
# The State of Victoria's Children report 2013-14:

## A report on resilience and vulnerability within Victoria's children and young people

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Cover artwork by Laurence, Year 1

# Ministerial foreword

I believe that no matter what someone's background or circumstances they deserve the best opportunities in life, including access to a quality education that allows them to reach their potential. Too many vulnerable young people face disadvantages that can make it harder for them to succeed, and it is not always easy to determine who they are. That is why we have focused on making sure we can identify and help vulnerable children whatever their situation.

This report focuses on vulnerable and disadvantaged Victorian children, young people and families. It draws on data, research findings and analysis to provide a picture of the challenges and risks they face. It also highlights the important role government agencies, service providers and the broader community have in protecting young people and helping them meet the challenges in their lives.

As Minister for Families and Children, I am encouraged by the quality of early childhood services and school education that our state provides. But we can always do more. Too many young children are not developing the fundamental skills required to get the best start in school. Student achievement is stalling in some areas. Every year around 10,000 young Victorians are dropping out of school before they complete secondary school.

Some young people and their families face an array of problems at the same time, and these complex situations can require a lot of help. But, we must be aware that risks exist for all children and all families. A young person's family environment can have a huge impact on their health, wellbeing and development.

This is why it is so important to provide disadvantaged families with the support they need. This means ensuring families have access to the services they need to bring up their children. It means providing a quality early education and enabling students to succeed at school. When we get this right children go on to succeed in further education and training, and that means they have fulfilling lives. Our reform agenda will help us meet the needs of all young Victorians.

The Education State aims to provide every child with the education that they need for their future. Early childhood development is central to the Victorian Government's vision for the Education State, so that each child has the best start in life and has access to high quality early childhood services that support them to learn, play and thrive.

The Roadmap for Reform will deliver transformative change to the design of services and programs provided to vulnerable children and families, including universal services, targeted interventions and the statutory system.

Victoria's 10-year Mental Health Plan aims to improve resilience and promote protective factors in all children and young people through a number of proposed actions. This includes work underway to improve child and mental health services.

I am sure that by working together, and learning the lessons in this report we will ensure we are responding to the concerns and needs of Victorian children, young people and their families, including those in the most need.

**Hon. Jenny Mikakos, MP**
Minister for Families and Children
Minister for Youth Affairs

# Acknowledgements

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We would like to express thanks to members of the Children's Services Interdepartmental Committee from across Victorian Government. 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.

This report was produced by the Performance and Evaluation Division of the Department of Education and Training. We would like to thank the children who provided artwork for this report, in particular students from Preston Primary School. We also thank Leigh Raymond for editing the report and Amanda Hill for her design work.

# Contents


| | |
|---|---|
| Executive Summary | iv |
| Introduction | 2 |
| Victoria's children, young people and their families | 8 |
| Early childhood and transition to school | 24 |
| Middle childhood and early adolescence | 54 |
| Parents and families | 114 |
| Supporting vulnerable children and their families | 152 |
| Conclusion | 177 |
| Glossary | 182 |
| Data sources | 183 |

# Executive summary

Artwork by Mia, Year 5

Each year the State of Victoria's Children report analyses outcomes for Victoria's children and young people focusing on a theme of interest or concern. This year's report looks at resilience, vulnerability and disadvantage in Victoria's children, young people and their families. Vulnerability is difficult to measure, as it is often influenced by a combination of factors affecting a child, their family and environment. For the purposes of this report, vulnerability ranges from increased risk of poor outcomes for health, wellbeing and learning, to children at risk of significant harm.

Vulnerability is also not static; children, and their families can be more or less vulnerable at different times. While this may be influenced by different life events, there are some specific factors that can accumulate to make a child more vulnerable and these factors may change as a child develops.

Resilience protects and promotes children and young people's health, wellbeing, learning and development. When children are resilient, they can overcome difficulties and have the skills to adapt to adversity and change.

Disadvantage affects a number of families, children and young people, through economic insecurity, living in areas of socio-economic disadvantage, through circumstances such as being a single parent or having a disability or having a change in circumstance, like a significant health issue or death in the family. However disadvantage and vulnerability do not always go hand in hand. The Australian Early Development Census (AEDC), a measure of early childhood development for children commencing school, finds that children from all levels of social and economic advantage are facing vulnerabilities in their development.

For families, children and young people, there are measurable protective and risk factors for resilience and vulnerability. Protective factors enhance their resilience; risk factors generally make them more vulnerable. Protective factors include living in a family with economic security, attending kindergarten in the year before school, feeling connected and safe at school, and having parents who avoid risky behaviours such as drinking at harmful levels or using illicit drugs. Depending on the age of the child, risk factors could include a parental history of illness including mental illness, not using Maternal and Child Health (MCH) services, absenteeism from school, death of a family member, or not being in the workforce, training or education.

For children and young people, there are also critical periods when risk and protective factors have the greatest influence on their development. These periods include transitions, for example, from early childhood services to school, or from primary to secondary school, and during adolescence when risk-taking behaviours increase. For parents, risk and protective factors influence their capacity to care, protect and provide for their children. Families can be placed on a spectrum of vulnerability and resilience, with some families more able to cope with stressors than others.

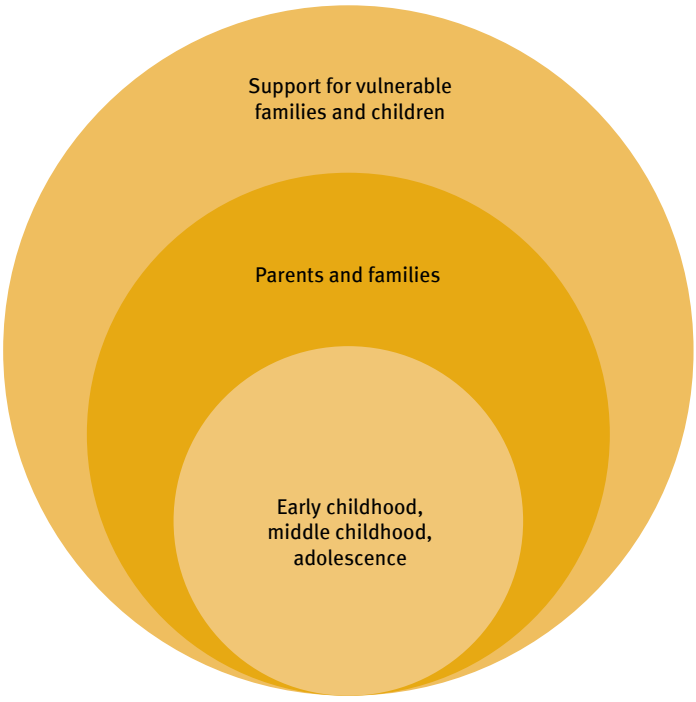
The most vulnerable families, children and young people in Victoria are exposed to greater risks, often in a combination of factors, and have fewer protective factors working for them. Generally, some groups of children are more likely to be exposed to a higher number of risk factors, such as those who are Aboriginal, come from low socio-economic areas, have a disability, are refugees or have recently arrived in Australia.

When disadvantage and risk factors for children, young people and parents are not counter balanced by protective factors, agencies and services have an important role to play. Such services include universal health and education services and more targeted services that support families. In the most extreme cases statutory child protection services may be required to intervene to prevent further abuse or neglect.

## Structure of the report

The report uses an ecological framework for human development to examine vulnerability, disadvantage and resilience. It places the child or young person at its centre, highlights the times in their lives when key risk and protective factors are most influential, and acknowledges the fundamental influence of family, community and society on outcomes for children and young people.

Figure 1: Model for child development




Through the findings of this report, government agencies and services will gain a more complete picture of the strengths and challenges facing children, young people and their parents. It will enable them to identify services, support and activities that could be extended or strengthened to provide better outcomes for Victoria's children and young people.

## Demographic context

Victoria was estimated to be home to more than 1,250,000 children and young people aged 0 to 17 in 2013. Around 1.3 per cent (or 16,000) were Aboriginal, around 8 per cent (or 100,000) were born overseas and around 2 per cent (or 25,000) required assistance with core needs indicating that they had a profound disability.

Only 11.6 per cent of Victorian children and young people live in the most socio-economically disadvantaged geographical areas in Australia (the bottom 20 per cent of areas) whereas 26.8 per cent live in the most advantaged areas (the top 20 per cent of areas). An estimated 24 per cent are listed on a Health Care Card indicating some form of disadvantage or parental ill health or disability.

Victoria's children and young people are more likely to live in a couple family (80 per cent) compared to other family types, and have parents born in Australia. Around 13 per cent of the parents of government school students are born outside Australia and 30 per cent speak a language other than English at home.

# Key findings

Although the majority of Victoria's children and young people have positive outcomes in terms of their health, safety, learning and development, a notable proportion of children and young people, face greater challenges often due to disadvantage. Outcomes for Aboriginal children and young people, for those who live in the most disadvantaged areas, those who interact with the child protection system and those who live in Out-of-Home-Care (OOHC) are generally poorer than those of their peers. Outcomes for children from Culturally and Linguistically Diverse (CALD) backgrounds or regional areas are however more mixed than children from other backgrounds or metropolitan areas.

Children in Victoria generally get a good start in life. They are born healthy, have high rates of participation in universally available services and transition to school successfully. The majority of Victoria's young people have a positive experience of school and develop the skills and resilience they need for adult life. This however is not true for all.

Aboriginal children and young people, for example, have poorer early childhood outcomes across a range of measures such as birth weight, immunisation, use of MCH services, kindergarten participation, engagement and safety at school, absenteeism, and participation and performance in national tests. Their families also experience higher levels of stress, and more commonly have a history of parental mental illness, abuse, gambling and drug and alcohol problems. In particular, interaction with the child protection system is an issue for Aboriginal children and young people, who are nearly seven times as likely to have a child protection substantiation and ten times as likely to be in OOHC. Some improvements have been made, for example, higher numbers of Aboriginal young people are completing Year 12 and transitioning to higher level qualifications.

Children and families living in disadvantaged areas and who are listed on Health Care Cards consistently report poorer outcomes on a range of measures relating to risk. For example, the parents of children who are listed on a Health Care Card are more likely to report that their child has socio emotional and behavioural difficulties. These parents are also less likely to report that their family has healthy functioning and that they have someone to turn to, or can access support in times of need. It should be noted however that this lack of social support may be due to being a sole parent rather than other aspects of disadvantage.

While children who live in regional areas are more likely to be born with low birth weight, they also have higher rates of attendance at MCH visits. The parents of children living in regional areas are also more likely to report that their child enjoys good or excellent health.

Children from CALD backgrounds generally do less well on national achievement tests such as the National Assessment Program Literacy and Numeracy (NAPLAN) than their peers in Year 3, however by Year 9 they are outperforming these students. This pattern does not extend to students who are believed to be refugees who are less likely to be performing in the top levels of NAPLAN than their peers.

Although some groups of children are more disproportionately affected than other children, risk factors exist for all children and all families. Instances of developmental vulnerability have been found to occur in communities of all levels of advantage, and experience of family stress is reported by all families of Prep children regardless of socio-economic status.

# Lifecycle stages

## Early childhood

Although most Victorian children are born healthy and receive the support they require from their families and from services in infancy, more can be done to give disadvantaged or vulnerable children the best start in life.

A child's development can be thought of as a scale, tipping towards either positive or negative development outcomes. Positive factors like responsive and stable caregiving and strong learning opportunities are stacked on one side, and negative factors like neglectful parenting, family violence and unmet higher needs are piled on the other.

A poor start in life writes itself into the brains of very young children, in ways that are very difficult to overcome later. Left unaddressed, vulnerability can severely reduce people's chances of a fulfilling, healthy and productive life, with knock on effects on welfare, health and justice services, and GDP.

Executive function and self-regulation are largely developed before the age of five – that is, our working memory, mental flexibility and self-control. Optimising these abilities has never been more important, given these are precisely the qualities demanded to actively participate in a progressive society and an advanced economy.

Victoria's universal MCH service means that nearly all children receive a home visit following birth, but only two-thirds attend the 3.5 year check. Of concern is the fact that Aboriginal children are less likely to use this important service than other children with a strong drop-off occurring by the 3.5 year check. This is particularly concerning as the MCH service is a platform for identifying vulnerability. For example, in 2013-14 MCH nurses identified that 8 per cent of children who attended their 3.5 year old Key Ages and Stages visit had an oral health issue, and referred them to further support.

Early learning plays a critical role in a child's development. Participation in early education services such as kindergarten is high with the majority of Victorian children participating in kindergarten in the year before school. The Australian Early Development Census (AEDC) indicates that children who did not attend kindergarten are more likely to be developmentally vulnerable in the year before school. It also shows that more disadvantaged children, such as Aboriginal children, those from lower socio economic areas and those who are not yet proficient in English are the least likely to attend kindergarten.

A number of factors affect children in the transition to school including speech and language difficulties, social and emotional development and a lack of English proficiency. These children are more likely to experience difficulties with learning and to perform less well than their peers in national tests. In the 2013 Victorian School Entrant Health Questionnaire 13.8 per cent of parents reported their child had a speech or language difficulty. This was highest for males, Aboriginal children and children from the most disadvantaged areas.

## Middle childhood and adolescence

While most Victorian adolescents have positive outcomes, risk factors that have a negative impact can emerge in middle childhood and adolescence. This includes wellbeing and engagement issues that can have a long lasting effect into adulthood.

Very few young Victorians meet daily physical activity guidelines. Risky health behaviours such as smoking, alcohol use and use of illicit drugs begin in adolescence. For Victorian teens, alcohol use is higher than smoking and illicit drug use. While small numbers of young people report having sex, less than two-thirds report always using a condom.

Connections to peers and adults are important moderating influences to risky behaviours. While most Victorian government school students feel that they belong and enjoy school, and are socially connected to their peers, perceptions of teacher empathy decrease as students move through school. Motivation is lower for Aboriginal students and decreases for all students as they age. Most students feel safe at school, however this is noticeably lower for Aboriginal students and those with a disability. Aboriginal students are also more likely to agree that they have been bullied.

Positive psychological development is another important protective factor. While most Victorian adolescents have positive psychological development, a small proportion report very high levels of psychological distress. Around 10,000 young Victorians use Child and Adolescent Mental Health Services or Child and Youth Mental Health Services and since 2007, rates of presentation and admission to hospital for mental health issues have risen. Increases have been seen in hospital admissions for intentional self-harm, emergency treatment for psychosocial reasons, and hospitalisation for psychosocial reasons.

Young people are over-represented as offenders and victims of crime. These crimes include assault and crimes against property and are much more likely to be committed by males than females. The use of cautions for juvenile offenders has gradually decreased since 2009–10 from 25 per cent of processing to 17 per cent. Importantly, the youth offender rate and the rate of young people in juvenile justice facilities also decreased slightly, while the rate of young people on community based orders has fluctuated in recent years.

Absenteeism is a significant risk factor and signifier of risk for students. On average, government school students miss around 14 to 15 days of school each year, peaking at around 20 days in Years 8, 9 and 10. Absenteeism is much higher for Aboriginal students and those in OOHC. In Year 3, these cohorts have equal levels of absenteeism to their peers, but from Year 5, higher levels of absenteeism occur. In contrast, language background other than English (LBOTE) students, including those that are likely refugees, have much lower absenteeism across all year levels.

These patterns of absenteeism apply to approved and unapproved absences. In primary school around a third of absences are unapproved but this rises to 50 per cent in the later secondary years. Unapproved absence is highest for Aboriginal students and OOHC students particularly in years 8, 9 and 10. In addition, a small number of children are suspended from government schools each year. This is very low in primary school (less than two per cent) but rises to around ten per cent of boys and four per cent of girls in Years 8 and 9. Aboriginal students have much higher rates of suspension than their peers across all year levels, but particularly in years 7, 8 and 9.

While Victoria's children and young people perform well in Year 3 on NAPLAN, they do not gain at the expected rate up to Year 9. Student performance is, however, variable. The performance of LBOTE students in government schools improves as they progress through school. They also have lower rates of absence from NAPLAN tests than their peers. Conversely, Aboriginal students and those in OOHC show lower performance as they age and also have much higher rates of absence from the NAPLAN test. While likely refugee students have low levels of absenteeism, their NAPLAN results are lower than their peers. This may reflect the age at which they entered Australia, with children starting in Prep more able to catch up to their peers by Year 3.

The 2011 Australian Bureau of Statistics Census of Population and Housing indicates that a very small number of Victorian 15 and 16 year olds are no longer in education and training (1.8 per cent and 4.2 per cent respectively), rising to 9.5 per cent for 17 year olds. Nearly half of the 17 year olds not in education and training were working either full-time (2.9 per cent) or part-time (1.6 per cent) with 1.7 per cent looking for either full-time or part-time work. Around 3,800 were not in the labour force. The reasons for this are unclear: it is possible that for some it may be due to ill health or family/caring responsibilities, or it may be that these young people are not considering entering the labour force. These figures have decreased since 2006 and are lower in Victoria than Australia overall.

The Year 12 or equivalent attainment rate has increased between 2009 and 2013 to 86.9 per cent. The numbers of Aboriginal students completing Year 12 or equivalent has also risen. The majority of these Year 12 completers move into Bachelor Degrees, Certificate/Diploma courses or employment. Higher numbers of Aboriginal students are undertaking Bachelor degrees, and vocational Certificates and Diplomas than in past years.

## Parents and families' influence

Some families face challenges due to a lack of economic security, social support, changes in circumstance (health issues, loss of a family member) or due to risky parental behaviours. While most Victorian families with children are able to get help in time of need and emergency, and are actively involved in their community, economic insecurity is a reality for some families. These families are more likely to have run out of food, have a lower ability to raise emergency funds when necessary, and have a greater experience of housing stress (and in some cases homelessness).

Family stress can also affect children and their families. While high levels of family stress are more common in Aboriginal families, economic security does not influence stress levels. Parents in the most advantaged areas are just as likely to report stress as those from disadvantaged areas.

A small number of children enter school each year with a history of family risk including parental mental illness, a history of witnessing or experiencing abuse of a parent or child, gambling, and alcohol and drug problems. These risk factors are more common for Aboriginal children and for children in the most disadvantaged areas.

The risk factor that most commonly affects Victorian families with a child entering school is a history of parental mental health issues (6.5 per cent). While most Victorian parents of school aged children report low levels of psychological distress, single parents are five times more likely to have a high risk of mental health issues. In 2010, nearly 10,000 parents accessed clinical mental health services.

Risky parental health behaviours include drinking, smoking and drug use. Fourteen per cent of parents with school-aged children report drinking at risk of short-term harm, and 2.5 per cent report drinking at levels of long-term harm. Drinking in pregnancy has decreased but is higher for women living in the most advantaged areas. Drinking is most common in women before they become aware of their pregnancy. Around 17 per cent of parents of school-aged children smoke and around 5,800 clients of Victorian drug and alcohol services are parents.

Family violence is an issue of concern for Victorian families with over 65,000 incidents submitted by Victoria Police in 2013–14. Children are present at around 35 per cent of family violence incidents each year, a trend that has remained relatively stable since 2009–10. There has been a substantial increase in the number of charges laid for family violence incidents, which rose from 26 per cent in 2009–10 to 45 per cent in 2013–14.

The majority of Victorian prisoners are also parents. Data from July 2014 indicates that 71 per cent of female prisoners are parents and 53 per cent of male prisoners are parents.

## Support services for vulnerable children and their families

Where the combination of disadvantage and risk factors for children and parents are not counter-balanced by protective factors, there is a greater need for targeted services and interventions. The Victorian Government provides a range of services to support disadvantaged and vulnerable children and families ranging from targeted services which build on universally available early childhood services, through to the child protection system for the most vulnerable children.

Targeted services in early childhood include Enhanced MCH in the first year of life and Early Start Kindergarten for eligible three-year-olds and supported playgroups. Provision of Enhanced MCH has remained stable, fluctuating around 16 per cent each year. Uptake of Early Start Kindergarten has increased following extensive work to improve access to three year-olds who are Aboriginal or known to child protection, although there is more to be done to capture all eligible children.

The Department of Health and Human Services provides Family Support Services for vulnerable families with 29,441 families using the service in 2012–13. Child and Family Information, Referral and Support Teams (Child FIRST) services also assist vulnerable families and children to receive the support they require. The number of assessments and interventions undertaken by Child FIRST has increased to 12,142 in 2013–14.

Public awareness of abuse and the changes to mandatory reporting may have contributed to progressive increases in child protection reports. In 2013–14 there were 56,515 reports, a rate of 44.6 per 1,000 for all children and 186.3 per 1,000 for Aboriginal children. Investigation times for reports have improved, with a third completed within 28 days or less and more than half completed in 62 days or less.

The increase in reports has contributed to a commensurate rise in substantiations in 2013–14 to 9 per 1,000 for all children and 60.3 per 1,000 for Aboriginal children. As at 30 June 2014, 7,710 children and young people were in OOHC, a rate of 6.1 per 1,000 of all children and 62.7 per 1,000 or 1,308 Aboriginal children.

The large number of Aboriginal children in child protection remains a significant issue with substantial work undertaken to ensure they remained connected to their families and communities while in care. The number of Aboriginal children placed in accordance with the Aboriginal Child Placement Principle has increased to 66.9 per cent in 2014. In August 2014, 55 per cent of Aboriginal children of Guardianship or long term Guardianship orders had a draft (partially completed) or finalised Cultural Support Plan.

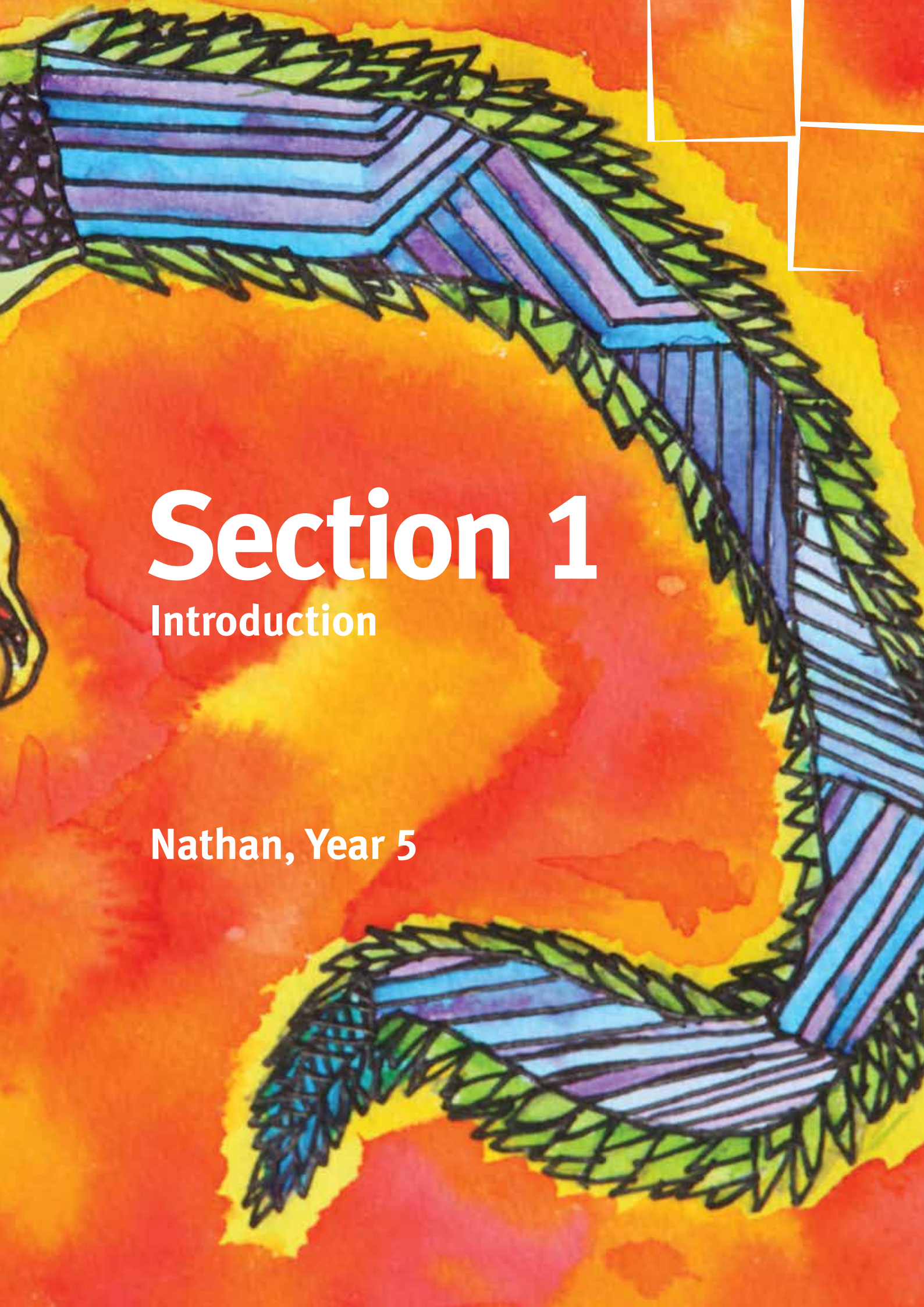
Improvements in Children's Court practices including the use of a new mediation model have been important in providing vulnerable families with support services. Clearance rates for cases in the Family Court have improved to almost 96 per cent in 2013.

# Conclusion

Although most Victorian families with children are doing well, and have community support and economic security, too many face challenges from economic insecurity, changes in circumstance and the presence of risk factors such as substance misuse, family violence and abuse. For these families, more targeted support services are required to build resilience.

While many challenges still remain for disadvantaged and vulnerable children and their families, the Education State reform will attempt to redress imbalance through

- all Victorians having the understanding and attributes to shape their futures in a changing world regardless of their location, background and circumstance
- an education system characterised by cohesion and consistent quality, with no weak spots or cracks to fall through – from birth, children and their families will be supported to thrive through their first thousand days, through their schooling years and onto their first career and subsequent careers
- being known as a place where education is recognised by all, as an accessible and powerful force for personal, social and economic renewal



# Section 1

## Introduction

Nathan, Year 5

# Introduction

Artwork by Panayiota, Year 6


Artwork by Asher, Year 3

## Victoria's vulnerable children, young people and their families

In recent years, outcomes for Victoria's most vulnerable children and young people have become a matter of increasing public interest and concern. The Protecting Victoria's Vulnerable Children's Inquiry noted that while the:

> 'vast majority of Victoria's children and young people live in families where they are loved, cared for and encouraged ... a significant number of Victoria's children and young people are not as fortunate.' [1]

In order to provide the fullest picture of outcomes for vulnerable children and young people, progress towards achieving these outcomes is reported in the context of the ecological framework. This includes a summary of resilience (protective factors) and vulnerability (risk factors) and how these factors influence children and young people at each stage of their development. The report also considers risk and protective factors within the family environment as well as summarising some of the key universal and targeted services which support these families.

Where possible, the report also includes cohort data to provide a picture of the risk and protective factors that may have a greater impact on some groups of children and young people. These groups include Aboriginal children, children with a disability or developmental delay, children from a CALD background, children experiencing socio-economic disadvantage and children in Out-of-Home Care (OOHC).

The report chapter structure is provided on page 4.

# Vulnerability, resilience and disadvantage

Children's vulnerability is defined here as the extent to which they are susceptible to harm from risks and challenges in their environment. It can be placed on a spectrum, influenced by a range of risk and protective factors. Individual, parenting, economic, and social factors all influence children's vulnerability and their capacity to resist, cope with and recover from challenges and risks. At the extreme end, Victoria's most vulnerable children experience, or are at immediate risk of, abuse and neglect.

There is no universal definition of resilience as the concept has been developed and elaborated over time and in different contexts. It is, however, generally described as a capacity to overcome the odds. A resilient individual has:

- personal strengths and the capacity to withstand adversity
- coping mechanisms, despite multiple and ongoing negative circumstances
- the capacity to recover from trauma.[2]

The factors that promote resilience in children have been identified by research into child development. Studies highlight the importance of individual factors such as personal traits and attributes, and their interconnectedness with factors external to the individual.[3]

Disadvantage presents in a number of ways: through SES (living in the most disadvantaged areas), elements such as being a sole parent, Aboriginal or in out of home care, show poorer outcomes, indicating a disadvantage of starting behind.

This report presents research and data associated with individual factors, and factors associated with family, community and society that may contribute to children's resilience and vulnerability.

## The relationship between risk and protective factors, and resilience and vulnerability

The interaction between risk and protective factors that produce positive or negative outcomes for children is complex and not fully understood. Nevertheless, when there are more protective factors in the child's life, there is a greater chance of resilience. Conversely, when more risks in a child's life occur at the same time, the child is more likely to be vulnerable and less able to cope.[4]

A child, young person or their family can change or influence many risk and protective factors. Speech and language difficulties, for example, or poor parenting skills, can be addressed through specific interventions. Very few risk and protective factors cannot be changed: examples include a child's innate temperament and age.

Just because there are specific risk factors in a child's life does not necessarily mean that they will eventually have a negative outcome or engage in negative behaviour. Rather, the risk or protective factors, through their influence on a child's life, can increase the probability or likelihood of a positive or negative outcome. No single risk or protective factor causes a particular outcome.[5]

# Structure of the Report

**Chapter 2 Demographics including:**

- key characteristics of Victoria's children and young people: age, cultural origin, socio-economic background, disability and special health care needs
- key characteristics of Victorian parents of children aged 0 to 17: cultural origin, family structure, employment levels, employment status, birth rates and teenage fertility rates.

**Chapter 3 Early Childhood risk and protective factors including:**

- low birth weight, breastfeeding, immunisation, child temperament and attachment, Maternal Child Health service use, and early education service use such as kindergarten participation
- at transition to school, developmental vulnerability, speech and language difficulties, general health, social competence, emotional behavioural difficulties and hospital admissions for injury and for psychosocial and maltreatment issues.

**Chapter 4 Middle Childhood and Adolescence risk and protective factors including:**

- risk taking behaviours, social support, psychological wellbeing, mental health issues, self-harming behaviours and hospitalisation for mental health issues
- interaction with Police and Justice as a victim of crime, as a young offender and through the youth justice system and Children's Court
- interaction with education including engagement with school, perceptions of safety and bullying, absenteeism, suspensions, educational outcomes and post school destinations.

**Chapter 5 Parents and Families' risk and protective factors which may affect children and young people including:**

- healthy family functioning, social support and inclusion, economic factors
- family stress and history of family risk factors such as poor parental mental health, poor parental behaviours, history of witnessing or receiving violence and abuse to parent or child.

**Chapter 6 Supports and Services used by vulnerable children and their families including:**

- health and education services such as enhanced MCH and Early Start Kindergarten
- Child FIRST and child protection services including OOHC
- Involvement with the Children's Court.

# Endnotes

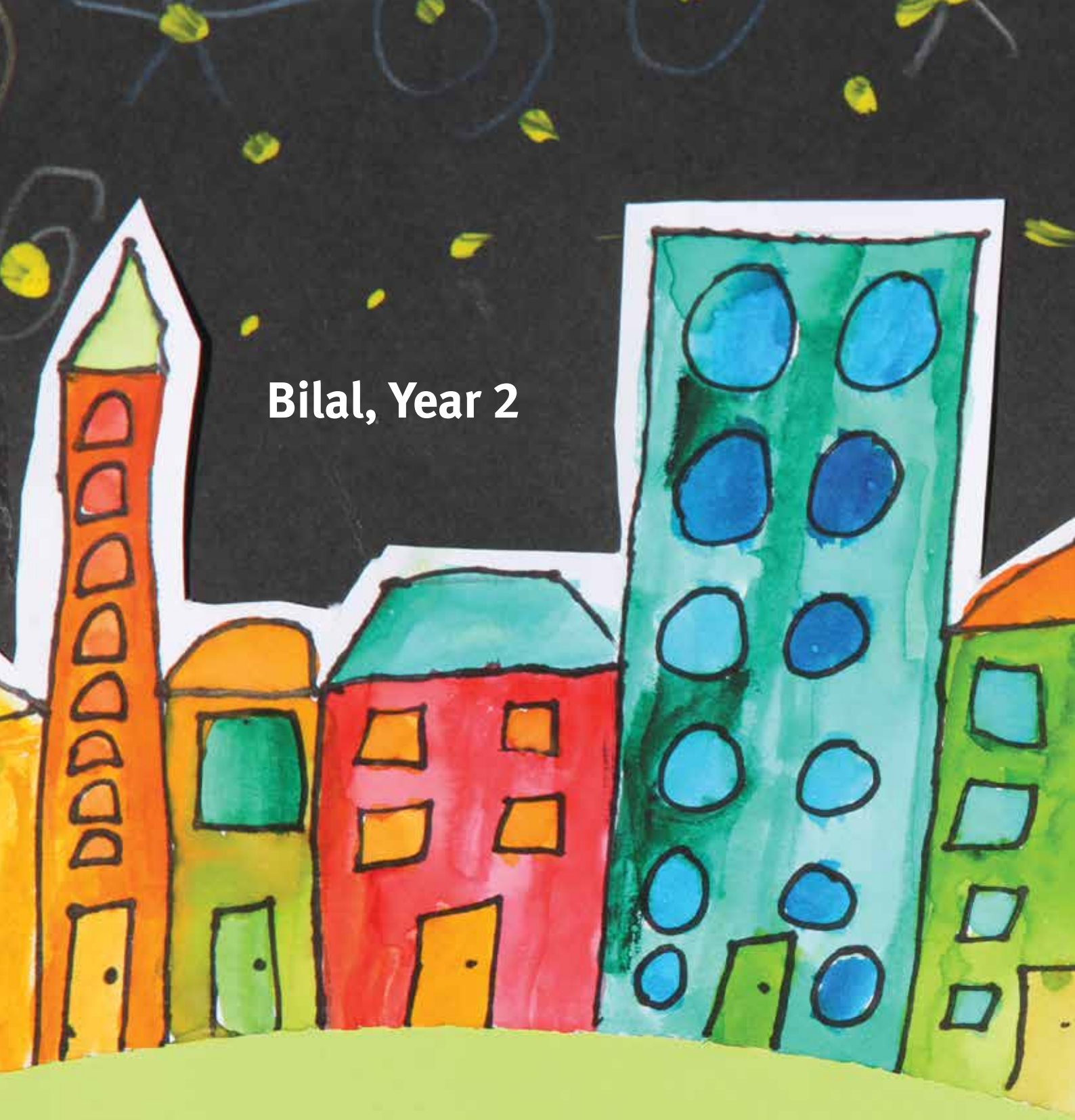
1 Department of Premier and Cabinet. (2012). Protecting Victoria's Vulnerable Children Inquiry, Volume 1, DPC, Melbourne. Accessed at: http://www.childprotectioninquiry.vic.gov.au/report-pvvc-inquiry.html on 12 March 2015

2 Hunter, S. (2012). Is resilience still a useful concept when working with children and young people? CFCA Paper No. 2. Australian Institute of Family Studies, Melbourne.

3 Seaman, P., McNeice, V.,Yates, G. & McLean, J. (2014) Resilience for public health, Supporting transformation in people and communities, Glasgow Centre for Population Health, Glasgow.

4 Hunter, S. (2012). Is resilience still a useful concept when working with children and young people? CFCA Paper No. 2. Australian Institute of Family Studies, Melbourne.

5 Department of Education and Early Childhood Development. (2011) State of Victoria's Children 2010, DEECD, Melbourne.




# Section 2

## Victoria's children, young people and their families

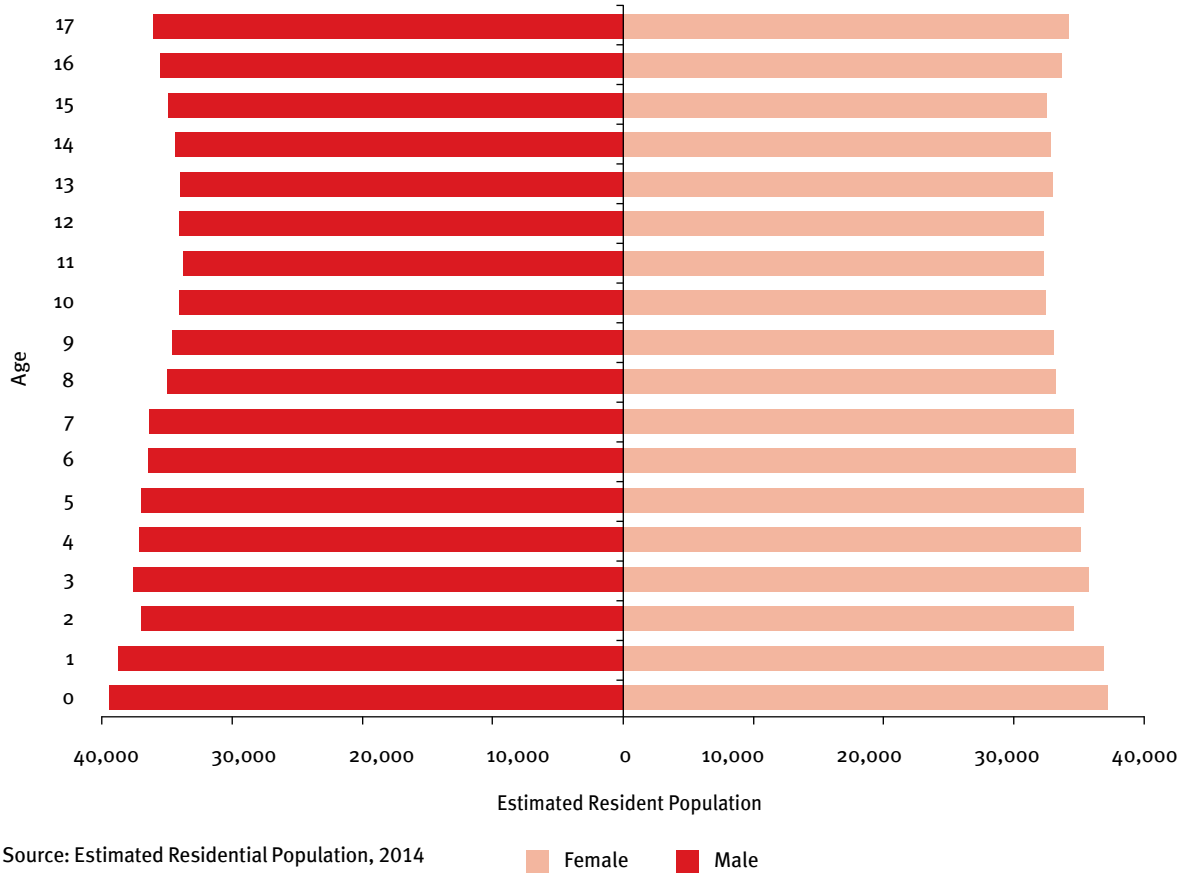
# Victoria's children, young people and their families

This chapter provides an overview of the number, growth, composition, locality and diversity of Victorian children and young people aged 17 and under. It also provides a picture of their family's structure, and parental background, employment and education.

## Victoria is home to nearly 1,258,000 children and young people

In 2013, Victoria was estimated to have 1,257,905 children aged between 0 and 17 (Figure 2.1). Most Victorian children and young people, 921,943 or 73.3 per cent, live in metropolitan areas while 335,962, or 26.7 per cent, live in rural and regional areas.

Figure 2.1: Number of children living in Victoria, by age and gender, 2013




Source: Estimated Residential Population, 2014

The 2013 population profile shows a greater number of younger children from birth to age 7. This contrasts with the population in 2003 in which there were 1,152,673 children aged 0 to 17 with higher numbers of children in the older ages (8 to 17).

This increase in the numbers of children aged 1 and under is reflected in the number of live birth notifications to Maternal and Child Health (MCH) which show that 76,422 children were born in Victoria in 2012–13, up from 75,158 in 2011–2012.

# Victoria's children and young people are diverse

The health, development, learning and safety outcomes of children and young people are influenced by the sub-population to which they belong. In this section, data for a number of groups are discussed, including Aboriginal children and young people, those from Culturally and Linguistically Diverse (CALD) backgrounds, those from regional and metropolitan areas, children and young people in Out of Home Care (OOHC) and children and young people with a disability.

## Victoria is home to nearly 16,000 Aboriginal children and young people

In the 2011 *ABS Census of Population and Housing* 15,855 Victorian children and young people were identified as Aboriginal and/or Torres Strait Islander.* Aboriginal children and young people make up around 1.3 per cent of the population aged 0 to 17, and 41.7 per cent of the overall Aboriginal population in Victoria. The total population of 0 to 17 year olds make up only 22.5 per cent of the total Victorian population.

These figures are up slightly from the 2006 census when around 13,000 children and young people reported being Aboriginal, comprising around 1.1 per cent of the total Victorian population.

While Aboriginal children and young people may face greater challenges than their peers, improvements are beginning to be seen against some key indicators. Work is being done to improve this through approaches such as the *Victorian Aboriginal Affairs Framework 2013–18* (VAAF) as detailed below.

The VAAF brings together Government and Aboriginal community commitments and efforts to create a better future for Victoria's Aboriginal population.

Significantly, the Framework recognises and values Aboriginal culture, integrates Government effort, and identifies the accountabilities of Victorian Government departments, agencies and funded service providers. This will enable more effective monitoring and evaluation of performance.

The VAAF focuses effort and resources on six strategic Action Areas that are central to closing the gap in Aboriginal disadvantage. It aims to improve Victorian Government effort and reform in Aboriginal disadvantage as well as improving Victorian Government effort and reform in Aboriginal affairs by:

- building prosperity through economic participation
- protecting and supporting vulnerable children and families
- ensuring access to services that meet the needs of Aboriginal people across the State.

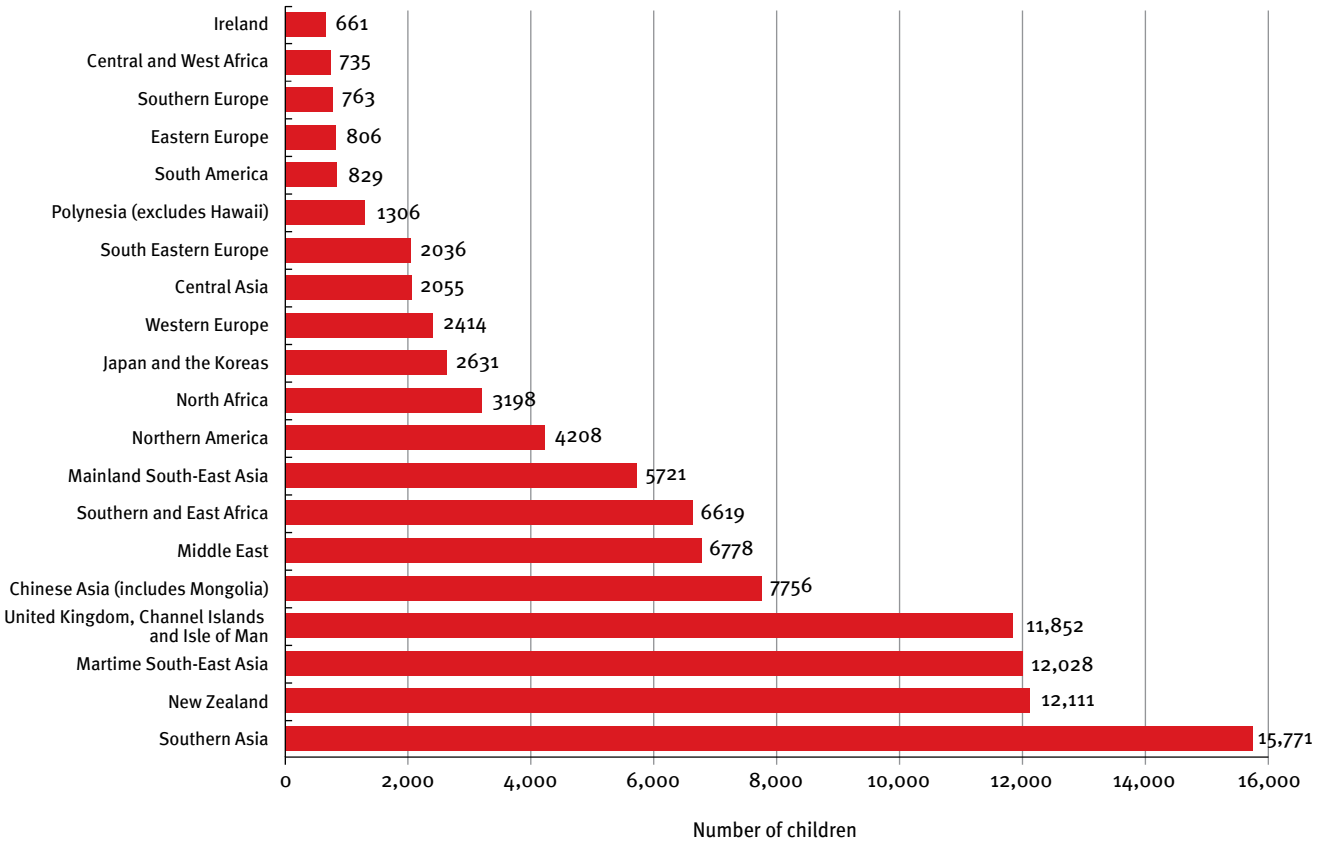
http://www.dpc.vic.gov.au/index.php/aboriginal-affairs/aboriginal-affairs-policy/victorian-aboriginal-affairs-framework

* Note: Throughout this report the term Aboriginal is used for the sake of consistency however individual data collections may use alternative terms.

## Victoria has many children from a Culturally and Linguistically Diverse background

Victorian children and young people come from a wide range of family backgrounds. In 2011, 101,261 or 8.4 per cent of Victoria's children and young people identified that they were born outside Australia (Figure 2.2). Most of these children were born in Southern Asia (15,771), New Zealand (12,111), Maritime South East Asia (12,028), the United Kingdom (11,852) and Chinese Asia (7,756).

Figure 2.2: Number of Victorians aged 0 to 17 born outside Australia, by top 20 birth regions, 2011




Source: ABS Census of Population and Housing, 2011

Victorian children and young people mostly speak English, with 77 per cent indicating they only speak English at home.[1] The most commonly spoken languages other than English include Vietnamese, Arabic, Mandarin and Greek.

The Department of Education and Training (DET) estimates that around 9,432 Victorian government school students in 2014 are from refugee backgrounds. This estimate is based on demographic data including how long the students have been enrolled in an Australian school (less than seven years), their country of birth, their main home language, and/or their visa category.

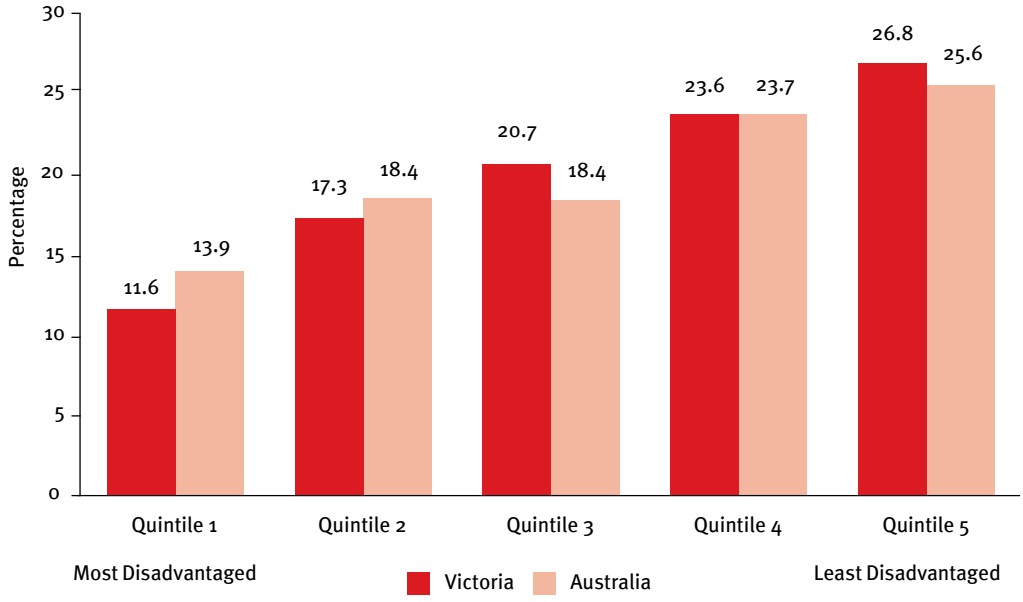
Section 02

## One in nine Victorian children live in areas of comparative socio-economic disadvantage

The Index of Relative Socioeconomic Disadvantage (IRSED) is used by the Australian Bureau of Statistics to consider the relative disadvantage of areas using a range of measures relating to income, housing, educational attainment, occupation, and proficiency in English. Quintile one describes the most disadvantaged areas in Australia overall and quintile five the least disadvantaged overall.

Figure 2.3 indicates that Victorian children and young people are more likely to live in the more socio economically advantaged areas (quintiles 3 to 5) than other Australians aged 0 to 17. However, one in nine children live in the most disadvantaged 20 percent of areas in Australia (11.6 percent in quintle 1)

Figure 2.3: proportion of 0 to 17 year olds by quintile of relative socioeconomic disadvantage, Victoria and Australia 2011




Source: ABS Census of Population and Housing, 2011

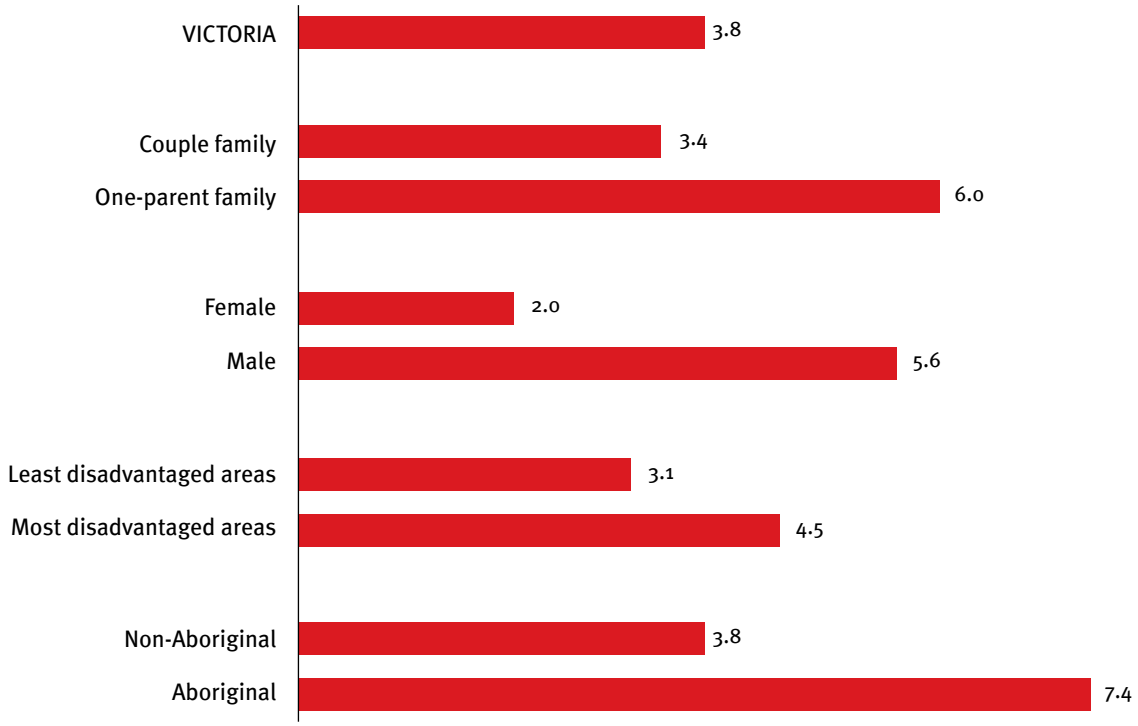
The Health Care Card is another indicator of socio economic disadvantage. Eligibility for a Health Care Card is determined by the eligibility (and registration) for various federal government welfare payments, or by low income thresholds. A Health Care Card will generally cover an individual's whole family (self, partner and children). An estimated 24 per cent of Victorian children aged from birth to twelve years are listed on a Health Care Card.[2]

## Children and young people with a disability

Children and young people with disabilities may face greater challenges in their development and may be at greater risk of harm. The 2011 ABS Census of Population and Housing indicates that over 25,000 children aged 0 to 17 years need assistance with core activities; 66 per cent of these children are over eight years old.

Around four per cent of parents of children entering primary school report that they have been told their child has an intellectual disability, learning disability or developmental delay (Figure 2.4). This is consistent with the number of Victorian government school students receiving assistance from the Program for Students with a Disability. Aboriginal children (7.4 per cent), males (5.6 per cent), children from the most disadvantaged areas (4.5 per cent), and children from one parent families (6.0 per cent) were more likely to have an intellectual disability, learning disability or developmental delay.

Figure 2.4: Proportion of children entering school with an intellectual disability, learning disability or developmental delay, 2013




Source: School Entrant Health Questionnaire, DET, 2013

The Department of Health and Human Services (DHHS) *Child and Family Service Outcomes Survey* 2012 found that more children accessing support services had a learning difficulty than the total population. The proportion was 27 per cent in Family Services, 28 per cent in Child Protection and 19 per cent in OOHC.[3] While the number with an intellectual disability was more difficult to gauge, the high proportion of these children who attend special schools suggests than many have more profound disability. For example, the proportion of Child Protection children attending special needs schools in 2011 was five times that of Victorian children. For Family Services it was more than six times, and for OOHC more than 11 times.[4]

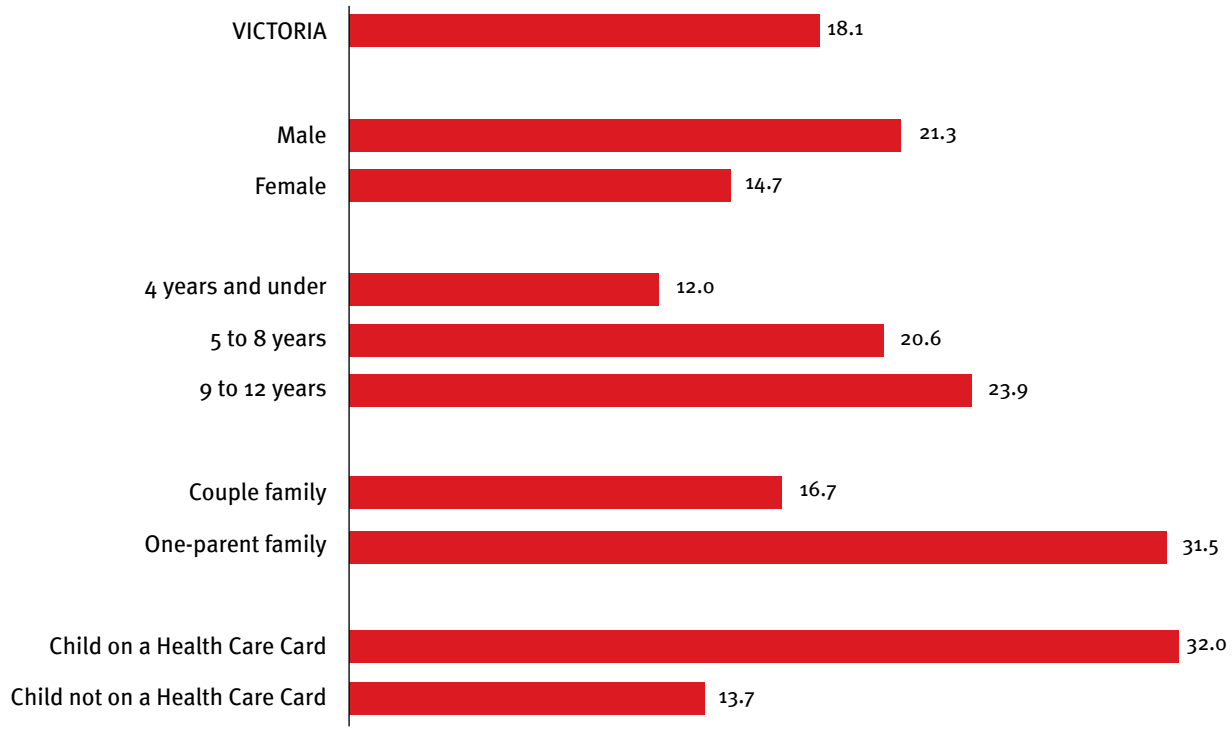
Section 02

## Children and young people with special health care needs

A special health care need is not based on a specific medical diagnosis. Rather, it is used to identify children who have increased service needs regardless of their specific diagnosis.[5] For example, children with conditions such as asthma, diabetes, birth defects, autism, cerebral palsy and mental illness have special health care needs. These needs include dependence on medication, functional limitations, and requiring or using more services (such as counselling and therapy) than is usual for children of their age. These children have an increased risk of chronic medical, developmental, behavioural or emotional conditions, and they rely on more complex services to ensure that they get the best possible care.

The Victorian Child Health and Wellbeing Survey (VCHWS) gives a picture of parental perceptions of the special health care needs in children aged 0 to 12 (Figure 2.5). Special health care needs are lowest from birth to 4 years of age (12 per cent). They increase to 20.6 per cent at 5 to 8 years, and 23.9 per cent at 9 to 12 years. Overall, special health care needs are highest for children on Health Care Cards (32 per cent), in one-parent families (31.5 per cent) and for boys (21.3 per cent).

Figure 2.5: Proportion of children aged 0 to 12 years with special health care needs, 2013




Source: Victorian Child Health and Wellbeing Survey, DET, 2013

# Victorian families are diverse

## Parents of Victorian children come from many countries other than Australia

The parents of Victorian government school students come from many countries (Table 2.1). Nearly 492,000 parents were born in Australia with 13.3 per cent being born outside Australia. The five most common countries of origin other than Australia were New Zealand, China, India, the United Kingdom, and the Philippines.

Table 2.1: Top twelve countries of birth for parents of Victorian government school students, 2014

| Country of birth other than Australia | No. of parents |
|---|---|
| New Zealand | 10,268 |
| China | 6,670 |
| India | 6,593 |
| United Kingdom | 3,626 |
| Philippines | 3,161 |
| Sri Lanka | 2,761 |
| Malaysia | 2,504 |
| Afghanistan | 2,447 |
| England | 2,325 |
| Vietnam | 2,104 |
| Thailand | 2,065 |
| Iran | 1,747 |

Source: Department of Education and Training enrolment system, CASES21, 2014

Section 02

## Parents of Victorian children speak a wide range of languages

Victorian children are exposed to a wide range of languages other than English with around 30 per cent of parents of government school students speaking a language other than English in the home. Arabic and Vietnamese are the two languages other than English most commonly spoken by the parents of Victorian Government school students followed by Chinese dialects (Mandarin, Cantonese, Chinese) and Greek (Table 2.2).

### Table 2.2: Top twelve languages other than English spoken by parents of Victorian Government school students, 2014

| Language other than English spoken at home | No. of parents |
|---|---|
| Arabic | 11,880 |
| Vietnamese | 11,629 |
| Manadarin | 7,437 |
| Greek | 7,210 |
| Chinese nfd * | 6,501 |
| Cantonese | 5,429 |
| Hindhi | 4,763 |
| Turkish | 4,447 |
| Sinhalese | 4,149 |
| Samoan | 4,034 |
| Dari | 3,619 |
| Macedonian | 2,905 |

Source: Department of Education and Training enrolment system, CASES21, 2014

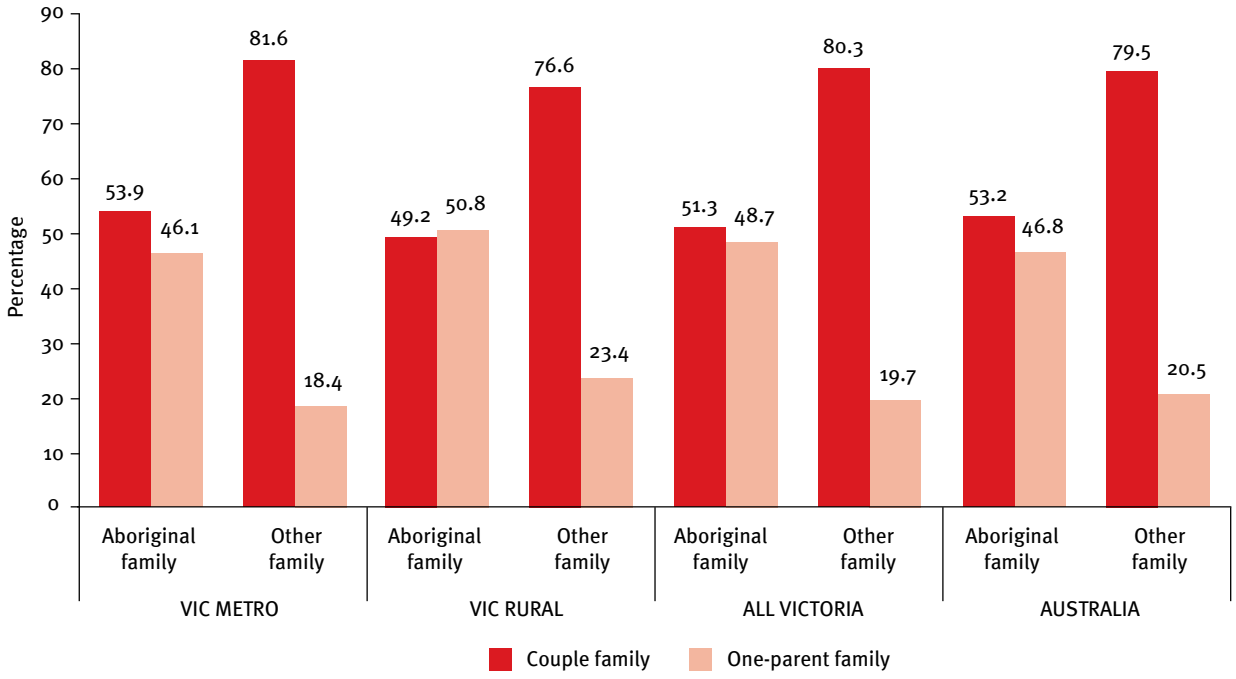
*Chinese in this context relates to Chinese not further defined

## One in five Victorian children live in one-parent families

Victoria's population includes a broad range of family types including married, cohabiting, step, blended and one-parent families.[6]

Most Victorian families with at least one child aged 0 to 17 in 2011 were couple families – around 489,592 (79.9 per cent) compared to 123,545 one-parent families (19.1 per cent). Figure 2.6 indicates that couple families are more common in metropolitan areas and in non-Aboriginal families. While one in five children live in one-parent families, this is the case for almost half of Aboriginal children.

Figure 2.6: Proportion of one-parent and couple families who have at least one child aged 0 to 17 years, Victoria and Australia, 2011




Source: ABS Census of Population and Housing, 2011

In general, one-parent families are more likely to be socio-economically disadvantaged than couple families, and to experience higher unemployment, lower income and greater financial stress.

Section 02

## Victorian fertility rate has been stable since 2003

Although the number of live birth notifications to MCH services has risen to an all-time high, the fertility rate has remained steady at between 1.7 and 1.9 per 1,000 women. The fertility rate is highest in the 30 to 34 age group (124.2 per 1,000 women) and the 25 to 29 year age group (88 per 1,000 women).[7] The fertility rate for Aboriginal mothers has increased since 2003 from 1.7 per 1,000 Aboriginal women to 2.2 in 2013, peaking at 2.4 in 2007. In general, Aboriginal mothers have their children at younger ages than other mothers in Victoria.

## Teenage mothers may face greater challenges than older mothers

Australian research indicates that teenage mothers are more likely to form one-parent families and to live in areas of greater disadvantage.[8] Teenage motherhood has been found to pose significant 'long-term risks for both mother and child, including poorer health, educational and economic outcomes.' [9] However it is important to note that 'while not all teenage births result in negative outcomes for mother and child, the factors that often contribute to teenage birth mean that many young mothers do not receive the support they need during pregnancy and after the birth.' [10]

Aboriginal teenage women are around six times more likely than other women of the same age to become pregnant (Figure 2.7). These mothers are more likely to face risks of poorer birth outcomes, discontinuing their education and subsequent unemployment and poor housing conditions.[11]

Figure 2.7: Rate per 1,000 of live births to women aged under 19 years, Victoria, 2008 to 2012


Source: Department of Health and Human Services (accessed via VCAMS)

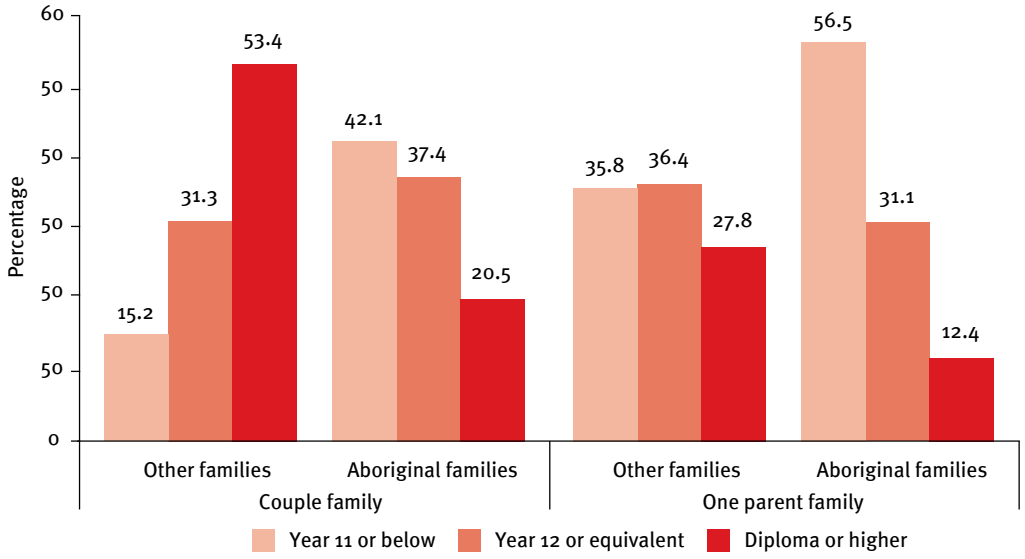
While being a 'teenage parent' does not necessarily mean that an individual or their children will have difficulties, there is evidence that many young people who become parents while they are still adolescents face significant challenges throughout their lives.[12] Support from extended families, friends and the wider community, including schools and other education services, can assist young parents to successfully face these challenges while raising their children.

## Education levels of parents vary by family structure

Parents in couple families with children aged 0 to 17 in Victoria have the highest levels of education with 53.4 per cent having achieved Diploma level or higher qualifications (Figure 2.8). Parents in one-parent families are more likely to have Year 11 (35.8 per cent) or Year 12 (36.4 per cent).

Education levels are lower for Aboriginal parents, particularly those in one-parent families where only 12.4 per cent have achieved a Diploma or higher qualification. Overall, Aboriginal parents in couple families have a higher profile of educational attainment with 20.5 per cent having achieved a Diploma or higher and 37.4 per cent having achieved Year 12 or equivalent.

Figure 2.8: Educational attainment of families with at least one child aged 0–17, Victoria, 2011




Source: ABS Census of Population and Housing, 2011

Section 02

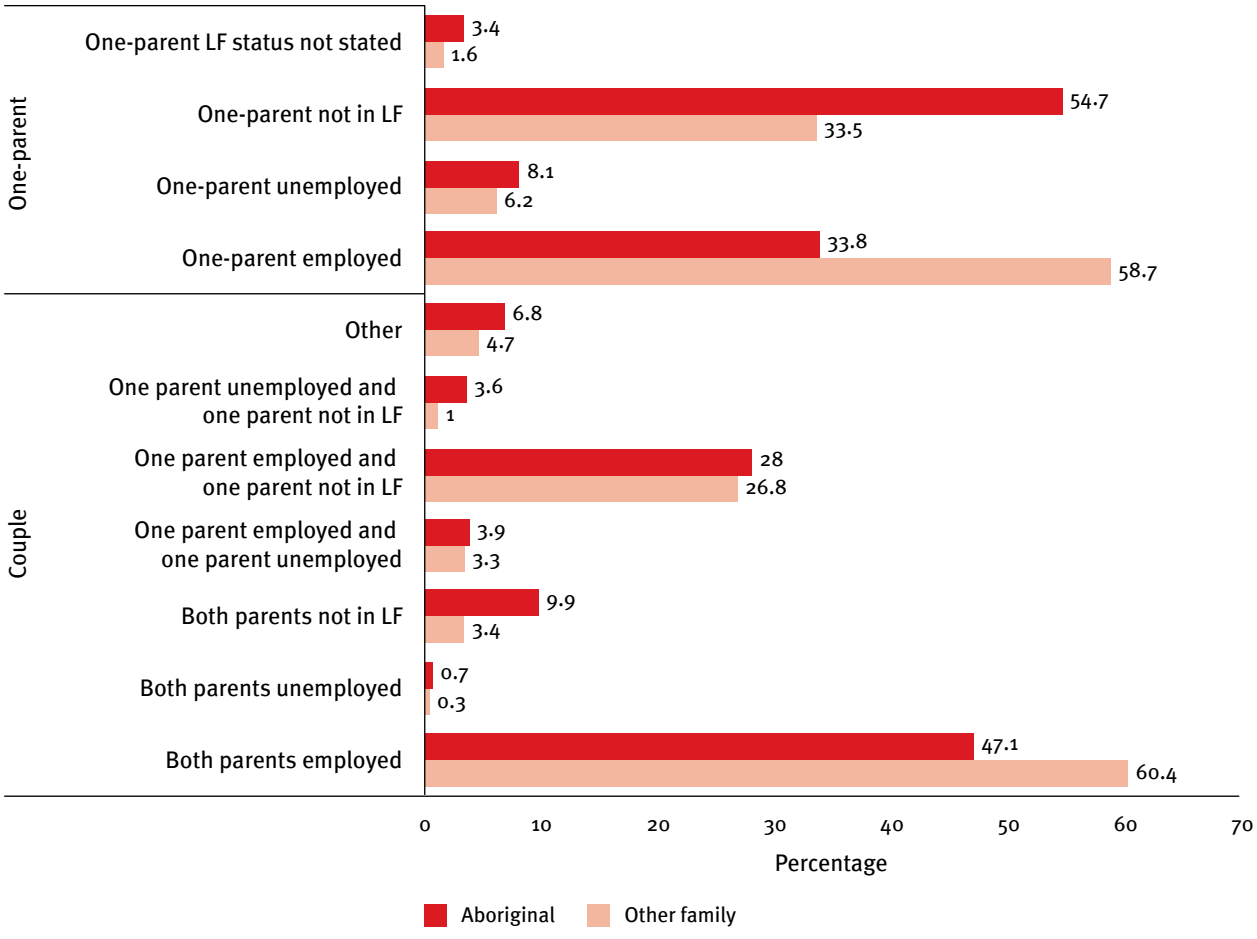
## Most Victorian parents are employed

As seen in Figure 2.9, the majority of Victorian parents are employed (60.4 per cent of couple families and 58.7 per cent of one-parent families) although employment is lower for Aboriginal parents (47.1 per cent for couple families and 33.8 per cent of one-parent families).

The number of families where the parent/s is not employed or in the labour force is low. For couple families, 3.6 per cent of Aboriginal families and 1 per cent of other families have one parent unemployed and one parent not in the labour force and 9.9 per cent of Aboriginal families and 3.4 per cent of other families have both parents not in the labour force.

A stronger pattern is seen in one-parent families where 54.7 per cent of Aboriginal parents and 33.5 per cent of other parents are not in the labour force and 8.1 per cent of Aboriginal parents and 6.2 per cent of other parents are unemployed.

Figure 2.9: Parental Labour Force (LF) status of families with at least one child aged 0–17, Victoria, 2011




Source: ABS Census of Population and Housing, 2011

# Endnotes


1 Australian Bureau of Statistics. Census of Population and Housing 2011. Custom extract from Table Builder December 2014.

2 Victorian Department of Education and Early Childhood Development. (2013) Victorian Child Health and Wellbeing Survey

3 Queensland University of Technology and Social Research centre. (2013). Child and Family Services Outcomes Survey, Victorian Department of Human Services, Melbourne.

4 Ibid

5 McPherson, M., Arango, P., Fox, H., Lauver, C., McManus, M., Newacheck, P., Perrin, J., Shonkoff, J., & Strickland, B. (1998). A new definition of children with special health care needs. Pediatrics 102. pp 137-140

6 Hunter, C. & Price-Robertson, R. (2010) Family structure and child maltreatment, CFCA Paper No. 10, Australian Institute of Family Studies, Melbourne.

7 Australian Bureau of Statistics, Births Australia 2013, cat. No. 3301.0, ABS, Canberra.

8 Australian Institute of Health and Welfare. Teenage Births, Accessed at http://www.aihw.gov.au/child-health/risk-factors/#teenage-birth on 5 March 2015

9 Ibid.

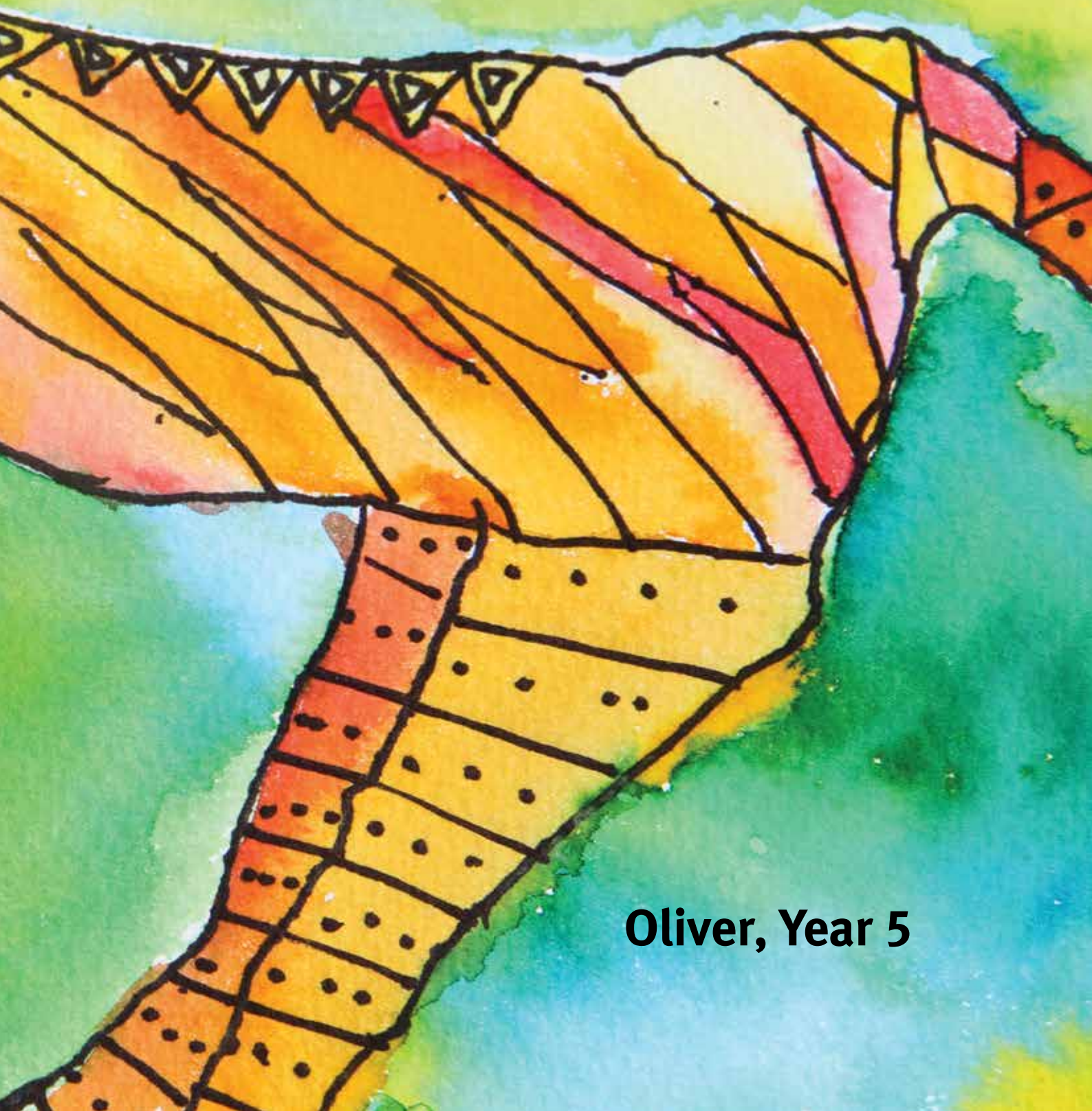
10 Ibid.

11 Jordan, B., Sketchley, R., Bromfield, L. & Miller, R. (2012) Infants and their families: Best interests case practice model Specialist practice resource. Victorian Government Department of Human Services, Melbourne.

12 Department of Education and Early Childhood Development (2011) State of Victoria's children 2010, DEECD, Melbourne.

# Section 3

## Early childhood and transition to school



Oliver, Year 5

# Early childhood and transition to school

Early childhood is a time in which critical periods of development occur across a range of abilities and capacities that are indispensable over the life span. Vulnerability begins at birth for some children who may face health and wellbeing risk factors such as low birth weight or poor nutrition. Early intervention is vital to protect and support children in these early years to help them overcome vulnerability and put them on track for later life.

Starting school is a key milestone and check point for children's wellbeing, developmental progress and future learning. Schools have an opportunity at transition to identify and support children at risk of physical, cognitive, and social and emotional developmental problems. Issues such as speech and language delays or behavioural difficulties are risk factors for children's wellbeing and for their learning potential. They may also be indicators of broader problems or family issues which can make children vulnerable.

Identifying developmental issues at transition, and supporting children's, families' and schools' readiness for school can improve wellbeing outcomes for children, and help to lay the foundations for resilient children as they progress through their school years.

This chapter discusses the key risk and protective factors of early childhood and the early years of school.

## Child health

### Victoria's children are born healthy

In general, Victorian children are born healthy and do well early in their lives. However, issues such as low birth weight, attachment and temperament, developmental delay and complex medical needs can affect the relationship between a child and their parents. They may also have a long-term impact on the child's health outcomes throughout life.[1 2 3]

### Infant mortality rates are declining

Since 2006, infant mortality rates have decreased from 4.3 deaths per 1,000 live births in 2006 to 2.8 per 1,000 in 2012.[4] This is lower than the Australian average which has decreased from 4.7 per 1,000 in 2006 to 3.3 per 1,000 in 2012.

Infant mortality rates in Victoria in 2012 were higher among males (3.1 per cent), in outer regional areas (3.8 per cent) and lower socioeconomic areas (3.3 per cent).

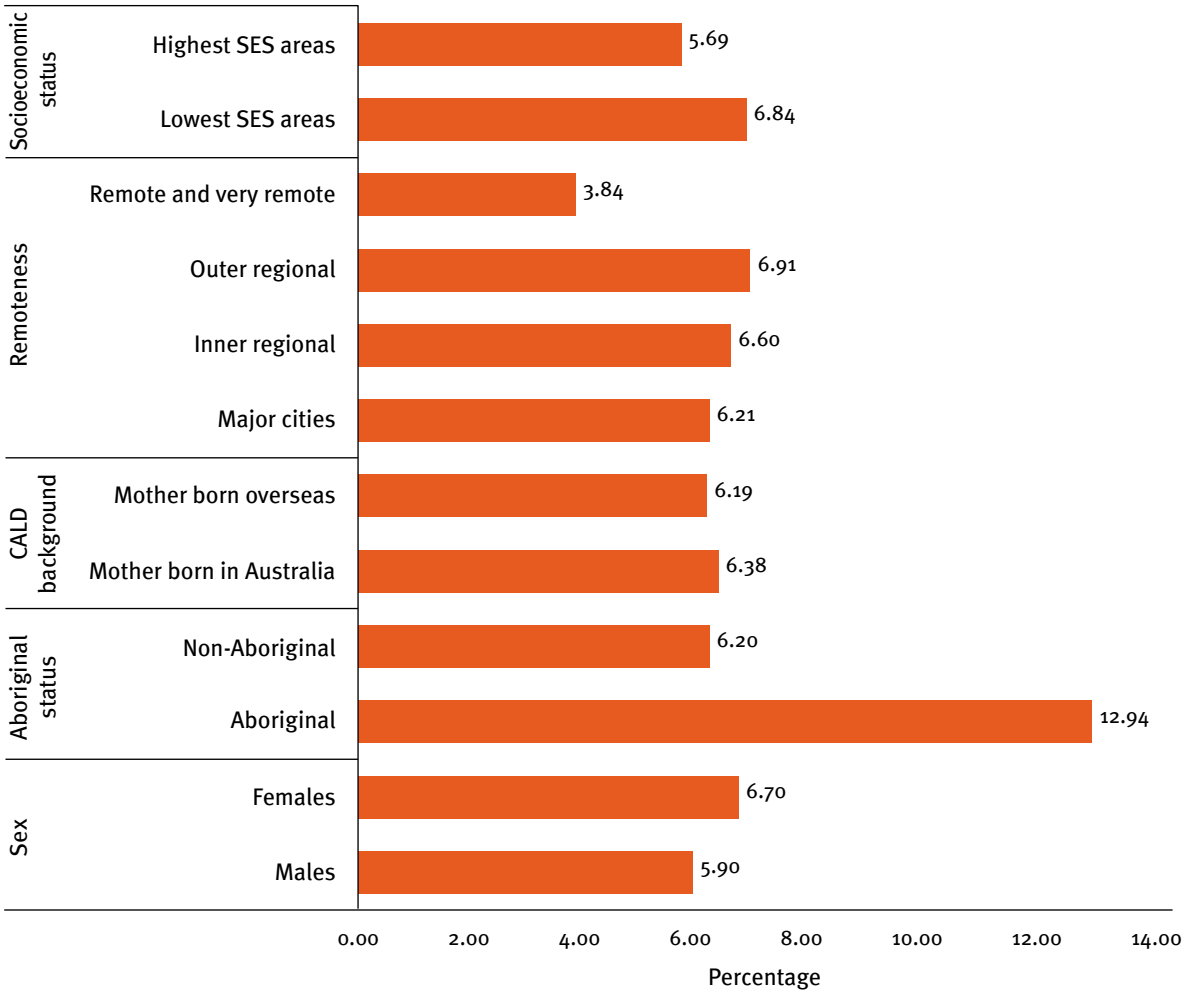
### Babies with low birth weight are at greater risk of poor health and development outcomes later in life

Children with low birth weight (under 2,500 grams) can face many challenges as they grow older including longer stays in hospital after birth, and greater risk of illness, disability and developmental delays. Children with these issues may bond poorly with their parents, potentially making them more vulnerable.

Low birth weight rates in Victoria have remained steady since 2006, decreasing from 6.4 per cent to 6.31 per cent in 2011.[5] This is slightly higher than the Australian average in 2011 (6.28 per cent). Low birth weight is more common in females, Aboriginal children, regional areas and lower socioeconomic areas (Figure 3.1). It is slightly less common in mothers born overseas, in remote areas and in areas of highest socioeconomic advantage.

Despite improvements to Aboriginal infant health over time, gaps remain between Aboriginal and non-Aboriginal babies for perinatal and infant mortality and low birth weight rates. These gaps are regarded as being due to preventable factors such as early teenage pregnancy (‹16 years), under-nutrition, smoking, infection, alcohol consumption during pregnancy and pre-existing chronic diseases and lack of availability and access to high quality and appropriate antenatal care.

Figure 3.1: Proportion of children born with low birth weight, Victoria 2011




Source: Australian Institute of Health and Welfare Child Indicators (http://www.aihw.gov.au/chi/)

Recent reports state that being born a heavier weight is an advantage for children, regardless of race or socioeconomic status. A study conducted at the Northwestern University in Evanston, Illinois found that heavier newborns performed better academically in elementary and middle school than peers with lower birth weights.[6]

**Australian governments are investing in Aboriginal maternal and child health.**

In October 2008, COAG agreed to the National Partnership Agreement on Indigenous Early Childhood Development with joint funding of $564 million over six years. This included Australian Government funding to state and territory governments for sexual health and young parent programs, and support for 85 New Directions: Mothers and Babies Services. These positions provide Aboriginal families with access to antenatal care, practical advice and assistance with parenting, and health checks for children. The National Partnership was completed at the end of June 2014.

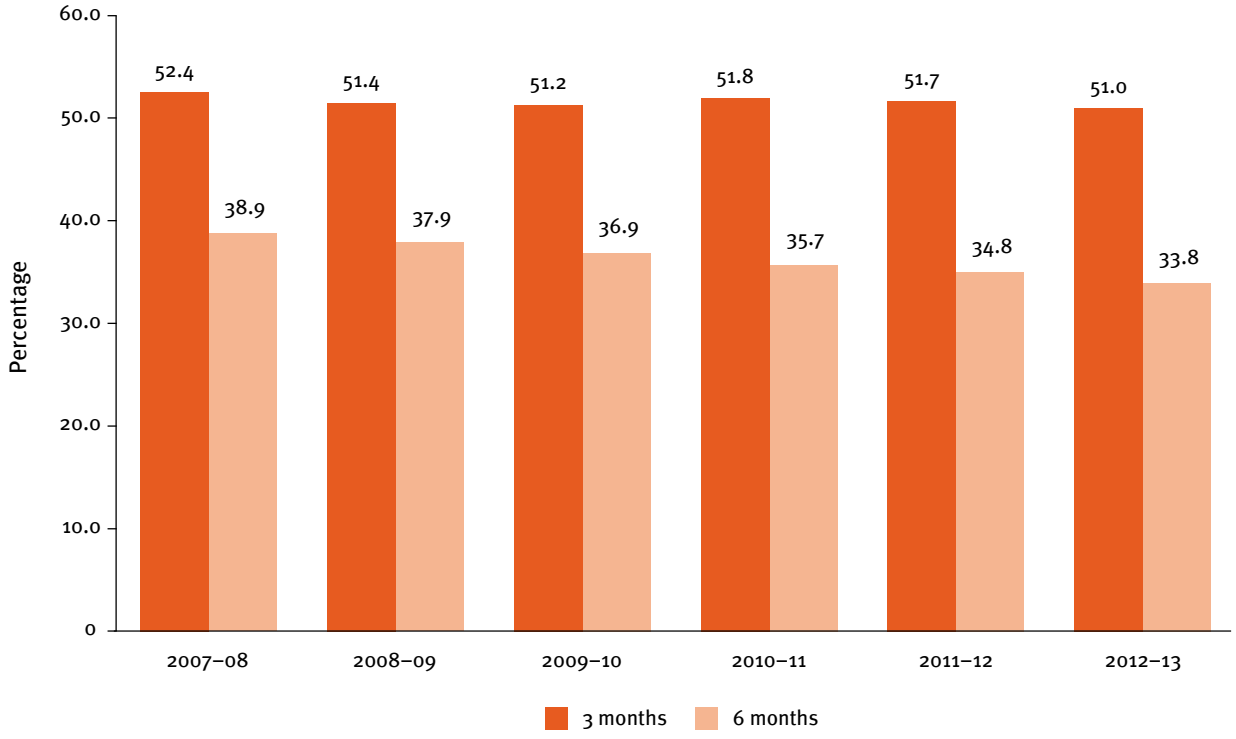
Source: http://www.aihw.gov.au/publication-detail/?id=60129552789

## Breastfeeding rates decline at six months

Breastfeeding provides nutrition and strengthens the immune system, benefitting mothers and babies. The World Health Organisation (WHO) and the National Health and Medical Research Council (NHMRC) recommend exclusive breastfeeding until at least six months of age. In exclusive breast feeding, an infant receives only breast-milk with no other liquids or solids except vitamins, mineral supplements or medicines.[7]

Just over half of Victorian infants (51 per cent) were fully breastfed at three months in 2012–13. In full breast feeding an infant receives breast-milk and water, water-based drinks, fruit juice or oral rehydration salts but no breast milk substitutes or solids (Figure 3.2). By six months only 33.8 per cent of infants are fully breastfed as partial breastfeeding (where the infant receives breast milk and solids or semi-solid foods or non-human milk) is more common.

Figure 3.2: Proportion of Victorian infants fully breastfed at 3 months and 6 months, 2007–08 to 2012–13




Source: Maternal Child Health collection, Department of Education and Training, 2007–08 to 2012–13

The nationally recognised key indicator for breastfeeding, reported by the AIHW, is the proportion of infants exclusively breastfed at four months.[8] Exclusive breastfeeding rates at four months are slightly lower in Victoria than Australia (38.5 per cent compared to 39.2 per cent). They are lowest in the most disadvantaged areas and for Aboriginal mothers.

The Victorian breastfeeding plan, based on evidence-informed practice, identifies strategies to support exclusive breastfeeding to around six months, and continuing breastfeeding, with appropriate introduction of solids, to 12 months and beyond.

These strategies will guide improvements in breastfeeding rates across Victoria.

http://www.education.vic.gov.au/childhood/professionals/health/Pages/breastfeed.aspx

## Immunisation rates are lowest in areas of highest socioeconomic advantage

Vaccination is an effective way to generate immunity and protect against the spread of infectious diseases. The National Immunisation Program Schedule for Victoria recommends and provides the following vaccines at no cost to children up to eight years: hepatitis B, diphtheria, tetanus, pertussis, polio, haemophilus influenzae type b, pneumococcal, measles, mumps, rubella, meningococcal C, chickenpox and rotavirus.[9] It is estimated that 90 per cent vaccination coverage is required to interrupt the transmission of disease.[10]

Overall, full immunisation rates for one- and two-year old children in Victoria have remained steady at above 90 per cent since 2005. The rates for five-year olds have increased dramatically over the same period from 76.7 per cent in 2005 to 92.6 per cent in 2013 (Figure 3.3a).

Immunisation rates for Aboriginal children show similar patterns for one- and five- year old children over the same time period increasing from around 75 per cent to around 92 per cent (Figure 3.3b). They are lower for two-year old Aboriginal children compared to all two-year old Victorian children (91.5 per cent of Aboriginal children compared to 92.8 per cent of all children).

Figure 3.3a: Proportion of Victorian children fully immunised, by age, 2005–2013

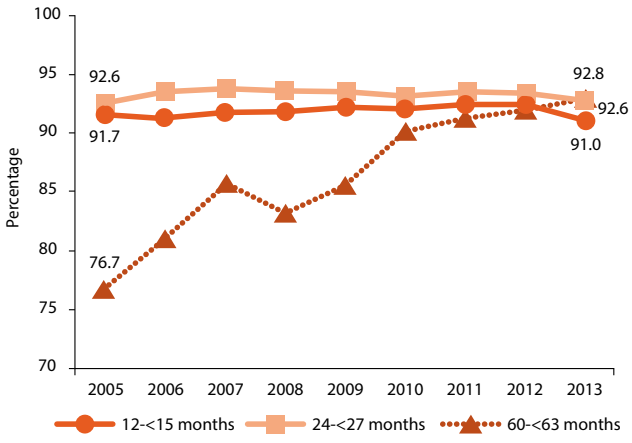
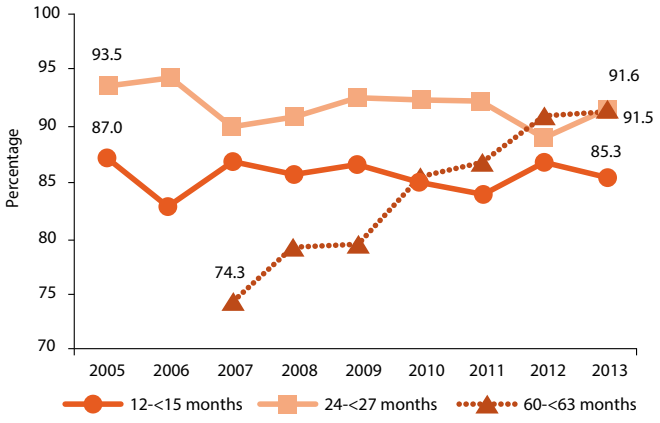



Figure 3.3b: Proportion of Victorian Aboriginal children fully immunised, by age, 2005–2013




Source: Australian Childhood Immunisation Register, 2005–2013

The Children's Headline Indicators published by the Australian Institute of Health and Welfare show that Victorian immunisation rates at two years are highest in regional and remote areas and lowest in the most socioeconomically advantaged areas. [11] The most commonly cited reason for lower immunisation rates is parental choice not to immunise.

## Temperament can affect a child's attachment and adjustment

A child's temperament is apparent from birth. It is made up of their innate personality, and their reactions to the world.

Temperament plays a role in many outcomes for a child from childhood through to adolescence.[12] The temperaments of a child and their primary care-giver can have an impact on their attachment and early relationships with parents.[13]

Temperament is an early risk factor indicating vulnerability to childhood onset depression.[14] The Longitudinal Survey of Australian Children data provides evidence that stressful family environments in a child's first year and highly reactive, avoidant, and impulsive temperament styles contribute to anxiety and depression in children at four years of age.[15]

Children with disabilities or difficult temperaments are more likely to have their parents disregard their social and emotional development. They are also more vulnerable to abuse.[16]

**Temperamental characteristics may not directly lead to adjustment problems, but can create vulnerability when there are other risk factors in a child's life**

The Australian Temperament Project (ATP) identifies aspects of temperament including 'sociability, reactivity, and persistence.[17] Aspects of temperament such as being easy-going, calm, happy, positive, adaptable and interested in new experiences are protective factors for children.[18] [19] In contrast a difficult temperament, being shy, being irritable or uncooperative and having relationship difficulties with their mother are all risk factors for children and have been found to predict later problems for the child.[20]

Other studies have found specific temperaments in infancy have:

- led to behavioural and emotional problems in early childhood and beyond, particularly if there are other risks in a child's life[21]
- been associated with the development of anxious and/or fearful behaviours in the early years of schooling[22] [23]
- been identified as a risk factor for child abuse and neglect.[24]

## Secure attachment is a protective factor for infant resilience and development

From birth, infants are able to communicate, express a wide range of emotions, and through positive interactions with parents and caregivers, develop socially and emotionally. A strong and secure attachment between a child and their primary caregiver (usually the mother) is a protective factor that assists them to develop socially and emotionally, and to enable them to develop attachments with others.[25] Secure attachment with at least one adult is a common protective factor for child resilience.[26]

There are several styles or forms of attachment including secure, insecure or disorganised, which can affect a child's development. Poor attachment is a strong indicator of developmental and protective risks for a young child [27] and generally involves an unresponsive, intrusive, hostile or violent caregiver.[28]

A child who is securely attached to his or her parent (or other familiar caregiver) will explore freely when their caregiver is nearby, typically engages with strangers, is often visibly upset when the caregiver departs, and is generally happy to see the caregiver return. The extent of exploration and of distress is affected by the child's temperamental make-up and by situational factors as well as by attachment status. A child's attachment is largely influenced by their primary caregiver's sensitivity to their needs. Parents who consistently (or almost always) respond to their child's needs create securely attached children. Such children are certain that their parents will be responsive to their needs and communications, and that the parent will return when they are out of sight.[29]

Research indicates that:

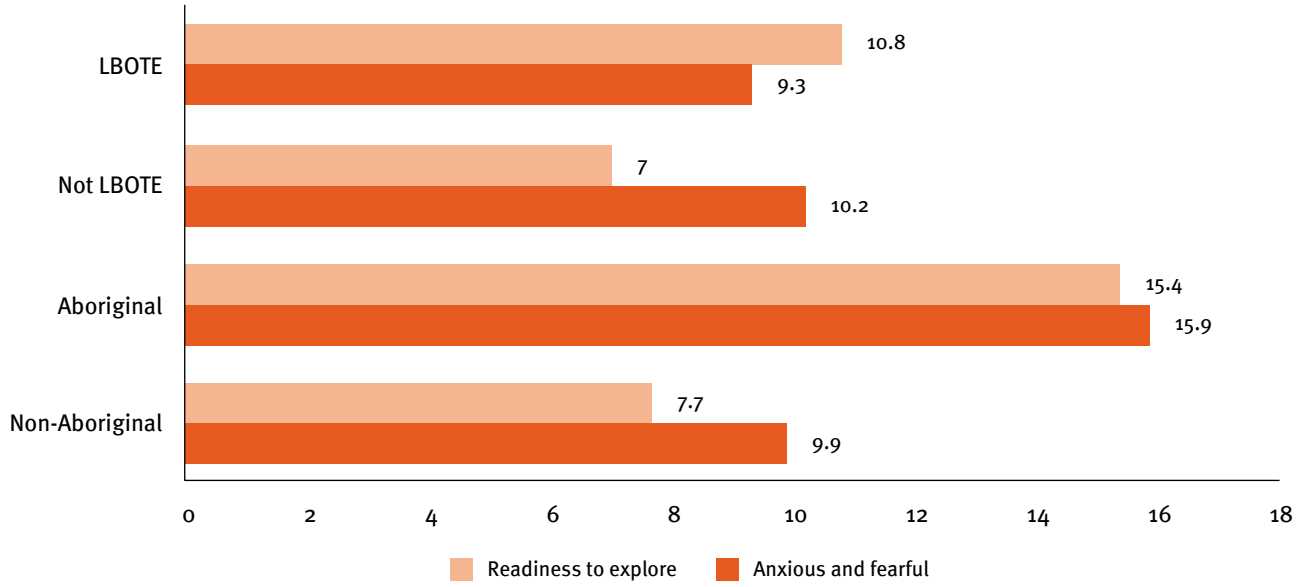
- 82 per cent of maltreated infants have attachment problems with their caregiver.[30]
- There is a link between maternal depression and attachment problems potentially leading to poor outcomes for children later in life.[31]
- Adolescent mothers talk less to their infants and have difficulty interpreting their cues or feelings, affecting attachment.[32]

While information about attachment in early childhood is not routinely collected at a population level, the Australian Early Development Census (AEDC) provides a picture of child behaviours at school entry which may serve as a proxy for understanding attachment. These behaviours may make children more vulnerable and suggest possible attachment and temperament issues. They include anxious and fearful behaviour and a lack of readiness to explore new things.

Between 2009 and 2012, the proportion of children vulnerable on the Anxious and fearful behaviour sub-domain of the AEDC decreased from 11.4 per cent to 10 per cent. Vulnerability on the Readiness to explore new things sub-domain remained stable at around 7.8 per cent.

Figure 3.4 shows that children from language backgrounds other than English were more likely to be vulnerable on the Readiness to explore new things sub-domain (10.8 per cent), but less likely to be vulnerable on the Anxious and fearful behavioural sub-domain (9.3 per cent), compared to other children. Higher proportions of Aboriginal children were vulnerable on both domains compared to non-Aboriginal children.

Figure 3.4: Proportion of children vulnerable on Readiness to explore new things, and Anxious and fearful behaviour AEDC sub-domains, by child characteristics, 2012




Source: Australian Early Development Census, 2012

*Supported playgroups* improve disadvantaged children's wellbeing and learning outcomes by improving the quality of parent-child interactions to support change in the home learning environment. They provide a professionally supported environment for parents in which they can develop their parenting skills and confidence and establish social and community connections. They also support transitions into other forms of early childhood education and care and other more intensive or targeted services.

In July 2015, the Department of Education and Training commenced a major reform of Supported Playgroups, including:

- incorporation of *smalltalk* across all Supported Playgroups – all facilitators of Supported Playgroups funded by the Department are required to undergo training and receive practice coaching in *smalltalk*.
- new guidelines – released to the sector in July 2015.
- requirement to employ Supported Playgroup facilitators with a minimum Diploma-level qualification
- increased accountability for program outcomes – assisted by clear performance targets for all funded service providers and a new online information management system.
- better targeting of the service to ensure families experiencing disadvantage have priority access to Supported Playgroups
- increased focus on the successful transition of families from Supported Playgroups to other programs and/or services.

# Maternal Child Health (MCH) supports parental learning and early identification

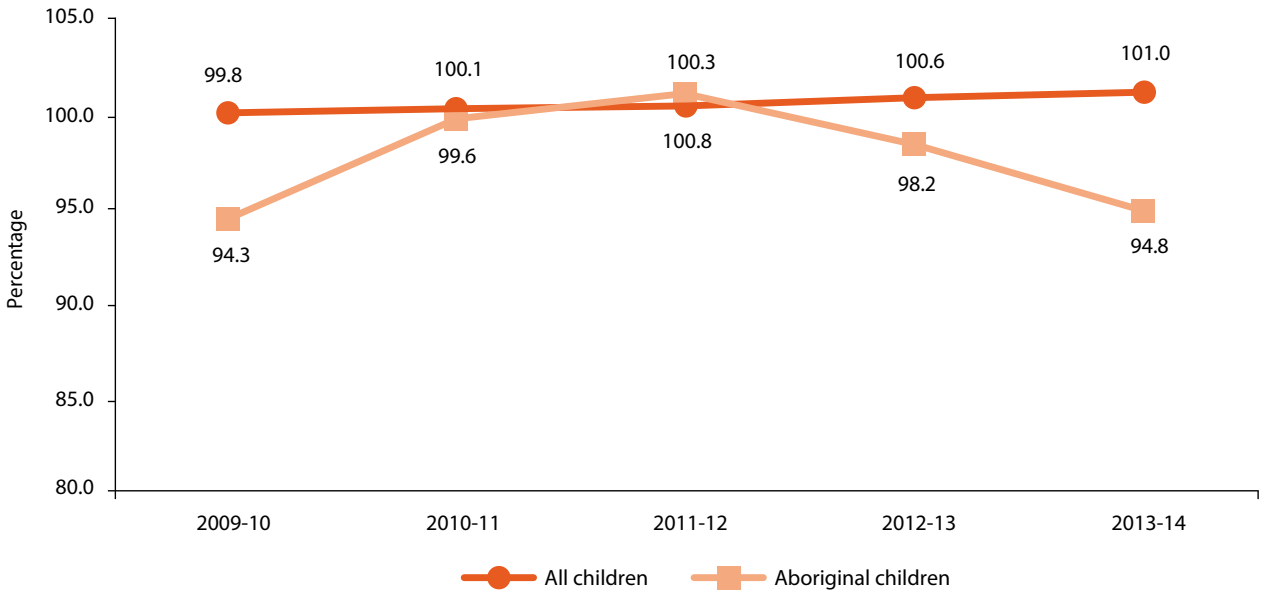
Active participation in early childhood programs such as MCH services can foster positive learning and development, and lessen or eliminate the effects of disadvantage before they become entrenched.

MCH identifies children's developmental problems early, and supports and advises parents in managing stresses and difficulties during infancy and early childhood.

## Almost all Victorian children receive a MCH home visit

The proportion of infants receiving the initial MCH home visit has remained relatively stable over the last few years at around 100 per cent (Figure 3.5). It has decreased for Aboriginal children in from a high of 100.8 per cent in 2011–12 to 94.8 per cent in 2013–14.

Figure 3.5: Proportion of infants receiving a Maternal and Child Health service home consultation, 2009–10 to 2013–14




Source: Maternal Child Health collection, Department of Education and Training, 2009–10 to 2013–14

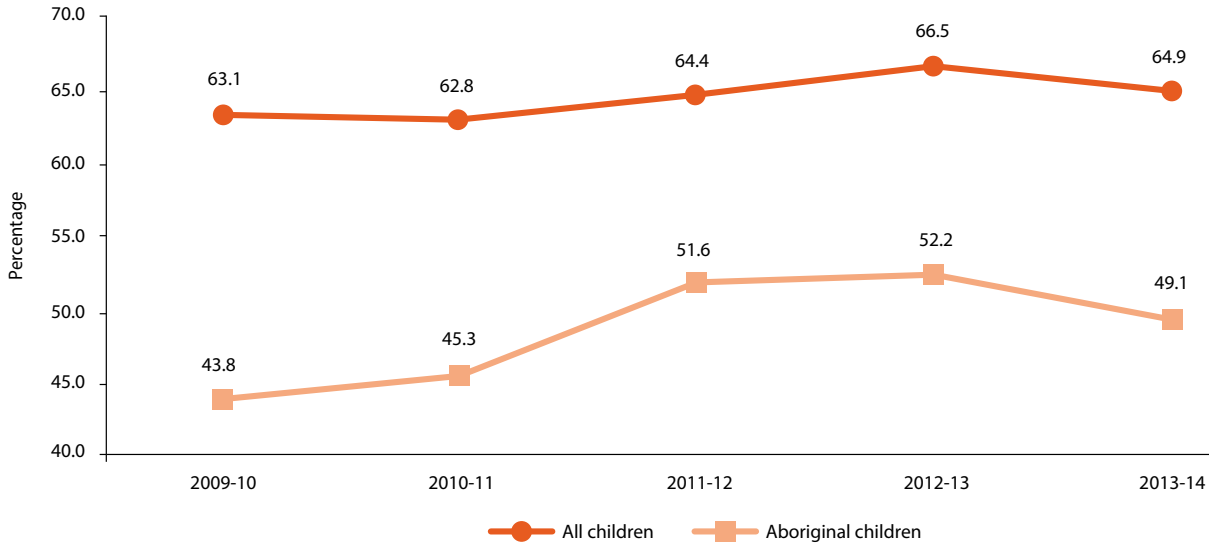
Note: MCH consultations are calculated by dividing the number of visits by the number of children registered with MCH centres. The initial home visit figure can exceed 100 per cent as children may have received the initial home visit before they have been registered at a centre.

The Koori Maternity Services Program operates from 11 sites across Victoria. It focuses on maternal and child health, including antenatal care and low birth weight. In total, $2.8 million has been invested in the 'A healthy start to life' Koolin Balit priority area. This includes a range of programs supporting women and families in the early years of raising children.

## One in three children are not attending the final MCH 3.5 year check

The proportion of children attending the 3.5 year MCH check has risen since 2009-10, reaching a peak of 66.5 per cent in 2012–13 and returning to 64.9 per cent in 2013–14 (Figure 3.6). Although the rate for Aboriginal children has also risen, it is still low at 49.1 per cent in 2013–14. One in three children (and 1 in 2 Aboriginal children) did not attend the 3.5 year check in 2013-14.

Figure 3.6: Proportion of Children attending the 3.5 year MCH key ages and stages visit, 2009–10 to 2013–14




Source: Maternal Child Health collection, Department of Education and Training, 2009–10 to 2013–14

The Victorian Government has committed $950,000 for a Maternal and Child Health Service Innovation Fund to support Victoria's Maternal and Child Health (MCH) services to continue to meet the evolving needs of children and families.

The fund will foster the development and adoption of sustainable practices to enhance outcomes for vulnerable children and families, and to provide information to foster system wide service improvements.

Analysis by the Melbourne School of Population and Global Health using the School Entrant Health Questionnaire indicates that MCH participation is highest for parents from regional areas (76.5 per cent compared to 72.1 per cent for metropolitan areas) and where the child or the mother was born in Australia (78 per cent and 79.8 per cent respectively). It is also higher where the mother had a degree qualification (79.6 per cent) compared to other qualifications, and in couple families (77.6 per cent compared to 65.5 per cent in one-parent families). Participation was lowest for Aboriginal children (64.5 per cent) and children on Health Care Cards (68.4 per cent).

Further analysis using data collected through the VicGen project suggests that birth order plays a role in attendance at MCH. Parents are more likely to attend all visits for their first child (80.4 per cent) than for subsequent children (67.1 per cent). This may indicate that parents feel more comfortable applying the knowledge they have learnt with their first child to their other children.

# Early learning and development

## Early learning and neurological development sets children up for life

The early years are vital to neurological development with early experiences having a long-term effect on physical and mental health, learning and behaviour.[33] Early experiences either enhance or diminish innate potential, laying a strong or a fragile foundation on which development and learning are built.

**What Neuroscience tells us about brain development in early childhood**

- Children are born ready to learn.
- Good nutrition, health and exercise are critical.
- The best learning happens in nurturing relationships.
- The brain develops through use.
- Children's wellbeing is critical to brain development and learning.
- Children learn through being engaged and doing.
- Children learn from watching and copying.
- Children's self-control is critical for learning, responsibility and relationships.
- Children learn language by listening to it and using it.
- Children are born ready to use and learn mathematics.
- The first five years last a lifetime.[34]

The human brain is most plastic or flexible in early life making children especially vulnerable to persistent negative influences during their early years.[35] A child who is exposed repeatedly to toxic stress is likely to develop different neural pathways to a child with positive experiences.

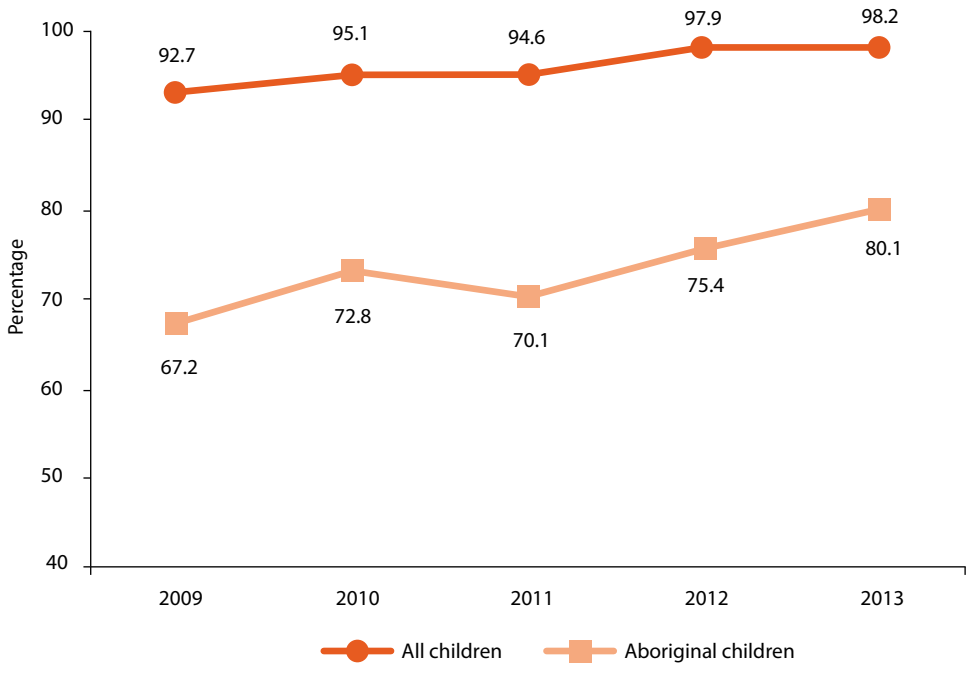
Programs which enhance children's experiences at an early age play a strong role in their future development. They are particularly important for vulnerable children who may have less exposure to new experiences than their peers.

## Kindergarten participation improves later learning outcomes for children

Participation in a kindergarten program promotes cognitive development in the short-term and prepares children to succeed in school.[36] Kindergarten participation has a direct causal effect on future learning. Children who attended kindergarten have been shown to be one term of formal schooling more advanced than children who did not attend as measured by the Year 3 NAPLAN.[37]

Kindergarten participation in the year before school has continued to increase reaching 98.2 per cent for all children in 2013 (Figure 3.7). The kindergarten participation rate for Aboriginal children also rose to its highest rate, 80.1 per cent, in 2013.

Figure 3.7: Proportion of Victorian children participating in kindergarten in the year before school, 2009 to 2013

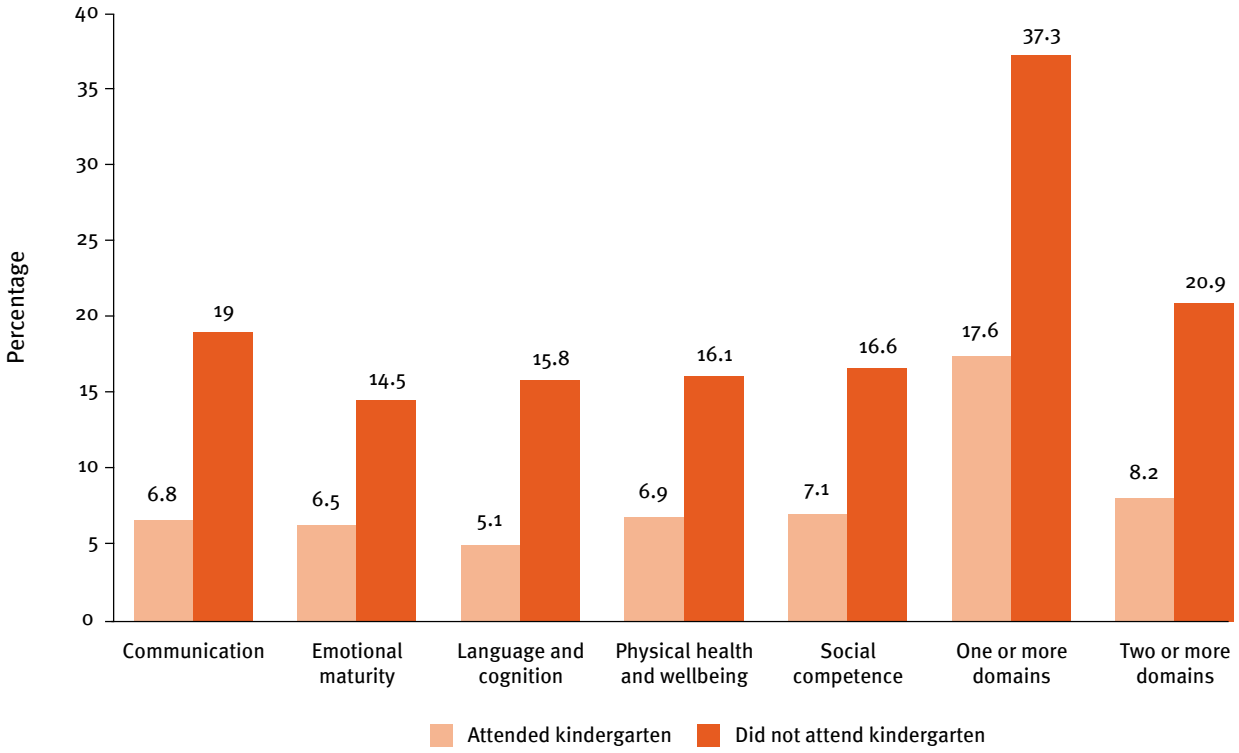



Source: Kindergarten Management System, Department of Education and Training, 2012 and 2013

From 2014, a new methodology will be used to calculate kindergarten participation. Using this methodology the participation rate for 2014 is 96.4 per cent with a comparable 2013 figure of 96.3 per cent. For Aboriginal children the revised rate is 77.1 in 2013 and 79.6 per cent in 2014.

The AEDC indicates that children who did not attend kindergarten were more vulnerable at school entry across all domains (Figure 3.8). The highest domain for vulnerability was communication followed by social competence, and physical health and wellbeing. Over 37 per cent of children who did not attend kindergarten were vulnerable in one or more domains of the AEDC in 2012.

Figure 3.8: Proportion of children vulnerable on AEDC domains, by kindergarten attendance (as reported by their teacher in the first year of school) 2012




Source: Australian Early Development Census, 2012

# School readiness and transition to primary school

## School readiness is influenced by the child, school, services, family and community

Children's school readiness is affected by parental marital status, health and wellbeing, family income and support networks.[38]

School readiness as a concept has shifted over time from a focus on the individual child's readiness for school according to maturation and chronological age to an understanding that readiness involves interrelated components including 'children's readiness for school, school's readiness for children, and the capacity for families and communities to provide developmental opportunities for their young children.' [39]

School readiness can predict long-term academic and occupational achievement.[40] Children starting school with social and academic difficulties are likely to continue to have problems at and beyond school years.[41]

For some children and families, transitioning to school can be a difficult and challenging time. A positive start to school can, however, promote children's mental health and wellbeing. For Aboriginal children, school readiness is affected by the school's cultural inclusiveness, and teachers' attention to individual learning needs.

Developmental vulnerability, health, and speech and language difficulties all influence school readiness.

## One in five Victorian children are developmentally vulnerable in the first year of school

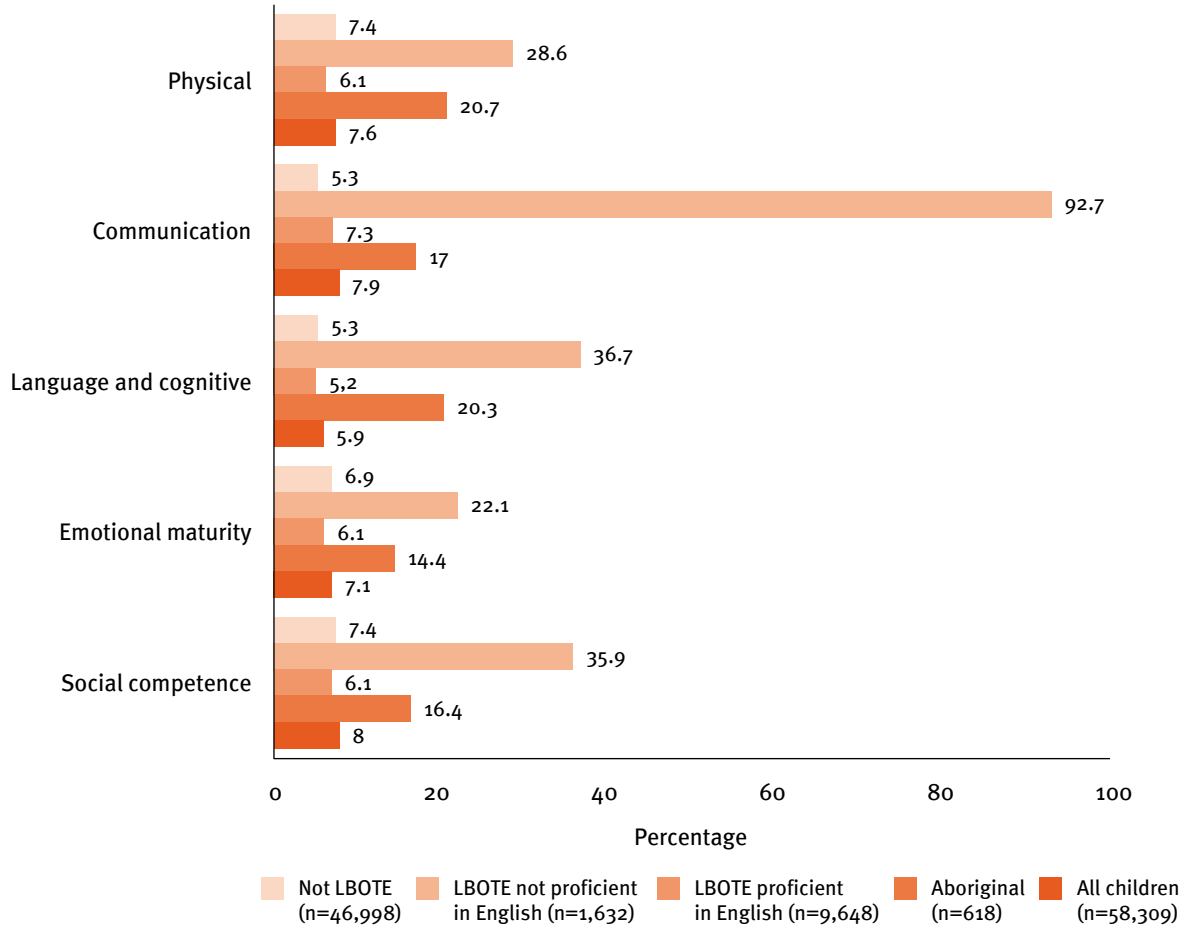
The AEDC considers five domains of potential developmental vulnerability for children at school entry: physical health; social competence; emotional maturity; language and cognitive skills; and communication. Around one in five Victorian children are vulnerable on one or more of these domains (19.5 per cent), and one in ten (9.5 per cent) are vulnerable on two or more domains. Both these figures are lower than the vulnerability rates for the rest of Australia (22.8 per cent and 11.2 per cent respectively).

Figure 3.9 shows that Victorian children are least likely to be vulnerable in language and cognitive skills (5.9 per cent) and most likely to be vulnerable in the communication and social competence (7.9 per cent and 8 per cent).

The group of children most vulnerable at school entry are children from a language background other than English who are not yet proficient in English, particularly in communication. This is partly because English is the predominant language in school and these children are also more likely to have come from socioeconomically disadvantaged areas and not to have attended kindergarten.

Aboriginal children are also more vulnerable than other children, particularly in physical health (20.7 per cent), and language and cognitive skills (20.3 per cent).

Figure 3.9: Proportion of Victorian children vulnerable on individual AEDC domains, by population group, 2012




Source: Australian Early Development Census, 2012

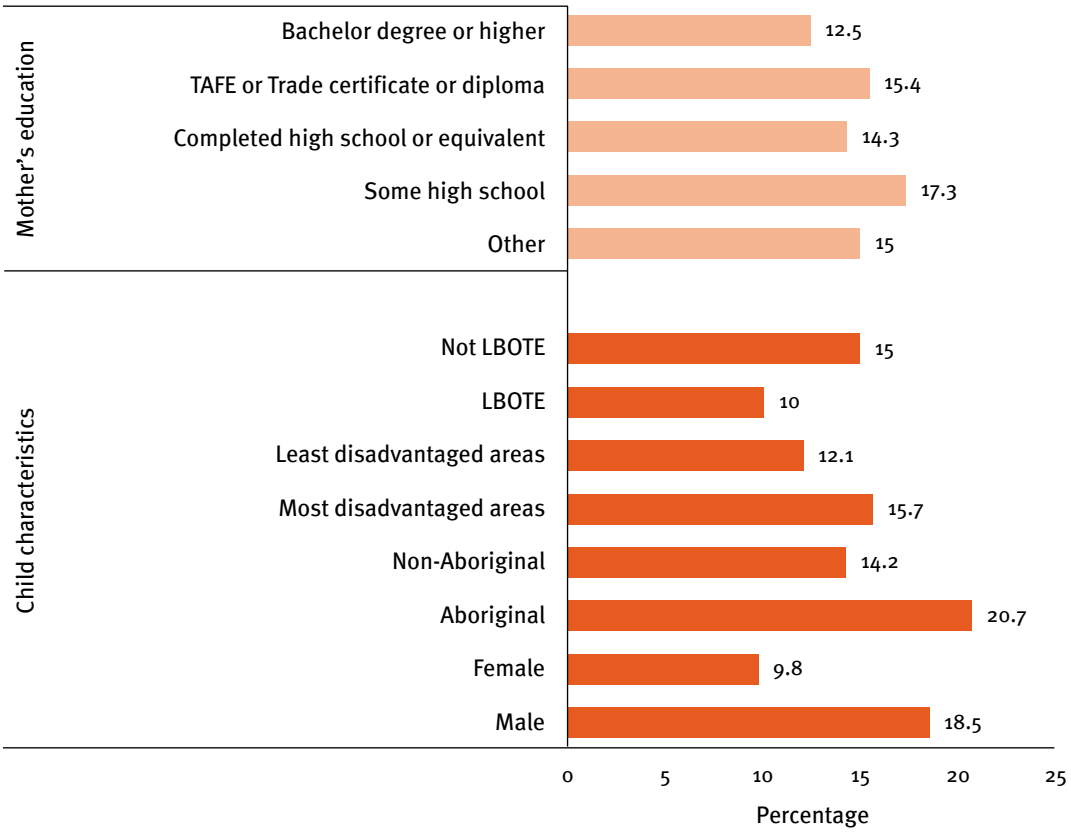
## Speech and language skills affect school readiness and children's wellbeing, learning and development

Speech, language and communication are critical to the development of children's cognitive, social and emotional wellbeing. Difficulties with speech and language can affect a child's social and academic outcomes.

In 2013, 13.8 per cent of parents reported that their child had speech and language difficulties at school entry (Fig 3.10). This was highest for males, Aboriginal children and children from the most disadvantaged areas. These figures have shown little change between 2010 and 2013.

Speech and language difficulties were lowest for children born to mothers with a Bachelor degree or higher, indicating a potential link between maternal education and development of children's language.

Figure 3.10: Proportion of children with speech and language difficulties at school entry, by child characteristics and mother's education level, 2013




Source: School Entrant Health Questionnaire, Department of Education and Training, 2013

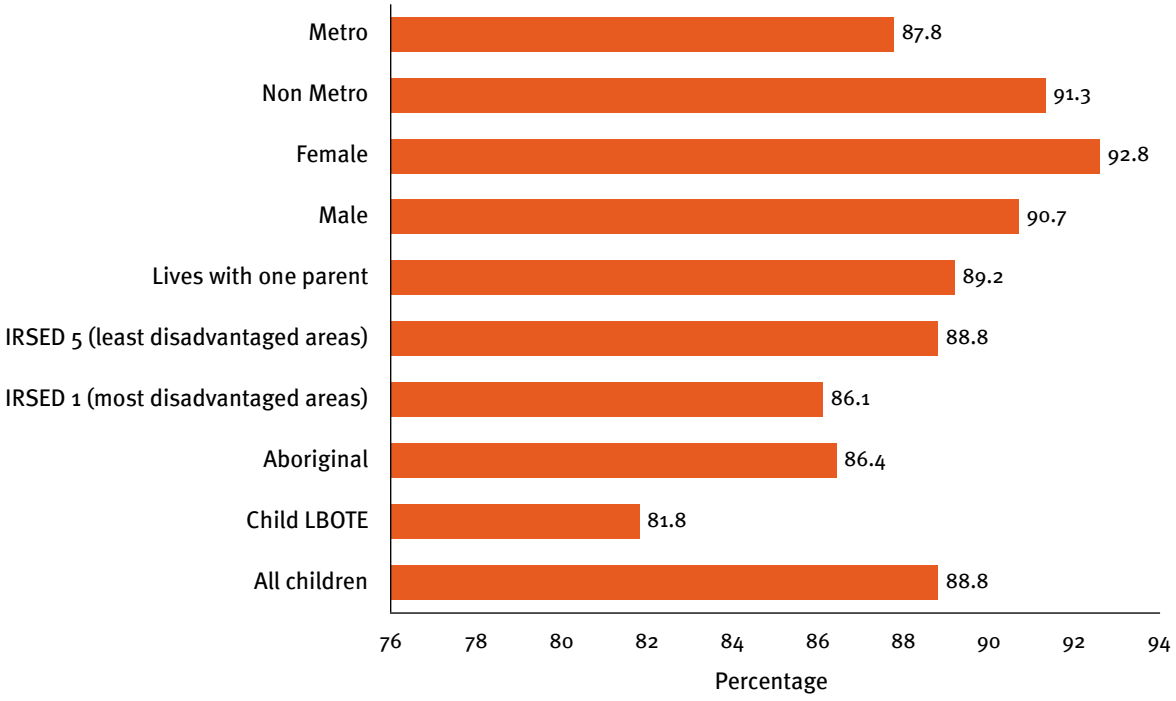
Poor oral language skills are a risk factor for adverse outcomes in later life. The Australian Institute of Criminology highlights research into high-risk young people and oral language skills. It reports that young people who become engaged with youth justice services are highly likely to have previously undetected oral language problems.[42]

Two Australian longitudinal studies identify oral language problems in the early years as a risk factor for anti-social behaviour in adolescence.[43] Further, in a recent CRC-funded study, a link between youth offenders with histories of interpersonal violence and oral language problems was shown.[44]

## Most children enter primary school with good general health

Each year around 90 per cent of parents report that their child has either excellent or very good health at school entry (Figure 3.11). However, Aboriginal parents, and parents from language backgrounds other than English, one-parent families and the most disadvantaged areas, are less likely to report that their child has good or excellent health.[45]

Figure 3.11: Proportion of parents reporting that their child has good or excellent health at school entry, by population group, Victoria, 2013




Source: School Entrant Health Questionnaire, Department of Education and Training, 2013

The most commonly reported health conditions at school entry were asthma (14 per cent) and allergies (10.8 per cent). These early childhood conditions may affect future health, learning and development, and in turn affect learning and development, academic performance and future opportunities.

# Social and emotional development and wellbeing

Social and emotional wellbeing generally refers to the way a person 'thinks and feels about themselves and others. It includes being able to adapt and deal with daily challenges (resilience and coping skills) while leading a fulfilling life'.[46]

For Aboriginal children and families, social and emotional wellbeing is described as a holistic concept which recognises 'connection to land, culture, spirituality, ancestry, family and community' as protective factors.[47 48] Building a sense of self-esteem includes the notion of 'voice' that 'creates a positive context for raising Indigenous children.' [49] For Aboriginal children and families, culture and cultural identity are critical to social and emotional wellbeing.[50 51]

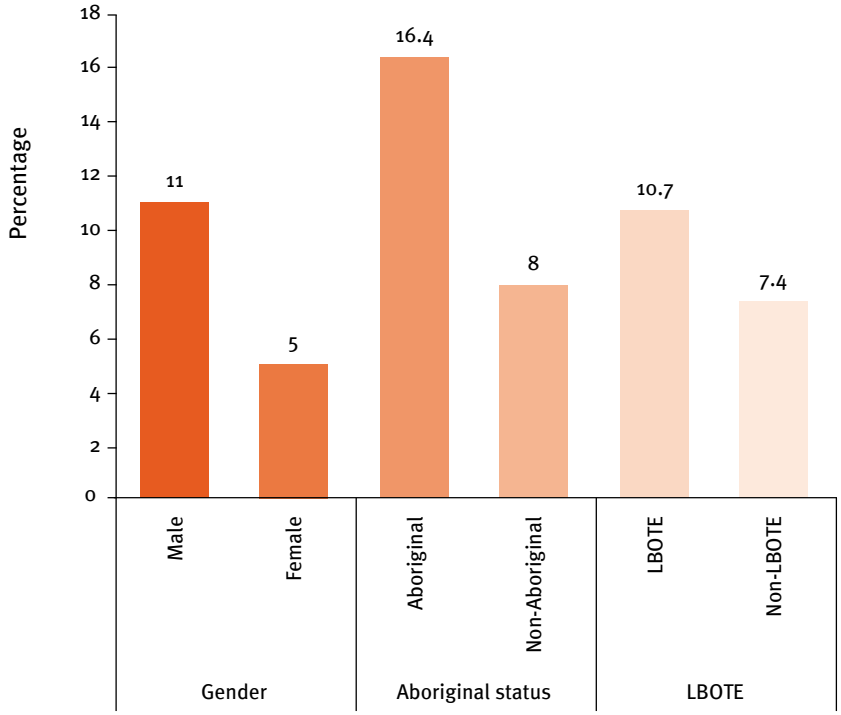
## Social competence is vital for positive social relationships

Children who are socially competent are able to establish, maintain and develop constructive social relationships, manage interpersonal difficulties and refrain from harming themselves or others.[52] Social competence includes social and emotional development and is a commonly identified factor for child abuse and neglect.[53 54]

In the early years, children are developing social competencies and capacities, as well as learning ways to cope with conflict, solve problems and develop relationships with the significant adults in their lives.[55] Children who have been maltreated or neglected are at risk of poor developmental outcomes, such as lower social competence.[56]

The AEDC considers children's social competence in terms of responsibility and respect, approaches to learning, readiness to explore new things and their overall social skills. Figure 3.12 indicates that boys, Aboriginal children and children from language backgrounds other than English are most vulnerable in social competence.

Figure 3.12: Proportion of children vulnerable on the Social Competence domain of the AEDC, 2012




Source: Australian Early Development Census, 2012

'Growing up strong' is a term used by some Aboriginal communities to describe the development of children with a strong sense of identity, belonging and competence. Children must be strong in culture, resilient and able to succeed within Aboriginal and all environments.' [57]

For Aboriginal children and families, protective factors for social and emotional wellbeing include connection to land, culture, spirituality, ancestry, family and community. Risks for social and emotional wellbeing can cover a broad range of problems resulting from 'unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination and social disadvantage.' [58 59]

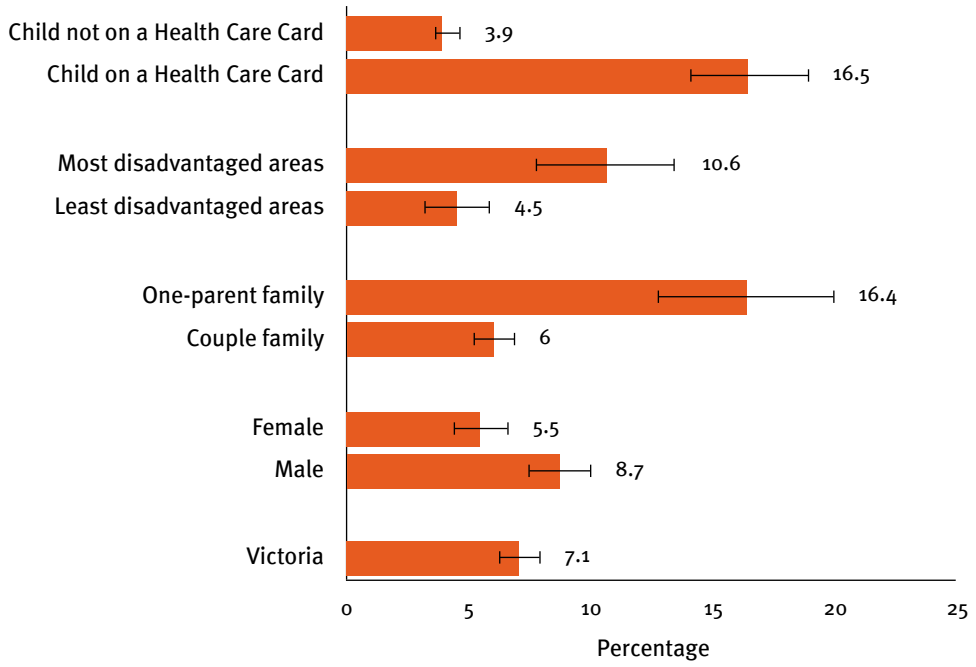
## One in fourteen Victorian children exhibit emotional and behavioural difficulties

Traumatic events have a strong, negative effect on an infant's development, and exposure to abuse, neglect or violence affects every dimension of their psychological functioning and can undermine their basic sense of trust in the world.[60]

Young children with problem behaviours are at risk for more serious disruptive and violent behaviours in the future. The majority of Victorian children show normal emotional and behavioural development. Some children, however, face greater problems. Goodman's Strengths and Difficulties Questionnaire (SDQ) is a commonly used behavioural screening tool to assess psychological attributes against five scales: emotional, conduct problems, hyperactivity, peer problems and pro-social behaviour.

Figure 3.13 indicates that around 7 per cent of Victorian children aged 4 to 12 were reported by their parents to have emotional and behavioural difficulties on the SDQ. Emotional and behavioural difficulties are more common for boys, children in one-parent families and the most disadvantaged areas, and for those on Health Care Cards.

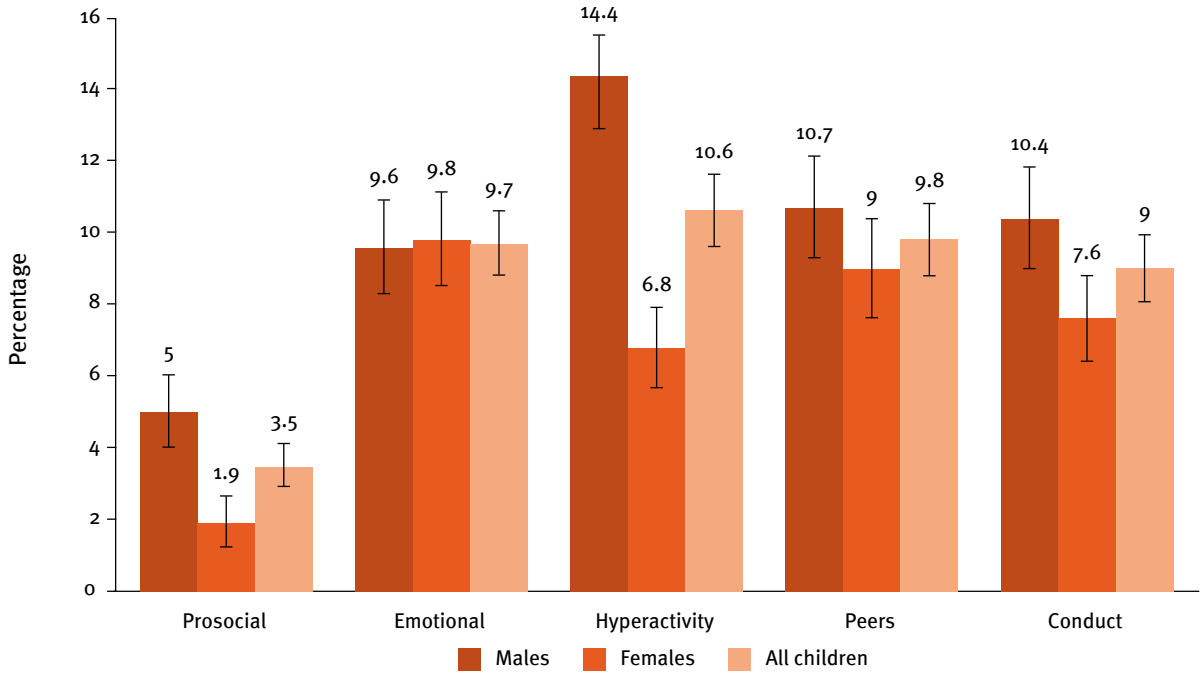
Figure 3.13: Proportion of Victorian children aged 4 to 12 years with emotional and behavioural problems of concern by child characteristics, 2013




Source: Victorian Child Health and Wellbeing Survey, Department of Education and Training, 2013

Hyperactivity is the most common behavioural problem for children, particularly boys (14.4 per cent for boys compared to 6.8 per cent for girls) (Figure 3.14). Emotional problems are very slightly higher for girls (9.8 per cent compared to 9.6 per cent for boys). Issues with pro-social behaviours (positive social behaviour) are the least common problems experienced by Victorian children, however boys are more likely to experience these issues than girls (5 per cent versus 1.9 per cent).

Figure 3.14: Proportion of children aged 4 to 12 years with emotional or behavioural problems of concern by SDQ domain and sex, 2013



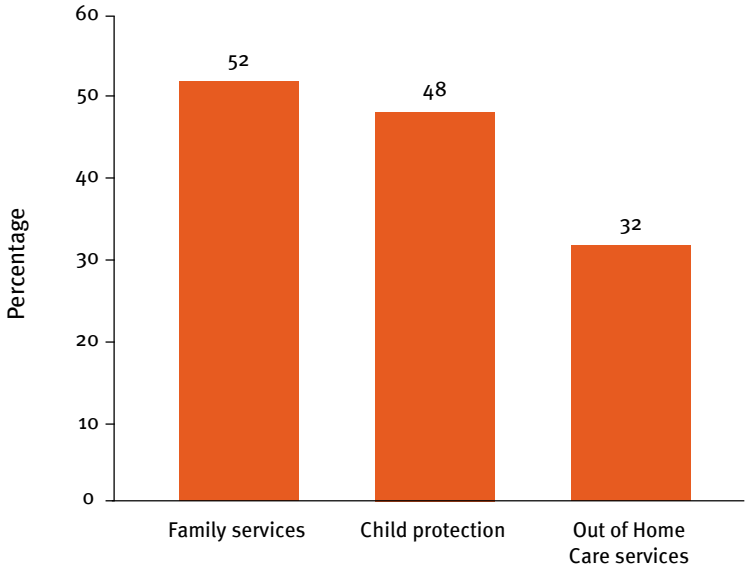

Source: Victorian Child Health and Wellbeing Survey, Department of Education and Training, 2013

Rates of emotional and behavioural problems at school entry have varied little since 2010, when the SDQ was added to the School Entrant Health Questionnaire.

Initial analysis of students with parent identified emotional and behavioural difficulties at school entry suggests that these children are far more likely to be performing at or below National Minimum Standard in NAPLAN four years later (around 67 per cent for reading and 48 per cent for numeracy). Conduct problems and hyperactivity / inattention are the problems most associated with poor performance on NAPLAN.

The Child and Family Services Survey (CAFSOS), conducted on behalf of the then Department of Human Services in 2012, found that emotional and behavioural problems as measured by the SDQ are an area of high concern for children accessing Child and Family Services. Figure 3.15 indicates that high numbers of these children required or received counselling for emotional and behavioural problems.

Figure 3.15: Proportion of survey children receiving or needing treatment or counselling for emotional and behavioural problems by service group




Source: The Child and Family Services Outcomes survey, DHS, 2012

The *Longitudinal Study of Indigenous Children* (LSIC), also known as *Footprints in time*, looked at pro-social behaviour and social and emotional wellbeing for Aboriginal children aged 0 to 5. It found:

- children who had primary carers that placed more importance on their Aboriginal identity had lower difficulties scores
- higher levels of pro-social behaviour were associated with a child having more people reading to them, telling a story and/or drawing with them
- lower levels of difficult behaviour were associated with higher socioeconomic status, being healthier and being a girl
- children with higher levels of pro-social behaviour were more likely to have lower levels of difficult behaviour
- higher levels of reported health and socioeconomic status were also associated with less difficult behaviours
- household size had no significant effect on social and emotional wellbeing.[61]

# Childhood injuries can have a profound and lifelong effect on health and development

## Unintentional injuries

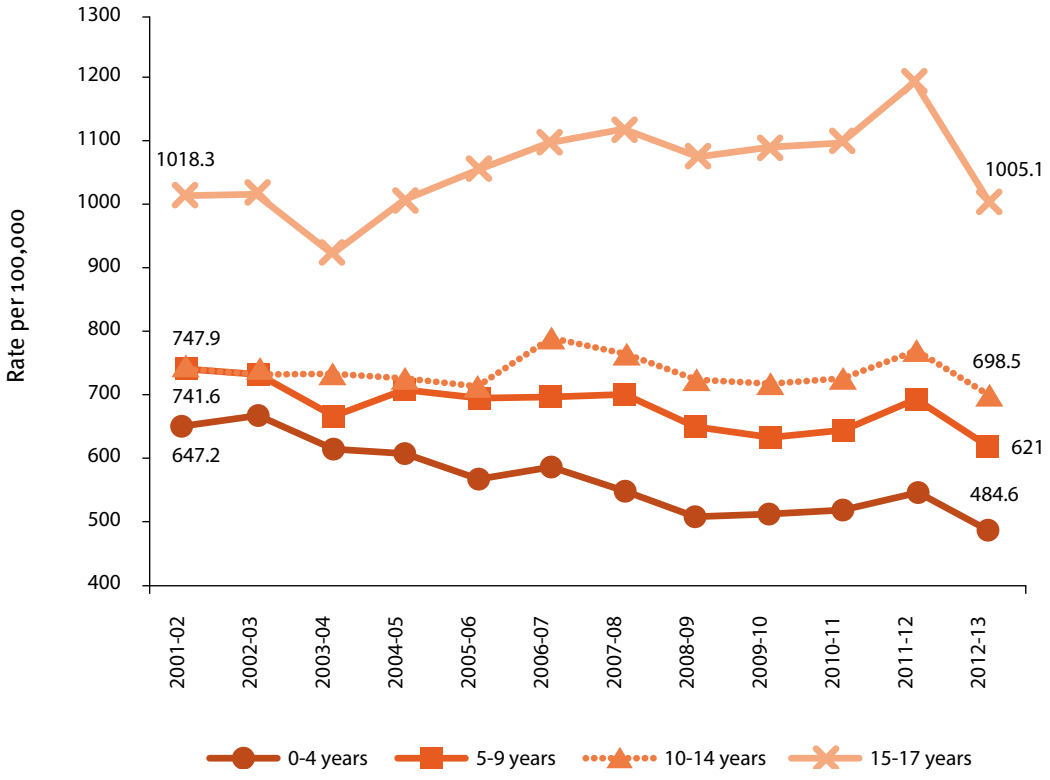
While most injuries to children and young people are unintentional, they are not necessarily random and may be prevented. Unintentional injuries include motor vehicle accidents, falls, drowning and poisoning. These injuries are the major cause of disabilities which can have a long-lasting impact on all facets of children's lives, including relationships, learning and play.

Many unintentional injuries are treated within the primary health care sector by general practitioners.[62] The risk of injuries varies with age, and time of life with early childhood and adolescence being times of higher risk.[63]

As seen in Figure 3.16, the hospitalisation rate for injury and poisoning has decreased for all children and young people between 2001–02 and 2012–13. The rate for 0 to 4 year olds decreased from 647.2 per 100,000 in 2001–02 to 484.6 per 100,000 in 2012–13.

Accidental injury and poisoning rates are highest for 15 to 17 year olds at 1005.1 per 100,000 in 2012–13.

Figure 3.16: Age specific hospitalisation rates from injury and poisoning for 0 to 17 year olds, Victoria 2001–02 to 2012–13




Source: Victorian Admitted Episodes Dataset, MUARC, 2001–02 to 2012–13

## Intentional injury

The most common intentional injury for infants from birth to around one year of age is child abuse or neglect.[64] Due to their physical fragility, infants are the group at highest risk of fatal abuse.[65] In Victoria, the Commission for Children in Young People's report into the deaths of children known to Child Protection found that over time, the greatest number of deaths was of infants aged between birth and six months. This is followed by children aged between six months and three years. Infants 0 to 3 years are the most represented age cluster, with 61 per cent of all deaths within the Child Protection population over time.[66]

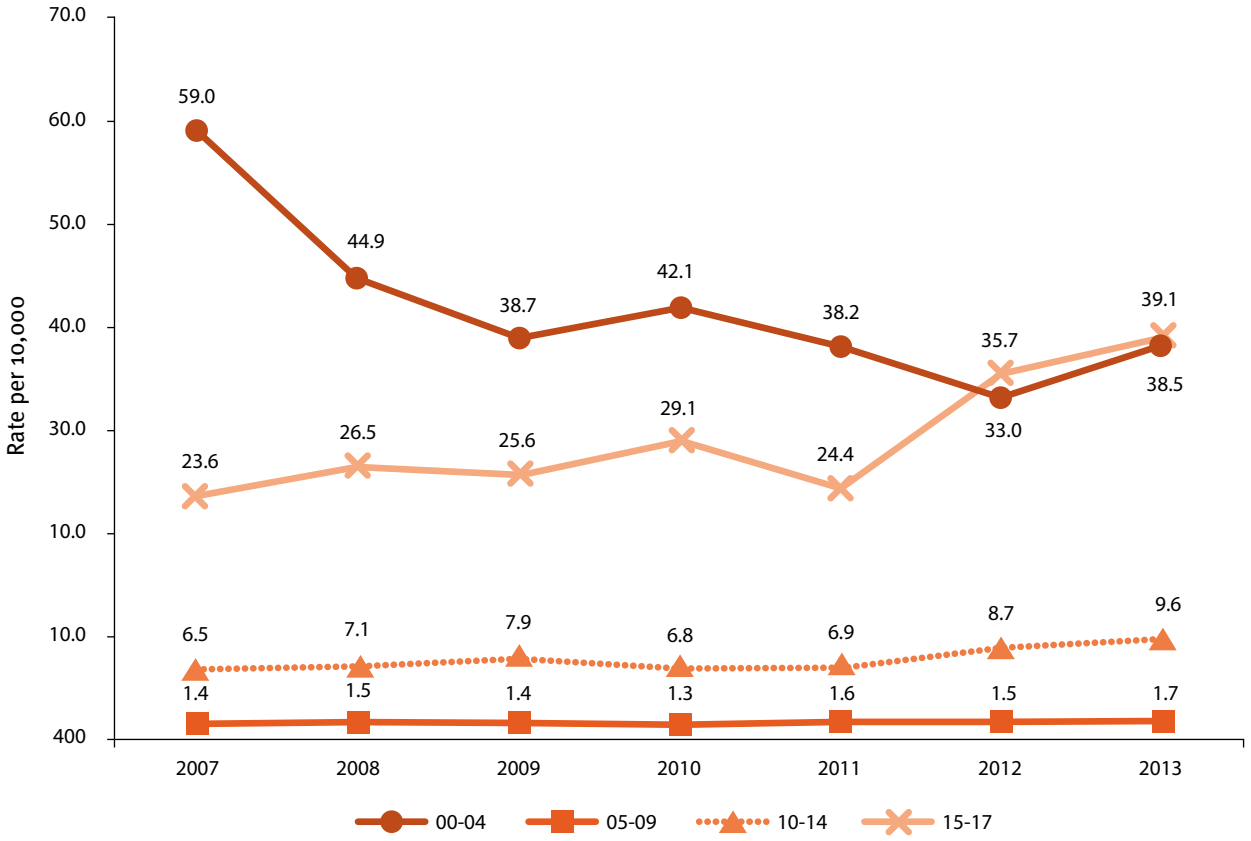
Shaken baby syndrome is a form of abuse that affects the health of babies and can result in brain damage, hearing loss, spinal cord injuries, speech difficulties and death. [67] [68] Overseas research has found that in the long-term, shaking can damage a child's brain so that they develop a range of sensory impairments, as well as cognitive, learning, and behavioural disabilities.[69]

## Hospital admissions for psychosocial issues and maltreatment have declined for very young children in recent years

Children are admitted to hospital not only through illness or injury, but for psychosocial reasons such as homelessness, upbringing and negative life events. Data from 2007 to 2013 indicates that hospital admissions for psychosocial issues and maltreatment are highest for the youngest children. Hospital admissions for 0 to 4 year olds decreased from 59 to 38.5 per 10,000 (Figure 3.17).

The rate of admissions remained stable for 5 to 9 year olds who had the lowest rate (around 1.5 per 10,000) and increased from 6.5 to 9.6 per 10,000 for 10 to 14 year olds. The rate of admissions has increased markedly for 15 to 17 year olds from 23.6 to 39.1 per 10,000.

Figure 3.17: Rate per 10,000 for hospital admissions for psychosocial issues and maltreatment, 2007–2013




Source: Victorian Admitted Episodes Dataset, DHHS, 2007–2013


Ella, Year 4

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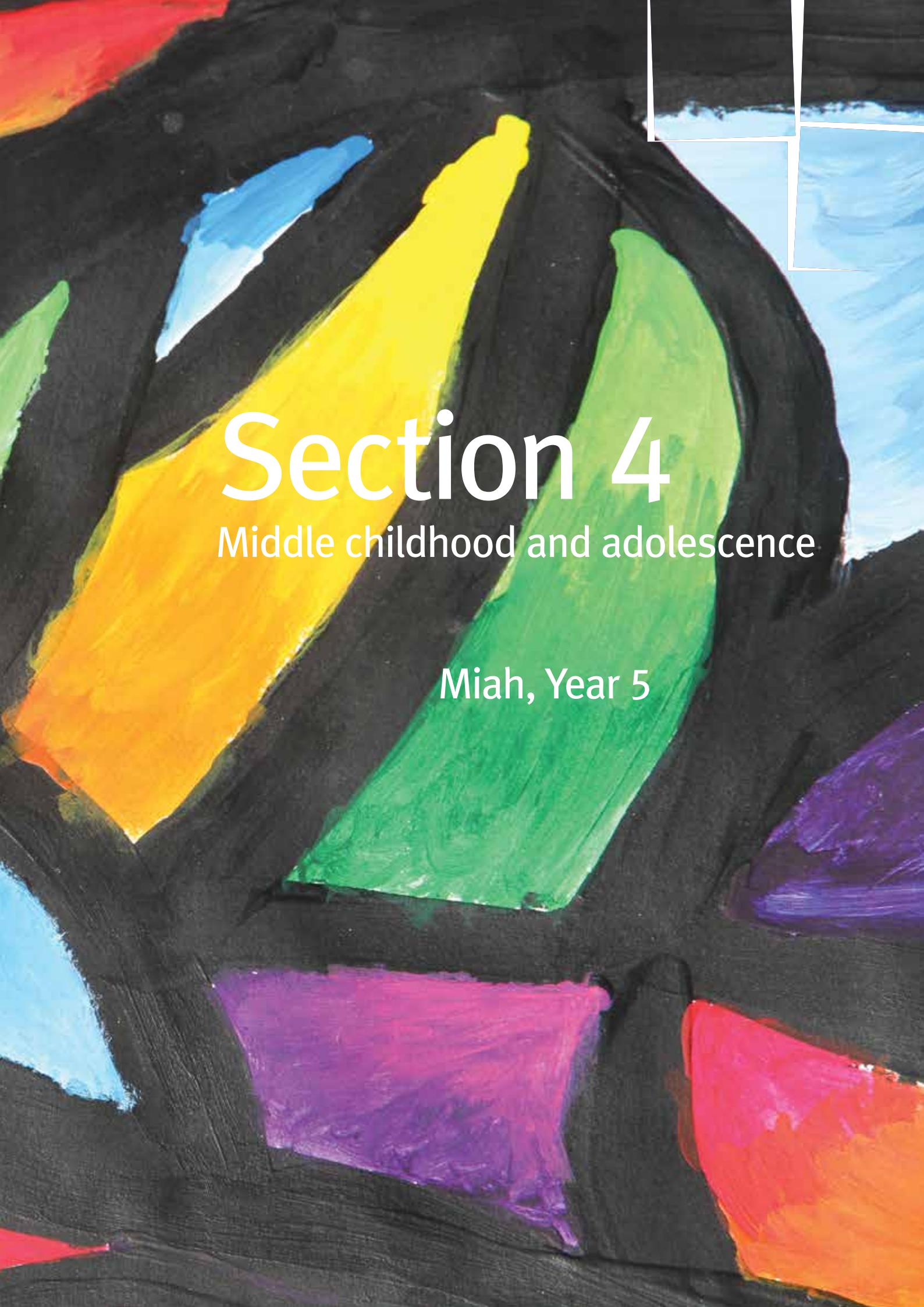


# Section 4

## Middle childhood and adolescence

Miah, Year 5

# Middle childhood and adolescence

Artwork by Emily, Year 4

Artwork by Holly, Year 1

The middle childhood and adolescent years are a time of major transition, as young people typically develop their sense of identity, have increasing responsibility for their own decision making, and begin to lay the foundations for their adult life.

Socially, young people form and shape their identities during these years. The experiences or activities that young people are exposed to significantly influence the development of the brain. The adolescent brain appears particularly adaptive to acquiring social competencies as young people move rapidly through different social environments than any other time in their life.[1]

Social status and social acceptance play an important role in how adolescents see themselves, and where they belong. Connectedness to peers, family, trusted adults and institutions such as school is considered a key protective factor for young people.

Mental health is an area of vulnerability which emerges for some young people during this time. Mental health issues are both an outcome of concern in their own right, and a risk factor for other health and wellbeing outcome areas for children and young people such as physical wellbeing, and social and academic engagement.

Engagement with learning during these years influences future learning and employment potential and aspirations as young people move towards adulthood, and strong engagement is an important protective factor for education and employment outcomes. Learning confidence and motivation are vital to achieving good educational outcomes, and attendance at school supports learning as well as social and emotional development for young people.

During the middle childhood and adolescent years, young people begin to have more responsibility for their own health behaviours, and their choices impact on their wellbeing and their future health and habits. Early drinking behaviours for example are a risk factor for short and long term health, and can lead to other risky behaviours such as unsafe sex. Young people who take up drinking alcohol early are also more likely to develop alcohol problems later in life.

Criminal behaviour is both an outcome of concern and a risk factor for vulnerable young people. A range of risk and protective factors may influence the likelihood of a young person being involved in the youth justice system. Young people exposed to family violence, for example are more likely to be involved with the youth justice system, while engagement with education is a protective factor. Young people entering the system at an earlier age are also at high risk of become long term offenders.

This chapter considers some common risk and protective factors that emerge during middle childhood and adolescence, including risky health behaviours and socio emotional factors. It also considers schooling outcomes and their influence on future education and employment outcomes.

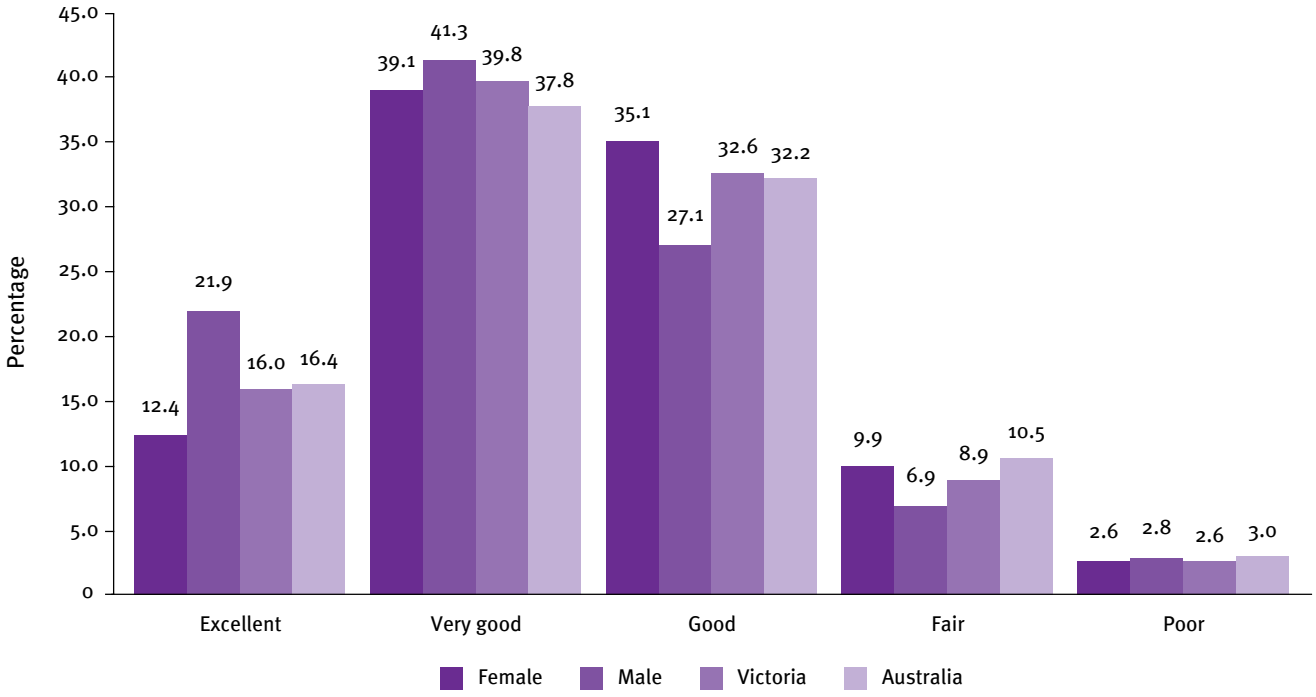
# Health behaviours in adolescence

While most young people enjoy good health, many poor and risky health behaviours emerge during adolescence. These behaviours present both short and long term risks to young people's health, wellbeing and safety, and can lead to ongoing unhealthy behaviours which continue into adulthood.

## Most young people rate their own health as good or better

In a recent survey, over 80 per cent of Victorian young people aged 15 to 19 years rated their health as either good, very good or excellent (Figure 4.1). Very few young people (2.6 per cent) felt their health was poor. Males were more likely than females to report that their health was excellent (21.9 per cent compared with 12.4 per cent), and less likely to report their health was fair (6.9 per cent compared with 9.9 per cent for females).

Figure 4.1: Young people's perception of their health, Victoria 2012




Source: Mission Australia Youth Survey, 2012, Victorian data

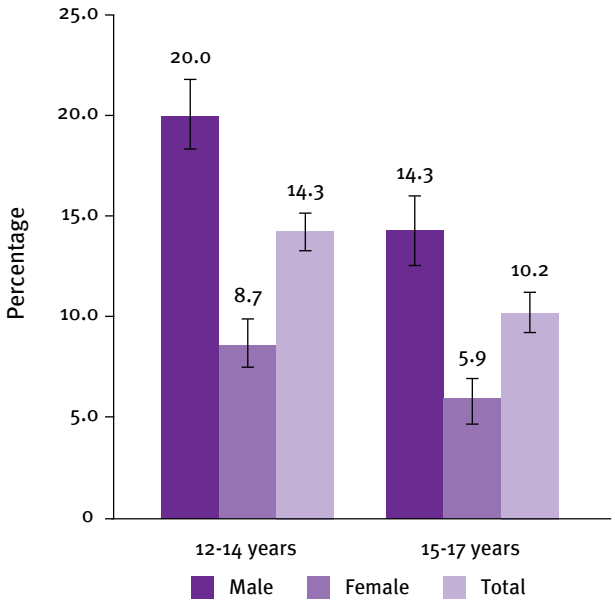
## Very few Victorian young people do enough physical activity

Participating in physical activity and sport has many benefits for young people. This includes benefits for self-esteem, positive social interactions, and a reduction in the symptoms of depression.[2] Physical activity also protects against overweight, obesity and other health issues.

As children reach adolescence, they participate less in sport and physical activity (Figure 4.2). Rates are particularly low for adolescent girls. Fewer than one in five (17.2 per cent) of adolescent boys and only seven per cent of girls meet the National Health Medical Research Council (NHMRC) minimum daily physical activity guidelines of one hour or more per day.

If Victorian adolescents are not playing sport, how are they spending their time? More than 50 per cent are using electronic media for more than two hours a day, exceeding the recommended NHMRC maximum. It is an indicator of sedentary behaviour and boys are more likely to exceed the recommended limit.

Figure 4.2: Proportion of Victorian young people who meet the Australian Physical Activity Guidelines, 2009




Source: HowRU?, Department of Education and Training, 2009

# Poor health behaviours in adolescence

Poor health behaviours that emerge in adolescence can have long-term health impacts. Adolescents are more likely than children or adults to engage in risk-taking behaviours such as smoking, illicit substance use, binge drinking, casual sex and criminal behaviour. Adolescent brain development, which occurs primarily in the prefrontal cortex, may explain adolescents' tendency to respond with emotion or engage in risky-behaviour.[3] Neuroscience suggests that risk taking is a result of 'dramatic remodelling of the brain's dopaminergic system' leading to increased reward or sensation seeking, particularly in the presence of peers.

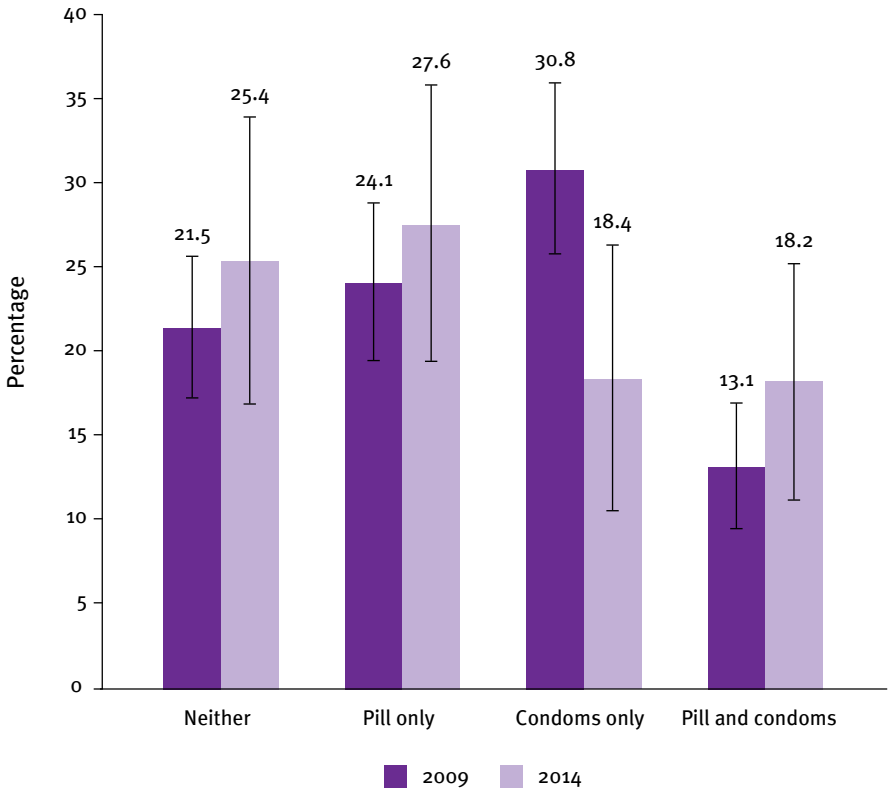
## Early sexual activity is a risk factor for adolescents' sexual health

Sexual intercourse before the age of 16 years is associated with lower use of contraception, more sexual partners, a higher risk of sexually transmitted infections and teenage pregnancy.[4] Recent Australian research with senior secondary students from all sectors found:

- 23 per cent of Year 10 students, 34 per cent of Year 11 students and 50 per cent of Year 12 students have had sex
- 63 per cent of students believe that 'most' or 'all' of their peers use a condom when they have sex
- 59 per cent of sexually active students reported using a condom the last time they had sex
- almost a quarter of sexually active students (23 per cent) had sex with three or more people in the past year
- only 52 per cent of young women reported having been vaccinated against human papilloma virus (HPV).[5]

In a 2014 survey, 5.7 per cent of Year 8 students and 32.9 per cent of Year 11 students reported that they had had sex. This is comparable to 2009 figures indicating that more than four per cent of 12 to 14 year olds and 22.4 per cent of 15 to 17 year old Victorian students had had sex.[6] There has been a decrease in the number of students reporting always using a condom from 54.6 per cent in 2009 to 38.4 per cent in 2014. Importantly, the number of Year 11 females who report using no contraception has increased between 2009 and 2014 from 21.5 per cent to 25.4 per cent (Figure 4.3). However use of the contraceptive pill only or with condoms has also increased, with sole condom use decreasing.

Figure 4.3: Proportion of sexually active Victorian female Year 11 students who report 'always' using selected contraception types, 2009 and 2014




Source: HowRU? and About You, Department of Education and Training, 2009 and 2014

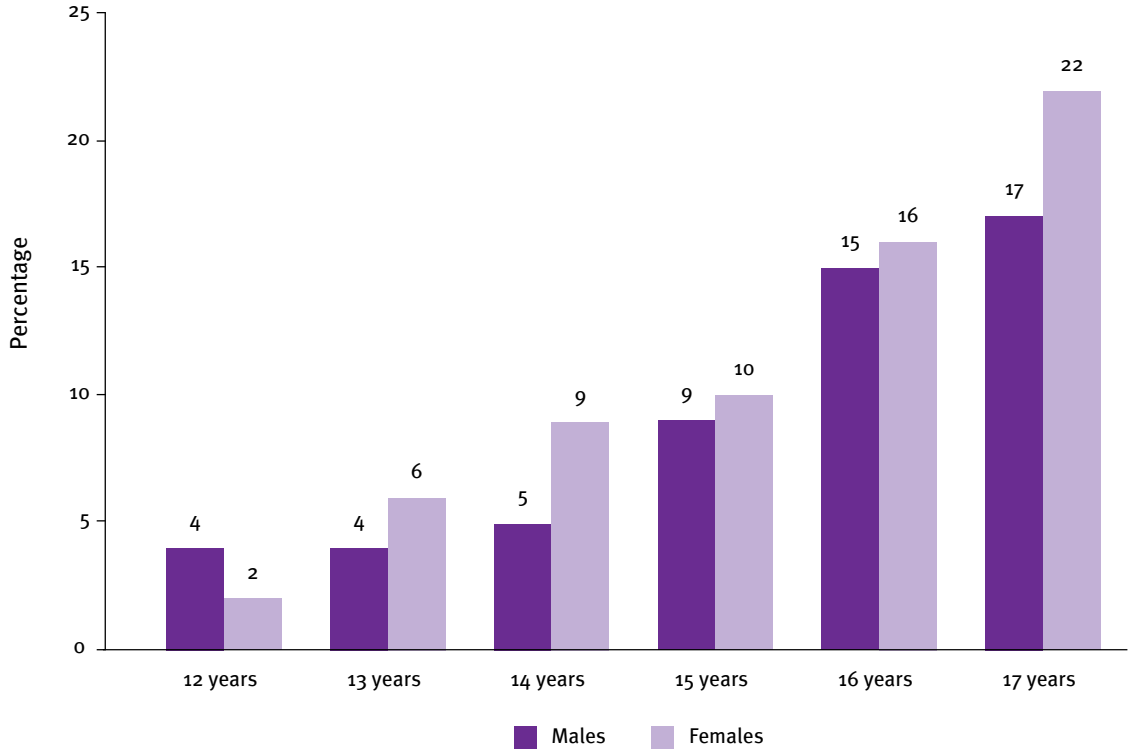
## Adolescent smoking has decreased in recent years

Smoking during childhood and adolescence causes a range of short-and long-term health problems. Young smokers are likely to be less physically fit than their non-smoking peers. As their tobacco consumption increases, their fitness declines and they may have sleeping disorders, recurrent headaches and changes in risk factors for cardiovascular disease.[7]

Victorian research with a large group of teenagers over ten years found that substance abuse, especially cannabis dependence, and psychiatric illness was more likely in continuing smokers.[8,9]

Rates of adolescent smoking have decreased over time. Figure 4.4 shows that while boys are more likely to have smoked in the past month at age 12, this pattern shifts to girls from age 13. In 2011, around 20 per cent of 17 year olds had smoked cigarettes in the last month.

Figure 4.4: Percentage of Victorian students who had smoked cigarettes in the past month, by age and sex, 2011




Source: Australian Secondary Students Alcohol and Drug survey, Cancer Council Victoria, 2011

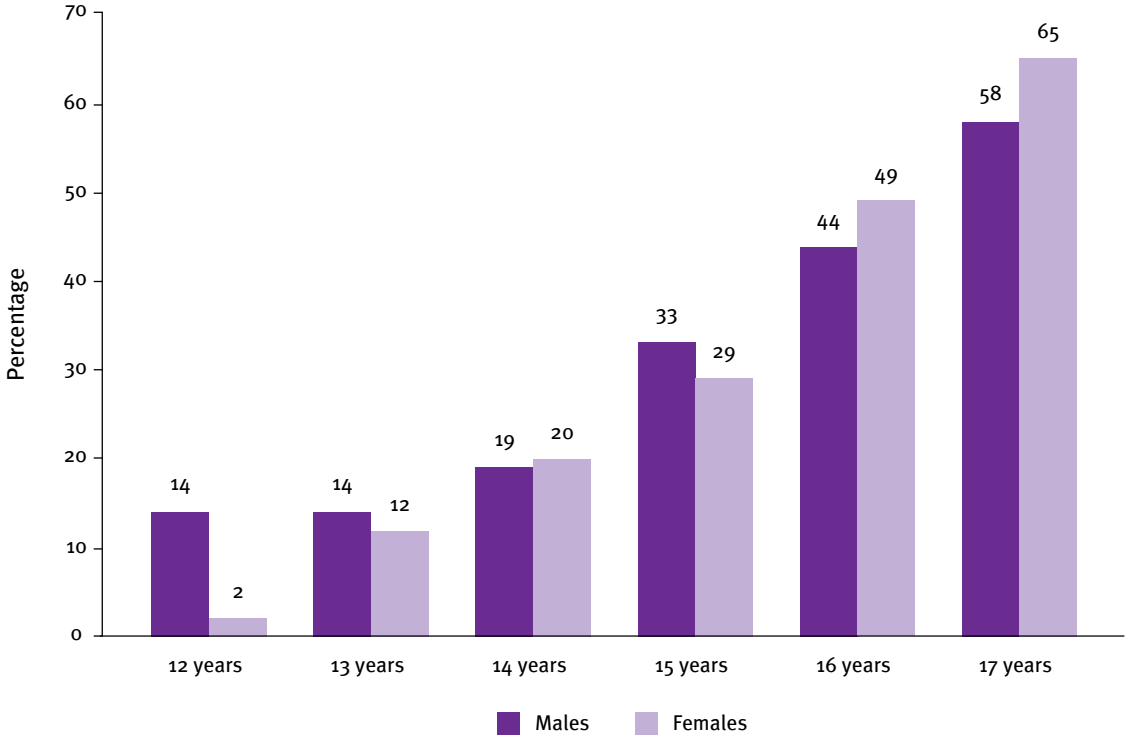
## Drinking is a health risk for young people, and can lead to other risky behaviours

Alcohol is widely used by young Australians. Almost 90 per cent of Australian teenagers over the age of 14 years have tried alcohol at least once and around 50 per cent of teenagers over 14 years drink alcohol at least weekly. Risk taking behaviours such as binge drinking, drink driving, unsafe sex and other drug use, as well as alcohol related harm can result from the misuse of alcohol.[10]

The number of young people who were current drinkers decreased significantly between 2008 and 2011. In 2008, 17 per cent of 12 to 15 year olds drank in the previous week compared to 11 per cent in 2011. These figures were higher for 16 to 17 year olds of which 38 per cent had drunk alcohol in the week before the survey in 2008 compared to 33 per cent in 2011.[11]

Long-term alcohol dependence is higher in those who began drinking at early ages. The percentage of boys who drank in the last month is much higher than the percentage of girls at age 12 (14 per cent compared to 2 per cent). By age 17, girls (65 per cent) are more likely than boys (58 per cent) to be drinking (Figure 4.5).

Figure 4.5: Percentage of Victorian students who used alcohol in the past month, by age and sex, 2011




Source: Australian Secondary Students Alcohol and Drug survey, Cancer Council Victoria, 2011

Drinking alcohol can affect how the brain develops in people under the age of 25, with young people under 15 years of age being particularly at risk due to the effect of alcohol on the developing brain. Alcohol consumption, particularly binge drinking, in teenagers is also linked to risky situations such as unsafe sex, fighting and brawling, drowning, drug overdose or self-harm and suicide.[12]

## Illicit substance use among young people is low

The 2011 Australian School Students' Alcohol and Drug Survey (ASSAD) found that 14 per cent of Victorian secondary school students aged between 12 and 17 years reported having used an illicit drug. However, slightly more than half of this percentage was cannabis use, leaving only six per cent of students having used another illicit drug. Compared to students' rates of licit substance use, this percentage is low, and suggests that experimentation with illicit substances other than cannabis is rare among Victorian secondary school students.

Overall, three per cent of students aged 12 to 17 years reported having used amphetamines. Lifetime use of amphetamines increased significantly with age, peaking at five per cent for both males and females at 17 years of age. Overall, rates of amphetamine use were significantly lower in the 2011 survey than in most previous years since 1996.

Further information about drug use comes from Victoria Police processing data for juvenile offenders, which shows a steady increase in juveniles aged 17 and under processed for drug use and possession since 2006–07 (Table 4.1). These figures peaked in 2012–13 at 225 arrests and 474 cautions for drug possession and use. Each year, they are consistently far higher for males than females.

Table 4.1: Number of juvenile offenders processed for drug possession and use, by processing category, Victoria 2006–07 to 2012–13

| | MALES | | | FEMALES | | | ALL | | |
|---|---|---|---|---|---|---|---|---|---|
| | Arrest | Caution | Summons | Arrest | Caution | Summons | Arrest | Caution | Summons |
| 2006–07 | 107 | 241 | 97 | 22 | 66 | 28 | 129 | 308 | 125 |
| 2007–08 | 131 | 215 | 118 | 21 | 53 | 25 | 152 | 268 | 143 |
| 2008–09 | 144 | 232 | 123 | 19 | 49 | 24 | 163 | 281 | 147 |
| 2009–10 | 133 | 325 | 143 | 25 | 65 | 46 | 158 | 391 | 189 |
| 2010–11 | 144 | 299 | 120 | 35 | 74 | 24 | 179 | 375 | 144 |
| 2011–12 | 150 | 344 | 131 | 28 | 85 | 26 | 178 | 431 | 157 |
| 2012–13 | 189 | 388 | 144 | 36 | 85 | 26 | 225 | 474 | 170 |

Source: Victoria Police Crime Statistics, Tables 4.2.1, 4.2.2 and 4.2.3

Recent reports indicate that the numbers of young people seeking treatment to wean themselves off methamphetamines, including ice, have increased fourfold over five years.[13]

In 2013–14:

- 1527 cautions and diversions were issued to all age groups for drugs other than cannabis, of which 38 were issued to people under 18
- 265 of the 491 cautions issued to juveniles for drug offenses including drug cultivation, were to first time offenders (54 per cent)
- 12 of the 497 juveniles cautioned for drug offenses including cultivation, were Aboriginal (see also table 4.4, page 77).

There are a range of youth specific services and initiatives for young people relating to alcohol and drug use funded by the Victorian Government. These include alcohol and other drug primary prevention (DrugInfo), peer education and information programs (Dancewize), drug treatment services and support for young offenders with substance use issues (Youth Support Service).

The Victorian Parliament's 2014 Inquiry into the Supply and Use of Methamphetamines, particularly 'ice', in Victoria identified the rise in ice use particularly focussed on young people between 20 and 29. However, within its 54 recommendations, the Inquiry included the need for continued support for initiatives and programs for school aged children that have been successful in preventing or reducing the uptake of drug use.

The Victoria Government's Ice Action Plan was delivered on 5 March 2015 and is supported by $45.5 million new funding. The plan identifies a number of key priorities focussed on reducing the harm associated with ice use among young people.

These include a focus on prevention through accessible information and advice for families and communities, supporting parents and schools to build resilience in children and young people, and reaching out to young people outside the formal school system and other groups most at risk through peer based education and other community programs.

The Government has funded a range of Aboriginal-specific education and awareness initiatives, and will continue to invest in this area. This includes working in partnership with Aboriginal Community Controlled Health Organisations to develop and deliver targeted interventions for high risk groups (for example, young people) and tailored information and support for families.

The Government will also continue to support the delivery of targeted information and support for Victoria's Lesbian Gay Bisexual Trans and Intergender communities, including alcohol and drug support provided by the Victorian Aids Council.

# Social connectedness and engagement

Connectedness to peers, family, trusted adults and institutions such as school is a key protective factor for adolescents.

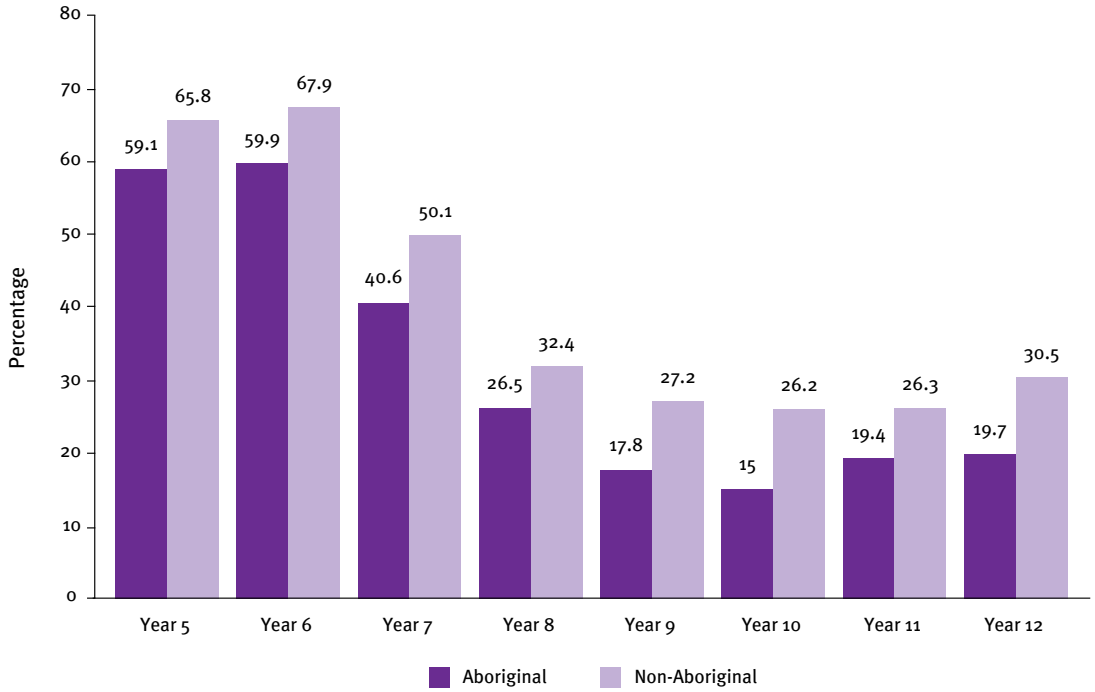
## A sense of belonging and connectedness to school is a protective factor for resilience in children and young people.[14]

Schools can reduce the effects of risks on children and provide them with a sense of stability and security through difficult periods. Adults who care about a child as a learner and an individual are critical to the child's sense of school connectedness.[15]

The majority of Victorian government secondary school students do not feel connected to their school. Only one third of primary school students feel the same (Figure 4.6). Connectedness to school progressively decreases as children age, with the sharpest drop occurring between Years 7 and 8 (50.1 per cent to 32.4 per cent). School connectedness improves slightly between Years 11 and 12 but is still low overall (30.5 per cent).

Aboriginal student connectedness to school is lower than for their peers but follows the same pattern, decreasing from primary school to secondary school. Importantly, the drop in connectedness occurs at the transition from primary to secondary (Years 6 to 7) rather than at Year 8. It also shows lower improvement from Year 11 (19.4 per cent) to Year 12 (19.7 per cent). This suggests that Aboriginal students are not making the transition to secondary school as successfully and not experiencing the same sense of belonging and connectedness.

Figure 4.6: Proportion of Victorian government school students who feel they belong and enjoy attending school, by year level and Aboriginal status, 2013

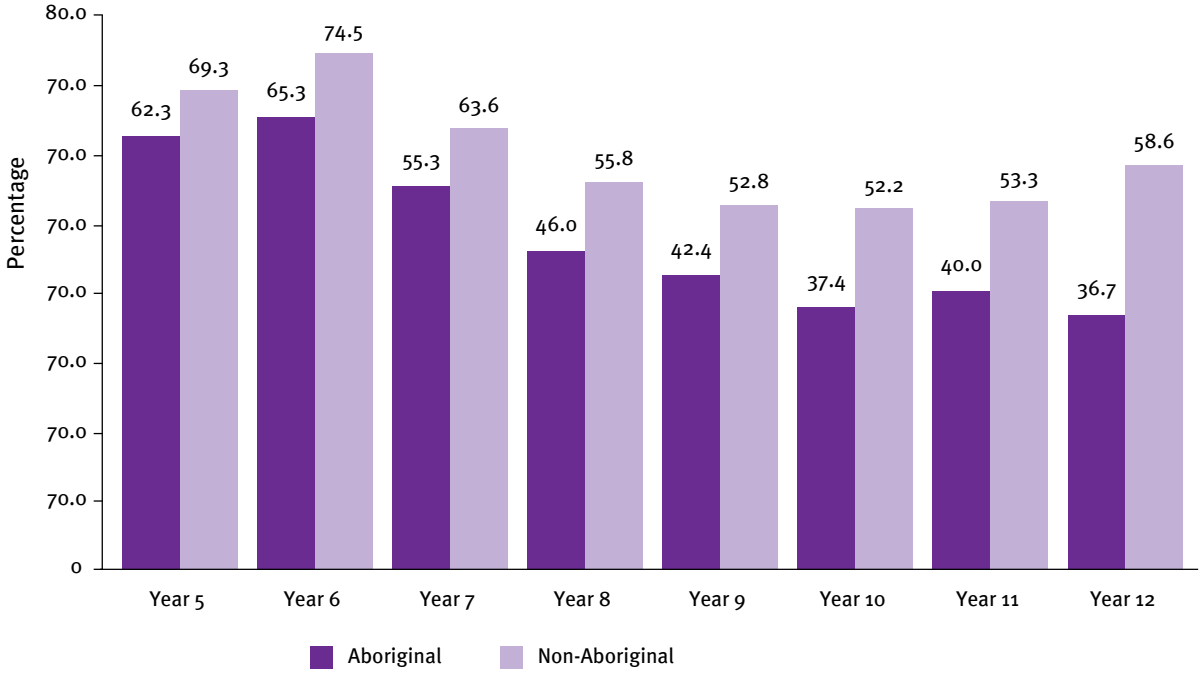



Source: Attitude to School Survey, Department of Education and Training, 2013
Note: These proportions are derived from multiple questions. Only students who responded with 'agree' or 'strongly agree' on all relevant questions are included in these results. Other students gave mixed or opposite views.

Connectedness to peers is also an important protective factor for learning, development and wellbeing. Peer acceptance can reduce the negative impact of disadvantage, violent marital conflict and harsh discipline. Peers can also moderate harsh, physical discipline for children.

2013 data shows that Victorian government students feel far more connected to their peers than to their schools. They are most connected in Year 6 (74.5 per cent) and least in Years 8 and 9 (around 52 per cent) (Figure 4.7). Connectedness to peers is lower for Aboriginal students but remains higher than their connectedness to school.

Figure 4.7: Proportion of Victorian government school students who feel socially connected and get along with their peers, by year level and Aboriginal status, 2013




Source: Attitude to School Survey, Department of Education and Training, 2013

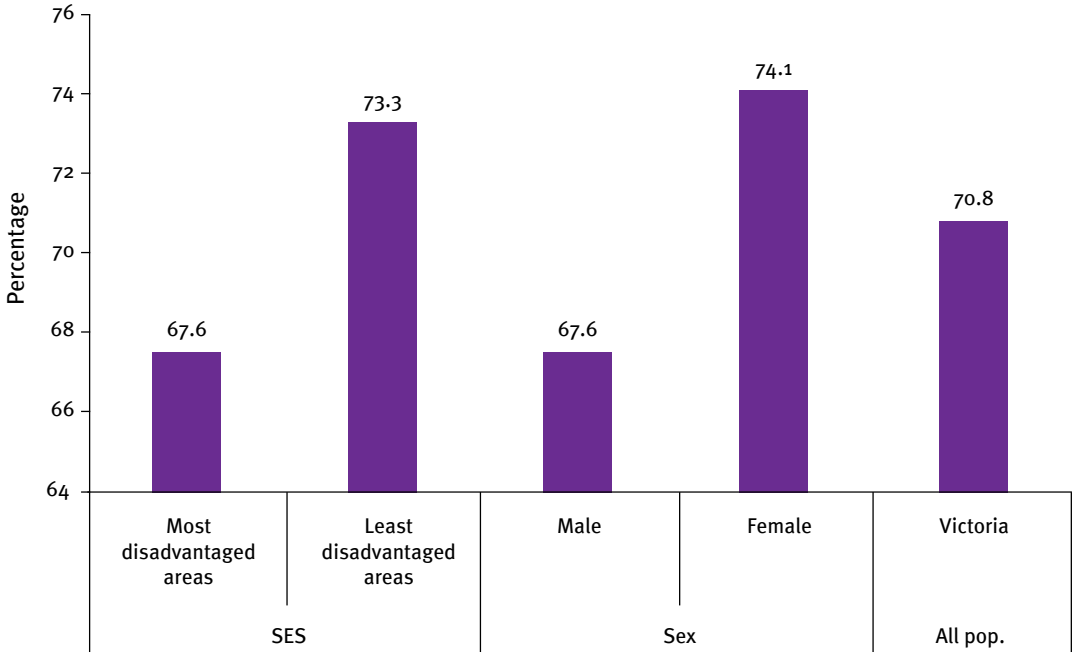
Note: These proportions are derived from multiple questions. Only students who responded with 'agree' or 'strongly agree' on all relevant questions are included in these results. Other students gave mixed or opposite views.

## Having a trusted adult provides support to young people

Parents, carers, relatives or teachers can play a significant role in building resilience in children and young people and contribute to learning and development, health and wellbeing. Most young people aged 12 to 17 years report having a trusted adult in their lives (70.8 per cent) (Figure 4.8).

Females and young people from more advantaged areas are more likely to report having a trusted adult in their lives (74.1 per cent and 73.3 per cent). Males and young people from the most socioeconomically disadvantaged areas are less likely to have a trusted adult in their lives (67.6 per cent).

Figure 4.8: Proportion of Victorian young people aged 12–17 years who report having a trusted adult in their lives, by socioeconomic status (SES) and sex, 2009



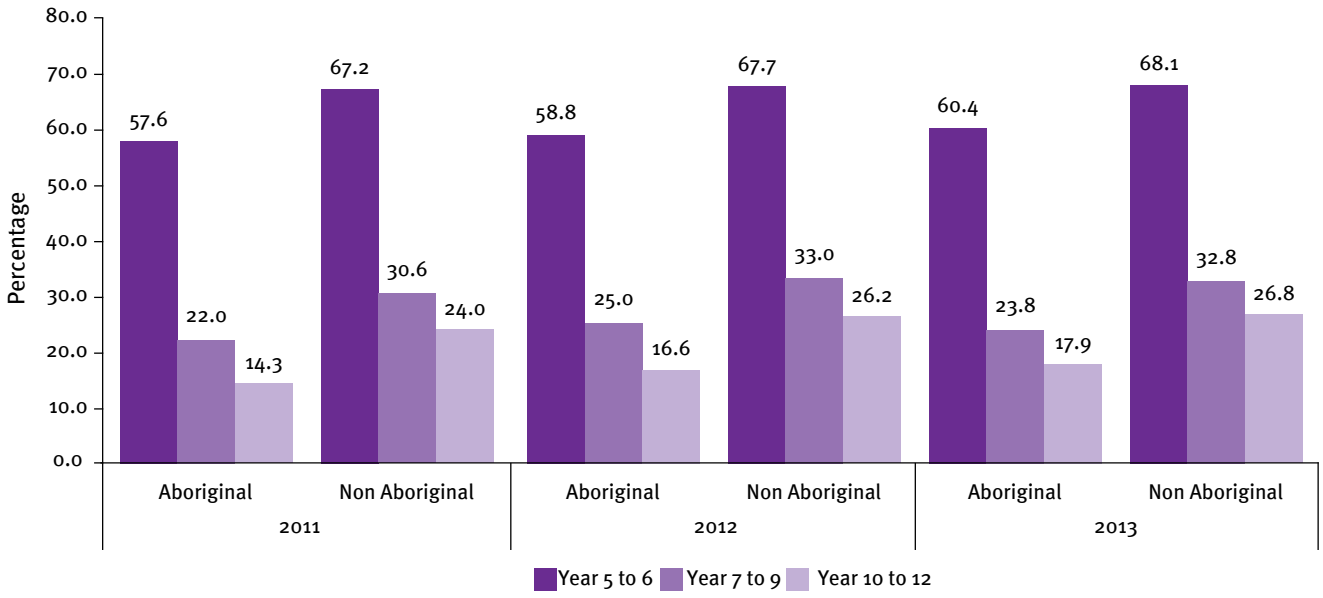

Source: HowRU, Department of Education and Training, 2009

## Teachers are significant adults for children and young people

Teachers can help build resilience through positive relationships with children. Listening, understanding their needs and concerns, and helping them develop coping skills and capacities can all be part of a positive relationship. Students see teachers as empathetic if they provide support, assist them with problems, listen and understand their needs.

Up to three quarters of secondary school students do not see their teachers as empathetic to their needs (Figure 4.9). There is a change as children move from primary to secondary school with students being less likely to perceive their teachers as empathetic. Although more than 50 per cent of all children believe their teachers listen, assist learning and understand their needs in Years 5 and 6, this has dropped to around 20 per cent by Years 10 to 12. Aboriginal students consistently have lower perceptions of their teacher's empathy than their peers.

Figure 4.9: Proportion of students who feel their teachers listen, assist learning and understand their needs, government schools, by year level group and Aboriginal status, 2011 to 2013




Source: Attitude to School Survey, Department of Education and Training, 2013

Note: These proportions are derived from multiple questions. Only students who responded with 'agree' or 'strongly agree' on all relevant questions are included in these results. Other students gave mixed or opposite views.

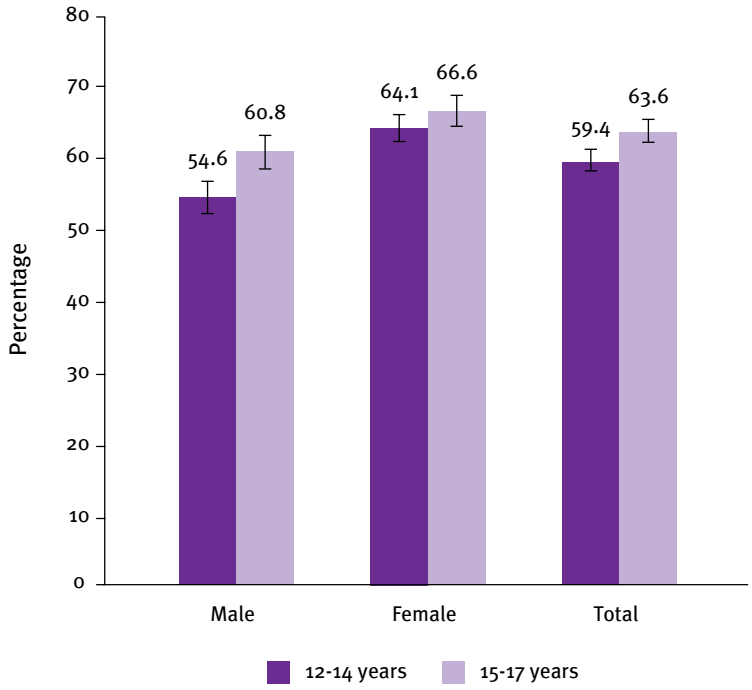
## Over one third of young Victorians do not have positive psychological development

For young people, positive psychological development is a resilient and healthy state of social and emotional functioning. It includes perceptions of autonomy (a sense of personal agency), relatedness (positive connections with others) and competence (feeling capable or masterful). [16]

Two-thirds of Victoria's young people have positive psychological development, with females having higher levels than males at ages 12 to 14 (64.1 per cent compared to 54.6 per cent) and 15 to 17 (66.6 per cent compared to 60.8 per cent) (Figure 4.10).

While this is a reasonably high proportion, it still means that nearly two in five young people do not have positive psychological development.

Figure 4.10: Proportion of young people with positive psychological development, 2009




Source: HowRU, Department of Education and Training, 2009

## Mental health issues can affect many aspects of a young person's life

Mental health is closely linked to social and emotional wellbeing. Mental health problems can affect thinking, emotions, behaviour and social abilities, and can cause concern and distress.[17]

Mission Australia's *Youth Mental Health Report* 2013 indicates that:

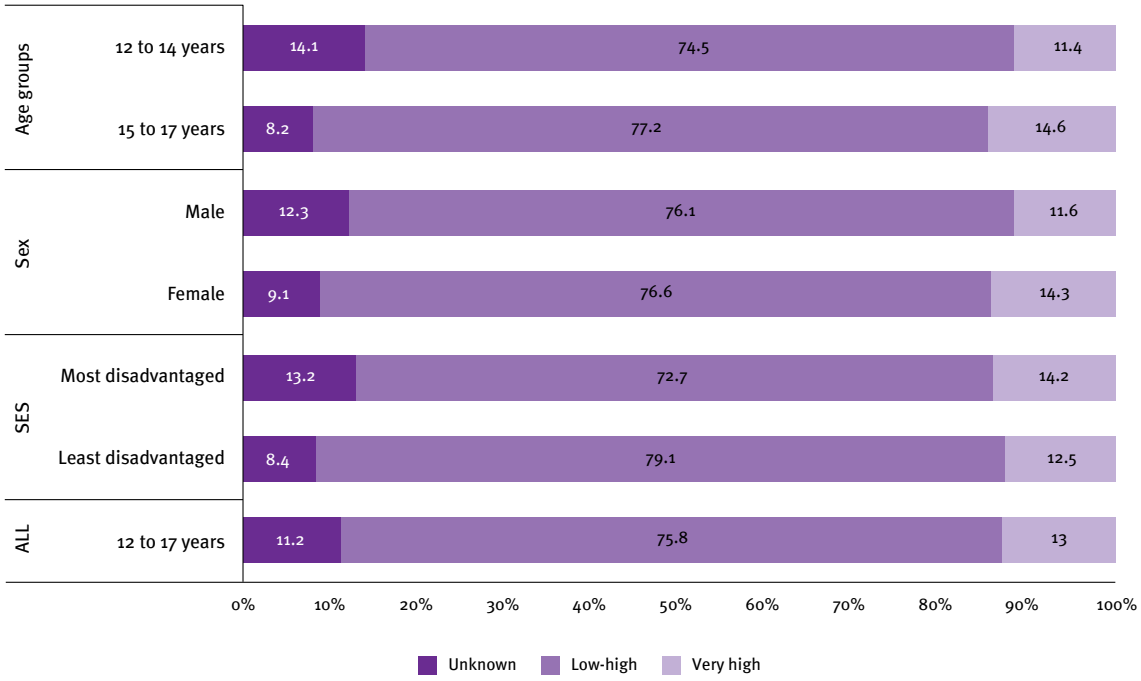
- 21.2 per cent of young people met criteria for a probable serious mental illness. Females were almost twice as likely as males to meet criteria (26.2 per cent of females compared to 13.8 per cent of males).
- Young people with probable serious mental illness were around five times more likely to express serious concerns about depression (57.0 per cent compared to 11.5 per cent) and suicide (35.3 per cent compared to 6.8 per cent) than their peers.
- Over 60 per cent of young people with probable serious mental illness were not comfortable seeking information, advice or support from professional services.[18]

Young people see many barriers preventing them from seeking assistance for mental health problems. These include their own inability to recognise mental health symptoms, and the stigma and embarrassment associated with having mental health issues. Adolescents are also more likely to attempt to solve problems by themselves than to seek help.[19]

## Some young Victorians experience psychological distress

In 2009, around 13 per cent of Victoria's young people aged 12 to 17 years had very high levels of psychological distress. The rate was higher for older adolescents (15 to 17 years), females and young people who live in areas of the most socioeconomic disadvantage (Figure 4.11). [20]

Figure 4.11: Proportions of young people with very high levels of psychological distress, by characteristics, 2009




Source: HowRU?, Department of Education and Training, 2009

These findings are consistent with national figures from 2007 in which around 14 per cent of children aged 4 to 17 had mental health problems, with males having the highest proportion of problems, largely due to higher attention deficit hyperactivity disorder prevalence rates. Family structure was also a factor, with higher numbers of children from one-parent or blended families having mental health problems (Table 4.2).[21]

Table 4.2: Proportion of Australian children experiencing mental health problems by family structure

| | Males (%) | Females (%) | Persons (%) |
|---|---|---|---|
| Families with two parents or carers | 13.9 | 9.6 | 11.8 |
| Original family | 12.4 | 8.4 | 10.4 |
| Step family | 21.1 | 15.6 | 18.3 |
| Blended family | 24.0 | 16.4 | 20.2 |
| Other family (a) | 29.5 | 18.4 | 23.7 |
| Families with one parent or carer | 25.3 | 19.2 | 22.4 |
| All Families | 16.3 | 11.5 | 13.9 |

'Original family' has at least one child living with their natural, adoptive or foster parents, and no step children.
'Other family' is where all children are not the natural, adopted, foster or step child of one or both carers.
(a) Data to be treated with caution due to low respondent numbers in this category.
Source: National Survey of Mental Health and Wellbeing, 2007

Other groups of young people who may have greater risk of experiencing psychological distress include:

- Aboriginal children, particularly where they are exposed to racism or have lower levels of resilience[22]
- Culturally and Linguistically Diverse and/or refugee children and young people who have been exposed to traumatic exposures prior to migration and who experience difficulties associated with resettlement
- Lesbian, gay, bisexual, trans and intersex (LGBTI) young people particularly where they have been exposed to verbal or physical homophobic abuse.[23]

Emotional distress affects children, young people and school communities every year. This may include mental health issues such as anxiety and depression, self harm behaviours, suicidal ideation and suicide. These issues have a significant impact on the health and wellbeing of children and young people, including their educational, developmental and wellbeing outcomes.

The Victorian Government has partnered with headspace, the National Youth Mental Health Foundation to develop *SAFEMinds: Schools And Families Enhancing Minds*, a comprehensive learning and resource package that will enhance the capacity of school communities to effectively identify children and young people with early signs of mental health issues, offer school-based interventions, effectively respond to self harm, and refer appropriately when needed.

http://www.education.vic.gov.au/school/parents/health/Pages/mentalhealth.aspx

## Around 10,000 children and young people use Child and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) or Child and Youth Mental Health Services (CYMHS) in Victoria are for children and young people up to the age of 18 years, or in some areas up to the age of 25, who have serious emotional disturbance. The target group includes young people with a diagnosable psychiatric disorder whose condition is seriously detrimental to their growth or development and/or who have serious difficulties in their social group or family.

DHHS note that in 2013–14 there were approximately 10,300 clients recorded as receiving a CAMHS/CYMHS service. Of these, approximately 2,700 were aged from 2 to 11 years old.

Many children and young people with emotional disturbance do not require specialist mental health services and are supported by primary care and other health, educational and support services. Specialist mental health services operate as part of this broader service network and must develop and maintain links with other services.

## Self-harming behaviour is an important risk factor for later suicide

Self-harm involves deliberate physical injury to the body. Typically, it is not suicidal but includes some actions that could lead to suicide. Self-harm is linked to strong feelings of depression or anxiety, low self-esteem, poor body image, post-traumatic stress disorder, family members who self-harm, impulsivity, and abuse.[24,25]

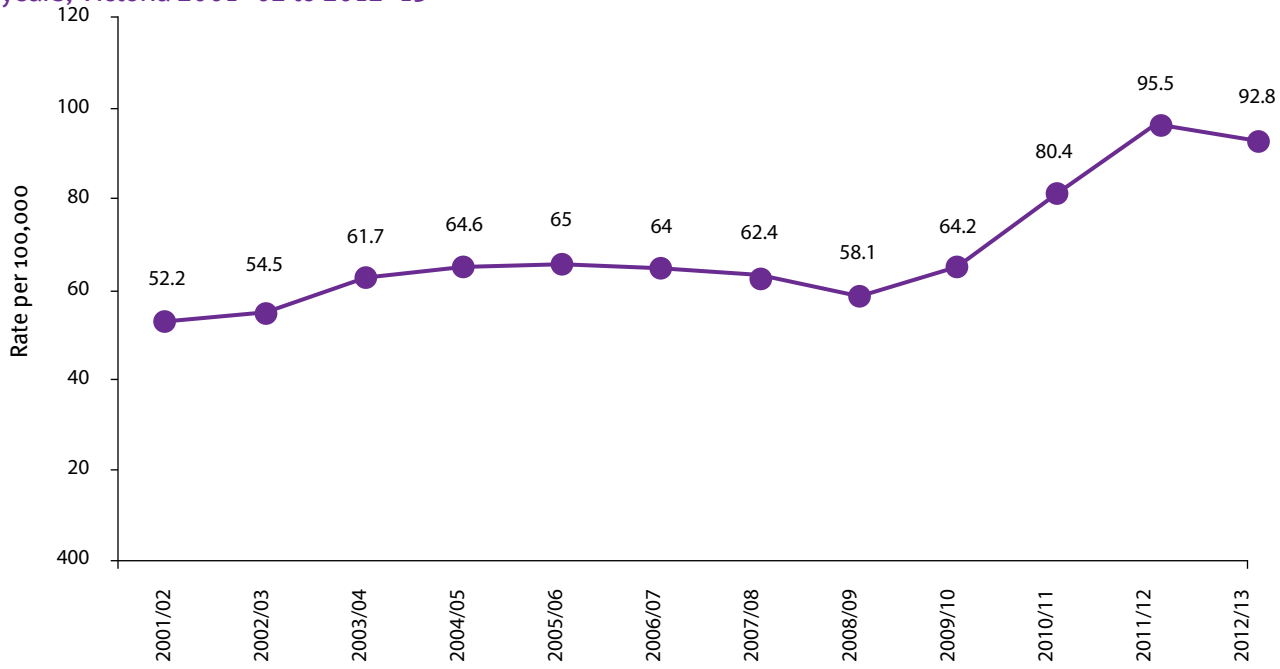
Self-harm is uncommon in childhood but rises dramatically in late puberty.[26] The average age at which it first occurs is around 12 to 14 years however children as young as eight have harmed themselves.[27] During adolescence, girls are

more likely than boys to self-harm.[28]

Self-harm is an important risk factor for later suicide. For young people presenting clinically with self-harm injury, rates of later suicide have been estimated to be 30 times higher.[29] Some young people engage in self-harm which is clearly associated with a level of distress and suicidal intent. In some instances, injuries may indicate the level of intent, but there are other instances, such as overdose and single vehicle accidents, where intent may be less clear.' [30]

Hospital admissions for intentional self-harm injury among young people aged 10 to 17 years have risen steadily since 2001–02 from 52.2 per 100,000 to 92.8 per 100,000 in 2012–13 (Figure 4.12).

Figure 4.12: Age specific rate of intentional self-harm injury admissions among young people aged 10–17 years, Victoria 2001–02 to 2012–13




Source: Victorian Admitted Episodes Dataset, MUARC, 2001–02 to 2012–13

Note: In July 2012 the Victorian Hospital Admission Policy changed significantly meaning that patients who received their entire care within a designated emergency department or urgent care centre could no longer be eligible for admission regardless of the amount of time spent in the hospital. This has had the effect of reducing the number of admissions recorded on the VAED for the 2012–13 financial year. For this reason caution should be exercised when interpreting potential changes in the number of hospital admissions in 2012–13 compared with previous years.

## Emergency hospital treatments for older adolescents experiencing mental illness have increased in recent years

Mental health problems have consistently been linked with child abuse and neglect, particularly in adolescents, and can require emergency hospital treatment and in some cases, hospitalisation.

Children and young people diagnosed with a mental health issue and accessing clinical medical services or receiving hospital treatment have very complex and critical needs. Figure 4.13a indicates that emergency admissions for children and young people experiencing mental illness are highest for 15 to 17 year olds and have almost doubled between 2007 and 2013 from 80.6 per 10,000 to 143.4 per 10,000. Hospitalisation for mental illness is also highest for 15 to 17 year olds (Figure 14.3b). These have increased between 2007 and 2013 from 115.2 per 10,000 in 2007 to 139 per 10,000 in 2013.

Figure 4.13a: Crude rate of children needing emergency hospital treatment involving mental illness by age band, 2007–2013

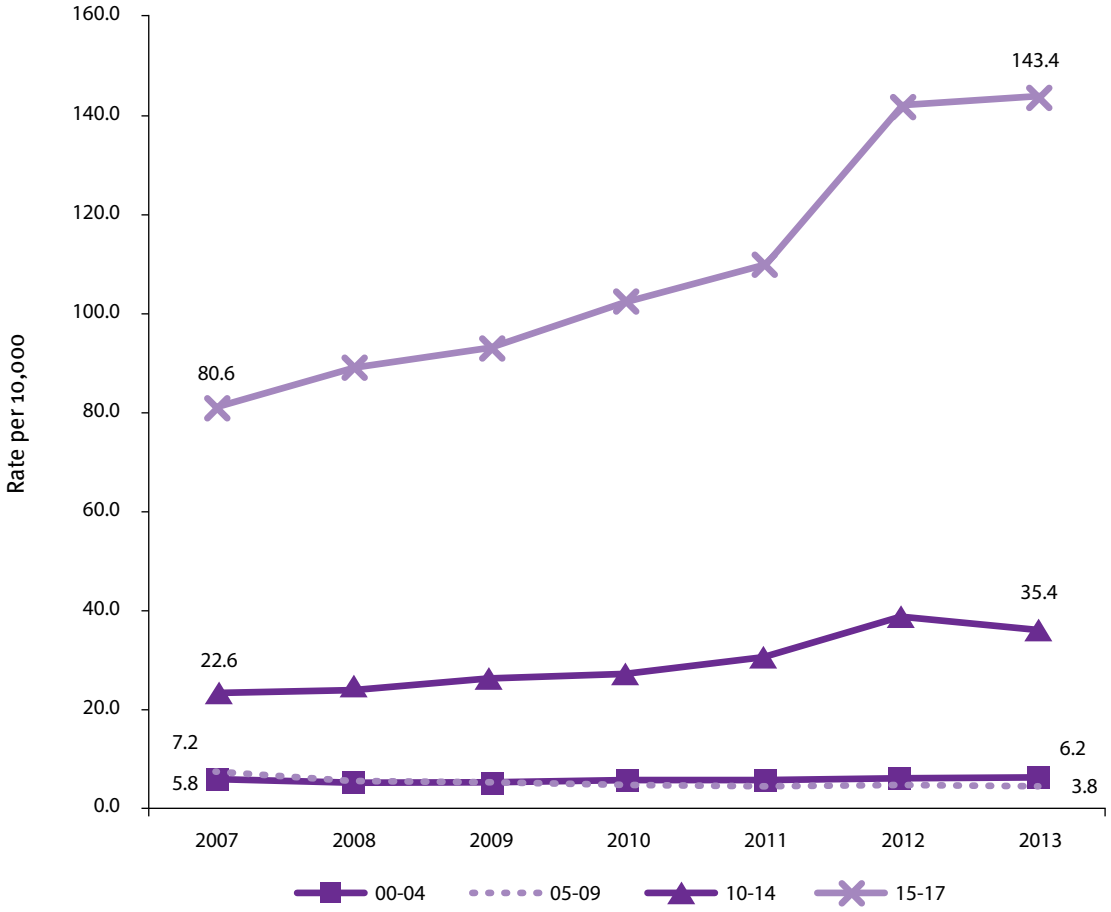
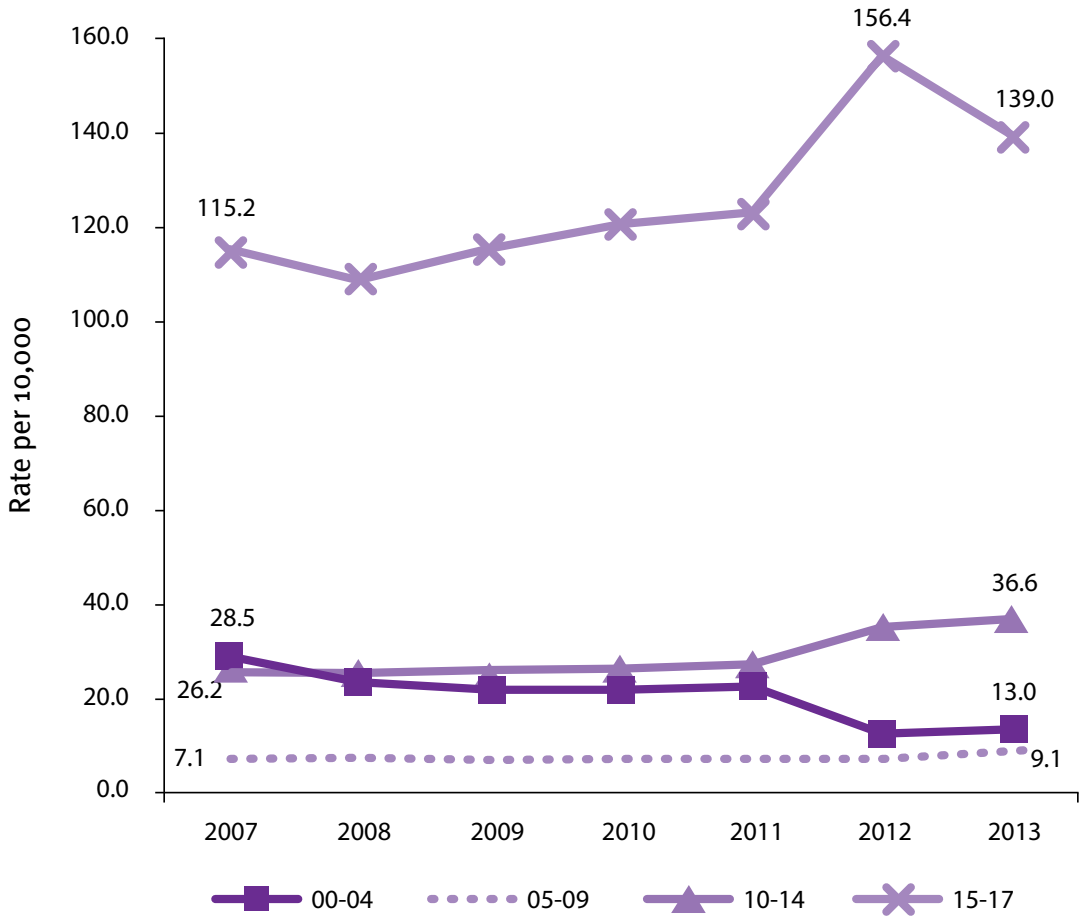


Figure 4.13b: Rate of children requiring an admitted period of hospitalisation involving their mental illness, 2007–2013




Source: Victorian Emergency Minimum Dataset and Victorian Admitted Episodes Dataset, Department of Health and Human Services, 2007 to 2013

# Young people as victims

## Adolescents are more likely to be the victim of crime than younger children

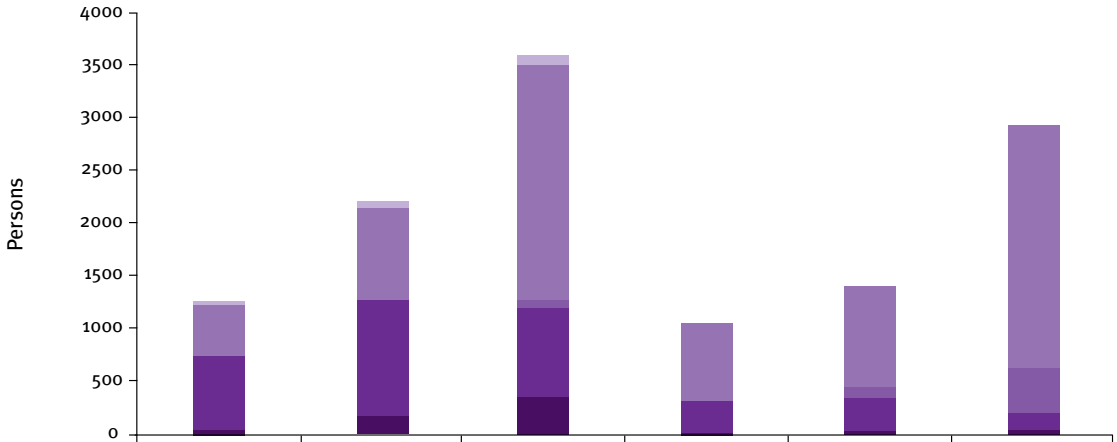
Being the victim of a crime can have wide ranging effects on both children and adults. In particular children and young people may experience physical and emotional reactions which they are unable to express and which can affect their daily functioning including trouble sleeping and bedwetting, reverting to earlier younger behaviours, becoming withdrawn or conversely fearful of being alone and trouble concentrating particularly at school. [31]

In 2013–14, 9,674 children and young people were victims of crime, a decrease of 1.6 per cent from 2012–13. [32] The most common crime against children and young people in 2013–14 was assault (5,243) which accounted for 54 per cent of crimes against the person.

The 2012–13 crime statistics indicate that crimes occurred most frequently against 15 to 19 year olds (Figure 4.14). Females were more frequently the victim of crime than males (7,036 compared to 5,421).

Females were also more affected by sex and rape crimes, particularly as older adolescents (around 46 per cent of crimes against females aged 19 and under and 74 per cent of crimes against 15 to 19 year old females). Assault affected slightly more males than females (3,944 compared to 3,563), particularly for males aged under 10.

Figure 4.14: Number of Victorian children and young people who were victims of crime by crime type, 2012–13




| | Females | | | Males | | |
|---|---|---|---|---|---|---|
| | <10 | 10-14 | 15-19 | <10 | 10-14 | 15-19 |
| Abduction/kidnap | 37 | 33 | 83 | 26 | 16 | 22 |
| Assault | 468 | 878 | 2217 | 714 | 942 | 2288 |
| Robbery | 0 | 12 | 74 | 2 | 99 | 414 |
| Sex (non-rape) | 698 | 1107 | 846 | 292 | 304 | 172 |
| Rape | 45 | 168 | 359 | 33 | 46 | 37 |
| Homicide | 8 | 2 | 1 | 4 | 1 | 9 |

Source: Victoria Police Crime Statistics 2012–13, Tables 3.2.2 and 3.2.3

# Young people involved in the youth justice system

Each year a small number of Victorian young people become involved in the youth justice system. Many of these young people who come before the Victorian Youth Parole and Youth Residential Boards have been exposed to violence at home when they were children. The issues associated with this trauma are a major risk factor for their future learning and development, health, safety and wellbeing. Despite being a relatively small group, young people aged 10 to 14 entering the youth justice system are at risk of becoming long-term offenders.[33]

## Becoming involved in the youth justice system

Protective factors that are likely to reduce young people's involvement in the youth justice system include:

- good social skills and competencies, good mental health, positive peer relationships and involvement in social activities
- a stable family environment, connectedness to family, participation in shared family activities, and family values
- participation in school with attainment of work-related skills and high parental expectations of school performance.

Risk factors that increase young people's involvement in crime include:

- low intelligence, impulsivity and poor social skills
- substance abuse in the family, family violence, abuse and neglect
- academic failure and bullying at school
- divorce and family breakup
- socioeconomic disadvantage. [34]

For infants and young children, exposure to family violence harms their brain development and cognitive functioning. Poor concentration and difficulties with school-work, and a greater risk of substance abuse and criminal behaviour in later life, have been associated with early family violence exposure. Children exposed to violence at home are also more aggressive than their peers.[35]

Table 4.3 indicates that young Victorian people detained on sentence and remand have experienced a range of known risk factors such as; expulsion from school; alcohol and drug use which is linked to their offending; a history of abuse, trauma or neglect; having a Child Protection involvement; having mental health issues; having a history of self-harm or suicidal ideation; and having issues with their intellectual functioning.[36]

Table 4.3: Characteristics of young Victorians detained on sentence and remand 2012, 2013

| Characteristics | 2012 Percentage | 2013 Percentage |
|---|---|---|
| Had a previous child protection involvement | 34 | 41 |
| Had current child protection order | 15 | 18 |
| Were victims of abuse, trauma or neglect | 64 | 60 |
| Had been suspended or expelled from school | 67 | 56 |
| Presented with mental health issues | 35 | 27 |
| Had a history of self-harm or suicidal ideation | 27 | 26 |
| Presented with issues concerning their intellectual functioning | 27 | 22 |
| Were registered with Disability Services | 9 | 11 |
| Have a history of alcohol and/or drug misuse | | 89 |
| Were alcohol users | 91 | |
| Were drug users | 88 | |
| Had alcohol and/or drug use related to their offending | 89 | 78 |
| Were parents | 13 | 13 |

Source: Youth Parole Board and Youth Residential Board Victoria Annual reports 2012–13 and 2013–14, DHHS

## Crimes committed by young people

The majority of juvenile alleged offenders in 2013–14 were processed for crime against property (57.2 per cent), a decrease of 1,251 from 2012–13 (Table 4.4). The number of juvenile alleged offenders processed for crimes against the person decreased from 6,619 in 2012–13 to 6,361 in 2013–14. The 2012–13 Victoria Police Crime Statistics show processing of alleged offenders for crimes such as assault (4,975) and robbery (1,074), with small numbers of juveniles alleged to have committed rape (106) and sex-related crimes (423).

Around five per cent of all juvenile alleged offenders processed in 2013–14 were Aboriginal. This was highest for crimes against the person and crimes against property. The 2012–13 Victoria Police Crime Statistics indicate higher numbers of processing of male juvenile alleged offenders than female (78.5 per cent of all alleged offenders) and higher numbers of processing for 15 to 19 year old alleged offenders. However, around 20 per cent of the juvenile alleged offenders were young people aged under 15. Young people aged under 14 years at the time of first contact with police have significantly longer involvement with the criminal justice system than young people aged 14 years and over at the time of their first contact.[37]

Table 4.4: Number of juvenile alleged offenders, crime type, processing category and Aboriginal status, 2012–13 to 2013–14

| | 2012–13 | | 2013–14 | |
|---|---|---|---|---|
| | Aboriginal | Total | Aboriginal | Total |
| Crime against the person | | | | |
| Arrest | 45 | 2,276 | 70 | 1,935 |
| Caution | 24 | 560 | 31 | 491 |
| Summons | 139 | 2,339 | 173 | 2,770 |
| Other | 61 | 1,444 | 70 | 1,165 |
| TOTAL | 269 | 6,619 | 344 | 6,361 |
| Crime against property | | | | |
| Arrest | 216 | 7,305 | 301 | 7,267 |
| Caution | 150 | 3,896 | 165 | 3,298 |
| Summons | 249 | 4,440 | 281 | 4,254 |
| Other | 139 | 1,829 | 109 | 1,400 |
| TOTAL | 754 | 17,470 | 856 | 16,219 |
| Drug offenses | | | | |
| Arrest | 7 | 273 | 6 | 281 |
| Caution | 17 | 486 | 12 | 491 |
| Summons | 5 | 184 | 7 | 207 |
| Other | 1 | 57 | 2 | 38 |
| TOTAL | 30 | 1,000 | 27 | 1,017 |
| Other Crime | | | | |
| Arrest | 29 | 1,148 | 71 | 1,831 |
| Caution | 26 | 755 | 19 | 651 |
| Summons | 43 | 1,716 | 70 | 1,819 |
| Other | 17 | 506 | 25 | 452 |
| TOTAL | 115 | 4,125 | 185 | 4,753 |

Source: Law Enforcement Assessment Program, Victoria Police special request

The number of first offenders has decreased between 2011–12 and 2013–14 from 5,891 to 4,763 (Table 4.5). The number of Aboriginal young people alleged to have committed offences has risen marginally from 171 in 2011–12 to 193 in 2013–14. This was around 4.1 per cent of all first time offences in 2013–14.

Table 4.5: Number of Aboriginal juvenile first offenders by crime type, processing category, 2011–12 to 2013–14

| | 2011–12 | | 2012–13 | | 2013–14 | |
|---|---|---|---|---|---|---|
| | Aboriginal | ALL | Aboriginal | ALL | Aboriginal | ALL |
| Crime against the person | | | | | | |
| Arrest | 9 | 126 | 2 | 112 | 4 | 113 |
| Caution | 9 | 344 | 11 | 365 | 19 | 334 |
| Summons | 12 | 294 | 7 | 282 | 22 | 397 |
| Other | 13 | 454 | 18 | 447 | 10 | 388 |
| TOTAL | 43 | 1,218 | 38 | 1,206 | 55 | 1,232 |
| Crime against property | | | | | | |
| Arrest | 9 | 136 | 3 | 150 | 3 | 120 |
| Caution | 87 | 3,033 | 94 | 2,575 | 89 | 2,048 |
| Summons | 7 | 258 | 13 | 260 | 17 | 255 |
| Other | 11 | 337 | 19 | 310 | 9 | 258 |
| TOTAL | 114 | 3,764 | 129 | 3,295 | 118 | 2,681 |
| Drug offenses | | | | | | |
| Arrest | 0 | 3 | 0 | 4 | 0 | 6 |
| Caution | 3 | 224 | 6 | 232 | 4 | 265 |
| Summons | 0 | 4 | 0 | 14 | 1 | 17 |
| Other | 0 | 4 | 0 | 6 | 0 | 5 |
| TOTAL | 3 | 235 | 6 | 256 | 5 | 293 |
| Other Crime | | | | | | |
| Arrest | 0 | 4 | 0 | 9 | 0 | 7 |
| Caution | 9 | 521 | 14 | 453 | 10 | 381 |
| Summons | 1 | 48 | 2 | 45 | 2 | 69 |
| Other | 1 | 101 | 2 | 120 | 3 | 100 |
| TOTAL | 11 | 674 | 18 | 627 | 15 | 557 |
| TOTAL CRIME | 171 | 5,891 | 191 | 5,384 | 193 | 4,763 |

Source: Law Enforcement Assessment Program, Victoria Police special request

## Cautions effectively divert young offenders away from the criminal justice system

In a submission outlining ways to improve diversionary practices for young people, the Law Institute of Victoria noted that:

'A criminal record can have an enormously negative impact on a person's future. Aside from the stigmatising effect of a criminal conviction itself, a conviction can adversely affect future employment prospects, the opportunity to hold public office, future overseas travel, and the ability to undertake jury duty.' The submission also notes that first contact with the criminal justice system provides a unique opportunity to identify issues affecting an offender, to assess the causes of offending, and to put in place supports to ensure that criminal offending is not repeated.' [38] Victoria Police uses cautions to divert young offenders away from the justice system. Young people who are cautioned, rather than charged, are less likely to have further contact with police than those who appear in court for their first offence. The later a young person enters the criminal justice system, the less likely they are to have continued involvement. [39]

The use of cautions decreased slightly between 2009–10 and 2013–14 from 25.2 per cent of processing to 17.4 per cent (Table 4.6). Cautions were most commonly used for drug related offences (between 48 and 51 per cent of all cautions).

Table 4.6: Proportion of cautions, Victoria 2009–10 to 2012–13

| | 2009–10 | 2010–11 | 2011–12 | 2012–13 | 2013–14 |
|---|---|---|---|---|---|
| Crime Against The Person | 10.7 | 9.5 | 8.8 | 8 | 7.7 |
| Crime Against Property | 29.2 | 29.1 | 24.3 | 22 | 20.3 |
| Drugs | 48.2 | 48.6 | 51 | 49 | 48.3 |
| Other Crime | 22.6 | 22.1 | 19.3 | 18.3 | 13.7 |
| TOTAL | 25.2 | 24.3 | 20.9 | 19.5 | 17.4 |

Source: Victoria Police Crime Statistics 2009–10 to 2012–13, Tables 4.2.1, 4.2.2, 4.2.3 and special request 2013–14

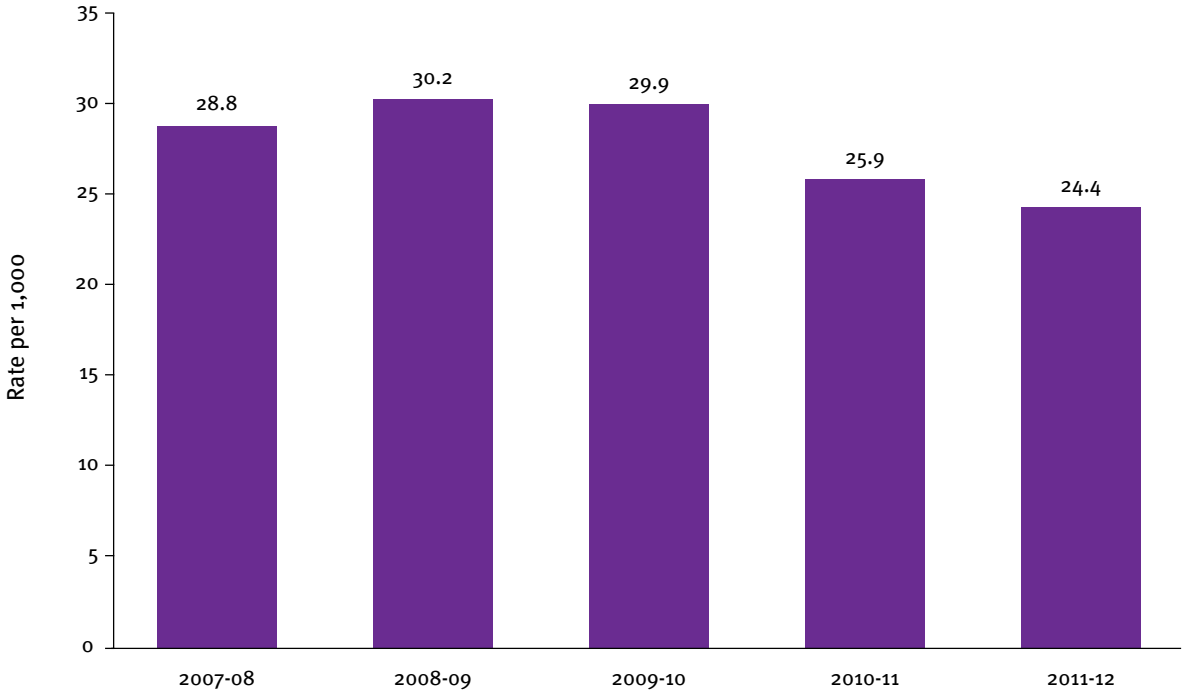
Since 2010, the Youth Support Service has worked with young people coming into contact with police who are at risk of entering the criminal or youth justice systems. It provides assessment, needs identification, case work and referral to other support services. The Youth Support Service engages with young people to address the causes of offending behaviour. Services are delivered by eight community organisations in Melbourne, Ballarat, Bendigo, Geelong, Latrobe Valley, Shepparton and Mildura.

An independent evaluation in 2013 indicated that the service was able to divert young people away from the criminal justice system. Young people were more likely to remain at home with family with improved family relationships, be re-engaged with education, and better connected with their community. A two-month post closure review of 400 case files showed 86 per cent of young people had not had further contact with police following the service's intervention.

## Youth offender rates have decreased

The youth offender rate decreased between 2007–08 and 2011–12 from 28.8 per 1,000 to 24.4 per 1,000 (Figure 4.15). This change can largely be attributed to diverting young people away from the criminal justice system through the use of cautions.

Figure 4.15: Youth offender rate per 1,000, Victoria 2007–08 to 2011–12




Source: Victorian Police, 2007–08 to 2011–12, accessed via VCAMS

## Matters finalised in the Children's Court have increased

Between 2011–12 and 2012–13 the number of matters for juvenile offenders finalised in the Children's Court rose from 11,223 to 11,573 (Table 4.7). The clearance rate for juvenile matters increased from 110.9 per cent to 117 per cent indicating that a higher number of matters were finalised in that year than were initiated.

Table 4.7: Number of matters initiated, finalised and pending, 2011–12 to 2012–13

| | Initiated | Finalised | Pending | Clearance rate |
|---|---|---|---|---|
| 2011–12 | 10,124 | 11,223 | 2,549 | 110.9% |
| 2012–13 | 9,895 | 11,573 | 2,207 | 117.0% |

Source: Children's Court Annual Report, 2012–13

## Youth detention and supervision rates have decreased

In Victoria, there is a link between children in child protection and involvement in the youth justice system. The Youth Parole Board and Youth Residential Board Annual Report notes that:

- 41 per cent of young people in youth justice centres had been in child protection
- 38 per cent of young people sentenced to a custodial order through the Children's Court were currently a dual client of child protection and youth justice services - this compares with 36 per cent of community-based clients with a history of child protection and 19 per cent who were currently a dual client. [40]

A small number of youth offenders are under detention or supervision in Victoria. Between 2008–09 and 2012–13 the number of young people in youth justice facilities decreased from 0.3 per 1,000 young people to 0.2 per 1,000 (Table 4.8).

Table 4.8: Rate of young people in youth justice facilities, Victoria, 2008–09 to 2012–13

| | 2008–09 | 2009–10 | 2010–11 | 2011–12 | 2012–13 |
|---|---|---|---|---|---|
| Rate of young people in youth justice facilities (per 1,000) | 0.3 | 0.3 | 0.3 | 0.3 | 0.2 |

Source: Department of Health and Human Services, 2008–09 to 2012–13

Aboriginal young people are over-represented at every stage of Victoria's criminal justice system. Although many of the risk and protective factors affecting young people's involvement in the criminal justice system are the same for both Aboriginal and non-Aboriginal young people, some specific factors have been identified for Aboriginal people. These include systemic racism, forced removals, and social disorganisation. In neighbourhoods and schools, risk factors include lack of culturally appropriate services, negative school environments and frequent school changes. Protective factors include the strength of family and community, and schools that support complimentary curricular activities. A strong individual sense of cultural identity and responsibility to family/community, are also protective factors. [41]

The Australian Institute of Health and Welfare reports that nationally, Aboriginal young people were 23 times as likely as non-Aboriginal young people to be under community-based supervision during 2011–12 and 25 times as likely to be in detention (excluding WA and NT). [42]

Of the 90 young people aged 15 to 17 subject to a Youth Justice Order in 2013–14, 15 were Aboriginal (17 per cent) (Table 4.9).

Table 4.9: Number of Aboriginal and non-Aboriginal young people who received Youth Residential Centre (YRC) and Youth Justice Centre (YJC) orders during 2013–14

| Type of order | Aboriginal | Non-Aboriginal | Number of young people |
|---|---|---|---|
| YRC Order 10-14 years | 1 (50 per cent) | 1 | 2 |
| Children's Court YJC order 15-17 years | 15 (17 per cent) | 75 | 90 |
| Adult Court YJC Order 18+ years | 14 (10 per cent) | 128 | 142 |
| Total | 30 (13 per cent) | 204 | 234 |

Source: Youth Parole Board and Youth Residential Board Victoria Annual Report 2013–14

While the number of young Aboriginal people in youth justice custody is low compared to previous years, the Youth Parole and the Youth Residential Boards remain concerned about the continued over-representation of young Aboriginal people in the youth justice system.

A range of early intervention and diversion programs for young Aboriginal people to minimise the likelihood of progression to community-based or custodial orders. There is also a range of services and supports to assist them in custody and support their return to the community.

The Koori Early School Leavers and Youth Employment Program operates in Mildura and north western metropolitan Melbourne and aims to prevent adverse contact with the justice system by engaging young Aboriginal people (aged 10–20 years) with school or alternative educational, vocational or employment pathways to counteract disconnection or poor connection to school, training or work.

The Koori Pre- and Post-Release Program provides intensive outreach services to young Aboriginal people exiting Victoria's youth justice centres and facilitates referrals to accommodation and community culturally specific services.

The Koori Youth Justice Program aims to reduce the over-representation of young Aboriginal people in the criminal justice system by providing a range of culturally appropriate intensive support to reduce, divert and rehabilitate young Aboriginal people who are at risk of offending or re-offending. The Boards are pleased that a key element of this program is the availability of the Aboriginal Cultural Support workers at Malmsbury Youth Justice Centre and Parkville Youth Justice Precinct. These staff support young Aboriginal people to strengthen connections with family and community and assist the Boards to understand the complexities of the young person's situation.

The aim of these programs is to support young Aboriginal people to access services that build strong links with their family and culture, engage them with their broader community and assist them to access activities, including education, training and employment.

In addition to the Aboriginal cultural support workers, Koori Youth Justice workers within the Department provide pre- and post-release support to young Aboriginal people, and support their contact with Koori Youth Justice workers employed by Aboriginal Community Controlled Organisations.

http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/youth-parole-board-and-youth-residential-board-annual-report

The number of young people on community-based supervision has also decreased from 2.7 per 1,000 young people in 2008–09 to 2.4 per 1,000 in 2012–13 (Table 4.10).

Table 4.10: Rate of young people on community based supervision, Victoria, 2008–09 to 2012–13

| | 2008–09 | 2009–10 | 2010–11 | 2011–12 | 2012–13 |
|---|---|---|---|---|---|
| Rate of young people on community based supervision (per 1,000) | 2.7 | 3.1 | 3.0 | 2.8 | 2.4 |

Source: Department of Health and Human Services, 2008–09 to 2012–13

Bail supervision is available to any young person appearing in the Criminal Division of the Children's Court who is at risk of remand. This includes young people already known to the youth justice service, for whom supervision is required to keep them in the community. Young people in contact with the youth justice system are supported by youth justice workers and community and youth justice teams.

There has been a steady increase in the delivery of supervised bail in the last four years, indicating a high level of acceptance by courts and other stakeholders. This has also contributed to greater diversion of young people away from youth justice supervision – around a third of young people are now on bail supervision rather than youth justice supervision.

# Participation in education and training

## Education and training have long-term benefits for young people

The later years of primary school and adolescence are a time when some young people disengage from school leading to poorer outcomes across their lives. Connectedness to learning and attending school ensure that young people are well set up for their future. For some children, however, bullying and racism can affect school attendance.

## School motivation and learning confidence help achieve positive educational outcomes

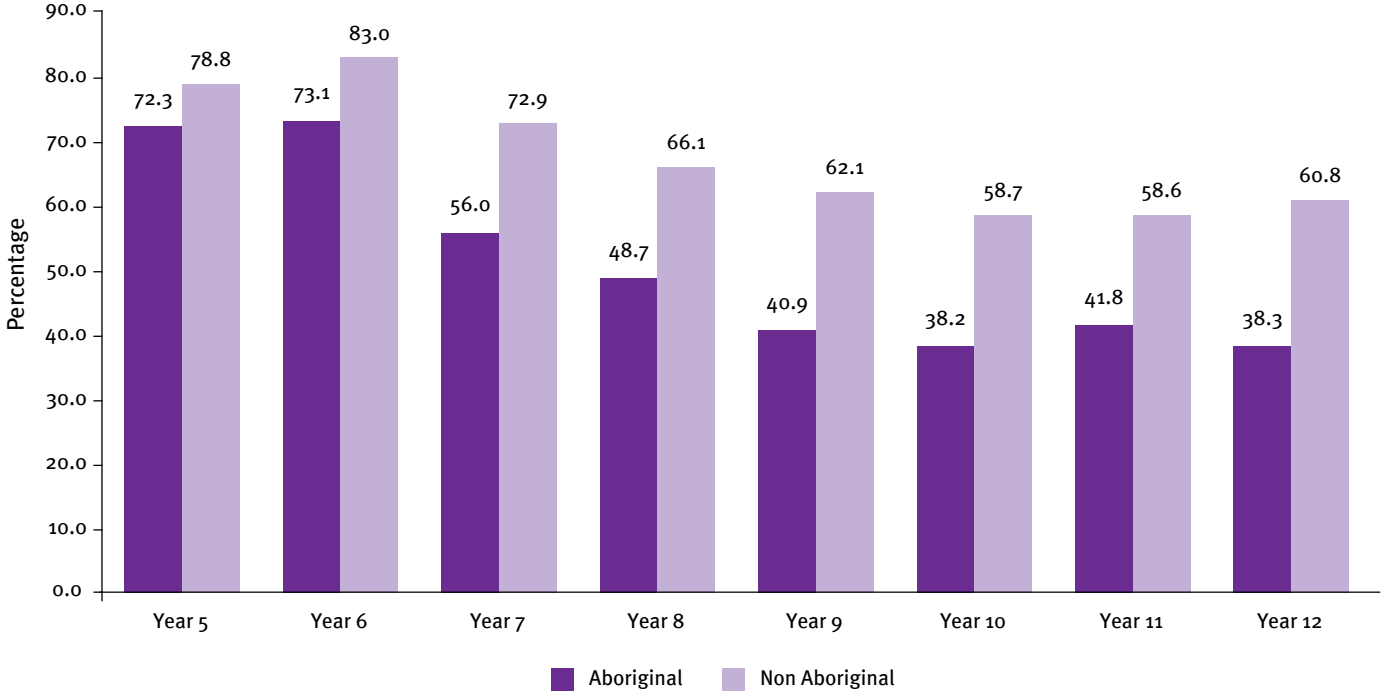
A vibrant and positive school culture with a shared enthusiasm for learning is key to successful student outcomes. Student engagement with school connects: [43]

- behaviours, including doing school work, participating in classroom sessions and following school rules
- emotions including their interests and values, reflected in their sense of belonging, their feelings towards teachers and their appreciation of success
- cognition, including motivation, effort and strategy use, problem solving flexibility, a willingness to work hard, and an investment in learning beyond just behavioural engagement, mental effort, and desire to master a task. [44,45]

In 2013, student learning confidence was highest in the final year of primary school (64.5 per cent), decreasing to around 37 per cent in Year 9 and 10 and only improving slightly by Year 12 (39.9 per cent). Aboriginal students consistently reported lower levels of learning confidence than their peers, with a difference of between 15 to 18 per cent in each year level.

In 2013, the majority of Victorian government school students felt motivated in their schooling, significantly more so in primary school than secondary, where up to 40 per cent did not. Aboriginal students are substantially less motivated compared to all Victorian government school students (Figure 4.16). Primary school students have higher motivation which decreases in secondary year levels.

Figure 4.16: Proportion of students who are motivated to achieve and learn, by year level and Aboriginal status, 2013




Source: Attitude to School Survey, Department of Education and Training, 2013

Note: These proportions are derived from multiple questions. Only students who responded with 'agree' or 'strongly agree' on all relevant questions are included in these results. Other students gave mixed or opposite views.

## Most Victorian children feel safe at school

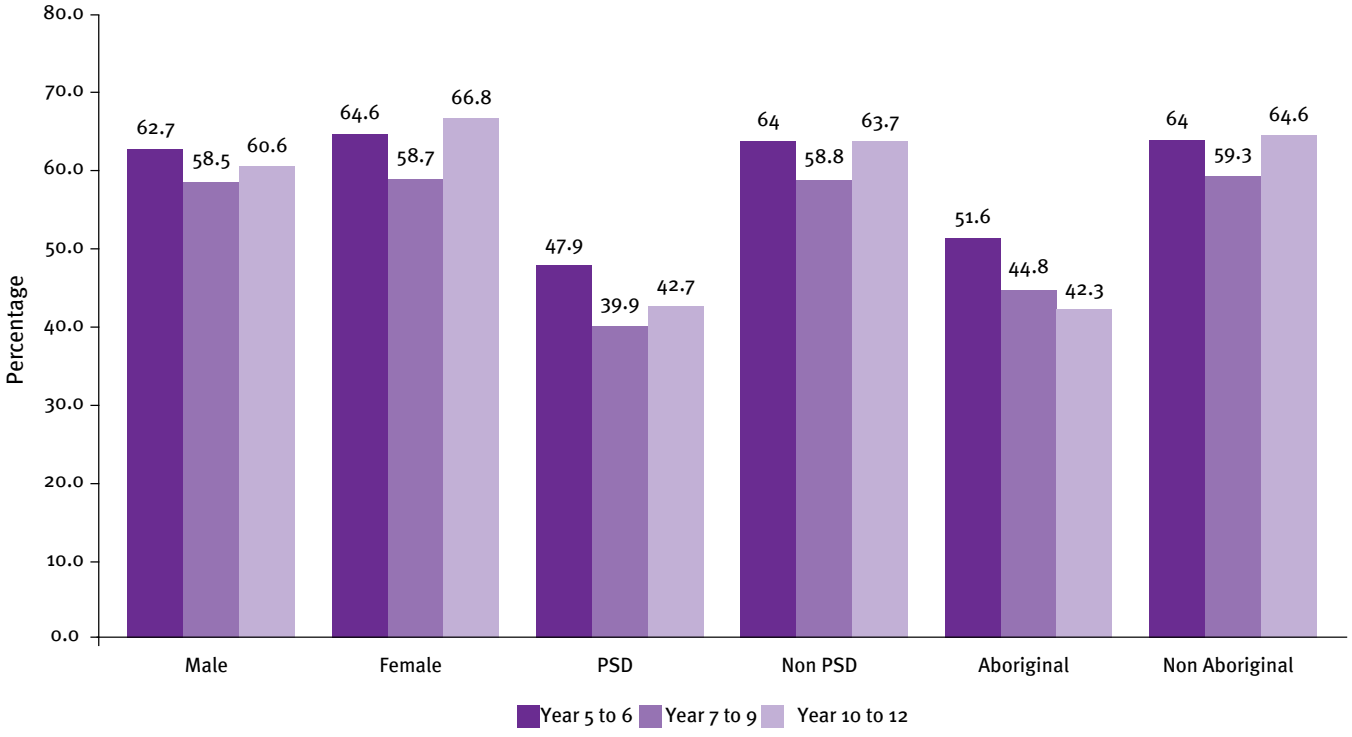
Safe and supportive school environments generally have a positive school climate which is nurturing, inclusive and has community feeling.

In 2013, while the majority of Victorian government school students reported feeling safe from bullying and harassment at school, up to one in three students did not (Figure 4.17). Students felt most safe in Years 5 to 6 (63.9 per cent in 2013) and 10 to 12 (63.5 per cent in 2013). They felt least safe in Years 7 to 9 (58.5 per cent in 2013). Lower perception of safety in Years 7 to 9 has been a consistent pattern from 2009 to 2013.

Female students reported feeling slightly safer than males in all year levels. Lower perceptions of safety can also be seen in Aboriginal students and those with disabilities. Aboriginal student perceptions of safety were between 13 and 22 per cent lower than their peers across all year levels with the largest difference occurring at Years 10 to 12 (42.3 per cent compared to 64.6 per cent for all other students). Importantly, the bounce back effect for Years 10 to 12 is not seen in Aboriginal students who instead feel progressively less safe as they move through school.

Students in the Program for Students with a Disability also exhibit lower perceptions of safety then their peers with the lowest feelings of safety again occurring in Years 7 to 10 (39.9 per cent compared to 58.8 per cent). These perceptions of safety are even lower than those of Aboriginal students.

Figure 4.17: Proportion of Victorian Government students who feel safe from bullying and harassment, by year level group and student characteristics, 2013




Source: Attitude to School Survey, Department of Education and Training, 2013

Note: These proportions are derived from multiple questions. Only students who responded with 'agree' or 'strongly agree' on all relevant questions are included in these results. Other students gave mixed or opposite views.

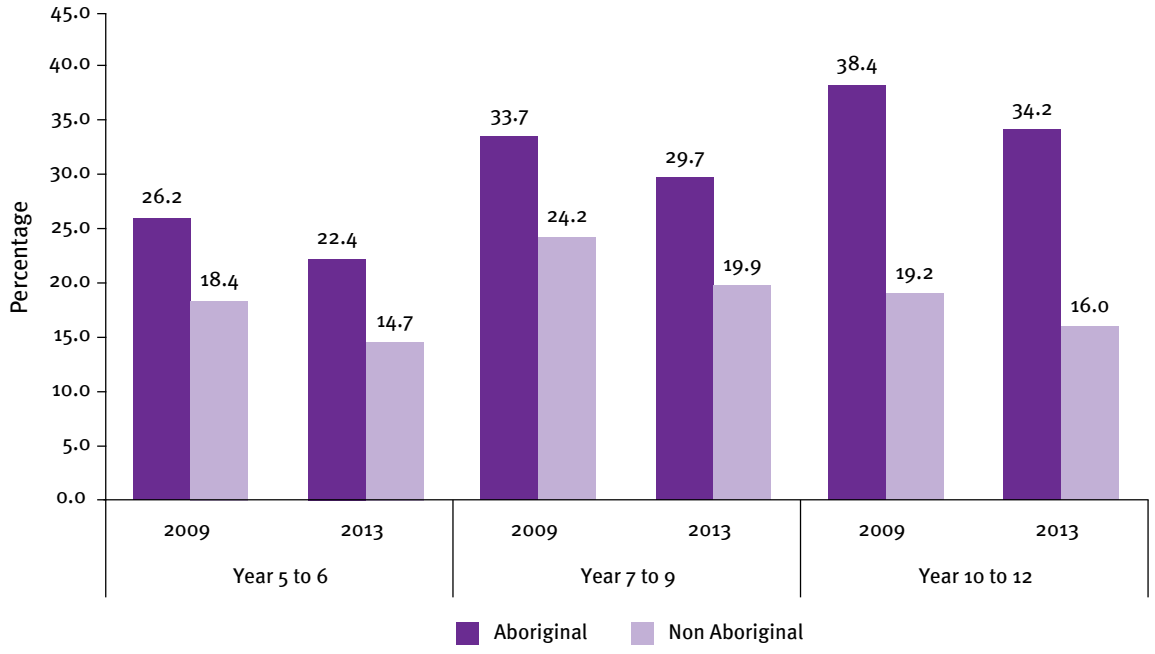
LGBTI (lesbian, gay, bisexual, trans or intersex) young people suffer high levels of verbal and physical homophobic abuse at school. In 2010, sixty-one per cent of LGBTI young people reported verbal abuse and 18 per cent physical (and often verbal) abuse. In terms of gender, young men (70 per cent) and gender questioning young people (66 per cent) reported more verbal abuse than young women (53 per cent). Homophobic abuse was associated with feeling unsafe, excessive drug use, self- harm and suicide in young people. [46]

## Reported bullying is significantly higher for some students

While feeling safe with peers can be a protective factor for positive engagement with learning for children and young people, bullying by peers can be a risk factor for engagement with learning. A higher proportion of Aboriginal students report being bullied at school. The proportion of children who report being bullied also tends to increase as students move into high school. The proportion of children who report being bullied has declined since 2009 for students in Years 5 and 6 and students in Years 7 to 9 (Figure 4.18). Despite this decrease, a much higher number of Aboriginal students report having been bullied particularly in higher years.

In 2013, 22.4 per cent of Aboriginal students in Year 5 to 6 reported being bullied compared to 14.7 per cent of non-Aboriginal students. This difference increases in Years 7 to 9 (29.7 per cent of Aboriginal students compared to 19.9 per cent) and peaks in Years 10 to 12 when Aboriginal student perceptions of bullying are twice as high as those of non-Aboriginal students (34.2 per cent compared to 16 per cent).

Figure 4.18: Proportion of Victorian government school students who agree that they have been bullied, by Aboriginal status, 2009–2013




Source: Attitude to School Survey, Department of Education and Training, 2009–2013

Note: Percentage of students who responded with a 3, 4 or 5 out of 5 to a single survey question 'I have been bullied recently at school.'

Bully Stoppers is a DET initiative that supports parents, teachers and principals in working together to make sure schools are safe and supportive places, where everyone is empowered to help reduce the incidence of bullying in all Victorian schools.
http://www.education.vic.gov.au/about/programs/bullystoppers/Pages/default.aspx

*The School-wide Positive Behaviour Support program* is an evidence-based framework for preventing and responding to student behaviour. It aims to create a positive school climate, a culture of student competence and an open, responsive management system for all school community members. It includes analysis of data in professional learning teams, implementation of evidence-based practices and organisational systems for establishing safe, purposeful and inclusive schools and classrooms. It also provides individual behaviour and learning supports for students to achieve academic and social success.

## Discrimination can be a form of bullying for some children

Anecdotal evidence suggests that significant numbers of LGBTI students drop out of school because of safety concerns.[47] Although it is difficult to assess the extent of harassment and bullying experienced by LGBTI students, a 2010 survey found: 'Of those students who reported suffering verbal, physical and other forms of harassment and bullying, 80 per cent experienced it at school. This figure is higher than that of the previous two surveys (74 per cent in 2004; 69 per cent in 1998).' [48]

Exposure to racism or discrimination is a risk factor for health and wellbeing including self-esteem and confidence, child abuse and neglect and mental health issues.[49]

Racism is a phenomenon that results in avoidable and unfair inequalities of power, resources and opportunities across racial and ethnic groups in society. [50] Racism is prevalent in the lives of Aboriginal children and those from culturally and linguistically diverse (CALD) backgrounds with studies reporting 'a relationship between racism and health and wellbeing, which indicated a link to anxiety, depression, suicide risk, substance abuse and overall poor mental and general health'. [51]

A small study in Victorian schools found:
- primary school students experienced significantly more direct racism compared to secondary school students
- students who were born in non-English speaking countries, had parents born in non-English speaking countries or did not know where their parents were born, reported more direct experiences of racism than student who were born in English-speaking countries and had parents born in English-speaking countries.

Victorian students reported witnessing racist behaviour experienced by other students in their school. Students were called names (65.6 per cent) and teased; and 44.3 per cent have been spat on, pushed or hit because of their cultural group.

Staff survey results presented different views to that of students' experiences. In terms of whether students at their school were treated unfairly by other students because of their race, ethnicity, culture or religion, staff responded as below:
- 47.3 per cent of staff reported sometimes
- 39 per cent reported never or rarely
- 14 per cent often/very often.

The report suggests that the differing results may indicate that some staff are not fully aware of discriminatory behaviour being perpetuated at school. [52]

## School attendance promotes both social and educational development

Children and young people who regularly attend school and complete Year 12 or an equivalent qualification have better health and employment outcomes and higher incomes across their lives. Developing habits of regular attendance at an early age benefits students' future outcomes.[53]

School truancy can have long lasting effects on young people's health and wellbeing. It is generally a symptom of other factors such as family dysfunction, school-related problems, economic issues, and mental health concerns. [54]

International studies indicate that students with lower socioeconomic status are at greater risk for truancy. Age and special education status are also truancy risks. Students who transfer to a different school, even within the same district, show increased risk of truancy. [55]

Children who are regularly absent from school may miss out on critical stages of learning and development, and are less likely to achieve educational and life success. [56]

School-related risk and protective factors have been associated with school absenteeism and truancy. While most children feel connected to school and their peers, absenteeism is an issue for some. Students' perceptions of teaching practices, student-teacher relationships, peer relationships and the school's climate are important components of a student's experience and their likelihood to truant.[57] For some students, disengagement with school leads to suspension and dropping-out.

The average number of days absent by government school students between 2009 and 2013 has remained relatively stable since 2009 (Table 4.11). Absenteeism peaked in Years 8 (19.3), 9 (21.7) and 10 (19.9) in 2013.

Table 4.11: Average absence days in government schools, Victoria, 2009 to 2013

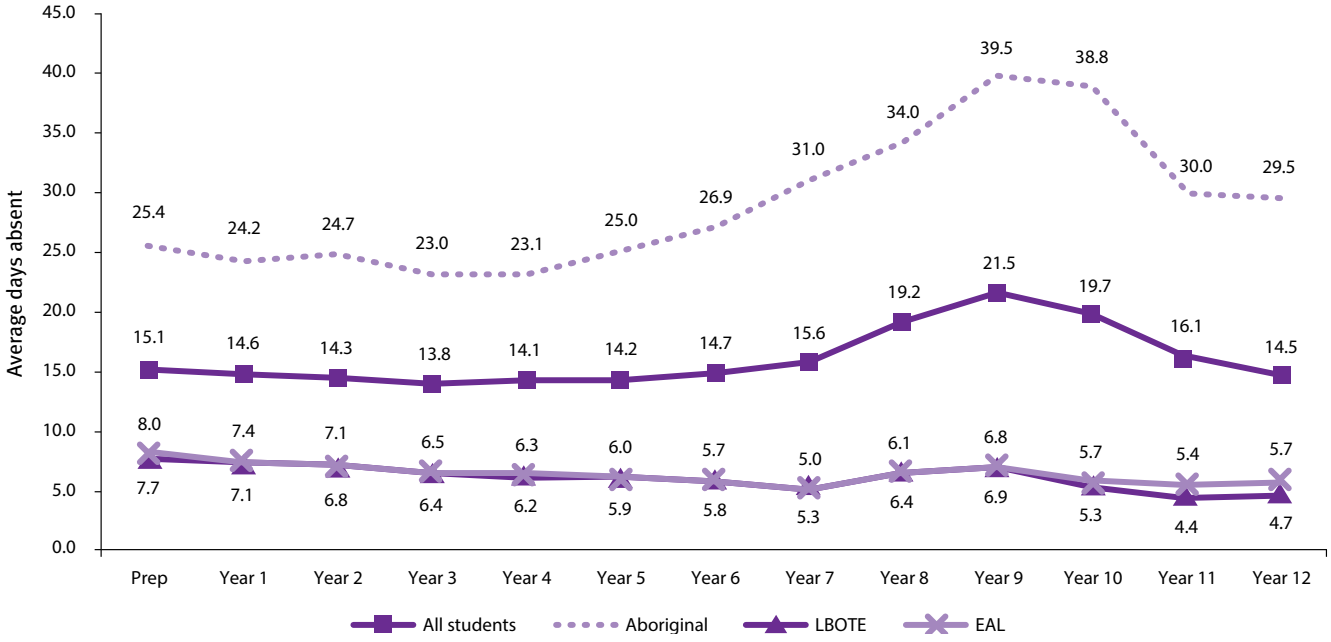
| School year | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|
| Prep | 14.7 | 14.3 | 14.6 | 14.9 | 15.2 |
| Year 1 | 14.4 | 14.1 | 14.2 | 14.5 | 14.7 |
| Year 2 | 14.0 | 13.8 | 14.0 | 14.0 | 14.4 |
| Year 3 | 13.6 | 13.5 | 13.6 | 13.8 | 13.9 |
| Year 4 | 13.7 | 13.6 | 13.9 | 13.9 | 14.2 |
| Year 5 | 14.0 | 13.8 | 14.0 | 14.4 | 14.3 |
| Year 6 | 14.4 | 14.2 | 14.4 | 14.5 | 14.8 |
| Year 7 | 16.2 | 15.9 | 16.0 | 15.4 | 15.7 |
| Year 8 | 19.8 | 19.2 | 19.8 | 19.2 | 19.3 |
| Year 9 | 22.5 | 21.4 | 21.9 | 21.0 | 21.7 |
| Year 10 | 20.9 | 20.3 | 19.6 | 18.3 | 19.9 |
| Year 11 | 15.8 | 15.1 | 14.8 | 14.1 | 16.4 |
| Year 12 | 13.0 | 11.6 | 11.0 | 10.9 | 14.7 |

Source: CASES21 government school enrolment system, Department of Education and Training, extracted August 2014

Note: The methodology for collecting absence data changed in 2013. As CASES is a live system data may change according to the day it is extracted.

Student background influences absenteeism (Figure 4.19). Aboriginal students have the most days absent (around 24 per year in early primary school, peaking at 40 per year in Year 9) and language background other than English (LBOTE) and English as an additional language (EAL) students have the least days absent (between 4 and 8 per year).

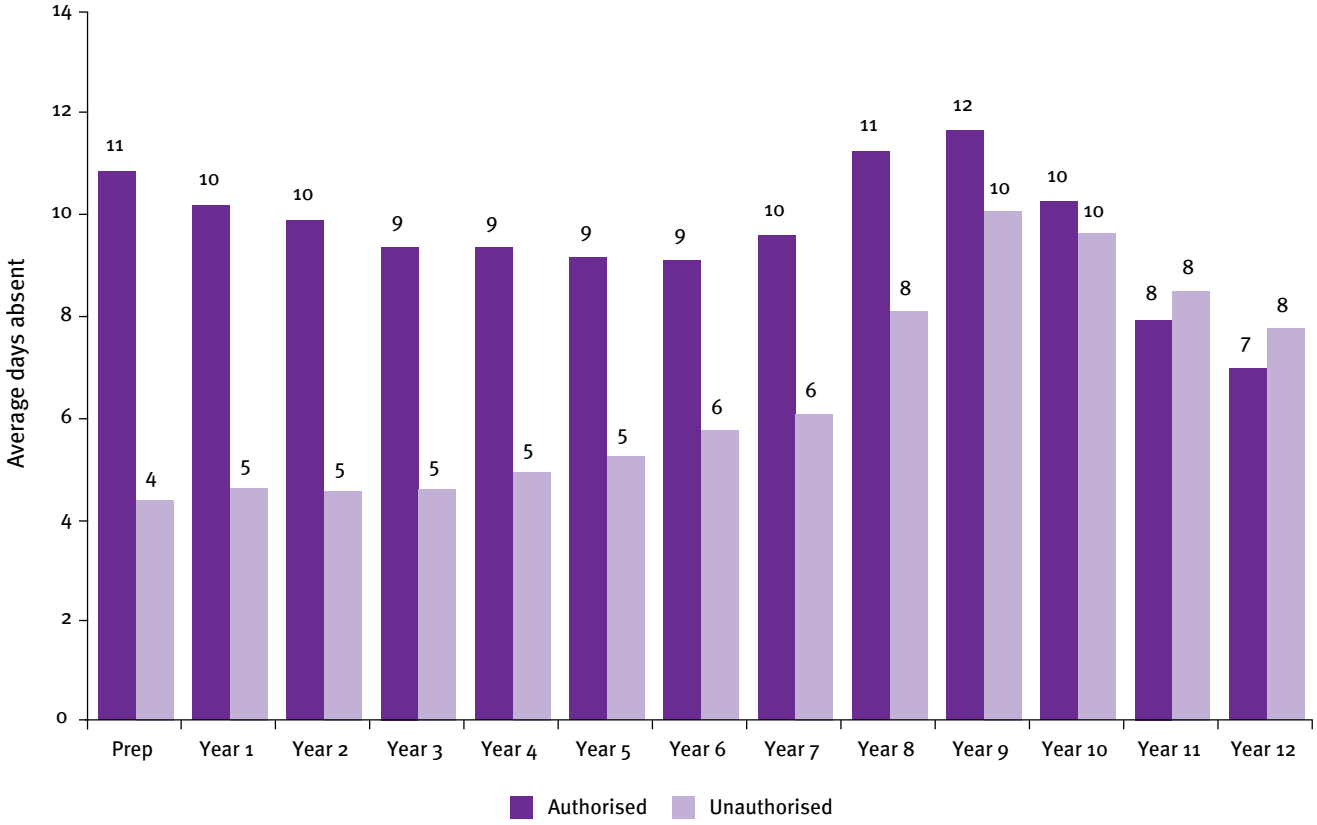
Figure 4.19: Average Number of Absence Days per student, per year, in Victorian government schools by cohort and year level, 2013




Source: CASES21 government school enrolment system, Department of Education and Training, extracted August 2014

Most Victorian government school students' absences are authorised by parents. Unauthorised absences (including not authorised by parent, unexplained absence and truancy) are also recorded by schools and increase as children progress through school. Unapproved absence starts from around 4 to 6 days per year in primary school to a peak of 10 days per year in Years 9 and 10 (Figure 4.20).

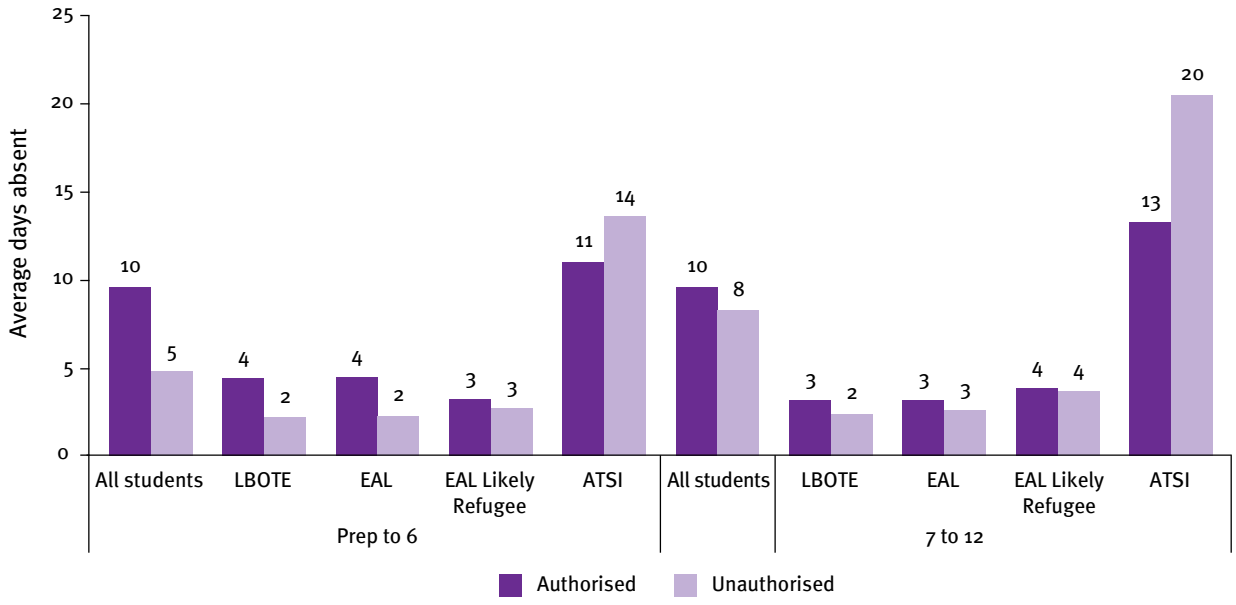
Figure 4.20: Average number of absence days per student, per year, in Victorian government schools by type of absence and year level, 2013




Source: CASES21 government school enrolment system, Department of Education and Training, extracted August 2014

Unauthorised absences are also very high for Aboriginal students, nearly three times as many as for all students in both primary and secondary school (Fig 4.21). In contrast, students from culturally and linguistically diverse backgrounds (LBOTE, EAL and EAL likely refugee) have lower levels of unauthorised absence, with similar levels in both primary and secondary school.

Figure 4.21: Average number of absence days per government school FTE, authorised versus unauthorised absence, by student characteristics, 2013



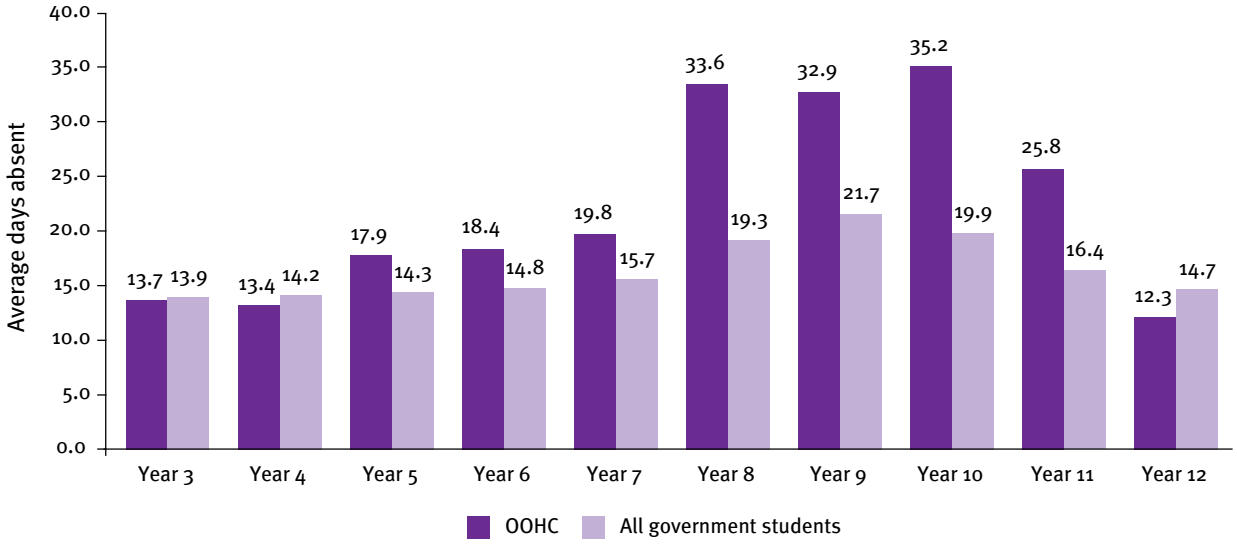

Source: CASES21 government school enrolment system, Department of Education and Training, extracted August 2014

Note: EAL Likely refugee is an estimate derived from a combination of student visa code, date of arrival in Australia and country of origin

## Absenteeism is an issue for children in Out-of-Home Care as they age

While the number of days absent for children in OOHC in government schools is similar to their peers in Years 3 and 4, absenteeism starts to climb from Year 5 reaching a peak of 35 days in Year 10 (Figure 4.22).

Figure 4.22: Average number of absence days from government schools, by student type, 2013

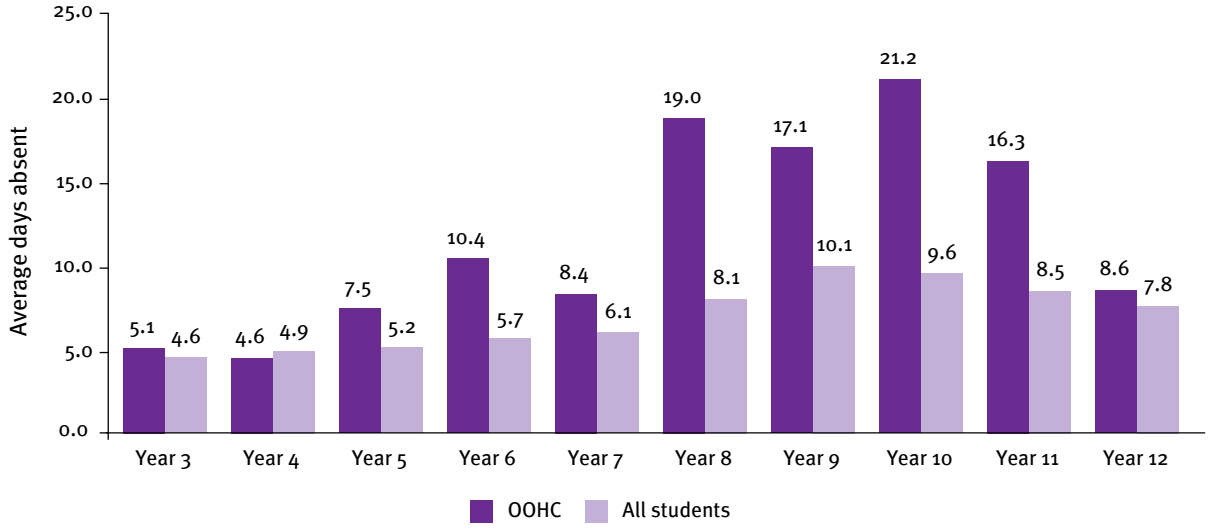



Source: CASES21 government school enrolment system, Department of Education and Training, 2013

Note: These figures are based on the government school enrolment system and do not capture all children in OOHC

Unapproved absences also make up a significant proportion of absences for students in OOHC (Figure 4.23). While these are at a similar levels to peers in Years 3 and 4 (around 5 days), by Year 8 they are more than double the amount of their peers (19 compared to 8). Importantly there is little difference in days absent between OOHC students and peers in Year 12.

Figure 4.23: Average number of unapproved absence days, government schools, by student type, 2013




Source: CASES21 government school enrolment system, Department of Education and Training, extracted August 2014

The *Out-of-Home Care Education Commitment* is a partnering agreement between the Department of Health and Human Services (DHHS), the Department of Education and Training (DET), the Catholic Education Commission of Victoria and Independent Schools Victoria.

The Partnering Agreement:

- outlines strategies to support the educational issues and social needs of children and young people in OOHC during the years they attend school, including flexible learning options,
- promotes common practices across Victoria and provides a framework to monitor educational engagement and achievement more closely,
- provides guidance about key areas in which support for children and young people in OOHC is required, including school enrolment, transition planning, attendance and engagement, achievement, case planning and school retention and
- outlines a process for implementing the Partnering Agreement and for monitoring outcomes.

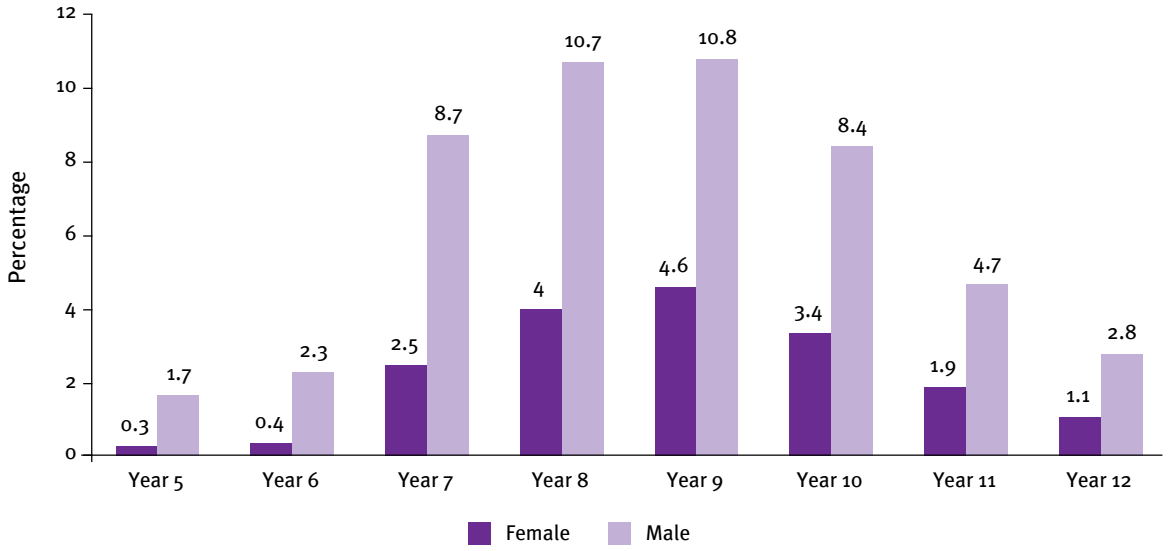
The agreement also outlines expected roles and activities for staff working in schools, case managers in the DHHS Child Protection Program or community organisations and relevant staff in DET and Catholic Diocesan regional offices.

## School suspensions peak in Years 7, 8 and 9

While attendance at school is a protective factor for children, some children and young people are suspended from their school. School suspension may arise from child abuse and neglect, mental health issues, disability, bullying, and difficulties at home. Some groups of students are more likely to be suspended, based on their 'socio-economic background, race, gender or other characteristics, such as learning or other developmental impairments'.[58]

In 2013, the proportion of students suspended in primary schools was relatively small (around 1 or 2 per cent). Suspensions rise in secondary school peaking in Years 7, 8 and 9 (Fig 4.24). Suspensions are higher for males than females, particularly in the middle years of school (around 10 per cent for males in Years 8 and 9 compared to 4 per cent for females).

Figure 4.24: Suspension rate for government school students, by sex, 2013



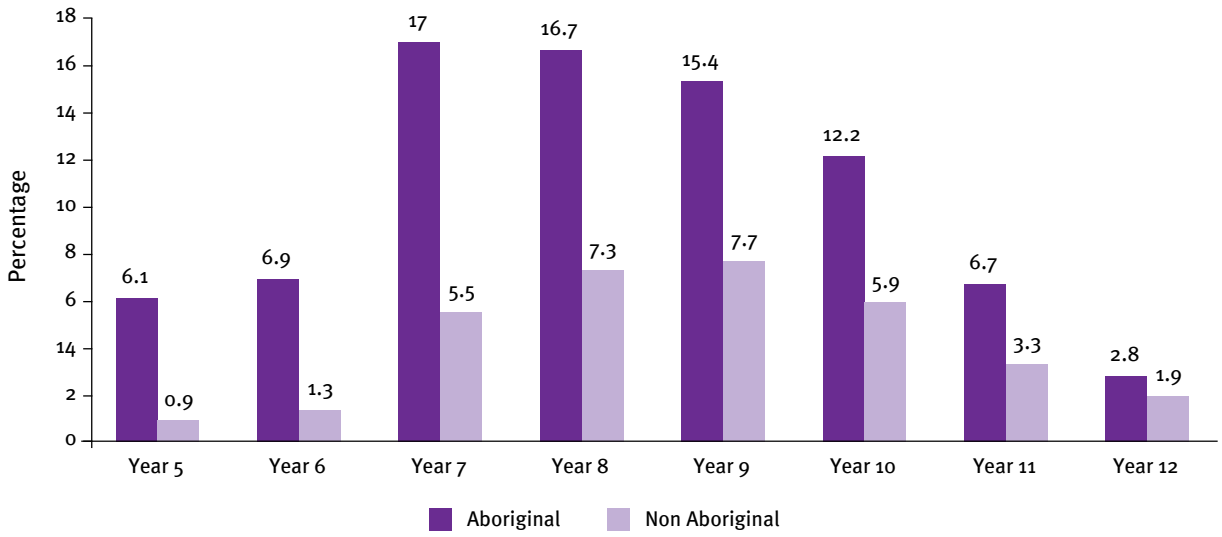

Source: August supplementary school census, Department of Education and Training, 2013

Note: These data are derived from the August supplementary census and relate to the number of students who have been suspended divided by the number of Full Time Equivalent students.

Recent reports show that more than 10 per cent of Year 8 boys were suspended from Victorian state schools last year, and that absenteeism and suspensions increase significantly as children move into secondary school. This is illustrative of the struggle some students face when transitioning from primary to secondary school.[59]

Suspension rates are much higher for Aboriginal students than for non-Aboriginal students (Fig 4.25). Suspension rates for Aboriginal students are six times higher in primary school and around three times higher in the middle years.

Figure 4.25: Suspension rate for government school students, by Aboriginal status, 2013




Source: August supplementary school census, Department of Education and Training, 2013

## Young people who leave school early face greater risks

Although Victoria's school retention rates are high (around 82 per cent in the last five years), a significant number of students leave school early. Research indicates that early school leavers are likely to experience social exclusion at three times the rate of students who have completed Year 12.[60]

Family factors which affect early school leaving include:

- parental educational level and parental expectations of the child's educational achievements
- non-nuclear families
- socio economic status
- residential mobility
- parenting practices and parent-child relationships.[61]

Other factors associated with early school leaving include:

- Gender - young men are more likely to drop out of school
- Educational attitudes and aspirations - students with high motivation levels and well developed cognitive capacities are more likely to stay at school
- Special needs, disability and health - students with a disability are three times more likely not to engage in employment or training compared to other groups
- Employment opportunities – students may choose to take up work
- School curriculum and environment – a negative and unrewarding school environment, lack of relevant curriculum, poor relationships with teachers and a history of being bullied may lead to early leaving.

Evidence shows that approximately 10,000 young people in Years 9 -11 leave their school each year and do not go on to any other Victorian education or training provider. A further 6,000 young people exit school to enrol with another education/ training provider, only to exit entirely from education within 12 months. The individual, economic and social costs of this disengagement are well documented, with evidence clearly demonstrating that disengagement from education has significant impacts on the health, wellbeing, future employment opportunities and trajectory of a young person's life and the lives of those around them.[62]

## The number of young people aged between 15 and 17 years not in education, training or employment has decreased

The Education, Training and Reform Act, 2006 requires students to stay at school until age 17. A small number of 15 to 17 year olds in Victoria are not attending education and are unemployed or not in the labour force. These figures have decreased between 2006 and 2011 from 6,452 to 5,524 and are highest for the 17 year olds (Table 4.12).

The number of 15 to 17 year olds unemployed and looking for full-time work has decreased from 2,011 in 2006 to 1,311 in 2011 while the number unemployed looking for part-time work has increased from 394 to 412. Around 4,000 young people stated that they are not in the labour force.

Table 4.12: The number of Victorian 15 to 17 year olds not in education and training by labour force status, 2006 and 2011

| | 2006 | | | | 2011 | | | |
|---|---|---|---|---|---|---|---|---|
| | 15 | 16 | 17 | TOTAL | 15 | 16 | 17 | TOTAL |
| Unemployed, looking for full-time work | 159 | 588 | 1264 | 2011 | 62 | 315 | 936 | 1313 |
| Unemployed, looking for part-time work | 66 | 140 | 188 | 394 | 53 | 107 | 252 | 412 |
| Not in the labour force | 913 | 1270 | 1865 | 4048 | 680 | 1165 | 1957 | 3802 |
| Employed, worked full-time | 310 | 1176 | 2788 | 4274 | 222 | 795 | 2010 | 3027 |
| Employed, worked part-time | 209 | 640 | 1391 | 2240 | 133 | 436 | 1108 | 1677 |
| Employed, away from work | 74 | 185 | 393 | 652 | 47 | 108 | 312 | 467 |
| Total not attending education or training | 1731 | 3999 | 7889 | 13619 | 1197 | 2926 | 6575 | 10698 |
| Total Victorian population | 67404 | 67738 | 66831 | 201973 | 67295 | 69034 | 69525 | 205854 |

Source: ABS Census of Population and Housing, 2006 and 2011

These patterns are broadly similar to the Australian figures (Table 4.13). Australia has a larger number of 15 to 17 year olds not attending full-time education (15.6 per cent of Australian 17 year olds compared to 9.5 per cent of Victorian 17 year olds). Australia overall also has higher proportions of 15 to 17 year olds reporting that they are looking for work or not in the labour force.

Table 4.13: Proportion of 15 to 17 year olds not in Education and Training who are employed, looking for work or not in the labour force, Victoria and Australia, 2011

| | VICTORIA | | | AUSTRALIA | | |
|---|---|---|---|---|---|---|
| | 15 years | 16 years | 17 years | 15 years | 16 years | 17 years |
| Unemployed, looking for full-time work | 0.1 | 0.5 | 1.3 | 0.1 | 0.8 | 2.3 |
| Unemployed, looking for part-time work | 0.1 | 0.2 | 0.4 | 0.1 | 0.3 | 0.5 |
| Not in the labour force | 1.0 | 1.7 | 2.8 | 1.2 | 2.1 | 3.7 |
| Employed, working full-time | 0.3 | 1.2 | 2.9 | 0.5 | 1.8 | 4.9 |
| Employed, working part-time | 0.2 | 0.6 | 1.6 | 0.3 | 1.1 | 3.5 |
| Employed, away from work | 0.1 | 0.2 | 0.4 | 0.1 | 0.3 | 0.7 |
| Total % not attending school | 1.8 | 4.2 | 9.5 | 2.3 | 6.4 | 15.6 |

Source: ABS Census of Population and Housing, 2011

## Youth underemployment

'Today, young people are more likely to be underemployed – to have some work but want more hours – than at any time in the last 36 years.... young Australians are facing a dual assault on their aspirations for the future as they negotiate the modern economy...' [63]

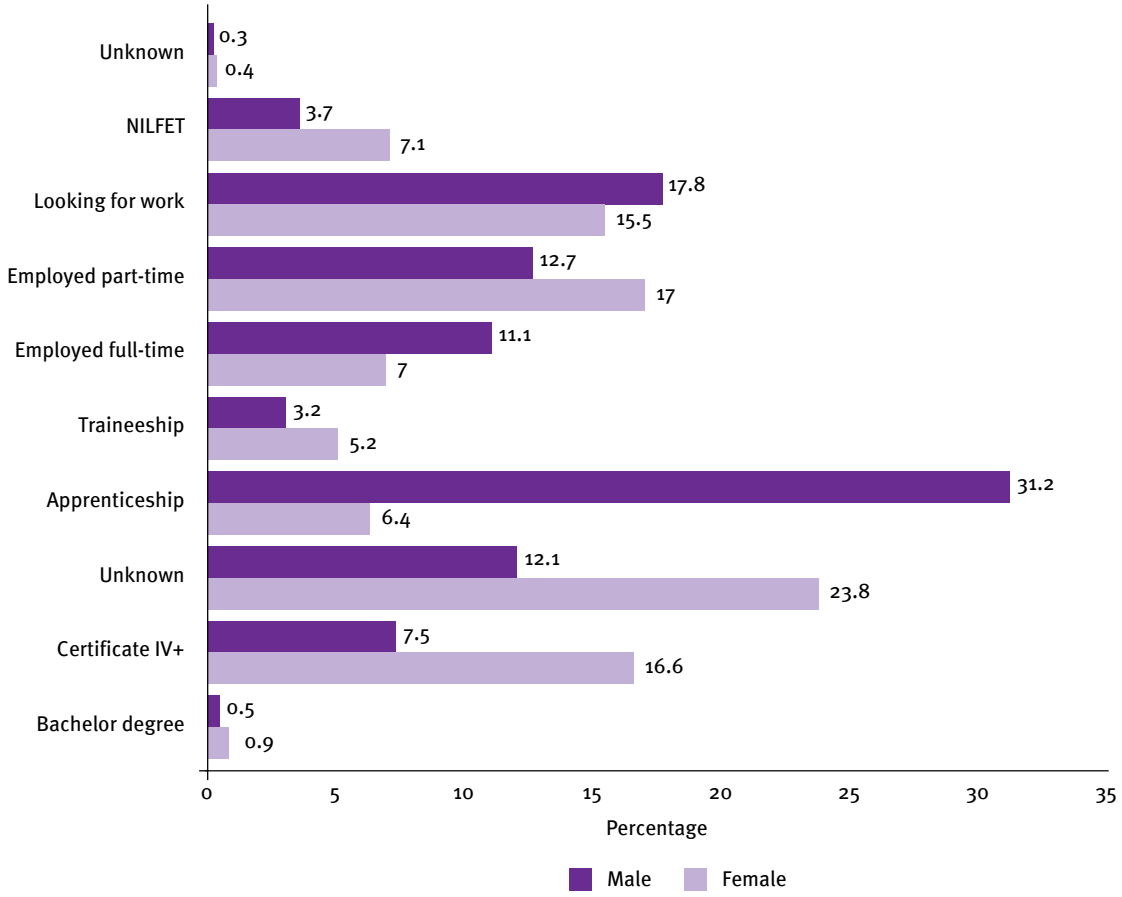
Young people are more likely to be in non-permanent jobs than those in other age groups and have high rates of labour force underutilisation (a combination of the unemployment and underemployment rate)

Source: Barely Working: Young and Underemployed in Australia. http://library.bsl.org.au/jspui/bitstream/1/6993/1/Barely_Working.pdf

## Most early school leavers move into vocational qualifications

In 2013 most young men surveyed through On Track, left school to undertake an apprenticeship (31.2 per cent) while young women left to undertake VET qualifications (40.4 per cent across Certificates I to IV) (Figure 4.26). Young men were more likely than women to be employed full-time (11.1 per cent compared to 7 per cent). Young men were, however, more likely to be looking for work (17.8 per cent compared to 15.5 per cent). Young women who left school early were twice as likely not to be in the labour force, education or training as young men.

Figure 4.26: Destinations of early school leavers, On Track, 2014




Source: On Track Survey (2013 leavers), Department of Education and Training, 2014

Early school leavers were most likely to have left school for work or career reasons (17.6 per cent) or because they did not like school or their teachers (16.3 per cent). Around 12 per cent cited ill health or family reasons for leaving school.

The majority of early school leavers noted that they would have stayed at school if they could have studied part-time while working (52 per cent) or had enjoyed a wider, more flexible range of classes including vocational subjects (around 48 per cent).

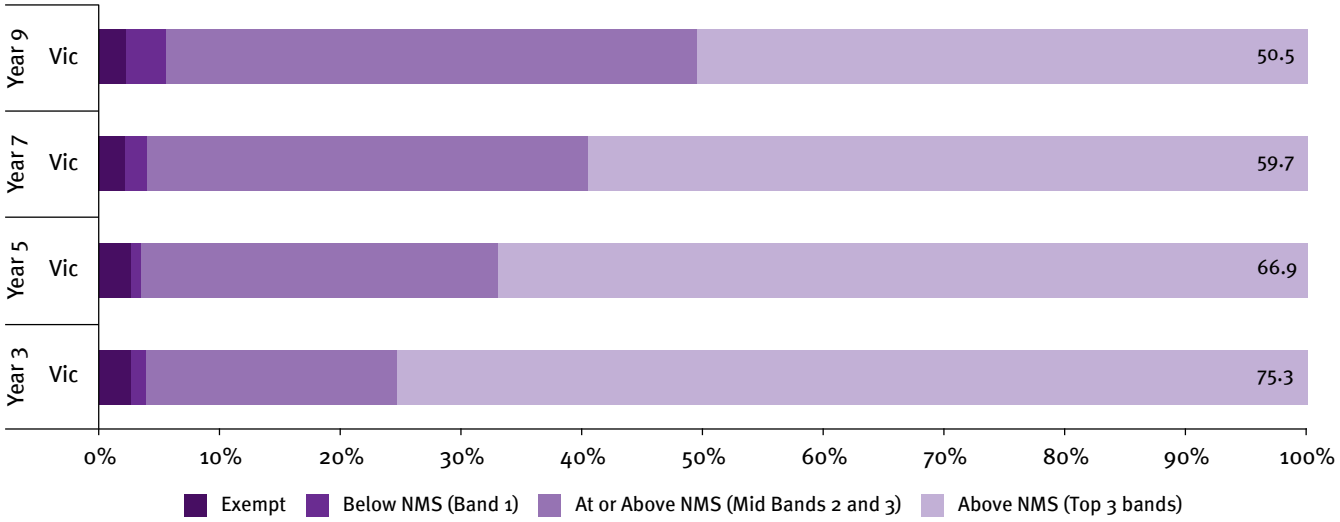
# Academic Outcomes

## NAPLAN performance decreases as children age and is lower for some groups of students

The majority of Victorian school children perform at or above the National Minimum Standard in NAPLAN Reading and Numeracy (the top 5 bands of 6 for the relevant year level). While these figures are higher than the Australian average, they have not varied substantially since the introduction of NAPLAN in 2008. Achievement decreases as children age. For example, in 2013 the proportion of children at or above NMS in reading decreased from 96 per cent in Year 3 to 94.3 per cent in Year 9. For numeracy, the decrease was from 96.2 per cent in Year 3 to 92.2 per cent in Year 9. [64]

When considering performance across the NAPLAN bands it becomes clear that the proportion of students performing in the top three bands for their year level decreases more substantially as children age. For reading, the proportion in the top three bands decreases from 75.3 per cent in Year 3 to 50.5 per cent in Year 9, a drop of nearly 15 per cent (Figure 4.27a).

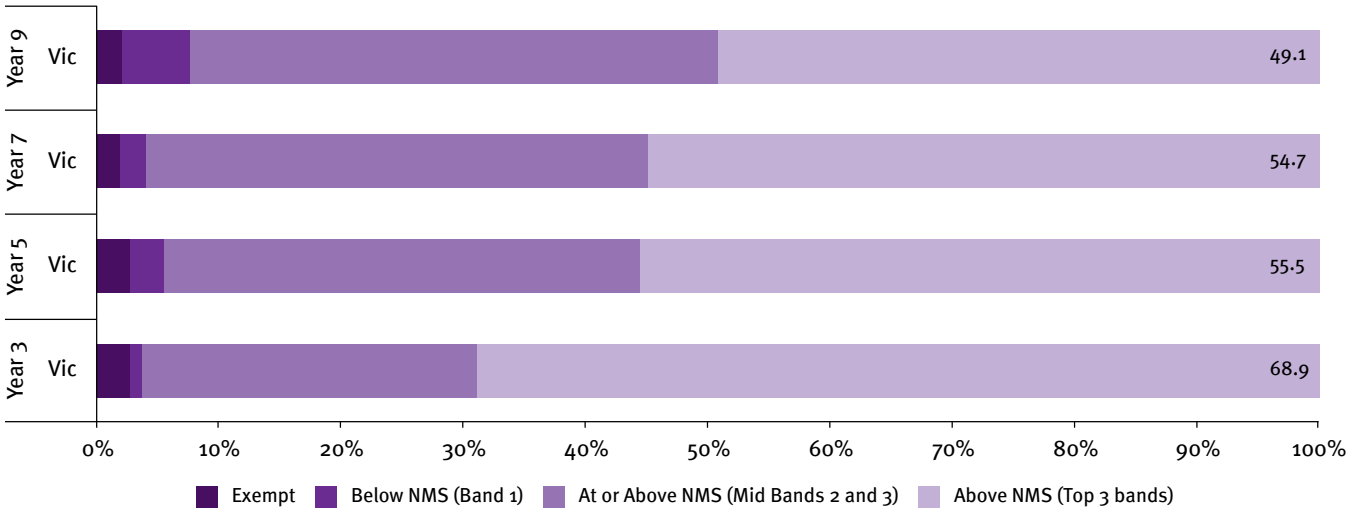
Figure 4.27a: NAPLAN performance in Reading, all Victorian students, 2013




Source: NAP website, ACARA

For numeracy (Figure 4.27b) the decrease is from 68.9 per cent in Year 3 to 49.1 per cent in Year 9, a drop of nearly 20 per cent. This decrease in performance mirrors patterns of a decrease in school connectedness to Year 9 along with a rise in absenteeism.

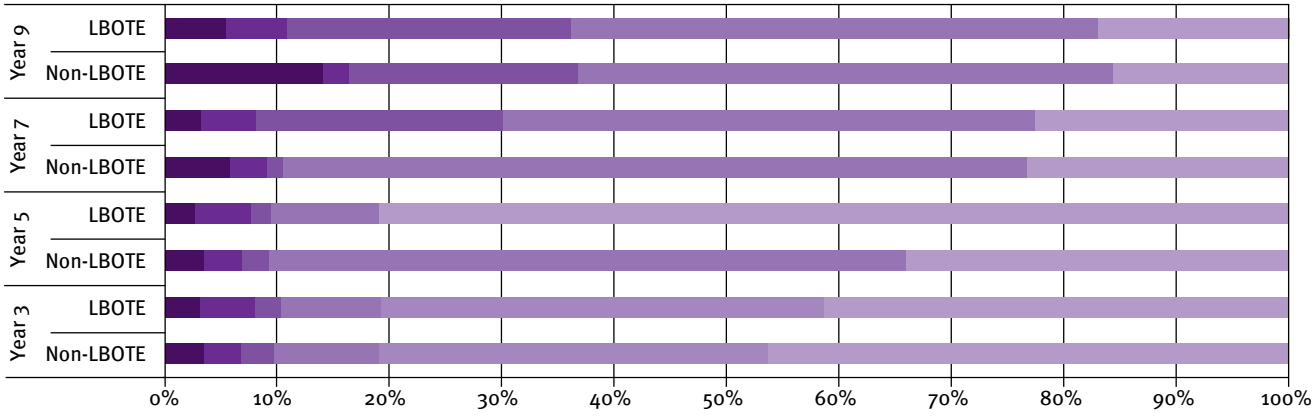
Figure 4.27b: NAPLAN performance in Numeracy, all Victorian students, 2013




Source: NAP website, ACARA

The exception to this pattern is LBOTE students (Figure 4.28). They have slightly lower proportions at or above NMS in Year 3 reading (9.0 per cent in the bottom two bands compared to 9.4 per cent of non-LBOTE students) but outperform their peers in the top two bands of NAPLAN by Year 9 (16.7 per cent compared to 15.6 per cent). While LBOTE students have consistent numbers exempted from NAPLAN across each year level (between 4 and 5 per cent), they are less likely to be absent than other students, particularly in Year 9 (5.5 per cent compared to 10.9 per cent).

Figure 4.28: NAPLAN Reading by Band Groups, by LBOTE status, government schools 2013




| | Year 3 | | Year 5 | | Year 7 | | Year 9 | |
|---|---|---|---|---|---|---|---|---|
| | Non-LBOTE | LBOTE | Non-LBOTE | LBOTE | Non-LBOTE | LBOTE | Non-LBOTE | LBOTE |
| Absent | 3.5 | 3.1 | 3.5 | 2.7 | 5.8 | 3.2 | 10.9 | 5.5 |
| Exempt | 3.2 | 4.9 | 3.3 | 5.0 | 3.3 | 4.0 | 3.1 | 4.3 |
| Withdrawn | 3.0 | 2.3 | 2.4 | 1.6 | 1.4 | 0.8 | 2.2 | 1.1 |
| Bot2 Bands | 9.4 | 9.0 | 8.2 | 9.7 | 17.4 | 22.1 | 20.4 | 25.3 |
| Mid2 Bands | 34.5 | 39.5 | 48.6 | 50.6 | 49.1 | 47.4 | 47.7 | 47.1 |
| Top2 Bands | 46.4 | 41.2 | 34.0 | 30.3 | 23.1 | 22.5 | 15.6 | 16.7 |

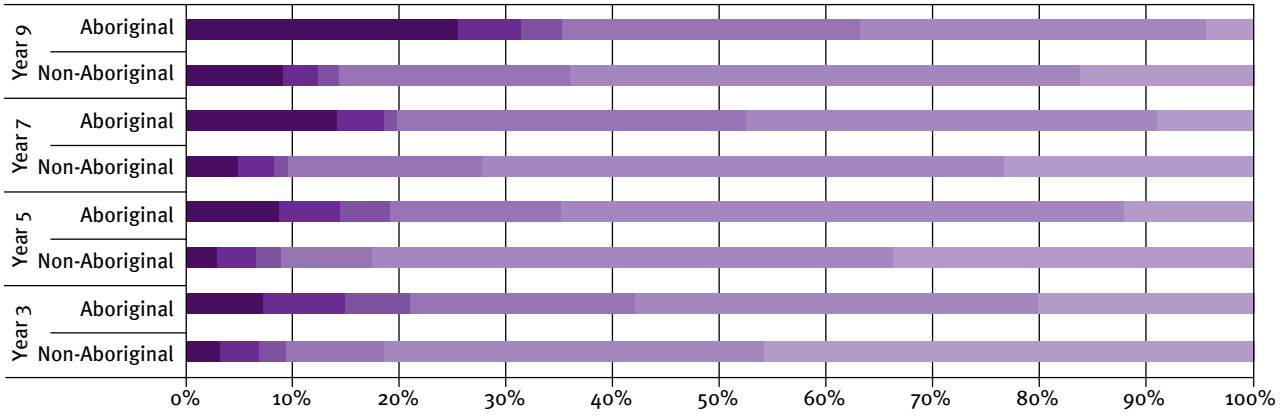
Source: Victorian Curriculum and Assessment Authority NAPLAN collection and Department of Education and Training administrative data, 2013

This pattern is stronger in NAPLAN numeracy, where almost twice as many LBOTE students are in the top 2 bands of NAPLAN in Year 9 compared to non-LBOTE students (27.7 per cent compared to 14.8 per cent) despite having similar levels of performance in Year 3 (around 36 per cent). Non-LBOTE students are twice as likely to be absent from NAPLAN in Year 9 than LBOTE students (11.7 per cent of non-LBOTE students compared to 6.1 per cent of LBOTE students).

Recent analysis of 2014 government school NAPLAN data indicates that likely refugee students are far less likely to be achieving above NMS than their peers (only 49.5 per cent in Year 3 compared to 79.5 per cent of all students and 32.6 per cent in year 7 compared to 73.1 per cent of all students). In addition, likely refugee students have far higher rates of exemption from the test (23.2 per cent in Year 3 and 24.7 per cent in Year 7).

Aboriginal children perform worse than their peers across all NAPLAN year levels (Fig 4.29). They also have much higher rates of absenteeism, exemption and withdrawal. In NAPLAN reading in 2013, the proportion of Aboriginal students in the top two bands decreased from 20 per cent in Year 3 to 4.4 per cent in Year 9.

## Figure 4.29: NAPLAN reading by band groups, by Aboriginal status, government schools 2013




| | Year 3 | | Year 5 | | Year 7 | | Year 9 | |
|---|---|---|---|---|---|---|---|---|
| | Non-Aboriginal | Aboriginal | Non-Aboriginal | Aboriginal | Non-Aboriginal | Aboriginal | Non-Aboriginal | Aboriginal |
| Absent | 3.3 | 7.3 | 3.2 | 8.8 | 5.0 | 3.2 | 9.2 | 25.5 |
| Exempt | 3.5 | 7.6 | 3.7 | 5.6 | 3.4 | 4.0 | 3.4 | 5.9 |
| Withdrawn | 2.7 | 6.2 | 2.2 | 4.7 | 1.3 | 0.8 | 1.9 | 3.9 |
| Bot2 Bands | 9.1 | 21.0 | 8.4 | 16.1 | 18.3 | 22.1 | 21.5 | 27.9 |
| Mid2 Bands | 35.7 | 37.9 | 49.0 | 52.8 | 48.8 | 47.4 | 47.9 | 32.4 |
| Top2 Bands | 45.6 | 20.0 | 33.5 | 12.1 | 23.2 | 22.5 | 16.1 | 4.4 |

Source: Source: Victorian Curriculum and Assessment Authority NAPLAN collection and Department of Education and Training administrative data, 2013

The number of Aboriginal students who were absent from NAPLAN reading in 2013 increased from 7.3 per cent in Year 3 to 25.5 per cent in Year 9. These rates were between two and three times higher than their peers'. The rate of exemption from NAPLAN reading for Aboriginal students was lowest in Year 7 (5.6 per cent) and highest in Year 3 (7.6 per cent). In contrast the proportion of non-Aboriginal students exempted was steady in each year level at around 3.5 per cent.

Similar patterns were seen in 2013 NAPLAN numeracy, where Aboriginal student performance in the top two bands decreased from 12.4 per cent in Year 3 to only 3.2 per cent in Year 9 and absenteeism increased from 8.2 per cent to 26.5 per cent.

Analysis of Year 9 NAPLAN outcomes in numeracy and reading and subsequent VCE performance indicates that while socio economic status can predict VCE performance and access to higher education, NAPLAN results have stronger predictive power.[65]

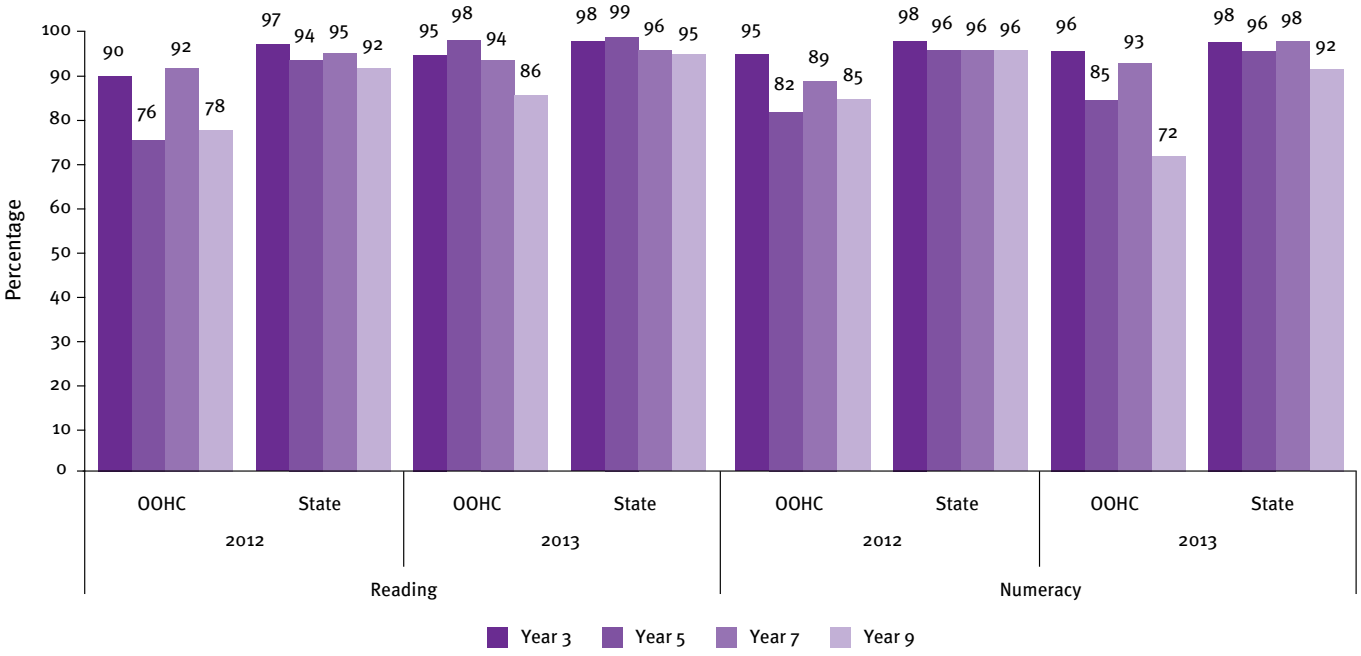
Source: Melbourne Institute of Applied Socio Economic Research. (2014) NAPLAN Scores as Predictors of Access to Higher Education in Victoria. Accessed at https://www.melbourneinstitute.com/downloads/working_paper_series/wp2014n22.pdf

## NAPLAN performance declines more sharply for children in OOHC as they age

Performance in NAPLAN can be an issue for children in OOHC as they progress through school (Figure 4.30). While children in OOHC are achieving at similar levels to their peers in Year 3 (95 per cent at or above NMS for reading and 96 per cent for numeracy in 2013), their performance has declined by Year 9 (86 per cent for reading and 72 per cent for numeracy in 2013). Performance for OOHC students in Years 5 and 7 has been variable between 2012 and 2013, generally decreasing in Year 5 and improving in Year 7.

Caution should be used when interpreting these figures as the small numbers of OOHC students undertaking NAPLAN leads to less reliable data compared to the state average. The broad pattern, however, of poorer performance compared to peers, particularly as they progress through school, generally remains. While these figures are for government school students only, around 90 per cent of children in OOHC are in government schools. These data are the best estimate of literacy and numeracy outcomes for this group of children.

Figure 4.30: Proportion of government school students in OOHC achieving at or above the national minimum standard in NAPLAN Reading and Numeracy, Victoria, 2012–2013

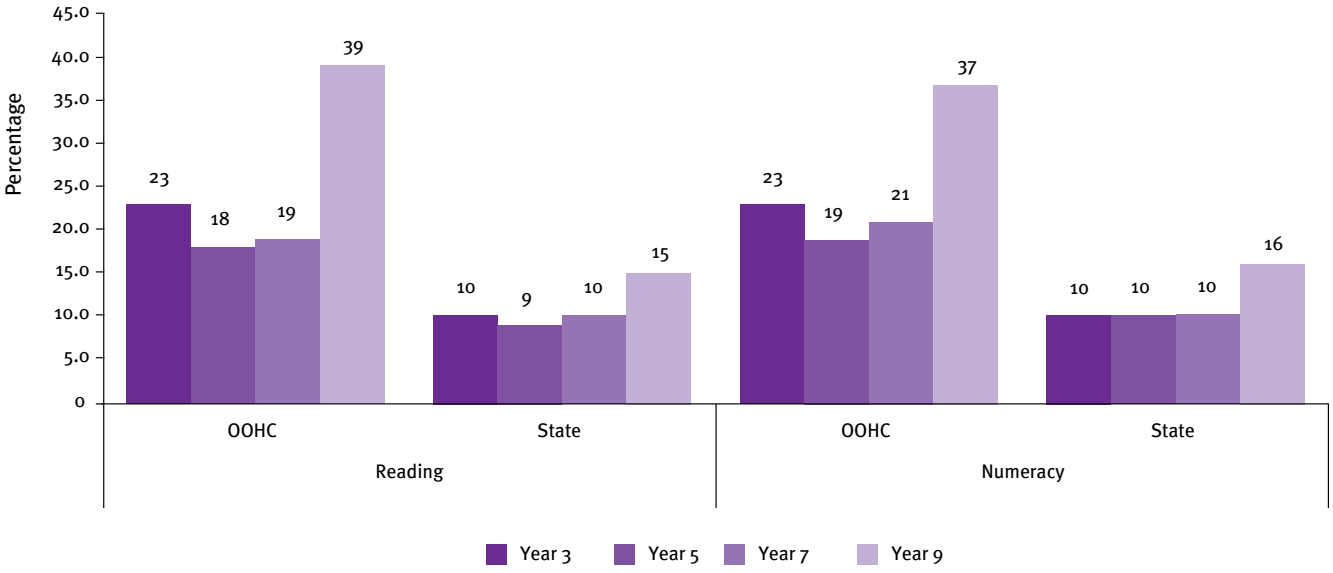



Source: Source: Victorian Curriculum and Assessment Authority NAPLAN collection and Department of Education and Training administrative data, 2013

Note: Some OOHC figures differ slightly to those outlined in the Victoria's Vulnerable Children Baseline Performance Data Report, due to a revised methodology now being used by DET to maximise the amount of NAPLAN results found for children in OOHC.

Government school OOHC students are more likely to be absent from the NAPLAN test than their peers, between 2 and 2.5 times more in each year level (Figure 4.31).

Figure 4.31: Proportion of government school students in OOHC, who were absent from NAPLAN, Victoria, 2013




Source: Source: Victorian Curriculum and Assessment Authority NAPLAN collection and Department of Education and Training administrative data, 2013

## Completion rates for Year 12 or equivalent continue to rise

Completing school means young people are more likely to be employed, have higher wages and positive outcomes. [66] The Year 12 or equivalent attainment rate at age 19 has increased since 2009 from 82.1 per cent to 88.3 per cent in 2013 (Table 4.14). Attainment is higher for females than males (84.8 per cent compared to 92.1 per cent in 2013).

Table 4.14: Year 12 or equivalent attainment rate at Age 19, Victoria, 2009–2013

| | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|
| Attainment Rate (%) | 82.1 | 82.5 | 84.9 | 87.7 | 88.3 |

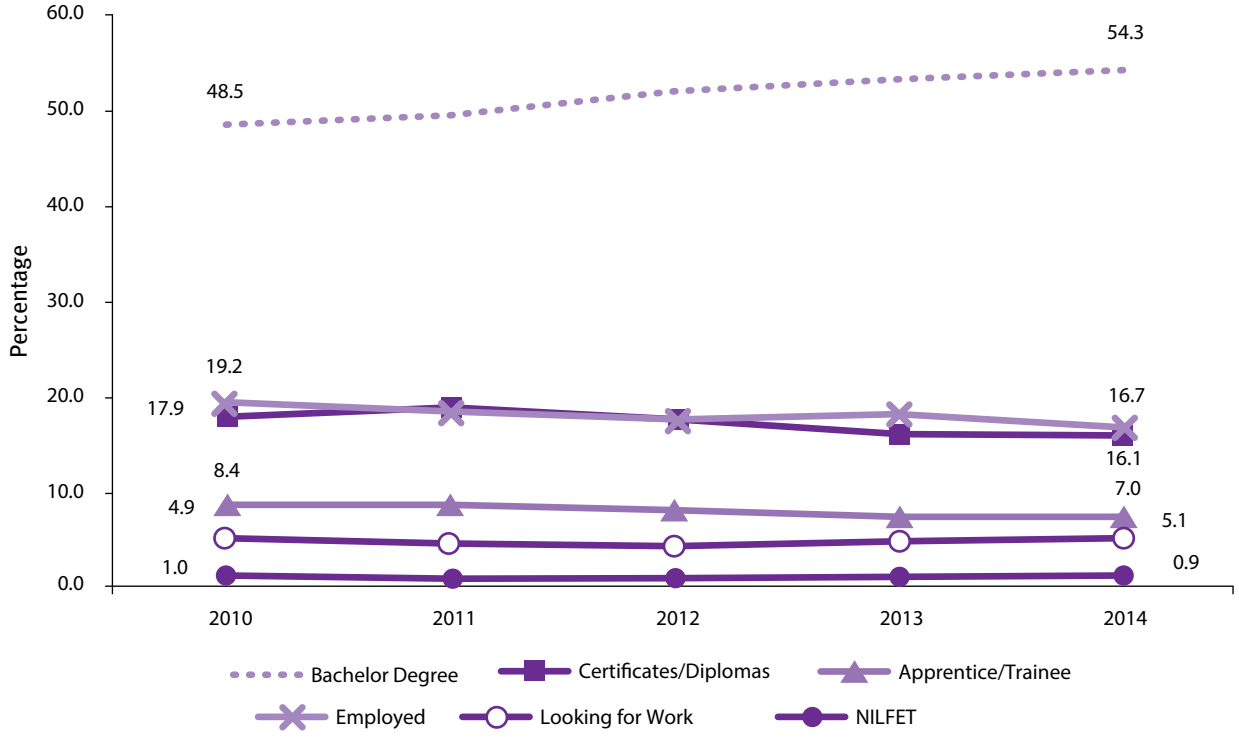
Source: DET analysis of VCAA and Skills Victoria data, 2009 to 2013

According to the Office of Aboriginal Affairs Victoria, the number of Aboriginal students completing Year 12 or equivalent has risen from 255 in 2009 to 380 in 2013, the highest numbers on record. [67] Access, attendance and achievement are the main factors influencing school completion for Aboriginal students.[68]

## Most school completers move into further education and training

Six months after school completion, most school completers who were surveyed through On Track have entered university (54.3 per cent), VET qualifications (16.1 per cent), apprenticeships/traineeships (7 per cent), or work (16.7 per cent) (Figure 4.32). Very low numbers of school completers were not in the labour force, education or training (0.9 per cent). Around 5.1 per cent were looking for work.

Figure 4.32: Post-school destinations of Year 12 completers, 2010–2014

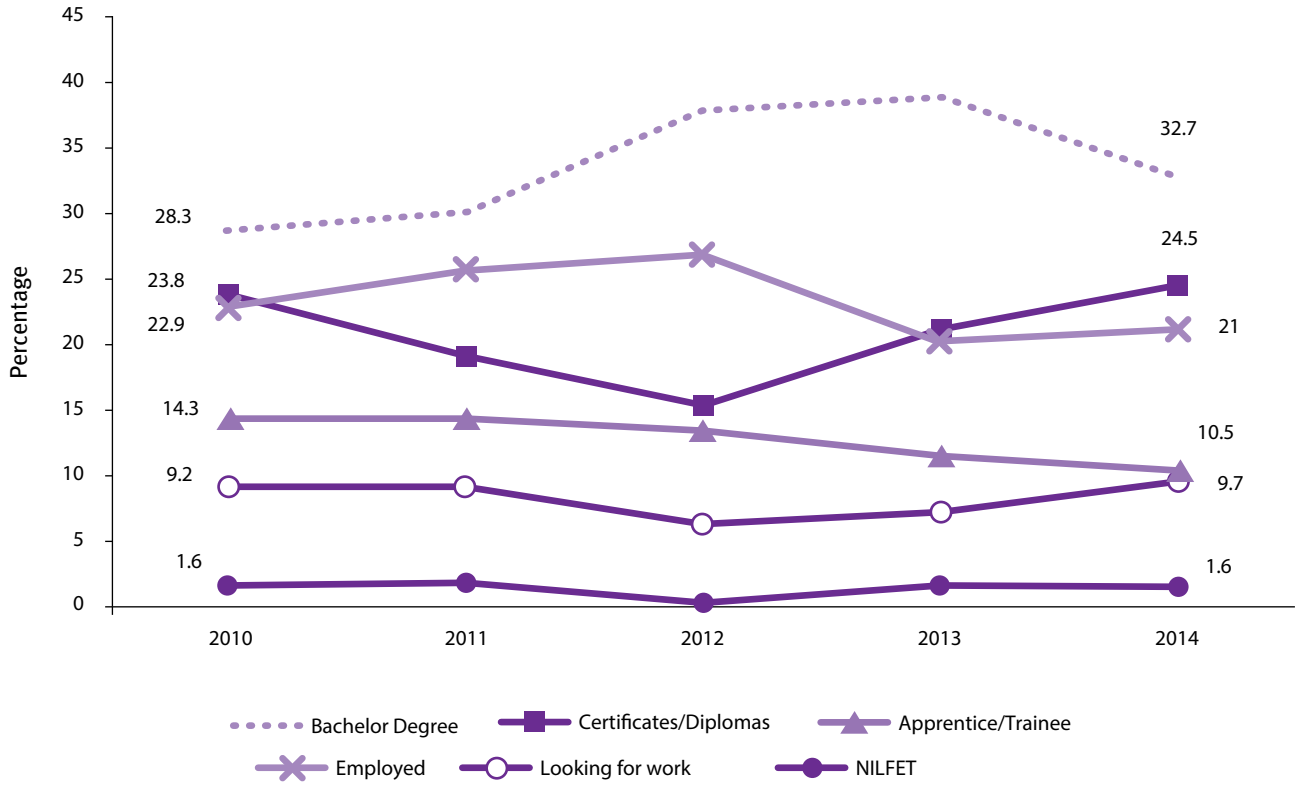



Source: On Track Survey (2013 completers), Department of Education and Training, 2010–2014

There has been a steady increase in Year 12 completers surveyed entering Bachelor degrees over time (48.5 per cent in 2010 to 54.3 per cent in 2014). There has been a commensurate decrease in Certificate/Diplomas and Apprenticeships/Traineeships (Certificates/Diplomas down from 17.9 per cent in 2010 to 16.1 per cent in 2014, and apprenticeships/traineeships, 8.4 per cent in 2010 down to 7 per cent in 2014).

The number of Aboriginal students who responded to On Track who have entered Bachelor degrees has increased since 2010 reaching 32.7 per cent in 2014 (Figure 4.33). There has also been a steady increase in the number of Aboriginal students undertaking Certificates and Diplomas over the last two years (to 24.5 per cent), while the numbers not in the labor force, education or training remain very low at 1.6 per cent.

Figure 4.33: Post-school destinations of Aboriginal Year 12 completers, 2010–2014




Source: On Track Survey (2013 completers), Department of Education and Training, 2010–2014

The most common reasons for not continuing in education and training are wanting to earn money/start work (around 40 per cent) or needing a break from study (38 per cent for females and 32 per cent for males) (Table 4.15).

Table 4.15: Reasons for not continuing in education or training, school completers, 2014

| | 2014 | | | |
|---|---|---|---|---|
| Reasons for not continuing in education or training | Female | % | Male | % |
| You wanted to start working / earning your own money | 1,383 | 40 | 1,732 | 41 |
| You just need a break from study | 1,325 | 38 | 1,327 | 32 |
| You never planned or intended to study | 379 | 11 | 691 | 17 |
| The courses you were interested in were not available locally | 378 | 11 | 427 | 10 |
| Total | 3,465 | | 4,177 | |

Source: On Track Survey, (2013 completers), Department of Education and Training, 2014

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# Section 5

## Parents and families

**Celeste, Year 6**

# Parents and families

Artwork by Alexia, Year 3

Artwork by Darshana, Year 6

Parents have a vital influence on the health, wellbeing, learning, development and safety of their children. Many risk and protective factors for children are determined in the family, and affect resilience and vulnerability throughout their lives.

This chapter discusses good parenting and healthy family functioning, social support and inclusion, and economic security which all protect children. As well, it also considers stresses on families, including a family history of risk, poor parental behaviours, parental health and mental health, and family violence.

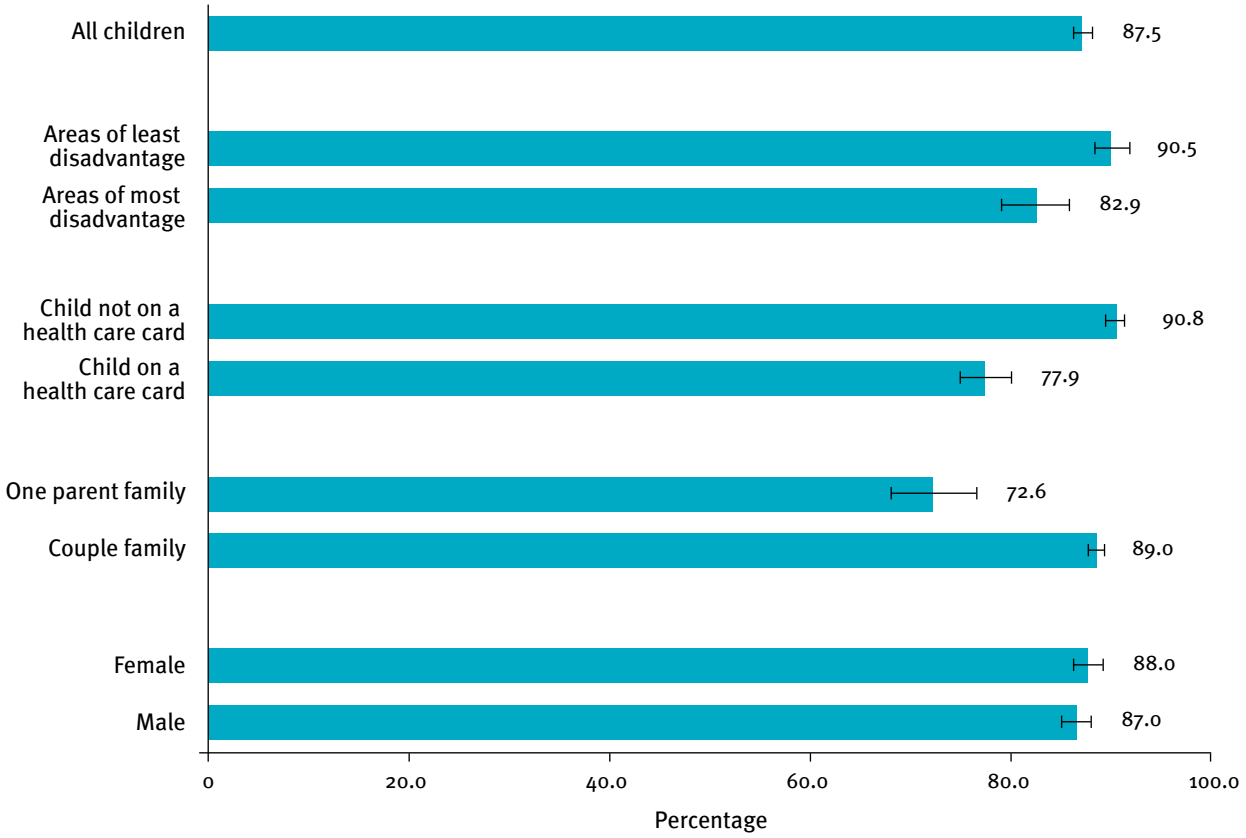
## Parenting and family functioning

### Most Victorian children have safe and supportive families and homes

Healthy family functioning is a key protective factor for children's resilience. It includes positive parenting that establishes fair rules and role models family values which contribute to a child's sense of wellbeing and to developing positive and self-regulating behaviours.

While most Victorian children (87.5 per cent) live in families with healthy family functioning where family members discuss feelings, make joint decisions and support, trust and accept each other (Figure 5.1), one in eight children do not have the benefit of this environment. Proportions of families with healthy functioning are significantly lower for children in areas of most disadvantage (82.9 per cent), children on Health Care Cards (77.9 per cent), and children in one-parent families (72.6 per cent), compared to other children.

Figure 5.1: Proportion of Victorian children aged 0 to 12 years living in families with healthy family functioning, 2013




Source: Victorian Child Health and Wellbeing Survey, DET, 2013

Data from 2009 indicates that 83.1 per cent of young people report living in families with healthy family functioning free from aggressive behaviours and having a good system to manage adolescent's school and social lives.[1]

Risky family functioning often includes deficient nurturing of the child; cold, unsupportive and neglectful relationships; and harsh or inconsistent behaviour management practices. It is likely to leave children vulnerable to a wide range of physical, health and psychological disorders.[2]

Densely populated family households, lack of social support, financial stress, and low educational status of parents can affect a family's ability to cope with everyday life. An absence of coping mechanisms can lead to family functioning difficulties, potentially leaving children vulnerable to abuse and neglect.

Children's learning and development, health and wellbeing are influenced by the quality of parenting they receive. Major studies of child resilience demonstrate a significant relationship between the 'quality of caregiving and the child's ability to adapt to adversity." [3]

Parental warmth, hostility, consistency and perception of own parenting capability are the strongest predictors of outcomes for infants. [4] Children's antisocial behaviour is associated with parents who are less positive, more permissive and inconsistent, and use more violent and critical discipline.[5]

The Longitudinal Survey of Australian Children shows that most Australian parents believe they are doing a good parenting job, reporting high levels of warmth and low levels of hostility (Table 5.1).

### Table 5.1: Mothers' and fathers' parenting style scores B cohort, Waves 1–3, Australia

| Parental Warmth | Mother | Father |
|---|---|---|
| 1-5 Likert Scale (mean score) | | |
| 0-1 years | 4.56 | 4.25 |
| 2-3 years | 4.60 | 4.32 |
| 4-5 years | 4.51 | 4.23 |
| Hostile Parenting | | |
| 1-10 Likert Scale (mean score) | | |
| 0-1 years | 1.93 | 1.99 |
| 2-3 years | 3.10 | 3.01 |
| 4-5 years | 3.19 | 2.91 |

Source: Longitudinal Survey of Australian Children Annual statistical report, 2010

Australian parents from disadvantaged families reported poorer parenting than other parents for a range of measures including overprotective parenting and confidence in own parenting capacity. Hostile parenting showed no associations with socioeconomic status whereas parental warmth showed inconsistent relationships with socioeconomic status.

There were significant differences in parenting for boys and girls. Fathers of four to five year old boys had a 30 per cent increase in low warmth compared to fathers of girls. Mothers and fathers of boys showed less overprotective parenting compared with those of girls.[6]

# Social support and inclusion

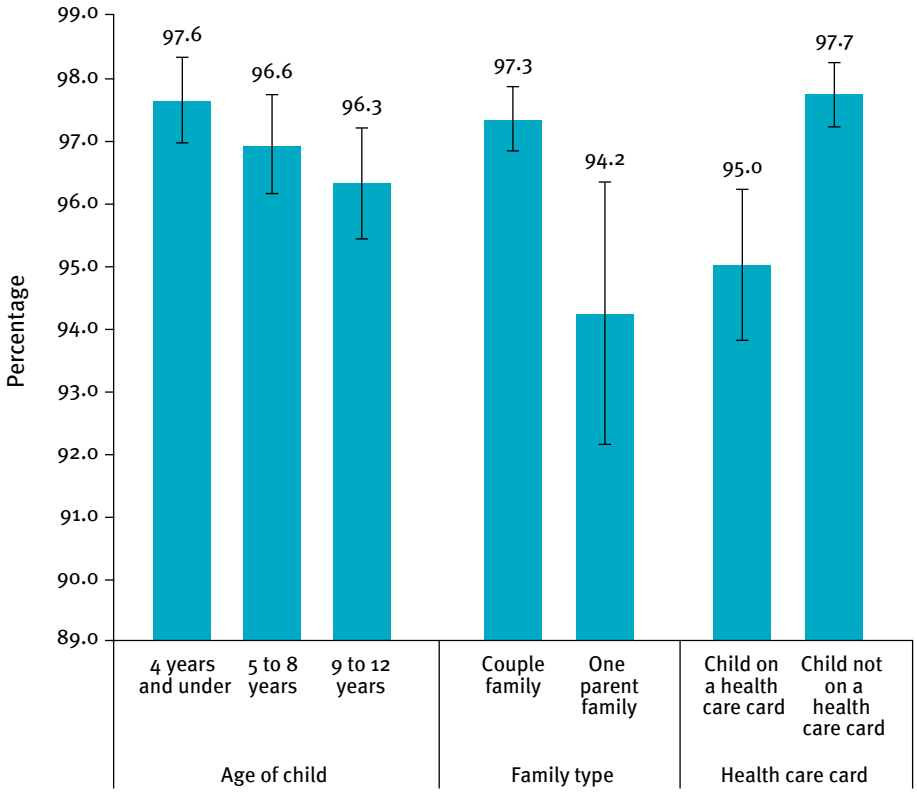
Social inclusion is important to healthy family functioning. It helps individuals feel connected to and supported by their community, experiencing a sense of belonging and feeling that their voice will be heard.[7] The ability to access support is an important part of social inclusion. Some families find it difficult to access formal or social support.

## Victorian families can access help and support when needed

Most Victorian adults are able to get help from family and friends when needed. Adults with school-aged children are less likely to be able to access help than those without school-aged children. For adults with school-aged children, accessing help from family is more difficult than accessing help from friends (88.9 per cent compared to 94.5 per cent). In contrast, 93.5 per cent of those without school-aged children felt they could get help from family and 94.9 per cent felt they could get help from friends.[8]

Having someone to turn to when having problems is easiest for parents with younger children (97.6 per cent), from couple families (97.3 per cent) and where the child is not on a Health Care Card (97.7 per cent) (Figure 5.2).

Figure 5.2: Proportion of children aged 0–12 with parents who have someone to turn to when having problems, 2013



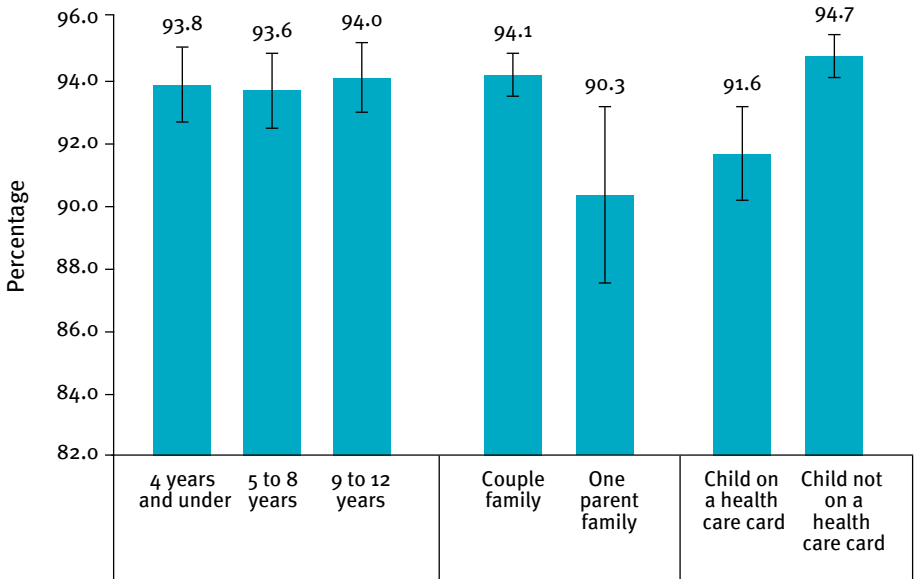

Source: Victorian Child Health and Wellbeing Survey, DET, 2013

## Around one in ten Victorian families cannot access help in times of emergency

The Victorian Population Health Survey (2011-2012) indicated that support in a time of emergency is particularly important for families. While most Victorian adults can get care in a time of emergency (around 90 per cent), parents with school-aged children are slightly less likely to report this (88.3 per cent) than those without school-aged children (89.4 per cent).[9]

Parents of children aged 0 to 12 report that they are least likely to be able to access support in an emergency when they are in one-parent families (90.3 per cent) and where the child is on a Health Care Card (91.6 per cent) (Figure 5.3). These separate surveys identify around one in ten families that are not able to get support when they need it.

Figure 5.3: Proportion of children aged 0–12 from families who are able to get support in a time of crisis, 2013



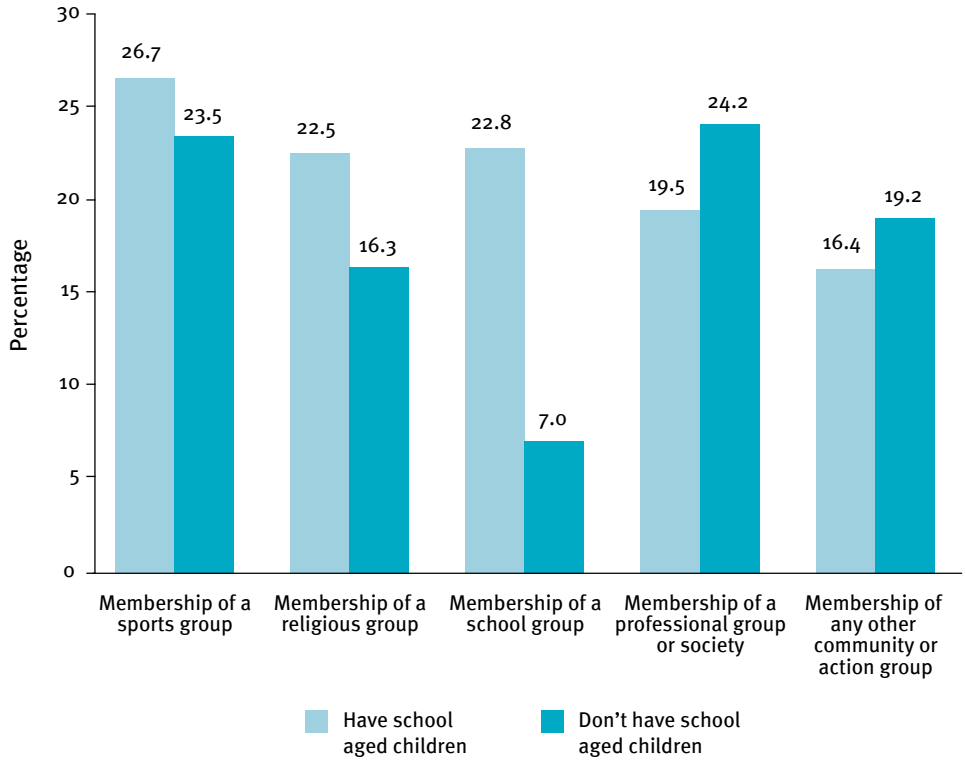

Source: Victorian Child Health and Wellbeing Survey, DET, 2013

## Victorian parents are actively involved in their community

Involvement in community activities helps build a sense of social inclusion. Victorian parents' participation in social groups depends on whether or not they are parents of school-aged children (Figure 5.4).

Parents of school-aged children are more likely than those without school- aged children to be members of sports groups (26.7 per cent), religious groups (22.5 per cent) and (unsurprisingly) school groups (22.8 per cent). They are less likely to be members of professional groups (19.5 per cent) and societies, and community action groups (16.4 per cent).

Figure 5.4: Proportion of Victorian adults who are members of social groups by parental status, 2011–12




Source: Victorian Population Health Survey, DHHS, 2011–12
Note: These adults may have children but they are not of school age

## The impact of social exclusion on vulnerable children and their families

Social exclusion is usually defined by a lack of social connectedness and participation.[10]

Australian children living in areas with a high risk of child social exclusion generally have worse health outcomes than those children living in other areas. The 'estimated rates of avoidable deaths among children 0 to 15 years increase with increasing risk of child social exclusion.' [11]

Social exclusion is linked to Aboriginal disadvantage in Australia because of the 'multi-dimensional, complex nature of Indigenous disadvantage and the ways in which ongoing racial discrimination plays a role in Indigenous people's limited opportunities'. [12]

Social exclusion goes beyond financial stress and 'may contribute to child abuse and neglect because parents with less material and emotional support lack positive parenting and role models, and feel less pressure to conform to social norms relating to parenting.' [13] It also notes that families referred to Child Protection are 'commonly living within a broad context of isolation and socioeconomic disadvantage.' [14] Most families involved with Child Protection are socially excluded.[15]

Child protection practitioners frequently deal with 'families who have been affected by poverty, social exclusion and trans-generational patterns of disadvantage and with parents who have been profoundly affected by their own experiences of trauma and adverse parenting, which are likely to have compromised their parenting resources and capacities.' [16]

Another potential flow on effect of social exclusion is radicalisation (economic and social exclusion is identified as a motivating factor for radicalisation). [17] Recent reports state that "the Andrews government has called in experts to help counter the growing threat of radicalised youth, admitting it is struggling to understand why increasing numbers of young people are turning to extremist groups such as Islamic State." [18]

The effort includes a $4 million research institute to advise on programs to strengthen multiculturalism and understand the terror threat; an advisory group of young community leaders; and more effort on keeping students engaged at school. While most recruitment happens online or through older peers, schools play a part in communicating and engaging with young people.

# Economic insecurity

A lack of economic security can contribute to stress within a family that may in turn affect child-parent relationships and family functioning. When there is not enough income to meet daily needs, basics such as food and housing cannot be provided.

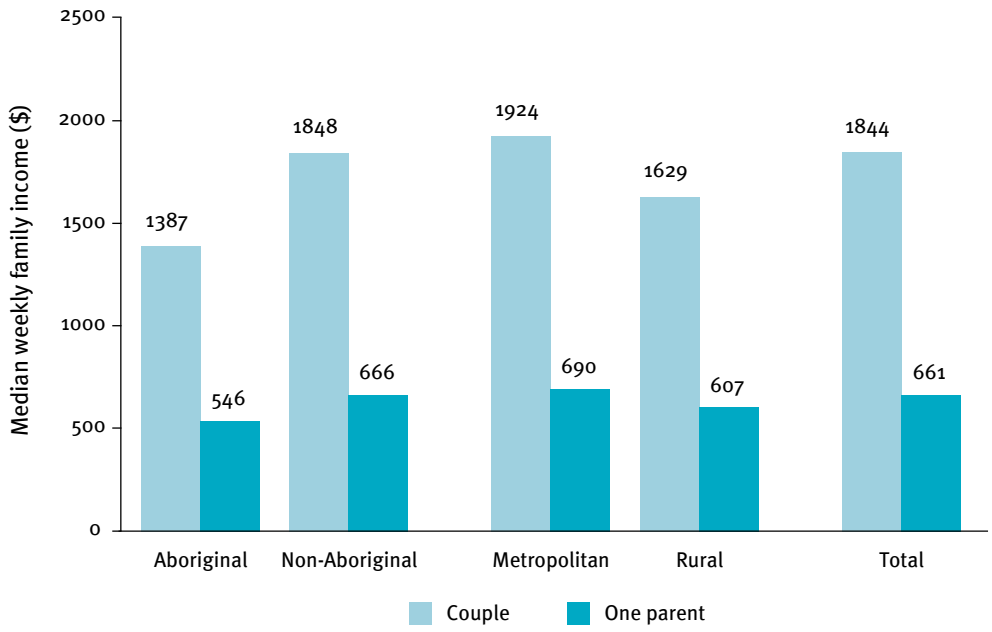
## Median family income is lower for one-parent families

An adequate income and a sense of security about future income is a critical aspect of healthy families and family wellbeing.[19] The median weekly family income for couple families with at least one child aged 0 to 17 years in Victoria is far higher than for one-parent families ($1,844 compared to $661) (Figure 5.5).

One-parent family incomes are lowest for Aboriginal families and rural families but are spread within a fairly small range compared to couple family incomes. Their incomes range from $1,387 per week for Aboriginal families to $1,848 for Non-Aboriginal families; and $1,629 for rural to $1,924 for metropolitan families.

The Victorian median weekly family income for families with children aged 0 to 17 is comparable for non-Aboriginal families and those living in metropolitan areas, but lower for Aboriginal families and those living in rural areas.

Figure 5.5: Median weekly family income for families with at least one child aged 0–17 years, by family type, 2011



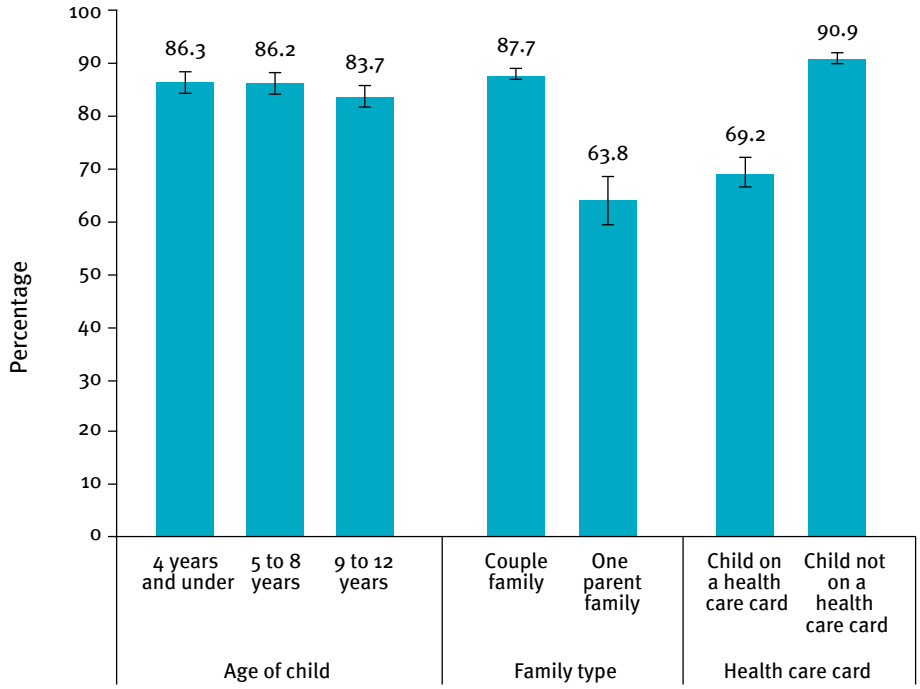

Source: ABS Census of Population and Housing, 2011

## More than one in ten Victorian families cannot access funds in an emergency

In addition to median family income, the ability to raise funds for an emergency such as an unexpected bill is considered an indicator of financial stress. A third of one-parent families (with children aged 0 to 12) are not able to access funds in an emergency (Figure 5.6).

Couple families (87.7 per cent) are more able than one-parent families (63.8 per cent) to raise the funds within two days. Additionally, 90.9 per cent of parents whose children are not on a Health Care Card could raise the funds, compared to 69.2 per cent whose children are on a Health Care Card.

### Figure 5.6: Proportion of children aged 0–12 years from families able to raise $2,000 within two days in an emergency, 2013



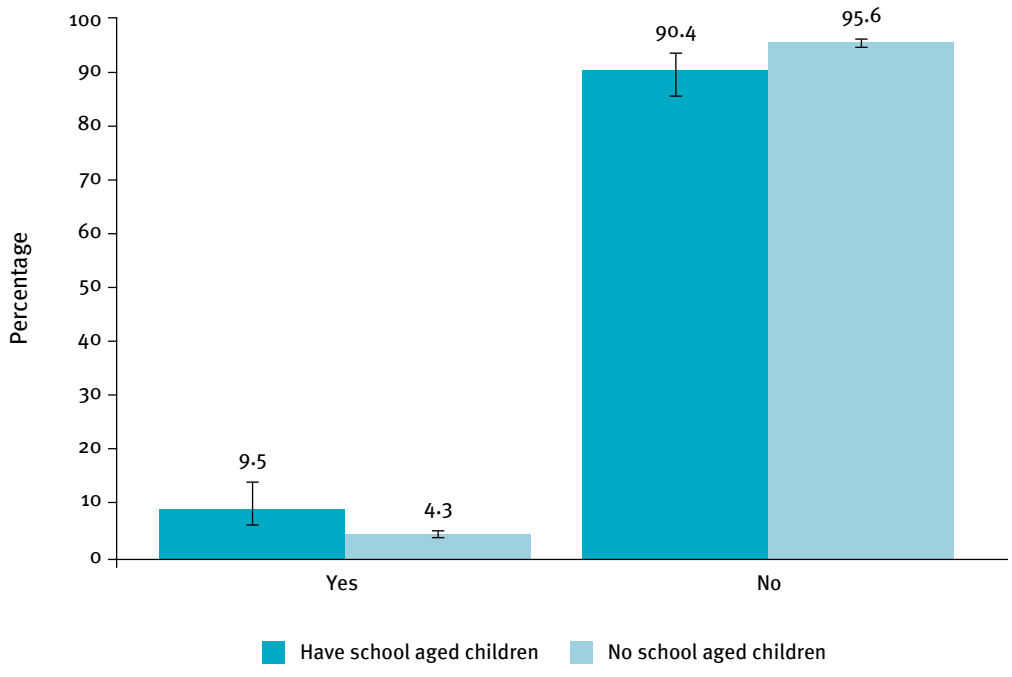

Source: Victorian Child Health and Wellbeing Survey, DET, 2013

## Parents with school-aged children are more likely to have run out of food than other adults

Some Victorians do not have regular access to safe, nutritionally adequate, culturally acceptable food from non-emergency sources.[20] They rely on charitable food supplies or on cheap food with low nutritional value. This food insecurity can have immediate effects including anxiety, hunger and lack of energy and longer term-effects such as a greater likelihood of being overweight and obese, or underweight. The problem is more likely to affect the most socio-economically disadvantaged.

While around 5 per cent of Victorians reported running out of food in the previous twelve months, this was twice as high for parents of school-aged children than for parents without school-aged children (9.5 per cent compared to 4.3 per cent) (Figure 5.7).

Figure 5.7: Proportion of adults who ran out of food in the previous 12 months, by parental status, 2011–12




Source: Victorian Population Health Survey, DHHS, 2011–12

Recent reports state that food relief charities have reported a spike in demand on their services over the past year, with some reporting increases as high as 30 per cent, and the concern that 35 per cent of the people relying on food relief are children. [21]

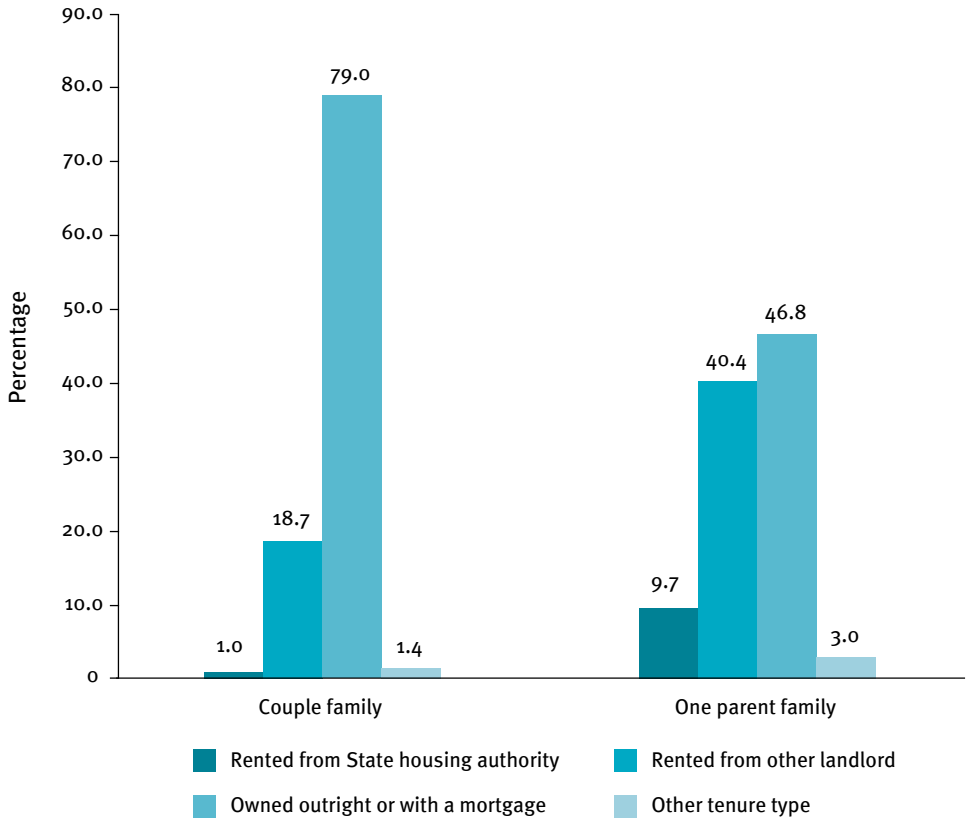
## Housing Stress can be an issue for families particularly one-parent families

Adequate housing is a protective factor for child maltreatment. Housing is based on:

- a physical structure
- the meaning of home as a protective and safe refuge where individuals develop a sense of identity and attachment
- the immediate housing environment
- the quality of the neighbourhood and its social cohesion, sense of trust and collective efficacy.[22]

While most Victorian families with children aged 0 to 17 years own their house with a mortgage or outright, a smaller number are renting from the state or from other landlords (Figure 5.8). Home ownership is much more common for couple families (79 per cent) than for one-parent families (46.8 per cent). Renting from a State Housing Authority or landlord is higher for one-parent families (9.7 per cent and 40.4 per cent).

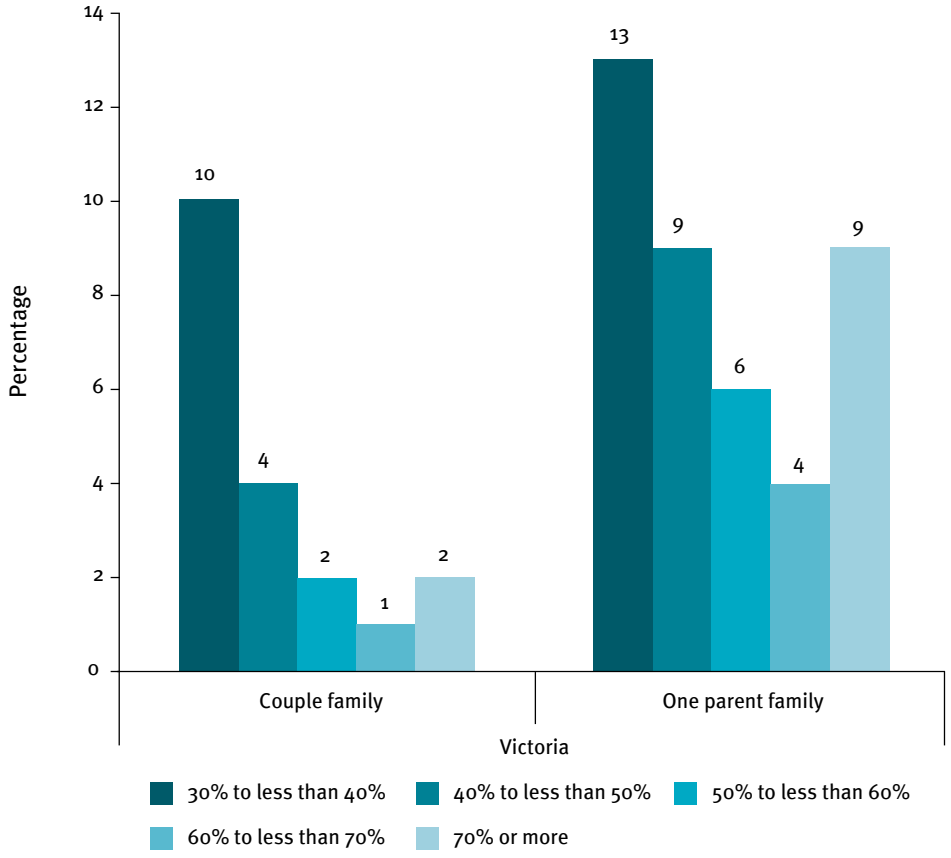
### Figure 5.8: Proportion of Victorian families with children aged 0–17 years by housing tenure and family structure, 2011




Source: ABS Census of Population and Housing, 2011

Larger proportions of one-parent families spend a high proportion of their household income on housing compared to couple families (Figure 5.9). This difference is most marked for families spending 70 per cent or more of household income on housing. Around nine per cent of one-parent families are in this situation compared with two per cent of couple families.

Figure 5.9: Proportions of Victorian families with children aged 0–17 years spending 30 per cent or more of household income on housing, 2011




Source: ABS Census of Population and Housing, 2011

## Homeless children and young people face many health and wellbeing challenges

Homelessness is a complex problem and can arise from a combination of factors. The major factors are a shortage of affordable housing, poverty, unemployment and discrimination. Family conflict, with violence and abuse, social isolation, mental illness and breaks from formal education, can also increase the likelihood of a person becoming homeless.[23]

Homeless children and young people are especially vulnerable, and are exposed to a range of additional risks and challenges compared to other children.

Assistance to people experiencing or at imminent risk of homelessness is delivered by both specialist and other services. Specialist homelessness services are funded by Governments across Australia and delivered by non-government organisations. They include agencies that specialise in delivering services to specific target groups (such as young people or people escaping domestic violence), as well as those that provide more generic services to those facing housing crises.

Homelessness services funded by government are accessed for a range of reasons including financial, accommodation, interpersonal relationships and health. In 2012–13, domestic and family violence was the most frequent main reason for which Victorian homelessness clients sought assistance with 20,379 clients (27 per cent) seeking assistance for this reason. Financial difficulties accounted for a further 13,176 (17 per cent) of clients seeking assistance.[24]

At the extreme end of social exclusion, homeless children and young people are vulnerable to health and safety problems, and exploitation.[25] They commonly face multiple forms of disadvantage, including poverty, poor access to health care, lower participation in education and poor employment prospects. Homeless children have less time in school, may move schools up to five times per year and are more likely to leave school altogether.[26] Homeless children have lower immunisation rates, higher rates of asthma and vision problems and are reliant on hospital emergency departments for their health care.[27] Homeless children are also more likely than children who have not been homeless to be homeless as adults.

Between 2011–12 and 2012–13 the number of clients accessing specialist homelessness services in Australia increased by three per cent to 244,000. Most of this increase was attributable to an increase in the number of clients in Victoria, which accounted for 81 per cent of this increase due to the commencement of a number of newly funded specialist homelessness agencies.[28]

Of the 16,053 children and young people assisted by Victorian specialist homelessness services in 2012–13, just over half were aged under nine years of age (Table 5.2). While females made up a slightly higher number of children and young people accessing these services, the number of males was higher for the under nine age group.

Table 5.2: Proportion of Victorian specialist homelessness service clients aged 0 to 17 years, by gender and Aboriginal status, 2012–13 (adjusted for non-response)

| | All clients | | | Aboriginal clients | | |
|---|---|---|---|---|---|---|
| | Males | Females | Total ALL | Males | Females | Total Aboriginal |
| 0–9 | 4,776 | 4,251 | 9,027 | 518 | 451 | 969 |
| 10–14 | 1,597 | 1,668 | 3,265 | 158 | 194 | 352 |
| 15–17 | 1,554 | 2,206 | 3,761 | 138 | 228 | 366 |
| TOTAL | 7,927 | 8,125 | 16,053 | 814 | 873 | 1,687 |

Source: Specialist Homelessness Services, AIHW, 2012–13

In children and young people, homelessness and related issues can cause developmental delays, social exclusion, interrupted education, and mental and physical health problems that can be exacerbated by a lack of access to support and community resources. The complex issues faced by homeless families can compromise a caregiver's ability to parent their children effectively in times of crisis, often compounding issues for children.

DHHS specialist homelessness services include children's support workers in most family violence refuges. They also include specialist children's resource workers who build the capacity of homelessness services to respond to the needs of children and families, and provide flexible brokerage specifically targeted to children.

Support for children is available through the integrated family violence system, including access to counselling.

Young people are a priority of the *Victorian Homelessness Action Plan (2012-2015)*, which has a key focus on early intervention and prevention and assisting people into education, training and employment to enable them to move on to economic and social participation and maintain stable housing.

A range of individually-based services are available to support young people aged 16 to 25 years from specialist homelessness services including crisis and transitional accommodation, case-managed support, support to access education, employment and training, living and life skills programs, strengthening connections to family and assistance to secure and maintain a private rental tenancy.

Accommodation and support for up to two years is also available to young people who are ready to commit to education and training in a number of youth foyers or foyer-like models around Victoria. Through youth foyers young people can access education, training and employment services and have a safe, secure and affordable place to live whilst they study.

http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/housing-and-accommodation/youth-foyers

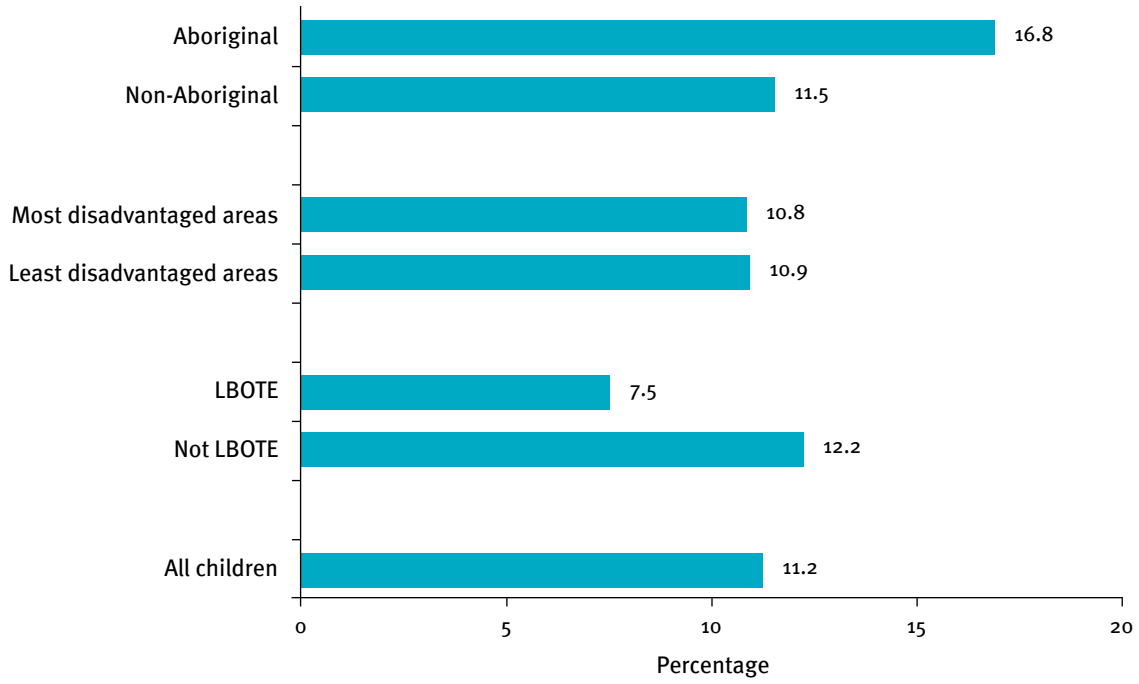
# Family stress

High parental stress is a risk factor for child vulnerability. Financial stress, time stress, parental mental health and substance abuse may add to the stress of daily life and damage parent-child relationships. Parental resilience influences the ability to deal with stress.

By successfully managing situational stressors, parents are likely to 'feel better and can provide more nurturing attention to their child, which enables their child to form a secure emotional attachment'.[29]

Around 11 per cent of Victorian children entering Prep are from families who have experienced high levels of stress in the last month (Figure 5.10). Stress levels are highest for Aboriginal children (16.8 per cent) and lowest for LBOTE children (7.5 per cent). However, children in the least disadvantaged areas were as likely to come from families experiencing high levels of stress as those from the most disadvantaged areas (around 10.85 per cent).

## Figure 5.10: Proportion of Victorian children at school entry who are from families with high levels of stress in the previous month, 2013




Source: School Entrant Health Questionnaire, DET, 2013

## Recent stressful events

A range of stressful events can affect children in the year before school (Table 5.3). The most common of these are moving to a new home (14 per cent), death of a relative or friend (12 per cent) and change of parent's job (11.6 per cent).

For Aboriginal children, children from one-parent families, and children from areas of highest socioeconomic disadvantage, the proportion of children affected by a stressful event is greater than the general population. However, there is little difference between boys and girls.

### Table 5.3: Proportion of Victorian children affected by stressful events in the previous twelve months, 2012

| Population group | Death of friend/ relative | Divorce/ separation | Move to new house | New baby in home | Parent change of job | Parent loss of job | Remarriage of parent | Serious illness of parent | Serious illness of sibling |
|---|---|---|---|---|---|---|---|---|---|
| All children | 12.0 | 7.8 | 14.0 | 8.0 | 11.6 | 3.3 | 1.1 | 4.3 | 2.0 |
| Language background other than English | 4.5 | 4.3 | 14.8 | 9.7 | 7.8 | 3.1 | 0.6 | 2.4 | 2.4 |
| Aboriginal or Torres Strait Islander | 16.8 | 17.4 | 23.9 | 11.1 | 12.9 | 6.1 | 2.7 | 9.0 | 3.8 |
| Areas of most disadvantage (IRSED 1) | 11.3 | 9.8 | 14.1 | 9.1 | 10.8 | 3.8 | 1.3 | 4.8 | 2.3 |
| Areas of least disadvantage (IRSED 5) | 11.3 | 5.0 | 13.9 | 6.9 | 11.0 | 2.8 | 0.8 | 3.5 | 1.7 |
| One-parent family | 13.6 | 41.8 | 27.2 | 6.4 | 13.3 | 4.5 | 4.0 | 7.5 | 2.5 |
| Boys | 11.4 | 7.8 | 14.4 | 8.2 | 11.7 | 3.4 | 1.1 | 4.3 | 2.1 |
| Girls | 13.2 | 8.0 | 14.3 | 8.3 | 11.9 | 3.4 | 1.2 | 4.4 | 2.1 |
| Rural/Regional areas | 14.6 | 9.9 | 16.4 | 8.3 | 14.4 | 3.6 | 1.5 | 5.1 | 2.5 |
| Metropolitan areas | 10.9 | 6.9 | 13.0 | 8.0 | 10.4 | 3.2 | 1.0 | 4.0 | 1.9 |

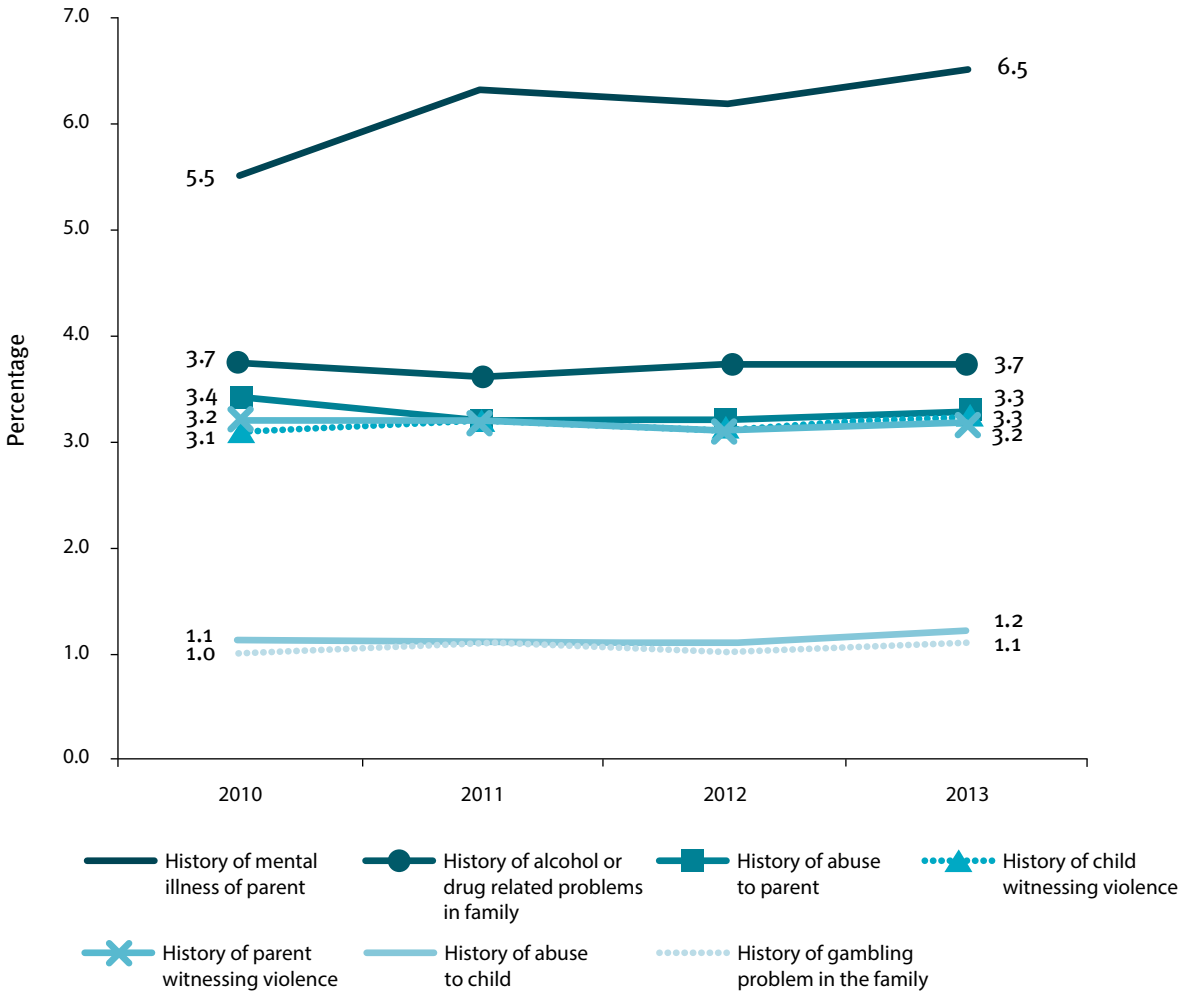
Source: School Entrant Health Questionnaire, DET, 2012

# Family risk factors arising from parents

A small number of children enter school each year with a history of family risk (Figure 5.11). These risk factors, which may have long-term effects on both parents and children, include parental mental illness, a history of abuse to the parent, gambling, and alcohol and drug problems.

The family risk history of children at school entry has remained relatively stable across time with the exception of parental mental illness, which increased from 5.5 per cent in 2010 to 6.5 per cent in 2013.

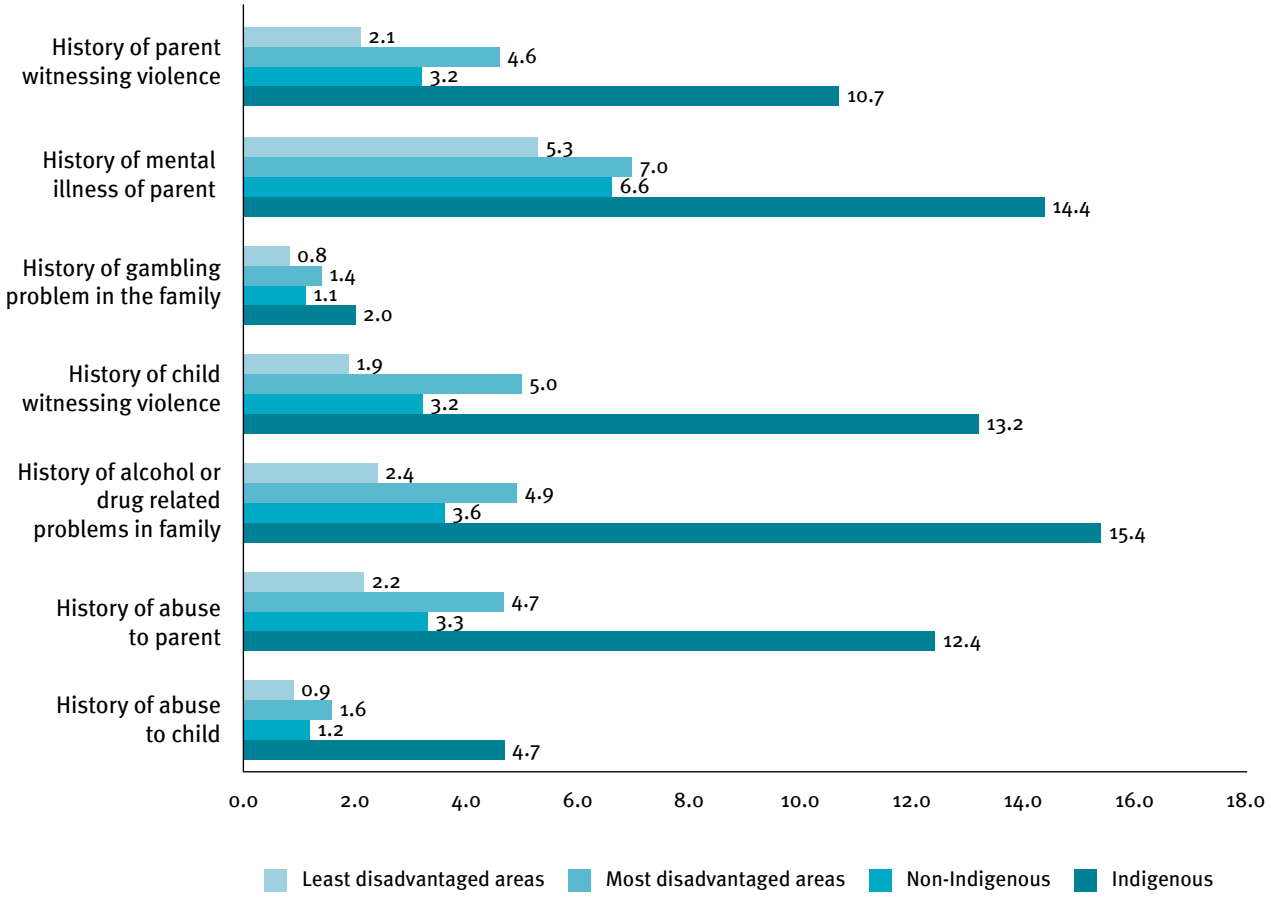
Figure 5.11: Family risk history of children at school entry, 2010 to 2013




Source: School Entrant Health Questionnaire, DET, 2013

The prevalence of these risk factors is highest for Aboriginal children and those from the most disadvantaged areas (Figure 5.12).

Figure 5.12: Family risk history, by Aboriginal status and SEIFA quintile (most disadvantaged and least disadvantaged quintiles), 2013




Source: School Entrant Health Questionnaire, DET, 2013

For Aboriginal children, more than one in seven are from families that have a history of alcohol or drug related problems, or a history of parental mental illness.

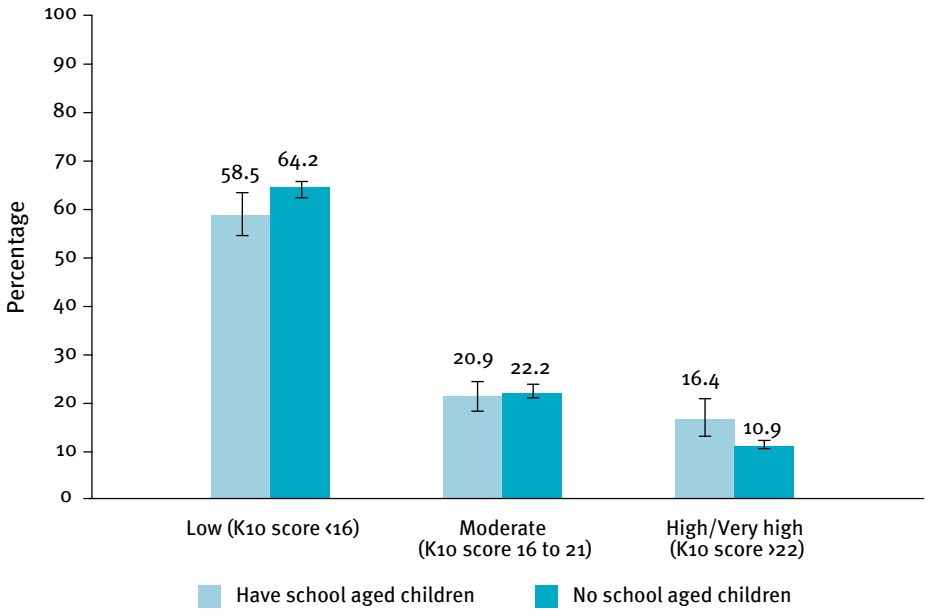
## One third of Victorian adults have moderate or high levels of psychological distress

Parents with a mental illness may find it difficult to maintain a consistent and structured approach to family life. They may also face a range of other challenging factors such as poverty, homelessness, lack of access to education and employment, an increased risk of family violence, and a lack of personal and social supports.

Around 6.5 per cent of children have parents who have a history of mental health issues (Figure 5.11, page 130).

The Kessler is a commonly used tool for assessing psychological distress (Figure 5.13). While most Victorian adults have a low Kessler score indicating low levels of psychological distress, parents of school-aged children are more likely to report a high or very high score (16.4 per cent) than those who do not have school-aged children (10.9 per cent).

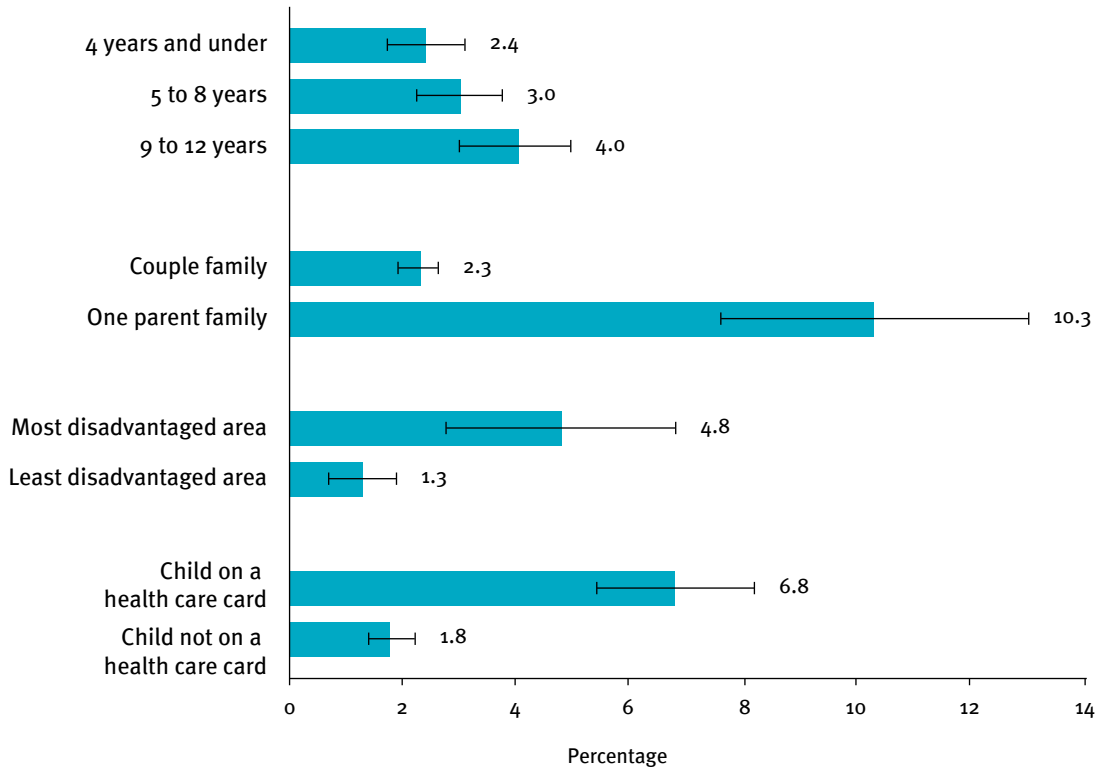
### Figure 5.13: Proportion of Victorian adults reporting low levels of psychological distress (Kessler 10), by parental status, 2011–12




Source: Victorian Population Health Survey, DHHS, 2011–12

A more detailed picture of the parents of children aged 0 to 12 who are at risk of mental health issues indicates that parents in one-parent families are at most risk of mental health issues (10.3 per cent) (Figure 5.14). Higher risk is also seen in parents of children aged 9 to 12 (4 per cent), of children on Health Care Cards (6.8 per cent) and children from the most disadvantaged areas (4.8 per cent).

Figure 5.14: Children aged 0 to 12 years with parent at very high risk of mental health issues (Kessler 6), 2013

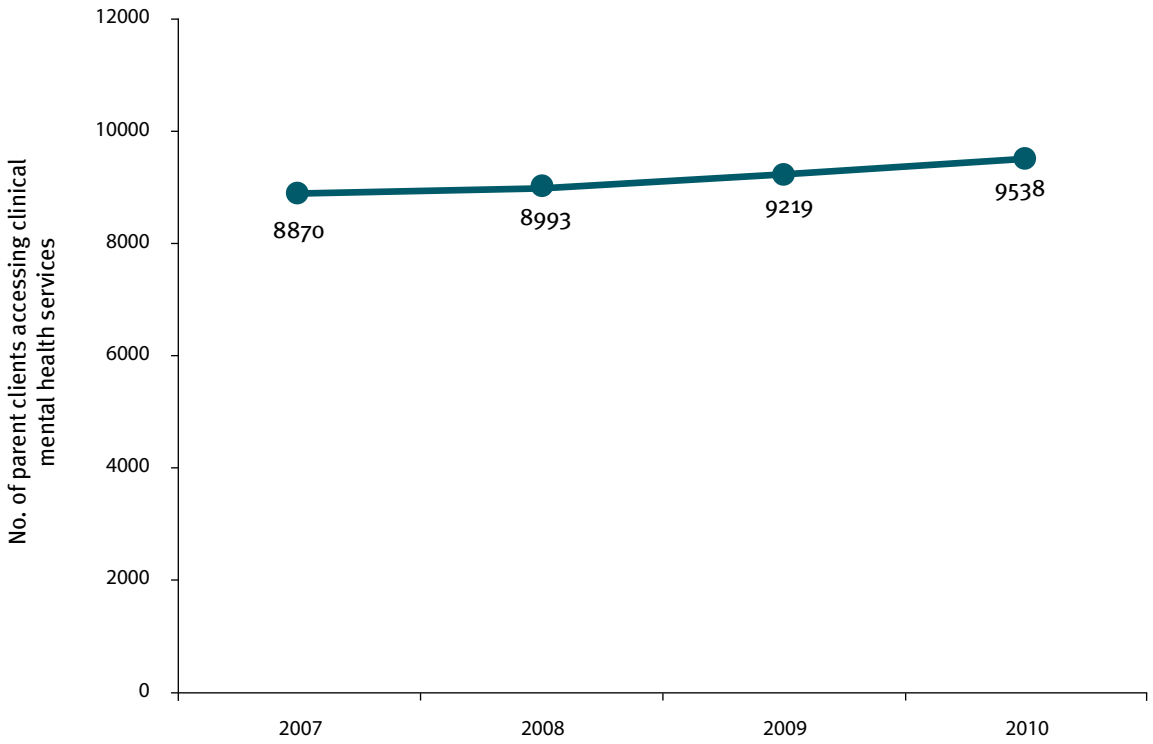



Source: Victorian Child Health and Wellbeing Survey, DET, 2013

The rate of Victorians using community mental health care services to manage their mental illness has increased since 2008 with an estimated 300 service contacts per 1,000 people in 2009–10.[30]

Figure 5.15 indicates that the number of clients who are parents in clinical mental health services also rose between 2007 and 2010 from 8,870 to 9,538.

Figure 5.15: Number of parent clients accessing clinical mental health services, 2007 to 2010




Source: National Community Mental Healthcare Database, 2007 to 2010

## Families where a Parent has a Mental Illness (FaPMI)

FaPMI coordinator positions are embedded in mental health services across the five rural regions and in three metropolitan area mental health services.

These positions work towards increasing support to mental health services to ensure timely identification and appropriate referrals to supportive services to reduce the impact of parental mental illness on the family. This is done via an array of service development activities involving mental health services and network partners such as universal and targeted early years services, child and family support services, housing and drug and alcohol services and primary care and community health services.

Examples of the work that the local coordinators are supporting or implementing include:

- Development of FaPMI resources for mental health services, eg to deliver orientation to new staff and creation of local tools and resources to support practice change.
- Support at an organisational level to embed family focused practice across the continuum of care in local policies and procedures.
- Development of collaborative practice protocols, agreements and training across participating cross-sector agencies.

In some areas, co-ordinators support peer support programs for children and young people, such as PATS (Pay Attention to Self) and Children and Mentally ill Parents (CHAMPS), and mental health promotion programs in primary schools such as SKIPS (Supporting Kids in Primary Schools).

Maternal depression has been identified as a risk factor for children's social, emotional and cognitive development. Perinatal depression covers two periods: from the antenatal period during pregnancy to postnatal up to 12 months after birth. Postnatal depression can affect an infant's emotional, behavioural and social development.

The 2010 Australian national Infant Feeding Survey found that over 10 per cent of Victorian mothers/carers of children aged 0 to 24 months had perinatal depression. Higher rates were found among mothers who were younger (aged under 25), smokers, from low-income households, born in Australia and from households where English was the main language.[31]

The longitudinal Australian Maternal Health Study of 1500 first time mothers has found that "almost one in three women in the study reported depressive symptoms between pregnancy and four years postpartum. Counter to the prevailing view that the perinatal period is a peak time of vulnerability to depression, the prevalence of depressive symptoms was higher at four years postpartum than at any point in the first 12 months after birth".[32] The strongest predictor of depressive symptoms at 4 years postpartum was having previously reported depressive symptoms either in early pregnancy, or in the first 12 months postpartum. Other factors associated with maternal depression at 4 years postpartum were:

- social health issues, such as housing problems
- separation or divorce
- losing your job or
- a close family member having a major illness or passing away.

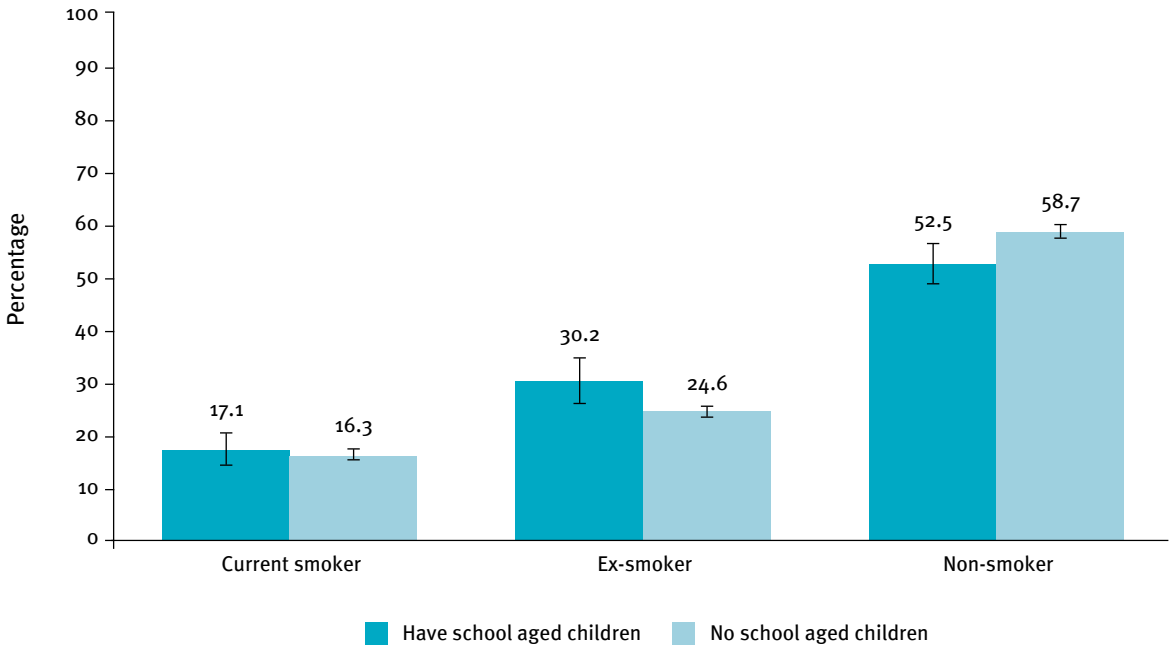
## Most Victorian parents are non-smokers

Children of parents who smoke are exposed to the same amount of nicotine as if they were actively smoking 60 to 150 cigarettes a year.[33] Exposure of infants to cigarette smoke is causally associated with an increased risk of lower respiratory tract infections such as bronchitis and pneumonia, increased prevalence of fluid in the middle ear, symptoms of upper respiratory tract irritation, and a small but significant reduction in lung function. This exposure also has been linked with new cases of childhood asthma and with additional episodes and increased severity of symptoms in asthmatic children.[34] Exposure to parental smoking affects children's vascular health up to 25 years later.[35] Parents who smoke also put their children at greater risk of developing asthma.

Smoking during pregnancy can severely affect the developing baby. It increases the risks of sudden infant death syndrome (SIDS or cot death) and makes children vulnerable to infection and health problems in adulthood.

Around 17 per cent of parents of school-aged children are current smokers and 30.2 per cent are ex-smokers (Figure 5.16). Victorian adults who are not the parents of school-aged children are slightly more likely to be a non-smoker (58.7 per cent compared to 52.5 per cent).

Figure 5.16: Proportion of Victorian adults by smoking status and parental status, 2011–12



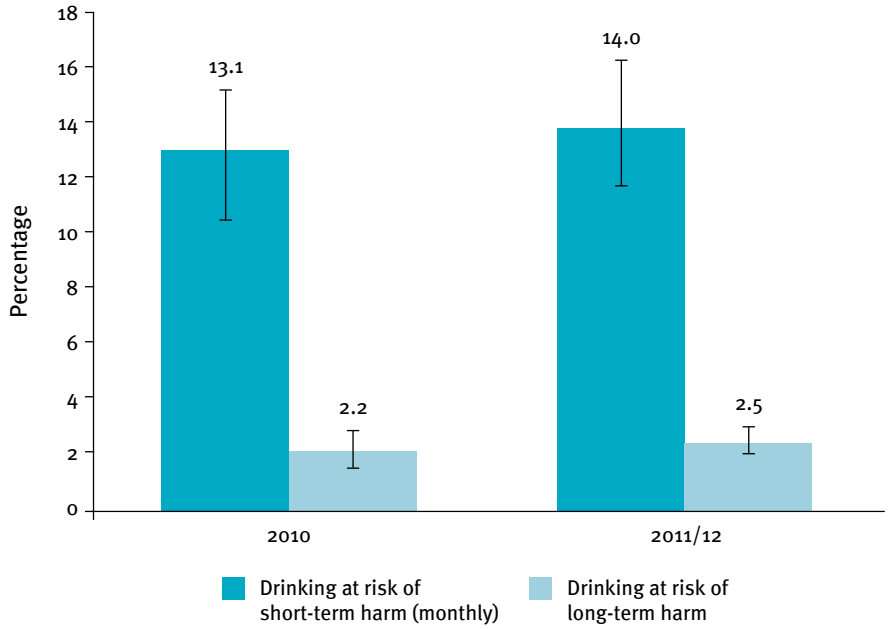

Source: Victorian Population Health Survey, DHHS, 2011–12

## Most Victorian parents are not risky drinkers

Strong links between parental alcohol abuse and child maltreatment have been found across Australia with more than one in four Australians reporting being a victim of physical or verbal abuse related to alcohol.[36] Parental alcohol misuse has a negative impact on parenting styles, with mood swings and inconsistent parenting practices. 'Parents may become controlling, punitive and authoritarian on some occasions, and overly permissive and neglectful on others. They may yell more often, become irritable and inattentive, and engage children in inappropriate levels of responsibility such as allowing children to take on a parenting-type role while the parent is intoxicated.' [37]

Risky drinking is defined as five to six drinks for males and three to four drinks for females. Drinking at these levels once a week is considered short-term harm and daily as long-term harm. The proportion of parents who reported drinking at levels of long-term harm increased marginally between 2010 and 2011–12 from 2.2 per cent to 2.5 per cent (Figure 5.17). Levels of risk at short-term harm increased from 13.1 per cent to 14 per cent.

Figure 5.17: Proportion of parents who report risky drinking, Victoria, 2010 to 2011–12



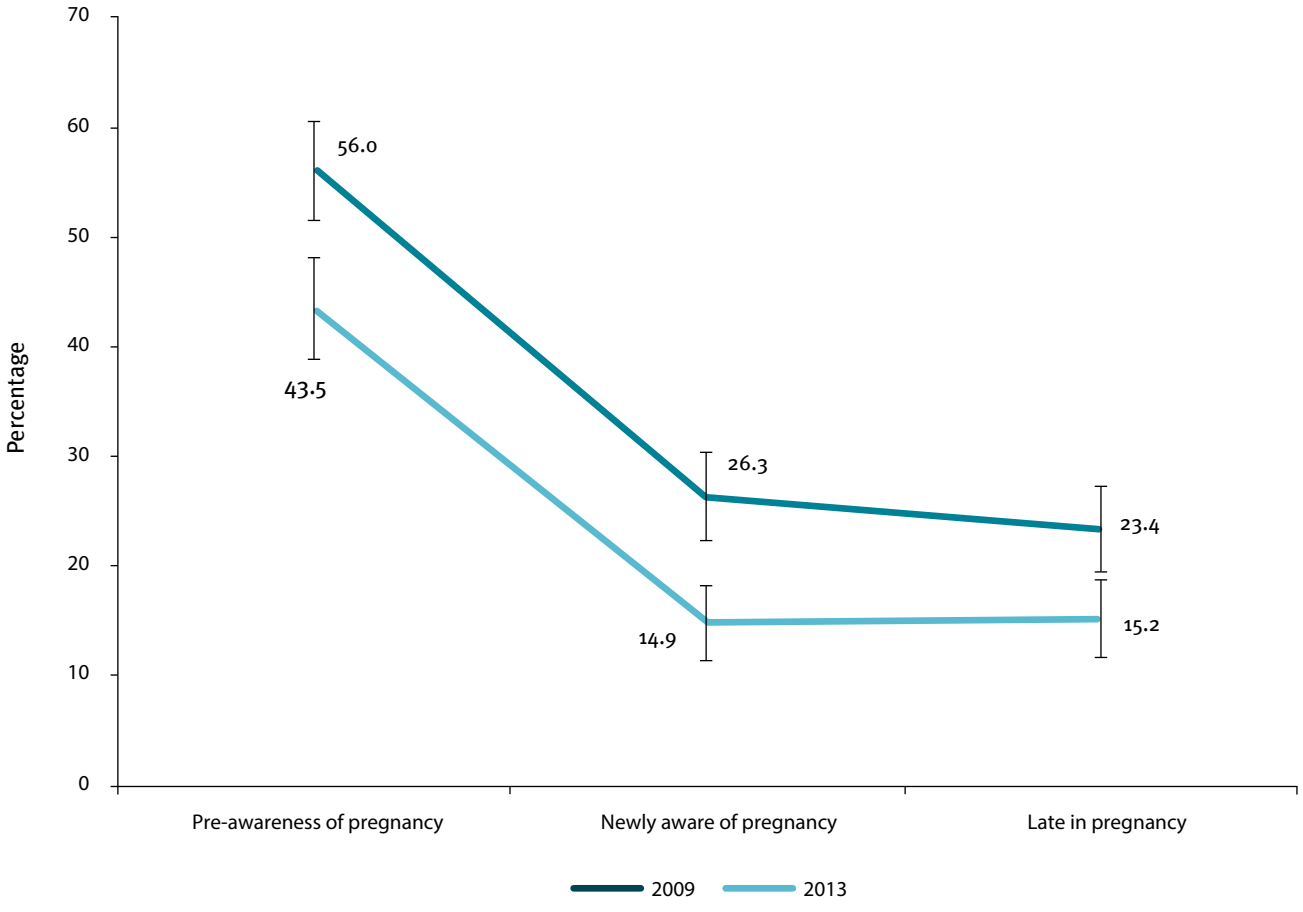

Source: Victorian Population Health Survey, DHHS, 2010 and 2011–12

Maternal alcohol consumption can harm the developing foetus or breastfeeding baby. The level of risk is highest when there is high, frequent maternal alcohol intake. An unborn baby's central nervous system is also vulnerable to alcohol.

Foetal Alcohol Spectrum Disorder (FASD) describes a range of disabilities and effects from prenatal alcohol exposure. Overall, the proportion of Victorian women drinking alcohol in pregnancy has declined considerably between 2009 and 2013 (from 59.7 per cent to 46.7 per cent).

The proportion of women drinking once they are newly aware of their pregnancy has declined from 26.3 per cent in 2009, to 14.9 per cent in 2013 (Fig 5.18). The proportion drinking late in pregnancy has also decreased in the same time period from 23.4 per cent to 15.2 per cent.

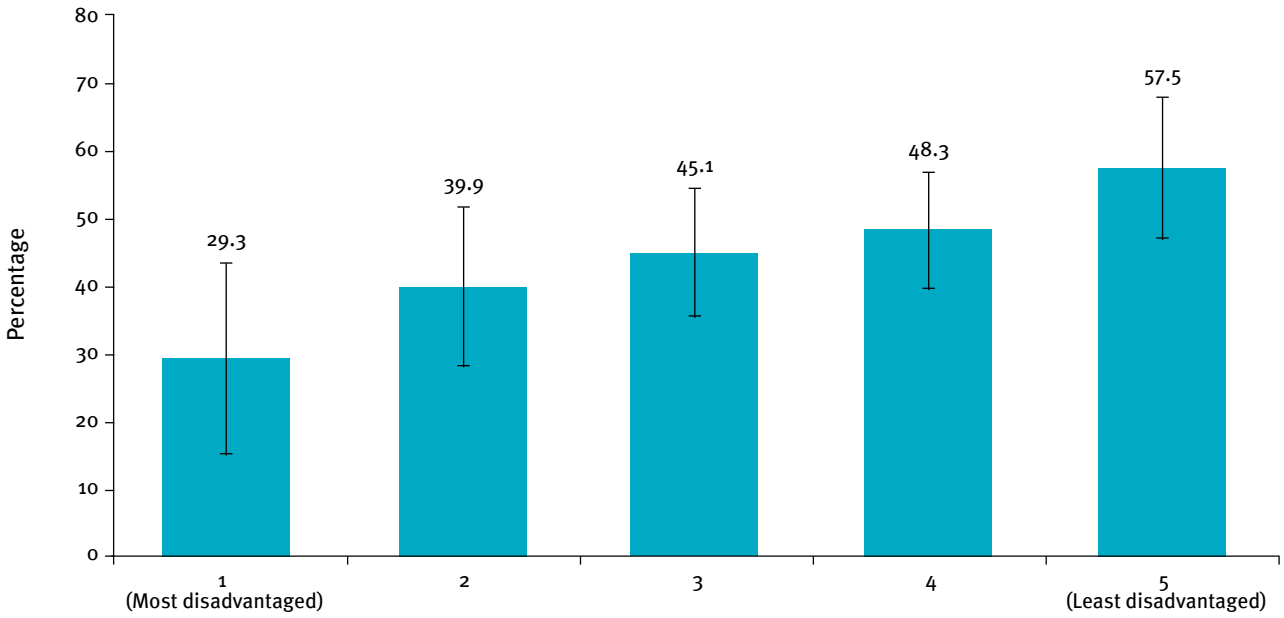
Figure 5.18: Proportion of Victorian children (aged under two years) exposed to alcohol in utero, by stage of pregnancy, 2009, 2013




Source: Victorian Child Health and Wellbeing Survey, DET, 2009 and 2013

Women from less disadvantaged areas are more likely to drink while pregnant (Figure 5.19).

Figure 5.19: Proportion of Victorian children (aged under two years) exposed to alcohol in utero, by SEIFA IRSED quintile, 2013



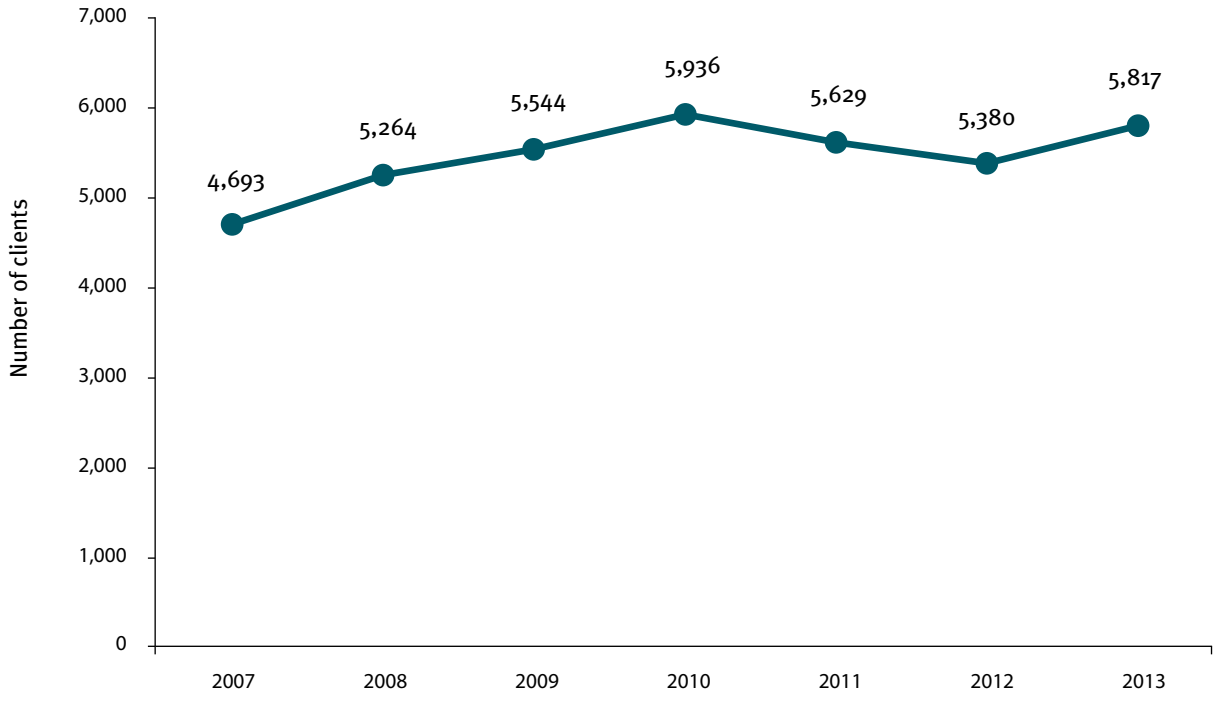

Source: Victorian Child Health and Wellbeing Survey, DET, 2013

## Few Victorian parents abuse substances such as illicit drugs

Parental substance misuse can be a factor in child maltreatment and neglect. While parental drug use is hard to quantify, around 3.7 per cent of parents or carers with children in their first year of school in 2013 noted that there was a history of alcohol or drug use in their family. This was highest for Aboriginal children (15.4 per cent) and those from the most disadvantaged areas (4.9 per cent) compared to 2.4 per cent in the least disadvantaged areas (Figure 5.12, page 131).

The number of parent clients accessing drug and alcohol services rose from 4,693 in 2007 to 5,817 in 2013 (Figure 5.20).

Figure 5.20: Number of parent clients accessing drug and alcohol services, 2007–2013




Source: Alcohol and Drugs Information System, DHHS, 2007 to 2013

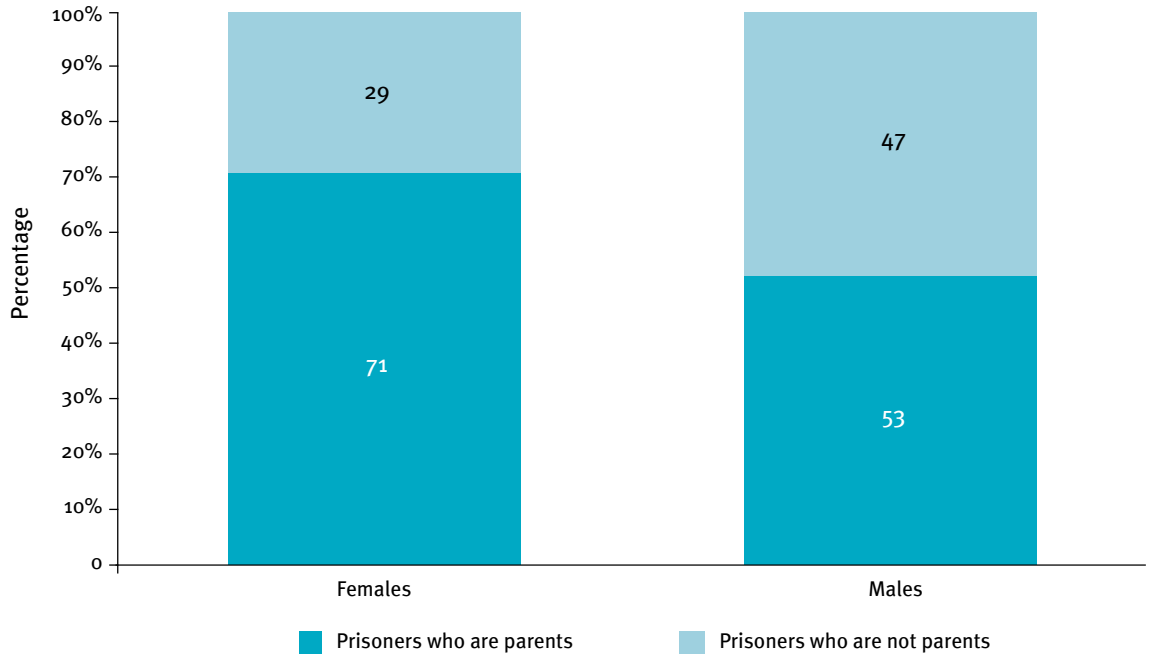
Specialist alcohol and drug treatment agencies offer a range of services to meet the needs of clients with alcohol or other drug problems. Services available to clients include individual, group and relationship counselling, family therapy, social skills training, psychotherapy, drink refusal skills, motivational interviewing, withdrawal services, therapeutic communities, pharmacotherapies, post-withdrawal rehabilitation and relapse prevention programs.

## Most Victorian prisoners are parents

Having a parent or family member who has a history of offending or incarceration is known to be a risk factor for a young person engaging in antisocial and criminal behaviour. Criminal offending can be transmitted generationally within families.[38] The number of criminal convictions of a parent has been positively linked to their children's rate of conviction. Children of parents who had been convicted between the child's seventh and thirteenth birthdays have more criminal behaviour in adolescence and adulthood than children whose parents were convicted in other periods.[39]

In 2013–14, 54.9 per cent of prisoners received into Victorian prisons reported that they had children. Of people in prison in July 2014, 303 females were parents (71 per cent) and 3,073 males were parents (53 per cent) (Figure 5.21).

Figure 5.21: Proportion of Victorian prisoners who are parents by gender, July 2014




Source: Department of Justice and Regulation, 2014

Corrections Victoria is responsible for the management and supervision of adult prisoners and offenders. It implements the judgments of the court and the orders of the Adult Parole Board. Its policies, programs and services ensure the safe and secure containment of prisoners, and seek to rehabilitate offenders by addressing the underlying causes offending behaviour.

The best interests of the child are paramount in assessing an offender's risk (both to the child and the community) and in determining the offender's access to correctional programs. Corrections Victoria delivers a range of programs and services that aim to reduce recidivism by maintaining family relationships and adopting law abiding lifestyles when prisoners are released. Prisoners are able to contact their family, and participate in parenting and self-development, employment and other programs. Intensive support is provided to prisoners to help them settle back into the community and the lives of their families.

# Family violence

## Some children are exposed to family violence

A safe and supportive family environment is a common protective factor for children, reducing the incidence of child abuse and neglect.

Family violence includes violence between people in a range of family and family-like relationships. As well as violence between current and separated intimate partners, abuse and violence also occurs amongst family members and those in family-like relationships. It can include violence by young people against their parents or other family members, abuse of elderly people by family members, abuse in same sex relationships and abuse of men. While anyone can be a victim or perpetrator of family violence, it is most likely to be committed by men against women.[40]

The *Family Violence Protection Act 2008*, describes family violence as:

(a) behaviour by a person towards a family member of that person if that behaviour—

(i) is physically or sexually abusive; or

(ii) is emotionally or psychologically abusive; or

(iii) is economically abusive; or

(iv) is threatening; or

(v) is coercive; or

(vi) in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person; or

(b) behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of, behaviour referred to above.

Children's exposure to family violence is a form of child abuse.[41] A key point in current literature relates to the use of the term 'witnessing' family violence as it 'fails to capture the extent to which children may become embroiled in the [family] violence.' Terms such as 'being exposed', 'living with' and 'being affected' are preferred.[42]

Exposure to family violence can involve a broad range of incidents, including the child:

- 'hearing the violence
- being used as a physical weapon
- being forced to watch or participate in assaults
- being forced to spy on a parent
- being informed that they are to blame for the violence because of their behaviour
- being used as a hostage
- defending a parent against the violence, and
- intervening to stop the violence'.[43]

Psychological and behavioural impacts of domestic violence include depression, antisocial behaviour, peer conflict and increased likelihood of substance abuse.[44] Eating disorders, leaving school early and suicide attempts have also been identified.[45]

Children and young people are often present when family violence occurs. Being exposed to family violence can have significant psychological, emotional and behavioural impacts and adverse developmental effects on children, comparable to direct experience of violence.[46]

## Links between family violence and child abuse

There are close links between family violence and child abuse, and they often coexist. Violence may be directed towards women and children. When a child is exposed to violence directed towards their mother or a sibling, even if the child is not a primary victim, it is a form of abuse.[47] Children who experience physical abuse are more likely to physically abuse their own children as adults.[48]

Around 3.3 per cent of children entering school in 2013 had witnessed violence and 3.2 per cent of their parents had witnessed violence (Figure 5.11, page 130).

## Family violence incidents

Children are frequently present at family violence incidents. In 2013–14, Victoria Police submitted reports for 65,393 family incidents, almost double the 2009–10 figure of 35,681 (Table 5.4). The proportion of these incidents where charges were laid has risen from 26.31 per cent in 2009–10 to 44.96 per cent in 2013–14.

The number of children present at family incidents has also risen between 2009-10 and 2013-14 from 12,690 to 22,445. This is around 35 per cent of incidents each year, although the figure dipped to a low of 31.1 per cent in 2012–13 before rising to 34.3 per cent in 2013–14.

Table 5.4: Victoria Police Family Incidents, 2009–10 to 2013–14

| Year | Family Incidents | Where charges laid | Percentage of charges laid for family incidents | Where children present | Percentage of children present at family incidents |
|---|---|---|---|---|---|
| 2009–10 | 35,681 | 9,387 | 26.31 | 12,690 | 35.6 |
| 2010–11 | 40,778 | 12,085 | 29.64 | 14,458 | 35.5 |
| 2011–12 | 49,945 | 18,007 | 36.05 | 18,128 | 36.3 |
| 2012–13 | 60,550 | 25,745 | 42.52 | 18,859 | 31.1 |
| 2013–14 | 65,393 | 29,403 | 44.96 | 22,445 | 34.3 |

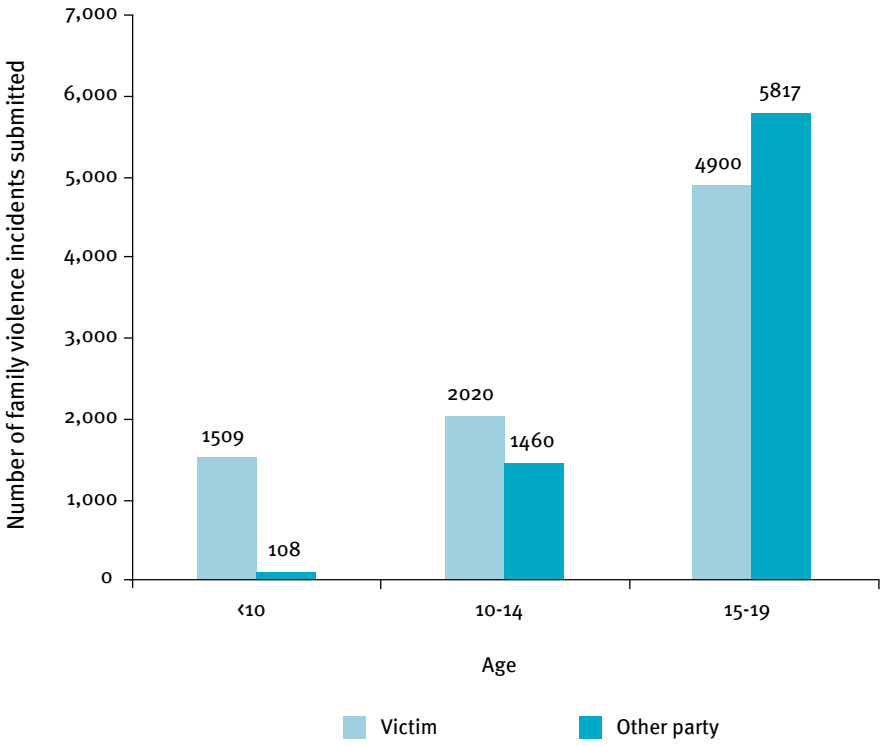
Source: Law Enforcement Assessment Program, Victoria Police, extracted on 18 July 2014 and subject to variation

The Victoria Police *Code of Practice for the Investigation of Family Violence* was introduced in 2004 as part of the Victorian Government's response to reduce family violence. The Code is designed to improve police response to family violence and to encourage community confidence to report these offences to police.

Recent reports indicate that 'family violence continues to plague Victoria, with crime statistics revealing the number of incidents has climbed to an average of more than 190 a day.' There have been large increases in incidents of stalking, harassment and threatening behaviour, and breach of order offences increased 48.1 per cent, which can all be linked to family violence offending. [49]

Figure 5.22 indicates that older children aged 15 to 19, were more likely to be the victim in a family violence incident than younger children in 2012–13 (4,900 over 15 years compared to 3,529 aged 14 and under).

Figure 5.22: Number of family incident reports submitted where a child or young person was the victim or other party by age group, 2012–13




Source: Victoria Police Crime Statistics, 2012–13

Females, children and young people were more likely to be the victim in a family violence incident than males: 5,775 victims aged 19 and under were female and 2,654 were male.

Conversely, males aged 15 to 19 were most likely to have been the other party or perpetrator in a family violence incident, equating to 11 per cent of all males who were the other party in a reported family violence incident.

The Victorian Government has commenced a Royal Commission into Family Violence which will include a full review of our legal system, our custodial system, the resources applied to Victoria Police, and the resources and supports provided to the sector that advocates for women and their children and protects them at their most vulnerable.

Specifically the terms of reference for the Royal Commission into Family Violence will report on how Victoria's response to family violence can be improved by providing practical recommendations to stop family violence. The Commission will:

1. examine and evaluate strategies, frameworks, policies, programs and services across government and local government, media, business and community organisations and establish best practice for:
    a. the prevention of family violence
    b. early intervention to identify and protect those at risk of family violence and prevent the escalation of violence
    c. support for victims of family violence and measures to address the impacts on victims, particularly on women and children and
    d. perpetrator accountability
2. investigate the means of having systemic responses to family violence, particularly in the legal system and by police, corrections, child protection, legal and family violence support services, including reducing re-offending and changing violent and controlling behaviours
3. investigate how government agencies and community organisations can better integrate and coordinate their efforts and
4. provide recommendations on how best to evaluate and measure the success of strategies, frameworks, policies, programs and services put in place to stop family violence.


Laurence, Year 1

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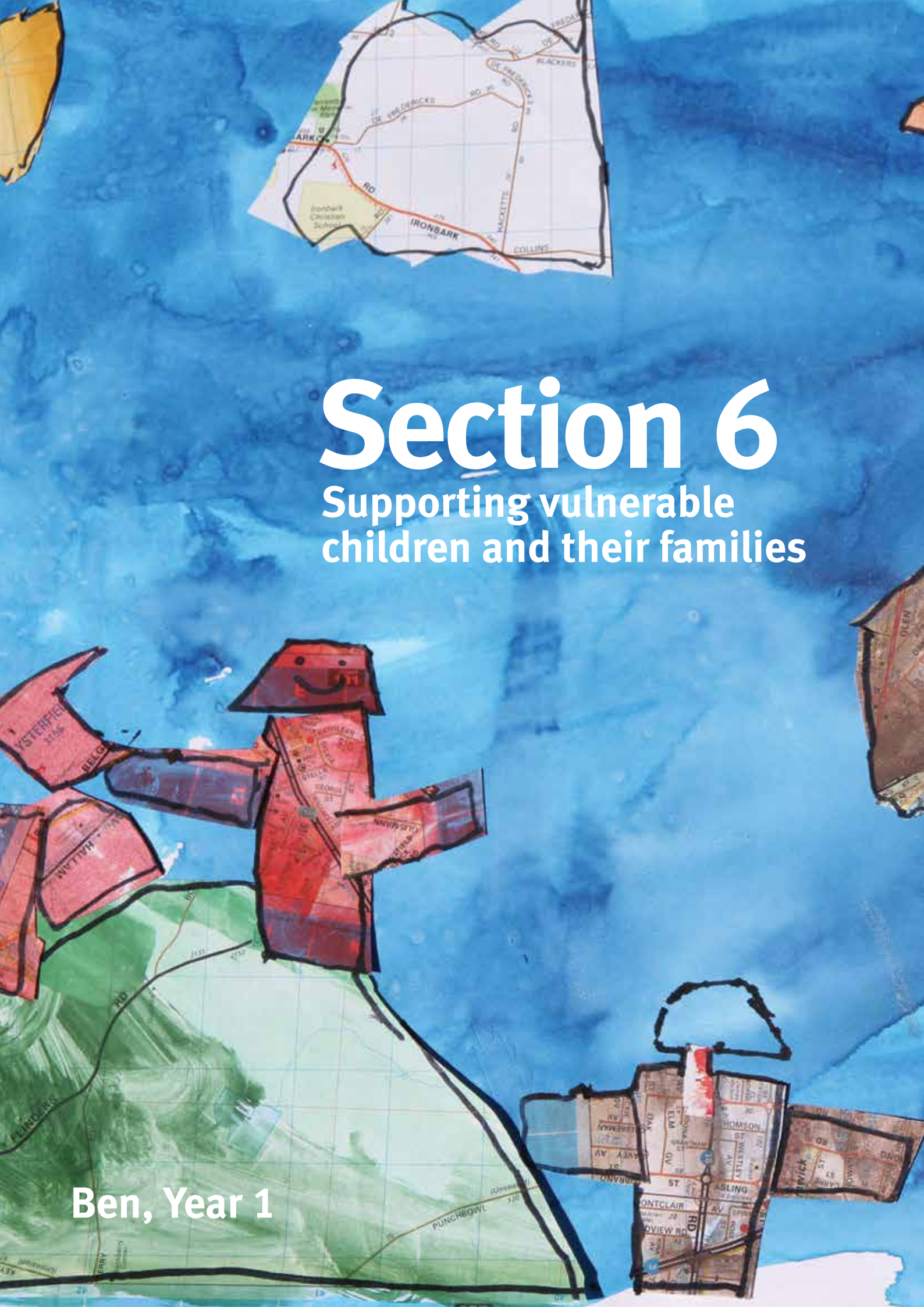



# Section 6

## Supporting vulnerable children and their families

Ben, Year 1


PDE
HWY
HAWTHORN
BRIGHTON
ROSEBERRY AV
BLANCHE
AGNEW ST
PRIMROSE CR
CUNTON ST
MARINE PDE
MELBOURNE
DORE
HWY
Cardinia
MELBOURNE
PRINCES
PAKENHAM
3810
BROADWAY
FAIRWAY CT
CANTY LA
DEER
ABRAHART
WTRS
ST

# Supporting vulnerable children and their families

Artwork by Jesse, Prep

Artwork by Brigitte, Year 3

While most of Victoria's children are doing well, some children are more vulnerable due to a combination of risk factors such as family financial stress, parental mental health issues, drug or alcohol abuse. These children may be at higher risk of abuse or neglect and require extra support to protect them. Meeting the needs of these children and making sure they are safe in a family environment is a shared responsibility between individuals, the family, the community and the government.

While the factors contributing to that vulnerability are not always evident there may be signs that a child is vulnerable. This can include risk factors reported throughout this report such as poor attendance at kindergarten or school, developmental delays in younger children, disengagement from school, hospital presentations for psychosocial and maltreatment issues and presence at family violence incidents. Where multiple risk factors are present, the chance a child is vulnerable increases.

Around eight per cent or 54,000 Victorian families with children have been estimated to be vulnerable. Of these, 10,000 families per year are investigated to assess if children are at risk of harm, and around 4,000 families per year are found to need child protection intervention. A further 20 to 30 per cent or 130,000 to 195,000 Victorian families with children might become vulnerable.[1]

The report of the Protecting Victoria's Vulnerable Children Inquiry articulates that the risk factors arising from parent, family and/or caregiver relationships include: [2]

- history of family violence
- alcohol and other substance misuse
- mental health issues
- intellectual disability
- parental history of abuse and neglect
- situational stress.

This chapter outlines the key service system responses that address the needs of vulnerable children, young people and families.

# Targeted services

Universal services play an important role in supporting vulnerable children and families. These include health services such as antenatal care, maternal and child health, and education services including early childhood development services, kindergarten, and primary and secondary school.[3]

Consistent with the concept of 'progressive universalism', many children whose vulnerability is identified by universal services will have their needs adequately met through focused support from practitioners working within those same services. But a smaller number of children will have significant or complex needs requiring a proportionally different response. Additionally, the needs of some children or young people are hidden by historical practices that limit enquiry or engagement to adult clients without acknowledging that they may also be parents. [4]

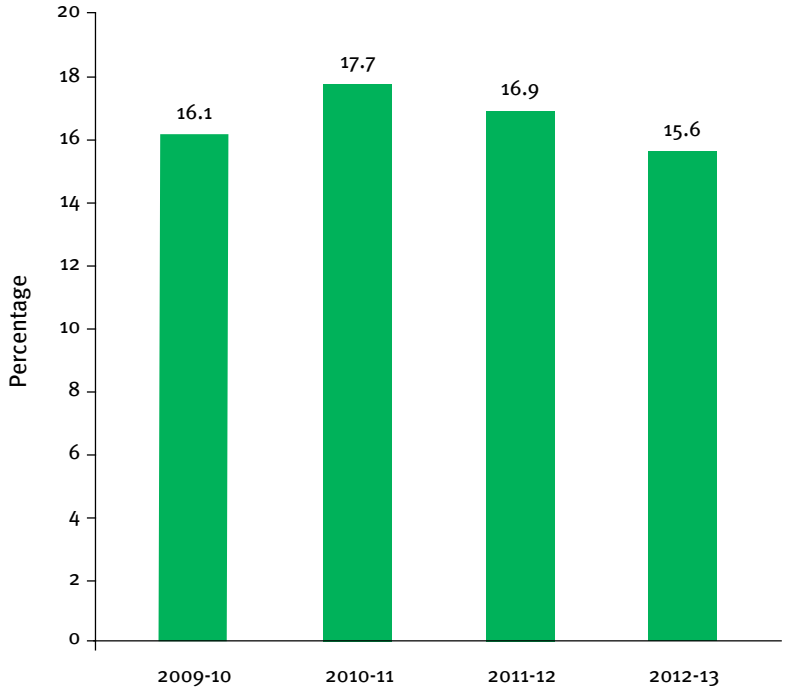
## Enhanced Maternal Child Health supports high-needs families

The Maternal Child Health Service (MCH) provides a key referral point to more specialised and targeted services, in particular to the Enhanced MCH Service, which provides more home visits to higher-need mothers during the first year of a child's life.

The Enhanced MCH Service actively responds to the needs of children and families at risk of poor outcomes, in particular where there are multiple risk factors. A particular focus for the Service is Aboriginal families who are not linked into, and/or require additional support to the universal MCH Service.

The percentage of MCH clients with children aged 0 to 1 year receiving Enhanced MCH Services has decreased slightly since 2009–10 (Figure 6.1).

Figure 6.1: Enhanced Maternal and Child Health participation, Victoria, 2009–10 to 2012–13




Source: Department of Education and Training data collected via the Department of Health and Human Services Integrated Reports & Information System, 2009–10 to 2012–13

## Early Start Kindergarten supports early learning and development for high-risk children

In addition to kindergarten in the year before school, the Early Start Kindergarten grant provides eligible three-year-old children with access to kindergarten for free. Eligible children include:

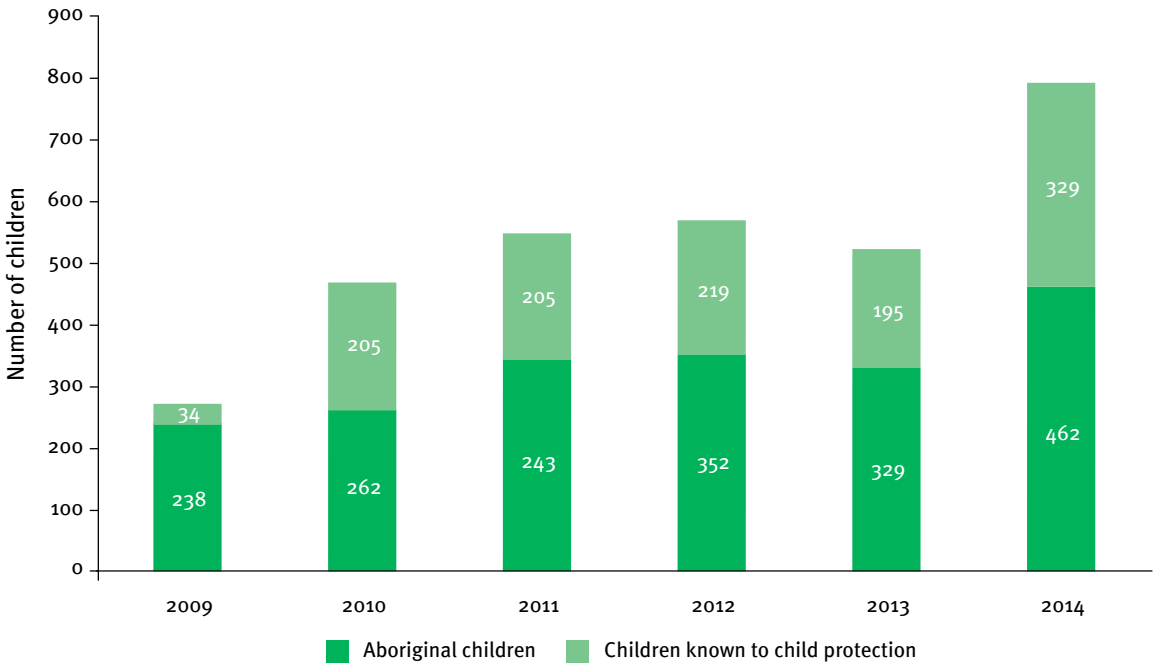
- children known to Child Protection including children referred from Child Protection to Child and Family Information, Referral and Support Teams (Child FIRST)
- Aboriginal children.

The overall number of children accessing Early Start has increased since 2009 with services being provided to a total of 791 children in 2014 (Figure 6.2). In 2014:

- 329 children known to Child Protection accessed Early Start - DET estimates that this represents only 19.5 per cent of the eligible population.
- 462 Aboriginal children accessed Early Start equating to approximately 37 per cent of eligible children.

Note: estimates for Aboriginal children for a single year of age are approximate only and subject to revision as better estimates become available.

### Figure 6.2: Number of children enrolled in Early Start Kindergarten, 2009 to 2014




Source: Department of Education and Training administrative data, 2009 to 2014

Throughout 2014 DET worked with DHHS and local government to raise awareness of the program and improve processes for identifying and linking eligible children with programs. This work has likely led to the increase in uptake between 2013 and 2014 and will continue. Despite the increased uptake in the past year, there is more to be done to capture all eligible children.

The Access to Early Learning initiative was introduced to improve access and engagement of vulnerable children and their families in early childhood education and care services. The initiative was informed by research into barriers that vulnerable families face in accessing early childhood, education and care services and the need to engage not only with children, but also to equip families with the skills and confidence to navigate the education and care system and support their child's lifelong learning.

Four sites were initially established to deliver Access to Early Learning programs, which include:

- Quality early childhood education and care services provided by degree-qualified educators, with a kindergarten program of 15 hours or more per week for each child.
- Professional and practice development to support staff to develop and refine the skills and competencies required to successfully engage vulnerable children and their families.
- Family support and in home learning support, linking the family to additional services and building the home learning environment, helping to sustain the participation and development of vulnerable children in education.

In 2014, Access to Early Learning was expanded to an additional three sites.

An evaluation found positive indications that the program is delivering outcomes for children as intended, including improved child development. It also found that it is supporting the emergence of multi-disciplinary approaches across the broader service sector and increasing the skill and capacity of educators to engage more effectively with vulnerable children and their families.

## Child FIRST assessments and interventions have risen

Early support for families where there are concerns about the wellbeing of children and young people is vital. Child FIRST (Child and Family Information, Referral and Support Teams) ensure that vulnerable children, young people and their families are linked effectively into the services they need to protect and promote their healthy development.

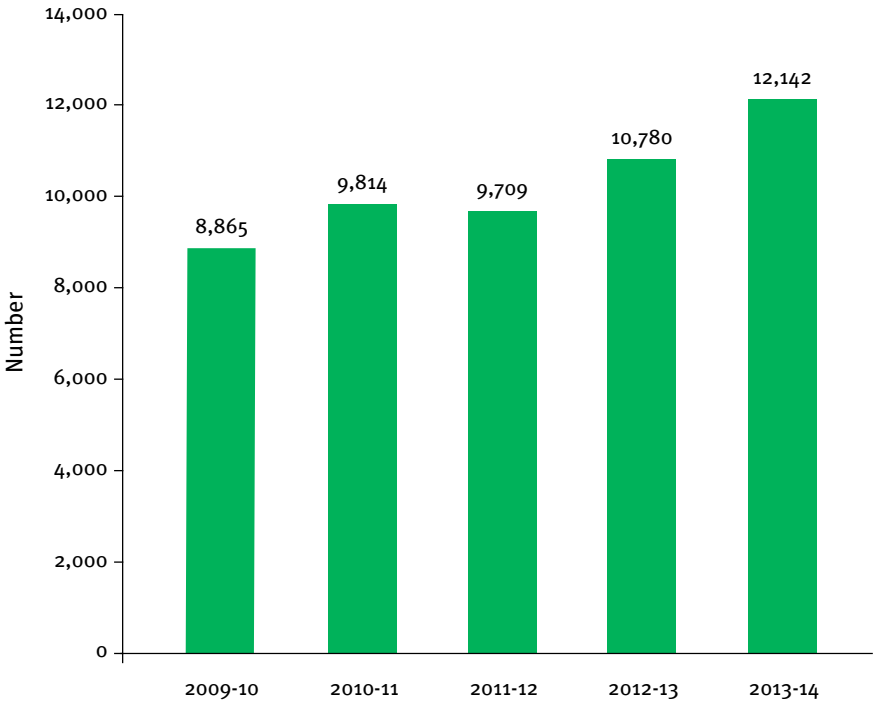
Child FIRST referrals are made where there are:

- significant parenting problems that may be affecting the child's development
- serious family conflict, including family breakdown
- families under pressure due to a family member's physical or mental illness, substance abuse, disability or bereavement
- young, isolated and/or unsupported families
- adverse impacts from significant disadvantage on a child's care or development.

Child FIRST agencies undertake an assessment of the needs and underlying risks for children, young people and their families to determine an appropriate service response and to determine if a child is in need of protection. Child FIRST makes referrals to other relevant agencies that assist children and families. They can also receive referrals from Child Protection or other agencies.

The number of Child FIRST assessments and interventions has progressively increased between 2009–10 and 2013–14 from 8,865 to 12,142, indicating that greater numbers of children and families have received assistance (Figure 6.3).

Figure 6.3: Number of Child FIRST assessments and interventions, 2009–10 to 2013–14




Source: Department of Health and Human Services, 2009–10 to 2013–14

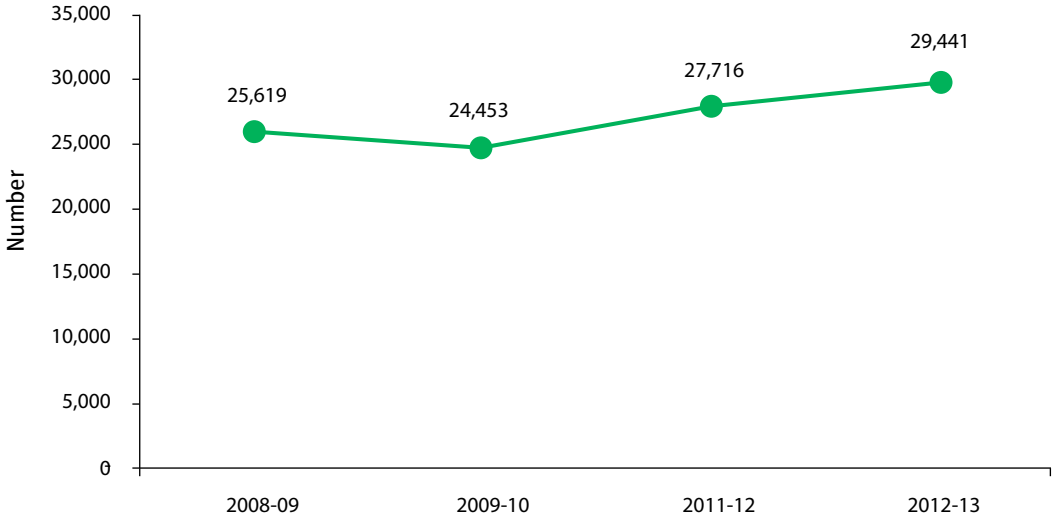
These changes may be influenced by available funding which can affect the capacity of the program to deliver services. The number of assessments and interventions provided is not necessarily an indication of the level of demand for the service as demand may outstrip the service's ability to provide an intervention.

## The number of families accessing family support services has increased

Where a Child FIRST assessment has been made, families may be referred to a range of Family Support Services that aim to promote safety, stability and development, and to build resilience.

The number of Victorian families accessing Family Support Services has increased since 2008–09 from 25, 619 to 29,441 in 2012–13 (Figure 6.4).

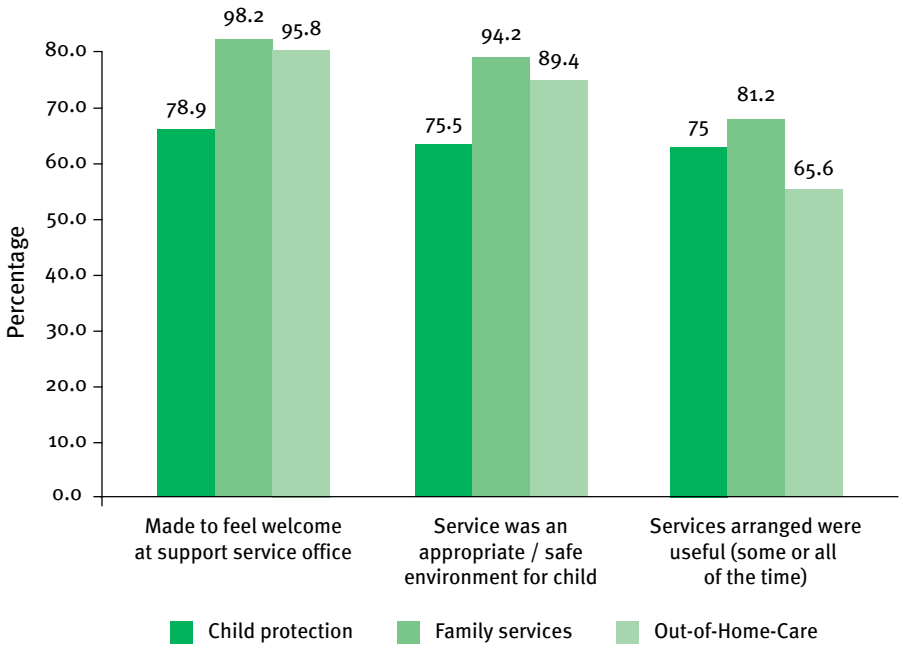
Figure 6.4: Number of families accessing Family Support Services




Source: Department of Health and Human Services (available on the VCAMS website)

The Child and Family Services Outcomes Survey (CAFSOS) indicates that most parents and carers were satisfied with the services provided by Family Services, Child Protection and Out-of-Home-Care (OOHC) (Figure 6.5). Parents and carers noted that these services made most parents and carers feel welcome (between 78.9 and 98.2 per cent), provided a safe environment for a child (75.5 to 94.2 per cent) and were useful (between 65.6 and 81.2 per cent). Satisfaction was highest for Family Services and lowest for Child Protection.

Figure 6.5: Proportion of respondents commenting on their service environment by service group, CAFSOS, 2012




Source: Child and Family Services Outcomes Survey, Department of Health and Human Services, 2012

Parents and carers using Family Services found the services useful and that workers were available when needed.[5] They felt that the worker had provided them with the information they required (84.9 per cent), that they were made aware of their right to access information (65.3 per cent) and that they were told about feedback and complaint processes (72.1 per cent).

Satisfaction with Child Protection and OOHC services was generally lower than for Family Services particularly in relation to the right to access information and feedback and complaint processes.[6]

# Child Protection

## Victorian Child Protection services aim to prevent and mitigate the harmful effects of child abuse and neglect

The Victorian Child Protection Service targets children and young people at risk of harm or where families are unable or unwilling to protect them. Child Protection provides child-centred, family-focused services to protect children and young people from significant harm resulting from abuse or neglect within the family. It also aims to make sure that children and young people receive services to deal with the impact of abuse and neglect on their wellbeing and development.[7]

The statutory Child Protection program within the DHHS receives and responds to reports from professionals and others in the community where they have significant concern for a child's wellbeing, including an unborn child, or where they believe a child is in need of protection.

## The number of children reported to Child Protection are increasing

The overall number of children reported to child protection in Victoria has increased substantially over the last five years from 37,761 in 2009–10 to 56,516 in 2013–14 (Table 6.1). This equates to an increased rate of 44.6 per 1,000 children and young people aged 0 to 17 (up from 31.2 per 1,000 in 2009–10).

The number of Aboriginal children reported has risen from 2,404 in 2009–10 to 3,856 in 2013–14. The rate per 1,000 Aboriginal children has also progressively increased since 2009–10, from 132.7 per 1,000 to 186.3 per 1,000 in 2013–14.

Table 6.1: Number and rates of children reported to child protection, children aged 0–17 years, Victoria, 2009–10 to 2013–14

| | 2009–10 | 2010–11 | 2011–12 | 2012–13 | 2013–14 |
|---|---|---|---|---|---|
| Number of all children | 37,761 | 41,459 | 47,612 | 52,111 | 56,516 |
| Number of Aboriginal children | 2,404 | 2,716 | 3,294 | 3,561 | 3,856 |
| Rate per 1,000 for all children | 31.2 | 34 | 38 | 41.8 | 44.6 |
| Rate per 1,000 for Aboriginal children | 132.7 | 136.5 | 163.2 | 174.2 | 186.3 |

Source: Report on Government Services 2015, Table 15A.8

Note: Due to revised population estimates, particularly for Aboriginal children, the rate per 1,000 is different from that published in previous years.

A number of factors may be influencing the increase in Child Protection reports. These include:

- Changes to police reporting practices. Children are listed as affected family members rather than observers in family violence incidents.
- Greater awareness of abuse and willingness to report rather than an increase in abuse itself. This is likely influenced by greater publicity relating to child abuse.
- Changes to legislation and reporting practices. There may be an increase in reports from professional groups mandated to report physical and sexual abuse such as teachers, doctors, nurses and police.
- A change in the definition of abuse and family violence within the Family Law Legislation Amendment (Family Violence and Other Measures) Act. The definition has been broadened so that the scope of harm to a child now includes harm caused by a child being subjected to, or exposed to, family violence.
- An increasing number of Child Protection re-reports. These are counted in the number of overall reports.

## Family structure and child maltreatment

While it may appear there is strong evidence that certain family structures place children at a much higher risk of maltreatment, the Australian Institute of Family Studies report on family structure and maltreatment raises a number of key issues:

- 'While most of the available research suggests that children in sole-mother families and step families tend to be at higher risk of maltreatment than those in married families, not all findings are consistent
- Generally, much of the perceived relationship between family structure and child maltreatment can be explained by factors such as poverty, substance misuse and domestic violence.
- There is no single cause of child maltreatment. Rather, maltreatment reflects the effects of multiple, dynamic, interrelated and, often, cumulative risk factors.
- Sole-mother families, sole-father families, and step or blended families are overrepresented in Australia's child protection systems. However, there are a number of limitations to the Australian child protection data, which must be noted when interpreting this finding.
- Although family structure is an easily identifiable risk factor for child maltreatment, its influence can easily be — and is often — exaggerated. It is important that practitioners and policy-makers look further and identify other risk factors that may be more conducive to intervention'.[8]

## Investigations resulting from reports

Where it is assessed that a reported child may be in need of protection, Child Protection practitioners will investigate the matter. As part of the investigation, more detailed information is sought from professionals who may hold relevant information.

Based on this assessment the reporter may be provided with advice, or the child and family may be offered assistance and support by community-based services, for example family support, or mental health, or drug and alcohol services. However if Child Protection determines that the reported concerns indicate the child is at risk of significant harm and that a parent has not been able to protect the child from that harm, they will accept the report as one which requires a direct investigation of the concerns.

An investigation is concluded when Child Protection makes a decision regarding whether or not the report has been substantiated and the level of current and future risk to the child.

Of the 82,056 Victorian reports dealt with in 2013–14, 21,243 were formally investigated and 60,813 were dealt with by other means such as referral to Child FIRST, a determination that no action was required or some other form of non-statutory intervention (Table 6.2).

### Table 6.2: Number of reports by investigation status and Aboriginal status, 2013–14

| | Aboriginal | Non-Aboriginal | Unknown Aboriginal status | TOTAL |
|---|---|---|---|---|
| Total investigations | 2178 | 19012 | 53 | 21,243 |
| Dealt with by other means | 4100 | 53729 | 2984 | 60,813 |
| Total reports | 6278 | 72741 | 3037 | 82,056 |

Source: Report on Government Services 2015, Table 15A.5

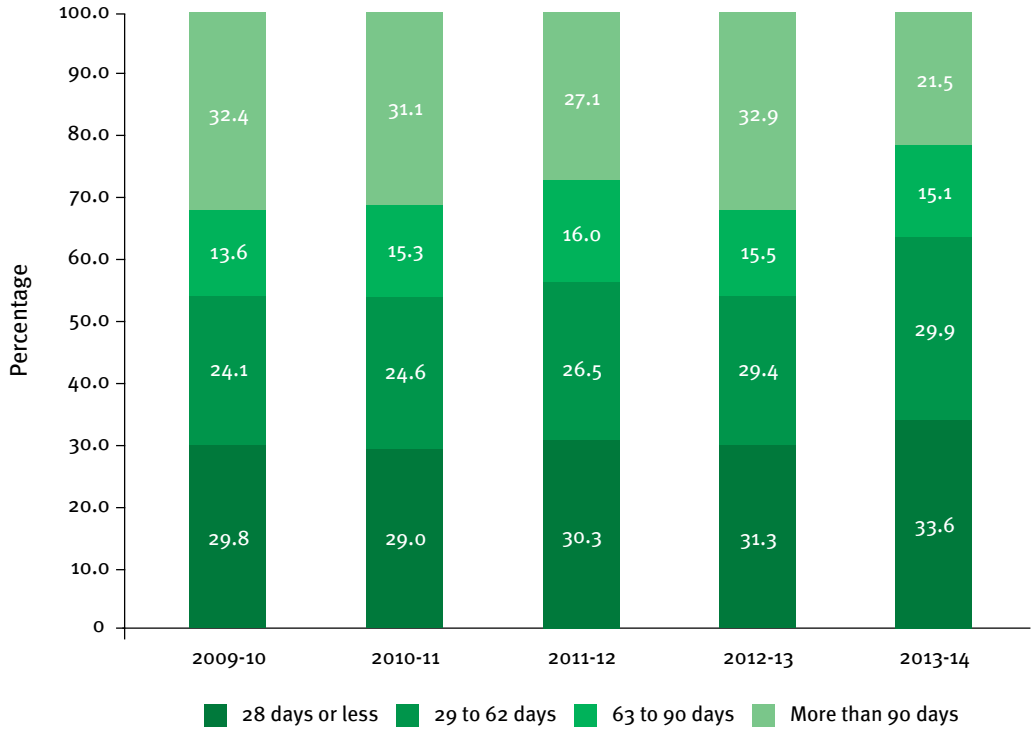
Recent reports cite 'a 92 per cent increase in children referred to Victoria's child protection services since 2008 has placed great strain on support agencies.' Early intervention is the key priority for the Victorian Government, with $48.1 million allocated in the recent 2015-16 Budget to these services for vulnerable children and families, a 13 per cent funding increase on last year. [9]

## Response times to complete an investigation are improving

Completing investigations in a timely manner is important, particularly for those children at greatest risk. Early and effective responses provide families with the support they need.

The proportion of investigations completed in 28 days or less has gradually increased since 2009–10 from 29.8 per cent of cases to 33.6 per cent of cases in 2013–14 (Figure 6.6). There has also been a decrease in the proportion of cases completed in more than 90 days (from 32.4 per cent in 2009–10 to 21.5 per cent in 2013–14).

Figure 6.6: Proportion of investigation of reports of abuse or neglect completed, by time frame, Victoria, 2009–10 to 2013–14




Source: Report on Government Services 2015, Table 15.A16

A new operating model for Child Protection practitioners was introduced in November 2012. Experienced Child Protection practitioners spend more time working with vulnerable children and supervising new practitioners. This operating model has resulted in increased numbers of staff, staff with higher levels of expertise and greater levels of staff retention. This promotes a more skilled Child Protection workforce and may have contributed to an improved response time.

## Child protection substantiation rates are rising, and are much higher for Aboriginal children

Substantiation decisions focus on whether a child has experienced significant harm to their safety, stability and/or development. Abuse is substantiated if there is reasonable cause to deem that a child has been, is being or is likely to be abused, neglected or otherwise harmed.

While there is no reliable measure on the overall prevalence of child abuse, around one per cent of children have a history of abuse at school entry. This is higher for Aboriginal children (4.7 per cent) and slightly higher for those from the most disadvantaged areas (1.6 per cent compared to those from the least disadvantaged areas, 0.9 per cent) (See Figure 5.12, page 131 for further detail).

Child protection substantiation rates continue to increase for all children, with rates rising from 5.3 per 1,000 children in 2009–10 to 9 per 1,000 in 2013–14 (Table 6.3). Rates of substantiation are higher for Aboriginal children, and have also increased (from 36.2 per 1,000 Aboriginal children in 2009–10 to 60.3 in 2013–14).

Table 6.3: Child protection substantiation rates, children aged 0–17 years, Victoria, 2009–10 to 2013–14

| | 2009–10 | 2010–11 | 2011–12 | 2012–13 | 2013–14 |
|---|---|---|---|---|---|
| All children per 1,000 | 5.3 | 6.0 | 7.1 | 8.0 | 9.0 |
| Aboriginal children per 1,000 | 36.2 | 38.6 | 47.7 | 51.3 | 60.3 |

Source: Report on Government Services 2015, Table 15A.8

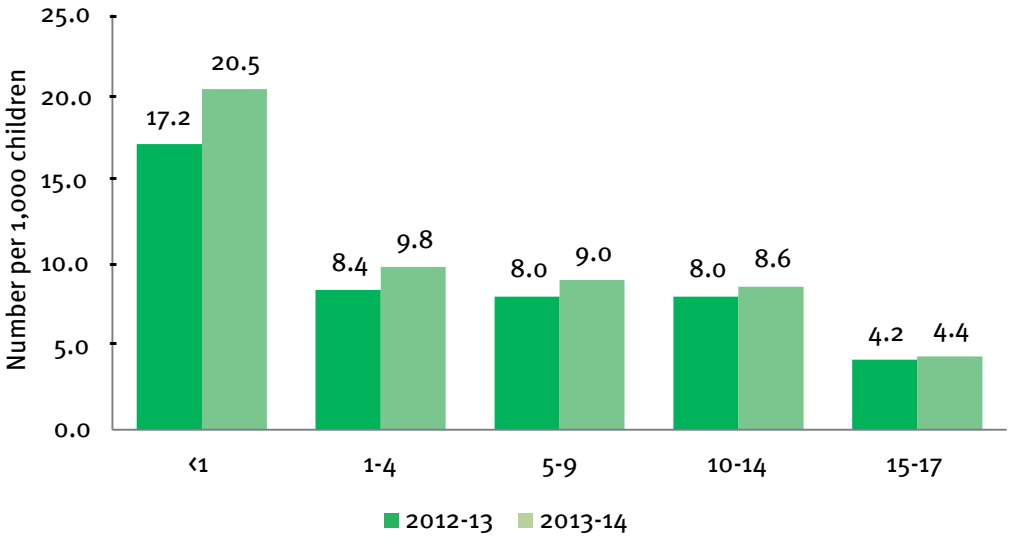
Note: Due to revised population estimates, particularly for Aboriginal children, the rate per 1,000 is different from that published in previous years.

Factors that may be influencing the increase in substantiations include:

- the increase in the number of reports and investigations undertaken
- the increased capacity of Child Protection to undertake investigations due to the implementation of the new operation model for child protection practitioners (see above)
- the increased retention of child protection workers which may have led to improved professional understanding of child abuse substantiations
- public awareness of child abuse - the public threshold for what is regarded as child abuse is believed to have lowered in recent years
- a broadened definition of abuse to include emotional harm and neglect.

Child protection substantiation rates are highest for children under one year. Rates decrease with children's age (Figure 6.7). The rate of substantiations for children under one increased from 17.2 per 1,000 in 2012–13 to 20.5 per 1,000 in 2013–14. This is an increase of 19 per cent.

Figure 6.7: Child protection substantiation rates per 1,000, by age, Victoria 2012–13 to 2013–14




Source: Child Protection Australia 2013–14, AIHW, Table 3.4

The most common reasons for substantiated abuse in 2013–14 were emotional abuse (56.6 per cent) and physical abuse (25.7 per cent) (Table 6.4). Girls were slightly more likely to be victims of sexual abuse than boys (14.0 per cent compared to 11.3 per cent). Five per cent of substantiated cases were due to neglect.

Table 6.4: Proportion of children whose report of abuse was substantiated by type of abuse or neglect, Victoria 2013–14

| | Boys | Girls | All |
|---|---|---|---|
| Physical | 26.9 | 24.4 | 25.7 |
| Sexual | 11.3 | 14.0 | 12.7 |
| Emotional | 56.3 | 57 | 56.6 |
| Neglect | 5.5 | 4.5 | 5.0 |

Source: Child Protection Australia 2013–14, AIHW, Table A7

Recent reports show that domestic violence is increasing in Victoria, with an 8.9 per cent increase in sexual offences being attributed to the Royal Commission into Institutional Child Sexual Abuse. [10]

Child abuse and neglect in Aboriginal families is caused by many factors. Generally, the Aboriginal perspective emphasises the impact of community and social causes. [11]

A number of prominent Aboriginal spokespersons believe that present dysfunctional behaviour in some Aboriginal communities, including the abuse and neglect of children, is grounded in unresolved grief associated with multiple layers of trauma that has spanned many generations.' [12]

Aboriginal children in Victoria's child protection system are: [13]

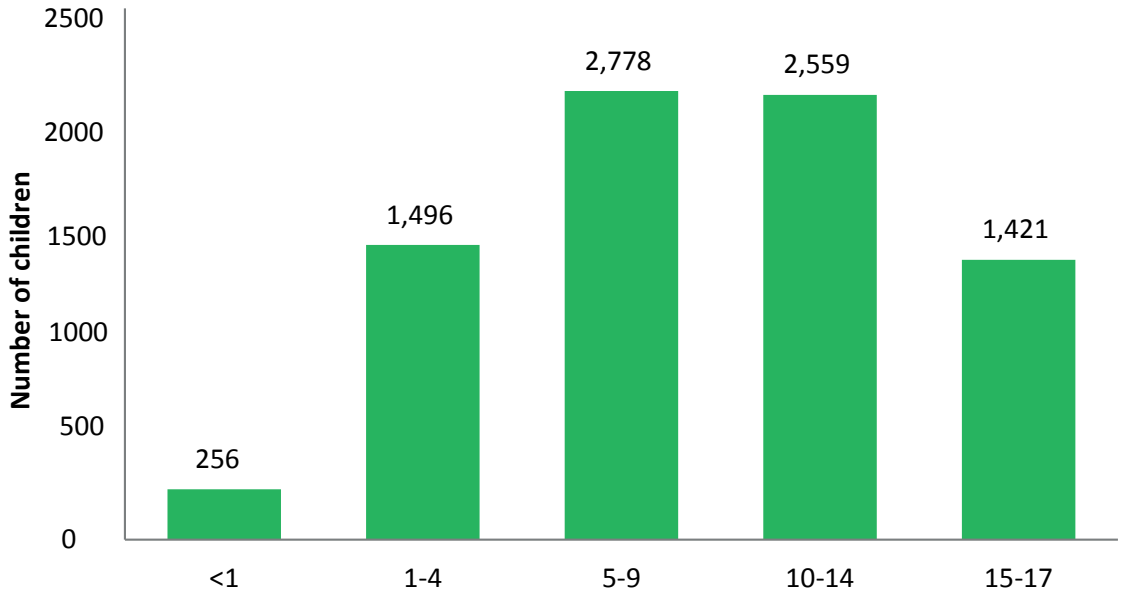
- 10 times more likely to have a child protection concern substantiated
- 15 times more likely to be placed on a protection order and
- 16 times more likely to be in OOHC than non-Aboriginal children.

## Rates of children in OOHC have increased in recent years

Victoria's OOHC system provides kinship care, foster care and residential care for children and young people who are unable to live at home due to the lack of a safe, stable and nurturing home environment. Some children and young people may live in an OOHC placement for only a few days or weeks, while others may be in care for many years.

In Victoria, 7,710 children and young people aged 0 to 17 were in OOHC at 30 June 2014 (Figure 6.8). Around 23 per cent of these children were aged under five. They had been subject to protective intervention by Child Protection and a range of Children's Court orders.

Figure 6.8: Number of children in OOHC aged 0 to 17, Victoria, as at 30 June 2014




Source: Child Protection Australia 2013–14, AIHW, Table A29

The rate of children in OOHC has risen from 4.5 per 1,000 in 2009–10 to 6.1 per 1,000 in 2013–14 (Table 6.5). The rate of Aboriginal children in OOHC remains high compared to other children, increasing from 41.3 per 1,000 in 2009–10 to 62.7 per 1,000 in 2013–14. Over the five year period from 2009–10 to 2013–14, this equates to an increase of 41 per cent for all children and 60.3 per cent for Aboriginal children. This increase is linked to the increase in child protection reports and substantiations.

Table 6.5: Number and rate of children aged 0–17 years in OOHC, Victoria, as at 30 June each year, 2009–10 to 2013–14

| | 2009–10 | 2010–11 | 2011–12 | 2012–13 | 2013–14 |
|---|---|---|---|---|---|
| Number of children | 5,469 | 5,678 | 6,207 | 6,399 | 7,710 |
| Number of Aboriginal children | 816 | 877 | 1,028 | 922 | 1,308 |
| Rate per 1,000 for all children | 4.5 | 4.6 | 5.0 | 5.1 | 6.1 |
| Rate per 1,000 for Aboriginal children | 41.3 | 43.8 | 50.5 | 44.9 | 62.7 |

Source: Report on Government Services 2015, Table 15A.18

Note: Due to revised population estimates, particularly for Aboriginal children, the rate per 1,000 is different from that published in previous years.

A key contributor to the growth in the number of children and young people in OOHC in Victoria has been the increasing length of care placements, with the proportion of children and young people staying in (non-permanent) care for five years or more having almost doubled over the last decade.[14]

The *Protecting Victoria's Vulnerable Children Inquiry* highlighted that the average time of just over five years taken between a child's first report and their ultimate permanent care order was too long, and that during this time, many children are subject to multiple placements, compounding the psychological harm they experience.[15] Further steps are required to ensure more timely decisions about the long-term care of children and young people are made.

The Victorian Parliament passed the *Children, Youth and Families Amendment (Permanent Care and other Matters) Act* 2014 in September 2014 which will directly address this issue. The main provisions of this Act will come into effect and be incorporated into the main *Children, Youth and Families Act* on 1 March 2016. The relevant amendments will align case planning processes and decisions with a new range of protection orders.

The Children's Court will be restricted in the types of order that can be made when a child has been in OOHC for one year or, if parents have made progress in addressing protection issues in that year, for a total of two years. The effect will be to drive a final decision about permanency (ie. either permanent alternative care or permanent reunification) when a child has been in OOHC for either one year (where no progress has been made) or after a second year (if reunification had been assessed as achievable at the end of the first year).

Significant work in relation to improving the OOHC system, with a specific focus on Aboriginal over-representation is underway. This includes

- establishment of a Ministerial Advisory Committee for children in OOHC
- the ongoing development of a foster care recruitment and retention strategy
- development, in collaboration with Aboriginal communities, of placement prevention strategies for Aboriginal children
- progressing a new approach to therapeutic residential care.

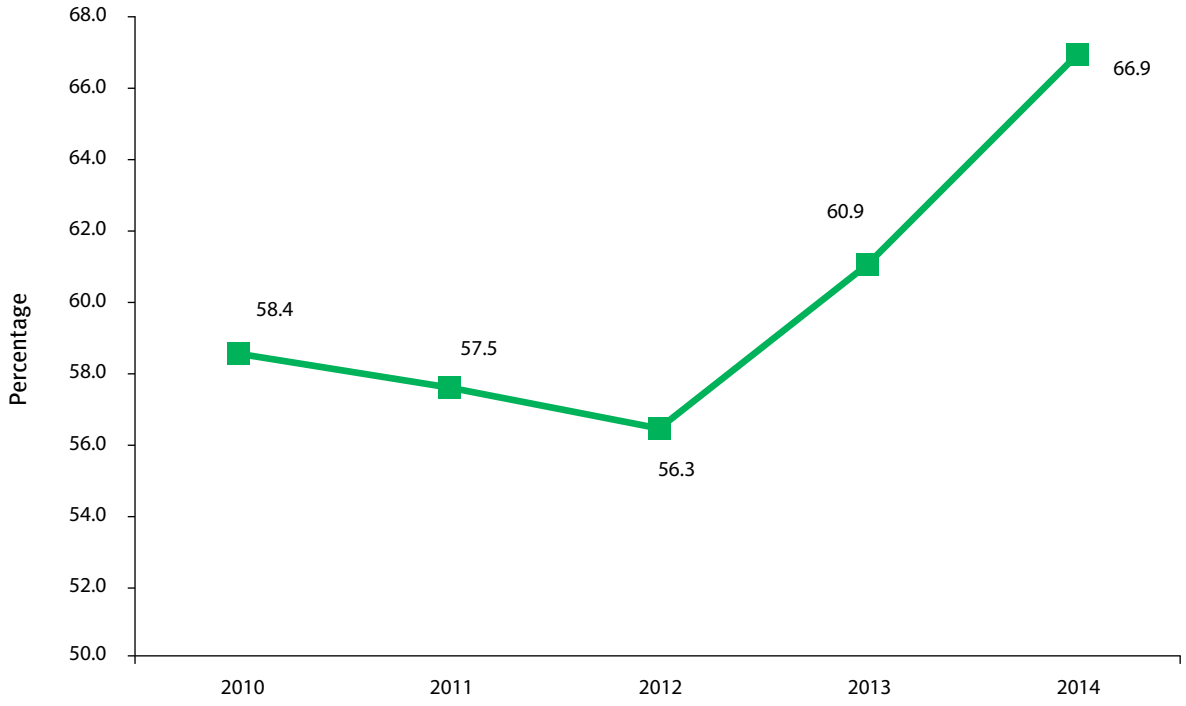
## Placement for Aboriginal Children

The Aboriginal Child Placement Principle governs the practice of Child Protection when placing Aboriginal children and young people in OOHC. The principle aims to ensure that Aboriginal children and young people remain connected to their families, communities and culture. In Victoria, where a child is to be removed from their family, the following criteria provide a guide that they be placed with:

1. the child's or young person's extended family or relatives (with kin)
2. an Aboriginal family from the local community
3. a non-Aboriginal family living in close proximity to the child's natural family, as a last resort ensuring the maintenance of the child's culture and identity through contact with the child's community.[16]

The proportion of Aboriginal children placed in accordance with the Aboriginal Child Placement Principle has increased between 2010 and 2014 from 58.4 per cent to 66.9 per cent (Figure 6.9).

Figure 6.9: Proportion of Aboriginal Children placed in accordance with the Aboriginal Child Placement Principle, Victoria, 2010 to 2014




Source: Report on Government Services, 2015, Table 15A.24

Note: this data relates to Aboriginal children who have been placed with relatives/kin, other Aboriginal carers, in Aboriginal residential care or with non-Aboriginal relatives/kin. It does not include placement with non-Aboriginal carers or placement in non-Aboriginal residential care.

*Taskforce 1000* aims to improve outcomes for the approximately 1,000 Aboriginal children in OOHC by:

- Improving the stability, life outcomes and cultural connections of Aboriginal children and young people in care.
- Reducing rates of entry to care for Aboriginal children and young people.
- Improving opportunities to reunite Aboriginal children and young people with their parents where it is in their best interests to do so.

Area Panels, co-chaired by the Commissioner for Aboriginal Children and Young People and Area Directors from DHHS, will review each Aboriginal child and young person currently in OOHC. Individual circumstances of will be discussed and considered by the Area Panels, who will identify any issues and initiate actions to immediately improve the wellbeing of Aboriginal children and young people in care from within existing resources.

Reviews by Area Panels in the pilot areas of Inner Gippsland, Southern Melbourne, Western Melbourne and the Mallee have been finalised.

DHHS is currently working with the Commission for Children and Young People to commence implementation of Taskforce 1000 in five additional areas: North Eastern Melbourne, Metropolitan Eastern Melbourne, Central Highlands, Barwon and Outer Gippsland. It is anticipated that Taskforce 1000 will be completed by December 2015.

The Taskforce 1000 Steering Committee (Steering Committee) is co-chaired by the Secretary of DHHS and the Commissioner for Aboriginal Children and Young People. It is comprised of 23 members, including Aboriginal and mainstream community service organisations, senior executives from the Departments of Health and Human Services, Justice and Regulation, Education and Training and representatives from the Centre for Excellence for Child and Family Welfare and the Commission for Children and Young People.

The Steering Committee will inform future responses and research, facilitate progress towards the *National Standards for Out-of-Home Care,* as well as provide advice to Area Partnerships on improving outcomes for Aboriginal children and young people.

## The proportion of Aboriginal children with Cultural Support Plans is gradually increasing

The *Children, Youth and Families Act* (s176.1) requires a Cultural Support Plan to be developed for Aboriginal children in OOHC who are subject to a Guardianship to Secretary or Long-term Guardianship to Secretary order. Cultural Support Plans are intended to support Aboriginal children who are placed in OOHC to remain connected to their families, communities and culture. It recognises that Aboriginal children and young people need to be connected to the Aboriginal community that they belong to, as each community is different.[17]

The Commission for Children and Young People stated in their Annual Report for 2013–14, that as at June 2013, less than 10 per cent of Aboriginal children who were required under legislation to have Cultural Support Plans had a finalised plan.

The Department of Health and Human Services collects information on the proportion of children in OOHC on Guardianship or long term Guardianship orders who have draft (partially completed) or finalised Cultural Support Plans. This measure was introduced as part of monthly performance monitoring from April 2014 (Table 6.6).

Table 6.6: Proportion of Aboriginal children on Guardianship or long term Guardianship orders who have a draft (partially completed) or finalised Cultural Support Plans

| | April 2014 | May 2014 | June 2014 | July 2014 | August 2014 |
|---|---|---|---|---|---|
| State Total | 47.9 | 47.1 | 50.9 | 54.6 | 55.0 |

Source: Client Relation Information System via extracts, Department of Health and Humans Services, 2014

In many cases, Child Protection practitioners commence work on Cultural Support Plans for Aboriginal children on content that is standard information that is collected about all children in OOHC (for example, a family tree and history). It has been reported, however, that some practitioners feel that they may lack the skills and knowledge to complete parts of the Cultural Support Plan specific to Aboriginal children without input from Aboriginal organisations.

Funding has been provided for Aboriginal family-led decision making convenors to undertake work on Cultural Support Plans. The Aboriginal family-led decision making process involves locating the child's kin and community and involving them in the development of a plan for the child's future care arrangements and maintenance of family and cultural connections. Much of the information gathered as part of this process is also required for a Cultural Support Plan however information gathered may not be clearly documented.

It is important that a greater proportion of Cultural Support Plans are completed. The absence of a Plan places Aboriginal children at risk of losing connection with their kin, their land, and their cultural identity.

There is scope to improve processes so that all Aboriginal children placed in OOHC have a plan to meet their cultural needs.

## Placement stability for children in OOHC has declined

Placement stability is important for children's positive development and wellbeing. It has been associated with positive outcomes in the transition to adulthood for young people leaving care. [18] For children in care, stable and nurturing carers can bolster their resilience and address the negative effects of earlier instability.[19]

OOHC placements vary from overnight to several years, depending on the individual circumstances of the child or young person. Stability of placement is an important indicator of service quality for children and young people in OOHC, particularly for those who require long-term placements.

Stability of placement is defined as the proportion of children and young people who had one or two placements during a period of continuous OOHC. A low number of placements (one or two) per period of care is desirable, but must be balanced against other placement quality indicators, such as placements in compliance with the Aboriginal Child Placement Principle, local placements and placements with siblings.

The percentage of children who left care in under 12 months with stable care (only one or two placements) has increased from 78.1 per cent in 2009–10 to 78.8 per cent in 2013–14, down from a peak of 88.4 per cent in 2011–12.

For children who left care after 12 months or more, the percentage with stable care decreased from 54.6 per cent in 2012-13 to 48.4 per cent in 2013–14 (Table 6.7). Older children are more likely to have spent more time in their current placement.[20]

Table 6.7: Children on a care or protection order with 1 or 2 placements, Victoria, 2009–10 to 2013–14

| | 2009–10 | 2010–11 | 2011–12 | 2012–13 | 2013–14 |
|---|---|---|---|---|---|
| Exiting care after less than 12 months | 78.1 | 75.6 | 88.4 | 85.4 | 78.8 |
| Exiting care after 12 months or more | 49.4 | 47.8 | 53.9 | 54.6 | 48.4 |

Source: Report on Government Services 2015, Table 15A.26

## Re-substantiation rates within 3 and 12 months have increased

Re-substantiation rates are an indicator of service outcomes and measure the extent to which Child Protection intervention has been effective in keeping those children, who have been assessed to be at risk, safe from further harm in the short-term and longer term.

If a Child Protection service has substantiated that a child has been harmed or is at risk, it is expected to intervene to ensure that the child is not harmed again. Child protection substantiation rates for re-substantiations within three months have increased between 2009–10 and 2012–13 from 0.7 per cent to 2.6 per cent. For re-substantiations within 12 months, the proportion re-substantiated has almost doubled from 7.4 per cent to 13.2 per cent (Table 6.8).

Table 6.8: Proportion of re-substantiations within 3 or 12 months of a previous substantiation Victoria, 2009–10 to 2012–13

| | 2009–10 | 2010–11 | 2011–12 | 2012–13 |
|---|---|---|---|---|
| Within 3 months | 0.7 | 1.2 | 1.2 | 2.6 |
| Within 12 months | 7.4 | 10.1 | 10.6 | 13.2 |

Source: Report on Government Services 2013, Productivity Commission, Table15A.11.

The CAFSOS indicates that 42.6 per cent of children surveyed who were in Child Protection had been the subject of a previous substantiation.[21] Many children in OOHC had also been the subject of a previous substantiation (42.7per cent). The most common type of harm experienced by these children and young people was emotional and psychological harm (321 out of 610 children). Only a small number of children were at risk from parental failure to protect them from sexual abuse (18 out of 610 children).

Section 06

# The Children's Court of Victoria

## Clearance rates in the Family Division of the Children's Court of Victoria have increased

The Children's Court of Victoria is a specialist court with two divisions dealing with cases involving children and young people (the Family Division and the Criminal Division). The Family Division hears:

- applications relating to the protection and care of children and young people at risk
- applications for intervention orders.

When children and families need to go to court, it is important that cases are finalised as soon as possible. Delays are not in the best interests of children as they can mean shorter-term orders, and more court hearings, and more disruption for children and their families.

The clearance rate is the number of matters initiated in a year compared with the number of matters finalised in the same period. Clearance rates in the Family Division of the Children's Court have fluctuated since 2009–10, increasing from 82.5 per cent in 2011–12 to 96.4 per cent in 2012–13 (Table 6.9). The most common outcomes for finalised primary applications were supervision orders (1,550 of 3,667), custody to Secretary Orders (681 of 3,667), or being struck out (534 of 3,667).

Table 6.9: Timeliness indicators for primary applications in the Family Division of the Victorian Children's Court, 2009–10 to 2012–13

| | 2009–10 | 2010–11 | 2011–12 | 2012–13 |
|---|---|---|---|---|
| Clearance rate (%) | 86.6 | 83.8 | 82.5 | 96.4 |
| Matters pending 9<12 months (%) | 7.2 | 5.2 | 6.8 | 6.9 |

Source: Children's Court of Victoria data, 2009–10 to 2012–13

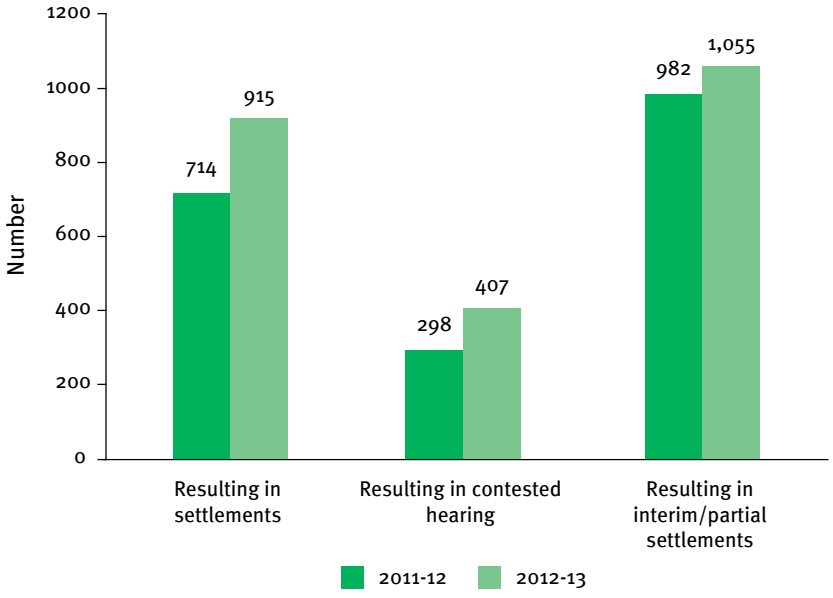
Cases that have not been finalised by the end of the financial year are classified as pending. An increase in cases pending may reflect a reduction in timeliness and is generally associated with increased delay. However, pending rates taken in isolation do not account for the greater time required for processes such as conciliation conferences, which may result in more beneficial outcomes for children and their families. At 30 June 2013, 6.9 per cent of matters were pending 9 to 12 months after initiation (Table 6.9). This figure is marginally higher than for 2011–12 (6.8 per cent).

In 2010, a new model of dispute resolution was introduced into the Family Division of the Children's Court. This model aims to promote improved outcomes for children and families and reduce the length of the court process. Other objectives include reducing the adversarial nature of the court system and the time people spend in court, and providing better support and preparation for child protection practitioners. Conciliation Conferences were implemented statewide from January 2013, with roll-out completed in 2014.

The Conciliation Conference model revolves around an eight-step formal mediation process. It involves greater preparation by all parties including the exchange of relevant information to enable all participants to be clear on the issues. Where possible, conferences take place outside of the court, with a court-employed convenor guiding the discussions. There is clear focus on enhancing family engagement, highlighting their strengths and looking to build upon them in the best interests of the child or children. Issues and concerns are raised and discussed in the conference and options for settlement or agreements are negotiated.

The total number of dispute resolution conferences held in the Children's Court increased from 1,994 in 2011–12 to 2,377 in 2012–13 (Figure 6.10). [22] These most commonly resulted in settlements (915 in 2012–13) or interim/partial settlements (1,055 in 2012–13).

Figure 6.10: Number of Dispute Resolution Conferences by outcome, 2011–12 to 2012–13




Source: Children's Court Annual Report, 2012–13

# Endnotes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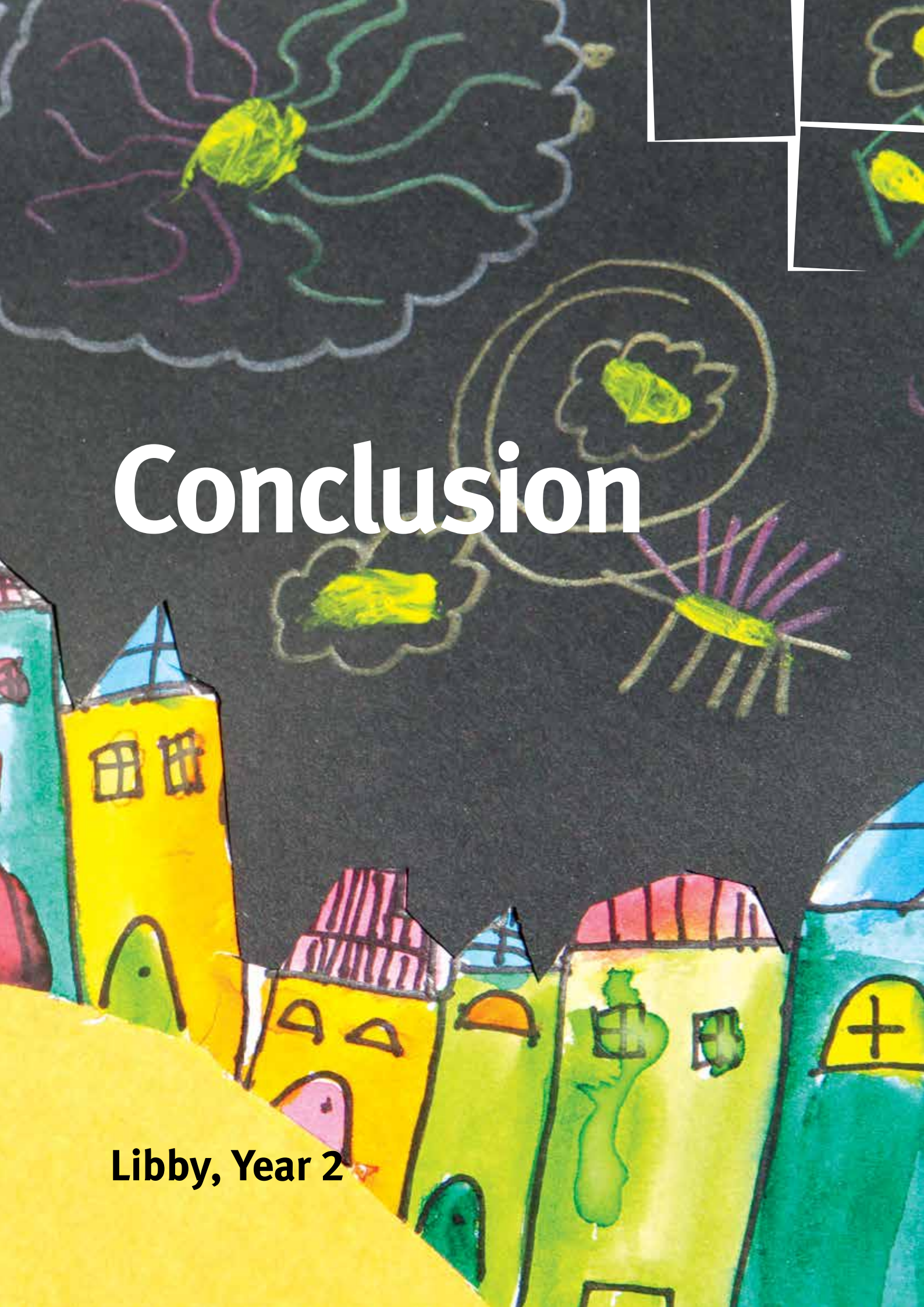
# Conclusion



Libby, Year 2

Beth, Kindergarten

# Conclusion

Artwork by Jesse, Prep

Artwork by Alexia, Year 3

The State of Victoria's Children 2013-14 presents a comprehensive analysis of the prevalence of vulnerability, resilience and disadvantage within Victoria's children and young people. It summarises the key risk and protective factors that affect children and young people's development. The report also summarises risk and protective factors within the family environment, the role of services available to all children in supporting vulnerable children, young people and families, as well as the targeted services which support the most vulnerable families.

As noted throughout this report, Victoria's children and young people are from a wide range of family backgrounds and have diverse characteristics which influence their development. This report also highlights the consistently poorer outcomes of some groups of children and young people, most particularly those who are listed on Health Care Cards, who are Aboriginal, and who are living in Out of Home Care (OOHC). This points to system change, building on the foundation platforms of early learning and maternal and child health services with a focus on outcomes for these groups to be strengthened to ensure that the compounding effects of the risk factors they experience are mitigated.

## Key insights

While the majority of children begin life well and grow up in protective environments which enhance their development, some are negatively affected by a range of risk factors. For these children, young people, and their families, improvements could be made to promote their health, safety, learning and development as shown below.

### Health

Although improvements have been seen in the health of very young Aboriginal children, these improvements have not yet reached the same level as their peers. Overall outcomes for infants continue to improve. Leading indicators such as infant mortality, low birth weight and immunisation rates have all improved, however breastfeeding shows differences with the rate for full breastfeeding at four months lower in Victoria than in other states.

While most Victorian adolescents rate their health as good, most do not do enough physical activity and some undertake risky behaviours such as smoking, drinking alcohol and, to a smaller extent, using illicit drugs. These behaviours gradually increase from age 12 to 17.

This report indicates that mental health issues are a risk factor for both adolescents and the children of parents with mental health issues. Around 10,000 young Victorians are using targeted mental health services, of which nearly 3,000 are aged under 11. This is coupled with increases in rates of self-harm and hospitalisations for psychological issues in recent years. Parental

mental health issues are also the most commonly reported family risk factor for children entering school. In particular, sole parents, those living in the most disadvantaged areas, and parents of children on Health Care Cards are more likely to have a very high risk of mental health issues. These findings indicate the need for services to support those affected by mental illness to ensure that they are able to actively engage in all parts of their life.

The majority of Victorian parents do not engage in risky health behaviours. Less than a fifth of parents are current smokers and a small number drink at risk of short term harm and long-term harm. Women from the most advantaged areas are the most likely to drink during pregnancy. Importantly the number of women drinking during pregnancy has decreased with the majority of those who do drink doing so before they realised they were pregnant.

## Learning and Development

Participation in early childhood health and education services is strong however those who need services the most are the least likely to use them. For example, Aboriginal children are less likely to attend later Maternal Child Health Key Age and Stage visits. More disadvantaged children are also less likely to have attended early childhood education and care services prior to school, leading to greater vulnerability at school entry. Further work is required to focus efforts on increasing the participation of vulnerable children and families in early childhood education and care services. Although targeted services such as Early Start Kindergarten are available, use of these services by eligible children is not yet as high as it could be. Work is being undertaken to increase the participation in Early Start Kindergarten by eligible three-year old children.

Temperament and adjustment issues can influence children's outcomes into adulthood however the prevalence of these issues in early childhood is difficult to track. School entry data does however suggest that children from language backgrounds other than English and Aboriginal children are more likely to be vulnerable on domains associated with attachment and temperament. These children are also far more likely to be vulnerable against all domains of the Australian Early Development Census, particularly children who are not yet proficient in English.

Monitoring outcomes at key transition points from early childhood to school, from primary to secondary school and from secondary school to further education and training remains important as poor transition can have a lasting negative impact. Mechanisms currently exist to monitor the transition to school through the School Entrance Health Questionnaire, which shows that while the majority of children are healthy at school entry, one in seven show early risks such as speech and language difficulties or behavioural problems.

Engagement and connectedness with school and peers are important protective factors for learning and development, particularly during adolescence. Findings that school attendance, engagement and connectedness are lower for more vulnerable groups highlights the need to ensure that all young people are having meaningful interactions at school to maximise their learning and future opportunities. In particular, bullying can be a strong risk for disengagement from school with some groups of children such as those with disability, Aboriginal children, and lesbian, gay and transgender young people being more likely to report bullying.

Absenteeism continues to be an issue, particularly for Aboriginal children and those in OOHC. Unapproved absence is a specific concern highlighting the importance of programs which reduce absenteeism in both secondary school and primary school, as issues behind disengagement frequently begin in middle primary school. Suspension from school is also a significant risk factor for some children and young people, particularly Aboriginal children.

Missing out on school also flows on to missing out on sitting national tests such as NAPLAN. Aboriginal children and young people and those in OOHC are far less likely to sit NAPLAN than their peers, while those that do sit have lower achievement than their peers, particularly from Year 5 onwards. Children and young people from a language background

other than English however have very low levels of absence from both school and NAPLAN and progressively improve their performance as they age.

While the majority of young people complete year 12 and move into further education and training, some do leave school early. These students report that greater flexibility of hours and a more flexible school curriculum would have encouraged them to stay at school. The most recent ABS Census indicates that around 11,000 are not engaged in education and training at age 17, with more than half reporting being employed, although nearly 2,000 are looking for work and 3,800 are not in the labour force. Further work could be done to uncover the characteristics of these young people and to investigate their life trajectories, particularly for those who are not in the labour force.

## Safety

Rates of injury and hospital admission for psychosocial issues and maltreatment in early childhood have decreased, although children under the age of one continue to have higher rates of substantiated child abuse than older children. Physical abuse is the second most common reason for substantiated abuse, after emotional abuse.

Anecdotal evidence suggests an increase in the number of Victorians, including young people who are taking the drug ice (methamphetamine) however this is not yet supported by existing data collections. Victoria Police processing data does however show an increase in the number of young people processed for drug offences.

The number of family violence incidents reported to police has risen dramatically in the last three years with children present at around a third of incidents. Family violence is also the largest cause of homelessness for Victorian women and their children accounting for over 20,000 cases of clients seeking access to homelessness services in 2012–13. Assault is also the type of crime most frequently affecting young female victims of crime. Importantly the number of family violence incidents resulting in charges has almost doubled indicating a stronger approach to these incidents by Victoria Police.

There has been a small increase in the number of crimes by young people, accompanied by a slight shift away from the use of cautions for youth offenders. The numbers of young people in youth justice have decreased. This is an area that needs continuing consideration due to the life-long impact of early interaction with the youth justice system, particularly the strong likelihood of remaining in contact with the justice system over the individual's life. Of particular concern is the overrepresentation of Aboriginal young people in the youth justice system and those who have been in contact with the child protection system.

The focus on child abuse and neglect in recent years has led to large increases in reports to Child Protection and an associated rise in both the number of substantiated cases and the number of children and young people entering OOHC. The number of families receiving assessment and interventions through Child FIRST has also risen.

There have been some system improvements in the area of Child Protection. For example, the time taken to investigate reports has improved, with a third being completed in 28 days or less and nearly 80 per cent completed in under 90 days. The placement stability of children in OOHC shows a more mixed pattern with fluctuations in the number of children with less than two placements (stable care) in recent years.

Of greatest concern is the over representation of Aboriginal children in the Child Protection system. While progress has been made to address these issues, including improvements to the numbers with Cultural Support Plans and increases in the numbers placed in accordance with the Aboriginal Child Placement principle, more needs to be done.

# Commitments to improve outcomes for vulnerable children, young people and their families

The Victorian Government is committed to improving outcomes for all of Victoria's children, young people and families, including those who are vulnerable and experience disadvantage. A diverse range of programs and policies are in place to achieve these and have been highlighted throughout this report.

In addition, significant activities to improve outcomes and address disadvantage are also outlined below.

## Responses for all children and young people

- Continuing to improve kindergarten, maternal and child health services, and parenting support services to ensure Victoria has a quality early childhood system
- Continuing to improve mental health services and outcomes for Victorian children and young people with mental health issues through Victoria's 10-Year Mental Health Plan
- A new cross-system strategy for better outcomes for all Victorian children, young people and families
- The Education State consultation – supporting all Victorians to live the lives they want to live and get the jobs they need

## Responses for the most vulnerable children

- Increased funding to support children and young people in residential care to move into placements in foster care or with kin with a specific focus on moving the youngest children out of residential care.

## Community health and safety

- The introduction of a Royal Commission into Family Violence to report on how Victoria's response to family violence can be improved. This includes practical recommendations for preventing family violence, early intervention, support for victims and perpetrator accountability with a focus on systemic responses family violence, investigating how government agencies and community services can integrate and coordinate their actions and how to evaluate and measure success
- The introduction of an Ice Action Plan to reduce the demand, supply and harm of ice use. This is also supported by the introduction of new offences, stronger penalties, new drug buses and funding to support grass roots action.

## Place based responses to disadvantage and vulnerability

- Children and Youth Area Partnerships are a placed based model being implemented across eight sites in Victoria to collectively improve the life chances of vulnerable children, young people and their families through effectively joining-up services and supports across multiple governments and services around shared priorities, with a focus on learning and development, and safety and wellbeing. They bring together senior leaders in a local area from Commonwealth, Victorian and local governments, the community, health and education sectors and the broader community. Area Partnerships seek to align partners' existing resources to deliver practice change and work across sectors to influence the systems change required to impact on population level outcomes.
- A continuing commitment to make state and local level data available to support policy and planning through multiple means including the State of Victoria's Children Report, the Victorian Child and Adolescent Monitoring System data portal, the DataVic portal and individual government department websites


Elizabeth, Kindergarten

# Glossary of abbreviations and acronyms

| | | | |
|---|---|---|---|
| AEDC | Australian Early Development Census | KESO | Koorie Engagement Support Officer |
| ABS | Australian Bureau of Statistics | HCC | Health Care Card |
| ACPP | Aboriginal Child Placement Principle | IRSD | Index of Relative Socioeconomic Disadvantage |
| AIFS | Australian Institute of Family Studies | FaPMI | Families where a Parent has a Mental Illness (strategy) |
| AIHW | Australian Institute of Health and Welfare | LEAP | Law Enforcement Assistance Program |
| ARACY | Australian Research Alliance for Children and Youth | LBOTE | Language Background Other Than English |
| BMI | Body Mass Index | LGAs | Local Government Areas |
| CAMHS | Child and Adolescent Mental Health Services | MCH | Maternal Child Health |
| CYMHS | Child and Youth Mental Health Services | NAPLAN | National Assessment Program – Literacy and Numeracy |
| CALD | Culturally And Linguistically Diverse | NHMRC | National Health and Medical Research Council |
| CHS | Community Health Services | NMS | National Minimum Standard (for NAPLAN) |
| COAG | Council of Australian Governments | OOHC | Out of Home Care |
| CRIS | Client Relationship Information System | SCRGSP | Steering Committee for the Review of Government Service Provision |
| CYMHS | Child and Youth Mental Health Services | SDQ | Strengths and Difficulties Questionnaire |
| DET | Department of Education and Training | SEHQ | School Entrant Health Survey |
| DHHS | Department of Health and Human Services | SES | Socioeconomic Status |
| DPCD | Department of Planning and Community Development (Vic.) | SOVC | The State of Victoria's Children |
| EAL | English as an Additional Language | UNICEF | The United Nations Children's Fund |
| ECE | Early Childhood Education | VCAMS | Victorian Child and Adolescent Monitoring System |
| ECEC | Early Childhood Education Care (services) | VCHWS | Victorian Child Health and Wellbeing Survey |
| ECIS | Early Childhood Intervention Service | VPHS | Victorian Population Health Survey |
| ERP | Estimated Residential Population | WHO | World Health Organisation |

# Data sources

Data collections used throughout this report.

| | |
|---|---|
| Australian Bureau of Statistics (ABS) | Census of Population and Housing 2011 |
| | Estimated Residential Population (ERP) |
| Australian Curriculum and Assessment Reporting Authority (ACARA) | National Assessment Program website |
| Australian Early Development Census (AEDC) | Australian Early Development Index collection 2009 and 2012 |
| Australian Government Department of Health | National Survey of Mental Health and Wellbeing |
| Australian Government Department of Health in association with state Cancer Councils | Australian Secondary Students Alcohol and Drugs Survey (ASSAD) 2011 |
| Australian Government Department of Human Services | Australian Childhood Immunisation Register |
| Australian Government Productivity Commission | Report of Government Services (ROGS) |
| Australian Institute of Family Studies | Australian Temperament Project |
| Australian Institute of Health and Welfare (AIHW) | Child indicators data portal |
| | Specialist Homelessness Services |
| | Longitudinal Survey of Australian Children |
| | Longitudinal Survey of Indigenous Children |
| | Longitudinal Survey of Australian Youth |
| | National Community Mental Healthcare Database |
| | Child Protection Australia |
| Children's Court of Victoria | Annual Report |
| Mission Australia | Youth Survey |

| | |
|---|---|
| Victorian Department of Education and Training (DET) | August Supplementary School Census |
| | Attitude to School Survey (AToSS) |
| | CASES 21 enrolment system |
| | Kindergarten Management System (KIM) |
| | Maternal Child Health (MCH) collection |
| | On Track survey |
| | School Entrant Health Questionnaire (SEHQ) |
| | Skills Victoria administrative data |
| | The Victorian Adolescent health and Wellbeing Survey (known as HowRU?) |
| | Victorian Child Health and Wellbeing Survey (VCHWS) |
| | Victorian Curriculum and Assessment Authority (VCAA) National Assessment Program Literacy and Numeracy (NAPLAN) collection and DET administrative data |
| Victorian Department of Health and Human Services (DHHS) | Alcohol and Drugs Information System |
| | Child and Adolescent Mental Health Services (CAMHS) |
| | Child and Family Services Outcomes Survey (CAFSOS) |
| | Child and Youth Mental Health Services (CYMHS) |
| | Client Relationship Information System (CRIS) |
| | Integrated Reports & Information System |
| | Perinatal data collection (teen fertility - check) |
| | Victorian Admitted Episodes Dataset (VAED) |
| | Victorian Emergency Minimum Dataset (VEMD) |
| | Youth Parole Board and Youth Residential Board |
| | Victorian Population Health Survey (VPHS) |
| Victorian Department of Justice and Regulation | Corrections data |
| Victoria Police | Crime Statistics |
| | Law Enforcement Assistance Program (LEAP) |

Beth, Kindergarten