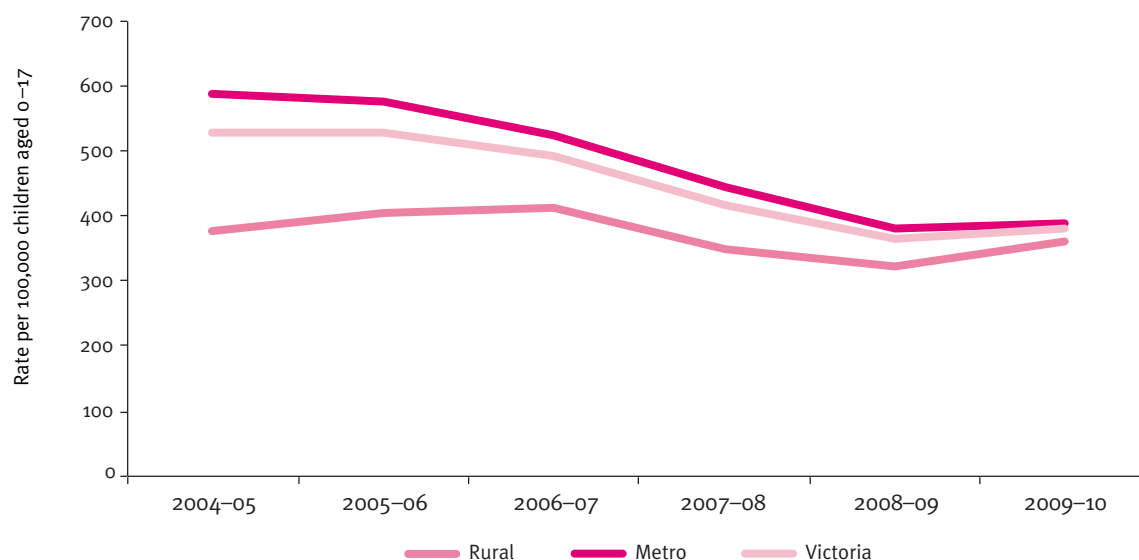
- Statewide Child Unit (12 beds) located at Austin Health
- adolescent beds at Austin Health (11 beds)
- adolescent beds at the Royal Children’s Hospital (12 beds)
- Box Hill (12 beds)
- Southern Health (15 beds)
- Orygen Youth Health (16 beds)

Rural Victoria

- Grampians (two beds)
- Gippsland (two beds)

Figure 3.14 shows trends in psychiatric hospitalisations for children and young people aged 0–17 years. These rates have declined from 2004–05 to 2008–09, with an increase observed in 2009–10. Rates are higher overall in metropolitan than in rural Victoria.

Figure 3.14: Psychiatric hospitalisation rate for children and young people aged 0–17 years (per 100,000), by region type, Victoria, 2004–05 to 2009–10



Source: Victorian Admitted Episodes Dataset 2004–05 to 2009–10, DoH (unpublished).

Variation by age

Rates are highest across Victoria for young people aged 15–17 years (1314.5 per 100,000 young people), followed by young people aged 10–14 (261.0 per 100,000 young people), children aged 0–4 (219.9) and children aged 5–9 years (76.4).

Regional variation

While rates of psychiatric hospitalisation are lower in rural Victoria, the highest rates across Victoria as a whole are in Gippsland. In 2009–10 the rate of psychiatric hospitalisations for children and young people aged 0–17 in Gippsland was 432.2 per 100,000 children and young people, compared with 382.6 for Victoria as a whole. The lowest rate was in Loddon Mallee (352.0 per 100,000 children and young people).

Self-harm hospitalisations

Self-harm includes a range of behaviours spanning mild injuries to suicide attempts. While suicide among young people is rare, the number of young people who self-harm is of concern. Many young people who self-harm will not come to the attention of hospitals, so the measure of ‘hospitalisations for self-harm’ probably underestimates the numbers involved.

The rate of hospitalisations for intentional self-harm in Victoria has increased from 65.9 (per 100,000 young people aged 10–17 years) in 2006 to 74.4 (per 100,000 young people aged 10–17 years) in 2010. The rate is consistently higher in rural than metropolitan Victoria.

In 2010 the rate of hospitalisations for young people aged 10–17 years for intentional self-harm was 101.0 (per 100,000) in rural Victoria, compared with 63.1 (per 100,000) in metropolitan Victoria. ARIA analysis shows that the rate of hospitalisations for intentional self-harm is higher in outer regional and inner regional Victoria and lowest in major cities (Figure 3.15).

Figure 3.15: Rate of hospitalisations for intentional self-harm for children and young people aged 10–17 years (per 100,000), by ARIA classification, Victoria, 2006–10



Source: Monash University Accident Research Centre (MUARC) 2011, Monash University; Estimated Resident Population 2006–2010, ABS.

Regional variation

In 2010, the hospitalisation for self-harm rate was highest in Gippsland (147.9 per 100,000 population), Hume (118.0) and Loddon Mallee (89.5). The rate was lowest in Northern Metropolitan Region (57.7 per 100,000 population). In rural Victoria, the rate was lowest in Barwon South Western (78.6) and Grampians (79.1 per 100,000 population).

Key policy directions relating to emotional and mental health

- Fourth National Mental Health Plan
- National Mental Health Reform program
- *Victorian Public Health and Wellbeing Plan 2011–2015* (2011)

Victorian government commitments and initiatives

- expansion of selected Headspace (known as ‘headspace’) services across the state
- investment to support Headspace, including capital improvement grants for Headspace Communities of Youth Services
- established Youth Prevention and Recovery Care services
- more than \$8 million for new and expanded eating disorder services
- established an Eating Disorders Taskforce
- \$4.2 m to December 2013, to enable continued implementation of child and youth mental health redesign (0–25 years) endeavours by a consortium led by Alfred Health and Ballarat Health
- \$3m for an intensive day patient program at the Royal Children’s Hospital (RCH)
- \$4m for targeted mental health and suicide prevention initiatives for gay, lesbian, bisexual and transgender young people
- \$14.5m for the Stamp Out Bullying initiative
- funding for an additional 150 Primary Welfare Officers
- funding for School Chaplains

Key policy directions relating to emotional and mental health

- Fourth National Mental Health Plan
- National Mental Health Reform program
- *Victorian Public Health and Wellbeing Plan 2011–2015* (2011)

Programs in place

- Intensive Mobile Youth Outreach Services (IMYOS)
- rural youth early intervention teams
- Youth Early Psychosis (YEP) Services
- Community Child and Adolescent Mental Health Services (CAMHS) and Child and Youth Mental Health Services (CYMHS)
- CAMHS and Schools Early Action (CASEA) program (an early intervention program delivered by CAMHS /CYMHS in primary schools for children in Prep to Year 3 who have serious behavioural problems)
- Headspace
- Primary and Secondary School Nursing programs and Primary Welfare Officers
- Student Support Services Officers
- *Promoting Healthy Minds for Living and Learning resources*
- Youth Partnerships
- DEECD partnership with Monash University to provide scholarships for education staff to obtain mental health qualifications and statewide training in mental health for education staff
- The *festival for healthy living*, promoting mental health and emotional wellbeing in primary and secondary schools and their communities
- *Kidsmatter* mental health and wellbeing framework for primary schools and early childhood education and care services

Box 3.11: Live4Life – a community-driven school community partnership initiative

The Live4Life initiative is a school and community collaboration that takes an evidence-based approach to suicide prevention by providing secondary local schools and the community with local networks, strategies and tools to assist with mental health awareness of over 6000 rural young people living in the Macedon Ranges Shire, with a particular emphasis on all Year 8 secondary students. The initiative was developed (and is evolving) based on local community need and is driven by a local network, consisting of both school-based and community organisations. The partnership framework is based on the VicHealth Mental Health Promotion Framework 2010.

Prior to the commencement of Live4Life, the five secondary schools involved had never met or collaborated to address young people's health and wellbeing. Live4Life brings together schools, community and families to share the responsibility to raise resilient, resourceful, adaptable and well-adjusted young people, who are connected to their local community. The needs analysis conducted in late 2009 identified that the teachers of the five secondary schools in the Macedon Ranges Shire were not in a position to resource mental health education. With the demands of curriculum, the lack of resources in rural schools, together with an understanding that the education and delivery of mental health curriculum, is a specialised area. Many of the school teaching staff felt that they did not have the skills necessary to deliver mental health education. As such, the partners of this project have collaborated to conduct the general mental health and mental health literacy of young people in the classrooms, resulting in the Live4Life initiative and creation of community educators.

Youth Mental Health First Aid training has conducted 24 x14-hour training sessions to some 300 parents, teachers from the five secondary schools and community and youth workers in the shire, thus providing adults in the community the information, literacy and confidence to better support and understand young people. This initiative was recently recognised with a national award from Mental Health First Aid Australia for addressing an identified community need for better mental health literacy in the community and demonstrating increased community capacity.

The vision is that the 'Live4Life' initiative will have a whole-school approach to student mental health and wellbeing that is developed by each school, based on local needs and curriculum capabilities relevant to the school. Community partners, together with the five secondary schools in the Macedon Ranges Shire, agreed to develop an approach to mental health that focuses on prevention, education and family involvement. The community partners are Cobaw Community Health, WayOut, Macedon Ranges Shire Council, Victoria Police, and Child and Adolescent Mental Health Service (CAMHS).

Key outcomes to date (through external evaluation) are:

- reported reduction in stigma
- increased use of local services
- greater collaboration and connection between schools and between schools and the community
- greater capacity for young people to identify and challenge unhelpful thoughts
- established network between schools and CAMHS
- positive Live4Life brand awareness among young people and the community
- over 300 local community members trained in Youth Mental Health First Aid (teachers, parents, community and youth workers)

Further information on the outcomes is contained in the 2011 evaluation (including testimony), available at www.live4life.org.au



What's special / the best thing about where you live?

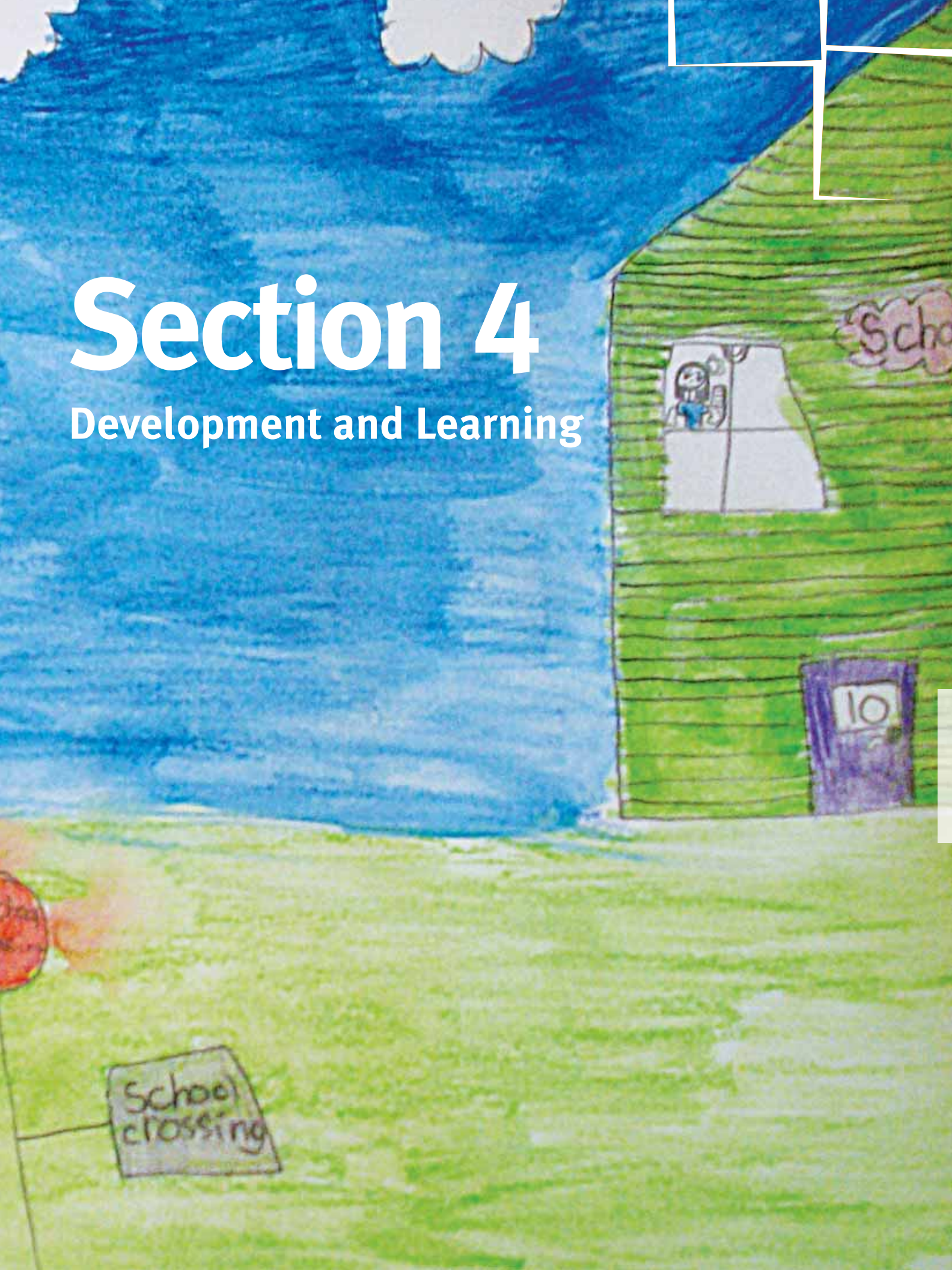
'There are a lot of nice friends and places and to go.'

**Artwork by Tahlia, Grade 3
Maiden Gully Primary School
Title: A sunny day at school**



Section 4

Development and Learning



4. Development and learning



Artwork by Ruby, Grade 4
Maiden Gully Primary School
Title: More schools

4.1 Early learning

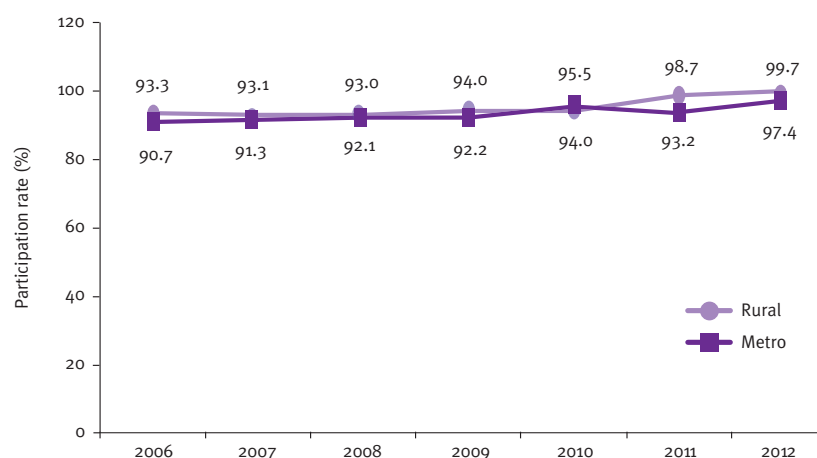
Research clearly demonstrates the importance of the early years in shaping future developmental outcomes. Learnings and skills that are developed in a child's early years provide the basis for life skills, behaviours and attitudes, and thus successful outcomes in later life. Participation in quality early child education programs contributes to optimal child development, cognitive development and early school success.

Kindergarten participation

Kindergarten participation rates (defined as the percentage of 4 year-olds enrolled in kindergarten) have increased in Victoria from 91.4% in 2006 to 97.9% in 2012.

Rates have generally been higher for children in rural Victoria compared with those in metropolitan Victoria (Figure 4.1). In 2012, the kindergarten participation rate in rural Victoria was 99.7%, compared with 97.4% in metropolitan Victoria. Kindergarten participation rates have improved in all the rural regions (2006–12).

Figure 4.1: Kindergarten participation rates, by region type, Victoria, 2006–12



Source: DEECD Annual confirmed kindergarten data collection.

Aboriginal kindergarten participation

Aboriginal kindergarten participation rates are lower than for the 4-year-old population as a whole, although they have increased across Victoria in 2007–10 (Figure 4.2). Kindergarten participation rates are consistently higher for Aboriginal children in rural Victoria, compared with metropolitan Victoria (Table 4.1).

Table 4.1: Aboriginal kindergarten participation rates, by region type, Victoria, 2007–10

| Region type | 2007 | 2008 | 2009 | 2010 |
|--------------|------|------|------|------|
| Metropolitan | 53.9 | 51.4 | 61.7 | 57.8 |
| Rural | 62.3 | 68.4 | 70.5 | 82.0 |
| Victoria | 59.0 | 62.0 | 67.2 | 72.8 |

Note: The Aboriginal participation rate is calculated using a different methodology.

Source: DEECD.

Regional variation

In 2010, Hume (90.4%) and Gippsland (88.1%) have the highest Aboriginal children kindergarten participation rates. Rates are lowest in Western Metropolitan Region (41.8%) and Southern Metropolitan Region (46.6%). The lowest rates in rural Victoria are in Loddon Mallee (73.4%).

Further information relating to supports to access kindergarten is included in Section 7.3 (access to child health and other services).

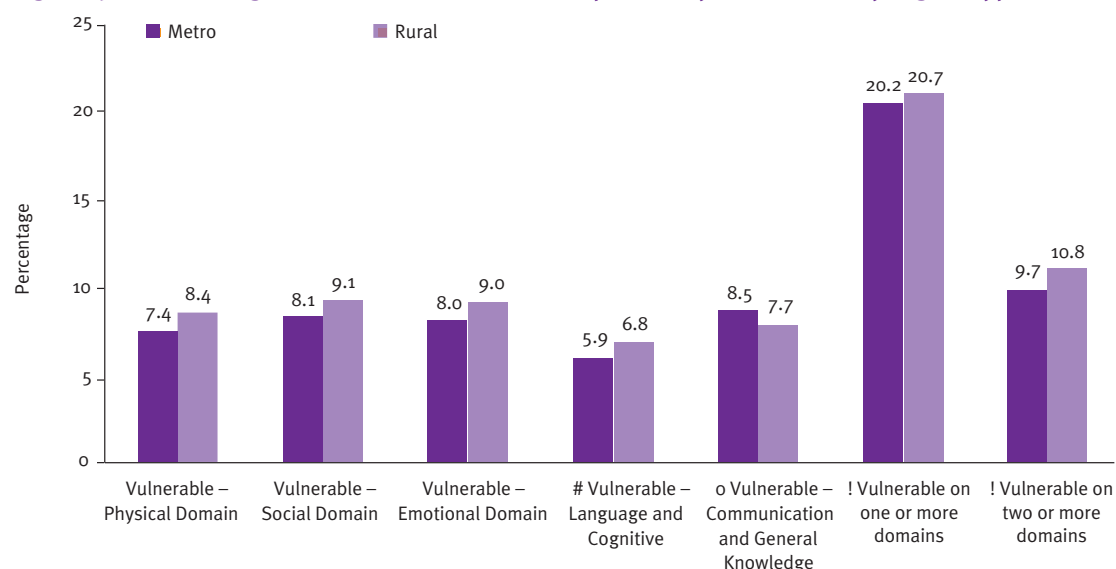
4.2 Development at school entry

Australian Early Development Index

The Australian Early Development Index (AEDI) is a population measure of young children's development, which is used to assist communities to assess early childhood development at the time children start school. It is based on a teacher-completed checklist of over 100 questions measuring five developmental domains: physical health and wellbeing; social competence; emotional maturity; language and cognitive skills; and communication skills and general knowledge.

Analysis of Victorian AEDI data suggests that, while differences are small, rural children are more developmentally vulnerable than metropolitan children across all AEDI domains (except communication and general knowledge) (Figure 4.2).

Figure 4.2: Percentage of children who are developmentally vulnerable, by region type, Victoria, 2009



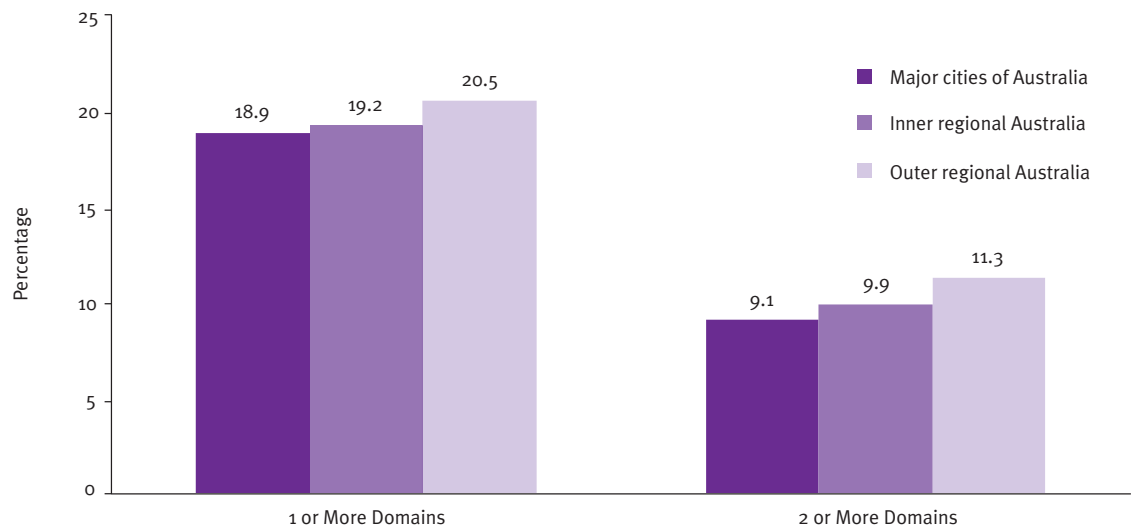
Source: Australian Early Development Index 2009, DEECD.

In total, 20.7% of rural children are vulnerable on one or more of the AEDI domains (compared with 20.2% of metropolitan children) and 10.8% of rural children are vulnerable on two or more domains (compared with 9.7% of metropolitan children).

Regional variation

Gippsland has the highest percentage of children who are vulnerable on one or more (23.5%) and two more (13%) of the AEDI domains. In rural Victoria, Barwon South Western Region has the lowest percentages of children who are vulnerable on one or more (18.5%) and two or more (9.3%) domains. The percentage of children who are developmentally vulnerable is highest in outer regional Victoria and lowest in major cities (Figure 4.3).³⁷

Figure 4.3: Percentage of children who are developmentally vulnerable, by ARIA classification, Victoria, 2009



Source: Australian Early Development Index 2009, DEECD; DEECD analysis by ARIA.

Speech and language development

Analysis of SEHQ data (2009–11) shows that parents in rural Victoria are consistently more likely (than parents in metropolitan Victoria) to report that their child has difficulties with speech and language (Table 4.2). In 2011, 17% of children in rural Victoria had parents who reported so, compared with 12.9% in metropolitan Victoria.

Table 4.2: Children at school entry whose parents reported that their child has difficulties with speech or language, by region type, Victoria, 2009–11

| Region type | 2009 | 2010 | 2011 |
|--------------|------|------|------|
| Rural | 17.4 | 16.5 | 17.0 |
| Metropolitan | 13.3 | 13.1 | 12.9 |

Source: SEHQ 2009–11, DEECD.

Regional variation

In 2011, the highest reported incidence of difficulties with speech and language was in the Grampians (18.9%), followed by Gippsland (17.6%) and Loddon Mallee (17.3%). Barwon South Western Region has the lowest reported incidence of reported speech and language difficulties in rural Victoria (15.3%). Parental concerns about child speech and language increase progressively with levels of remoteness (major cities 13.0%, inner regional 16.5%, outer regional 18.7%, remote 20.1%).

Aboriginal children

Analysis suggests that Aboriginal children in rural Victoria are more likely to be vulnerable on two or more AEDI domains than Aboriginal children in metropolitan Victoria (with 28.3% of rural Aboriginal children vulnerable on two or more domains, compared with 22.6% of metropolitan Aboriginal children).

Rurality does not appear to notably affect the likelihood of vulnerability on two or more domains for non-Aboriginal children (10.4% of rural non-Aboriginal children are vulnerable, compared with 9.6% of metropolitan non-Aboriginal children).

Parents of Aboriginal children are more likely to report that their child has difficulties with speech and language (Table 4.3). Similar proportions of Aboriginal children in rural (23.2%) and metropolitan (23.3%) Victoria have parents who report that their child has difficulties with speech and language.

Table 4.3: Children at school entry whose parents reported that their child has difficulties with speech or language, by Aboriginal status and region type, Victoria, 2009–11

| Region type | Aboriginal | Non-Aboriginal |
|--------------|------------|----------------|
| Rural | 23.2 | 17.2 |
| Metropolitan | 23.3 | 13.1 |

Source: SEHQ 2011, DEECD.

Key policy directions: early childhood development

- National Partnership Agreement on the National Quality Agenda for Early Childhood Education and Care (2008)
- National Partnership Agreement on Early Childhood Education (2008)
- National Partnership Agreement on Indigenous Early Childhood Development (2008)
- National Early Childhood Development Strategy – Investing in the Early Years (2009)
- *Supporting parents, supporting children: A Victorian Early Parenting Strategy* (2010)
- *Victorian Early Years Learning and Development Framework* (2009)
- Community Health Service Child Health teams

Victorian government initiatives

- \$62.7m over four years for free Universal MCH services and \$16.3m to sustain Enhanced MCH
- \$8.3m to provide ECE for 3 year-olds known to Child Protection authorities
- small rural kindergartens funding and Kindergarten Inclusion Support Services improvements
- \$16.5m for Supported Playgroups, the *smalltalk* program and the E4Kids longitudinal study
- \$19m to expand ChildFIRST and Integrated Family Services in areas of high demand
- Cradle to Kinder: 10 new programs, including two Aboriginal specific programs

- \$29m for *Stronger Families* program delivered in four ChildFIRST catchments across Victoria, with services to be established in two additional locations in 2012–13
- *Victorian Government Indigenous Aboriginal Affairs Report 2010–11*, tabled in Parliament in March 2012
- *The Victorian Aboriginal Affairs Framework 2010–2013*

Programs in place

- Maternal and Child Health (MCH) and Enhanced MCH services
- Early Parenting Services
- *Cradle to Kinder* and *Aboriginal Cradle to Kinder*
- *Healthy mothers, Healthy Babies*
- Regional Parenting Services
- In-Home Support for Aboriginal families; the Aboriginal Home-Based Learning Program
- Best Start and Aboriginal Best Start
- *Smalltalk* program, delivered by the Early Home Learning Study, and E4Kids
- Languages Support Program for Young Children
- Early Start Kindergarten
- *Transition: A Positive Start to School*
- Early Childhood Intervention Service (ECIS)
- Out-of-home care placement prevention

Table 4.1: Box 4.1: Access to Early learning service model

Access to Early Learning (AEL) is a new service model that is trialling a more intensive approach to engaging vulnerable children and their families in early childhood education and care programs. This initiative is currently located in four sites: Ballarat, inner Melbourne public housing areas in Flemington and Carlton, Doveton and the Outer East Child FIRST catchment covering the municipalities of Knox, Yarra Ranges and Maroondah.

The AEL model incorporates four key elements centred on quality early childhood education and care:

- A key facilitation worker role to ensure families are enrolled and engaged with services that are matched to their needs.
- Outreach family support is also provided to address additional needs, such as establishing routines after a crisis, enabling families to be better able to support children's ongoing participation in early childhood education.
- Professional and practice development to build the capacity of early childhood education and care services to be more responsive to the individual and often challenging needs of vulnerable children.
- Brokerage funding to address practical barriers to access such as transport.

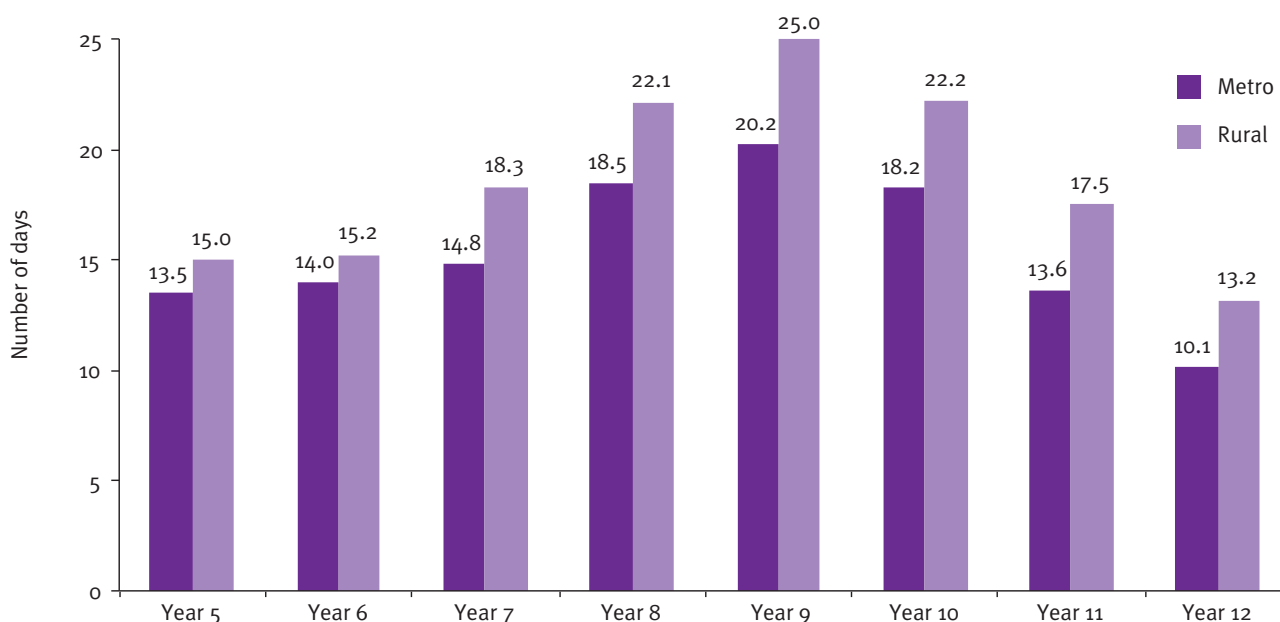
AEL is currently being evaluated by the international auditing firm KPMG to examine the impact of the service on outcomes at a child, family and local service system level. An initial report regarding progress to date indicates the AEL model is effective in engaging vulnerable children and that the key facilitation worker has been pivotal in this regard. AEL is also showing positive impacts on building the capacity of early childhood education and care services to be inclusive of vulnerable children and increasing the broader uptake of Early Start Kindergarten. Further development and expansion of AEL will be considered in light of evaluation findings.

4.3 Engagement in school and learning

Attendance

Analysis of DEECD 2011 school absence data (for Years 5–12) shows that the average number of absence days in Victorian government schools increases gradually from Year 5 to a peak in Year 9, then decreases in Year 10 and more markedly again in Years 11 and 12. Average absence days are also higher in rural than metropolitan Victoria, with the most notable differences observed in Years 7–12 (Figure 4.4).

Figure 4.4: Average absence days in government schools, by region type, Victoria, 2011



Source: Student Absence Data Collection 2011, DEECD.

Regional variation

In 2011, the highest average absence rates in Year 7 were in Loddon Mallee (19.8 days) and Hume (19.2 days); in Year 9 in Loddon Mallee and Hume (both 26.7 days); and in Year 11 in Hume (18.8 days) and Loddon Mallee (18.7 days).

Connectedness to school

Connectedness with school is a key component of student wellbeing, and being engaged with school and the school environment can confer important benefits, enhancing social and emotional wellbeing. Analysis of trend data shows that scores for student connectedness to school have increased steadily (2007–11) (Figure 4.5). Scores are high in Years 5 and 6, but lower in Years 7 and 9. Connectedness scores are slightly lower, overall, for students in rural than metropolitan Victoria, more notably in Years 7 and 9.³⁸

Figure 4.5: Student connectedness to school, by school year level and region type, Victoria, 2007–11



Source: Attitudes to School Survey 2006–2011, DEECD.

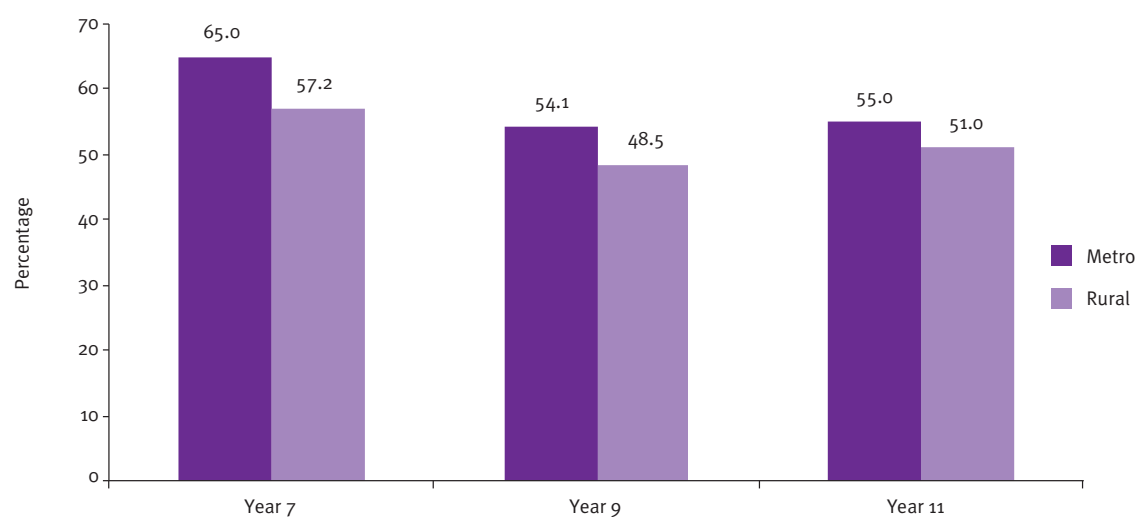
Regional variation

In 2011, in Years 5 and 6, the mean connectedness to school score in rural Victoria was highest in Grampians Region (4.40) and lowest in Hume (4.27). In 2011, in Years 7 and 9, the mean connectedness to school score in rural Victoria was highest in Barwon South Western Region (3.68) and lowest in Gippsland (3.53).

Enjoyment of school

Analysis of HOWRU 2009 data shows that young people's reported levels of enjoyment at school are lower in Year 9 than in Year 7, and rise again in Year 11. In line with the connectedness to school findings, young people in rural Victoria also appear to enjoy school less overall, than young people in metropolitan Victoria (Figure 4.6).

Figure 4.6: Young people who enjoy school almost always/often, by school year level and region type, Victoria, 2009



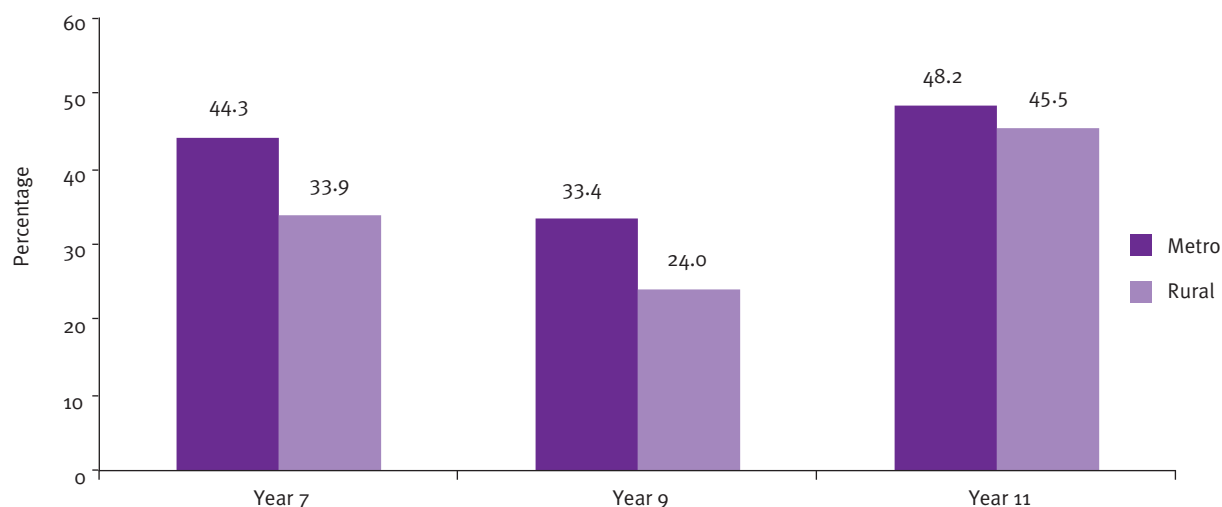
Source: HOWRU 2009, DEECD.

Interest in school subjects

Further analysis of HOWRU data also shows that children and young people's reported interest in school subjects also lessens in Years 7–9 and increases notably in Years 9–11. This pattern, which is broadly observed in all analysed data relating to school engagement, may be indicative of higher levels of commitment to learning, attainment and post-school aspirations in those students who embark on Years 11 and 12 studies, as well as a tendency for those students who are less engaged to leave school early.

When compared with metropolitan Victoria, rural Victoria shows a more marked increase in Years 9–11 in the proportion of young people who report finding their school subjects (very or quite) interesting (Figure 4.7).

Figure 4.7: Young people who find their school subjects very/quite interesting, by school year level and region type, Victoria, 2009



Source: HOWRU 2009, DEECD.

Regional variation

Overall (across all school year levels), young people in Gippsland (61.5%) are the most likely to report that they almost always/often enjoy school, while young people in the Grampians (45.3%), Barwon South Western (47.2%) and Loddon Mallee (50%) are the least likely to report this.

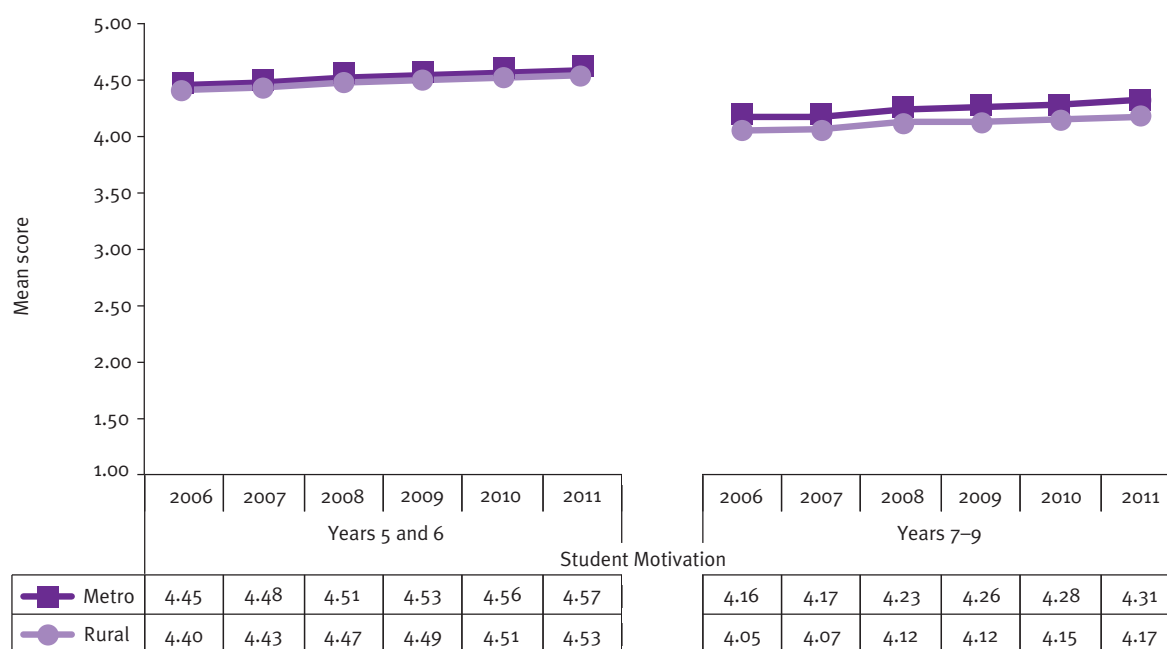
Young people in Loddon Mallee (28.8%), Grampians (30.7%) and Barwon South Western (31.9%) regions are also the least likely to report finding their school subjects (very or quite) interesting. In rural Victoria, Gippsland has the highest percentage of young people (40.2%) who find their subjects (very or quite) interesting, followed by Hume (38.9%). Analysis by school year level highlights that students in Hume and Gippsland have notably higher levels of reported interest when compared with other regions in Year 11.

Student motivation

Student motivation scores³⁹ are high overall but they are lower in Years 7–9 than in Years 5 and 6.

The scores of rural students are consistently lower than scores of metropolitan students. Over the last six years (2006–11) in rural Victoria, motivation scores have improved slightly for students in Years 5 and 6 and 7–9 (Figure 4.8).

Figure 4.8: Student motivation, by school year level and region type, Victoria, 2007–11



Source: Attitudes to School Survey 2006–2011, DEECD.

Years 10–12 retention rates

Years 10–12 retention rates provide a measure of students' continuing engagement with school from Years 10 to 12, although some caution should be used when interpreting these rates.⁴⁰ The rate refers to the Year 12 enrolments in full-time education (FTE,) expressed as a proportion of Year 10 FTE enrolments two years earlier. Rates are consistently higher for students in metropolitan Victoria than rural Victoria. In 2011, the rate was 74% in rural Victoria, compared with 87% in metropolitan Victoria.⁴¹

Regional variation

Hume has the lowest retention rate (71.1%) and Northern Metropolitan Region has the highest (93.9%). Gippsland has the highest retention rate in rural Victoria (77%).

Key policy directions: engagement in school

- National Partnership Agreement on Youth Attainment and Transitions (2009)
- *Aboriginal Education Strategy Wannik Learning Together – Journey to Our Future* (2008)
- Local Solutions Year 12 Retention Fund (rural/regional emphasis)
- *Building Respectful and Safe Schools – A resource for school communities* (2010)
- Re-engagement programs guidance
- DEECD–MAV Partnership

Victorian government initiatives

- boosted support for vulnerable children
- equipment for sight-impaired children
- re-engagement program pilots
- Promoting Youth – Opportunities for social and economic participation (\$8.2m)
- Promoting youth pathways – regional and rural community radio-training workshops
- Chaplaincy services
- *Victorian Government Indigenous Affairs report 2010–11*, tabled in Parliament in March 2012
- *Victorian Aboriginal Affairs Framework 2013–2018*
- *Springboard* – Intensive education and employment support for young people leaving care

Programs in place

- Education re-engagement programs
- *Out-of-Home-Care Education Commitment: A Partnering Agreement* between Department of Human Services, Department of Education and Early Childhood Development, Catholic Education Commission Victoria and Independent Schools Victoria
- Access and Equity Indigenous Education and Training projects
- Koorie Transitions Officers
- Koorie Education Coordinators
- Koorie Engagement Support Officers
- School Focused Youth Service
- Primary Welfare Officers
- Student Welfare Coordinators
- Student Support Services Officers
- Youth Mentoring and Capacity Building Initiative (MCBI)
- Student Mapping Tool (SMT)
- Managed Individual Pathways (MIPs)
- Local Learning Employment Networks (LLENs), including Regional Youth Commitments
- Careers Mentoring Network Initiative (CMNI)
- Extended School Hub Field Trials

Box 4.2: Wimmera Local Learning and Employment Network

There are 31 Local Learning and Employment Networks (LLENs) in Victoria. LLENs aim to improve participation, engagement, attainment and transition outcomes for young people. They have a particular focus on those young people who are at risk of disengaging or who have already disengaged from education and training and are not in meaningful employment.

The Wimmera Southern Mallee Local Learning and Learning Network (WSMLLEN) has 147 members, comprising primary and secondary schools, local governments, industry and business groups, education and training organisations, community groups and individuals. The WSMLLEN is involved a range of programs to improve education, training, employment and a broader range of life outcomes for young people who are ‘at risk’ or disengaged. For example, it is working in partnership with Wimmera Uniting Care, schools and stakeholders to plan and deliver the Aiming for Independence (A4I) program. A4I is targeting ‘at risk’ and disengaged young people, including young people who are making the transition from out of home care to independent living. A feature of the program is the partnership between schools, local business, community groups, health and welfare providers working together to improve education and life outcomes for our young people.

The program will focus on three core areas, 'Education, Employment and Training', 'Health and Wellbeing' and 'Independent Living Skills'. A wide range of workshops and modules will be developed and will cover employment pathways, employability skills, writing job applications and resumes, developing interview skills, dealing with stress, building confidence, improving resilience, communication skills, drug and alcohol education, healthy relationships, budgeting, cooking, housing and consumer rights and responsibilities. The program will also facilitate participation in supported work placements and mentoring programs. It will be able to be used by VCAL students to satisfy a significant number of learning outcomes required to achieve the VCAL qualification.

Box 4.3: Brophy Mentoring Program

The Brophy Mentoring Program aims to connect young people aged 12–18 to the wider community, through a mentor, and includes young people transitioning from State Care to independent living, funded (in-part) by the Department of Human Services. (The pilot program commenced in November 2010.) Mentoring has shown to improve school attendance with a longer term focus for further education and gaining employment. The role of a 'guide' or 'mentor' is simply to 'show the young person the ropes'.

The program aims to provide those young people who are sometimes disadvantaged (and therefore excluded from some aspects of society) with greater opportunities to interact with adults in positive community settings and to promote personal relationships and positive networks towards a better connection to the wider community and greater social integration.

Young people have an opportunity to:

- learn from someone in their community and extend their networks
- try out a new activity
- work with a community-based organisation
- make a positive contribution to their local community
- focus on short-, medium- and long-term goals for education and/or employment.

The Brophy Mentoring program had great success in 2011 and, as a result, it is hoped to extend it to more young people in Warrnambool, Hamilton, Portland and also Corangamite Shire.

Case study

In one case the School Chaplain had particular concerns for a young boy, 'A' aged 12 years, who would be transitioning the following year to a very large secondary college, where he clearly would have struggled. 'A' had difficulties socialising, which caused ongoing issues when interacting with other children at school. He displayed obsessive-compulsive disorder (OCD) behaviours at times of stress, including pulling his hair.

'A' was matched to a mentor who was a police officer. Apart from winning every game of chess, he was ecstatic at having the opportunity to 'go behind the scenes' and check-out Warrnambool's Police station and the cells.

A few months later he did transition to the local secondary college. He was suspended 8–9 times but completed his first year at secondary college, and the change in his behaviours and attitude to school and others was marked. At the end of that first year at college 'A' moved to Melbourne with his mother. However, the mentor has maintained contact with both 'A' and his mother and has feedback that 'A' settled easily in his new school environment and continues to report that he is doing well and maintaining regular school engagement.

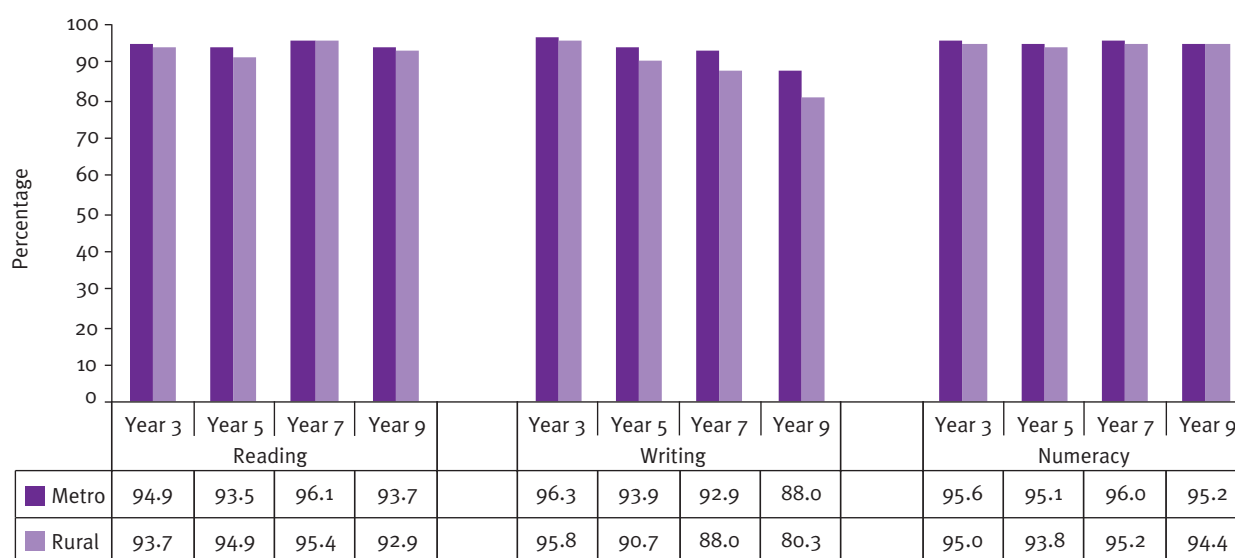
4.4 Educational attainment

National Assessment Program – Literacy and Numeracy

Since 2008, students in Australia have been assessed using a common assessment test under the National Assessment Program – Literacy and Numeracy (NAPLAN). The percentage of Victorian students who are achieving at or above the National Minimum Standard (NMS) has remained stable, overall, in the period 2008–11.

In 2011 a higher percentage of students in metropolitan Victoria (than rural Victoria) are achieving at or above the National Minimum Standard (NMS) for the three NAPLAN domains (reading, writing, numeracy) at all assessed year levels (Figure 4.9).

Figure 4.9: Percentage of students meeting National Minimum Standards on NAPLAN, by region type, Victoria, 2011



Source: NAPLAN 2011, VCAA.

Regional variation

Eastern Metropolitan Region has the highest percentage of students attaining at or above the NMS for all year levels and NAPLAN domains.

Year 7

Across Victoria, Loddon Mallee and Hume have the lowest percentages of students attaining at or above the NMS in reading and in numeracy, while Hume and Gippsland have the lowest percentages attaining at or above the NMS for writing. In rural Victoria, Grampians has the highest percentage of students attaining at or above the NMS for reading, while Barwon South Western has the highest percentage for writing and numeracy.

Year 9

Across Victoria, Northern Metropolitan Region and Gippsland have the lowest percentages of students attaining at or above the NMS in reading and in numeracy, while Gippsland and Loddon Mallee have the lowest percentages attaining at or above the NMS for writing. In rural Victoria, Barwon South Western and Grampians regions have the highest percentages of students attaining at or above the NMS for reading, writing and numeracy.

Major cities have the highest percentages of students achieving at or above the NMS at all school year levels in writing and at all year levels in numeracy (excluding Year 5). No significant differences are shown for reading.

Outcomes for Aboriginal children

Analysis of NAPLAN data (2008–11) identifies that Aboriginal students in Victoria perform less well than non-Aboriginal students in all assessed subjects and year levels.

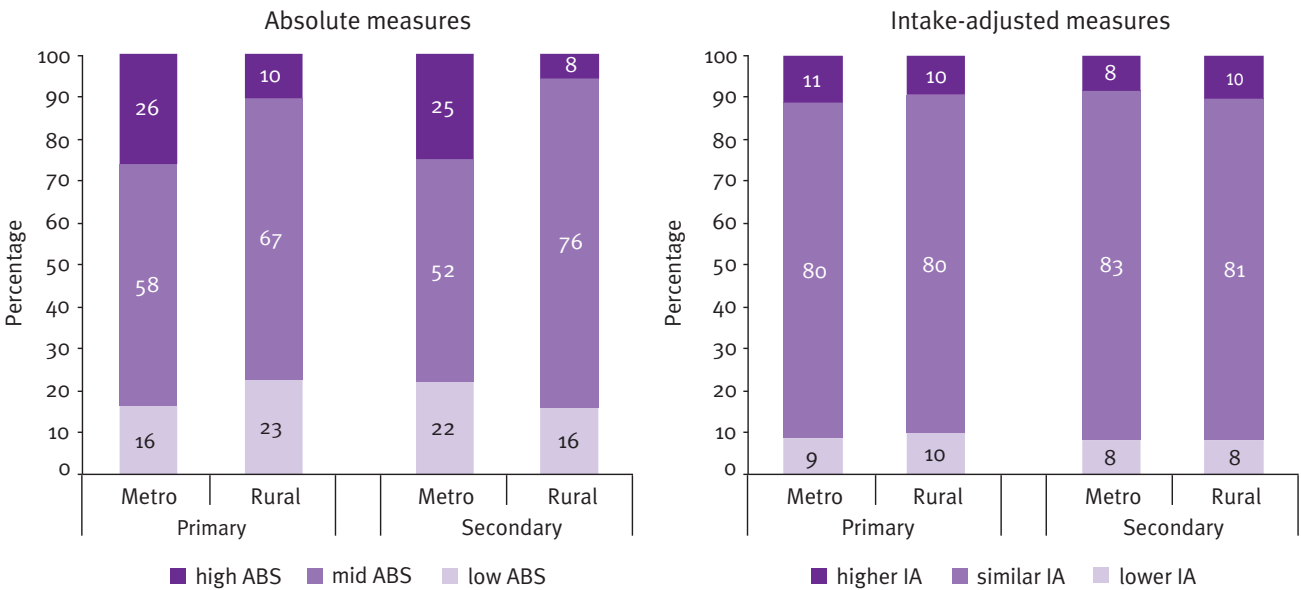
In general, Aboriginal students in rural Victoria attain less well, across all subjects and school year levels,⁴² than Aboriginal children in metropolitan Victoria. The attainment gap between Aboriginal and non-Aboriginal students in rural Victoria is also larger than the attainment gap between Aboriginal and non-Aboriginal students in metropolitan Victoria.

Factors influencing disparities in student attainment

Further analysis of Victorian government schools data helps to explain how contextual factors may be contributing to rural and metropolitan disparities in attainment.

The analysis measures student learning after taking account of the measurable context factors that are known to make the biggest difference to variations in learning outcomes. These factors are described in Box 4.4. Findings from this analysis, presented in Figure 4.10,⁴³ show that when factors that are known to influence learning outcomes are taken into account the observed rural and metropolitan disparities largely disappear.

Figure 4.10: Student learning, by region type, Victoria



Source: The Student Learning Outcome is based on teacher judgments, NAPLAN and Victorian Certificate of Education results.

This suggests that the relative socioeconomic disadvantage of rural Victoria (as reflected in school intake characteristics) may be a key factor in explaining the disparities in learning outcomes described in this section of the report. Rurality, as reflected in distance from education and employment options in rural Victoria, may also be an important contributory factor.

Box 4.4: Measurable factors that are known to influence school performance outcomes

- a measure of the school's academic composition
- the school's Student Family Occupation (SFO) Density
- the proportion of students funded under the Program for Students with Disabilities (PSD)
- the proportion of Indigenous students
- the proportion of refugee students
- the proportion of students with English as a Second Language (ESL)
- the school's rurality
- the school size
- the proportion of female enrolments.

(DEECD 2009b)

Completion of Year 12

The completion of Year 12 certificate or an equivalent qualification, such as an apprenticeship or a traineeship, has been shown to reduce the probability of unemployment, to increase workforce participation and to increase wages throughout life. Year 12 or equivalent attainment rates are consistently lower in rural Victoria (Table 4.4).

Table 4.4: Year 12 or equivalent attainment rates at age 19, by region type, Victoria, 2006–10

| Region type | 2006 | 2007 | 2008 | 2009 | 2010 |
|---------------|------|------|------|------|------|
| Rural | 74.3 | 73.1 | 73.2 | 73.9 | 73.1 |
| Metropolitan* | 80.2 | 79.3 | 82.5 | 82.1 | 82.8 |

Source: VCAA and Skills Victoria administrative data; Estimated Resident Population 2006–2010, ABS.

* Table amended from first release

Regional variation

In 2010, Eastern Metropolitan Region had the highest Year 12 attainment rates at age 19 across the state (87.4%). Gippsland (68.4%) and Grampians (69.5%) regions had the lowest. In rural Victoria, Barwon South Western Region had the highest Year 12 attainment rate (76.3%).

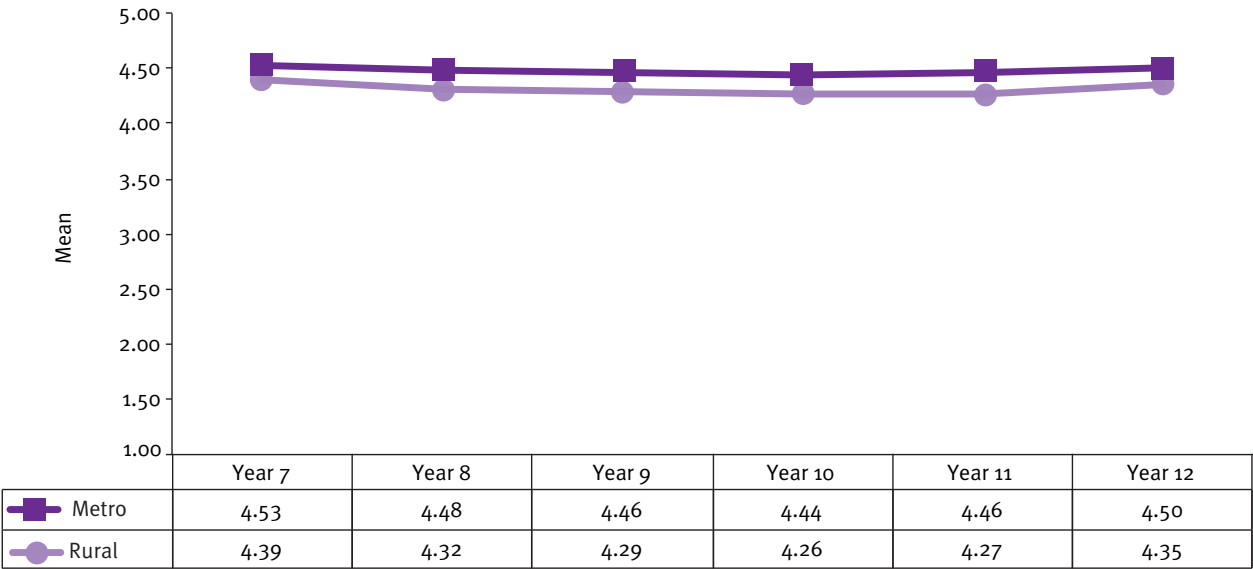
4.5 Further education and training

Preferences for further education and training

As part of the DEECD Attitudes to School Survey, students are asked to rate on a five-point scale (with five being the best possible score) how far they agree with the statement 'continuing or completing my education is important to me'.

Overall, the findings suggest that students place considerable value on continuing or completing their education (Figure 4.11). Findings reflect a similar pattern to that shown for engagement in school, with a dip followed by a rise in student ratings of the importance of continuing or completing education, and rural students rating this slightly less highly than metropolitan students.

Figure 4.11: Student perception of importance of continuing or completing education, by school year level and region type, Victoria, 2011



Source: Attitudes to School Survey 2011, DEECD.

Analysis of HOWRU 2009 data also shows that young people in rural Victoria are more likely than young people in metropolitan Victoria to express a preference for trade, apprenticeships and TAFE (Figure 4.12).

Figure 4.12: Educational preferences of young people, by school year level and region type, Victoria, 2009



Source: HOWRU 2009, DEECD.

Regional variation

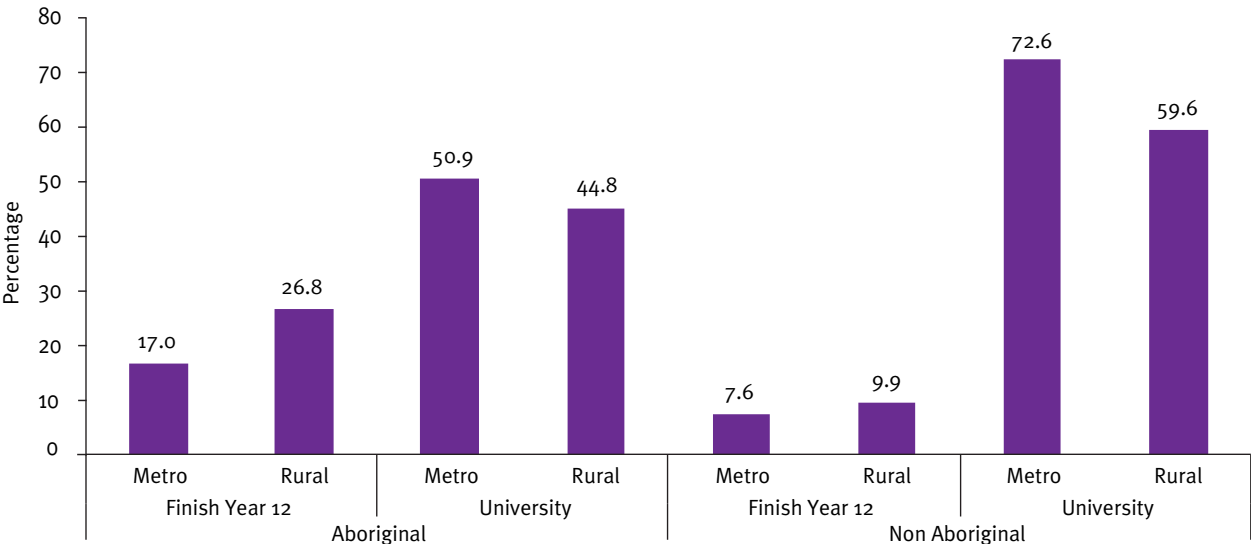
In Year 11, in rural Victoria, Barwon South Western (32.4%) and Loddon Mallee (23.3%) had the highest percentage of young people expressing a preference for trade, apprenticeships and TAFE, while Grampians (13.7%) and Gippsland (15.8%) had the lowest.

Aboriginal young people

Analysis shows that Aboriginal young people are more likely to express a desire to complete Year 12 (as their highest level of education) and less likely to express a preference for university education, when compared to non-Aboriginal young people (Figure 4.16).⁴⁴

Aboriginal young people in rural Victoria are also more likely to express a preference to complete Year 12 (as their highest level of education) and less likely to express a preference for university, when compared with Aboriginal young people in metropolitan Victoria (see Figure 4.13).

Figure 4.13: Educational preferences of young people, by Aboriginal status and region type, Victoria, 2009



Source: HOWRU 2009, DEECD.

A marked disparity between the preferences of Aboriginal young people in rural and in metropolitan Victoria is highlighted in Year 9, with 46.3% of rural Aboriginal young people in this level expressing a preference to complete Year 12, compared to 19.2% in metropolitan Victoria. Likewise, 19.4% of Aboriginal young people in rural Victoria in Year 9 express a preference for university, compared to 51.3% in metropolitan Victoria.

Post-school destinations

Analysis of longitudinal On Track data (2008–11)⁴⁵ shows that there have been increases across Victoria (2008–11) in the proportion of young people who have completed Year 12 going on to a bachelor degree, with a higher increase in rural than metropolitan Victoria (7.2 versus 5.2 percentage point increase).

Year 12 rural school students make fewer transitions, however, than metropolitan students, to bachelor degree and to upper-level vocational training (VT); and they are more likely to defer a university place (15.6% of rural Year 12 students deferred in 2011, compared with 8.4% of metropolitan students). Transitions to entry-level VT, apprenticeships, traineeships and the labour market are higher in rural regions.

In 2011, 65.8% of Year 12 completers from rural Victoria were in education or training (compared with 80.5% from metropolitan Victoria) and 34.2% were in the labour force (compared with 19.5% from metropolitan Victoria).

Box 4.5: Destinations of rural and metropolitan deferrers

A recent report, published by the Youth Affairs Council of Victoria, presents findings from a cohort of 2009 Year 12 deferrers, identified through the 2010 On Track survey of school leavers.

When contacted in 2011, 61% of the cohort were attending university, 20% were working, 11.8% had entered vocational education and training course and 4.3% had entered traineeships or apprenticeships. Only 1.9% were looking for work and 1% were inactive (not in education or training, or working/seeking work).

For metropolitan students, the rate of transition to university was found to rise as socioeconomic status rises, whereas for rural students, the rate of transition was very similar across the SES categories.

In rural Victoria, factors such as financial and distance-related barriers appeared to affect the likelihood of taking up a university place; with rural students four times more likely to report that they did not take up studies because they had been waiting to qualify for youth allowance (Polesel et al. 2012).

Early leavers

In 2012, 1548 early leavers in rural Victoria were interviewed for the On Track Survey, compared with 2004 early leavers in metropolitan Victoria. Of early school leavers from rural Victoria, 62.3% were in education and training versus 51.9% from metropolitan Victoria. This difference was due to a higher take-up of apprenticeships in rural Victoria.

Early leavers from metropolitan Victoria were more frequently not working, not studying and looking for work (18.1%) than early leavers from rural Victoria (11.1%).⁴⁶ In rural Victoria, Hume and Gippsland had the highest percentages of early leavers who were looking for work (12.8% and 11.4%, respectively) and Barwon South West and Grampians had the lowest percentages (10.5% and 10.4%, respectively).

Early leavers and socioeconomic status

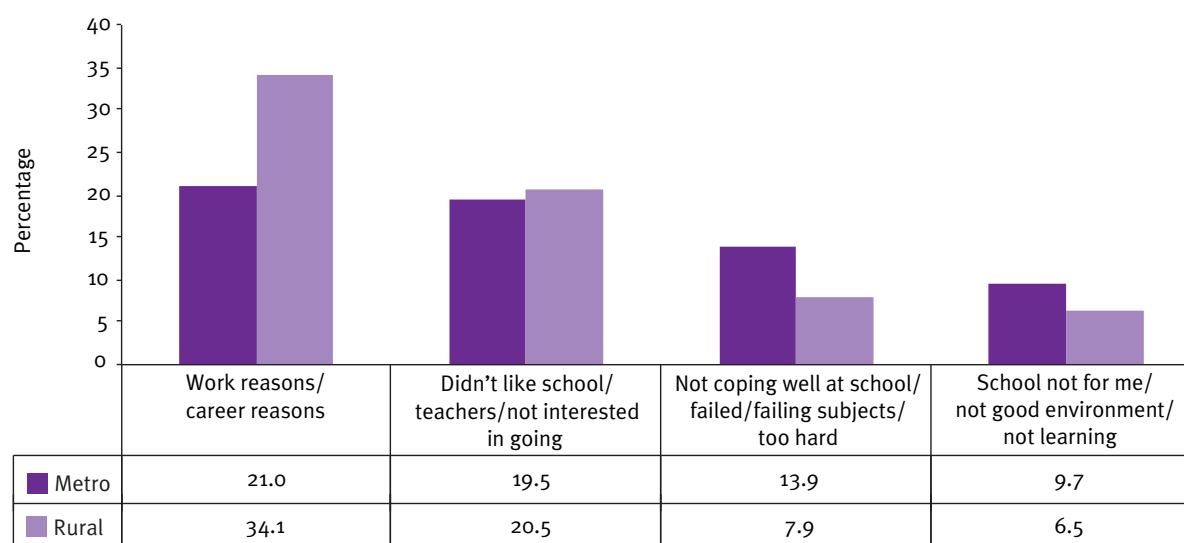
Analysis of 2008–2012 On Track data shows that early leavers who are looking for work in rural Victoria are more likely than those from metropolitan Victoria to be from lower Socioeconomic Indexes for Areas (SEIFA) quartiles, and less likely to be from higher SEIFA quartiles.⁴⁷ This finding also applies to early leavers who are not in the labour force.

Reasons for leaving school

Figure 4.14 shows the ‘push’ factors that are cited by young people as reasons for leaving school. While metropolitan young people are more likely to cite school and learning environment as push factors, rural young people are more likely to cite work/career options as the reasons for leaving school.

Further analysis of 2012 On Track data suggests that levels of satisfaction with career advice were generally high among rural early leavers, with no differences identified between metropolitan and rural Victoria.

Figure 4.14: Percentages of young people citing different ‘push’ factors as reasons for leaving school, by region type, Victoria, 2012



Source: On Track Survey 2012, DEECD.

Unemployment six months after leaving school

Table 4.5 shows that early school leavers in rural Victoria are less likely (than early leavers in metropolitan Victoria) to be unemployed six months after leaving school.⁴⁸

Table 4.5: Proportion of early school leavers who are unemployed six months after leaving school, by region type, Victoria, 2007–12

| Region type | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|--------------|------|------|------|------|------|------|
| Metropolitan | 17.1 | 14.9 | 20.1 | 18.5 | 18.5 | 18.1 |
| Rural | 12.5 | 12.6 | 16.9 | 14.2 | 14.9 | 11.1 |
| Victoria | 15.3 | 14 | 18.7 | 16.7 | 17 | 15.1 |

Source: On Track Survey 2012, DEECD.

Aboriginal early leavers and unemployment

While the percentage of Aboriginal early leavers who are unemployed six months after leaving school has decreased across Victoria (2008–12), they are slightly more likely than non-Aboriginal early leavers to be unemployed (in 2012, 16.7% of Aboriginal early school leavers in Victoria were unemployed compared with 15.1% of non-Aboriginal ones). Analysis by region type, however, highlights that this pattern is largely explained by higher levels of Aboriginal early leaver unemployment in metropolitan Victoria. In 2012, in metropolitan Victoria, 25% of Aboriginal early school leavers were unemployed, compared with 17.9% of non-Aboriginal early leavers. In contrast, 8.9% of Aboriginal early leavers in rural Victoria were unemployed six months after leaving school, compared with 11.4% of non-Aboriginal early school leavers.⁴⁹

Key policy directions: educational attainment, aspirations and post-school destinations

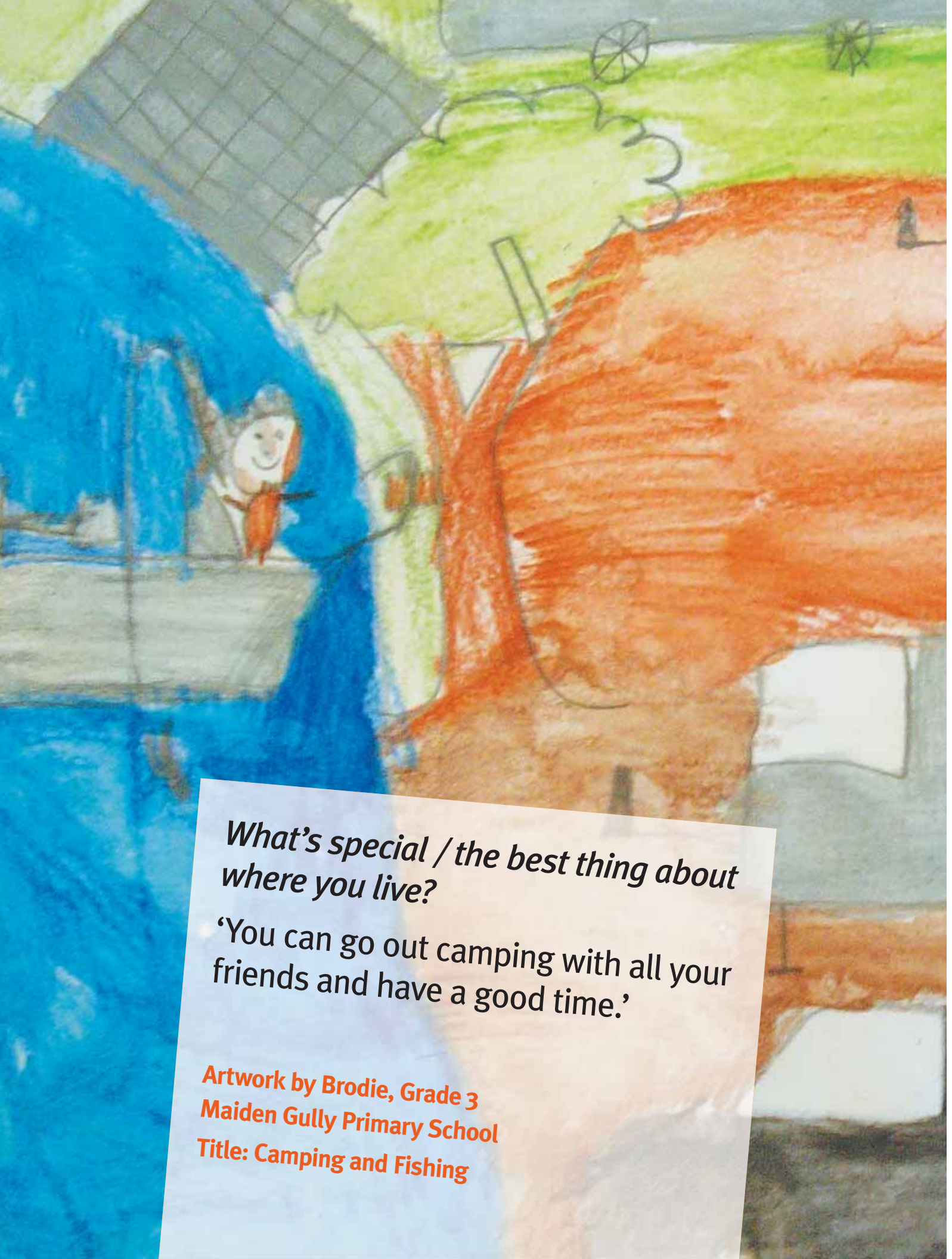
- MCEETYA, *Melbourne Declaration of Educational Goals for Young Australians* (2008)
- National Partnership Agreement on Literacy and Numeracy (2008)
- National Partnership Agreement on Low SES School Communities (2008)
- National Partnership Agreement on Youth Attainment and Transitions (2009)
- Australian Government, *Skills for All Australians* (2012)
- *Securing Jobs for Your Future – Skills for Victoria* (2008)
- Wannik Education Strategy for Koorie Students (2008)
- Victorian Training Guarantee (2008)
- *Towards Victoria as a Learning Community* (2012)

Victorian government initiatives

- primary mathematics and science specialists
- school specialisation grants
- boosted support for vulnerable children
- Promoting Youth – Opportunities for social and economic participation (\$8.2m)
- Promoting Youth Pathways – regional and rural community radio training workshops
- \$1m for Zero-fee TAFE places for children leaving out-of-home care
- *Victorian Government Indigenous Affairs report 2010–11*, tabled in Parliament in March 2012
- *Victorian Aboriginal Affairs Framework 2013–2018*
- Children, Youth and Families and Disability Services Operating Framework – Supporting integrated practice (2012)
- more integrated Education Services in Youth Justice Custodial Centres
- Youth Connection – Custodial Post-Release Education, Training and Employment Services
- *Springboard* – Intensive education and employment support for young people leaving care

Programs in place

- Student Mapping Tool (SMT) and Managed Individual Pathways (MIPs)
- Senior Secondary Re-engagement Programs
- flexible curriculum for senior secondary students: VCAL, VETiS, apprenticeships, traineeships
- Local Solutions Year 12 Retention Fund and Partnership Facilitation fund (rural/regional)
- Local Learning and Employment Networks (LLENs), including Regional Youth Commitments
- Access and Equity Indigenous education and training projects
- Koorie Transitions
- Youth Mentoring and Capacity Building Initiative (MCBI)
- Workplace Learning Coordinators and Careers Mentoring Network Initiative (CMNI)



*What's special / the best thing about
where you live?*

*'You can go out camping with all your
friends and have a good time.'*

**Artwork by Brodie, Grade 3
Maiden Gully Primary School
Title: Camping and Fishing**

A child's drawing of a playground scene. The background is green, representing grass. In the upper right, there's a grey structure with a circular wheel-like element. A large red area dominates the middle, representing a slide. To the left of the red area is a grey structure with a circular wheel-like element. In the bottom left, there's a grey structure with a circular wheel-like element and a small white square with a simple drawing of a person with arms raised. The text "Section 5" is written in large white letters across the red area, and "Safety" is written in smaller white letters below it.

Section 5

Safety

5. Safety



Artwork by Chelsea, Grade 3,
Maiden Gully Primary School
Title: Fun in the sun

5.1 Neighbourhood safety

The characteristics of local neighbourhoods, including neighbourhood safety (whether perceived or real), can have an important impact on outcomes for children, young people and their families. Perceptions of neighbourhood safety, including the perceived level of crime, are closely related to the quality and nature of community engagement (see Section 7 for further discussion).

Overall, a very high proportion of Victorian children (around 95%) and a high proportion of young people are reported to live in safe neighbourhoods (VCHWS⁵⁰ and HOWRU). There are no observed differences, by region type or in ARIA analysis, in the percentages of children or young people reported to live in safe neighbourhoods.⁵¹

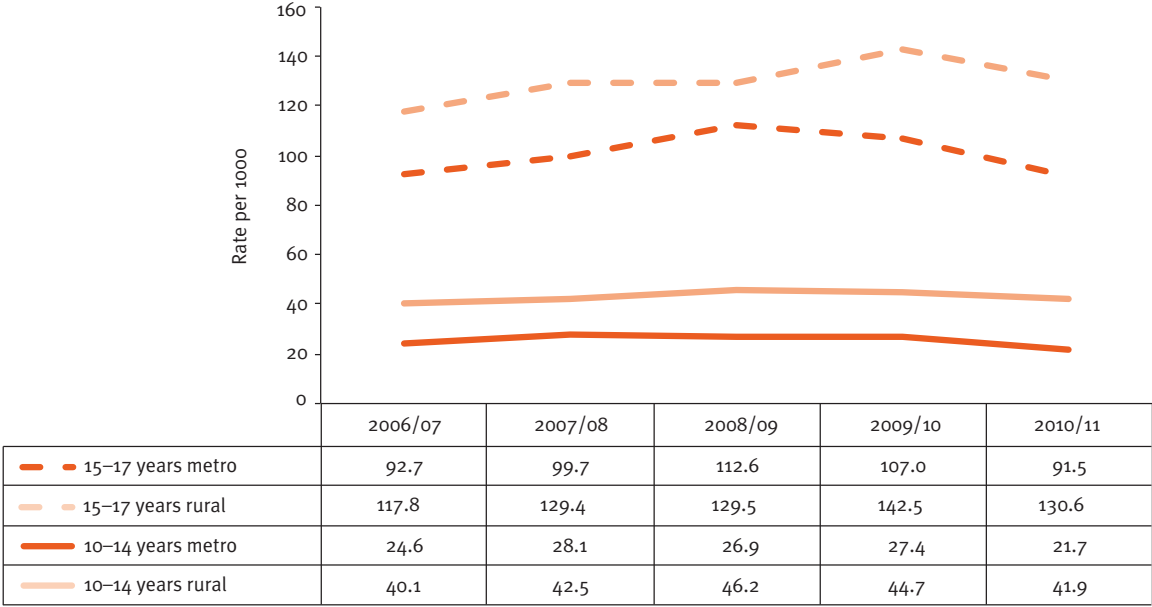
5.2 Offending

In the course of their childhood and adolescence, some young people become involved in offending behaviour. Most are involved in one-off and relatively minor events; however, a very small proportion of young people become involved in more serious and persistent crime (DEECD 2008). Research suggests that young people who commit crimes are often disadvantaged or vulnerable, with multiple risk factors. Risk factors may be individual or systemic and include individual vulnerabilities (e.g. mental illness or impaired intellectual functioning), family influences (e.g. socioeconomic disadvantage or exposure to crime and violence) and community characteristics (e.g. living in communities with high crime rates) (DEECD 2012).

Analysis of Victoria Police Law Enforcement Assistance Program (LEAP) data from 2006–07 to 2010–11 shows that the rate of youth crime (per 1000 children and young people aged 10–17 years) has decreased in metropolitan Victoria, while it has increased in rural Victoria. In contrast to the picture for overall crime,⁵² rates of crime among young people are also higher in rural than in metropolitan Victoria.⁵³ The reasons for this disparity in youth crime rates are not fully understood. Additionally, there are a number of issues that should be considered when interpreting this data. The indicator is a measure of alleged offenders⁵⁴ who are processed by police and it does not provide a direct measure of crimes committed.

Figure 5.1 presents the rate of crime (per 1000 young people aged 10–17 years) by age group and region type. In 2010–11, the rate of crime (per 1000) young people aged 15–17 years was 130.6 in rural Victoria and 91.5 in metropolitan Victoria. For 10–14 year-olds, the rate was 41.9 (rural) and 21.7 (metropolitan). In rural Victoria, the rate of crime among 10–14 year-olds has remained stable (with some fluctuations) from 2006–07 to 2010–11, whereas the rate of crime among 15–17 year-olds has increased over the five-year period.

Figure 5.1: Alleged offenders processed aged 10–17 years, expressed as a rate per 1000 population, by age group and region type, Victoria, 2006–07 to 2010–11



Source: LEAP 2006–07 to 2010–11, Victoria Police.

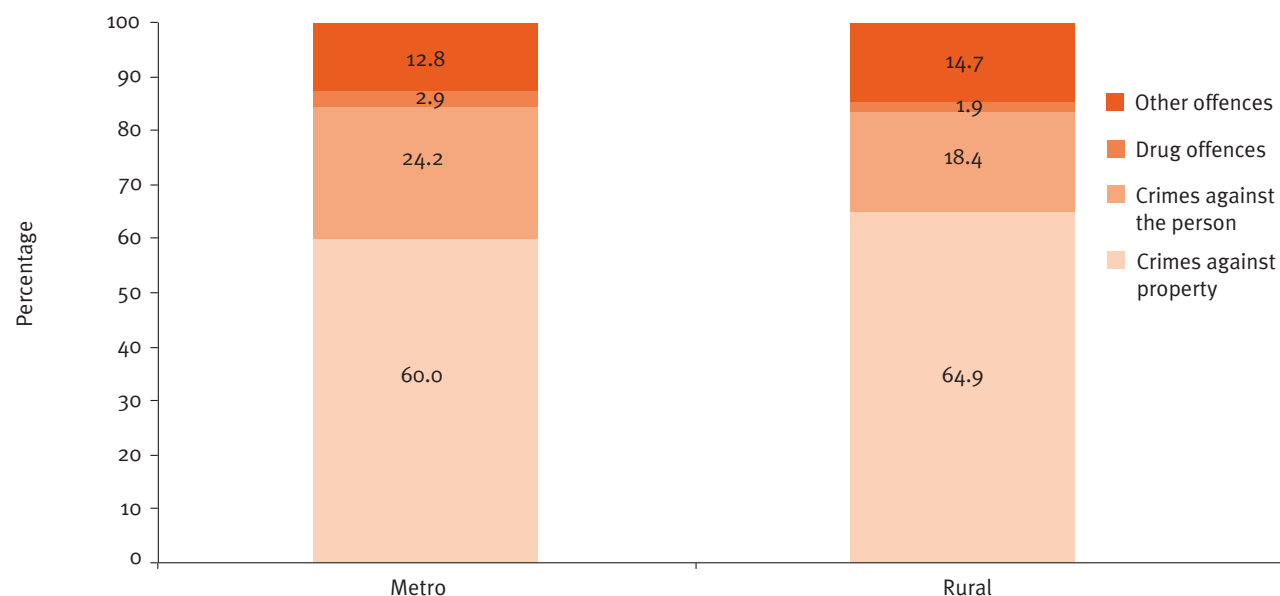
Regional analysis

Analysis of LEAP 2006–07 to 2010–11 data shows that the highest rates of crime among young people are in remote Victoria (from 2007–07 to 2009–10) and in outer regional Victoria in 2010–11. Major cities have the lowest rates.

Type of crime

As Figure 5.2 shows, crimes against property account for the greatest proportion of crimes committed by young people in Victoria. Those in rural areas are more likely than those in metropolitan areas to commit crimes against property, whereas young people in metropolitan areas are more likely than those in rural areas to commit crimes against the person.

Figure 5.2: Types of crime committed by children and young people aged 10–17 years, by region type, Victoria, 2010–11



Source: LEAP 2010–11, Victoria Police.

Gender differences

The majority of crimes committed by young people are committed by young males. Among young people aged under 18 years, females in rural Victoria are marginally less likely to commit crimes than those in metropolitan areas, although more than a quarter (26.1%) of the crimes committed in 2010–11 in Gippsland were committed by females (an increase from 18.7% in 2007–08). Hume had the lowest percentage of crimes committed by females (18.6%).

Box 5.1: Young people and crime

Only a very small proportion of Victoria’s children and young people become involved in crime, either as victims or as perpetrators. However, the impact of any exposure to crime and the youth justice system is potentially significant for a child’s development. Whether from the perspective of victim or perpetrator, exposure to serious crime and the psychosocial repercussions can potentially impact the long-term wellbeing of those affected (DEECD 2012a).

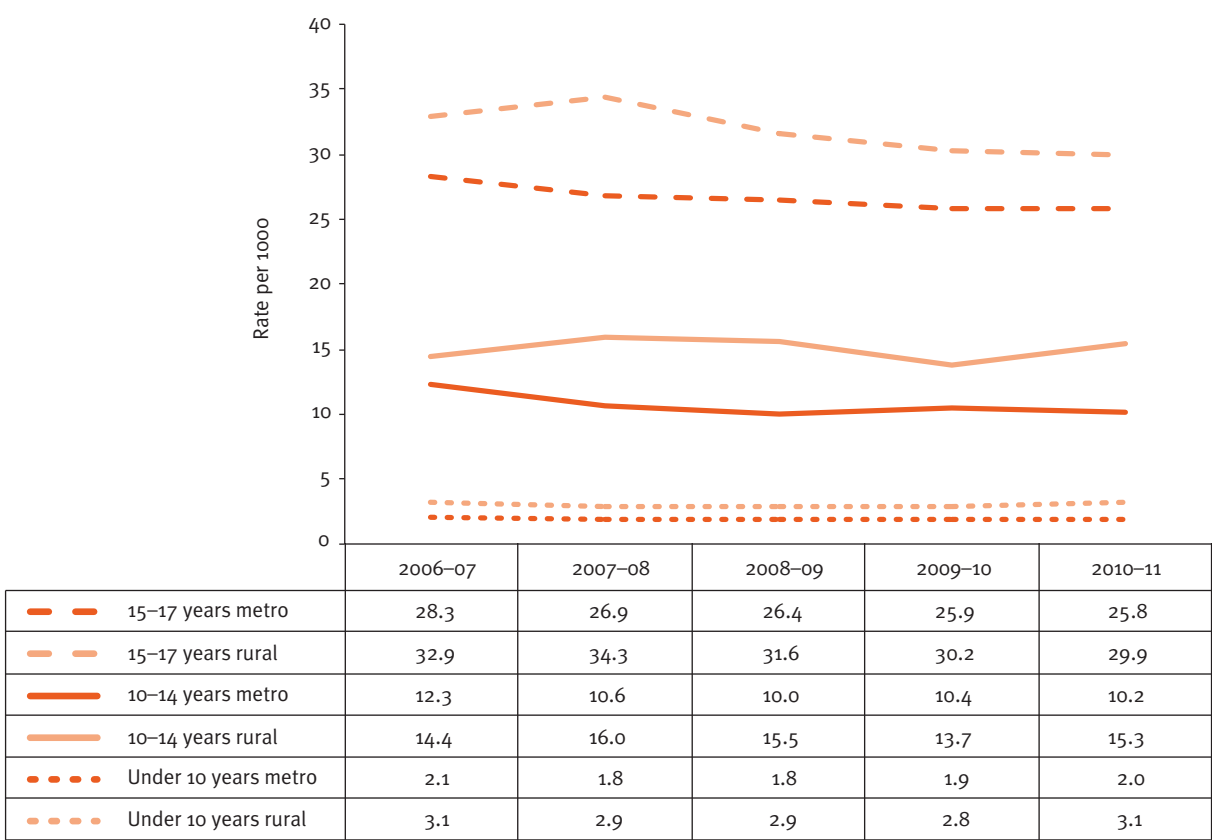
5.3 Victims of crime

It is difficult to obtain an accurate estimation of the number of children and young people who are victims of crime, as it is likely that many crimes are unreported to the police for reasons such as reluctance to report a crime where the perpetrator is known to the victim (DEECD 2012).

Analysis of LEAP data for the five years 2006–07 to 2010–11 shows that the rate of crime (per 1000 population) where the victim was a child or young person aged 0–17 years has remained fairly stable in Victoria over the period, with a small overall decrease from 10.2 (per 1000 population) in 2006–07 to 9.1 (per 1000 population) in 2010–11).

The rate is consistently higher in rural than in metropolitan Victoria.⁵⁵ In 2010–11, the rate of crime (per 1000 population) where the victim was a child or young person was 11.6 in rural Victoria and 8.2 in metropolitan Victoria. Figure 5.3 presents the rate of crime (per 1000 population) where the victim was a child or young person, by age group and region type. Crime rates where the victim was a child or young person are highest among 15–17 year-olds and lowest for children under 10 years, and have shown an increase in rural Victoria for young people aged 10–14 years.

Figure 5.3: Rate of crime per 1000 young people where the victim was a child or young person, by age group and region type, Victoria, 2006–07 to 2010–11



Source: LEAP 2006–07 to 2010–11, Victoria Police.

Types of crime

The types of crimes for which young people are victims are similar in rural and metropolitan areas, comprising around 70% crimes against the person.

Regional variation: young people as offenders and victims

Gippsland consistently has the highest rates of crime where the child or young person was aged 10–17 (2006–07 to 2010–11), whereas rates are consistently the lowest in Eastern Metropolitan Region. In rural Victoria rates are lowest in Barwon South Western Region.

Crime rates where the victim was a child or young person aged 0–17 are consistently highest in Gippsland and lowest in Eastern Metropolitan Region. In rural Victoria, rates are lowest in Barwon South Western Region (LEAP 2006–07 to 2010–11, Victoria Police).

Key policy directions relating to children, young people and crime

- National Youth Policing Model (2010)
- *Victorian Police Child and Youth Strategy 2009–13* (2009)

Victorian government initiatives

- Step Back, Think program to address alcohol related crime among young people (Department of Justice)
- Diversion and rehabilitation for young offenders through intensive bail supervision (Department of Human Services)
- Protecting Children: Protocol between Department of Human Services, Child Protection and Victoria Police (2012)

Diversion programs to reduce progression into the criminal justice system

- Victorian Early Intervention Pilot Program
- Youth Support Service (YSS) DHS initiative to lower risk of youth offending
- Central After Hours and Bail Placement Service (DHS)
- Gain Respect, Increase Personal Power (GRIPP) program in Dandenong
- Local Learning and Employment Networks (LLENs)
- Youth Justice Group Conferencing
- Youth Justice Service – Bail Supervision, Court Advice Service
- Youth Referral and Independent Person Program – government funded partnership between Victorian Police and community agencies – assisting young people during police interviews
- Victoria Police Cautioning Program
- Police Cautioning & Youth Diversion Project (Koorie) (Victoria Police and Victorian Aboriginal Legal Service (VALS))
- Victoria Police Diversion Programs, e.g. ROPES – available in the Children’s Court
- RIGHT STEP Pilot – Children’s Court at Moorabbin

5.4 Injuries

Hospitalisation for injuries and poisoning

Injury and poisoning are the main cause of death and the major causes of morbidity for children and young people in Australia, with Aboriginal children and children from low SES backgrounds showing a disproportionately high risk of injury leading to death or hospitalisation (DEECD 2012).

Hospitalisation rates for injuries and poisoning have shown a small decrease (2006–10). Rates for males are higher than for females,⁵⁶ and rates are consistently higher for children in rural, than metropolitan, Victoria. In 2010, the hospitalisation rate (per 10,000 children and young people aged 0–17 years) for injuries and poisoning was 49.6 in rural Victoria, compared with 33.0 in metropolitan Victoria. Hospitalisation rates for injury and poisoning are lowest in major cities and increase progressively with levels of remoteness.

Regional variation

Rates of hospitalisation for injury and poisoning are consistently highest in Barwon South Western Region (2006–10).

In 2010, the rate of hospitalisation for injury and poisoning was 95.7 per 10,000 population in Barwon South Western, followed by 89.7 in Hume. The lowest rate of hospitalisation for injury and poisoning was in Western Metropolitan Region (56.4). In rural Victoria, the lowest rate was in Gippsland (71.5 per 10,000 population).

Key policy directions: injuries

- WHO, *Child and adolescent injury prevention: A WHO plan of action 2006–15* (2006)
- National Injury Prevention and Safety Promotion Plan 2004–14 (2005)
- COAG, *National Framework for Protecting Australia's Children 2009–2020* (2009)
- *Victorian Public Health and Wellbeing Plan 2011–2015* (2011)

Programs in place

- Safe from injury and harm – MCH Program
- adolescent safety
- services to address risk taking behaviours among vulnerable young people

5.5 Child protection and out-of-home care

Child abuse

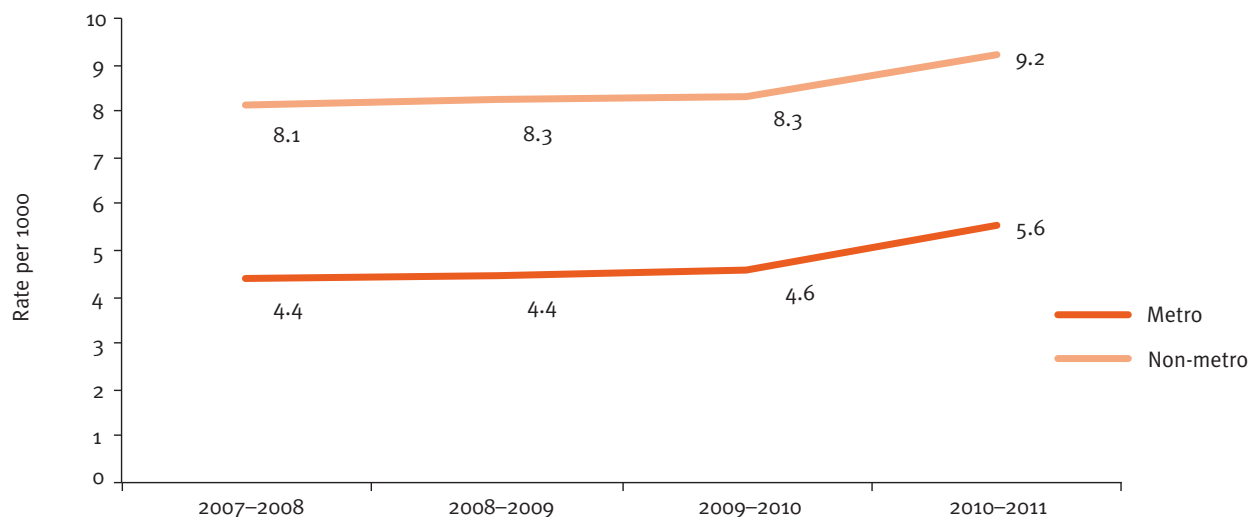
Child abuse and neglect have both current and long-term adverse consequences for children, including behavioural and learning problems, substance use, antisocial and criminal behaviour, and poor physical and mental health (DEECD 2012). Child abuse and neglect are commonly classified into categories of physical abuse, sexual abuse, emotional abuse and neglect. Substantiated child abuse (see following) is most prevalent among young children aged 0–4 years.

It is important to note that there is no reliable measure on the overall prevalence of child abuse. The following substantiation data reported only relate to situations where the child has come to the attention of the Child Protection authorities.

Reported and substantiated child abuse

Incidents of substantiated child abuse (where incidents are reported to, investigated and verified by the Department of Human Services) decreased between 2005–06 and 2006–07 (DEECD 2012). However, rates have increased overall between 2007–08 and 2010–11 (Figure 5.4). The figure also shows that rates of substantiated abuse are much higher in rural (9.2 per 1000 population) than in metropolitan Victoria (5.6 per 1000 population) (2010–11).

Figure 5.4: Rate of child abuse substantiations of children aged 10–17 years (per 1000 population), by region type, Victoria, 2007–08 to 2010–11



Source: Client Relationship Information System 2007–08 to 2010–11, Estimated Resident Population 2005–2009, ABS; DHS (unpublished),

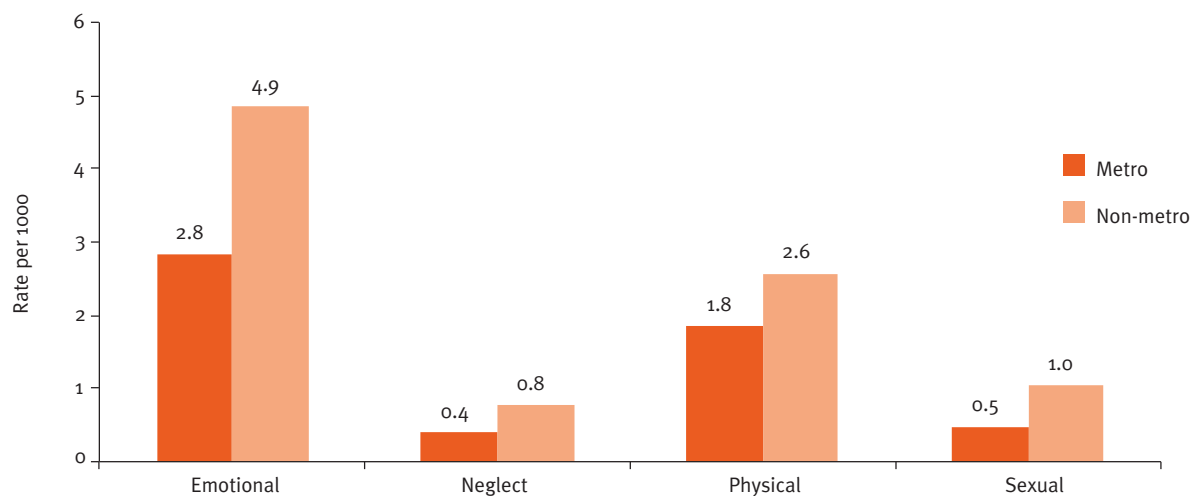
Regional variation

The rate of child abuse substantiations is lowest in major cities and increases progressively with levels of remoteness. In 2010–11, the rate was 16.4 in remote areas and 5.5 in major cities (inner regional 9.10, outer regional 10.9).

Types of substantiated abuse

As Figure 5.5 shows, the most frequently substantiated type of abuse in Victoria, overall, is emotional abuse, followed by physical abuse, neglect and sexual abuse.

Figure 5.5: Rate of substantiated child abuse reports of children and young people aged 0–17 years (per 1000 population), by type of abuse and region type, Victoria, 2010–11



Source: Client Relationship Information System 2010–11, DoH (unpublished); Estimated Resident Population 2009, ABS.

Regional variation

There are marked differences at regional levels in rates of substantiated child abuse, with Gippsland showing the highest rates (since 2007–08). Gippsland has the highest rate of emotional abuse (6.5) and Western Metropolitan Region the lowest (2.3). Gippsland also has the highest rate of physical abuse (4.5) and Eastern Metropolitan Region has the lowest (1.4).

Children on Child Protection Orders

Most families and children who come into contact with Child Protection authorities are referred to support services. In some instances, if there are serious concerns about a child's safety and wellbeing, further intervention is required, and a child protection practitioner may apply to the Children's Court for a Care and Protection Order.

The rate of children and young people aged 0–17 years on a Care and Protection Order in 2010–11 was more than double (9.1 per 1000) in rural Victoria, compared with metropolitan Victoria (3.9 per 1000).

Regional variation

Regional analysis shows a similar pattern to substantiated abuse data, with the highest rates of children on a Care and Protection Order in Gippsland (11.4 per 1000 population) and Grampians (9.4 per 1000 population) and the lowest rate in the Eastern Metropolitan Region (3.1 per 1000 population). Rates of children on Care and Protection Orders are lowest in major cities (3.8) and highest in outer regional areas (8.5) (inner regional 6.9 versus remote 7.9).

Children in out-of-home care

Children may need to be accommodated in out-of-home care when they are not able to live with their parents. The majority of these children will be on Care and Protection Orders and be placed with relatives and kin, or in foster or residential care. Most will eventually return to live with their family (DEECD 2009, p. 164).

As at 30 June 2011 in Victoria, 5511 children and young people aged 0–17 years were in out-of-home care, representing a total of 2605 (children and young people) in rural Victoria and 2906 in metropolitan Victoria. The rate of children in out-of-home care was more than double in rural (7.6 per 1000 children 0–17 years) compared with metropolitan Victoria (3.3) and Victoria as a whole (4.4), with the lowest rates in major cities.

Regional variation

As at 30 June 2011, the highest rates of children in out-of-home care (per 1000 population) are in Gippsland (9.7), the Grampians (8.9) and Loddon Mallee (7.4), whereas the lowest rate was in the Eastern Metropolitan Region (2.8 per 1000 population).

Box 5.2: Protecting Victoria's Vulnerable Children Inquiry – issues in rural Victoria

The 2012 *Inquiry into Protecting Victoria's Vulnerable Children* reports that the significant over-representation of Aboriginal children and young people on care and protection orders and in out-of-home care is a matter of great concern.

The inquiry notes that rates of Child Protection authorities' reports and substantiations are higher in rural than Victoria than metropolitan Melbourne, and that children in rural Victoria are much more likely to be placed in out-of-home care. It also identifies that in areas where child protection reports are higher there is a higher proportion of children who are vulnerable on the AEDI (one or more domains) and higher socioeconomic disadvantage (as measured by SEIFA).

Regional and remote challenges to service delivery were raised by submissions to the inquiry, including recruitment and demands placed on staff once recruited (p. 97; p. 106).

Child protection workers as well as vulnerable children and families face specific challenges due to the spatial locations and service access in rural/regional areas. The inquiry recognised that varying system capacity and access to services across Victoria varied by community and regions.

The types of services that rural and regional areas have less access to, as identified in the inquiry report, include early parenting centres, access to child protection workers, local access to children's court and services, clinical court services, out-of-home care, family services, placement and support services (Parliament of Victoria 2012).

Key policy directions: child abuse, child protection and out-of-home care

- COAG, *National Framework for Protecting Australia's Children 2009–2020* (2009)
- COAG, *National Plan to Reduce Violence Against Women and their Children 2010–2022* (2010)
- *Victorian Strategic Framework for Family Services* (2007)
- *Living Free From Violence – Upholding the Right: Victoria Police Strategy to Reduce Violence Against Women and Children 2009–2014* (2009)
- *Victoria's Action Plan to Address Violence Against Women and Children – Everyone has a responsibility to act* (released October 2012)
- *Strong Culture, Strong Peoples, Strong Families – Towards a safer future for Indigenous families and communities* (10-year plan) (2008)
- *Supporting Parents, Supporting Children: A Victorian Early Parenting Strategy* (2010)
- *Victoria's Vulnerable Children: Our Shared Responsibility – Directions Paper*, May 2012
- *Victoria's Vulnerable Children Strategy* (under development)

Victorian government initiatives

- \$8.3m to provide Early Childhood Education or 3 year-olds known to Child Protection authorities
- childcare for at-risk children, to provide specialist, early years care and education for children under 3 years
- \$16m for *Cradle to Kinder*: 10 new programs, including two Aboriginal specific programs
- \$29m for *Stronger Families* program delivered in four ChildFIRST catchments across Victoria, with services to be established in two additional locations in 2012–2013
- intensive antenatal and post-natal case management support for vulnerable expectant mothers and fathers from birth until the child is 4 years
- *Chief psychiatrist's guideline: Priority access for out-of-home care* (2011) sets out arrangements for mental health services to give priority consideration to referrals for children and young people (up to 18 years) who are in out-of-home care
- *Protecting Children: Protocol between Department of Human Services, Child Protection and Victoria Police* (2012)

- The Government has outlined, as part of its response to the Protecting Victoria's Vulnerable Children (PVVC) Inquiry, \$336m of initiatives to provide supports from vulnerable children experiencing child abuse and neglect. Measures to support Victoria's most vulnerable children include child protection workforce reform, greater help for families, improved intervention and diversion programs, expansion of places in therapeutic out-of-home care and innovative reform of the Children's Court, including a new Children's Court at Broadmeadows
- three new Multidisciplinary Centres in partnership with Child Protection, Sexual Offence & Child Abuse Investigation Teams (Victoria Police) and Centre Against Sexual Assault (CASA) staff (2012–13 Budget commitment) Family Group Conferencing and Aboriginal Family Decision Making – expanded use of Family Group Conferencing and Aboriginal Family Decision Making to strengthen planning, support and intervention to improve the safety and wellbeing of children

Programs in place

- Maternal and Child Health (MCH) and Enhanced MCH, including the Safe from Injury and Harm Program
- Sexual Offence & Child Abuse Investigation Teams (SOCIT)
- *Cradle to Kinder* and *Aboriginal Cradle to Kinder*
- ChildFIRST and Integrated Family Services for vulnerable families
- Community Health Services (CHS) Child Health Teams (CHTs)
- treatment programs for young people displaying inappropriate sexual behaviour
- Aboriginal *Stronger Families* program and Aboriginal Child and Family Services
- Aboriginal Family Preservation and Restoration programs
- *Stronger Families* program and support for vulnerable families
- Primary and Secondary School Nursing Programs
- Healthy Mothers, Healthy Babies Program
- mandatory reporting of child abuse (by certain professionals under the *Children, Youth and Families Act 2005* (not a community requirement))
- Children's Court Conferencing
- sexual assault support services
- existing Multidisciplinary Centres

Box 5.3: Multidisciplinary centres: a collaborative, integrated response to sexual assault

Multidisciplinary centres (MDCs) co-locate specialist responders – Victoria Police, sexual assault support services and Child Protection authorities – to provide collaborative and integrated responses to sexual assault. Three MDCs are currently funded in Frankston, Mildura and Geelong.

Children and young people experience the highest rates of sexual assault of any age group. Improved outcomes for children can be achieved in the MDC setting as a result of the increased capacity of police, counsellor/advocates and child protection staff to work together and support more targeted child protection interventions.

Within the MDC setting, children are supported to make disclosures in relation to a form of abuse that is often shrouded in secrecy. With the assistance of counsellor/advocates, child protection workers can engage non-offending parents and assist them to act protectively. As a result, fewer protective applications are required; children feel believed and trust that their parent can provide safety for them.

MDCs minimise the practical challenges of accessing services and have the capacity to significantly improve health outcomes across the life span and reduce the need for down-stream services.

Workers within the MDC setting have the opportunity to engage in interagency training that increases their skills and expertise in relation to responding to sexual assault, as well as developing a culture of strong partnerships.

The 2012–13 budget allocated \$20 million over four years to establish a further three MDCs. Two rural centres and a principal centre in metropolitan Melbourne will be rolled out over 2012–15.

Nurses will be introduced into MDCs to provide specialised health services responding to victim survivors' immediate and long-term needs arising from their experiences of sexual assault.

The principal centre will improve coordination and service provision of paediatric and adult forensic services statewide including remote supervision of rurally based practitioners.

5.4: Therapeutic treatment services for children and young people with problem sexual behaviours or sexually abusive behaviours

Research indicates that 30–60% of childhood sexual assault and sexual abuse is perpetrated by other children and young people. Many children who exhibit these behaviours have experienced family violence, long-term neglect, or sexual abuse. Early intervention can interrupt such behaviours and prevent them from becoming more entrenched, intrusive and more serious.

The *Children, Youth and Families Act 2005* sought to address the issue through the best interest principles. Based on a long consultation process with police, sexual assault services, child protection authorities and the legal fraternity, the best interest principles seek to ensure that the entire service system works collaboratively to respond to children, young people and their families in a way that promotes the safety, rights and development of children and young people. In accordance with the Act, a child may be placed on a Therapeutic Treatment Order or Therapeutic Treatment Placement Order by the Family Division of the Children's Court.

To support the legislation a statewide therapeutic treatment service was established in October 2007 via 13 agencies located throughout the state. Access to these services may be voluntary or, where necessary, via one of the orders outlined above to ensure the child's access to and attendance at a treatment service.

There is high demand for the program, and early data arising from a two-year evaluation indicate improved outcomes for children and young people who engage with the service.

The 2012–13 Budget allocated an additional \$7.3 million over four years to respond to increasing demand for the program.

5.6 Family violence

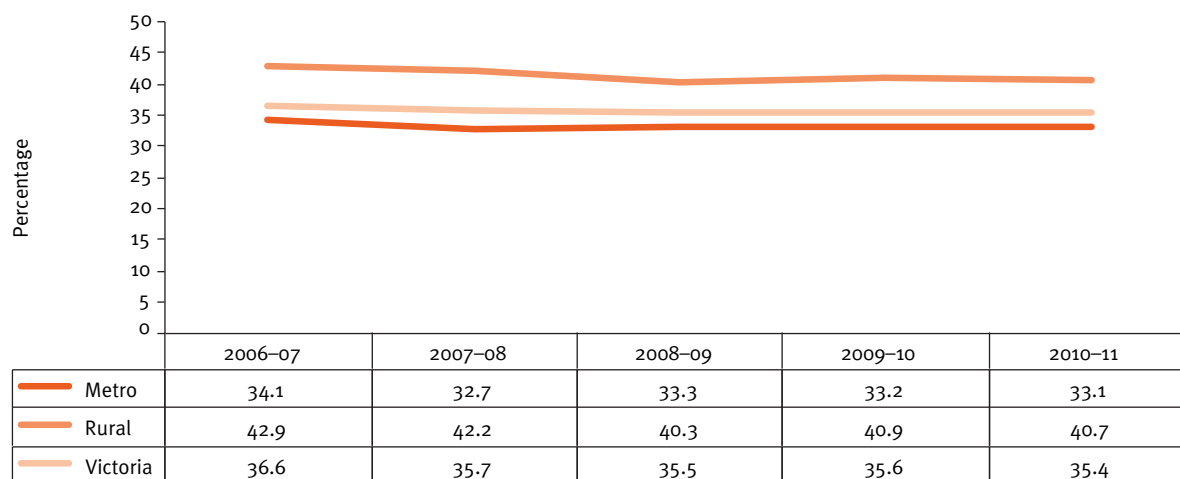
Family violence refers to any behaviour that controls or dominates a family member and causes them to fear for their own, or other family members' safety and wellbeing. This can include physical, sexual, psychological, emotional or economic abuse and any behaviour that causes a child to hear, witness or otherwise be exposed to the effects of that behaviour (*Victorian Family Violence Protection Act 2008*, cited in DEECD 2012, p. 262).

The Victorian Family Violence Database (Department of Justice 2012) identifies an 82% increase in the number of family violence incidents reported to police between 1999–2000 (19,597 incidents) and 2009–10 (35,720 incidents). This increase is unlikely to represent an increase in the actual incidence of family violence, but it is likely that it reflects an increase in reporting to police and an increasingly proactive police approach to family violence.

The number of children recorded as affected family members (victims) in police family violence incidence reports has tripled over the same period (from 915 to 2755 children). In addition, the number of children recorded as present at family violence incidents attended by police has increased from 18,541 children present in 1999–2000 to 24,180 children present in 2009–10. These increases can probably be attributed to increased awareness of the impact of family violence on children and acknowledgment of children as victims in their own right (Department of Justice 2012).

Figure 5.6 shows the percentage of family violence incidents where children and young people are present in Victoria, by region type, from 2006–07 to 2010–11. The percentage is consistently higher in rural Victoria.

Figure 5.6: Percentage of family violence incidents where children and young people aged 0–17 years are present, by region type, Victoria, 2006–07 to 2010–11



Source: LEAP 2010–11, Victoria Police.

Box 5.5: Community attitudes to violence against women

There is broad international agreement that the key drivers of violence against women and their children, including family violence are:

- unequal power relations between men and women
- adherence to rigid gender stereotypes
- broader cultures of violence (VicHealth 2007).

Attitudes that support violence can perpetuate it and have negative impacts on the responses of victims, service providers and the community.

The 2006 *Violence Against Women Community Attitudes Project* used a range of methods, including a Victorian survey of people aged 18 and over, to explore community attitudes relating to violence against women. The survey was largely based on an earlier national survey conducted by the then Federal Office of the Status of Women (OSW 1995). The research found that urban or regional location was not a consistent predictor of attitudes. However, strong disagreement with the justification of physical force against a current wife or partner was greater for respondents in urban rather than regional locations. Living in a regional location was associated with greater agreement with the belief that ‘it is hard to understand why women stay in a violent relationship’ (VicHealth 2006).

A subsequent national survey (VicHealth 2010) found that location influenced how likely respondents were to intervene in hypothetical situations involving domestic violence where their relationship to ‘the victim’ ranged from being a stranger, to a neighbour, to a friend or close relative. Living outside a capital city was a strong predictor for suggesting that a respondent would be ‘very likely’ to intervene where the victim was a stranger and was being physically assaulted by her partner in public, or was a neighbour that they didn’t know well.

Regional variation

Percentages of family violence incidents where children and young people are present are consistently highest in Grampians (44.7% in 2010–11) and Hume (44.7%) and lowest in Southern Metropolitan (31.4%) and Western Metropolitan regions (31.1%). SEHQ 2011 data also suggest that a higher percentage of children in rural Victoria have a history of witnessing violence (4.6% in rural compared with 2.7% in metropolitan Victoria), with the highest percentage observed in Gippsland (5.6%) and Loddon Mallee (4.8%) regions.

Family violence incidents where children and young people are present are consistently lowest in major cities and highest in inner regional Victoria (2007–08). In 2010–11, children and young people were present at 42.2% of family violence incidents in inner regional Victoria, compared with 33% in major cities (38.5% outer regional and 40.1% remote).

Key policy directions: family violence

- COAG, *National Plan to Reduce Violence Against Women and their Children 2010–2022* (2010)
- *Victoria's Action Plan to Address Violence Against Women and Children—Everyone has a responsibility to act* (released October 2012)
- *Living Free From Violence – Upholding the Right: Victoria Police Strategy to Reduce Violence Against Women and Children 2009–2014* (2009)
- *Strong Culture, Strong Peoples, Strong Families – Towards a safer future for Indigenous families and communities* (10-year plan) (2008)

Programs in place

- Safe from injury and harm – MCH Program
- Aboriginal Child and Family Services
- Gain Respect Increase Personal Power (GRIPP) program operating across Monash, Casey, Greater Dandenong and Cardina LGAs
- counselling and support for women and children experiencing family violence
- men's family violence services (men's behaviour change programs and case management)
- Indigenous services (Time out and Healing services, and women's and men's case management)
- refuges and emergency accommodation
- family violence outreach services
- multi-agency demonstration projects for responding to high-risk clients
- Court outreach, advocacy and referral – for women seeking intervention orders and support to children
- specialist family violence services in courts
- Koori Family Violence Court Support Program
- Family violence court intervention program (court-mandated men's behaviour change programs)
- Child Witness Service providing support to children required to give evidence in court
- ChildFIRST and Integrated Family Services for vulnerable families
- sexual assault support services
- multidisciplinary centres
- Sexually Abusive Behaviour Treatment Services – for children and young people under 15 years, and for 15–17 year-olds displaying sexually abusive behaviour

Box 5.6: MAV Prevention of Violence Against Women: Victorian councils leading progress in the prevention of violence against women

An increasing number of Victorian councils are supporting or are directly involved in preventing violence against women activity. Much of this work is guided by the current research showing that the key determinant of violence against women is the persisting inequities between men and women. The MAV is committed to providing leadership through four key strategies: advocacy, building capacity, promoting local government's role, and supporting local councils. The MAV has demonstrated their commitment to this issue by developing the *Promoting Gender Equity and Preventing Violence Against Women Leadership Statement*, which was launched at the MAV State Council meeting in May 2012. The leadership statement provides clear endorsement and encouragement for local councils to continue progressing their efforts and activity in promoting gender equity and preventing violence against women in their local areas. It is available at <http://www.mav.asn.au/policy-services/social-community/gender-equity>.

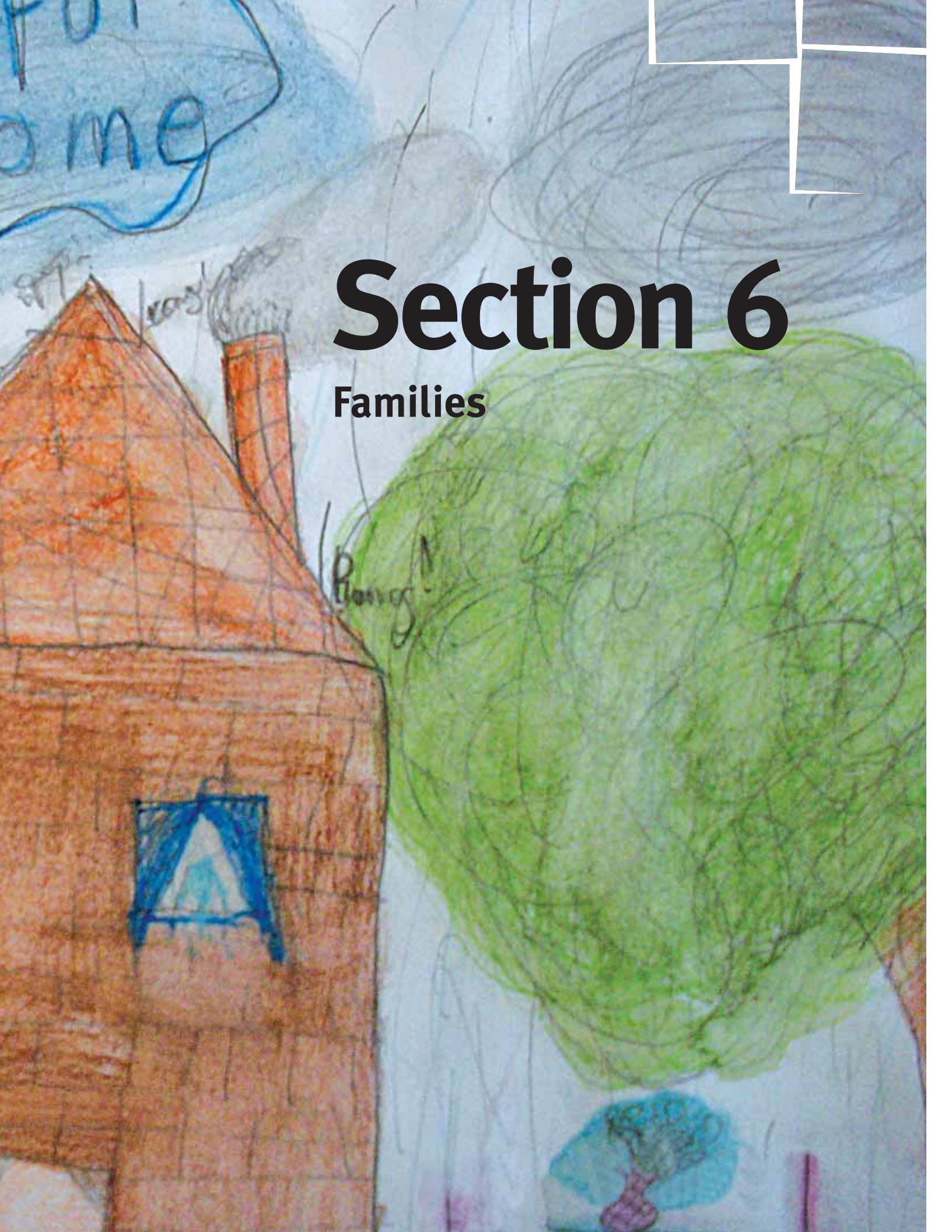


*What's special / the best thing about
where you live?*

*'To feel the comfort of your own
home.'*

**Artwork by Danielle, Grade 4
Maiden Gully Primary School**

Title: A sunny day at school



Section 6

Families

6. Families



Artwork by Bobby, Grade 6,
Mortlake College
Title: My house

Parents play a key role in promoting the health and development of their children in early childhood, through infancy and in adolescence. For the majority of Victorian children, parental influence is positive. However, some parental health behaviours and family risk factors may impact negatively on the wellbeing of children and young people. High levels of substance use, parental mental illness, poor family functioning and high levels of family stress are all known to have negative impacts. Research also highlights that parental contact with the criminal justice system has a range of adverse impacts on the life chances of children, although reliable data are not available on the children and families of offenders (Robinson 2011).

This section focuses on health promoting parental behaviours in early childhood (6.1), parental health behaviours (6.2) and family factors (6.3) that may impact on the wellbeing of children and young people (0–17 years).

6.1 Parents promoting health in early childhood

Folate in pregnancy

Intake of folate before and during pregnancy has been shown to significantly reduce the risk of spina bifida. Just under a quarter (22.9%) of Victorian women of child-bearing age reported taking folate supplements in the 2007 Victorian Public Health Survey. There was no statistically significant difference in the percentages of women taking supplements in rural and metropolitan Victoria; however, there was marked regional variation (see following).

Regional variation

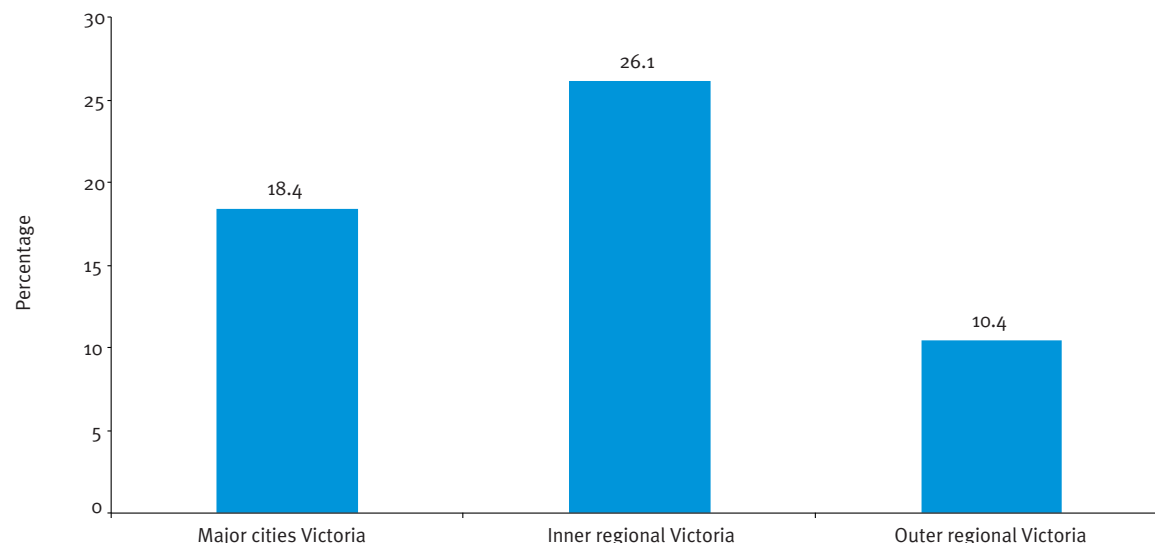
The percentage of women of child-bearing age taking folate supplements ranged from 12.7% in Gippsland to 35.4% in North and West Metropolitan Regions (data based on Department of Health, not DEECD regions). In rural Victoria, the highest percentage of women taking folate supplements was in Barwon South Western Region (30.3%).

Alcohol and smoking in pregnancy

Alcohol

The 2009 Victorian Child Health and Wellbeing Survey found that 59.7% of women reported ever drinking alcohol in pregnancy in Victoria, with no difference observed between women's reported drinking in rural and metropolitan areas. There was also no difference observed between rural and metropolitan Victoria in women reporting binge drinking in pregnancy (19.5%). ARIA analysis identifies, however, that women in inner regional Victoria are much more likely than women in outer regional Victoria to report binge drinking in pregnancy (26.1% of women in inner regional Victoria reported this, compared with 10.4% in outer regional Victoria and 18.4% in major cities) (Figure 6.1).

Figure 6.1: Percentage of children aged under 2 years whose mothers reported binge drinking during pregnancy, by ARIA classification, Victoria, 2009



Source: VCHWS 2009, DEECD; DEECD analysis by ARIA.

Regional variation

There was considerable variation across Victoria. Within rural Victoria, Gippsland had the lowest percentage of women who had ever drunk in pregnancy (56.7%), and Hume had the highest percentage (67.2%).

Among those who had ever drunk, 14.5% of women in Western Metropolitan Region and 26.6% of women in Barwon South Western Region reported binge drinking in pregnancy. Around a quarter (25.8%) of women in Hume reported binge drinking.

Box 6.1: Effects of substance use in pregnancy

Substance use in pregnancy can have significantly harmful effects on foetal development. Alcohol consumption in pregnancy is related to low birth weight, premature births and increased risks of cognitive defects and congenital abnormality (2008 SOVC). The particular effects of low levels of consumption are uncertain, but heavy consumption is of greatest risk. Other factors, including the stage of foetal development when alcohol is consumed, can affect the risk. Australian Guidelines recommend that the safest option is not to drink any alcohol in pregnancy (NHMRC 2009).

Smoking in pregnancy increases the risk of premature birth, stillbirth, low birth weight and Sudden Infant Death Syndrome (SIDS). There are also some long-term risks for the child, including an increased chance of obesity, high blood pressure and asthma (evidence cited in DEECD 2009b and DEECD 2012).

Smoking

There was no significant difference shown between rural and metropolitan Victoria in the percentage of women who report smoking in pregnancy, with 18.3% of women reporting this in Victoria as a whole. ARIA analysis also showed no significant differences.

Regional variation

Regional analysis highlights marked variation in rural Victoria, from 15.4% of mothers reporting smoking in pregnancy in Loddon Mallee to 30.3% in Barwon South Western (the rural region that also has with the highest reported smoking rates among young people).

Socioeconomic status

Reported alcohol consumption in pregnancy in rural Victoria increased where the household income was \$40,000 per annum or higher; where the child was not listed on a health care card; where the child was in a couple-parent family; and where the child did not live in the most disadvantaged SEIFA quintile.

Analysis of VCHWS data identifies a strong association in Victoria between some key indicators of disadvantage and the likelihood of reported smoking in pregnancy; for example, indicators of being from a one-parent family and not completing high school were associated with a more than five-fold increase in the likelihood of smoking in pregnancy. The likelihood of reported smoking in pregnancy was also found to be much greater in rural compared with metropolitan Victoria for all indicators of disadvantage. In contrast to this, consuming alcohol in pregnancy is associated with measures of socioeconomic advantage. (Detailed findings are included in the online Technical Appendix.)

Infants put on their backs to sleep

Research shows that placing an infant to sleep in a prone (face-down) sleeping position is a risk factor for Sudden Infant Death Syndrome (SIDS). The vast majority of Victorian parents (90.2%) report putting their infant to sleep on their back from birth, with no significant differences between rural (90.2%) and metropolitan (86.5%) parents, or between ARIA classifications.

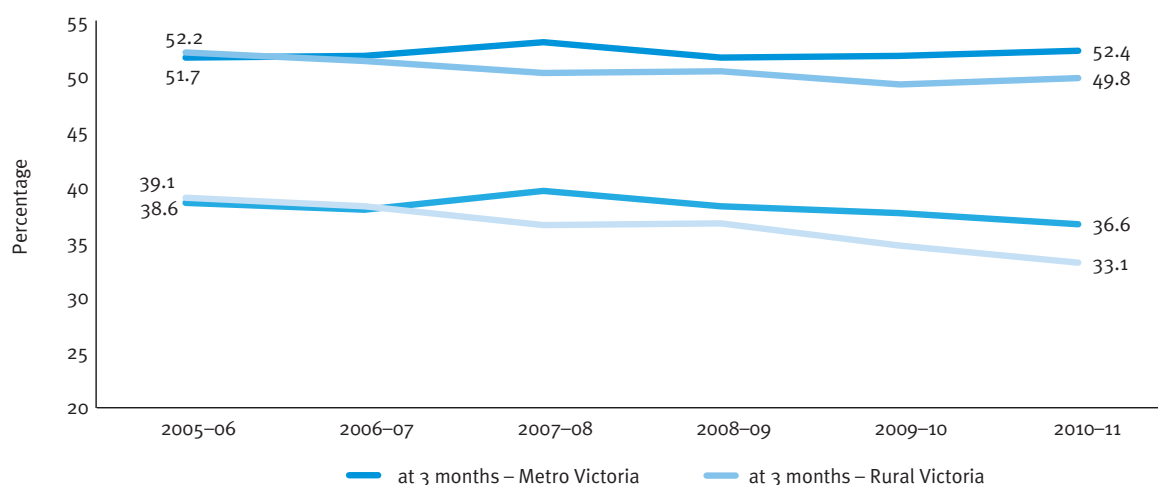
Breastfeeding

Breastfeeding has positive effects on the survival, development and growth of babies, including protection from disease through antibodies in the mothers' milk (DEECD 2009b, p. 115; Amir et al. 2010). The World Health Organisation recommends that infants are exclusively breastfed until the age of 6 months.

Figure 6.2 shows the percentages of fully breastfed infants in rural and metropolitan Victoria from 2005–06 to 2010–11. The percentage of fully breastfed infants at 3 months of age has shown a slight decrease over time in rural Victoria and has remained stable in metropolitan Victoria.

The percentage of fully breastfed infants at 6 months of age has decreased over time in both rural and metropolitan Victoria. This decrease is more notable in rural Victoria, which also has lower rates of infants who are fully breastfed (2010–11) at both age 3 and 6 months when compared to metropolitan Victoria (Figure 6.2).

Figure 6.2: Infants fully breastfed at 3 and 6 months, by region type, Victoria, 2005–06 to 2010–11



Source: DEECD Online MCH Annual Reports 2000–01 to 2010–11.

Regional variation

In Victoria, Eastern Metropolitan Region consistently has the highest percentages of infants fully breastfed at 3 months (2000–01 to 2010–11) and the highest percentages of infants fully breastfed at 6 months from 2000–01 until 2009–10.⁵⁷

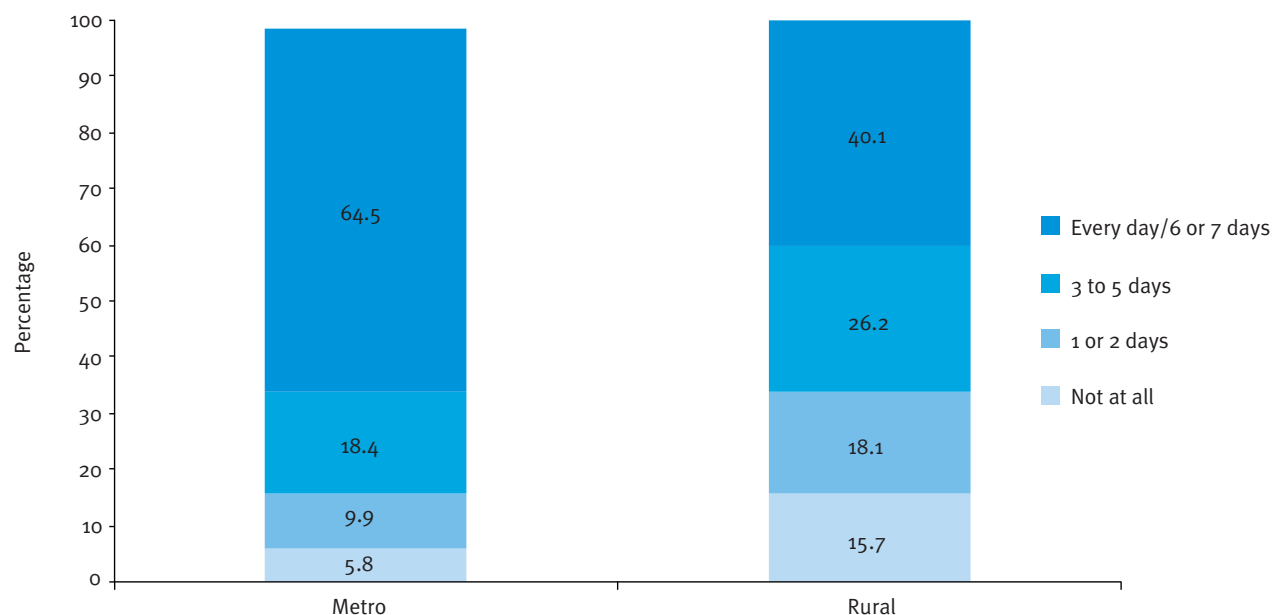
In rural Victoria, Barwon South Western Region consistently has the highest percentages of infants fully breastfed at 3 months and at 6 months. Hume has the lowest percentage of infants fully breastfed at 6 months in 2010–11 (with a rapid decline from 37.9 per cent in 2000–01 to 24.3 per cent in 2010–11).

Reading to children

Parents can assist in their children’s early learning and development by engaging in informal ‘learning’ activities, such as reading to their children. Benefits associated with parents reading to their children include the development of positive associations with reading, greater understanding of language through contextualisation, improved listening skills and increased vocabulary skills, as well as improved school literacy.

The VCHWS finds that 48.3% of parents report reading every day to their children (aged 6 months to 12 years), although 25% of parents report that they do not read to their children at all. There are no notable differences overall in the proportions of metropolitan and rural parents who read regularly to their children (Figure 6.3).

Figure 6.3: Reported frequency of parents reading to their children aged under 1 year, by region type, Victoria, 2009



Source: VCHWS 2009, DEECD.

Regional variation

The percentages of parents who reported that they read to their children (aged 6 months to 12 years) every day ranged from 43.8% in Northern Metropolitan Region to 52.3% in Western Metropolitan Region. In rural Victoria, the range was from 44.6% of parents who reported reading to their child every day to 48.6% in Loddon Mallee.

Socioeconomic disadvantage

Analysis identifies that there is no significant association in rural Victoria between socioeconomic disadvantage (as measured by a range of indicators) and whether a child (aged 1– 4 years) is not read to every day. However, significant associations were found between some indicators of disadvantage (low household income, being in the most disadvantaged SEIFA quintile, respondent parent not completing high school) and not reading to children are found in metropolitan Victoria. (For detailed findings, see online Technical Appendix).

Key policy directions: parents promoting health in early childhood

- *National Evidence-based Antenatal Care Guidelines* (currently under development)
- *Ministerial Council on Drug Strategy: National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* (2006)
- *National Breastfeeding Strategy 2010–15* (2009)
- NHMRC, *Dietary Guidelines for Children and Adolescents* (2003)
- *Supporting parents, supporting children: A Victorian Early Parenting Strategy* (2010)
- *Victorian Early Years Learning and Development Framework* (2009)
- Community Health Services Child Health teams

Victorian government initiatives

- \$62.7m over four years for free Universal MCH services and \$16.3m for Enhanced MCH
- \$16m for *Cradle to Kinder*: 10 new programs, including two Aboriginal specific programs
- \$29m for *Stronger Families* program delivered in four ChildFIRST catchments across Victoria, with services to be established in two additional locations in 2012–13

Programs in place

- Maternal and Child Health (MCH) and Enhanced MCH services
- *Cradle to Kinder* and *Aboriginal Cradle to Kinder*
- Perinatal Emotional Health Program and universal screening
- *Victorian Breastfeeding Action Plan*
- Mum-to-Mum 24-hour breastfeeding helpline
- Supporting Breastfeeding in Local Communities (SILC) trial of interventions aimed at increasing breastfeeding in Victorian communities
- Regional Parenting Services
- Aboriginal Family Preservation and Restoration Program, delivered in rural/regional Aboriginal communities
- Ban of smoking in vehicles carrying children
- Early Parenting services

6.2 Parental health behaviours

Parental fruit and vegetable consumption and physical activity

Role-modelling of positive nutrition and physical activity by parents and siblings can play an important role in promoting positive nutrition, physical activity behaviours and associated healthy weight in children and young people (DEECD 2012). The *Dietary Guidelines for Australian Adults* (NHMRC 2003) recommend the consumption of two serves of fruit and five serves of vegetables daily in order to ensure a healthy diet.

The *National Physical Activity Guidelines for Adults* (Australian Government 1999) recommend that adults should engage in at least 30 minutes of moderate-intensity exercise on at least five days per week.

The 2008 Victorian Population Health Survey (VPHS) shows no significant differences,⁵⁸ by region type, in parental fruit and vegetable consumption or physical activity.⁵⁹ The proportion of parents reporting that they consumed the recommended daily intake of fruit was 44% in rural Victoria and 49.4% in metropolitan Victoria, while the proportion of parents who consumed the recommended daily intake of vegetables was 7.6% in rural Victoria and 7.2% in metropolitan Victoria. In rural Victoria, 68.8% parents met the recommended physical activity levels, compared with 66% in metropolitan Victoria.

Parental substance use

Parental risky drinking

Children whose parents misuse substances are at a higher risk of neglect, physical and emotional abuse and low social and emotional wellbeing. Parental substance use and parental attitudes to substance are also important influences on substance use in young people, together with other factors, including parental monitoring and supervision, and peer use of substances (DEECD 2012).

According to the 2001 *National Health and Medical Research Council Guidelines*, consuming more than four standard drinks in any one day for women and more than six for men increases the risk of accident or injury (short-term harm). More than two standard drinks per day for women (or 14 per week) and four for men (or 28 per week) increases alcohol-related disease risks (i.e. long-term harm) (NHMRC 2001).

The 2008 VPHS data were analysed on the basis of these 2001 guidelines. However, it should be noted that the NHMRC introduced a new set of guidelines in 2009 (NHMRC 2009). Analysis of 2008 VPHS data by region type shows that similar proportions of rural and metropolitan parents reported drinking at levels that risk short-term harm on at least a weekly basis (10.7% in rural Victoria versus 11% in metropolitan Victoria). The data also finds no difference in the proportion of parents who reported drinking at levels that risk long-term harm (3.9% in rural Victoria/2.8% in metropolitan Victoria).

Parental history of substance use

The 2011 SEHQ suggests that families in rural Victoria are more likely than those in metropolitan Victoria to have a history of alcohol or drug-related problems (5.1% of children in rural Victoria are in families with a history of a drug or alcohol problem, compared with 3% in metropolitan Victoria).

Aboriginal parents are more likely than non-Aboriginal parents to report a history of alcohol or drug-related problems (16.2% of Aboriginal parents in rural Victoria, compared with 4.9% of non-Aboriginal parents).

This difference, by Aboriginal status, is of similar magnitude in rural and metropolitan Victoria (Table 6.1).

Table 6.1: Percentage of children at school entry with a history of alcohol or drug-related problems in the family, by region type and Aboriginal status, Victoria, 2011

| Region type | Aboriginal | Non-Aboriginal | % difference |
|--------------|------------|----------------|--------------|
| Rural | 16.2 | 4.9 | 11.2 |
| Metropolitan | 13.2 | 3.0 | 10.2 |

Source: SEHQ 2011, DEECD 2012a.

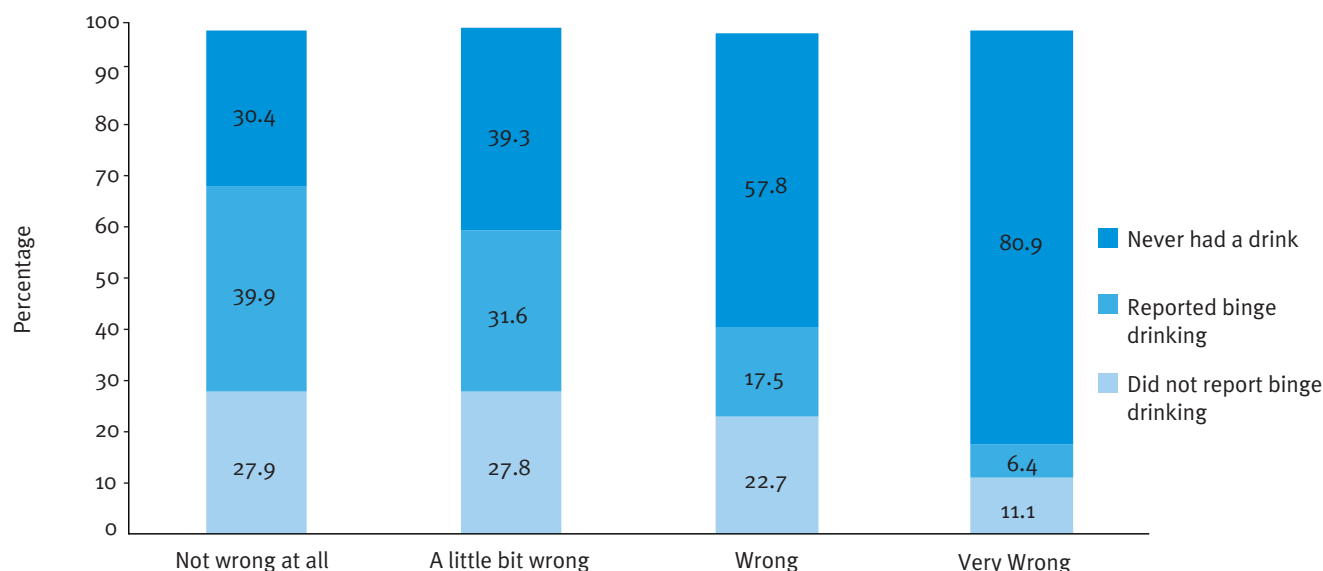
Regional variation

In 2011, the highest percentages of families with a history of alcohol or drug-related problems were in Gippsland (6%) and Grampians (5.2%) regions, while the lowest percentages were in Eastern Metropolitan (2.7%) and Northern Metropolitan (2.8%) regions.

Relationship between parental attitudes to drinking and young people's drinking behaviours

Analysis of Victorian HOWRU 2009 data finds a strong relationship between young people's report of their parents' attitude towards drinking and the likelihood of i) a young person reporting drinking (in the last 30 days), and ii) reporting binge drinking (Figure 6.4).⁶⁰

Figure 6.4: Whether young person reported binge drinking in the last two weeks, by parental attitude to drinking (beer or wine regularly), Victoria, 2009



Source: HOWRU 2009, DEECD.

Exposure to tobacco smoke

Exposure to tobacco smoke significantly increases the likelihood of developing a range of serious health problems and is an important factor in the incidence of sudden infant death syndrome. Exposure to tobacco smoke also increases the likelihood that children and young people will become smokers themselves (DEECD 2012).

Children of smokers in rural Victoria are more likely than their metropolitan peers to have been exposed to tobacco smoke in the home (30.5% of children in rural Victoria, compared with 23.0% in metropolitan Victoria).⁶¹ Percentages of children who are exposed to cigarette smoke are also higher in inner regional Victoria (32.5%) than in major cities (22.6%).

Regional variation

Regional variation for children of smokers is considerable, with 22.5% of children in Northern Metropolitan Region and 35.8% of children in Gippsland exposed to cigarette smoke in the home.

Key policy directions: parental health behaviours

- WHO, *Global Strategy to Reduce the Harmful Use of Alcohol* (2010)
- NHMRC, *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* (2009)
- *National Drug Strategy, 2012–15* (2012)
- *Victorian Alcohol and Drug Strategy* (under development)
- *Supporting parents, supporting children: A Victorian Early Parenting Strategy* (2010)

Victorian government initiatives

- \$62.7m over four years for free Universal MCH services and \$16.3m for Enhanced MCH services
- five new Regional Mother-Baby Units across Victoria
- \$16.5m for *Cradle to Kinder*: 10 new programs, including two Aboriginal specific programs
- Small rural kindergartens funding and Kindergarten Inclusion Support Services improvements
- \$16.5m for Supported Playgroups, the *smalltalk* program and the E4Kids longitudinal study
- \$22m to expand ChildFIRST and Integrated Family Services in areas of high demand
- \$29m for *Stronger Families* program delivered in four ChildFIRST catchments across Victoria, with services to be established in two additional locations in 2012–13
- \$8.3m for provide ECE for 3 year-olds known to child protection authorities

Programs in place

- Maternal and Child Health (MCH) and Enhanced Maternal and Child Health services
- Regional Parenting Services Promotion of smoking reduction strategies by health and early childhood practitioners
- ban of smoking in vehicles carrying children
- Quit campaign – VicHealth
- *Healthy Mothers, Healthy Babies* program
- Victorian Prevention and Health Promotion Achievement Program
- BEACON Project, a family-focused approach in Alcohol and Other Drugs service
- secondary supply of alcohol laws, which make it an offence to supply alcohol to a child in a private home unless there is parental consent
- Early Parenting services

6.3 Family factors

Family functioning

Family functioning refers to how a family operates as a unit and how family members interact with each other. It reflects parenting styles, family conflict and the quality of family relationships. The capacity of a family to function well is particularly important in promoting positive outcomes for children and young people (DEECD 2012).

VCHWS and HOWRU analysis shows that the vast majority (89.9%) of Victorian children and young people are living in families with healthy family functioning, with similar percentages by region type (90.1% of rural children and 83.9% of rural young people live in families with healthy family functioning,⁶² compared with 89.9% of children and 82.7% of young people in metropolitan Victoria).⁶³

Socioeconomic analysis

Further analysis of VCHWS data suggests that socioeconomic disadvantage (as measured by a range of indicators) increases the likelihood in Victoria of unhealthy family functioning, most notably where a child is on a health care card, in low income families and for children of single parents. However, the risks associated with disadvantage were slightly greater, overall, in metropolitan, than in rural Victoria (for detailed findings, see online Technical Appendix).

Regional variation

Hume has the highest percentage of children living in families with healthy family functioning (88.3%) and Western Metropolitan Region the lowest (81.2%). Grampians has the highest percentage of young people living in families with healthy family functioning (93.1%) and Western Metropolitan Region the lowest (87.9%).

In rural Victoria, the lowest percentages of children in families with healthy family functioning are found in Loddon Mallee (81.5%) and of young people in Gippsland (88.6%), also regions with lower median family income (Section 2).

Family stress

While many families may have the resources to deal with a serious stressful event (such as divorce, death, new baby, illness of parents or siblings, job loss, and family violence and abuse), exposure to multiple stressful events may compromise family functioning. High levels of family stress can have adverse impacts on a child's learning, behaviour, physical and mental health, particularly when this is experienced in early childhood (DEECD 2012).

As part of the SEHQ, parents of children at school entry are asked to rate their family's perceived stress level during the month previous to the survey on a five-point scale. As Table 6.2 shows, more children in rural (than metropolitan) Victoria were reported to be living in families experiencing high or highest levels of family stress in the month prior to the SEHQ.

Table 6.2: Percentage of children living in families experiencing family stress, by region type, Victoria, 2011

| Region type | Highest | High | Middle | Low | Lowest |
|-------------|---------|------|--------|------|--------|
| Metro | 1.5 | 8.8 | 27.6 | 28.9 | 26.2 |
| Rural | 1.8 | 10.4 | 27.2 | 30.7 | 22.8 |
| Victoria | 1.6 | 9.3 | 27.5 | 29.4 | 25.3 |

Source: SEHQ 2011, DEECD.

Regional variation

Across Victoria, Hume and Gippsland had the greatest proportions of children experiencing high or highest levels of family stress (both 13%) and Western Metropolitan Region had the lowest (9.7%). Rates in Loddon Mallee (12.6%) and Grampians (11.9%) regions were also high. In rural Victoria, Barwon South Western Region had the lowest percentage of children experiencing high or highest levels of family stress (11%).

Analysis of longitudinal SEHQ data shows that the proportion of children experiencing high or highest levels of family stress has increased from 2009–11 in all DEECD regions, with the exception of Southern Metropolitan Region.

Outer and inner regional Victoria have the greatest proportion of children living in families experiencing high or highest levels of family stress (12.9% and 12.2%, respectively), while major cities have the smallest (10.2%).⁶⁴

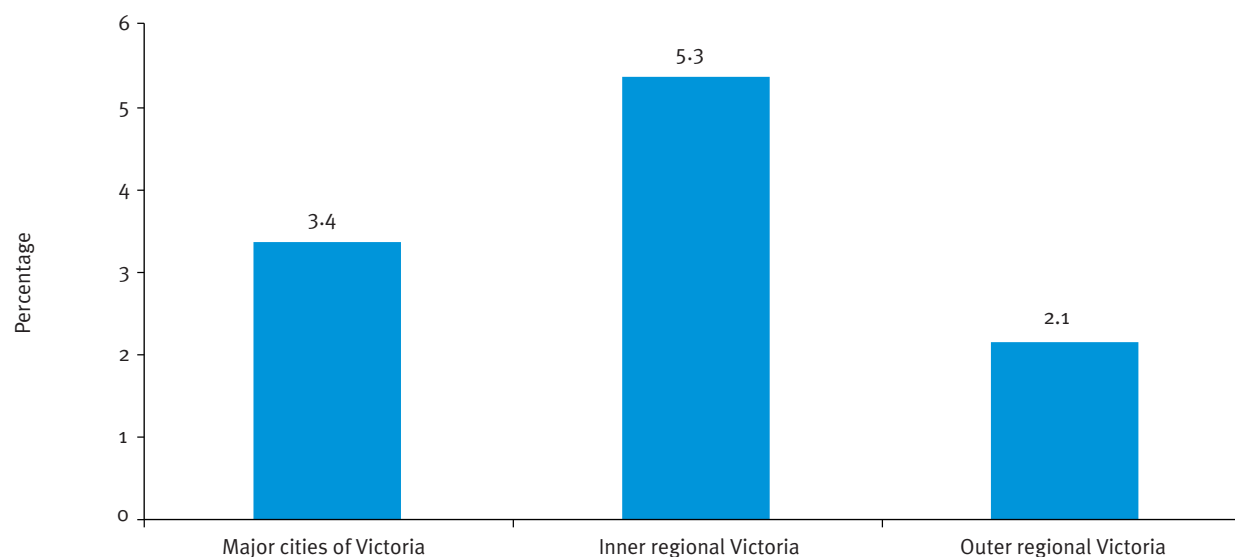
Parental psychological distress

The Victorian Population Health Survey (VPHS) uses the Kessler 10 (K10) Psychological Distress Scale to categorise the level of parental psychological distress over a four-week period. (See Box 3.8 for further information.)

The 2008 VPHS finds that 12.2% of parents in rural Victoria are at high or very high risk of experiencing psychological distress.⁶⁵ The proportion for metropolitan parents is also 12.2%.

The VCHWS uses questions from the shorter Kessler 6 scale to identify parents who are at risk of experiencing psychological distress (Kessler et al. 2002). VCHWS 2009 data highlight no region type differences in the proportion of parents at high risk of experiencing psychological distress. However, ARIA analysis of VCHWS data shows that parents in inner regional Victoria are more likely to be at high risk of experiencing psychological distress, when compared with parents in outer regional Victoria (Figure 6.5).

Figure 6.5: Percentage of children under 12 years with parents at high risk of experiencing psychological distress, by ARIA classification, Victoria, 2009



Source: VCHWS 2009; DEECD analysis by ARIA.

Parental mental illness

Where a parent is affected by a mental health problem or illness, this may have serious implications for the wellbeing of family members, especially children. Children with a parent with a mental illness may also take on significant caring roles in the home; and evidence suggests that young carers in rural and remote areas may be particularly disadvantaged (Carers Australia 2011).

The proportion of children at school entry who have been affected by mental illness of a parent is higher in rural (8.5%) than in metropolitan Victoria (5.4%). Analysis of longitudinal SEHQ data shows that the proportion of children who have been affected by mental illness of a parent in Victoria has increased between 2009 and 2011, more notably in rural Victoria (Table 6.3).

Table 6.3: Percentage of children at school entry who have been affected by mental illness of a parent, by region type, Victoria, 2009–11

| Region type | 2009 | 2010 | 2011 |
|--------------|------|------|------|
| Rural | 4.2 | 7.5 | 8.5 |
| Metropolitan | 3.3 | 4.7 | 5.4 |

Source: SEHQ 2009–11, DEECD.

Regional variation

Gippsland has the highest percentage of children with parents at risk of mental health difficulties (6.3%), and Eastern Metropolitan Region the lowest (2.2%). In rural Victoria, the lowest percentage is in Barwon South Western Region (2.9%). In the 2011 SEHQ, Grampians Region has the highest proportion of children who have been affected by mental illness of a parent (8.9%), followed by Gippsland and Loddon Mallee (both 8.6%). Western Metropolitan Region has the lowest proportion (4.8%). In rural Victoria, the lowest percentage of children who have been affected by mental illness of a parent is (as with the VCHWS) in Barwon South Western Region (8.1%).

History of abuse to a parent

In line with the child abuse substantiations data reported earlier (in Section 2.2), 2011 SEHQ data show that a higher percentage of children in rural areas have a history of abuse to a parent (4.6% in rural Victoria compared with 2.7% in metropolitan Victoria).

Regional variation

Regions with the highest percentage of children with a history of abuse to a parent in 2011 were Loddon Mallee and Gippsland (5.1%). Regions with the lowest percentages were Eastern Metropolitan Region (2.2%) and Western Metropolitan Region (2.6%).

Aboriginal families

In the 2011 SEHQ, Aboriginal parents are much more likely than non-Aboriginal parents to report a history of abuse to a parent. Of Aboriginal children at school entry in rural Victoria, 15.3% are reported to have a history of abuse to a parent, compared with 4.3% of non-Aboriginal parents (Table 6.4).

Table 6.4: Percentage of children at school entry whose parents report a history of abuse to a parent, by Aboriginal status and region type, Victoria, 2011

| Region type | Aboriginal | Non-Aboriginal |
|--------------|------------|----------------|
| Rural | 15.3 | 4.3 |
| Metropolitan | 13.2 | 2.7 |

Source: SEHQ 2011, DEECD.

Aboriginal parents are also much more likely than non-Aboriginal parents to have children with parents who have a history of mental illness (Table 6.5).

Table 6.5: Percentage of children at school entry who have been affected by mental illness of a parent, by Aboriginal status and region type, Victoria, 2011

| Region type | Aboriginal | Non-Aboriginal |
|--------------|------------|----------------|
| Rural | 13.3 | 8.5 |
| Metropolitan | 14.8 | 5.5 |

Source: SEHQ 2011, DEECD.

Key policy directions: family factors

- Victorian Government, *Families Statement* (2011)
- National Perinatal Depression Initiative (2009)
- *Supporting parents, supporting children: A Victorian Early Parenting Strategy* (2010)

Victorian government initiatives

- \$29m for *Stronger Families* program delivered in four ChildFIRST catchments across Victoria
- \$16m for *Cradle to Kinder* and *Aboriginal Cradle to Kinder*

Programs in place

- MCH and Enhanced MCH
- Perinatal Emotional Health Program and universal screening in rural/regional Victoria
- Early Parenting services
- ChildFIRST and Integrated Family Services for vulnerable families
- Primary Welfare Officers in schools
- *Stronger Families* and support for vulnerable families
- Regional Parenting Services
- Parenting Assessment and Skill Development Services
- ParentLine, for parents of children aged 0–18 years
- Strengthening Parent Support Program
- Aboriginal *Stronger Families* program and Aboriginal Child and Family Services
- Families where a Parent has a Mental Illness (FaPMI) strategy
- Youth Partnerships



*What's special / the best thing about
where you live?*

*'I think we have good bushland, great
people and awesome population.'*

**Artwork by Montana, Grade 4
Maiden Gully Primary School
Title: Bushland**

A child's drawing on a light-colored background. At the top, there are several trees with green foliage and brown trunks. The central tree is the largest. Below the trees, there is a large rectangular area outlined in orange. Inside this area, there is a smaller rectangle filled with green vertical lines. To the right of the green-filled rectangle, there is a large rectangle outlined in black. Below the orange-outlined area, there is a horizontal line with a series of small vertical lines underneath it, resembling a fence. At the bottom, there are two small red rectangles and a small green tree. The text "Section 7" is written in large, bold, black letters, and "Community factors" is written in smaller, bold, black letters below it.

Section 7

Community factors

7. Community factors



Artwork by Erin, Keira and Rosie,
Grades 5 and 6
Mortlake College
Title: Our Place

High levels of social capital in Victoria's rural communities are identified through Victorian Community Indicators Survey data. Research demonstrates that the higher the social capital in a community, the better the outcomes will be for children, young people and their families who live there (DEECD 2012a). The advantages of social capital in local communities are widely recognised in rural health literature, both in Australia (AIHW 2008; Bourke et al. 2010a) and internationally.

The characteristics of local neighbourhoods (such as cleanliness, traffic levels and access to basic services, recreational facilities and transport) also have important influences on outcomes for children, young people and their families. These characteristics (actual and perceived) are linked to the quality and nature of community engagement.

7.1 Neighbourhood characteristics

Physical environment

Neighbourhood cleanliness

Victorian parents are more likely than adolescents to report that their neighbourhood is clean (95.8% versus 77.2%). Metropolitan respondents are less likely to report this than rural respondents, and perceptions of cleanliness improve with remoteness levels.

Traffic levels

Analysis by region type shows no notable difference in the proportion of parents and of young people who agree that there is heavy traffic in their neighbourhood (32.1% of metropolitan parents and 29.4% of rural parents, alongside 20% of metropolitan young people and 17.4% of rural young people).

ARIA analysis finds a significant difference between the perceptions of parents in major cities and in inner regional Victoria, with 32.5% of parents in major cities agreeing that there was heavy traffic in their neighbourhood, compared with 28.1% in inner regional Victoria (outer regional 28.9%).

Regional variation

There is considerable variation at regional level. Parents' report shows the highest percentage agreeing that there was heavy traffic in Western Metropolitan Region (35.8%), followed by 34.7% of parents in Hume, with the lowest percentage reportage in Gippsland (24%).

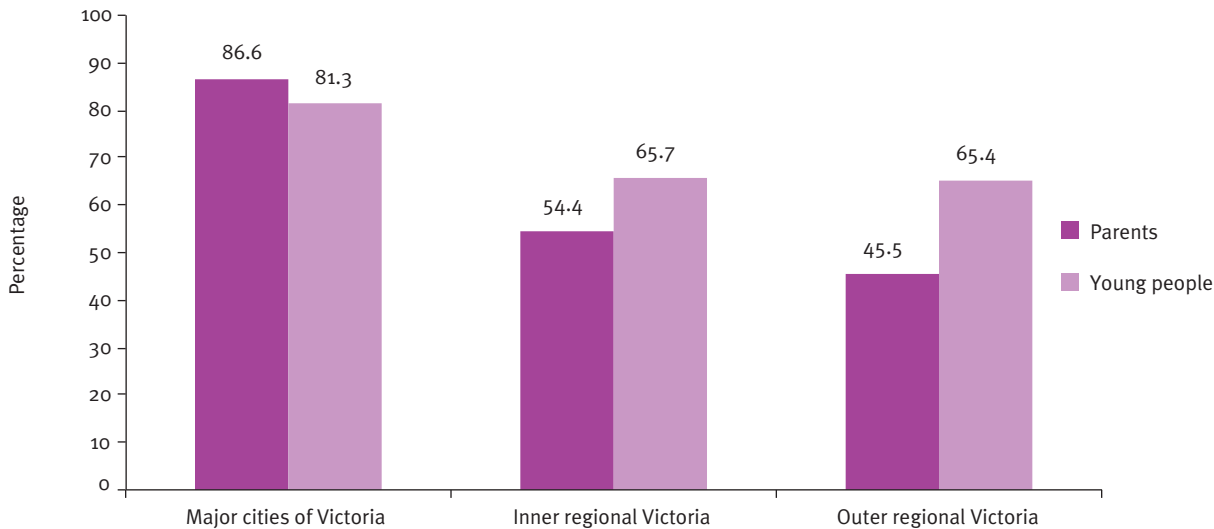
Access to service and facilities

Rural Victorians have much lower reported access to basic services and shopping facilities than metropolitan Victorians.

Of rural parents, 87.5% report that they have access to basic shopping facilities, compared with 96.8% in metropolitan Victoria. Similarly, 69.9 of rural young people report that they have access to basic shopping facilities, compared with 83.7% in metropolitan Victoria.

This regional–metropolitan disparity is also evident in reported access to basic services (such as banks and medical clinics), with 55.7% of rural parents reporting that they have access to basic services, compared with 85.4% of those in metropolitan Victoria. Likewise, 66.8% of rural young people report that they have access to basic services, compared with 80% of those in metropolitan Victoria. As Figure 7.1 shows, access to these services declines progressively with remoteness.

Figure 7.1: Parents and young people’s report of access to basic services, by ARIA classification, Victoria, 2009



Source: VCHWS 2009; HOWRU 2009, DEECD; DEECD analysis by ARIA.

Regional variation

There is marked regional variation in parental reported access to basic services (40.1% in Gippsland to 86.9% in Eastern Metropolitan Region). In rural Victoria, Barwon South Western Region has the best reported access to basic services (64.9%).

Access to parks, playgrounds and play spaces

Parents in rural Victoria are less likely than those in metropolitan Victoria to report having access to good parks, playgrounds and play spaces; and young people also reflect this view, with much lower perceptions of access than among parents (Table 7.1).

Table 7.1: Parents and young people’s report of access to recreational facilities, by region type, Victoria, 2009

| Region type | Parent’s view | Child’s view |
|--------------|---------------|--------------|
| Rural | 76.4 | 45.1 |
| Metropolitan | 89.8 | 49.7 |

Source: VCHWS 2009; HOWRU 2009, DEECD.

Regional variation

In rural Victoria, Hume has the lowest reported access (72.1%) to parks, playgrounds and play spaces and Gippsland has the best reported access to parks, playgrounds and play spaces (80.7%). In rural Victoria, Loddon Mallee has the lowest reported access (40.7%) to parks, playgrounds or gyms and Hume has the best reported access (47.6%) to parks, playgrounds or gyms.

Access to parks, playgrounds and play spaces (parents' report) and to parks, playgrounds and gyms (young people's report) declines with increasing remoteness.

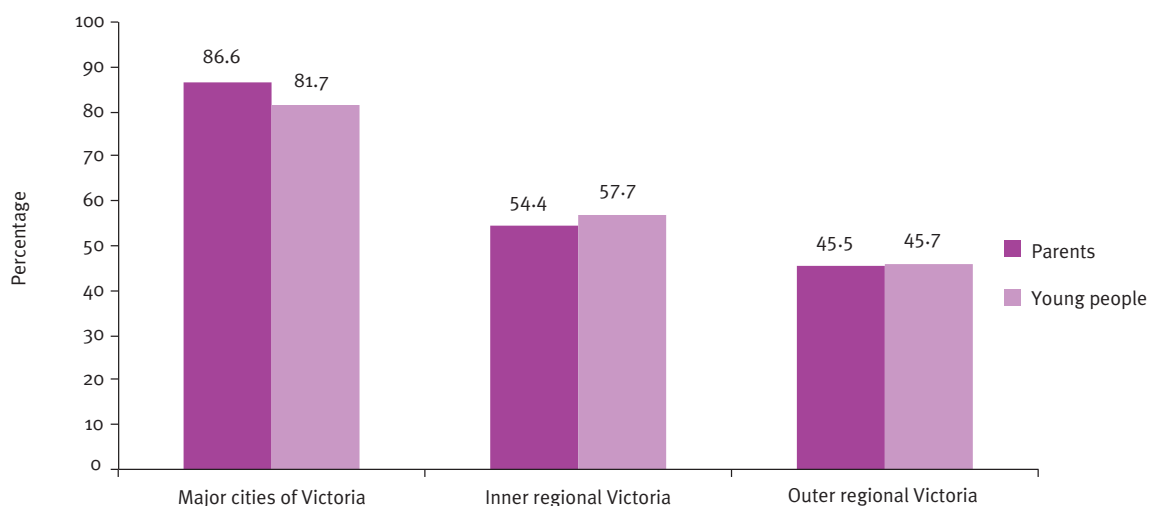
Access to transport

Transport has a key role to play in ensuring that rural Victorians access important educational, employment and human services. Good transport is essential if young people are to access education and training opportunities and for ensuring the long-term economic prosperity of regions (Victorian Government 2011).

Parents in rural Victoria are much less likely than parents in metropolitan Victoria to report having access to close, affordable and regular public transport (55.7% in rural versus 85.4% in metropolitan). Young people in rural Victoria are also much less likely to report that they have access to public transport (56.4% of young people in rural Victoria reported this, compared with 80.6% of young people in metropolitan Victoria).

A considerable proportion of young people in Victoria report that lack of transport makes it hard to work, study, see a doctor and/or socialise (44.2%), with higher proportions reporting this in rural (51%) than metropolitan Victoria (41.4%). As Figure 7.2 shows, reported access to transport by parents and young people declines progressively with remoteness.

Figure 7.2: Parents and young people's report of access to transport, by ARIA classification, Victoria, 2009



Source: VCHWS 2009; HOWRU 2009, DEECD; DEECD analysis by ARIA.

Regional variation

In rural Victoria, regional variation in reported access to transport for parents ranges from 40.1% in Gippsland to 64.9% in Barwon South Western Region.

Regional variation in reported access to transport for young people ranges from 43.8% in Loddon Mallee to 68% in Grampians Region. Grampians also has the lowest percentage of young people reporting that lack of transport makes it hard to work, study, see a doctor and/or socialise (38.6%).

Gippsland has the highest percentage of young people reporting that lack of transport makes it hard to work, study, see a doctor and/or socialise (60.6%).

7.2 Community support and opportunities for engagement

Although rural and regional Victoria faces challenges associated with recent social and economic changes, it has major strengths associated with high levels of social capital, with high levels of community participation and engagement and high levels of social support.

Research clearly highlights an association between levels of social capital in a community and outcomes for children, young people and their families within that community, with higher levels of social capital linking to more positive outcomes.

Support for families

Support for parents

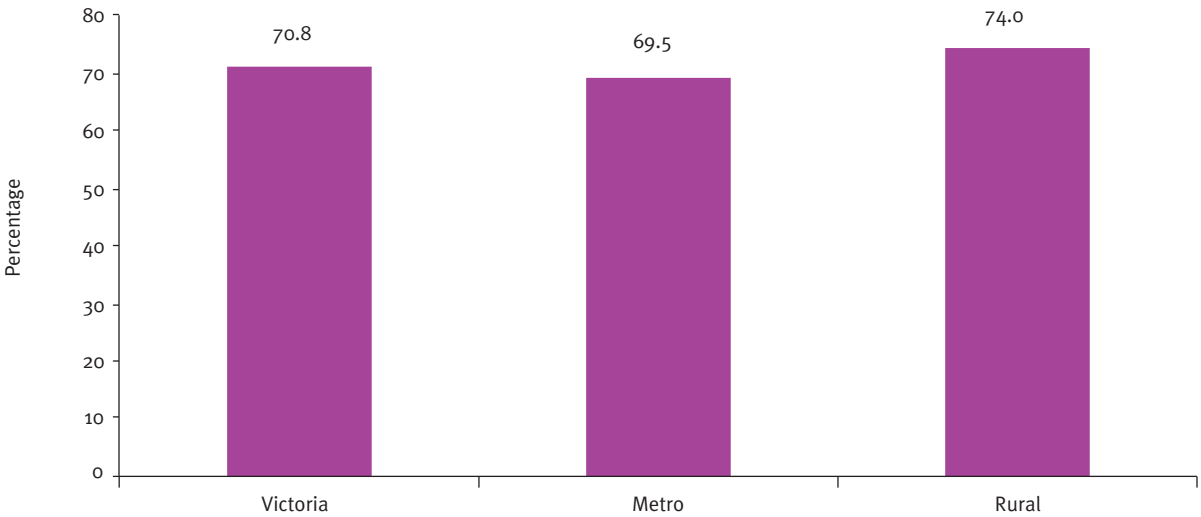
The vast majority of parents in rural and metropolitan Victoria agree or strongly agree that there is someone they can turn to for advice if they are having problems (97.5% rural/97% metropolitan) and that they can turn to each other for support in a time of crisis (98.6% rural/98.8% metropolitan).

While there is little region type variation observed in the percentages of parents reporting that there is someone they can turn to for advice, ARIA analysis shows that the highest percentage of parents reporting that they can get support from each other in a time of crisis is in major cities (81.3%) and the lowest is in outer regional Victoria (74.6%).

Support for young people

While there are no significant differences in the percentages of parents reporting that they have access to support, young people in rural Victoria are more likely than those in metropolitan Victoria to report that they have someone to turn to for advice (88.1% in rural Victoria versus 85.2% in metropolitan) and more likely to report that they have a trusted adult in their life, as shown in Figure 7.3.

Figure 7.3: Young people reporting that they have a trusted adult in their life, Victoria, 2009



Source: HOWRU 2009, DEECD.

Regional variation: parents' report

There is some regional variation in the percentage of children whose parents reported that they can turn to each other for support in a time of crisis (ranging from 74.9% in Loddon Mallee to 83.4% in Barwon South Western Region).

Regional variation: young people's report

Regional variation is much wider in rural than in metropolitan Victoria. Percentages of young people reporting that they have someone to turn to for advice range from 84% in Grampians to 93% in Gippsland Region; and for those reporting that they have a trusted adult in their life, from 68.1% in Grampians to 80.4% in Hume.

Community participation and engagement

Parents and young people are also asked in the 2008 Victorian Population Health Survey (parents) and the HOWRU 2009 survey (young people) about the opportunities for local community participation and engagement, including opportunities to have a say on, and be involved in, decisions about issues that matter to them.

The VPHS found that rural parents were significantly more likely than metropolitan parents to believe their family had opportunities to participate in community, cultural and recreational activities, with 69.4% of rural parents agreeing that this was the case in rural Victoria, compared with 55.9% in metropolitan Victoria (VPHS 2008).

The HOWRU survey found that young people in rural Victoria were more likely than those in metropolitan Victoria to report that there were opportunities in their neighbourhood to volunteer or offer community service (66.7% of rural young versus 61.3% metropolitan).

Regional variation

Almost three-quarters (72.8%) of young people in Hume reported this, while the lowest percentage of young people reporting this was in Grampians (59.6%).

Having a say

The 2008 VPHS found that 40.5% of parents in Victoria believed that they have a say on issues that matter to them. No difference in the proportion of parents reporting this was identified by region type.

HOWRU 2009 found that young people in rural Victoria were more likely to agree that adults pay attention to what young people say (63.9% of rural young people agreed, compared with 59.8% of metropolitan young people); and were more likely to believe that they can help decide about activities in their neighbourhoods (50.1% rural versus 45.9% metropolitan). ARIA analysis shows that young people's reported capacity to 'have a say' increases progressively with levels of geographical remoteness.

Regional variation

The percentage of young people who thought that adults in their neighbourhood paid attention to what young people say was highest in Hume (70.1%) and lowest in Western Metropolitan Region (56.1%). Within rural Victoria, the lowest percentage of young people was in Loddon Mallee (59%) (2009 HOWRU).

Hume also had the highest percentage of young people reporting that they can help decide about activities in their neighbourhood (56.8%), and Western Metropolitan Region had the lowest (44.5%). Within rural Victoria, the lowest percentage was in Barwon South Western Region (45.1%) (2009 HOWRU).

Key policy directions: community factors

- Regional Development Australia partnership
- Australian Government, Social Inclusion Agenda (2011)
- Victorian Government, Strategic Framework for Family Services (2007)
- *Engage, Involve, Create: Victorian Government Youth Statement* (2012)

Victorian government initiatives

\$0.4 million over four years to support the newly established Regional Advisory Councils to enable the Victorian Multicultural Commission to fulfil its role in regional Victoria

Programs in place

- Neighbourhood Renewal
- Community Enterprise grants
- Adult, Community and Further Education (ACFE) programs
- multi-faith and inter-faith grants to promote harmony and social cohesion
- Refugee Action Program
- Regional Advisory Councils, Victorian Multicultural Commission
- Regional Arts Partnerships and Regional Arts Projects
- Access for All Abilities Program (inclusive sports for people with a disability)
- Transport Connections
- Advancing Country Towns programs
- Regional Growth Fund (RGF), including the Local Government Infrastructure Program and the Putting Locals First program

7.3 Access to child health and other support services

This section focuses on the access of rural families to key services, including Maternal and Child Health (MCH) kindergarten and child care. Information is also included about family support services and services for children in out-of-home care.⁶⁶

MCH services

The Maternal and Child Health Service is a primary health service, free for all Victorian families with children aged from birth to school age. It supports families with parenting, health and development; promotes family health, wellbeing and safety; provides referrals; and helps to link families with local communities.

Participation

MCH participation rates are higher for children in rural Victoria as shown in Table 7.2.

Table 7.2: Percentage of children attending MCH services, by age group and region type, Victoria, 2010–11

| DEECD region | Age in years | | | | | |
|-----------------------|--------------|------|------|------|------|-----|
| | 0–1 | 1–2 | 2–3 | 3–4 | 4–5 | 5–6 |
| Metropolitan Victoria | 100 | 90.6 | 74.8 | 31.8 | 43.4 | 4.2 |
| Rural Victoria | 100 | 91.7 | 75.3 | 35.6 | 48.0 | 8.0 |
| Victoria | 100 | 90.9 | 74.9 | 32.8 | 44.6 | 5.2 |

Source: DEECD Online MCH annual reports.

Regional variation

In 2010–11, in rural Victoria, Grampians Region had the highest MCH participation rate and Loddon Mallee had the lowest MCH participation rate for children in the following age groups: under 2 years, 2–3 years and 4–5 years.

MCH home consultation visit

While the percentages of children receiving an MCH home consultation visit have increased over time across the state, a slightly greater proportion of children in metropolitan Victoria receive this visit compared with rural Victoria (100% and 98.3%, respectively).

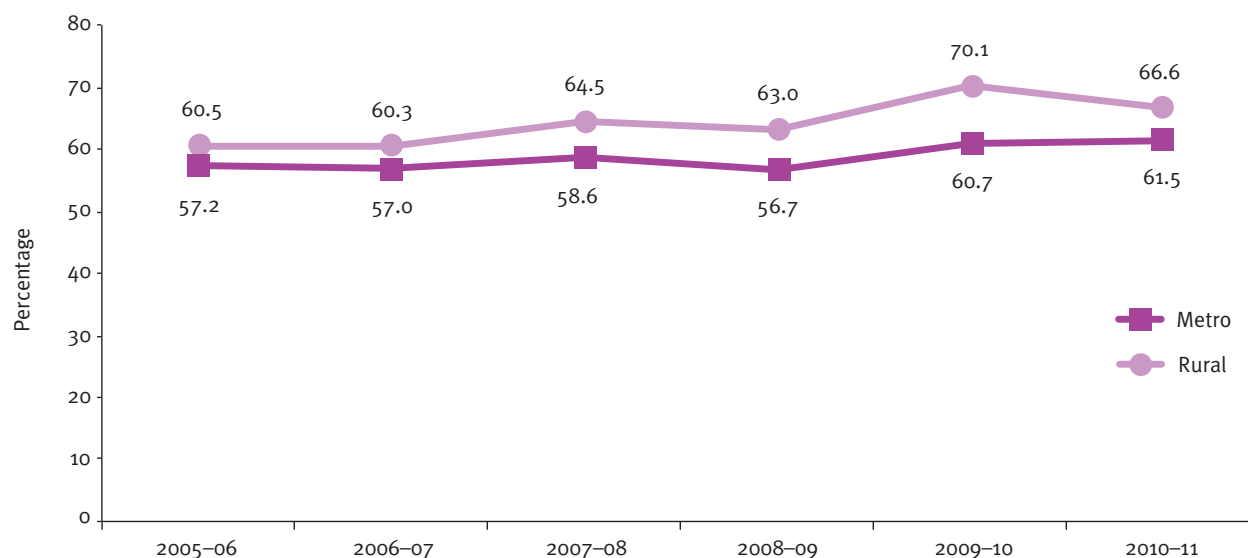
Regional variation

In 2010–11, Northern Metropolitan Region had the highest proportion of infants receiving an MCH home consultation visit, while Loddon Mallee had the lowest.

The 3½ years key ages and stages visit

The percentage of children attending the MCH 3½ years key ages and stages visit has also increased over time. Higher proportions of children in rural Victoria attend this visit compared with those in metropolitan Victoria (Figure 7.4).

Figure 7.4: Children attending the 3½ years key ages and stages visit, by region type, Victoria, 2005–06 to 2010–11



Source: DEECD online MCH annual reports 2005–06 to 2010–11.

Regional variation

In 2010–11, Hume Region had the highest proportion of children attending the 3½ years key ages and stages visit (71.0%), while Western Metropolitan region had the lowest (51.8%).

Major cities consistently have the lowest percentages of children attending the 3½ years key ages and stages visit.

Aboriginal children

Across Victoria, Aboriginal children are much less likely than non-Aboriginal children to attend the 3½ years key ages and stages visit (parents' report in Table 7.3).⁶⁷

Table 7.3: Percentage of children at school entry whose parents report that they attended a 3½ Year MCH check, by Aboriginal status and region type, Victoria, 2011

| Region type | Indigenous | Non-Indigenous |
|--------------|------------|----------------|
| Rural | 62.2 | 76.4 |
| Metropolitan | 62.0 | 72.9 |

Source: SEHQ 2011, DEECD.

Support to access kindergarten services

Placements attracting a kindergarten fee subsidy

The kindergarten fee subsidy supports eligible families by meeting the cost of 15 hours kindergarten per week.⁶⁸ Eligible families include those with a Health Care Card, Pensioner Concession Card, Temporary Protection visas and parents of triplets or quadruplets.

In 2012, 35.3% of children in rural areas attending kindergarten had placements attracting a fee subsidy, compared with 20.8% of children in metropolitan Victoria. As Figure 7.5 shows, the percentage (of children with fee subsidy placements) increases markedly with levels of remoteness (major cities 21.0%, inner regional 33.5%, outer regional 44.5% and remote 49.8%).

Figure 7.5: Percentage of children attending kindergarten with placements that attract a fee subsidy, by ARIA classification, Victoria, 2006–12



Source: Children's Services Online (CHISOL) database (CHISOL) 2006–2012, DEECD.

Kindergarten enrolments in a long-day-care setting

There has been an increase in the percentage of kindergarten enrolments in a long-day-care setting (from 14.8% in 2008 to 23.2% in 2012). However, the majority of enrolments in long-day-care settings are in metropolitan (27.5%) compared with rural (11.3%) Victoria.

As Figure 7.6 shows, the percentage of enrolments in long-day-care settings is lowest in outer regional Victoria (3.5%) and highest in major cities (27.1%); however, the reverse of the pattern identified with fee subsidy placements.

Figure 7.6: Percentage of kindergarten enrolments in a long-day-care setting, by ARIA classification, Victoria, 2008–12



Source: Children's Services Online (CHISOL) database 2008–12, DEECD.

Children assessed by the Primary School Nursing Program

The Victorian Primary School Nursing Program employs primary school nurses to conduct a health assessment of students in their first year of school, including vision and hearing screening.

Rural children are more likely than metropolitan children to have received an assessment by the primary school nursing program (91.3% compared with 82.9%). Aboriginal children are more likely, overall, to have been assessed than non-Aboriginal children. However, Aboriginal children in rural areas are less likely than Aboriginal children in metropolitan Victoria to have been assessed.

Regional variation

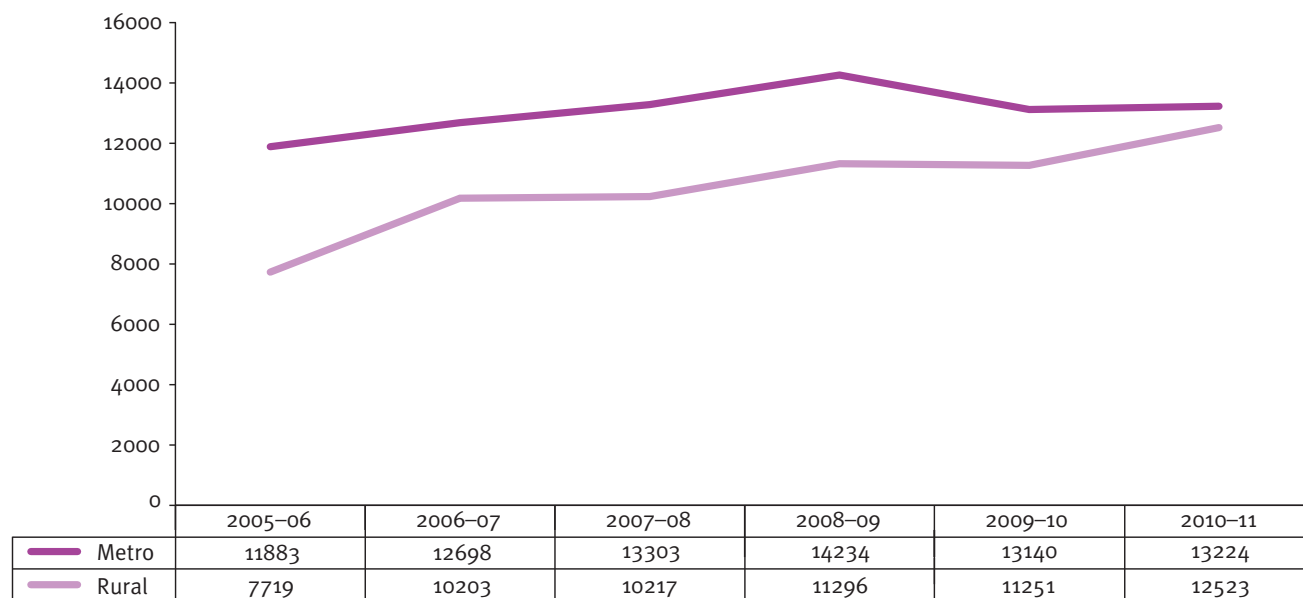
Regional findings of children assessed by the primary school nursing program range from 79.4% in Southern Metropolitan Region to 93.4% in Grampians. The highest percentage of assessments (92%) is completed in remote areas and the lowest in major cities (83.2%).

Family support services

Family Services in Victoria aim to promote the safety, stability and wellbeing of vulnerable children, young people and their families; and to support the building of child, family and community capacity and resilience. The number of families accessing Family Services (including in Family Support Innovation sites) is shown in Figure 7.8.

Numbers are higher in metropolitan than rural Victoria (expected as this is a unweighted count), with 12,523 families in rural Victoria and 13,224 families in metropolitan Victoria accessing services in 2010–11. The total number of families accessing family support services has increased across Victoria between 2005–06 and 2010–11 (Figure 7.7).⁶⁹ However, the increase is more marked in rural compared with metropolitan Victoria. The findings also suggest that rural families are more likely to be accessing these services (than metropolitan families), because they are disproportionately represented.

Figure 7.7: Number of families with children aged 0–17 years accessing Family Support Services within a reference period, by region type, Victoria, 2005–06 to 2010–11



Source: IRIS survey 2005–06 to 2010–11, DHS

Regional variation

Regional analysis shows that in rural Victoria there have been marked increases (2005–06 to 2010–11) in the numbers of families accessing family support services in Gippsland (from 1141 to 2700) and in Hume (from 1952 to 3125).

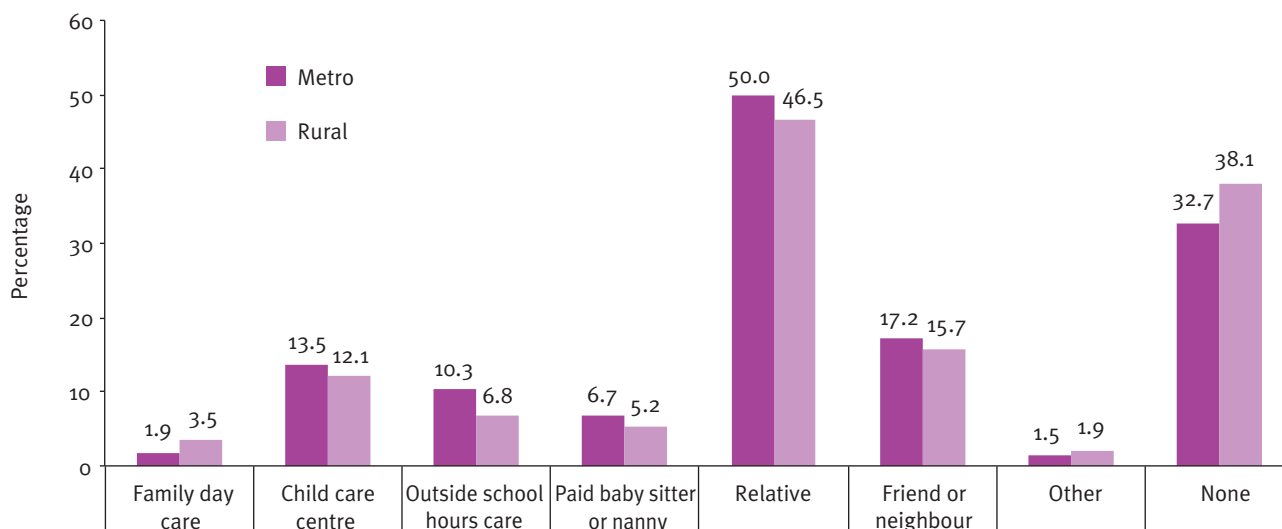
Child care

In the 2009 VCHWS, parents are asked to identify the type of child care that they have used in the last month. As Figure 7.8 shows, a considerable number of parents did not use any form of child care and, where child care was used, parents were much more likely to rely on their relatives, friends or neighbours, than other forms of care.

Overall use of family day care and outside-school-hours care (OSHC) was low. However, metropolitan parents were significantly more likely to have used these types of care, when compared with rural parents (3.5% of metropolitan parents had used family day care versus 1.9% of rural parents; while 10.3% of metropolitan parents had used OSHC compared with 6.8% of rural parents).

Rural parents were also significantly more likely to have not used any form of child care (38.1% of rural/32.7% metropolitan parents).⁷⁰

Figure 7.8: Parents reported use of child care in the last month, by region type, Victoria, 2009



Source: VCHWS 2009, DEECD.

Regional variation

Parents in Loddon Mallee (41.7%) and Gippsland (41.3%) were the most likely to have not used any form of child care (ranging to 30.1% in Eastern Metropolitan Region). Use of formal child care centres ranged from 9.2% in Gippsland to 16.1% in Hume, and use of paid baby sitters or nannies from 2.2% in Gippsland to 7.7% in Eastern Metropolitan Region.

Use of OSHC by parents ranged 4% of Gippsland parents and 6.7% in Loddon Mallee, up to 10% in Eastern Metropolitan Region and 14.1% in Northern Metropolitan Region.

Box 7.1: Children accessing outside-school-hours care

Formal childcare services can offer considerable benefits to vulnerable children and families. However, a 2012 study by the National Centre for Social and Economic Modelling (NATSEM) at the University of Canberra found that children from more affluent areas were much more likely to be accessing Outside Hours School Care (OSHC) than children from low socioeconomic areas. The study, which was commissioned by Uniting Care, found that 17% of children living in affluent areas accessed OSHC, compared with 3% of children in disadvantaged areas. Only 1% of children living in low income families accessed OSHC, as compared with over one-fifth in the top income quintile Bottrell & Russell, cited in Cassells & Miranti 2012).

Services for children in out-of-home care

Out-of-home care placements

As at 30 June 2011, out-of-home care placements for children on a Care and Protection Order when exiting out-of-home care were higher in metropolitan (781) than rural Victoria (707) (an expected finding as this is a count).

Placements in home-based care and with relatives/kin

It is generally accepted that children under the age of 12 years are most appropriately placed with carers in the carer's home, as opposed to other residential facilities, such as family group homes or residential care (DEECD 2009).

As at 30 June 2011, the percentages of children aged under 12 years in out-of-home care placed in home based-care were similar in rural and metropolitan Victoria (rural 96.2%/metropolitan 97.7%). At a regional level, percentages in Victoria ranged from 94.8% in Grampians to 99.1% in Western Metropolitan Region.

There was also no notable region type difference in the percentage of children aged under 12 years in out-of-home care who were placed with relatives/kin (rural 45.4%/metropolitan 47.6%). There was marked regional variation, however, with percentages across Victoria ranging from 32.9% in Grampians to 55.5% in Hume.

Regional variation

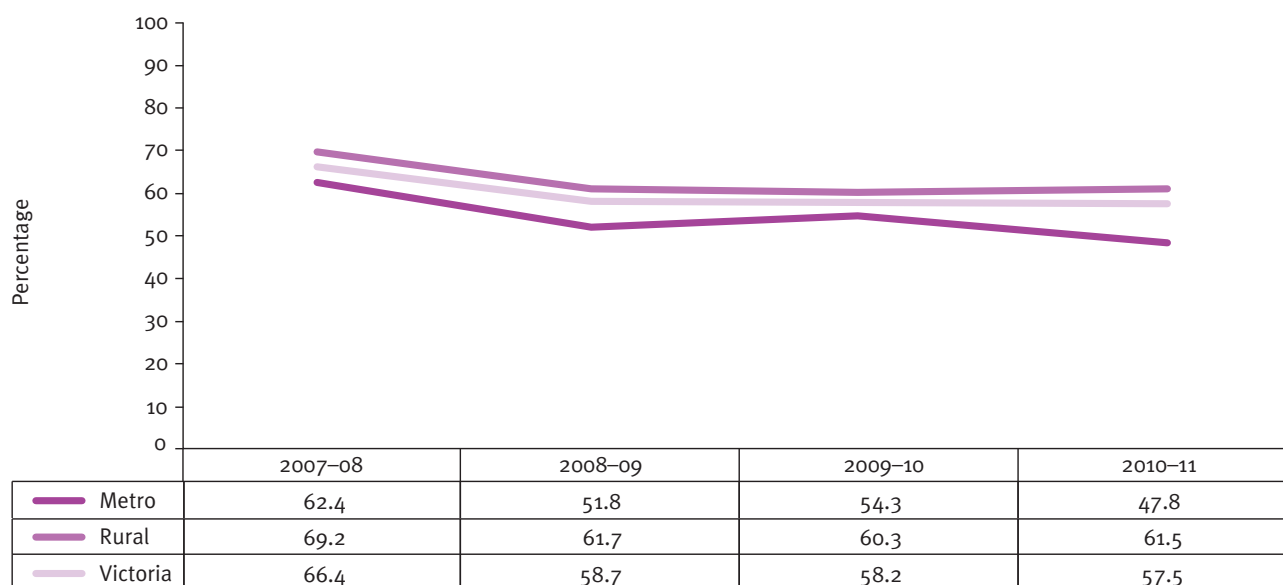
There have been increases over time in the percentages of children placed in home-based care in major cities, while percentages in outer regional Victoria have decreased. As at 30 June 2011, major cities had the highest percentage (97.4%), whereas outer regional Victoria had the lowest (94.6%). Percentages of children placed with relatives are higher in major cities and inner regional Victoria.

Placement in accordance with the Aboriginal Child Placement Principle

The Aboriginal Child Placement Principle (ACPP) is a nationally agreed standard used in determining the placement of Aboriginal children in out-of-home care. It aims to enhance and preserve Aboriginal children's sense of identity through ensuring that strong connections are maintained with family, community and culture (DEECD 2009b).

The percentage of Aboriginal children in care who are placed in accordance with the ACPP has declined across Victoria, from 66.4% (at 30 June 2008) to 57.5% (at 30 June 2011). In rural Victoria, Aboriginal children are consistently more likely to be placed in accordance with the ACPP (compared with Aboriginal children in metropolitan Victoria), and the decline in ACPP placements is less marked in rural regions (Figure 7.9). At 30 June 2011, 61.5% of Aboriginal children in out-of-home care in rural Victoria were placed in accordance with the ACPP (metropolitan 47.8%).

Figure 7.9: Percentage of Aboriginal children in out-of-home care placed in accordance with the Aboriginal Child Placement Principle, by region type, Victoria, 30 June 2008–11



Source: Client Relationship Information System 2007–08 to 2010–11, DHS (unpublished).

Regional variation

The decline in ACPP placements (30 June 2008 to 30 June 2011) is most marked in Eastern Metropolitan and Western Metropolitan regions. Hume and Northern Metropolitan regions are the only DEECD regions where there has not been a decline in ACPP placements.

Key policy directions: access to child health and other support services

- National Partnership Agreement on the National Quality Agenda for Early Childhood Education and Care (2008)
- National Partnership Agreement on Early Childhood Education (2008)
- National Partnership Agreement on Indigenous Early Childhood Development (2008)
- *Supporting parents, supporting children: A Victorian Early Parenting Strategy* (2010)
- Community Health Service Child Health teams Victorian government initiatives

Victorian government initiatives

- \$62.7m over four years for free Universal MCH services and \$16.3m to sustain the Enhanced MCH service for vulnerable families
- \$8.3m to provide Early Childhood Education for 3 year-olds known to Child Protection authorities
- Small rural kindergartens funding and Kindergarten Inclusion Support Services improvements
- \$16m for *Cradle to Kinder*: 10 new programs, including two Aboriginal specific programs
- \$16.5m for Supported Playgroups, the smalltalk program and the E4Kids longitudinal study
- \$22m to expand ChildFIRST and Integrated Family Services in areas of high demand
- \$29m for *Stronger Families* program delivered in four ChildFIRST catchments across Victoria, with services to be established in two additional locations in 2012–13

Programs in place

- Maternal and Child Health (MCH) and Enhanced MCH services
- MCH Line and ParentLine, providing support to parents by telephone
- Mother Baby Units
- Regional Parenting Services
- *Cradle to Kinder* and *Aboriginal Cradle to Kinder*
- In-Home Support for Aboriginal families and the Aboriginal Home-Based Learning Program
- Best Start and Aboriginal Best Start
- Play groups and Early Start Kindergarten
- Small Rural Kindergarten Grants program
- Kindergarten Fee Subsidy and Kindergarten Inclusion Support Service
- Early Childhood Development program in 3 regions
- Early Parenting services
- Primary School Nursing Program



*What's special / the best thing about
where you live?*

'It is quiet and not all crowded.'

**Artwork by Gus, Grade 4
Maiden Gully Primary School
Title: Bush**



Section 8

Reviewing the Findings

8. Reviewing the findings



Artwork by Alex, Grade 4,
Cowes Primary School
This is a map where I live.

8.1 Overview

While the majority of children and young people in rural and regional Victoria are faring well, this report demonstrates clear disparities in health, wellbeing, safety and learning and development outcomes between rural and regional children and young people and their metropolitan counterparts. It further identifies that for many outcomes there is marked variation between the DEECD rural regions, reflecting the diversity of experience for children, young people and families.

Analysis of factors that may be contributing to these outcomes has also included a focus on the role of parents (behaviour and family factors) together with broader community factors, such as neighbourhood characteristics, access to local services and facilities, and access to and use of a range of child health and other support services.

This section does not seek to summarise findings from across the report, this is done in the Executive Summary. Rather it aims to draw together patterns and insights that have emerged for particular population groups and consolidate the evidence around the impact of socio-economic disadvantage and remoteness.

8.2 Key insights

How does geographical remoteness impact on outcomes?

Analysis by ARIA remoteness classifications (refer online Technical Appendix) complements the DEECD regional analysis by highlighting how outcomes differ between major cities and other areas of Victoria; additionally, it allows for a focus on how levels of remoteness (distance from major cities) may be impacting on outcomes for children, young people and their families.

This analysis suggests that the most commonly observed pattern is for outcomes for children and young people in Victoria to become progressively poorer with increasing levels of distance or remoteness from major cities. However, in many instances, increasing remoteness is associated with better outcomes.

Broadly, outcomes that are associated with child vulnerability and risk (AEDI vulnerability, child abuse substantiations, intentional self-harm, crime involving young people) and outcomes linking with access to basic services and transport tend to become poorer with increasing remoteness, whereas outcomes that are related to the physical quality of local environments and community strength and connectedness (particularly in young people report) improve progressively with increasing remoteness.

Outcomes are commonly in the 'middle range' in inner regional Victoria, although there are some exceptions to this. Inner regional Victoria has the

highest percentage of parents (of children up to 12 years) who may be at risk of mental illness, and the highest percentage of family violence incidents where children and young people are present. It also has the highest percentages of children (up to 12 years) who have had fillings or tooth extractions and the highest rates of STIs among young people (12–17 years).

Does living in rural and regional Victoria have an effect on outcomes for key groups of children?

Outcomes for Aboriginal children

Analysis confirms that Aboriginal children and young people in rural and regional Victoria are faring less well than non-Aboriginal children in rural and regional Victoria against key outcomes of health, development and learning. This finding was consistent and reflects Victorian and national evidence on disparities in outcomes between Aboriginal and non-Aboriginal populations.

For some outcomes that were analysed, however, the disparity or gap between Aboriginal and non-Aboriginal outcomes was also more marked in rural and regional compared with metropolitan Victoria.

It is possible that this finding may reflect greater levels of disadvantage in the rural and regional Aboriginal population, when compared with the Aboriginal population in metropolitan Victoria. However, as analysis of Aboriginal data was limited to selected outcome areas and data sets (as detailed in the online Technical Appendix), this finding should be interpreted with caution. Further analysis of a wider range of data would be needed to confirm whether the disparity between Aboriginal and non-Aboriginal outcomes is consistently more marked in rural and regional compared with metropolitan Victoria.

Socioeconomically disadvantaged children

Analysis was used for selected survey data and indicators (from the 2010 SEHQ and 2009 VCHWS) to explore whether the ‘odds’ or chances of children having particular outcomes varied both with different indicators of disadvantage and with whether the child was living in rural and regional or metropolitan Victoria.

Overall, this analysis showed that socioeconomically disadvantaged children (as measured by a range of indicators) generally had an increased chance of having poorer outcomes, with the impact of disadvantage varying with indicator of disadvantage and outcome measure.

In general, direct indicators of household disadvantage (particularly being on a health care card) were a better predictor of poorer outcomes than living in the most disadvantaged Socioeconomic Indexes for Areas (SEIFA) quintile.

Living in rural and regional (as opposed to metropolitan) Victoria did not appear to increase the overall likelihood of disadvantaged children having poorer outcomes, suggesting that geographical location was not a principal factor, on its own, in predicting poorer outcomes among disadvantaged children.

Impacts of socioeconomic disadvantage and protective factors

Analysis of regional variation identifies some clear associations between socioeconomic disadvantage in rural Victoria (as measured by low income) and outcomes; together with important links between low income, family risk factors and poorer access to services.

Across many of the themes discussed in the report, outcomes are poorest in two regions with lower median family income (Gippsland and Loddon Mallee).

Regional analysis further highlights that regions with lower incomes are also those with higher levels of early childhood vulnerability and identified family risk factors.

Regions with lower incomes also have poorer reported access to basic services (including transport) and child health and other support services.

Analysis also suggests that in some regions higher income and higher levels of community connectedness may be acting as protective factors.

8.4 Conclusions

Evidence presented in this report shows that, while most children and young people in rural and regional Victoria are faring well, there are disparities between rural and regional and metropolitan children in relation to key outcomes of early childhood development and learning, child abuse, alcohol use, sexual health, involvement in crime, and engagement with and achievement at school.

Analysis suggests that these relatively poorer outcomes of children and young people in rural and regional Victoria are linked to a complex range of inter-linked factors, including socioeconomic disadvantage, family risk factors and local service access issues.

While it is not possible, on the basis of the findings, to determine the specific contribution of each of these factors to the overall picture of relatively poorer outcomes, it is likely that socioeconomic disadvantage, as measured by relatively low income, may be key, with geographical location (in terms of remoteness) also being significant, but less so.

It is anticipated that the findings from this report will make a valuable contribution to local planning for children, young people and their families in rural and regional Victoria.

In considering and interpreting these report findings, it is important to note, however, that:

- Most children and young people in rural and regional Victoria are faring well, as are most children and young people across Victoria.
- Children and young people in rural and regional Victoria are *relatively* disadvantaged when compared with their metropolitan peers, but *smaller numbers of children* in rural and regional Victoria are affected by disadvantage.
- Many of the issues that are identified as of concern for rural and regional children are also of concern for children *across the state*. This report has sought to understand *whether and how* these concerns may be affecting rural and regional children disproportionately.

This is the first time information on outcomes for children, young people and families in rural and regional Victoria has been brought together and analysed in one document. The report raises a number of questions and draws attention to data gaps, providing a basis for future research, analysis and data development.

The report findings also present important new insights to shape future planning for children, young people and their families in rural and regional Victoria. It is clear there is already good alignment between government initiatives and programs in place and some of the emerging challenges in the report, but there is still room for improvement.

It will be important to engage with regions and communities on the findings and what they mean in a local context in order to realise the full potential of the report. Victorian government departments are committed to working with regions through established networks and forums to disseminate these data and support application to local planning and community responses.

Box 8.1: Engaging communities in using evidence: The State of Bendigo's Children report

'I like to go to the library 'cos you feel safe and people like kids are there ...' (Bendigo child).

Following the release of the 2008 *The state of Victoria's children* report, the City of Greater Bendigo, a recently nominated Child Friendly City, decided to replicate its own local version to demonstrate its commitment to creating a place where children feel safe and secure, and are able to explore and learn about the world.

The State of Bendigo's Children report shows how Bendigo is faring against the Victorian average, and a the selected indicators confirm Bendigo's children and young people are doing well in many ways.

To establish Bendigo as a child-friendly city, St Luke's Anglicare, the city of Greater Bendigo, regional state government agencies, community groups and business leaders formed a Leadership Group. The Group initiated *The State of Bendigo's Children Report* to support planning and policy-making.

In early meetings the group looked to the Australian Early Development Index (AEDI) as a publically available measure of progress. The 2009 AEDI findings confirmed that the majority of Bendigo's children were on track. The findings from the AEDI provided a starting point and the Victorian AEDI project at DEECD provided matched resources to assist Bendigo analyse, write and produce a report that reflected its findings.

The Leadership Group brought together early childhood services, health and welfare services, governments, human geographers and urban planners to select 20 indicators that they believed would best recognise Bendigo's strengths in supporting its children and young people, and its areas of greatest need. The benefit in having a broad range of stakeholders involved was that knowledge and expertise were able to be shared, so that a thorough understanding of Bendigo's children, and the service system surrounding them, could be better understood.

Indicators in the report included 'Children are developing well by age six' (informed by 2009 AEDI findings) to 'Families and the community model good citizenship' (informed by the Department Planning and Community Development Indicators of Community Strength). Other indicators drew on data sources, such as Maternal and Child Health Participation Rates, kindergarten participation rates, child protection notifications, Centre-link data, and information housed in Victoria's Child and Adolescent Monitoring System.

Being transparent about how their child and youth population are faring in a public report heralded a desire to keep the Leadership Group accountable for the health, learning and wellbeing of Bendigo's children and young people. The group has committed to publishing the report every two years, so that improvements over time can be discerned.

The State of Bendigo's Children report demonstrates the importance of presenting evidence to communities in relevant and useful ways and the value of bringing the complementary data together effectively in an increasingly complex and demanding environment. By bringing together the local community stakeholders with data experts and others the leadership group acknowledged that improving outcomes for their children is a shared responsibility and the role of human contact and collaborative networks cannot be overstated.

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Glossary of abbreviations and acronyms

| | |
|--------|--|
| ACFE | Adult, Community and Further Education |
| AEDI | Australian Early Development Index |
| ABS | Australian Bureau of Statistics |
| ACSC | ambulatory care sensitive condition |
| AIHW | Australian Institute of Health and Welfare |
| ARIA | Accessibility/Remoteness Index of Australia |
| ASCF | ABS Australian Standard Classification |
| ASSAaD | Australian Secondary Students' Alcohol and Drug (Survey) |
| BBV | blood-borne viruses |
| BMI | body mass index |
| CAMHS | Community Child and Adolescent Mental Health Services |
| CASA | Centre Against Sexual Assault |
| CASEA | CAMHS and Schools Early Action (Program) |
| CHS | Community Health Services |
| CHTs | Child Health Teams |
| CMNI | Careers Mentoring Network Initiative |
| COAG | Council of Australian Governments |
| CRIS | Client Relationship Information System |
| CSE | Child Social Exclusion |
| CYMHS | Child and Youth Mental Health Services |
| DEECD | Department of Education and Early Childhood Development (Vic.) |
| DoH | Department of Health (Vic.) |
| DHS | Department of Human Services (Vic) |
| DPCD | Department of Planning and Community Development (Vic.) |
| ECE | early childhood education |
| ECIS | Early Childhood Intervention Service |

| | |
|---------|--|
| ERP | estimated residential population |
| ESL | English as a second language |
| FaPMI | families where a parent has a mental illness (strategy) |
| FTE | full time education |
| GRIPP | Gain Respect, Increase Personal Power Program |
| HOWRU | Victorian Adolescent Health and Wellbeing Survey |
| HPV | human papillomavirus |
| IRSED | Index of Relative Socioeconomic Disadvantage |
| K10 | Kessler 10 Psychological Distress Scale |
| LEAP | Law Enforcement Assistance Program |
| LLENs | Local Learning Employment Networks |
| LGAs | local government areas |
| MCH | Maternal and Child Health |
| MIPs | Managed Individual Pathways |
| NaSSDA | National Secondary Students' Diet and Activity (Survey) |
| NAPLAN | National Assessment Program – Literacy and Numeracy |
| NATSEM | National Centre for Social and Economic Modelling |
| NATSISS | National Aboriginal and Torres Strait Islander Social Survey |
| NHMRC | National Health and Medical Research Council |
| NILF | not in labour force |
| NMS | National minimum standard (for NAPLSN) |
| PCM | prevention community model |
| PVVC | Protecting Victoria's Vulnerable Children |

| | |
|-------|--|
| RCH | Royal Children's Hospital |
| RGF | Regional Growth Fund |
| SDQ | Strengths and Difficulties Questionnaire |
| SEHQ | School Entrant Health Survey |
| MCBI | (Youth) Mentoring and Capacity Building Initiative |
| SEIFA | Socioeconomic Indexes for Areas |
| SES | socioeconomic status |
| SFO | Student Family Occupation |
| SIDS | sudden infant death syndrome |
| SLAs | statistical local areas |
| SMT | Student Mapping Tool |
| SOCIT | Sexual Offence & Child Abuse Investigation Teams |
| SOVC | <i>The State of Victoria's Children</i> |
| STIs | sexually transmitted infections |
| SWCs | Student Welfare Coordinators |
| TAFE | tertiary and further education |
| VAED | Victorian Admitted Episodes Dataset |
| VCAL | Victorian Certificate of Applied Learning |
| VCAMS | Victorian Child and Adolescent Monitoring System |
| VCHWS | Victorian Child Health and Wellbeing Survey |
| VET | vocational education and training |
| VETis | vocational education and training in schools |
| VPD | vaccine preventable diseases |
| VPHS | Victorian Population Health Survey |
| WHO | World Health Organisation |
| YSAS | Youth Substance Abuse Service |
| YSS | Youth Support Service |

Endnotes

Executive summary notes

- ¹ Children with special health care needs are those who, for 12 months or more, are reliant on medication; or have some form of physical, developmental, behavioural or emotional functional limitation; or are likely to use health services more than other children.
- ² www.education.vic.gov.au/statewideoutcomes

Section 2 notes

- ³ Social exclusion involves a lack of resources, rights, goods and services, with a resulting inability to participate fully in society. The concept has more commonly been used in relation to adults and the general population than in relation to children. In applying the concept in relation to children, the choice of indicators of disadvantage has been influenced by an understanding of the importance of both the current wellbeing and future potential of children (Abello et al. 2012).
- ⁴ The quintiles are child population weighted in order to control for the effects of different population sizes in SLAs (McNamara 2008).
- ⁵ The five rural areas are Swan Hill - Robinvale; Central Goldfields – Marlborough; Greater Bendigo – Eaglehawk; Corio – Inner; and Latrobe – Morwell.
- ⁶ The rural SLAs are South Gippsland – Central; Wellington – Avon; Macedon Ranges – Bal; South Grampians – Wannon; Golden Plains – South East; Surf Coast – East; and Queenscliff.
- ⁷ One of these is Swan Hill – Robinvale, in rural Victoria; the other is Hume – Broadmeadows, in metropolitan Victoria.
- ⁸ The five rural SLAs are Golden Plains – South East; Surf Coast – East; Macedon Ranges – Bal; Queenscliff; and South Gippsland – Central.
- ⁹ Preliminary estimates from the ABS Census of Population and Housing 2011 indicate that the Aboriginal population in Victoria has increased to 47,327 over the five-year period (2006–11).
- ¹⁰ The Census of Population and Housing defines the profound or severe disability population as ‘those people needing help or assistance in one or more of the three core activity areas of self-care, mobility and communication, because of a long-term health condition (lasting six months or more), a disability (lasting six months or more) or old age’.
- ¹¹ Children with special health care needs are children who (for 12 months or more) are reliant on medication, or have some form of physical, developmental, behavioural or emotional functional limitation; or are likely to use health services more than other children.
- ¹² Research also suggests that Victoria’s Interface Councils at the interface of metropolitan Melbourne and rural Victoria face challenges placing particular demands on the human services system. These councils have experienced population growth and have relatively young populations. Challenges faced relate to the planning, infrastructure, funding and accessibility of services (including transport and mental health services), education and employment, and housing and homelessness (Interface Councils 2007).

Section 3 notes

- ¹³ A child is described as ‘fully immunised’ when they have received all National Immunisation Program Schedule recommended vaccines at the appropriate age.
- ¹⁴ Secondary school children are immunised in Year 7 against chickenpox with the Varilix vaccine and against human papillomavirus with Gardasil 3 dose course (girls only). They are also immunised against hepatitis B with H-B-Vax 11 Adult 2 course (this is not required if previous course of hepatitis B vaccine completed).

- ¹⁵ Secondary school children are immunised in Year 10 against diphtheria, tetanus and pertussis with the Boostrix vaccine.
- ¹⁶ The increase in the rate of notifications of vaccine preventable diseases in 2009 coincided with the H1N1 influenza pandemic (swine flu) (DEECD 2012).
- ¹⁷ In 2009–10, in rural Victoria, the top three causes of hospitalisation for children and young people aged 0–17, excluding singleton born in hospital, were dental caries unspecified, chronic tonsillitis and asthma unspecified (Department of Health, 2010, Victorian Admitted Episodes Dataset).
- ¹⁸ This pattern differs from that identified in the 2010 SEHQ, when the highest percentages of children with parents reporting concerns about their child’s oral health were in the Grampians (14.8%) and Loddon Mallee (14.4%).
- ¹⁹ Parents are asked: How many cups of soft drink, fruit juice, cordials, or sports drink, does (child) usually drink in a day? (1 cup = 250ml. One can of soft drink = 1½ cups. One 500ml bottle = 2 cups).
- ²⁰ A recent survey of 45 practitioners working in Aboriginal Health Services and Early Years Settings across four regional and four urban sites in Victoria found that inappropriate introduction of solids and a reliance on sweet drinks and bottles, resulting in oral health problems, was the most frequently reported nutrition concern raised by both parents and early childhood practitioners (Myers et al. 2012).
- ²¹ For children who were listed on a health care card in rural Victoria, the likelihood of consuming sugary drinks daily was increased by 71% (compared with 34% in metropolitan Victoria). For children in low income households in rural Victoria, the likelihood of consuming sugary drinks daily was increased by 64% (compared with 54% in metropolitan Victoria).
- ²² For children in the ‘most disadvantaged SEIFA quintile’ in metropolitan Victoria, the likelihood of consuming sugary drinks daily was increased by 67% (compared with 25% in rural Victoria). For children in a ‘single parent family’ in metropolitan Victoria the likelihood of consuming sugary drinks daily was increased by 96% (compared with 80% in rural Victoria).
- ²³ Ambulatory Care Sensitive Conditions are conditions for which hospitalisations is considered to be preventable.
- ²⁴ For example, in metropolitan Victoria, being in a one-parent family increased the likelihood of a child having a tooth filling by 90%, compared with 26% in rural Victoria.
- ²⁵ The NHMRC dietary guidelines for children and adolescents are currently under review. New evidence emphasises the relevance of sugar-sweetened drinks to the development of excess weight.
- ²⁶ Parents were asked: ‘How often does the child eat chips, French fries, wedges, fried potatoes or crisps?’ Of rural children aged 1–12 years, 58.3% consumed fried potato products one to less than four times a week, compared with 51.9% of metropolitan children; 7% of rural children consumed fried potato products rarely or never, compared with 8.5% of metropolitan children.
- ²⁷ Although young people who have ‘ever’ consumed alcohol may not be regular consumers, ‘ever drinking’ provides a measure of exposure to alcohol at a young age (DEECD 2012).
- ²⁸ Chroming is the term used to mean sniffing chrome-based aerosol spray paint.
- ²⁹ This pattern differs from that identified through ARIA analysis of the 2010 SEHQ, where levels of reported parental concern appeared to show some increase with remoteness (major cities: 14.8%; inner regional 16.3%; outer regional 17.3% and remote 18.6%).
- ³⁰ It should be noted that this analysis was based on the 2010 SEHQ.

- ³¹ In Victoria, 'Being on a health care card increased the likelihood of a child scoring 'of concern' on at least one domain of the SDQ more than fourfold, while 'being from the most disadvantaged SEIFA quintile' was associated with an increased likelihood of 61%.
- ³² In rural Victoria, 'being on a health care card' increased the likelihood of a child scoring 'of concern' on at least one domain of the SDQ by nearly five times, while in metropolitan Victoria the likelihood was increased by nearly four times.
- ³³ ARIA analysis finds that the percentage of young people with a high level of emotional wellbeing is highest in outer regional (64.9%) and lowest in inner regional Victoria (60.7%), although this difference is not statistically significant.
- ³⁴ Young people responding to a recent national survey are clearly concerned about body image, identifying this as a key area of concern. The top three issues of concern identified by young people were school or study problems (37.3%), coping with stress (35.4%) and body image (33.1%) (Mission Australia 2011).

Section 4 notes

- ³⁵ Students in Years 5 and 6 and Years 7–9 are asked how far they agree with the following statements: I have been bullied recently at school; I have been teased in an unpleasant way recently at my school; Students are mean to me at this school; I have been deliberately hit, kicked or threatened by another student recently; and Other students often spread rumours about me at my school.
- ³⁶ Higher scores represent higher ratings of safety.
- ³⁷ Remote category excluded from this analysis.
- ³⁸ The Attitudes to School Survey also measures student connectedness to peers. This can be a key factor in promoting or hindering engagement with schools and learning. Findings on connectedness to peers are broadly similar to connectedness to school findings, with an increase in reported connectedness (2006–11) and lower scores for student in rural than metropolitan Victoria. However, while student connectedness to peers scores are lower in Years 7 and 9 than in Years 5 and 6, the dip in scores by school year level is less marked than that for connectedness to school.
- ³⁹ In order to measure student motivation, students are asked to rate on a five-point scale how far they agree with the following statements: 'doing well at school is very important to me'; 'continuing or completing my education is important to me'; 'I try very hard in school'; and 'I am keen to do very well at my school'.
- ⁴⁰ These rates, known as 'apparent retention rates', are based on school enrolment information and do not track individual students or take account of changes, such as students undertaking secondary school studies in non-school locations, students repeating year levels or migrating or transferring between schools.
- ⁴¹ It should be noted that these retention rates are for government schools only.
- ⁴² Excluding Year 3s in numeracy in 2010 and Year 9s in numeracy in 2011.
- ⁴³ Findings for the absolute measures are presented in three groupings: high absolute score, mid absolute score and low absolute score. Findings for the intake-adjusted measures show whether the school's performance is higher than, lower than or broadly similar to the level of performance that might be expected given the school intake factors.
- ⁴⁴ While the percentage of non-Aboriginal young people who express a preference for university increases between Years 7–9, the reverse pattern applies for Aboriginal young people, although by Year 11 the gap between Aboriginal and non-Aboriginal young people has closed.

- ⁴⁵ This longitudinal On Track study is available at <http://www.education.vic.gov.au/sensecyouth/ontrack/default.htm>
- ⁴⁶ The destinations of early leavers are strongly associated with the year level at which a young person left school. The higher the year of exit, the greater the likelihood those early school leavers will be working in either a full-time or part-time capacity.
- ⁴⁷ It should be noted that some data collections assign respondents to SEIFA rankings using quartiles while other data collections use quintiles.
- ⁴⁸ ARIA analysis shows that 17.7% of early school leavers in major cities are unemployed six months after leaving school, compared with 11.0% in outer regional Victoria (11.0%). The proportion in inner regional Victoria is similar (11.6%).
- ⁴⁹ It should be noted that this pattern is liable to fluctuation from year to year. As the total number of Aboriginal early leavers is small, a slight change in this number may result in a large percentage change.

Section 5 notes

- ⁵⁰ Parents' report.
- ⁵¹ These findings are in contrast to Victorian findings from the Healthy Neighbourhoods Survey (HNSS), which suggested that among children and young people in Years 6 and 8, rural children were more likely than metropolitan children to report feeling safe in their neighbourhoods.
- ⁵² The rate of recorded crime in the community is consistently higher in metropolitan than rural Victoria (LEAP 2005–06 to 2010–11 data, Victoria Police). In 2010–11, the crime rate was 65.4 (per 1000 population) in metropolitan Victoria, compared with 62.9 in rural Victoria, with the highest reported rates in Western Metropolitan Region (97.0) and the lowest in Eastern Metropolitan Region (40.6). In rural Victoria, Gippsland region had the highest rate of reported crime (71.3 per 1000 population), while Barwon South Western had the lowest (59.6).
- ⁵³ In rural Victoria, crime is nearly twice as likely to be committed by a person under age 18, when compared with metropolitan Victoria. (In 2010–11, in rural Victoria, 13.6% of crimes were committed by children and young people, compared with 7.1% of crimes in metropolitan Victoria) (LEAP 2010–11 data, Victoria Police).
- ⁵⁴ Alleged offenders refers to persons who have allegedly committed a criminal offence and have been processed for that offence, by either arrest, summons, caution, penalty notice, official warning or warrant of apprehension. Persons are counted on each occasion they are processed and for each offence (e.g. a person processed on three occasions during a financial year will be counted three times).
- ⁵⁵ Rates of crime where the victim was a child or young person are much higher in outer regional and remote Victoria and lower in major cities (ARIA analysis).
- ⁵⁶ In 2010, the hospitalisation rate for injury and poisoning for males was 49.6 per 10,000 population, while for females the rate was 25.1 per 10,000 population.

Section 6 notes

- ⁵⁷ In 2009–10, Grampians and Eastern Metropolitan Region have the highest percentage of infants fully breastfed at 6 months. In 2010–11, Barwon South Western Region has the highest percentage of infants fully breastfed at 6 months.
- ⁵⁸ As noted in the Online Technical Appendix, statistically significant differences between outcomes for different groups are noted as being evident for relevant sample survey data where 95% confidence intervals do not overlap. In this instance (as in other instances where no difference is reported) the confidence intervals overlapped and so no difference could be inferred.

- ⁵⁹ The report includes the most recently available VPHS data. Recently published Victorian Health Monitor data build on the VPHS data and provide assessments, based on measured physical and biomedical information, of the health status of adult Victorians. A companion report on food and nutrition presents detailed information about food and nutrition intake. The Health Monitor reports are available at: <http://www.health.vic.gov.au/healthstatus/survey/vhm.htm>
- ⁶⁰ Rural fathers are also significantly more likely than metropolitan fathers to be reported to be drinking most days or every day.
- ⁶¹ HOWRU analysis shows no difference by region type in percentages of young people exposed to cigarette smoke in the home.
- ⁶² Based on a count of young people who are not living in families where there is family conflict and poor family management.
- ⁶³ ARIA analysis shows no significant differences, by location, in the percentages of children or young people living in families with healthy family functioning.
- ⁶⁴ In the 2009 and 2010, SEHQ inner regional Victoria had the greatest proportion of children living in families with high or highest levels of family stress. Major cities consistently have the smallest proportion of children living in families with high or highest levels of family stress (2009–11).
- ⁶⁵ Using the K10, individuals are categorised to four levels of psychological distress, based on their score: low (10–15), moderate (16–21), high (22–29) and very high (30–50) (Andrews & Slade 2001, in DoH 2010).

Section 7 notes

- ⁶⁶ VCAMS also collects data relating to Child Protection services for the following indicators: proportion of children who are the subject of a child abuse report within 12 months of a previous report; proportion of children who are the subject of a Child Protection substantiation within three months of a decision not to substantiate; and proportion of re-substantiations within 12 months. However, updated (2010–11) data for these indicators was not available at the time of writing.
- ⁶⁷ It is of interest that SEHQ findings suggest higher rates of attendance at the 3½ year MCH check, when compared with MCH data, as shown on Figure 7.6.
- ⁶⁸ From 2013, previously it was 10 hours and 45 minutes.
- ⁶⁹ Since the progressive roll-out of the ChildFIRST service (April 2007 to February 2009), IRIS data has included both the count of cases of support provided by ChildFIRST (intake component) and family service (case work component). Some families will have received a support from both components, contributing to the total increase in the number of families accessing family support services between 2005–06 and 2010–11.
- ⁷⁰ It should be noted that there are limited child care options in small remote communities in Victoria.

