State of Victoria’s Children 2017

A Focus on Health and Wellbeing

Contents

[Ministerial foreword 6](#_Toc15657998)

[Executive Summary 7](#_Toc15657999)

[A healthy start 8](#_Toc15658000)

[Families and the family environment 9](#_Toc15658001)

[Inclusive and enabling communities 10](#_Toc15658002)

[Physical and mental health 12](#_Toc15658003)

[Learning and Education 14](#_Toc15658004)

[Within Victoria 16](#_Toc15658005)

[Introduction 17](#_Toc15658006)

[1.0 Population demographics 19](#_Toc15658007)

[1. 1 Number of children 19](#_Toc15658008)

[1.1.1 Number of Aboriginal children 19](#_Toc15658009)

[1.1.2 Disadvantaged children 19](#_Toc15658010)

[1.1.3 Diverse backgrounds 20](#_Toc15658011)

[1.1.4 Refugee arrivals 20](#_Toc15658012)

[1.1.5 Disability 20](#_Toc15658013)

[2.0 A Healthy Start 22](#_Toc15658014)

[Key facts 22](#_Toc15658015)

[Introduction 23](#_Toc15658016)

[2.1 A healthy start from conception to birth 24](#_Toc15658017)

[2.1.1 Infant mortality rates 24](#_Toc15658018)

[2.1.2 Birthweight 26](#_Toc15658019)

[2.1.3 Children exposed to tobacco and alcohol in utero 27](#_Toc15658020)

[2.2 A healthy start – preparing infants for a happy and healthy life 29](#_Toc15658021)

[2.2.1 Breastfeeding rates 30](#_Toc15658022)

[2.2.2 Immunisation rates 31](#_Toc15658023)

[2.2.3 Accessing and engaging Maternal and Child Health services 33](#_Toc15658024)

[2.2.4 Early childhood education 35](#_Toc15658025)

[3.0 Families and the family environment 38](#_Toc15658026)

[Key facts 38](#_Toc15658027)

[Introduction 39](#_Toc15658028)

[3.1 Household composition 39](#_Toc15658029)

[3.2 Family economics, parental education and a child’s wellbeing 40](#_Toc15658030)

[3.2.1 Parental education 40](#_Toc15658031)

[3.2.2 Households’ employment 41](#_Toc15658032)

[3.2.3 Earning power of different family types 43](#_Toc15658033)

[3.2.4 The impact of poverty, low incomes and financial hardship 43](#_Toc15658034)

[3.2.5 Housing and housing stress 46](#_Toc15658035)

[3.2.6 Homelessness 48](#_Toc15658036)

[3.3 The family environment 50](#_Toc15658037)

[3.3.1 Parenting capability and family functioning 51](#_Toc15658038)

[3.3.2 Parenting attitudes and behaviours 53](#_Toc15658039)

[3.3.3 Parental mental health and psychological distress 53](#_Toc15658040)

[3.3.4 Children and young people exposed to family violence 56](#_Toc15658041)

[3.3.5 Child abuse and child protection 61](#_Toc15658042)

[4.0 Inclusive and enabling communities 67](#_Toc15658043)

[Key facts 67](#_Toc15658044)

[Introduction 69](#_Toc15658045)

[4.1 Community support and the social environment 69](#_Toc15658046)

[4.1.1 Support in times of need 70](#_Toc15658047)

[4.1.2 Young people who have a trusted adult in their life 70](#_Toc15658048)

[4.1.3 Adults who thought multiculturalism definitely made life in their area better 71](#_Toc15658049)

[4.1.4 Voluntary work 71](#_Toc15658050)

[4.2 Healthy, accessible and enabling communities 71](#_Toc15658051)

[4.2.1 Physical environment 72](#_Toc15658052)

[4.2.2 Transportation 73](#_Toc15658053)

[4.3 Neighbourhood safety 74](#_Toc15658054)

[4.3.1 Community disorganisation and reported crimes committed against young people 75](#_Toc15658055)

[4.3.2 Youth custody and crime 76](#_Toc15658056)

[5.0 Physical and mental health 80](#_Toc15658057)

[Key facts 80](#_Toc15658058)

[Introduction 83](#_Toc15658059)

[5.1 Protective factors 84](#_Toc15658060)

[5.1.1 Resilience 84](#_Toc15658061)

[5.1.2 Nutrition 85](#_Toc15658062)

[5.1.3 Sleep 86](#_Toc15658063)

[5.1.4 Physical activity 87](#_Toc15658064)

[5.1.5 Importance of connection to culture and community for Aboriginal children 88](#_Toc15658065)

[5.2 Risky behaviours and factors that negatively impact health 90](#_Toc15658066)

[5.2.1 Young smokers 90](#_Toc15658067)

[5.2.2 Young drinkers 91](#_Toc15658068)

[5.2.3 Young drug users 92](#_Toc15658069)

[5.2.4 Sexual health 93](#_Toc15658070)

[5.2.5 Sedentary behaviours 95](#_Toc15658071)

[5.2.6 Racism 96](#_Toc15658072)

[5.2.7 Bullying 97](#_Toc15658073)

[5.3 Overall Health 100](#_Toc15658074)

[5.3.1 Prevalence of mental disorders 100](#_Toc15658075)

[5.3.2 Experiences of psychological distress amongst young people 102](#_Toc15658076)

[5.3.3 Social and emotional health and difficulties 102](#_Toc15658077)

[5.3.4 Special Health Care Need and disability 103](#_Toc15658078)

[5.4 Common physical conditions 105](#_Toc15658079)

[5.4.1 Dental Health 105](#_Toc15658080)

[5.4.2 Asthma 108](#_Toc15658081)

[5.4.3 Allergies 110](#_Toc15658082)

[5.4.4 Healthy weight 111](#_Toc15658083)

[5.4.5 Cancer 112](#_Toc15658084)

[5.5 Common mental disorders 113](#_Toc15658085)

[5.5.1 Attention Deficit Hyperactivity Disorder 113](#_Toc15658086)

[5.5.2 Anxiety disorders 114](#_Toc15658087)

[5.5.3 Major depressive disorders 114](#_Toc15658088)

[5.5.4 Conduct disorders 115](#_Toc15658089)

[5.5.5 Intentional self-harm in young people and suicide 115](#_Toc15658090)

[5.6 Access to health services 118](#_Toc15658091)

[5.6.1 Emergency Departments 119](#_Toc15658092)

[5.6.2 Hospital presentation and separation data on mental illnesses 120](#_Toc15658093)

[6.0 Learning and education 121](#_Toc15658094)

[Key facts 121](#_Toc15658095)

[Introduction 124](#_Toc15658096)

[6.1 Developmental vulnerabilities in early childhood 124](#_Toc15658097)

[6.1.1 Developmental vulnerabilities and academic performance 125](#_Toc15658098)

[6.1.2 Speech and language 125](#_Toc15658099)

[6.1.3 Emotional and behavioural difficulties 127](#_Toc15658100)

[6.2 Family factors and achievement outcomes 128](#_Toc15658101)

[6.2.1 Home learning environment 128](#_Toc15658102)

[6.2.2 Family risk factors 129](#_Toc15658103)

[6.3 Student health and wellbeing and school 131](#_Toc15658104)

[6.3.1 Wellbeing and absenteeism 131](#_Toc15658105)

[6.3.2 Health, wellbeing and academic achievement 134](#_Toc15658106)

[6.3.3 Accumulation of health and wellbeing difficulties 135](#_Toc15658107)

[6.4 How the school environment can influence and shape health and wellbeing 137](#_Toc15658108)

[6.4.1 Social engagement 137](#_Toc15658109)

[6.4.2 Support for positive health and wellbeing at school 139](#_Toc15658110)

[6.4.3 Expulsions 140](#_Toc15658111)

[6.4.4 Student safety 140](#_Toc15658112)

[6.5 Post-school pathways 141](#_Toc15658113)

[6.5.1 Year 12 or equivalent successful completion rates 142](#_Toc15658114)

[6.5.2 Young people engaged in full time education and/or work 142](#_Toc15658115)

[7.0 Within Victoria 144](#_Toc15658116)

[Introduction 144](#_Toc15658117)

[7.1 Measuring disadvantage by place 144](#_Toc15658118)

[7.1.1 Victorian LGAs by relative socioeconomic disadvantage 145](#_Toc15658119)

[7.2 Comparing metropolitan and rural outcomes 145](#_Toc15658120)

[7.2.1 Early childhood health considerations in rural Victoria 145](#_Toc15658121)

[7.2.2 Family and Community Characteristics 146](#_Toc15658122)

[7.2.3 Education and health outcomes 147](#_Toc15658123)

[7.3 Location-based disadvantage 147](#_Toc15658124)

[8.0 Conclusion 150](#_Toc15658125)

[Acronyms 152](#_Toc15658126)

[References 154](#_Toc15658127)

[Full reference list (alphabetically sorted) 154](#_Toc15658128)

[Endnotes 181](#_Toc15658129)

# Ministerial foreword

The *Child Wellbeing and Safety Act 2005* establishes the Children’s Services Coordination Board (the Board). Each year the Board reports on the outcomes of government actions in relation to children, particularly the most vulnerable young people in the community.

The **2017** **State of Victoria’s Children Report** (the report) focuses on the health and wellbeing of children. The report brings together current research and recent data to provide a comprehensive picture of how Victorian children are faring. This year’s report illustrates that most children and young people in Victoria are healthy, happy and have adequate support to help them to thrive. However family pressures, socioeconomic disadvantage and an accumulation of risk factors can lead to a compounding effect on health and wellbeing outcomes.

A child’s start in life can influence their long term health and wellbeing. This report demonstrates the value of maternal health during pregnancy, vaccination and a child’s engagement with early childhood education services. The Victorian Government has committed to strengthening the Maternal and Child Health service and providing an additional year of early childhood education. All Victorian children will be provided with access to five hours of three-year-old kindergarten by 2022 with this extended to 15 hours over the next decade.

The report illustrates the impact of the family environment on a child’s emotional, physical and social wellbeing. Healthy family functioning nurtures a child’s development and can mitigate against negative factors such as exposure to violence, mental and physical health issues or homelessness. The Victorian Government is providing early childhood teachers and educators with culturally competent professional development so that they can support children who have experienced trauma and family violence as well as being equipped to identify children at risk of abuse.

As the report shows, mental health concerns, self-harm and bullying contribute to children reporting behavioural, emotional problems and psychological distress. The Victorian Government has announced a new mental health in schools program, which allows government secondary schools across the state to employ qualified mental health professionals such as counsellors and psychologists to support student wellbeing. The Andrews Government is also establishing a Royal Commission into Mental Health recognising this as a priority health and wellbeing issue in Victoria.

The evidence demonstrates that physical activity, good nutrition, adequate sleep, a healthy weight and dental care are key factors in a child’s health and wellbeing. The Victorian Government will be providing free dental care at all government primary and secondary schools over the next four years responding to preventable dental hospitalisations of children in Victoria.

I am pleased that the Department of Education and Training has led this valuable work in partnership with the Board, Department of Premier and Cabinet, Department of Treasury and Finance, Department of Health and Human Services, Department of Justice and Community Safety and Victoria Police.

The report serves as an important resource for government and the community sector as we work towards our overall objective of improving outcomes for children and young people in Victoria in terms of their achievement, engagement and wellbeing.

# Executive Summary

The 2017 State of Victoria’s Children report adds to the evidence-base about children’s health and wellbeing and is intended to support the development of policies that can improve lives.

The report shows that children’s health outcomes are shaped by complex interactions between multiple factors. The families in which they grow, their parents’ health and experiences, their genetics, their communities and the opportunities available within them, their schools and the services that support them, and their individual characteristics affect children’s ability to flourish.

Children’s wellbeing is not predetermined by any one of these, but rather is shaped by this combination of intrinsic, longitudinal, genetic and environmental factors.

The vast majority of Victorian children are healthy and happy and the necessary supports are in place to enable them to thrive. There have also been significant improvements in some outcomes during the past decade. In particular, there have been significant improvements in the Aboriginal perinatal mortality rate and a decrease in the proportion of Aboriginal babies born with a low birthweight. Furthermore, fewer young people are smoking and more Victorian children are living in smoke-free homes. There has also been a significant improvement in the number of preventable dental hospitalisations in young Victorian children living in regional Victoria. These are outcomes Victorians can be proud of.

However, as the report shows, a significant minority of Victorian children experience poor developmental, health and learning outcomes. The report shows that as health adversities accumulate, particularly when combined with developmental vulnerabilities and problems in the family, they compound to have an effect that is greater than the sum of the parts.

The report also highlights some specific areas of concern, including in relation to obesity, bullying, increases in hospitalisations due to anaphylaxis and presentations at emergency departments for self-harm.

And while technological advancements have undoubtedly benefitted the health of Victorians, they come with challenges. For example, the internet and smart phones have provided children with vast amounts of information at their fingertips. However, they have also created an environment where children are exposed to new threats to their wellbeing, such as cyberbullying. As more children watch television and play computer games at home for longer periods, fewer are engaging in the necessary levels of physical activity.

In addition, research is linking changes in modern lifestyles, such as exposure to chemicals, overuse of antibiotics and less exposure to green spaces, to changes in the development of key bodily systems. Indeed, the physical environments children grow up in and the stressors children are exposed to are factors that are now recognised as having an effect on children’s susceptibility to a range of health conditions and the development of the immune and metabolic systems, with possible links to issues such as obesity and allergies.

The report highlights that while children in all parts of Victorian society experience bouts of poor health, social disadvantage continues to underpin many inequitable health outcomes across the state. Financial hardship affects a family’s ability to provide for their children’s long-term and immediate needs. It also increases stress among family members, including children. It is often associated with lower levels of parental education as well as knowledge about healthy behaviours. Indeed, the gap between children’s developmental outcomes based on socioeconomic differences is too often evident from a very early age and widens over time. Importantly, the length of time that a child is exposed to the effects of poverty and the degree of disadvantage are significant factors that influence the impact on outcomes.

In addition, the report shows how traumatic or adverse experiences, such as family violence, child abuse and parental substance abuse, can have severe consequences for children’s immediate and long-term wellbeing. The report also uses linkage capacity between government administrative data sets to highlight the greater challenges and vulnerabilities faced by children who have experienced abuse and violence, including in relation to homelessness, risky health behaviours and learning. The report also highlights research that shows traumatic and adverse experiences rarely occur in isolation, and that as these experiences accumulate, they can have a compounding effect on children’s health and wellbeing.

Counter-productively, it is often children and families who most need support that have the fewest protective resources to draw upon and are least able to access support services. Differences in service usage occur for a variety of reasons, including cost as well as barriers such as distance and stigma. For some, such as parents in abusive relationships, they may not access services out of fear for their own and their child’s safety or because of other possible ramifications, including the child being taken away from the family.

However, neither poverty nor traumatic experiences necessarily determine a child’s future. The report highlights research showing children exhibiting significant resilience in the face of adversity and growing up to achieve outcomes comparable to/or exceeding their peers.

The report also explores research that illustrates that a nurturing home environment can mitigate the impact of poverty and examples of effective services enabling children to overcome challenging circumstances and fulfil their potential. These are important points to make, as they illustrate that families, communities and services can play a role in supporting all children to live happy and fulfilling lives.

## A healthy start

The beginning of life is a period of great importance. It is the period when children are most adaptable. From after a child is conceived and through infancy, children adapt to their physical and social environments. While this offers significant opportunity for positive development, it also leaves infants particularly vulnerable to adverse events. There is evidence that many childhood and adult health conditions are rooted in events during the first years of life.

The first section of this chapter explores key indicators of maternal health during pregnancy, and infant health. The section shows improvements during the past 20 years with falling infant mortality rates and a reduction in women smoking and drinking during pregnancy. There have been particularly significant improvements among Aboriginal women and families, with the Aboriginal perinatal mortality rate in Victoria now no higher than the non-Aboriginal rate, and a significant reduction in the proportion of Aboriginal babies being born with a low birthweight. Key findings include:

* The Victorian Aboriginal perinatal mortality rate declined from 23.1 deaths per 1,000 births in the 2001-2003 triennia to 9.0 in the 2014-16 triennia, slightly below the non-Aboriginal rate (9.1) (Department of Health and Human Services (DHHS) 2017e).
* The proportion of babies with a low birthweight born to Aboriginal mothers has decreased in recent years from 12.1 per cent in 2013 to 9.8 per cent in 2016 (Ibid.).
* Smoking is declining across Victoria, however, younger pregnant women, pregnant women in regional areas and pregnant Aboriginal women are more likely to smoke than the average.

The second section in this chapter explores the period after birth and indicators that are associated with stronger health outcomes and improved development. Overall the section shows significant improvements in the proportion of Victorian children being vaccinated. The section also illustrates the importance of early years’ services. It highlights promising improvements in service usage among Aboriginal families, including in relation to Maternal and Child Health (MCH) services and early childhood education. Key findings include:

* Since 2006-07, Aboriginal participation at all MCH key ages and stages consultations has improved by between 10 and 19 percentage points.[[1]](#footnote-2)
* Participation in early childhood education the year before school is high in Victoria (93.4 per cent). Aboriginal children’s participation improved from 59 per cent in 2007 to 94 per cent in 2017.[[2]](#footnote-3)

## Families and the family environment

Families shape children’s development, life choices, beliefs and ultimately health and wellbeing. Healthy families promote children’s emotional, physical and social wellbeing and provide important support to draw upon during challenging periods. Conversely, a poor family environment can increase the risk related to negative developmental outcomes due to factors such as harsh and inconsistent parenting, exposure to family violence, promoting unhealthy behaviours, often due to the effects of living in poverty.

The first section of this chapter explores the composition of Victorian households. A key finding is:

* In 2016, around 18 per cent of families with dependent children under 15 in Victoria were single-parent households and most were headed by females (85 per cent) (Public Health Information Development Unit (PHIDU) 2018b; Australian Bureau of Statistics (ABS) 2017e). Around 47 per cent of Aboriginal families with dependent children under 15 years of age were single-head households (PHIDU 2018a).

The second section of this chapter explores parental education, families’ economic situations, housing and the relationship between those factors and children’s health and wellbeing. It finds that overall Victorian parents are better educated than a decade ago and fewer children are living in jobless households. However, those experiencing social disadvantage are facing increasing cost of living challenges, with food insecurity on the rise. In particular, single-parent families are facing increasing cost of living challenges as the gap between their income, employment outcomes and education levels and that of couple-parent families widens. The section also looks at the impact of poverty and homelessness, finding they have significant ramifications for the short and long-term wellbeing of children. Key findings include:

* In 2017, 25 per cent of children in single-parent households attending government schools were living with a guardian whose highest level of education is below Year 12, compared to eight per cent of children in couple-parent families. More than 40 per cent of single-parent households with dependent children (under 15 years) are jobless, compared to six per cent of couple-parent households (ABS 2017e).
* One in five zero to 12-year-olds living in single-parent families experienced food insecurity in 2017[[3]](#footnote-4) and the proportion of these families’ gross income being spent on housing increased from 16 per cent in 1995-96 to 24 per cent in 2015-16 (ABS 2017d).
* From 2011-12 to 2016-17, the number of Victorian children accessing homelessness services increased by 56 per cent, with vulnerable groups such as those experiencing family violence and children in out-of-home care (OOHC) significantly overrepresented (Australian Institute of Health and Welfare (AIHW) 2017d).

The third section looks at the family environment. It finds the vast majority of children live in happy and supportive families, and this has been consistent during the past decade. However, unhealthy family functioning is associated with a higher probability of children smoking, drinking and trying illicit drugs. It also finds that children of parents with positive attitudes to smoking are more likely to smoke. The section explores the impact of parental mental illness on children and finds an association with behavioural problems at school entry and only a small association with poorer academic achievement. In addition, it explores the prevalence and impact of family violence on children and finds a strong association between witnessing violence, child abuse and developmental problems as well as poorer academic achievement. Finally, the section highlights significant increases in children living in OOHC. Key findings include:

* Around 28 per cent of children whose parents reported a mental illness had an emotional or behavioural problem upon school entry, compared to less than nine per cent of children whose parents did not.
* Around 58 per cent of children who had not been abused before starting school were in the top two bands for National Assessment Program – Literacy and Numeracy (NAPLAN) Reading in 2017, compared to 43 per cent of children who had experienced abuse.
* On 30 June 2017, there were 10,312 children in OOHC, up from 5,052 on 30 June 2007 (AIHW 2006-07 & 2016-17), an increase of 104 per cent.

## Inclusive and enabling communities

Communities are a key environmental influence on children’s health and wellbeing. They provide families and children with a range of protective resources and supports to draw upon in times of need. Positive social and physical community environments can model and encourage healthy behaviours. Conversely, a lack of safety or fragmented communities can be harmful for children. For example, children might not be able to engage in outdoor activities due to poor perceptions of safety, may experience social isolation or be exposed to crime.

The first section of the chapter explores the social environment of Victorian communities. It finds that the vast majority of Victorian children and families have the necessary supports and social connections. However, families and children experiencing higher levels of socioeconomic disadvantage are less likely to have supportive relationships in their communities and are more likely to experience social isolation. A key finding is:

* Seven in 10 school-aged children in Victoria report having a trusted adult in their life, however older students (64 per cent of Year 11s) and those in single-parent families (66 per cent) were less likely to have a trusted adult in their life.[[4]](#footnote-5)

The second section of the chapter explores the physical environment and transport services in Victorian communities. It highlights that the vast majority of Victorian children have good access to parks and playgrounds, although children in disadvantaged areas have worse access than their more advantaged peers. It also explores the food environment confronting Victorian children, and finds children from disadvantaged areas are exposed to significant amounts of unhealthy food choices. The report then highlights the disparity in access to public transport between children living in regional and metropolitan areas. Key findings include:

* In 2017, there was a 20.5 percentage point gap between the proportion of children in the most disadvantaged quintile of communities (75.7 per cent) who reported good access to parks and the proportion of children in the least disadvantaged quintile of communities (96.2 per cent).[[5]](#footnote-6)
* On average, 75 per cent of the populated area of metropolitan local government areas (LGAs) in Victoria is within a 20-minute walk of public transport. However, in regional Victoria, the figure falls to around 22 per cent.[[6]](#footnote-7)
* Across Victoria, 48 per cent of populated areas in the most disadvantaged LGAs were within a 20-minute walk of public transport. However, 72 per cent of populated areas within the least disadvantaged areas were within easy walking distance of public transport.[[7]](#footnote-8)

The final section explores neighbourhood safety. It finds most Victorian parents perceive their neighbourhoods to be safe, however, this follows a social gradient. It also finds when children feel unsafe and report witnessing fights and crime in their community (disorganised communities) they are more likely than others to have lower levels of resilience and engage in risky health behaviours like smoking and trying illegal drugs. The report then explores the number of people under youth justice supervision and shows that the number of children being found guilty of an offence has fallen in recent years. It also highlights that many young people engaged with the youth justice system experience a range of complicating characteristics, including childhood abuse, familial criminal activity, cognitive impairment, mental health concerns and family conflict. Key findings include:

* In 2017, around 81 per cent of children (aged zero to 12 years) living in the most disadvantaged areas were living in neighbourhoods that their parents thought were safe, compared to 98 per cent of children in the least disadvantaged areas.[[8]](#footnote-9)
* Twenty per cent of children in disorganised communities reported high levels of resilience compared to 59 per cent of children who reported living in communities that did not exhibit the characteristics or disorganisation.[[9]](#footnote-10)
* In 2016-17, a total of 2,822 young people were found guilty of an offence, down from 6,633 in 2008-09 (Children’s Court of Victoria 2018).

## Physical and mental health

Children’s physical and mental health are individually important, interrelated and central to their overall wellbeing. A healthy child is better able to engage with their education, flourish into a happy adult and make a positive contribution to society.

Rapid technological change during the past century has significantly enhanced children’s health in terms of medical advancement and vaccination, however this has also been countered by the impact of technology on mental health, bullying and physical activity.

All children can experience poor health outcomes but evidence suggests that socioeconomic factors, such as family circumstance and community disadvantage, make a group of Victorian children significantly more vulnerable to experiencing poor health and wellbeing outcomes.

This chapter explores the physical and mental health outcomes of Victorian children, with a particular focus on the most vulnerable. This includes: key protective factors that support positive health outcomes; risky behaviours and other factors that detract from children’s health; an overview of Victorian children’s health; trends in a few important physical health indicators; common mental disorders; and access to several Victorian health services.

The first section looks at protective factors that support positive health outcomes for children and young people. These factors include:

* resilience
* nutrition
* getting enough sleep
* participating in regular physical activity.

Overall, younger children are more likely to display these protective factors than older children:

* In 2016, younger students (72 per cent of Year 5 students) were more resilient than their older peers (68 per cent of Year 11 students).[[10]](#footnote-11)
* In 2016, older students (56 per cent in Year 11) were more likely to report issues with their sleep than younger students (45 per cent in Year 5).[[11]](#footnote-12)

The second section outlines risky behaviours and factors that negatively impact health. Factors identified include:

* smoking and exposure to smoking at a young age
* consumption of alcohol
* using illicit drugs
* practising unsafe sex
* a sedentary lifestyle
* racism
* being bullied.

There are differences in the profile of children and young people who are more likely to be exposed to these risk factors. These include:

* Older students are more likely to have used illicit drugs, be sexually active and report higher levels of electronic media use (linked to sedentary lifestyle).[[12]](#footnote-13)
* Children and young people in rural and regional areas, with a mental illness, in OOHC and those who are in contact with the youth justice system are more likely to have experienced some of these risk factors including smoking, drinking alcohol and using drugs (Lawrence et al 2015, DHHS 2017b, Armytage & Ogloff 2017).
* Children from areas of greater social disadvantage are more likely to have been exposed to smoking in the home, to engage in sedentary behaviours and to have experienced bullying.[[13]](#footnote-14)
* Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) and Aboriginal Victorians are more likely to have experienced bullying than the statewide average (Hillier et al 2010).

Promisingly, the proportion of children and young people reporting they have consumed alcohol has declined in recent years and the proportion living in smoke-free homes has increased. However, the proportion of young people who reported trying an illicit drug increased in 2016.

The third section examines the overall health of children and young people in Victoria. In 2016, 75 per cent of students reported feeling satisfied with their life and 87 per cent reported their health as good, very good or excellent. The most recent study of the prevalence of mental disorders among Australian children found that around 14 per cent of Australians aged between four and 17 had experienced a mental disorder in the previous 12 months. Children in child protection and children in contact with the youth justice system experienced worse mental health outcomes.

The fourth section highlights common physical health concerns and their prevalence among young people. It focuses on:

* Dental health – in 2017, the Victorian Child Health and Wellbeing Survey (VCHWS) found that 17.7 per cent of children aged six months to 12 years had a filling.
* Asthma – parent reported data from the 2017 VCHWS found that 12.1 per cent of children aged one to 12 years had asthma.[[14]](#footnote-15)
* Allergies – in 2016-17, there were 687 hospitalisations of children due to anaphylaxis in Victoria, up from 200 in 2005-06.[[15]](#footnote-16)
* Weight concerns – in Victoria, 32 percent of 10 to 14-year-olds, 31 per cent of five to 17-year-olds and nearly half of young people aged 18 to 24 are overweight or obese (ABS 2015a; AIHW 2018f).
* Cancer – cancer in children and young Victorians is relatively rare with almost 60 per cent of tumours developing in people over 65 years of age (DHHS 2018c).

The fifth section focuses on common mental disorders. Children and young people in families with lower incomes, lower levels of parental education and those in jobless households were more likely to experience a mental disorder. Prevalence of disorders was also found to generally be higher outside of greater capital cities and worse for children living in families with poor family functioning. Specifically, the section focuses on:

* Attention Deficit Hyperactivity Disorder (ADHD) – the most common mental disorder for children and adolescents in 2013-14 with 7.4 per cent of young people (four to 17 years of age) assessed as having ADHD (Lawrence et al 2015).
* Anxiety disorders – the second most common mental disorder affecting 6.9 per cent of people aged four to 17 years of age (Ibid.).
* Major depressive disorder – the overall prevalence amongst people aged four to 17 years of age was 2.8 per cent (2013-14), but this was significantly higher among older youths (aged 12 to 17 years of age) compared to younger children (aged four to 11 years of age) (Ibid.).
* Conduct disorder – the prevalence rate of conduct disorders among four to 17-yearolds was 2.1 per cent (2013-14) (Ibid.).
* Intentional self-harm and suicide – measuring incidents of self-harm is difficult because many young people do not seek help, but over the past decade there has been an increase in the number of children and young people presenting to hospitals for self-harm, with numbers highest amongst females.[[16]](#footnote-17)

The final section in this chapter explores children’s and families’ access to health services. The vast majority of Victorian children live in households that have access to basic health services. Results from the past four VCHWS illustrate that access to services is improving across Victoria. In 2017, more than 93 per cent of respondents to the survey said they had access to basic services, such as a health centre or medical clinic, up from 88 per cent in 2006.

## Learning and Education

Positive health and wellbeing enables a child to fully engage with school life from the early years. Education influences health through a range of complex mechanisms such as income, access to health care and better employment opportunities. Participation and engagement in education nurtures human development, social relationships and wellbeing and can promote positive choices and a healthy lifestyle. Education matters to health through the direct effect it has on learners, its impact on people’s choices and opportunities, and its potentially transformative effect on families, workplaces, community and wider society.

This chapter demonstrates the relationship between health and wellbeing and learning and education over three life stages; from the time before a child starts school, through their school life as a student, and a young person’s pursuit of life opportunities post-school.

The first section explores the relationship between developmental vulnerabilities and educational outcomes. Key findings include:

* Vulnerability in the language and cognitive skills domain in the Australian Early Development Census is more strongly associated with poorer academic performance than any other domain. Children identified as vulnerable in the language and cognitive skills domain at school entry have been shown to be nearly five times less likely to achieve in the top two bands in Year 3 NAPLAN Reading compared to children who were on track in Prep. By Year 5 this increased to seven times.
* Beginning school with behavioural and emotional problems is an indicator of poorer future academic achievement. Fifty nine per cent of children who started school at low risk of emotional and behavioural problems went on to reach the top two bands in Year 3 NAPLAN Reading compared to 40 per cent of children at moderate to high risk.[[17]](#footnote-18)

The second section explores the relationship between extrinsic factors such as the family environment and student achievement. Key findings include:

* Children’s performance in Year 3 NAPLAN Reading and Numeracy is related to the frequency of in-home activities and out-of-home activities. Their Year 3 NAPLAN performance was related to being read to frequently and having more than 30 books in the home (Commerford 2015).
* In 2017, 69 per cent of Victorian children aged under five were read to by a family member every day (parent reported).[[18]](#footnote-19) Rates were lower for children living in metropolitan areas, those from single-parent families and those listed on a Health Care Card.
* Lower proportions of children whose parents responded ‘yes’ to their child being exposed to family risk factors (such as witnessing violence, experiencing abuse, or addictive behaviours such as parental substance use) as they commenced primary school went on to achieve in the top two bands of NAPLAN Reading in Year 3.[[19]](#footnote-20)

The third section explores the relationship between a student’s overall sense of health and wellbeing and their attitude to learning and academic achievement. Key findings include:

* Lower levels of health and wellbeing can contribute to student absence from school. Chronic absenteeism was shown to be more common among students reporting being bullied, and was associated with more negative responses in relation to internal levels of resilience, sense of confidence, and connectedness to school.[[20]](#footnote-21)
* The accumulation of risk factors is associated with progressively worse academic achievement. An analysis of the association between development, health and family factors of children entering primary school and their Year 3 NAPLAN outcomes shows speech difficulties, declining health and experiences of witnessing violence are associated with a lower probability of high academic achievement. When these experiences and difficulties co-occur they compound, reducing the probability of high academic achievement by more than the sum of the individual factors.[[21]](#footnote-22)

The fourth section looks at the positive and negative influences of the school environment, the classroom and school grounds on student health and wellbeing. Key findings include:

* There is a strong relationship between bullying and achievement. In 2017, students in Years 5, 7 and 9 who reported not being bullied were more likely to achieve in the top two bands and less likely to achieve in the bottom two bands of NAPLAN Reading than their peers who reported being bullied.[[22]](#footnote-23)

The fifth section explores the relationship between school completion and post-school pathways on health and wellbeing outcomes. Key findings include:

* Victoria has high levels of school completion, with around eight out of 10 Victorians completing Year 12 or an equivalent qualification by age 19 (Productivity Commission 2018a). However, students experiencing socioeconomic disadvantage remain less likely to finish school.
* Those of higher socioeconomic status (SES) are more likely to be engaged in further education, and more likely to be engaged in a Bachelor’s Degree as opposed to an apprenticeship, certificate or diploma level qualification as compared to their lower SES peers.[[23]](#footnote-24)

## Within Victoria

The place in which a child grows up has a substantial influence on that child’s outcomes later in life. Factors such as rurality, socioeconomic conditions and the education and employment opportunities in an area can influence the opportunities and challenges that the children and families who live there encounter.

This chapter compares the outcomes of children and families living in metropolitan areas to those living in rural Victoria. It also uses the Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-Economic Disadvantage (IRSD) to compare outcomes across areas with different levels of socioeconomic disadvantage.

A comparison of outcomes for children and families in metropolitan and rural Victoria shows that they face different challenges in early childhood, in their families, in their communities as well as in relation to their education and wellbeing. Outcomes for children in rural areas are more positive across some factors when compared to outcomes for children living in metropolitan areas:

* In 2017, parents reported that children in rural areas were more likely to be enrolled in an accredited preschool or kindergarten before school (90.4 per cent compared to 87.7 per cent),[[24]](#footnote-25) and were more likely to be read to every day by a family member (75.8 per cent compared to 66.8 per cent).[[25]](#footnote-26)
* In 2016, students in rural areas reported higher levels of healthy family functioning (82 per cent compared to 79 per cent).[[26]](#footnote-27)

Conversely there are important factors where children and families from rural areas experience worse outcomes than their metropolitan counterparts:

* Children in rural areas are more likely to be exposed to tobacco in early life with a higher proportion of mothers smoking during pregnancy in 2016 (15 per cent compared to 7 per cent).[[27]](#footnote-28)
* There is a higher rate of children in rural areas with speech and language difficulties upon school entry (17.8 per cent compared to 12.7 per cent in 2017)[[28]](#footnote-29) and young people in rural areas are less likely to be enrolled in full-time secondary school at 16 years of age (82.5 per cent compared to 87.4 per cent) (PHIDU 2018c).
* Families living in rural areas are facing higher levels of family stress (11 per cent compared to 8 per cent in 2017), financial insecurity (16.2 per cent compared to 9.9 per cent in 2017) and food insecurity (9.7 per cent compared to 6.2 per cent in 2017). These families also report lower levels of access to basic services (85.6 per cent compared to 95.8 per cent).[[29]](#footnote-30)

Children and families living in areas of high disadvantage experience poorer outcomes than their more advantaged peers across a range of areas:

* Families in the most disadvantaged areas experience higher levels of financial insecurity (25.6 per cent for the most disadvantaged areas compared to 4.2 per cent for the least disadvantaged) and food insecurity (13.5 per cent compared to 2.7 per cent) and have greater reliance on government services.[[30]](#footnote-31)
* Children in disadvantaged areas are less likely to be enrolled in education services (80.4 per cent compared to 91.6 per cent) for full-time school at age 16 years (PHIDU 2018c).
* There are also higher rates of children with developmental and behavioural problems, including speech and language difficulties (15.5 per cent compared to 11.5 per cent) in disadvantaged areas.[[31]](#footnote-32)

# Introduction

Children’s Services Coordination Board annual report on health and wellbeing

Every child deserves to grow up healthy and happy. Growing up in Victoria should provide the opportunities and experiences that promote children’s health and the abilities required to flourish into adolescence and adulthood. This year’s State of Victoria’s Children report is focused on health and wellbeing because of its inherent importance and strong links to a child’s ability to fulfil their potential.

The healthy development of children is complex. It is affected by multiple interrelationships between individual and environmental factors, which can protect and promote healthy development, as well as those that increase vulnerabilities and risks of poor health outcomes. Navigating a healthy path can be difficult for children and parents alike, particularly in a period characterised by significant economic, social and technological change. However, on balance, most children in Victoria are well guided through their developmental journey. They are taught about healthy behaviours and live in supportive and nurturing environments that empower them to take advantage of life’s possibilities. They are able to draw upon personal strengths, supportive relationships and their community to deal with the ups and downs of growing up.

However, some children are less fortunate with social and economic disadvantage, particularly influential in poor health outcomes for children. This is not to say growing up in a family that experiences economic disadvantage determines a child’s future. However, children who experience challenges related to various social determinants of health, such as their family and community’s economic standing, are more likely to encounter ill health and lower levels of wellbeing than young people from more advantaged backgrounds.

The opportunities that children can take advantage of and the services they can access also affect their health and wellbeing. For example, children in regional Victoria are less able to access important and high quality services that are more readily available in metropolitan areas. Furthermore, systems established during colonisation have entrenched structural racism and have ongoing ramifications for the opportunities afforded to Aboriginal young people and their families, the services they use and their health outcomes.

While no single combination of risk and protective factors causes a child to experience poor health outcomes, there are a range of individual and environmental factors that are known to be influential. For example, factors that can strongly influence a person’s health and wellbeing include: attitudes towards nutrition and risky behaviours such as drinking and smoking; low levels of education among parents; difficulty finding and maintaining stable employment; and a safe and liveable community with access to services. As multiple types of social and economic disadvantage accumulate, particularly when coupled with community dysfunction or exposure to traumatic events, the probability of a child or young person experiencing poorer health and wellbeing outcomes increases.

This report seeks to shine a light on how Victoria’s children are faring, with an emphasis on providing a voice for those children who are most vulnerable and often overlooked by society. The report uses a broad definition of a child’s health that encompasses their physical, mental, social and emotional wellbeing, and is separated into seven chapters:

* Demographics of Victoria’s children
* A healthy start
* Families and the family environment
* Inclusive and enabling communities
* Physical and mental health
* Learning and education
* Within Victoria.

While these chapters are interrelated, each plays a significant role in children and young people’s health and wellbeing. The report will attempt to explain the importance of these factors and relationship with children’s health using measures from the Victorian Child and Adolescent Monitoring System, as well as other relevant sources. It draws on the most recent available data to provide the most comprehensive view of outcomes. Therefore, the report draws on 2017 data where possible. However, additional statistics from less frequent collections are also used where relevant. In addition, given the complexities of many issues covered in this report, it is important to give regard to societal and generational trends that have lead us up to this point. As such, data spanning differing time periods has been included for many measures in order to provide the contextual information necessary to correctly interpret the key findings presented.

# 1.0 Population demographics

## 1. 1 Number of children

Victoria has the second largest population of any Australian state or territory. The average age is 37 years. In 2017, there were nearly 1.4 million children (aged 0-17) in Victoria, an increase of more than 200,000 children or a little under 17 per cent since 2007 (ABS 2018a). Over the same period Victoria’s overall population increased by over 1,200,000 (24.4 per cent), while Australia’s population grew by over 4,000,000 (19.4 per cent). The child-aged population in Victoria is almost evenly split between males (51.3 per cent) and females (48.5 per cent).

Table 1 Victorian population, by age group, June 2007 and June 2017. Source: Australian Bureau of Statistics, Australian Demographic Statistics.

|  |  |  |
| --- | --- | --- |
| **Age group** | **Total 2007** | **Total 2017** |
| 0 to 17 years | 1,177,992 | 1,381,477 |
| 0 to 4 years | 322,116 | 407,282 |
| 5 to 9 years | 317,490 | 395,846 |
| 10 to 14 years | 332,172 | 363,262 |
| 15 to 19 years | 348,980 | 373,849 |

The table above shows that all age groups have increased in size during this current decade, with larger spikes in the number and proportion of children in the zero to four and five to nine age groups. Similarly, the largest rise in the Aboriginal child-aged population has been among these younger cohorts.

Overall, Victorian children account for around 22 per cent of the Victorian population. Victorian Aboriginal children account for just over 39 per cent of the Victorian Aboriginal population.

## 1.1.1 Number of Aboriginal children

According to the 2016 ABS Census, the Aboriginal population in Victoria makes up around 0.8 per cent of Victoria’s population but is growing much faster, and consequently has a much younger average age of 23 years (ABS 2017b). In 2016, it was estimated that there were around 18,800 Aboriginal children (aged zero to 17 years) – evenly split between males and females. That figure is up from around 13,200 in 2006 – an increase of around 42 per cent over the decade.

## 1.1.2 Disadvantaged children

The ABS’ Socio-Economic Indexes for Australia (SEIFA) are a widely used measure of relative socioeconomic advantage and disadvantage among communities across Australia. For the purposes of this report, the Index of Relative Socio-economic Disadvantage (IRSD) will be used as a standard for analysis. Generally, lower scores on the SEIFA indicate greater disadvantage in a given area, while higher scores demonstrate a reduced level of disadvantage. These indexes are measured using variables from census data, including the proportion of low income households, people with no qualifications, or people working in lower skilled occupations (ABS 2018c).

As an example, the table below shows the number of Victorian children in each age group who fall into a given quintile of socioeconomic disadvantage, by age group. The data shows that a greater number of children aged zero to four years (77,727) fell in the most disadvantaged quintile than at any other age stage, while the smallest number of children were in the most disadvantaged quintile at 10 to 14 years of age (65,434) (PHIDU 2018c).

Table 2 Usual resident population, by age group and SEIFA quintile, Victoria, 2016. Source: Public Health Information Development Unit (PHIDU), 2018c.

| **Age group** | **Q1** | **Q2** | **Q3** | **Q4** | **Q5** |
| --- | --- | --- | --- | --- | --- |
| 0-4 years | 77,727 | 75,382 | 78,859 | 73,492 | 65,400 |
| 5-9 years | 71,801 | 72,784 | 75,190 | 73,891 | 74,754 |
| 10-14 years | 65,434 | 66,119 | 66,925 | 68,513 | 73,903 |
| 15-19 years | 71,591 | 72,944 | 67,294 | 70,398 | 73,747 |
| 0-19 years | 286,553 | 287,229 | 288,268 | 286,294 | 287,804 |

The SEIFA will be explored further in the report as a standard for analysis, while Chapter 7 (Within Victoria) will explore the ways in which socioeconomic disadvantage plays out across the state.

## 1.1.3 Diverse backgrounds

Victoria has a diverse population. According to the 2016 ABS Census, 28 per cent of Victorian residents were born overseas. Of those born in Australia, more than 20 per cent had at least one parent born overseas. Around 26 per cent of Victorians speak a language other than English at home. All of these statistics have increased since the previous census in 2011. While European immigrants remain the largest overseas born group, their percentage share is decreasing. Since 2006, there has been larger growth in the number and proportion of immigrants arriving from Southeast, Southern, Central and Northeast Asia (Department of Premier and Cabinet (DPC) 2017).

The five most common non-English languages spoken in Victorian homes are Mandarin (3.2 per cent of the population), Italian (1.9 per cent of the population), Greek (1.9 per cent of the population), Vietnamese (1.7 per cent of the population) and Arabic (1.3 per cent of the population). The proportion of Victorians speaking a foreign language at home increased by 25 per cent from 2011 to 2016 (DPC 2017).

## 1.1.4 Refugee arrivals

Victoria is also home to large numbers of young refugees. In 2016-17, 1,721 young people aged 12 to 24 years were settled through Australia’s humanitarian program (Centre for Multicultural Youth (CMY) 2018). This is up from 1,048 in 2014–15 and 940 in 2015–16 (CMY 2016, 2017). In 2016–17, most of the arrivals were from Iraq and Syria. In 2015-16 these arrivals mostly came from Myanmar and Afghanistan, whereas in 2014–15 they predominately came from Myanmar, Thailand, Afghanistan and Iraq.

## 1.1.5 Disability

According to the ABS Survey of Disability, Ageing and Carers, in 2015 there were around 140,600 people with a disability under the age of 25 years in Victoria, up from 135,200 in 2012 (ABS 2016). Around 57 per cent of young Victorians (aged zero to 24 years) with a disability were male. In 2015, around 63,600 young Victorians with a disability (45 per cent) reported having a profound or severe core activity limitation and 96,700 reported having a schooling or employment restriction. DHHS reported in 2017 that Aboriginal Victorians are around 2.4 times more likely to have a disability than non-Aboriginal people (State of Victoria 2017).

In 2017, the Nationally Consistent Collection of Data on School Students with a Disability identified that 19.1 per cent of Victorian students require some level of adjustment to enable them to participate in education on the same basis as other students (Education Council 2018). Around five per cent of Victorian students or around 26 per cent of Victorian students with a disability require substantial or extensive adjustments.

In 2017, the most common disability among Victorian students was a cognitive disability, which accounted for 50 per cent of students with a disability. The second most common broad category of disability was social and emotional (29 per cent) with the third most common being physical (18 per cent).

# 2.0 A Healthy Start

The importance and lasting benefits of a healthy start on children’s health and wellbeing

## Key facts

**A healthy start is proven to have long term impacts on health and wellbeing, with investments in the early years delivering better results at a lower cost in the long term.**

Good maternal health during pregnancy is a critical first step. In Victoria, we have seen a reduction in mothers engaging in risky behaviour during pregnancy and improvements in perinatal mortality rates for Aboriginal children.

*Exposure to alcohol and tobacco can increase the risk of complications during pregnancy.*

The proportion of Victorian children from the least disadvantaged areas that are exposed to alcohol in utero (61%) is higher than the Victorian average. Fewer mothers are reporting drinking during the later stages of pregnancy – down from 34% in 2006 to 14% in 2017.

Table 3 Children exposed to alcohol in utero, Victoria, 2006 to 2017. Source: Victorian Child Health and Wellbeing Survey, 2006 to 2017.

| **Year** | **Proportion of children exposed to alcohol in utero** |
| --- | --- |
| 2006 | 65% |
| 2009 | 60% |
| 2013 | 47% |
| 2017 | 56% |

*Perinatal mortality\* is a key measure of maternal health, as it can reflect the quality of health services and exposure to risk.*

Victoria’s overall perinatal mortality rate is decreasing. Since 2010-12, the rate among Aboriginal children has more than halved.

**Table 4 Perinatal mortality rate (deaths per 1,000 births), Victoria, 2009-11 to 2014-16. Source: Victoria’s Mothers, Babies and Children Report, 2016.**

| **Triennia** | **Non-Aboriginal perinatal mortality rate\*** | **Aboriginal perinatal mortality rate\*** |
| --- | --- | --- |
| 2009-2011 | 10.2 | 21.7 |
| 2010-2012 | 9.8 | 19.4 |
| 2011-2013 | 9.7 | 17.8 |
| 2012-2014 | 9.5 | 17.2 |
| 2013-2015 | 9.4 | 13.6 |
| 2014-2016 | 9.1 | 9.0 |

*\* The perinatal mortality rate measures the rate of stillbirths and neonatal deaths (death of an infant in the first 28 days after birth)*

**Engagement with key services can contribute to better health and educational outcomes later in life. Victoria enjoys high vaccination rates and strong participation in key early childhood services, with particular improvements seen among Aboriginal children.**

*Vaccinations protect children against dangerous diseases, with a high uptake required in order to be most effective.*

While Victorian vaccination rates at 12, 24 and 60 months of age are high, statewide coverage at 24 months has fallen from 94% in 2008 to 91% in 2017 while the other age groups have increased.

**Table 5 Immunisation rates at 12 months, Victoria, 2011 to 2017. Source: Australian Immunisation Record, 2018.**

| **Year** | **Statewide** | **Aboriginal** |
| --- | --- | --- |
| 2011 | 92% | 84% |
| 2013 | 91% | 85% |
| 2015 | 92% | 87% |
| 2017 | 94% | 93% |

*Children’s participation in quality early childhood education is associated with reduced developmental vulnerability and improved educational outcomes.*

While kindergarten participation amongst Victorian children from disadvantaged areas and Aboriginal backgrounds is high, the lower quality of services in disadvantaged areas contributes to worse developmental outcomes.

**Table 6 Proportion of Victorian Prep children developmentally vulnerable on two or more domains, 2015. Source: AEDC, 2015 and DET analysis.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Kindergarten attendance** | **Statewide** | **Aboriginal** | **Most disadvantaged\*** |
| No Kinder | 25% | 35% | 38% |
| Kinder | 9% | 23% | 17% |

*\*SEIFA IRSD used as measure of disadvantage.*

## Introduction

Children actively respond to changes in their environments even in utero. Many physical and mental health challenges as well as educational difficulties faced in adult life can be traced back to a child’s early years. Therefore, a healthy start to a child’s life is very important for both early development and longer-term health and wellbeing.

The importance of the first few years of a child’s life is largely attributable to developmental plasticity, the capacity to adapt to social and physical environments, which is strongest in the earliest stages of life. From the time a child is conceived it begins reacting to its environment. After birth, the brain goes through a period of rapid development as connections are formed. This means that experiences, both positive and negative, have the ability to embed biologically, with lifelong impacts on health outcomes.

While this ability to adapt is remarkable and presents significant opportunities, it also leaves infants particularly vulnerable to adverse events. Although a child’s developmental journey is not set after infancy, the ability to adapt diminishes over time, meaning the effort required to change course increases. This underlies the importance and lasting influence that early experiences, both positive and negative, have on a child’s life.

In 2016, there were 80,549 babies born in Victoria, an increase of two per cent from 2015. In 2016, 1.5 per cent of the 79,319 women who gave birth in Victoria were under 20 years of age while 25.3 per cent were over 35. The proportion of women giving birth in Victoria via a caesarean section has increased from 15.3 per cent in 1985 to 34 per cent in 2016 (DHHS 2017d, 2017e).

This chapter considers indicators that provide insights into a mother’s health and behaviours before birth, and how this has lasting impacts on the child’s health and wellbeing. It then looks at the period after birth, specifically indicators that relate to parental behaviours associated with preparing children for a healthy life and a successful transition to school.

## 2.1 A healthy start from conception to birth

Following conception, maternal nutrition and wellbeing have an impact on the growth and development of the foetus. Thus a healthy start for a child begins with a healthy mother during pregnancy and a healthy home environment.

*Kate is a proud Wathaurong woman and was very excited about having her first baby. After confirming her pregnancy, she connected early with Sarah the Aboriginal health worker and Mary the midwife who provide the* ***Koori Maternity Service*** *at Wathaurong Aboriginal Co-operative for Kate's ongoing pregnancy care. Kate's early pregnancy progressed smoothly with regular antenatal care appointments, however during her second trimester her blood pressure began to rise. While this change required an obstetrician to join Kate's pregnancy care team, a well-established partnership between the Koori Maternity Service and Barwon Health saw Kate continue to receive her pregnancy care from Sarah and Mary, with regular review and joint case conferencing by an obstetrician from Barwon Health. This partnership and a shared commitment to culturally safe birthing, saw Mary stay with Kate when her labour began, supporting her through birth. Kate’s new son Max was welcomed to country in a placenta planting ceremony and naming day ceremony organised for all new families by the Koori Maternity Service at Wathaurong Aboriginal Co-operative.*

### 2.1.1 Infant mortality rates

Infant mortality rates capture the number of deaths of children before their first birthday per 1,000 live births in the same calendar year. The infant mortality rate is a good indicator of the overall health and wellbeing of any given population as well as a key measure of the effectiveness of the health system in maternal and perinatal health (AIHW 2017a; ABS 2012). It is used internationally as a measure of hygiene and general health conditions in the community (ABS 2012; AIHW 2017a). There are a range of economic and social factors that influence child mortality rates. Factors include maternal health, social disadvantage, joblessness, teenage pregnancy and maternal education levels (AIHW 2017a; Gracey & King 2009).

In 2016, 75 infants died in Victoria between 28 days of age and their first birthday. Nearly half (47 per cent) died due to congenital anomalies, while Sudden Infant Death Syndrome accounted for 19 per cent of deaths and prematurity a further nine per cent (DHHS 2017e). In 2016 in Victoria, the main cause of stillbirths and death of infants in their first 28 days of life was congenital anomalies and spontaneous pre-term birth (DHHS 2017e).

The infant mortality rate in Victoria trended downward between 2000 and 2016. In 2016, Victoria’s infant mortality rate per 1,000 births was 3.0, slightly better than Australia’s rate of 3.2 (DHHS 2017e). However, in the same year Australia ranked 17th among the 34 Organisation for Economic Co-operation and Development (OECD) countries (Ibid.).

Infant mortality rates are often worse among socioeconomically disadvantaged populations. Looking at data from 2007 to 2016, the mortality rate for Victorian children in the most disadvantaged communities has been consistently higher than those in the most advantaged areas. In 2007, the infant mortality rate in Victoria was 3.8 per 1,000 live births. In the highest SES areas in Victoria it was 3.7 per 1,000 and in the lowest SES areas it increased to 5.4 per 1,000. In 2016, this disparity had reduced although was still apparent, with an infant mortality rate of 3.2 deaths per 1,000 Victorian births in the most disadvantaged communities, compared to a rate of 2.1 in more advantaged areas (AIHW 2018f).

The Aboriginal infant mortality rate more than halved in Australia between 1998 and 2016, falling from 13.5 per 1,000 births to 6.0 (AIHW 2017a, AIHW 2018f). This has seen the difference between Aboriginal and non-Aboriginal rates narrow by more than 80 per cent. In Victoria, the Aboriginal infant mortality rate was 4.3 deaths per 1,000 births in 2016. This was lower than the Aboriginal rate for Australia but remains slightly higher than the non-Aboriginal rate (2.6) for Victoria and Australia (3.0) (AIHW 2018f).

The perinatal mortality rate measures the rate of stillbirths and neonatal deaths and is another key indicator of maternal and infant health. It is also a key measure of the quality of health care, including antenatal care, obstetric services and the quality of care for babies in the hospital and community (Department of Human Services (DHS) 2005).

In 2016, the adjusted perinatal mortality rate in Victoria was 8.8 per 1,000 births. Notwithstanding a peak in 2009 (10.7 deaths per 1,000 births), this figure has declined steadily since 2001. In 2016, the adjusted Victorian stillbirth rate was 6.2 per 1,000 births and the adjusted neonatal mortality rate was 2.7 per 1,000 births. Both have declined slightly since 2001 (DHHS 2017e).

Table 7 Adjusted perinatal mortality rates, per 1,000 births, by rolling triennia, Victoria, 2001-2016. Source: DHHS data - Victoria's Mothers, Babies and Children, 2016.

|  |  |  |
| --- | --- | --- |
| **Year** | **Non-Aboriginal adjusted perinatal mortality rate** | **Aboriginal adjusted perinatal mortality rate** |
| 2001-2003 | 10.0 | 23.1 |
| 2002-2004 | 9.9 | 22.0 |
| 2003-2005 | 9.9 | 18.6 |
| 2004-2006 | 9.8 | 15.6 |
| 2005-2007 | 10.2 | 16.6 |
| 2006-2008 | 10.3 | 18.0 |
| 2007-2009 | 10.4 | 21.2 |
| 2008-2010 | 10.3 | 23.6 |
| 2009-2011 | 10.2 | 21.7 |
| 2010-2012 | 9.8 | 19.4 |
| 2011-2013 | 9.7 | 17.8 |
| 2012-2014 | 9.5 | 17.2 |
| 2013-2015 | 9.4 | 13.6 |
| 2014-2016 | 9.1 | 9.0 |

While Aboriginal mothers have historically had much higher stillbirth rates and rates of neonatal deaths, this pattern has begun to change in recent years. The stillbirth rate for Aboriginal mothers in Victoria has declined from a peak of 17.1 in the 2008-10 triennia[[32]](#footnote-33) to 4.8 in the 2014-16 triennia — below the non-Aboriginal rate of 6.5 in 2014-16. The neonatal mortality rate has also fallen in recent years and in the 2014-16 triennia was reported as 4.2 for Aboriginal mothers and 2.6 for non-Aboriginal mothers. These improvements have seen the overall perinatal mortality rate for Aboriginal mothers (9.0 deaths per 1,000 births) reduce to slightly below the non-Aboriginal rate (9.1 deaths per 1,000 births) in the 2014-16 triennia (DHHS 2017e).

As noted above, premature births are one of the leading causes of infant mortality. In 2016, 8.3 per cent of babies born in Victoria were pre-term, which is defined as before 37 weeks gestation. The premature birth rate for Aboriginal women (13.2 per cent) has remained around 60 per cent higher than the non-Aboriginal rate (8.2 per cent) in recent years (DHHS 2017e).

The maternal mortality rate in Victoria from 2014-16 was 8.9 per 100,000 women who gave birth (DHHS 2017e). From 2011 to 2016, there were 68 maternal deaths (Ibid.). The most common causes of death were related to pre-existing cardiovascular disease, bleeding not related to childbirth and pre-existing mental health disorders (Ibid.). In 2016 the leading cause of maternal deaths in Victoria was suicide (discussed further in Section 3.3.3) (Ibid.). Family violence was known to be a contributing factor in three maternal deaths between 2011 and 2016 (Ibid.). Women are at increased risk of violence during pregnancy (Campo 2015). Violence during pregnancy is related to poor birth outcomes, including low birthweight and post-natal depression, as well as long-term effects on the child (discussed further in Section 3.3.4).

*The* ***Cradle to Kinder*** *and* ***Aboriginal Cradle to Kinder*** *programs are intensive ante and post-natal support service to provide longer term, intensive family support for vulnerable young mothers and their families. Cradle to Kinder and Aboriginal Cradle to Kinder provide a whole-of-family service in the form of pre-birth support, intensive and longer-term interventions and casework support, until the child reaches the age of four.*

*The program also provides intensive and specialised early parenting support to strengthen the relationship between parents and their children. This assists parents to meet the health, development, safety and wellbeing needs of their infants and young children. Further to this, it helps parents to build their own self-reliance and sustainability through access to education, vocation training and employment.*

*The service provides a combination of individual and group, centre/community and home-based interventions and supports. The service currently operates in 17 areas across Victoria.*

### 2.1.2 Birthweight

Babies who weigh below 2,500 grams at birth are considered to have a low birthweight. These babies face higher risks of death in the first year of life as well as neurological and physical disabilities (Barker 1994; Flak et al. 2014).

Table 8 Adjusted perinatal deaths and adjusted stillbirths, by birth weight, rate per 1,000 births, Victoria, 2016. Source: Department of Health and Human Services, 2017e.

| **Weight** | **Stillbirths**  **(number)** | **Stillbirths**  **(rate)** | **Perinatal deaths**  **(number)** | **Perinatal deaths**  **(rate)** |
| --- | --- | --- | --- | --- |
| <500g | 196 | 723.2 | 265 | 977.9 |
| 500-999g | 125 | 296.9 | 186 | 441.8 |
| 1,000-1,499g | 38 | 76.3 | 54 | 108.4 |
| 1,500-1,999g | 39 | 36.5 | 49 | 45.9 |
| 2,000-2,499g | 27 | 7.9 | 35 | 10.2 |
| 2,500-2,999g | 33 | 2.5 | 51 | 3.9 |
| 3,000-3,499g | 25 | 0.8 | 40 | 1.3 |
| 3,500-3,999g | 12 | 0.5 | 25 | 1.1 |
| >4,000g | <5 | 0.4 | 6 | 0.7 |
| Not known | <5 | 90.9 | <5 | 90.9 |
| Total | 501 | 6.2 | 714 | 8.8 |

Risk factors associated with giving birth to babies with a low birthweight include maternal age, multiple pregnancies, low SES, and/or living in remote or disadvantaged areas. A range of maternal health factors are also risk factors associated with low birthweight including smoking, drinking alcohol, maternal nutrition and illness during pregnancy (McCormick 1985; Horta et al. 1997; Kramer & Kakuma 2004; AIHW 2016b). An Australian study found a relationship between low birthweight and maternal stress, which was linked to a mother’s social health characteristics, such as: being less than 25 years of age; single, divorced or widowed; having less than Year 12 qualifications; earning lower than the average income; smoking during pregnancy; being underweight; and being Aboriginal (Brown et al. 2011).

In 2016, around 6.8 per cent of babies were born with a low birthweight (including very low birthweight), with 1.3 per cent born with a very low birthweight (under 1,500 grams) in Victoria. This is higher than in 1985, when 5.5 per cent of babies born had low birthweights, including 1 per cent in the very low category (DHHS 2017e).

The proportion of babies with a low birthweight born to Aboriginal mothers has decreased in recent years from 12.1 per cent in 2013 to 9.8 per cent in 2016 (DHHS 2017e). This is down from a peak, in the past 20 years, of 17.1 per cent in 2004 suggesting lasting improvements are being made (DHS 2008).

Children in OOHC are significantly more likely to have been born with a low birthweight. An OOHC outcomes survey completed by case managers revealed that 31 per cent of zero to four-year-olds in OOHC (for whom case managers knew the birthweight) were born with a low birthweight (DHHS 2017b), which is nearly five times higher than the Victorian average (7 per cent) (AIHW 2018e).

### 2.1.3 Children exposed to tobacco and alcohol in utero

Babies who are exposed to tobacco and alcohol in utero may be at risk of developmental and other problems later in life. Maternal smoking during pregnancy results in higher risks of adverse outcomes for the baby before and after delivery. These include low birthweight, premature birth, miscarriage and perinatal death, poor intra-uterine growth and Sudden Infant Death Syndrome (AIHW 2005; Chomitz et al. 1995; McCormick 1985; McDermott et al. 2002; Laws et al. 2006). Children exposed to smoking and alcohol in utero have a higher risk of disability and developmental delay, decreased lung function and increased respiratory illness (Laws et al. 2006; O’Leary 2002).

Younger mothers, Aboriginal women, women from outside Melbourne, and women from disadvantaged communities are more likely to smoke during pregnancy than their counterparts (AIHW 2017e). From 2012 to 2014, the places with highest rates of smoking during pregnancy in Victoria were Ballarat, Loddon and the Surf Coast (PHIDU 2018b).

In 2016, the smoking rate during pregnancy for Victorian mothers was 8.9 per cent, down from 11.7 per cent in 2011 (AIHW 2017e; DHHS 2017e). Around 38 per cent of Aboriginal women smoked during their pregnancy compared to 8.5 per cent of non-Aboriginal mothers.[[33]](#footnote-34)

A proportion of women who smoked during pregnancy quit before 20 weeks gestation, which was 13 per cent for Aboriginal and 27 per cent for non-Aboriginal women. The smoking cessation rate for Aboriginal mothers, defined as a relative reduction of smoking in the second half of pregnancy compared with the first half, increased from 21.1 per cent in 2015 to 25.2 per cent in 2016. This is a positive sign, however the rate remains much less than non-Aboriginal mothers (40.2 per cent) (DHHS 2017e).

Mothers in regional Victoria are more likely to smoke than those in metropolitan areas.[[34]](#footnote-35) In 2016, the smoking during pregnancy rate in regional Victoria was 14.5 per cent compared to 7.2 per cent for mothers in the metropolitan area. In 2011, the proportion of women in regional areas who smoked during pregnancy was even higher at 17.9 per cent.

Table 9 Proportion of Victorian mothers that smoked during pregnancy, 2011 and 2016. Source: Data request to the Victorian Agency for Health Information.

| **Year** | **Statewide** | **Aboriginal** | **Non-Aboriginal** | **Metro** | **Rural** | **Australian born** | **Overseas born** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 2011 | 12% | 40% | 11% | 10% | 18% | 15% | 5% |
| 2016 | 9% | 38% | 8% | 7% | 15% | 12% | 3% |

Age is also a factor in whether a woman smokes during pregnancy. In 2015, Victorian pregnant women under the age of 20 (38 per cent) were more likely to smoke compared to those aged 30 to 34 years of age (6.2 per cent), 35 to 39 years of age (5.8 per cent) and over 40 years (6.5 per cent) (AIHW 2018f). And while there have been reductions in the proportion of women in the older age brackets who smoke during pregnancy, there has been little change among the youngest age group. Mothers born in another country (3.2 per cent) were less likely to smoke than Australian born mothers (12 per cent) during pregnancy in 2016.[[35]](#footnote-36)

Drinking during pregnancy is associated with greater risk of stillbirths, low birthweights, premature births and higher risk of cognitive defects and congenital abnormality (O’Leary 2002, Single et al 1999). Foetal Alcohol Spectrum Disorder is used as a general term to describe the effect alcohol exposure can have on babies, and includes delayed development, slow growth, and behavioural disorders (National Health and Medical Research Council (NHMRC), 2009). While there is no safe level of alcohol consumption during pregnancy, the risk to an unborn baby is highest when a mother drinks frequently and at higher volumes (Better Health Channel 2016).

The Victorian Child Health and Wellbeing Survey (VCHWS) asks mothers with children under the age of one if they drank during pregnancy. In 2017, it was reported that 56.2 per cent of children were exposed to alcohol in utero. While this represented a 10 percentage point increase on the 2013 result, rates of drinking during pregnancy have followed a declining trend since 2006.

Table 10 Proportion of Victorian children under the age of one exposed to alcohol in utero, 2006 to 2017. Source: Victorian Child Health and Wellbeing Survey, 2006-2017.

| **Year** | **Proportion of children exposed to alcohol in-utero** |
| --- | --- |
| 2006 | 64.8% |
| 2009 | 59.7% |
| 2013 | 46.7% |
| 2017 | 56.2% |

Looking at the characteristics of mothers drinking during pregnancy provides interesting insights into the behaviour. Interestingly, this indicator does not follow the same social gradient as others. A higher proportion of children from the least disadvantaged areas are exposed to alcohol in utero. This is a consistent trend. Single mothers are also less likely to drink than those in couples, as are mothers on a Health Care Card compared to those who are not.[[36]](#footnote-37)

The majority of mothers drinking during pregnancy do so in the earliest stages of pregnancy, prior to finding out they are pregnant. In 2017, only 14 per cent of mothers drank towards the end of their pregnancy, which was a significant reduction on the 33.9 per cent in 2006. In 2017, 49 per cent of mothers who drank during pregnancy reported at least one occasion of binge drinking, this almost exclusively occurred prior to finding out about their pregnancy. While any drinking during pregnancy is not recommended, the reduction in drinking after finding out about the pregnancy is a positive shift.[[37]](#footnote-38)

## 2.2 A healthy start – preparing infants for a happy and healthy life

This section looks at the period after birth and indicators that are associated with stronger health outcomes and improved development including: breastfeeding rates among Victorian mothers; vaccinations rates of young children; engagement with MCH services; and the importance of participation in early childhood education.

*The* ***Inner Gippsland Children and Youth Area Partnership*** *(IGCYAP) is working with local organisations, industry experts and community members with lived experience to ensure all children thrive in their first 1000 days (conception to age two). Their target is that by 2030 all children in Inner Gippsland will have the best opportunity to be developmentally on track when they start school and for every subsequent life milestone into adulthood.*

*As part of work to achieve this, the IGCYAP has co-designed three place-based innovation projects with local communities. These aim to develop fresh approaches to support parents in creating an environment where their children can thrive. One of these, The Journey, aims to support Aboriginal children and their families to develop a strong and resilient connection to community and culture.*

*The team for The Journey project includes three local Aboriginal women from Inner Gippsland who have roles with Anglicare Victoria, Latrobe City Council and the Department of Education and Training (DET). The team easily adopted the co-design approach of working holistically with the whole community, noting that it was reflective of their own community’s way of working.*

*Through the co-design process, The Journey team learned more about the challenges for their community, the things that were showing promise, and of the incredible local Aboriginal leaders who care deeply for the communities’ children. The team also learned that in order to really understand the issues families experienced, they needed to look at the history of each individual, their family and the community, so as to understand the impact of trauma on their lives.*

*Engagement with young Aboriginal parents and Aboriginal Elders was fundamental to the co-design process. A series of yarns with local Elders were held to develop ideas. Through this engagement and the use of local data, the team developed The Journey – a family tree activity, a children’s book and a Welcome to Country ceremony to connect families to their mob and Elders.*

*One of the participants said, ‘We are seriously kicking goals together. Not only are we supportive of one another, but we continue to push one another to reach our full potential. It’s inspiring.’*

*The Journey project received funding through the Latrobe Health Innovation Fund to further develop and test the prototypes, and to implement the new approach. This will include ongoing engagement with the local Aboriginal community and Elders.*

### 2.2.1 Breastfeeding rates

Breast milk provides babies with the best possible nutrition to support growth and development. Not only can breastfeeding enhance the bond between mother and baby, it also protects babies from many common acute conditions and chronic diseases, including gastrointestinal illness, respiratory tract infections and middle ear infections (Duijts et al. 2009; Eidelman 2012). It also reduces the risk of breast and ovarian cancers for mothers (Better Health Channel 2018b). Compared to infants who are fed with formula, being breastfed is associated with a reduced risk of becoming obese in childhood, and in later life. The national guidelines recommend children are exclusively breastfed until around six months of age when solid foods are introduced and continued along with solids until 12 months of age or for as long as the mother and child desire (NHMRC 2012).

Victoria’s data on breastfeeding rates provides some interesting insights. In 2014-15, around 51.4 per cent of babies were exclusively breastfed at three months of age while a further 13.1 per cent were at least partially breastfed[[38]](#footnote-39). However, this means 35.5 per cent of babies are not being breastfed at three months of age.[[39]](#footnote-40)

Beyond three months of age, exclusive breastfeeding rates drop from around half to a little over a third at six months of age. In 2014-15, 34 per cent of infants were reportedly exclusively breastfed at six months of age in Victoria, while 15.6 per cent of infants were partially breastfed. While the rates of babies exclusively breastfed at both three months and six months of age had remained fairly stable for the preceding four years, the partially breastfed rate at both three and six months of age increased over this time by 2.7 percentage points and 4.5 percentage points respectively. In 2014-15, only 49.6 per cent of Victorian children were breastfed at all, exclusively or partially, at six months of age.[[40]](#footnote-41)

Table 11 Proportion of Victorian infants that were exclusively or partially breastfed at 3 and 6 months, 2010-11 to 2014-15. Source: Maternal and Child Health data, Department of Education and Training.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year** | **Partially**  **(3 months)** | **Exclusively**  **(3 months)** | **Partially**  **(6 months)** | **Exclusively**  **(6 months)** |
| 2010-11 | 10.4% | 51.8% | 11.1% | 35.7% |
| 2011-12 | 11.4% | 51.7% | 13.0% | 34.8% |
| 2012-13 | 12.1% | 51.0% | 14.2% | 33.8% |
| 2013-14 | 12.7% | 50.6% | 14.6% | 33.9% |
| 2014-15 | 13.1% | 51.4% | 15.6% | 34.0% |

The breastfeeding rates for children from disadvantaged backgrounds are generally lower than for more advantaged Victorian children. From 2010-11 to 2014-15 the proportion of children from disadvantaged families being partially breastfed at three months of age increased to 13.6 per cent, slightly above the statewide figure. The proportion of children from socioeconomically disadvantaged families being fully breastfed at three months of age was 44.1 per cent in 2014-15, up 1.5 percentage points since 2010-11. In 2014-15, only 57.7 per cent of socioeconomically disadvantaged children in Victoria were breastfed at all, partially or exclusively, at three months of age.[[41]](#footnote-42)

Over the same period, the proportion of children from disadvantaged backgrounds who were partially breastfed at six months of age increased from 10.3 per cent to 17.6 per cent. However, the proportion exclusively breastfed at six months of age fell from 28.4 per cent to 23.9 per cent. In 2014-15, 41.5 per cent of socioeconomically disadvantaged children in Victoria were breastfed at all, partially or exclusively, at six months of age.[[42]](#footnote-43)

Table 12 Proportion of Victorian infants from a low SES background that were exclusively or partially breastfed at 3 and 6 months, 2010-11 to 2014-15. Source: Maternal and Child Health data, Department of Education and Training.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year** | **Partially**  **(3 months)** | **Exclusively**  **(3 months)** | **Partially**  **(6 months)** | **Exclusively**  **(6 months)** |
| 2010-11 | 10.6% | 42.6% | 10.3% | 28.4% |
| 2011-12 | 13.2% | 42.0% | 13.0% | 26.3% |
| 2012-13 | 12.8% | 41.6% | 13.5% | 26.3% |
| 2013-14 | 12.8% | 41.3% | 16.7% | 23.0% |
| 2014-15 | 13.6% | 44.1% | 17.6% | 23.9% |

### 2.2.2 Immunisation rates

Vaccines protect children from consequences of serious illness and complications from vaccine-preventable diseases. Vaccinations are one of the most important advancements in health technology and have led to large reductions (and in some cases eradication of) illnesses and diseases, such as polio, which previously had lifelong negative impacts on children’s health and wellbeing. As recently as the 1950s children died from diseases such as tetanus and diphtheria, which are now preventable thanks to vaccinations.

Immunisations protect Victorian children against a range of dangerous diseases, including whooping cough, measles, hepatitis, diphtheria, pneumococcal, mumps, rubella, rotavirus, pertussis, tetanus, varicella and meningococcal.

Vaccines protect both those individuals who receive the vaccination, and vulnerable people in the broader community who are too young or sick to be immunised against certain diseases. These vulnerable individuals can be protected through a process known as herd immunity, that is, when enough people in the community have been vaccinated against any given disease. To prevent the spread of many diseases and achieve this immunity, around 90 per cent of a population needs to be vaccinated. However, some diseases are more infectious and as such require a higher threshold of immunisation. For example, to prevent measles from spreading in a community, around 95 per cent of any given population must be vaccinated.

There has been an overall increase in the proportion of Victorian children being immunised. In 2017, more than 90 per cent of children aged 12, 24 and 60 months of age were fully immunised in Victoria. The 60-month immunisation coverage rate was 94.5 per cent in 2017, rising from 83.1 per cent coverage in 2008. Although there has been a drop in the proportion of children being fully vaccinated at 24 months of age, the rate remains high, sitting at 91.2 per cent in 2017.[[43]](#footnote-44)

Immunisation rates for Victorian Aboriginal children have followed a similar, although more pronounced, pattern of change. The proportion of Aboriginal children who were fully vaccinated at 12 months of age in 2017 was 93.1 per cent, up from 85.7 per cent in 2008. The proportion of Aboriginal children fully vaccinated at 60 months of age has also increased, from 78.9 per cent in 2008 to 94.7 per cent in 2017. However, there was a reduction in the proportion of Aboriginal children who were fully immunised at 24 months of age during that period, although it remains relatively high at 89.2 per cent.[[44]](#footnote-45)

Immunisation rates amongst Victorian children in OOHC are high with case managers reporting that 99 per cent of children were vaccinated at 12 to 15 months, 97 per cent at 24 to 27 months and 100 per cent at 60 to 63 months (DHHS 2017b).

*Although Victoria’s overall childhood immunisation coverage is high, there are geographic pockets with much lower rates. The No Jab No Play legislation was introduced to boost vaccination rates further across the state and protect the whole community.*

***No Jab No Play*** *commenced on 1 January 2016, requiring children to be immunised before they can enrol in early childhood services, unless they have a medical exemption. The law is designed to provide parents/carers with a reminder point and additional motivation to keep their children’s vaccinations up to date.*

*At the same time the Commonwealth Government introduced No Jab No Pay. This policy meant that parents were required to have their children immunised, regardless of conscientious objections, in order to receive child care and family benefits.*

*While it is difficult to separate out the effect of No Jab No Play, and the Australian Government’s No Jab No Pay, immunisation rates for the one, two and five-year-old cohorts for Victoria have increased since No Jab No Play commenced.*

*Victoria now has its best immunisation coverage in history.*

### 2.2.3 Accessing and engaging Maternal and Child Health services

*Digital technology is rapidly changing how Victorians seek information, and young families in particular prefer to find information online using smartphones. Developed in consultation with families, the* ***MCH app*** *provides convenient access to reliable, evidence-based knowledge from Victoria’s MCH service.*

*The free smartphone app includes topics matched to each child’s age - such as feeding, sleeping and managing those critical ‘first weeks’ for new families. Plus, there are contact lists, reminders about upcoming MCH consultations, and an interactive search feature with Nora, the digital assistant.*

*Feedback from families on social media has been enthusiastic:*

*“Very simple and user friendly”*

*“Looks really great”*

*“Great idea! Love that it is customised to the age of baby”*

*The MCH app has grown to 25,000 downloads in the first few months since launching in March 2018.*

MCH services monitor Victorian children’s health and development between birth and six years of age. Regular engagement with these services is strongly encouraged to minimise preventable developmental and behavioural issues, as well as to increase the probability of early diagnosis and treatment of conditions affecting a child’s wellbeing. These services can also provide counselling or, where needed, refer families on to another more appropriate professional.

There are 10 key ages and stages (KAS) visits provided through the MCH service. These begin at birth and become progressively less frequent as a child gets older with the last one occurring at three-and-a-half years. The pattern across Victoria in terms of attendance at these visits has not changed in recent years. While around 100 per cent of children enrolled in a MCH service receive the first home consultation, this progressively declines as children grow older. In 2016-17, around 62.9 per cent of children attended their three and-a-half year visit. The largest falls in participation occur between the four and eight month visits (93.8 per cent to 84.3 per cent in 2016-17) and between the 12 and 18 month visits (81.9 per cent to 71.0 per cent in 2016-17). While some reduction is to be expected, addressing the magnitude of the decline in participation could improve the health and wellbeing of children. Evidence indicates that some families are less likely to attend MCH services than others, including those who are Health Care Card holders, Aboriginal families, one-parent families and those in which parental education is low.[[45]](#footnote-46)

The same pattern of participation in the KAS visits is observed for Aboriginal children. While there was 99.3 per cent participation at the home consultation in 2016-17, only 56.4 per cent of Aboriginal children attended the three-and-a-half-year consultation. However, in contrast to the statewide trend, participation has been improving for Aboriginal children at the later visits. Since 2006-07 participation at all of the KAS consultations has improved between 10 and 19 percentage points. While participation rates remain lower than for non-Aboriginal children, this is a promising trend.[[46]](#footnote-47)

Table 13 Aboriginal participation in MCH services, Victoria, by KAS visit, 2006-07 and 2016-17. Source: Maternal and Child Health data, Department of Education and Training.

| **Year** | **Home consult** | **2 weeks** | **4 weeks** | **8 weeks** | **4 months** | **8 months** | **12 months** | **18 months** | **2 years** | **3.5 years** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2006-07 | 88% | 80% | 77% | 77% | 69% | 59% | 55% | 44% | 44% | 37% |
| 2016-17 | 99% | 91% | 89% | 89% | 85% | 71% | 70% | 61% | 57% | 56% |

*As part of the Roadmap for Reform: Strong Families, Safe Children, funding of $1.6 million over two years was provided to work with Aboriginal communities to co-design a MCH service model to deliver culturally responsive and high-quality MCH services for Aboriginal families.*

*The co-design process resulted in a development of the* ***Aboriginal MCH Initiative*** *Service Model, governed by five service principles across three delivery settings, articulating flexible, responsive, accessible and culturally safe service provision.*

*The service model is currently being trialled at nine sites across Victoria, including at Aboriginal Community Controlled Organisations (ACCOs), local governments, and through integrated partnerships between local government and ACCOs.*

MCH nurses can also refer children formally to another medical professional to address an identified concern. In 2016-17 the most common reason for referral was Developmental Dysplasia of the Hip (DDH), followed by concerns relating to development, potentially disabling conditions and communication. Referrals for DDH increased significantly — from 1,246 in 2000-2001 to 9,980 in 2014-15 — before decreasing to 6,538 in 2016-17. Referrals relating to development more than doubled between 2000 and 2015 — from 4,090 to 9,194 — before declining to 5,748 in 2016-17. Referrals related to auditory issues, congenital anomalies, illness and nutrition have decreased significantly since 2000-01.[[47]](#footnote-48) The increase in referrals for DDH is related to a one-off initiative in the 2007 Victorian State Budget to improve information and training for MCH practitioners in relation to the management of congenital dysplasia of the hips. The subsequent drop in referrals may be attributable to a change in data systems and issues with data collection.

*Victoria’s* ***MCH service*** *is a universal service available for all families with children from birth to school age, supporting health, development and parenting. The* ***Enhanced MCH program*** *is offered to selected families as an extension of the Universal program, providing flexible actions and interventions to families who would benefit from targeted support.*

*Young mother Gillian lived with her partner Matt and two-week-old baby James. Gillian was exhausted physically and mentally and exhibited a degree of confusion, anxiety and fear. Gillian was wary of her referral to a MCH service. Matt had health issues that had affected his employment and limited his ability to assist around the house or with the baby. There were no supports for the couple. The couple apologised for the state of the house. Gillian stated: “I am too tired to do anything as I have two people to look after.”*

*Baby James was quietly sleeping in a bassinette. The MCH nurse, using a strength-based approach, encouraged Gillian around her decision to breastfeed and the great care of her baby to date. Matt and Gillian talked happily about their baby. Gillian ceased to be fearful when made aware in a non-judgemental manner that the MCH service was available to offer support, evidence-based information around the development of her baby, and referral to organisations such as Child First to help with housing and financial advice. Gillian was excited about meeting other young mothers through a ‘Starting out supported playgroup’. Matt and Gillian were happy to accept assistance from the MCH service and a referral for further support to the Enhanced MCH program.*

### 2.2.4 Early childhood education

Another key service that supports healthy development is kindergarten. In Victoria, kindergarten is not compulsory but is available for one or two years before primary school. Participating in early childhood education fosters early cognitive and social development and provides families with networks and support to give children the best possible preparation for schooling. Children who attend kindergarten are less likely to be vulnerable at school entry, are more likely to perform at a higher level academically at school and reach higher levels of academic achievement (OECD 2017). Longitudinal research shows that these benefits often carry into adulthood in the form of improved employment outcomes, higher earnings, improved health outcomes as well as reduced crime and incarceration rates (Schweinhart 2013; Conti et al 2016).

There is a large body of evidence that shows the positive impact that attendance at kindergarten has on children’s development. A study by the University of Melbourne found, after controlling for a rich set of socio-demographic characteristics, that there was a significant positive association between attendance at preschool in the year before school and improvements in Year 3 NAPLAN achievement (particularly in the domains of Numeracy, Reading and Spelling) (Warren & Hasiken-DeNew 2013). Looking at the NAPLAN results of Year 3 students who had attended kindergarten in their year before school, they were 15 to 20 weeks more advanced than their peers who did not attend a kindergarten program.

The Australian Early Development Census (AEDC) is run every three years and asks teachers to answer questions about children in their first year of school. Children are assessed across physical health and wellbeing, social competence, emotional maturity, language and cognitive skills and communication skills/general knowledge. In 2015, one in five Victorian Prep students was identified by their teacher as having a developmental vulnerability on one or more of the five domains. Children assessed as vulnerable on one of the AEDC domains are around half as likely to achieve in the top two NAPLAN Reading bands in Year 3, and even less likely in Year 5.

Analysis conducted by DET in 2015 used the AEDC to highlight the positive relationship between kindergarten and healthy development. The analysis showed that around nine per cent of children who attended kindergarten were developmentally vulnerable on two or more domains at school entry. In contrast, 25.1 per cent of children who had not attended kindergarten were developmentally vulnerable on two or more domains. This increased developmental vulnerability of those who did not attend kindergarten is also evident across population groups, including Aboriginal children, those from a Language background other than English (LBOTE) or the most socioeconomically disadvantaged areas of Victoria.

Table 14 Proportion of Victorian children developmentally vulnerable on two or more AEDC domains, 2015, by kindergarten attendance.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Kindergarten attendance** | **Statewide** | **Aboriginal** | **Most dis-advantaged** | **Language background other than English** |
| No Kinder | 25.1% | 34.5% | 37.5% | 30.3% |
| Kinder | 8.8% | 22.8% | 16.5% | 11.9% |

This analysis clearly shows the importance of kindergarten for reducing developmental vulnerability. It also highlights the importance of Victoria having a high proportion of children enrolled in a preschool program in the year before school. In 2017, 93.4 per cent of Victorian children were enrolled in a kindergarten program in the year before school.

The participation rate for Aboriginal children has increased during the past decade. In 2017, 94 per cent of Aboriginal children were enrolled in a kindergarten program in the year before school, up from 59 per cent in 2007. In addition, case managers reported that 70 per cent of children under five years of age in OOHC in Victoria in 2016 attended a government-approved kindergarten or early childhood education and care (ECEC) service (DHHS 2017b). This is vitally important given research that shows that the positive impact of kindergarten is most pronounced for children experiencing disadvantage (Fox & Geddes 2016).

*There are two notable initiatives that aim to fund an additional year of kindergarten for vulnerable three-year-old children. These programs recognise the value of an extra year of kindergarten provided by a qualified educator for children more likely to face developmental challenges or at greater risk of developmental delay.*

*The* ***Early Start Kindergarten (ESK)*** *grants provide free access or low cost kindergarten to three-year-old Aboriginal children and children known to child protection. The* ***Access to Early Learning (AEL)*** *program is also designed to provide three-year-old children with access to kindergarten, and includes Aboriginal children, children known to child protection as well as other children with defined complex needs.*

*These initiatives have seen increasing numbers of vulnerable children participating in an extra year of kindergarten. Through the ESK and AEL programs, around 57 per cent of three-year-old Aboriginal children were enrolled in a kindergarten program with a qualified educator* — *up from 38.2 per cent in 2014. In 2017, there were a total of 1,667 ESK and AEL enrolments (1,529 and 138 respectively). Based on data collected by service providers, the average attendance rate for ESK and AEL children combined was 73 per cent in 2017* — *around the same level as the previous three years. Children supported through AEL continued to attend at a higher rate of 81 per cent.*

Another important piece of the picture is the quality of services. The quality of kindergarten programs is central to improving outcomes for children with research showing this is critical to their impact on improving outcomes for children. Children who participate in high-quality ECEC settings generally perform better academically than their peers, with socially disadvantaged children showing the most benefits (AIHW 2015b).

The Effective Early Education Experiences for Kids study (Tayler et al. 2016) tracked the outcomes of 2,500 children living in Victoria and Queensland. Key findings were:

* teacher-child engagement in early childhood programs is key, particularly for children living with a range of risk factors
* most early childhood services’ instructional quality was below the level required to positively shift children’s learning trajectories
* a positive home learning environment is key
* early childhood centres in disadvantaged areas rated consistently lower than advantaged areas in the level of teaching and learning support provided.

The National Quality Standards (NQS) are part of a national framework that aims to improve the quality of ECEC. The NQS set benchmarks for quality in seven areas that are demonstrably important to the quality of services. The proportion of services below and above the standards has been improving in recent years. In 2017, Victorian services assessed under the framework were rated as exceeding standards (34.2 per cent); meeting standards (49.6 per cent); and working towards the standards (16.2 per cent). Compared to other states and territories, Victoria has a high proportion of quality services. At the end of 2017, Victoria had the fourth highest percentage of services exceeding the standards, the highest proportion meeting the standards and the lowest working towards the standards (Australian Children's Education & Care Quality Authority (ACECQA) 2018).

Across Victoria, services in more disadvantaged communities were found to be of comparatively lower quality. While 83.8 per cent of ECEC services across Victoria met or exceeded NQS in 2017, only 78.9 per cent of services in the most disadvantaged communities met or exceeded those standards (ACECQA 2018, unpublished data). This difference was also evident in the measure that assesses the quality of the educational program and practices within ECEC services. In 2017, there were 88.8 per cent of services across the state that met or exceeded the educational program and practice quality standard. However, this figure dropped to 83.3 per cent among the most socially disadvantaged communities in Victoria, and has fallen since 2014 (86.4 per cent) (ACECQA 2018, unpublished data).

# 3.0 Families and the family environment

Relationships between families and children’s health and wellbeing

## Key facts

**Quality parenting and a nurturing family environment has a profound impact on children’s health and wellbeing, providing them with positive role models and a secure start to life.**

The financial security of families has a significant influence on the family environment and children’s wellbeing. In 2016, more than a third of Victorian children from single-parent families lived in jobless households, compared to only 5% of children from couple-parent families.

*Food insecurity\* can cause distress and often causes families to rely on unhealthy low-cost foods which has ramifications for children’s health.*

While the proportion of Victorian children experiencing food insecurity increased from 6% in 2006 to 7% in 2017, the increase has been larger amongst children in disadvantaged areas.

**Table 15 Victorian children (aged 0-12 years) from households with food insecurity\*, by SEIFA quintile, Victoria. Source: Victorian Child Health and Wellbeing Survey, 2009 to 2017.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Quintile 1 (most disadvantaged)** | **Quintile 2** | **Quintile 3** | **Quintile 4** | **Quintile 5 (least disadvantaged)** |
| 2009 | 8.6% | 5.9% | 5.1% | 4.7% | 1.8% |
| 2013 | 9.6% | 6.6% | 6.3% | 4.3% | 2.3% |
| 2017 | 13.5% | 9.0% | 9.2% | 6.4% | 2.7% |

*\*Food insecurity is defined here as running out of food and not being able to afford more.*

*Housing stress\* places significant pressure on family budgets and makes it difficult to provide for children’s other needs.*

From 2001 to 2016, the proportion of Victorian children (aged 0-14 years) in households experiencing housing stress increased from 13% to 21%.

**Table 16 Proportion of Victorian children (aged 0-14 years) living in households with housing stress, 2001 to 2016. Source: Australian Institute of Health and Welfare, 2018.**

| **Year** | **Single parent family** | **Lowest SES areas** |
| --- | --- | --- |
| 2001 | 32.9% | 16.7% |
| 2006 | 43.8% | 26.0% |
| 2011 | 50.6% | 30.2% |
| 2016 | 50.0% | 28.8% |

*\*Housing stress is defined as households spending more than 30% of their gross income on housing.*

While four in five Victorian families enjoy good family functioning, for the families that don’t, the impacts on children can be grave. Family violence, child abuse and neglect, can have lasting impacts on children’s health and academic outcomes.

*Exposure to family violence can have devastating impacts on children and young people, and is associated with lower academic achievement.*

Instances of family violence in Victoria have risen to more than 76,000 in 2016-17 with a child present in nearly 32% of cases.

**Table 17 Victorian students achieving in the top two NAPLAN bands in Year 3 in 2017 versus SEHQ responses in 2014. Source: School Entrant Health Questionnaire, 2014 & NAPLAN, 2017.**

| **NAPLAN domain** | **Abuse to child** | **No abuse** | **Child witnessed violence** | **No violence witnessed** |
| --- | --- | --- | --- | --- |
| Reading | 43.2% | 57.5% | 41.8% | 57.8% |
| Numeracy | 36.8% | 47.9% | 32.1% | 48.3% |

*Child abuse is debilitating for children and young people, with severe long-term consequences on health and wellbeing.*

Substantiations of child abuse or neglect have risen sharply, with these children more likely to face challenges like homelessness, mental health issues and family violence.

**Table 18 Children subject to a child abuse or neglect substantiation, by Aboriginal status, Victoria, 2009-10 to 2016-17. Source: Australian Institute of Health and Welfare, 2009-2017.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Statewide** | **Aboriginal** | **Non-Aboriginal** |
| 2009-10 | 6,403 | 710 | 5,690 |
| 2011-12 | 8,741 | 963 | 7,778 |
| 2014-15 | 13,300 | 1,415 | 11,880 |
| 2016-17 | 15,488 | 1,858 | 13,625 |

## Introduction

The environment in which children grow up has a profound influence on their development, life choices, beliefs and ultimately health and wellbeing. Perhaps the most important environmental factors relate to our families. Families can provide protective resources, for example through warm and nurturing relationships, to draw upon during challenging periods. Conversely, they can increase the risk related to negative developmental outcomes due to things such as harsh and inconsistent parenting, exposure to family violence, promoting unhealthy behaviours and the effects of living in poverty.

This chapter will look at some of the factors in the family environment that impact a child’s health and wellbeing. This includes: common family types in Victoria; the most influential social determinants of health; access to housing; levels of parental education; and the home environment

## 3.1 Household composition

In 2016, there were 586,463 families with dependent children under 15 years of age in Victoria. Around 18 per cent, or 107,499, of those families were single-head households, with around 85 per cent parented by females (PHIDU 2018b; ABS 2017e).

Victoria has a smaller proportion of single-parent/guardian families with dependent children under 15 years of age than all states and territories (except the Australian Capital Territory) at 18 per cent. However, outside of Greater Melbourne (metropolitan Melbourne and Geelong) 24 per cent of families with dependent children under 15 years of age were single-parent households. The highest proportions of single-parent families in Victoria were found in the Central Goldfields, Latrobe and Benalla at a touch over 30 per cent (PHIDU 2018b). In 2006, 20 per cent of families with children under 15 years of age were single-parent households (PHIDU 2011).

A much larger proportion of Victorian Aboriginal families are headed by single-parents. In 2016, almost 47 per cent of Aboriginal families with dependent children under 15 years of age were single-head households, this figure rose to over 50 per cent outside of Melbourne (PHIDU 2018a). This is a little less than in 2006 when almost 51 per cent of Aboriginal families with dependent children under 15 years of age were single-head households (PHIDU 2011).

The most important familial factors relate to parenting style and providing a positive home environment. Family type is another factor to consider — for example, compared with other family types, one-parent families are more likely to face greater financial stress and increased disadvantage in relation to housing, employment and social participation (ABS 2007). As will be discussed in following sections, these factors are often linked to greater risk of poor health and wellbeing outcomes.

## 3.2 Family economics, parental education and a child’s wellbeing

There is evidence that the social and economic conditions which we are born into and grow up in have a profound impact on our health. People with greater social and economic capital are generally more likely to experience better health outcomes. This is due to a range of factors including parental education, income, employment and housing. These factors impact health and wellbeing in a range of ways including through social connection, access to services, knowledge about behaviours and intergenerational effects related to education, income and employment. Using longitudinal data from the Household, Income and Labour Dynamics in Australia (HILDA) survey, the National Centre for Social and Economic Modelling (NATSEM) found health is affected by household income, education levels, employment, housing tenure and social connectedness (Brown & Nepal 2010). NATSEM found that people who are most socioeconomically disadvantaged are twice as likely to have a long-term health problem as people who experience the least disadvantage.

### 3.2.1 Parental education

Parental education is important for a variety of reasons, not least because increased levels of educational attainment are associated with higher paying employment opportunities. Education has also been linked to health outcomes. For example, evidence suggests that lower levels of literacy are associated with less knowledge about health and healthy behaviours. There is also an intergenerational effect related to parental education. A Productivity Commission report shows that educational differences tend to continue across generations which reduce social mobility (McLachlan et al. 2013). While the gap in attainment can be partially attributed to differences that emanate in the early years of life and grow during school years, studies suggest that low levels of parental education can increase the probability that parents and children will place less emphasis on schooling or have fewer educational aspirations (PHIDU 2016a; McLachlan et al. 2013).

Over the past eight years, Victorian children attending government schools have increasingly been living in more educated households. The proportion of these children living with a caregiver that has at least a bachelor’s degree has increased from 24 per cent in 2009 to 37 per cent in 2017. The proportion of children living with parents whose highest level of educational attainment is below Year 12 has decreased from 20 per cent in 2009 to 12 per cent in 2017. However, there is a large difference between the educational attainment in single-parent and couple families. A quarter of children in single-parent families attending government schools are living with a guardian whose highest level of education is below Year 12. This is in contrast to eight per cent of children living with two parents where the highest level of educational attainment is below Year 12 or an equivalent qualification.[[48]](#footnote-49)

Table 19 Proportion of government school children, by parental educational attainment, Victoria, 2017. Source: Department of Education and Training data.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Family type** | **Bachelor Degree** | **Advanced Diploma** | **Certificate I to IV** | **Year 12 or Equivalent** | **Year 11 or below** |
| Statewide | 37% | 16% | 27% | 8% | 12% |
| Couple parent | 43% | 16% | 25% | 7% | 8% |
| Single parent | 17% | 15% | 33% | 10% | 24% |

Given the vast majority of single-parent Victorian households with dependent children are headed up by women (85 per cent), it is particularly important to understand maternal education levels (ABS 2017e). In 2016, around 13 per cent of children in Victoria lived in families (single-parent or couple-parent) where their female caregiver’s highest level of education was Year 10 or below. This compares to around 17 per cent of all Australian children (PHIDU 2018b).

### 3.2.2 Households’ employment

Employment has a range of benefits for children and families. Working parents are better able to provide for all of the necessities that many Victorians take for granted, such as food, housing and clothing. This is in addition to other non-essential items that enrich children’s lives such as toys and recreational activities. Work also provides people with purpose, can improve mental health and aid greater social connection. Employment is also a good measure of skill level in the community, with participation in the labour market increasing with education levels. This all has benefits for children’s immediate and long-term health and wellbeing.

Most Victorian children live with parents who are employed. In 2017, more than 94 per cent of two-parent households with dependent children under 15 years of age had a job, stable since 2013. This compared to 56 per cent of single-parent households with dependent children under 15 years of age, up from 54 per cent in 2013. Only 27 per cent of parents in single-head households were employed full-time in 2017, up from 26 per cent in 2013. This compared to 87 per cent of couple-parent families that had at least one parent working full-time, up from 86 per cent in 2013. While only six per cent of couple-parent households were jobless, more than 40 per cent of Victorian single-parents with dependent children under 15 years of age were unemployed or not in the labour force (ABS 2017e).

*The Victorian Government developed* ***Jobs Victoria*** *in late 2016 to assist Victorians who face difficulties in finding work and are either long-term unemployed or at risk of long-term unemployment. Jobs Victoria provides tailored support to jobseekers most in need and is better coordinating Victorian Government employment services to make it easier to access the right support at the right time. The main Jobs Victoria program is the Jobs Victoria Employment Network that has now supported almost 5,000 long-term job seekers into employment via 51 specialist employment services. This includes over 300 single-parents and 1,500 young people who have been assisted into work. Complementing this network of Jobs Victoria partners, the Victorian Government also has a number of bespoke programs with specialist services for young people. For example, the Youth Employment Scheme offers 280 annual traineeships with the Victorian Public Sector to young Victorians aged 15 to 24.*

Jobless households face much greater financial stress, social isolation and risk of experiencing poverty. This creates instability in the family environment, which is shown to have wider impacts on health and wellbeing. Research suggests that economic disadvantage increases the risk of poor health outcomes and reduced opportunities to partake in social activities, which may cause greater isolation and in turn negatively impact wellbeing (ABS 2010). One study of jobless households in communities with high levels of disadvantage and unemployment, found children who lacked role models in terms of employment were negatively impacted in their job prospects and transition to work (Hand et al. 2011). Another study that looked at families receiving intensive income support found children in these families were less likely to be studying or attending university and were more likely to exhibit risky health behaviours (such as smoking and/or drinking), take social risks (including run away and/or have contact with police) and experience poor health (for example asthma and/or depression) (McLachlan et al. 2013).

Other studies have found that children living in jobless households have poorer social-emotional wellbeing and educational outcomes (Gray & Baxter 2012; Gray, Taylor & Edwards 2011). The Longitudinal Study of Australian Children (LSAC) found that the effects of joblessness on social and emotional wellbeing increases with a stepwise pattern across generations. For one cohort of children studied, 17 per cent of children had social and emotional problems where maternal grandparents had been jobless, 24 per cent where parents (but not grandparents) had been jobless, and 33 per cent where both grandparents and parents had both been jobless. Among children without a family history of joblessness, 13 per cent had a social-emotional problem (Hancock et al. 2012).

In 2016 there were around 278,539 jobless families with children under 15 years of age in Australia, which accounted for around 12 per cent of all families. These families cared for around 503,293 children or around 12 per cent of all children. (PHIDU 2018b)

In Victoria in 2016, 11 per cent of families with children under 15 years of age, or 64,429 families, did not have a job. Around 11 per cent of children under 15 years of age, or 114,194 children, were living in jobless families. Outside of Melbourne and Geelong around 12 per cent of children were living in jobless households (PHIDU 2018b). In 2006, 14 per cent of families with children under 15 years of age, or 69,759 families, did not have a job. That equated to around 124,300 children living in jobless families, around 10,000 more than a decade later (PHIDU 2010).

In 2016, there were 3,269 Aboriginal families with children under 15 years of age in Victoria, where no parent or caregiver was employed. That constituted 32.4 per cent of Aboriginal families with a child under the age of 15. A little less than 5,800 Aboriginal (or 36.5 per cent) children under the age of 15 were living in those jobless families. Outside of Melbourne and Geelong, 42.1 per cent of Victorian Aboriginal children under the age of 15 were living in jobless households (PHIDU 2018a), a fact which underscores the greater levels of vulnerability experienced by Victorian Aboriginal children. In 2006, 42 per cent of Aboriginal families with children under 15 years of age, caring for around 3,400 children, were jobless (PHIDU 2010).

Table 20 Jobless Victorian families, 2006 and 2016. Source: Public Health Information Development Unit Social Atlas, 2010, 2011, 2018b.

| **Year** | **Jobless families with children under 15 (Aboriginal)** | **% jobless families (Aboriginal)** | **Children under 15 years in jobless families (Aboriginal)** | **Jobless families with children under 15 (Statewide)** | **% jobless families (Statewide)** | **Children under 15 years in jobless families (Statewide)** |
| --- | --- | --- | --- | --- | --- | --- |
| 2006 | 2,773 | 42.2 | 3,417 | 69,759 | 13.7 | 124,317 |
| 2016 | 3,269 | 32.4 | 5,792 | 64,429 | 11.0 | 114,194 |

In 2015, Victorians with a disability were less likely to be employed, more likely to be underemployed and more likely to be out of the labour market. The unemployment rate for Victorians with a disability was two percentage points higher than for Victorians who didn’t have a disability (8.6 and 6.1) and the participation rate was nearly 30 percentage points lower (53.1 and 82.4) (ABS 2016). However, education levels are improving. The proportion of Victorians with a disability who had not completed Year 12 fell from 77.6 per cent in 2003 to 67.1 per cent in 2015, similar to the Australia wide trend (Ibid.).

### 3.2.3 Earning power of different family types

Comparing the weekly incomes of single-parent families and couple-parent families highlights the heightened financial pressures faced by single-head households. In 2016, the median income of a Victorian couple-parent family with dependent children under the age of 15 was around $2,100 per week. For a single-parent family it was around $730. In 2006, the median income of a Victorian couple-parent family with dependent children under the age of 15 was around $1,400, compared to $575 for a single-parent family.[[49]](#footnote-50) While the average income for both family types has increased, the income of couple-parent families has increased more quickly. In 2006 the difference between the average incomes of a single-parent family and a couple-parent family was around $820. In 2016, the difference was around $1,360. It is important to note that according to the HILDA Survey, since 2009 there has been almost no real growth in household income (Wilkins & Lass 2018).

Victorians, and Australians as a whole, have experienced long-term economic growth and rising average incomes. Yet some members of the community continue to be left behind. This can result in deep and persistent disadvantage, including poverty, housing stress and social exclusion. There is also some evidence that there is some intergenerational transmission of income (McLachlan et al. 2013). According to the Productivity Commission’s report on disadvantage, children of fathers with higher levels of education and higher status occupations were more likely to be in occupations associated with higher SES (Ibid.).

### 3.2.4 The impact of poverty, low incomes and financial hardship

The impact of poverty on a child’s life can be extreme. It can have both short and long-term consequences for children’s health, education and overall wellbeing. As seen earlier in this report, in families experiencing high levels of disadvantage, children are more likely to be born with a low birthweight and exhibit greater developmental vulnerabilities, while their mothers have lower rates of breastfeeding (Amir and Donath 2008). From birth, children living in poverty are more likely to be exposed to a range of interconnected factors that can have a negative impact on their development. Poverty is associated with lower levels of parental education, less frequent reading to children, poorer quality and unstable housing and reduced ability to invest in children’s non-immediate developmental needs (Centre for Community Child Health (CCCH) 2009, 2017). Financial hardship and the social isolation associated with poverty often stops even the most well-meaning of parents from providing a healthy and stimulating environment for their children.

This in turn may cause psychological distress for parents and impact on their caregiving capacity. In addition, mothers living in poverty are also more likely to be exposed to a range of stressors including homelessness and family violence (CCCH 2017). It is important to note that poverty does not cause family violence and that family violence can lead to housing and financial insecurity. Furthermore, when mothers are exposed to high levels of stress during pregnancy which can be related to financial hardship, their bodies’ normal hormone regulation can be affected which in turn impacts on the growing foetus (Ibid.). Maternal stress is also associated with other risky behaviours such as drinking, smoking and drug use during pregnancy as well as poor nutrition (Ibid.). All of these factors and behaviours are associated with a higher probability of negative outcomes for children.

While relieving poverty can have lasting benefits, often the factors that cause deep and persistent disadvantage endure across generations. Studies have shown a close relationship between children's health and wellbeing and parental earnings, educational levels, occupational status, and receipt of welfare (d’Addio 2007). This reflects low levels of intergenerational social and economic mobility. It means that children who experience poverty will not only suffer from worse health outcomes, poorer nutrition and lower educational prospects, but their children are more likely to grow up in socioeconomically disadvantaged households (Ibid.).

This intergenerational impact can be seen in the LSAC, a study which looked at the impact of unemployment and living in a single-parent household across three generations (Hancock et al. 2012). It found that children were more likely to live in single-parent households if one set of grandparents were divorced and this increased if both maternal and paternal grandparents were divorced. The study found the same pattern for joblessness with a higher proportion of parents experiencing at least six months of unemployment if either or both of the study child’s grandparents had also experienced joblessness. Given the increased probability that single-parent families and jobless households will experience financial hardship, these patterns illustrate how circumstances related to these economic difficulties can persist across generations.

Using a poverty line of 50 per cent of the median household income, the Australian Council of Social Services estimates that 17.4 per cent of children across Australia in 2014 were living in poverty (Australian Council of Social Service 2016). Based on this report, it was estimated that around 12.8 per cent of Victorians were living in poverty in 2014 (Victorian Council of Social Services, 2016). Forty one per cent of single-parent families were living under the poverty line that year. Children living in single-parent families were three times more likely to be living in poverty than those living with two parents. Most people living in poverty were renters and relied on social security payments as their main source of income.

The VCHWS assesses financial insecurity experienced by young Victorians by asking parents of children aged zero to 12 if they could raise $2000 in an emergency. While only 11.5 per cent of Victorian children are living in households that could not raise $2000 in an emergency, the survey found clear differences that related to socioeconomic disadvantage, family type and location. In relation to socioeconomic disadvantage, the 2017 survey found more than a quarter (25.6 per cent) of Victoria’s most disadvantaged families would be classed as financially insecure using this measure (up from 19.6 per cent in 2013 and 21.9 per cent in 2006). In relation to family type and receipt of healthcare benefits, each survey since 2006 has found differences between the financial security of single-parent and coupled families as well as between those families with or without a child on a Health Care Card. In addition, while 9.9 per cent of Victorian children in metropolitan areas lived in families unable to raise $2000 in an emergency, this increased to 16.2 per cent in regional areas.[[50]](#footnote-51)

#### 3.2.4.1 Food insecurity

Financial hardship is a powerful factor in food insecurity, defined as running out of food and not being able to afford more. Families and children can develop poor eating behaviours, often relying on cheaper unhealthy foods in order to cope with food insecurity, with subsequent negative impacts on weight, nutrition and health (Burns 2004). It is often associated with chronic disease (Turrell & Kavanagh 2005; Seligman et al 2010) and poorer academic achievement (Winicki & Jemison 2008).

In the 2017 VCHWS, 7.1 per cent of children aged zero to 12 years came from a household that had experienced food insecurity in the past 12 months.[[51]](#footnote-52) This was a significant increase on the previous survey in 2013 that reported 4.9 per cent of Victorian children aged zero to 12 years came from households facing food insecurity.

A much larger proportion of children from single-parent households (21.3 per cent) experienced this challenge compared to children from couple families (4.2 per cent). Both represented an increase in the past decade. Food insecurity has a clear social gradient, with children coming from the most disadvantaged backgrounds, as measured by the SEIFA index of disadvantage, experiencing higher levels of food insecurity than others. The difference between the most and least disadvantaged households’ experiences of food insecurity has increased over the decade. This has occurred despite an increase in earnings for both single-parent and couple-parent households suggesting growth has not kept pace with the rising cost of living.[[52]](#footnote-53)

Table 21 Proportion of Victorian children (aged 0-12) who experienced food insecurity in the past 12 months, by SEIFA-IRSD quintile, 2006 to 2017. Source: Victorian Child Health and Wellbeing Survey, 2017.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Q1** | **Q2** | **Q3** | **Q4** | **Q5** |
| 2006 | 9.2% | 5.9% | 6.8% | 6.1% | 2.9% |
| 2009 | 8.6% | 5.9% | 5.1% | 4.7% | 1.8% |
| 2013 | 9.6% | 6.6% | 6.3% | 4.3% | 2.3% |
| 2017 | 13.5% | 9.0% | 9.2% | 6.4% | 2.7% |

Another survey conducted in 2014 provides further detail of the types of families facing food insecurity. It found that overall, 13 per cent of parents in Victoria relied on unhealthy low-cost options for their children as a strategy to avoid running out of money to buy food. This figure increased to 53 per cent among Aboriginal families (DHHS 2018a), while jobless and low-income households were overrepresented. Twenty three per cent of families with an annual household income of $40,000 to $60,000 reported they relied on unhealthy low-cost food for their children as a strategy to avoid running out of money for groceries (Ibid.). A healthy food basket[[53]](#footnote-54) for a household of four represents a third of the budget for low income families based on research in 26 LGAs in 2012 to 2015 (Palermo et al. 2016). Given that welfare-dependent families constitute approximately 20 per cent of the Australian population, these statistics suggest that many families in Victoria are having trouble affording healthy foods for their children (Kettings & Sinclair 2009).

### 3.2.5 Housing and housing stress

Access to quality housing plays an important role in the wellbeing of families, particularly children. Access to stable accommodation allows for the enjoyment of many economic, social and cultural aspects of life (AIHW 2010). Housing quality and satisfaction is positively associated with psychological wellbeing (Robinson and Adams 2008). For most people housing is about more than physical shelter; feelings of ‘home’ can provide a sense of psychological security (Robinson and Adams 2008). Conversely, poor housing quality, satisfaction and security are associated with poorer mental health outcomes. For example, there is an association between mental ill-health and living in a house that does not protect against climate and noise; has insufficient space; lacks light and/or external windows; does not facilitate socialisation; and is prone to vandalism (Bonnefoy et al. 2004).

Housing costs have increased in recent years while wages growth has been relatively flat, compounding and contributing to issues around financial insecurity. The magnitude of growing housing costs can be seen in the proportion of gross household income being spent on housing costs. For couple families with dependent children in Victoria, housing costs as a proportion of gross household income have increased from 13 per cent in 1995-96 to around 14 per cent in 2015-16 (ABS 2017d). Over the same period, single-parent families with dependent children have seen the proportion of their gross household income spent on housing increase from 16 per cent in 1995-96 to 24 per cent in 2015-16, representing a 50 per cent increase.

At the same time housing stress (defined as the proportion of low income rental households spending more than 30 per cent of their gross income on housing costs) has increased for low income families (Robinson and Adams 2008). In 2015-16, around 47 per cent of low income rental households in Victoria fell into this category, the national figure was 44 per cent (ABS 2017d). While the number of low income rental households increased by 19 per cent in Victoria between 2007 and 2016, the proportion spending more than 30 per cent of their gross income on housing costs increased by 44 per cent, providing cause for concern. This is important because many of the families with children that are under the most significant financial stress are renting.

There is also clear evidence that children in families experiencing socioeconomic disadvantage are experiencing higher levels of housing stress. According to the ABS Census, the proportion of Victorian children in households experiencing housing stress increased from 13.3 per cent in 2001 to 25.3 per cent in 2011, before falling to 21.3 per cent in 2016 (AIHW 2018h). This compares to 28.8 per cent of children from socioeconomically disadvantaged areas that lived in households experiencing housing stress in 2016, up from 16.7 per cent in 2001 (Ibid.). The proportion of children in single-parent families who were living in households experiencing housing stress in 2016 was 50 per cent, up from 32.9 per cent in 2001 (Ibid.).

Table 22 Proportion of Victorian children (aged 0-14 years) living in households experiencing housing stress, by year, 2001 to 2016. Source: Australian Institute of Health and Welfare, Children's Headline Indicators - Housing Stress.

| **Year** | **Statewide** | **Single parent** | **Lowest SES** | **Highest SES** |
| --- | --- | --- | --- | --- |
| 2001 | 13.3% | 32.9% | 16.7% | 11.5% |
| 2006 | 21.4% | 43.8% | 26.0% | 18.0% |
| 2011 | 25.3% | 50.6% | 30.2% | 22.0% |
| 2016 | 21.3% | 50.0% | 28.8% | 16.0% |

Housing costs are contributing to growing financial stress across Australia. However, it is low income households that are feeling the impact most. For children and their families, having a stable home and financial situation is a key factor in their health and wellbeing, including their mental health and ability to meet living costs (Victorian Auditor-General's Office (VAGO) 2017).

Social housing is an important option for those with the greatest need, such as people who have recently experienced homelessness or family violence. In Victoria, social housing is an umbrella term used to describe the more than 64,600 government owned public housing premises as well as around 19,000 community housing dwellings owned and/or managed by not-for-profit organisations (VAGO 2017).

As of the end of the March 2018 quarter, the total number of applications on the Victorian Housing Register, which has replaced the former Public Housing Waiting List, was 44,028, up from 41,602 a year earlier (DHHS 2018d). At the end of March 2018, there were 57,877 adults and 24,622 children on the register (Ibid.). There are a further 15,528 community housing applications that are yet to be transferred onto the Victorian Housing Register. In addition, due to the waiting list and wait times, there is additional unexpressed demand among eligible households that are not motivated to apply (DHHS 2017f; VAGO 2017).

Demand for social and affordable housing is outstripping supply. Between 2006 and 2016, public housing stock declined by 581 dwellings and community housing stock increased by 9,593 dwellings (VAGO 2017). Despite the increase in the total number of social housing dwellings, the number has decreased as a proportion of all housing from 3.8 per cent in 2006 to 3.5 per cent in 2016 (DHHS 2017f; Parliament of Victoria 2018a). This is lower than the national average of 4.5 per cent (Parliament of Victoria 2018a). Recent research suggests that in order to keep pace with current housing growth and maintain the current level of social housing as a proportion of all housing, around 1,700 new long-term social housing premises need to be built every year for the next two decades (DHHS 2017f).

Taking into account the Victorian Housing Register, low income households experiencing housing stress and Commonwealth Rent Assistance recipients paying more than 50 per cent of their income on housing, Infrastructure Victoria estimates that between 75,000 and 100,000 disadvantaged low income households in Victoria lack affordable housing (DHHS 2017f). In addition, based on current eligibility criteria, nearly one per cent of Victorian households not currently in social housing would be eligible for priority access (DHHS 2017f). This suggests that unmet demand for priority access is almost double that expressed through the Victorian Housing Register (DHHS 2017f). Addressing this shortage of social housing is vital given the importance of housing and stability for children’s health and wellbeing and the large number of children that remain on the waiting list.

*In March 2017, the Victorian Government announced its housing strategy, Homes for Victorians, which is providing record investment of over $1 billion in housing and homelessness support and $2.1 billion in financial backing to kick start new forms of social housing investment.*

*The key initiatives being delivered include:*

* *the Public Housing Renewal Program which is redeveloping nine rundown inner city public housing estates with new, environmentally designed public housing homes*
* *the $1 billion Social Housing Growth Fund which will fund a pipeline of projects by bringing together community housing providers with the finance, not-for-profit and philanthropic sectors to deliver more social housing*
* *the $1.1 billion Social Housing Loans and Guarantees which provide low interest loans and government guarantees to community housing organisations.*

*Homes for Victorians is also providing more funding for women and children escaping family violence and extra funding to address youth homelessness.*

### 3.2.6 Homelessness

Homelessness can seriously jeopardise children’s health and wellbeing. Studies of Australian children who have been homeless have revealed that some of the most important issues are safety, security, connection to supports, stigma and common childhood experiences such as playing with toys and other children (Moore, Nobel-Carr & McArthur 2007; Keys 2009). Children who experience homelessness can often be escaping family violence or be exposed to violence while homeless, which can have severe negative consequences for their health and wellbeing (Anooshian 2005, Moore, Nobel-Carr & McArthur 2007). Domestic and family violence is the leading cause of homelessness for children (Australian Institute of Family Studies (AIFS) 2015).

Children also report a lack of security of their possessions and a lack of outdoor play space (Keys 2009). For some infants, homelessness can be associated with delays in mental and physical development, while for older children it can cause stress, anxiety, mental health problems and behavioural disorders (AIHW 2012a). It has also been associated with increased risk of asthma, poor dental health, skin problems and vision problems (Ibid.; Keys 2009; Taylor & Edwards 2012). Homelessness impacts on relationships within the family, negatively affecting parent-child attachment, as well as community and social engagement. It impedes attendance at school, which is associated with lower academic achievement (Bland & Shallcross 2015).

In Australia, the ABS collects data on homelessness through the census. Their definition includes people sleeping in improvised dwellings, tents or sleeping out, staying temporarily with friends or relatives, using emergency accommodation or living in boarding houses.

From the 2016 Census, the ABS estimated that more than 24,800 Victorians were homeless. This included around 5,380 people between the ages of zero and 18 years, up from around 4,760 in 2006 (ABS 2018b). Of these 49 were sleeping in improvised dwellings, tents or sleeping out. A further 2,500 were sleeping in supported accommodation for the homeless, 389 were staying temporarily with other households, 92 were staying in boarding houses, 3 in other temporary lodgings and more than 2,350 in severely crowded dwellings.

Table 23 Number of children (aged 0-18) who were homeless, by homelessness type, Victoria, 2016. Source: Australian Bureau of Statistics, 2017.

| **Homelessness type** | **Number of homeless persons aged 0-18** |
| --- | --- |
| Improvised dwellings, tents or sleeping out | 49 |
| Living in supported accommodation for homeless | 2,500 |
| Staying temporarily with other household | 389 |
| Living in boarding houses | 92 |
| Living in 'severely' crowded dwellings | 2,352 |
| **All homeless persons aged 0-18** | **5,382** |

The AIHW publishes statistics on specialist homelessness services. In 2017, the AIHW estimated that on any given night in Victoria, 19,300 people were accessing these services. Of these almost 3,000 were young people aged 15 to 24 years who were presenting alone, and almost 4,800 were children in families (AIHW 2017d).

In 2016–17, there were 24,201 Victorian children (aged zero to 17 years) who accessed homelessness services (AIHW 2017d). This represented 22 per cent of all Victorian clients in 2016-17. From 2011-12 to 2016-17, the number of Victorian children accessing homelessness services increased by 56 per cent. This was driven by a 65 per cent increase in children aged zero to nine years and a 76 per cent increase in children aged 10 to 14 years.

*The AIHW also reports on characteristics of children accessing homelessness services. In 2016-17:*

* *five per cent of Victorian children who accessed homelessness services had reported a drug or alcohol problem*
* *thirty two per cent of Victorian children were homeless when they presented to specialist homelessness services, up from 18 per cent in 2011–12*
* *fifty four per cent of Victorian children were seeking assistance because of family violence or were assessed as having a need for assistance related to family violence*
* *nine per cent were Aboriginal*
* *six per cent had a diagnosed mental health issue, and 21 per cent had a reported mental health issue*
* *ninety one young people were exiting custody, up from 28 in 2011–12*
* *fourteen per cent (3,353) were identified as being subject to a child protection order during their assistance period (AIHW 2017d).*

Homelessness affects some of the most vulnerable people and children in Victoria’s community, including children involved with child protection services (including OOHC) and children in contact with the youth justice system. The AIHW undertook a data linkage project to understand the characteristics of children accessing homelessness services who have also come into contact with child protection and/or the youth justice system.

The linkage revealed there were 6,702 Victorian children (aged between zero and 17 years) who accessed specialist homelessness services between 2011 and 2015 and had received child protection services between 2013 and 2014. A little over half (51 per cent) were female, 65 per cent were aged between zero and nine years and 16 per cent were Aboriginal. Compared to the children (zero to 17 years) who only accessed specialist homeless services during the same timeframe, the matched group were:

* more likely to have experienced family violence (50 per cent compared to 41 per cent)
* more likely to be experiencing a mental health issue (28 per cent compared to 20 per cent, noting that clients are only assessed for mental health issues if they are over 10 years of age).

The linkage also revealed that there were 967 Victorian children aged between 10 and 17 who had accessed specialist homelessness services between July 2011 and June 2015, and had also been under youth justice supervision between July 2011 and June 2014. Compared to the equivalent specialist homelessness services only group, the matched cohort were more likely to be experiencing a mental health issue (42 per cent compared to 20 per cent). They were also significantly more likely to report problematic drug or substance use as one of the reasons for seeking homelessness services (24 per cent compared to 3.3 per cent). A larger proportion also reported a lack of support from family or community (40 per cent compared to 17 per cent) and relationship/family breakdown (55 per cent compared to 30 per cent). (AIHW 2016d, unpublished data).

A further 430 children had accessed specialist homelessness services between July 2011 and June 2015, received child protection services between July 2013 and June 2014, and been under youth justice supervision between July 2011 and June 2014. This group had the highest proportion who were experiencing mental health challenges (44 per cent) and had reported experiencing family violence (39 per cent). Twenty four per cent reported problematic drug or substance use as a reason for seeking housing assistance, 51 per cent reported that their relationship or family had broken down and 44 per cent reported a lack of family and/or community support (AIHW 2016d, unpublished data).

A separate study looked at children who exited OOHC between 2013 and 2015 and homelessness data from 2015–16. The analysis found that 32 per cent of the children leaving care were identified as accessing homelessness services. Forty seven per cent of children exiting residential care were found in the homelessness data, compared with 13 per cent from permanent care settings. Furthermore, the analysis found that of the 2006-12 OOHC cohort, 29 per cent were found in the public tenancies data and 22 per cent were found in the housing applications data within three years of exiting OOHC (DHHS).

***Compass*** *will deliver a new model of support for 200 care leavers in Melbourne’s west, inner north and Bendigo over the next five years. It will provide them with safe, secure housing along with ongoing support from case workers to help link them with education, training and job opportunities and boost their health and wellbeing.*

*Its success will be measured against targets of reduced homelessness, improved health and reduced involvement with the criminal justice system, which, if achieved, will deliver tangible benefits for participants as well as economic returns for government and other program funders.*

## 3.3 The family environment

A safe and supportive home environment for children’s health and wellbeing is important. Parenting capacity and skills and the family environment have a lasting impact on children’s functioning and health.

Healthy families help promote children’s emotional, physical and social wellbeing. Warm and consistent parenting improves positive parent-child attachment by creating a warm and loving bond, which helps build confidence in seeking support and comfort with closeness as well as promoting emotional regulation and social skills (CCCH 2017; Price-Robertson, Smart & Bromfeld 2010). Nurturing home environments and parent relationships can shape developmental outcomes in areas such as self-reliance, self-efficacy, empathy and social competence (CCCH 2017; AIHW 2012b). Positive childhood experiences and effective parenting practices are associated with higher levels of subjective happiness (Price-Robertson, Smart & Bromfeld 2010). Parental skills, resources, time, energy and knowledge are all influential factors in parents’ decisions and engagement (Hoovey-Dempsay et al. 2005). Chronic stress and being time-poor are associated with lower quality parenting, while parental confidence, self-awareness and self-regulation are factors associated with positive parenting (Volmert et al. 2016).

The evidence is equally clear that harsh parenting and unhealthy family environments increase the risks of adverse health and developmental outcomes (CCCH 2017). Social and personal conditions such as poverty, disability, mental health problems and substance abuse are associated with impaired parenting (CCCH 2007). Violence in the home is also a particularly powerful negative factor on children’s lives and can harm the bond between child and parent, which is often the goal of perpetrators of violence. However, it is important to note that positive parenting can be a particularly powerful protective factor in mitigating the negative effects family violence and poverty can have on a child’s development (State of Victoria 2016; Kiernan & Mensah 2011).

This section will explore: the Victorian family environment; the influence of parental attitudes on a child’s wellbeing; parental mental health; the impact of family violence; and child abuse and the child protection system.

### 3.3.1 Parenting capability and family functioning

*Tracie is a young mum who benefitted from early identification and connection to services. At 16 years of age she was pregnant, not going to school, couch surfing and dabbling in drugs. Tracie was connected to her local* ***Cradle to Kinder service****. The Cradle to Kinder program started working with her during her pregnancy and still works with her today. Now her baby, Aimee, is a healthy 18-month-old girl and Tracie is in stable housing and doing a TAFE course part-time. Cradle to Kinder helped Tracie get clean from drugs, get into stable housing and prepare for her baby's birth. The service taught and helped Tracie with practical skills for looking after her baby, and helped her to recognise her baby's needs and develop a strong attachment. Cradle to Kinder also helped Tracie set up her own networks of support. Child Protection remained involved until Aimee was six-months-old. Child Protection and Cradle to Kinder worked together until Tracie was doing well.*

Perhaps the most influential factor in a child’s development is the parenting they receive. The choices parents make are influenced by their circumstances and experiences. In addition, parent-child relationships are strongly related to social and emotional wellbeing as well as academic outcomes (AIHW 2012b). Parents and their circumstances affect children’s experiences both in and outside the home. This is part of the reason why children’s ability and wellbeing are, from an early age, correlated with families’ circumstances and environments. Positive characteristics that have been linked to improved wellbeing outcomes include warm and supportive parenting (Ibid.; Volmert et al. 2016).

Healthy family functioning promotes children’s emotional, physical and social wellbeing. These families are able to establish close interpersonal relationships that are commonly associated with confident and well-adjusted young people. They provide the type of supportive networks that are so essential during times of difficulty. Parenting that establishes fair rules and models positive family values contributes to a child’s sense of wellbeing and to developing positive and self-regulating behaviours.

The Victorian Student Health and Wellbeing Survey (VSHAWS), conducted with primary and secondary aged students, provides information on healthy family functioning. In 2016, 79 per cent of students reported healthy family functioning with a higher proportion of females (83 per cent) than males (76 per cent). Family functioning was more likely to be reported as healthy for students in regional areas (82 per cent) relative to those living in metropolitan areas (79 per cent).[[54]](#footnote-55)

Family functioning is considered unhealthy when family conflict is present and the family environment is unsupportive. The VCHWS is conducted with parents of children aged zero to 12 years, and reports on unhealthy family functioning. In 2017, 8.1 per cent of Victorian children were living in families with unhealthy functioning. This result was statistically similar to the previous three surveys. Looking at results categorised using the SEIFA index of disadvantage, there is a clear social gradient to unhealthy family functioning. Each of the past four surveys show that children living in groups experiencing greater socioeconomic disadvantage, such as children from families with a Health Care Card and those from single-parent families, are more likely than their counterparts to report living in a family that exhibits unhealthy functioning. It is important to note that a family’s characteristics do not cause unhealthy functioning; if this were the case then much higher proportions of particular family types would exhibit unhealthy functioning.[[55]](#footnote-56)

Table 24 Proportion of Victorian children (aged 0-12 years) living in families with unhealthy family functioning, by family type, 2006 to 2017. Source: Victorian Child Health and Wellbeing Survey, 2006-2017, Department of Education and Training internal analysis.

|  |  |  |
| --- | --- | --- |
| **Year** | **Couple parent family** | **Single parent family** |
| 2006 | 6.9% | 14.1% |
| 2009 | 5.8% | 15.0% |
| 2013 | 6.6% | 17.9% |
| 2017 | 6.6% | 15.5% |

Understanding patterns of students’ survey responses provides insights into correlations between unhealthy family functioning and children’s health and wellbeing. According to the VSHAWS, students in families who reported unhealthy family functioning were more likely to show depressive symptoms than students in families that did not exhibit unhealthy functioning. They were also more likely to have had alcohol, smoked cigarettes or tried illicit drugs. This illustrates the association between unhealthy family functioning and negative health and wellbeing outcomes. While a nurturing home setting can provide strength during difficult periods, the opposite environment can increase the probability that children will experience psychological distress and engage in risky behaviours.

Table 25 Proportion of students (Years 5, 8 and 11) reporting risky behaviours or psychological distress, by family functioning, Victoria, 2016. Source: Victorian Student Health and Wellbeing Survey 2016, Department of Education and Training internal analysis.

| **Family functioning** | **Psychological distress** | **Drunk alcohol** | **Tried illicit drugs** | **Tried cigarettes** |
| --- | --- | --- | --- | --- |
| Healthy family functioning | 20.6% | 38.6% | 10.9% | 13.4% |
| Unhealthy family functioning | 15.9% | 34.1% | 4.4% | 6.7% |

### 3.3.2 Parenting attitudes and behaviours

Parental attitudes to health and behaviours, as well as the examples they set, impact children and young people’s health and wellbeing. Research has shown that differences in teenage drinking patterns can be influenced by the attitudes of parents to alcohol use (Chan et al. 2016).

In the 2016 VSHAWS, parental attitudes to smoking were correlated with student smoking. A little less than six per cent of Year 8 students had smoked a cigarette if their parents disapproved of smoking. However, 36 per cent of Year 8 students who said their parents would consider them smoking only a little wrong or not wrong at all, had smoked. The strength of this relationship was stronger for younger students who were four times less likely to smoke, compared to older students who were more than two times less likely to smoke if their parents disapproved of smoking. Among Year 11 students whose parents had favourable attitudes to smoking, 60 per cent had tried cigarettes, while 25 per cent of Year 11 students whose parents had negative attitudes towards smoking had smoked.[[56]](#footnote-57) These results support findings in the 2014 survey, which found that parental approval or disapproval of smoking was correlated with whether their child had tried cigarettes.

### 3.3.3 Parental mental health and psychological distress

Another key measure that provides insights into family environments in Victoria is the proportion of parents experiencing psychological distress or mental disorders. While the majority of parents have good mental health and enjoy good outcomes, those with a mental illness are more likely to face additional challenges related to raising children. Mental illness among parents is a risk factor for poorer health and wellbeing outcomes for children (Robinson, Rodgers & Butterworth 2008; Department of Community Services (DoCS) 2008).

The mental health of parents can affect children directly and indirectly. In infancy, a mother’s stress and the side effects of medication are associated with perinatal complications and behavioural problems (Connell & Goodman 2002). In addition, parents experiencing a mental illness, such as depression, may find it difficult to develop a strong bond with their child (Robinson, Rodgers & Butterworth 2008). They may provide less stimulating parenting which can affect children’s physical and psychological health (Burke 2003). Parents experiencing a mental disorder often suffer from other factors that increase the risk of poor outcomes for children such as poverty, a lack of social support and family violence (DoCS 2008). In turn, these factors are associated with less healthy family functioning and poorer parenting. There is evidence that this combination of factors, including disadvantage, parental mental illness, unhealthy family functioning and low quality parenting, results in higher rates of behavioural, developmental and emotional problems later in childhood (DoCS 2008; Cicchetti, Rogosch & Toth 1998; VanDeMark et al. 2005).

Children of a parent with a mental illness may also have to care for their parent. The 2012 ABS Survey of Disability, Ageing and Carers found that just below 15 per cent of the nearly 225,500 informal mental health carers in Australia were under the age of 25 (Diminic et al 2017). Around eight per cent were categorised as the primary carer (Ibid.). A 2016 survey conducted by the University of Queensland revealed that up to 68 per cent of care duties for mental health carers involved emotional support but almost 30 per cent of care also involved practical tasks including household tasks, health care coordination, literacy and communication and transport assistance (Ibid.).

In addition, children with parents with a mental disorder are more likely to experience a mental illness themselves (Robinson, Rodgers & Butterworth 2008; DoCS 2008). This is attributed to a range of factors including genetic predisposition, parenting style and learned behaviour (Tunnard 2004). One study in Denmark found that children of parents with a severe mental illness were two to four times more likely to experience this as well (Thorup et al. 2018). Having two ill parents increased this probability (Ibid.).

However, the risk of harm or developmental delay is not inevitable. For example, a parent’s ability to recognise their mental health problem and strong social support networks can act as protective factors that reduce the impact of parental mental illness on children (Robinson, Rodgers & Butterworth 2008; DoCS 2008). In addition, while there is clearly a genetic component to the transmission of mental illness, there is also evidence that the family environment and good parenting can mitigate this increased risk (DoCS 2008).

The findings from Parenting Today in Victoria broadly reflect a positive story for the majority of Victorian parents, with 87 per cent of parents reporting good physical health, while 79 per cent reported good mental health. More than nine in 10 report that they are confident in themselves as parents, with many parents indicating that they feel supported in their parenting, and are ready and equipped for taking on information about how to improve their children’s health, wellbeing and educational outcomes. This is also true for families living in more disadvantaged and rural areas (Parenting Research Centre 2017).

The Kessler Psychological Distress Scale is an international measure that assesses people’s nervousness, agitation, psychological fatigue and depression. Psychological distress is a risk factor for a range of conditions, including heart disease, depression and anxiety, and a person with very high psychological distress on this scale may require professional help (ABS 2009).

Higher levels of psychological distress in a family can increase the risk of poorer health and wellbeing outcomes for children, particularly when this distress results in parents engaging in harsh or less attentive parenting (Jaffee et al. 2003; Thompson et al. 2007). It is difficult to draw a direct link between the psychological distress of parents and health outcomes of their children. This is because it is difficult to disentangle the effects of circumstances that can occur concurrently with psychological distress such as disadvantage as well as other factors such as parenting ability. Despite this challenge, parental psychological distress remains an important indicator of vulnerability for children.

The Victorian Population Health Survey provides some insights into the psychological wellbeing of parents. According to this survey, 17.4 per cent of adults with school-aged children reported high or very high psychological distress in 2016. This was similar to the general adult population and was down from the 2015 result of 20.1 per cent. Parents not in the labour force were more likely to report high or very high levels of psychological distress than parents who were employed, as were parents earning less than $40,000 a year compared to parents earning between $40,000 and $100,000 annually.

The School Entrant Health Questionnaire (SEHQ) asks parents of children beginning primary school in Victoria to rate their family’s level of stress over the previous month. In 2017, 8.8 per cent of parents reported high or the highest stress levels in their family, down from 9.9 per cent in 2015. Single-parent families (17.5 per cent) and Aboriginal families (13.0 per cent) are more likely to report the highest level of stress. However the proportion of Aboriginal families experiencing high/highest stress levels has declined since 2015 when the figure was 16.2 per cent. Families with children from a language background other than English, and from metropolitan areas are least likely to report high/highest stress levels.

Table 26 Families reporting high/highest stress combined by population groups, Victoria, 2015-2017. Source: School Entrant Health Questionnaire, 2015-2017.

| **Population group\*** | **2015 (%)** | **2016 (%)** | **2017 (%)** | **2017 number** |
| --- | --- | --- | --- | --- |
| All Children | 9.9 | 9.2 | 8.8 | 5,639 |
| Language background other than English | 5.5 | 5.3 | 4.7 | 481 |
| Aboriginal or Torres Strait Islander | 16.2 | 16.0 | 13.0 | 136 |
| Areas of most disadvantage (IRSD 1) | 9.1 | 9.1 | 8.7 | 1,069 |
| Areas of least disadvantage (IRSD 5) | 10.0 | 9.2 | 8.7 | 1,253 |
| One-parent family | 17.9 | 17.5 | 17.5 | 1,271 |
| Boys | 10.5 | 10.0 | 9.5 | 2,887 |
| Girls | 10.2 | 9.3 | 9.3 | 2,709 |
| Rural/Regional areas | 11.5 | 10.6 | 11.0 | 1,849 |
| Metropolitan areas | 9.3 | 8.6 | 8.0 | 3,783 |

\*Note: population group categories will not sum to ‘all children’ due to missing or invalid data.

*Significant illness in a parent can obviously affect their children and other family members, as well as the parent themselves. The* ***Families where a Parent has a Mental Illness (FaPMI)*** *strategy aims to reduce the impact of parental mental illness on all family members through timely, coordinated, preventive and supportive action.*

*FaPMI coordinators are employed across adult mental health services statewide. They work closely with mental health services and network partners, such as maternity services, primary health services and school nurses. Coordinators provide support and advice to network partners, as well as workforce development, coordination and local collaborative care and support for peer programs for children and young people.*

*FaPMI coordinators champion and organise activities within their catchment area designed to meet the needs of the region.*

The SEHQ asks about a range of family issues, including child abuse, abuse to the parent, drug or alcohol problems in the family, if the child or parent has witnessed violence, problem gambling in the family and parental history of mental illness. In 2017, parental history of mental illness was the most common issue reported. Seven per cent of families reported a history of parental mental illness. Aboriginal parents and single-parents (about 20 per cent for both groups) have the highest rates, followed by parents of children from rural/regional areas (11 per cent). A range of factors are associated with either increased vulnerability or increased resilience in families affected by parental mental illness. These include the severity of the illness, the level of parental awareness and insight into the effects on oneself and their children.

DET analysis of the 2017 SEHQ shows the relationship between developmental vulnerability and parental mental illness. Around 27.6 per cent of children whose parents reported having a history of mental illness in the 2017 survey had an emotional or behavioural problem upon school entry. However, only 8.5 per cent of children whose parents did not have a history of mental illness were recorded as having a behavioural or emotional problem.

Analysis linking results from the SEHQ in 2014 to NAPLAN Year 3 Reading and Numeracy results in 2017 has also shown a small association between parental mental illness, family stress and children’s academic achievement. Students who had a history of parental mental illness were slightly less likely to achieve scores in the top two bands for NAPLAN Reading (56 per cent to 58 per cent) or Numeracy (46 per cent to 48 per cent). A similar difference was found between children living in families with high levels of stress and those living in families with low to medium levels of stress for NAPLAN Reading (55 per cent to 58 per cent) and Numeracy (45 per cent and 48 per cent).

Additional Victorian data shows the devastating results of mental health disorders among mothers. In 2016, the leading cause of maternal deaths in Victoria was suicide or intentional self-harm. Psychosocial causes were attributed as the cause of eight out of 17 maternal deaths in 2016, including five from suicide and three deaths from intentional self-harm (DHHS 2017e). Most (75 per cent) of these women had a pre-existing mental health disorder (Ibid.). Substance dependence was a contributing factor in three deaths, social isolation was a factor in one death and family violence was a factor in two deaths (Ibid.). Family violence has been shown to increase the risk of experiencing mental illness (Braaf and Meyering 2013). Nationally around one in seven women who give birth in Australia are affected by post-partum depression (DHHS 2017e).

The research and data outlined in this section indicate that parents’ mental health and stress have a significant impact on children. They are another illustration of the increased vulnerability faced by some children from single-parent families and Aboriginal families. The results are particularly important in regards to children’s health and wellbeing, given the known link between familial mental health conditions and child developmental delay as well as mental health concerns (Centre for Genetics Education 2012; DoCS 2008; Robinson, Rodgers & Butterworth 2008; Thorup et al. 2018).

*All Victorians should experience the best possible health, including mental health. Victoria’s 10-year mental health plan, released in November 2015, aims to achieve better outcomes for Victorians with mental illness, their families and carers. Major initiatives under the 10-year plan include:*

* *the Victorian suicide prevention framework 2016-2025, with 18 suicide prevention trials around the state*
* *the Mental health workforce strategy, including a new Centre for Mental Health Workforce Learning and Development*
* *more support for children and young people with mental illness*
* *investment in forensic mental health services.*

*In 2015-16 an outcomes framework to measure progress of the plan was developed and published. The framework brings together information about the mental health of all Victorians from a range of sources, including Victorian population health surveys and national mental-health related surveys. Progress is measured annually and the results published in Victoria’s mental health services annual report.*

### 3.3.4 Children and young people exposed to family violence

Family violence involves a pattern of coercion, control and domination by one person over another and is rarely a one-off event. There is an increased risk of family violence during pregnancy, the first year after birth and separation (or attempted separation). Family violence can occur between different family members. However most commonly, it occurs between intimate partners and is committed by men against their current or former female partner (State of Victoria 2016). Overwhelmingly the majority of victims are women and children (Ibid.)

Exposure to family violence can have devastating effects on children and young people, whether they are directly targeted, witness the violence or are aware of the violence in the family (Kaspiew et al 2017, State of Victoria 2016). Family violence is recognised as a form of child abuse in itself. Children can suffer from a variety of physical, emotional, mental and developmental issues as a result of family violence (State of Victoria 2016). These can include depression, anxiety, withdrawal, low self-esteem, poor peer relationships and academic outcomes (State of Victoria 2016). A number of longitudinal, meta-analytic and population-based studies show exposure to family violence can affect a child's mental wellbeing and lead to poorer educational outcomes and behavioural issues (AIFS 2015).

Without intervention, for some children family violence can also lead to risky behaviours such as self-harm, substance abuse and youth offending. Long-term effects of trauma from family violence can be carried into adulthood and result in a range of detrimental emotional, mental and behavioural problems.

Research indicates that some children exposed to family violence draw on a number of coping strategies and show resilience, while others do not exhibit negative outcomes (AIFS 2015). A meta-analysis of 118 empirical studies published between 1978 and 2000 (Kitzmann et al 2003) found that 37 per cent of children exposed to domestic and family violence fared better or equal to the average child in terms of academic success, cognitive ability, mental health and wellbeing.

Research suggests that newborns exposed to family violence in utero are born with high levels of stress-related hormones (Mercedes 2015). A mother who experiences family violence during pregnancy can have higher stress levels and increased adrenaline and cortisol production which may adversely affect the foetus’ brain development. Maternal stress in early pregnancy is associated with lower birthweights, higher probability of premature births, and reduced ability to fight infection. Violence during pregnancy also increases the risk of miscarriage (State of Victoria 2016).

In 2016, the Royal Commission into Family Violence’s final report described the range of effects on children, including:

* experiencing physical harm
* being scared of loved ones
* anxiety about safety
* feeling responsible for the violence
* caring for an abused parent or sibling
* becoming homeless or losing possessions
* experiencing disrupted schooling due to absences or moving schools
* being socially marginalised and unable to have friends over to play.

Family violence can also have significant long-term impacts on children’s health and wellbeing (Kaspiew et al 2017). Exposure in childhood increases the risk of specific health adversities later in life, such as high blood pressure and type 2 diabetes. Children and young people that experience family violence are more likely than their peers to develop drug and/or alcohol problems (State of Victoria, 2016).

It is important to note that while many parents go to extraordinary lengths to protect and care for their children, family violence can significantly compromise parenting and negatively impact the bond between parent and child. That is because many perpetrators purposefully try to undermine the relationship between the victim parent and the child (State of Victoria 2016). Research conceptualises domestic violence as an attack on the mother-child relationship (AIFS 2015).

In addition, the parent victim’s mental health can be harmed, they can be focused on the needs of the perpetrator in an attempt to prevent further violence, may be physically prevented from caring for a child or unable to nurture a loved one due to physical injury (State of Victoria 2016; Kaspiew et al 2017; Braaf and Meyering 2013). While there are limited studies of the father-child relationship in the context of family violence, research suggests violent fathers often fail to see the effects of their behaviour on their children (AIFS 2015). Children are also more likely to be subjected to greater parental irritability and inconsistent parenting (Kaspiew et al 2017). All of these factors impact a parent's ability to provide warm and consistent parenting.

As the negative effects of family violence accrue, they produce an accumulation of harm to the child. The Royal Commission into Family Violence highlighted that this cumulative harm can have an exponential impact across different parts of a child’s life (State of Victoria 2016). Children who experience family violence are often exposed to other risk factors that can co-occur such as parental mental illness and parental substance abuse. In addition, vulnerable families, such as those experiencing poverty, are also overrepresented in family violence statistics, which can further magnify the impact on children.

However, many children who experience family violence demonstrate significant resilience and are able to achieve outcomes that are comparable to their peers. Evidence suggests that there are a range of factors that can protect children and mitigate the impact of family violence. These include supportive adult relationships and positive parental mental health (State of Victoria 2016).

*The transition to parenthood is a time of heightened family violence risk, with one in five women reporting intimate partner violence in the year after giving birth (Murdoch Children’s Research Institute, 2015). Due to its universal nature, the* ***Victorian MCH service*** *is well placed to identify and provide initial support to families at risk of, or experiencing, family violence. The additional MCH family violence consultation aims to increase capacity within the service to provide greater support to affected families in a location that suits their needs. It is often provided where family violence is identified or suspected and may include joint consultation with specialist services. The Victorian Government is supporting MCH nurses to deliver this additional consultation through ongoing funding and targeted training and support.*

Children and young people make up a significant portion of the victims of family violence. In 2017-18, there were 76,124 reported family violence incidents in Victoria, up from 65,179 in 2013-14. Between 2013-14 and 2017-18, police recorded that children were present for around a third of family violence incidents. Between 2013-14 and 2015-16 the number of family violence incidents, attended by police, where a child was present increased from 22,375 to 25,831. However, the number fell in 2016-17 (to 24,130) and again in 2017-18 (to 23,595). This corresponded with a fall in the proportion of incidents in which a child was present, from 33 per cent in 2015-16 to 31 per cent in 2017-18. It also corresponded with a change in police reporting practices in June 2016 in five LGAs, which means children present at family violence incidents are not necessarily captured in data collections.[[57]](#footnote-58)

Table 27 Total family violence incidents and proportion where a child was present, Victoria. Source: Crime Statistics Agency.

| **Family violence incidents** | **Jul 2013 – Jun 2014** | **Jul 2014 – Jun 2015** | **Jul 2015 – Jun 2016** | **Jul 2016 – Jun 2017** | **Jul 2017 – Jun 2018** |
| --- | --- | --- | --- | --- | --- |
| Total incidents | 65,179 | 70,901 | 78,006 | 76,494 | 76,124 |
| Percentage of incidents where a child was recorded as present | 34.3% | 34.5% | 33.1% | 31.5% | 31.0% |

Despite recent government and community efforts to improve reporting of family violence and increases in reported family violence incidents, it is likely that these statistics still underrepresent the scale of the problem. Incidents where police are called to attend only represent the more serious incidents. Following the focus on family violence in the public discourse over recent years, it can also be argued that there has been an increase in the number of family violence incidents attended by police due to victims feeling empowered to report the matter (State of Victoria 2016).

The 2017 SEHQ provides further insights about children’s experiences of family violence. The survey asks parents of children starting primary school about family issues. One question asks parents if their child has witnessed violence. While the question does not specifically use the term family violence, it is probable that children identified as witnessing violence have witnessed violence in the home. Children beginning primary school are generally closely supervised by parents and are unlikely to witness violence in other settings. In addition, the question is included in the family section of the questionnaire and follows questions about children and parents experiencing abuse. It is therefore likely that answers to this question are inferring witnessing family violence. However, it is also possible that some of the children identified as witnessing violence saw the violence outside of the home.

The questionnaire found that 3.2 per cent of Victorian children had witnessed violence before starting school. Violence is present in all parts of society, however this survey shows that parents of children in particular family types or population groups report a higher incidence of violence. In 2017, children in one-parent families (16.7 per cent) and Aboriginal children (15.9 per cent) were more likely than other children to have a history of witnessing violence. The survey also found a history of abuse to 1.1 per cent of Victorian children before they started Prep. This was highest for Aboriginal children (6.4 per cent) and children in one-parent families (5.4 per cent). The statistics for one-parent and Aboriginal families show that the increased economic vulnerability explored earlier in this chapter is compounded by experiences of violence for a significant minority of these children. When interpreting these statistics, it is important to note that family violence is not part of Aboriginal culture and family violence is perpetrated by non-Aboriginal and Aboriginal people.

Analysis undertaken using SEHQ illustrates the relationship between violence and developmental outcomes. According to analysis of the 2017 survey, 34.3 per cent of children who had witnessed violence before beginning school had an emotional or behavioural problem upon school entry. However, only 9.3 per cent of children who had not witnessed violence were recorded as having a behavioural or emotional problem. Analysis of 2015 SEHQ responses showed that children who had witnessed violence before beginning school exhibited emotional and behavioural problems at more than five times the rate as their peers who had not witnessed violence, 21.7 per cent compared to 4.2 per cent.

Furthermore, research and DET analysis highlight a link between witnessing violence and lower academic achievement (Kaspiew et al 2017). Linking SEHQ data from 2014 to NAPLAN Year 3 Reading and Numeracy results in 2017 shows that witnessing violence prior to school entry has a strong association with lower educational achievement. Around 58 per cent of children who had not witnessed violence when they started school in 2014 went on to achieve in the top two bands in Year 3 NAPLAN Reading in 2017, compared to 42 per cent of children who had witnessed violence. In Year 3 NAPLAN Numeracy in 2017, 48 per cent of children who had not witnessed violence were in the top two bands and 32 per cent of children who had witnessed violence were in the top two bands. As discussed above, while the questionnaire doesn’t explicitly ask parents about whether their child witnessed family violence, it is probable that a significant portion of children identified as witnessing violence, saw this violence in the home. In addition, the relationship between witnessing violence and academic outcomes would likely be at least as strong, if not more pronounced, for children witnessing family violence.

A similar pattern was observable for children who had been abused prior to beginning school. Around 58 per cent of children who had not been abused were in the top two bands for NAPLAN Reading in 2017, compared to around 43 per cent of children who had experienced abuse. In NAPLAN Numeracy in 2017, 48 per cent of children who had not experienced abuse were in the top two bands, significantly higher than the nearly 37 per cent of children who had experienced abuse.

Table 28 Proportion of Victorian children in the top two bands for Year 3 NAPLAN Reading and Numeracy 2017, by SEHQ response 2014. Source: Department of Education and Training internal analysis, SEHQ 2014, NAPLAN 2017.

| **NAPLAN domain** | **Abuse to child** | **No abuse** | **Child witnessed violence** | **No violence witnessed** |
| --- | --- | --- | --- | --- |
| Reading | 43.2% | 57.5% | 41.8% | 57.8% |
| Numeracy | 36.8% | 47.9% | 32.1% | 48.3% |

Data on MCH referrals and counselling also provide some further clarity about incidents of family violence in the early years. Overall, the number of mothers and families receiving counselling through a MCH service declined between 2000-01 (84,300) and 2016-17 (69,229). However, during that period the number of mothers receiving counselling for family violence increased from 978 to 4,015.[[58]](#footnote-59) A similar pattern is seen in referrals, with the total number declining since 2000-01, while the number of referrals for family violence increased. It should be noted that these increases do not necessarily reflect increasing incidences but may reflect changes in service offerings, such as policy changes a decade ago that required MCH nurses to do a family violence screening check.

Research shows that particular population groups are more likely to experience family violence. Women with a disability are more likely than those without a disability to experience family violence (Brownridge 2006; State of Victoria 2016). The Royal Commission into Family Violence found that children with disabilities experienced family violence at 3.4 times the rate of children without disabilities (State of Victoria 2016). In addition, same-sex attracted Victorians face additional challenges accessing services, such as homophobic or transphobic attitudes in refuges or a lack of staff sensitivity (Leonard et al 2012; State of Victoria 2016). Rigid gendered stereotypes can disproportionately affect young people from LGBTI communities.

### 3.3.5 Child abuse and child protection

Child abuse can be devastating for children and young people and has severe long-term consequences. There are a range of protective factors that increase resilience and help mitigate the impact of maltreatment (Child Welfare Information Gateway 2008; Hunter 2012). These include personal characteristics such as self-esteem, features of the family environment such as parenting quality, and extra-familial and community resources such as relationships with friends (Haskett et al. 2006; Hunter 2012). However, there are also a range of factors that may exacerbate the impact of violence and neglect, such as disability, parental drug addition, socioeconomic disadvantage, social isolation and community disorganisation (Dubowitz & Bennett 2007; Jaffee & Maikovich-Fong 2011).

Research has also illustrated a wide variety of health problems caused by abuse. Young people experiencing abuse often lack supportive parental relationships. They are exposed to chronic stress which has been found to have a particularly negative impact on growing brains and can result in ongoing psychological problems (National Scientific Council on the Developing Child (NSCDC) 2007, 2012). Researchers have found abuse or neglect can impact a child’s ability to form healthy interpersonal relationships, and can increase the chance of a range of mental health conditions as well as the risk of suicidal ideation (AIFS 2014). They have also found an increased probability of substance abuse, violent behaviour and poor physical health. An American study found that around 14 per cent of children from non-abusive family settings had used drugs, while 28 per cent of the children who had been physically abused had used illicit drugs (Perkins & Jones 2004). The health outcomes of Victorian children in OOHC are explored in Chapter 3 in relation to homelessness and relevant parts of Chapter 5 in this report, including in relation to smoking rates, drinking, drug use and mental health.

Children receiving child protection services are among the most vulnerable in Victoria. For example, a 2007 survey of 614 children in OOHC in Victoria found that more than one in five had, in the preceding six months, interactions (cautioned or charged) with police (Wise et al 2008). It is important to note that while children in OOHC are overrepresented in youth justice data, being in OOHC itself is not the cause of interactions with the youth justice system.

DHHS data linkages identified that of the 2006 to 2015 OOHC cohort, the following could be identified in youth justice data sets:

* overall 24 per cent were in the youth justice data
* twenty-one percent of children exiting OOHC at 15 years of age were in the youth justice data
* thirty per cent of children exiting at 16 years of age were in the youth justice data
* forty-one per cent of children exiting at 17 years of age were in the youth justice data
* fourteen per cent of children exiting at 18 years of age were in the youth justice data (DHHS, no date).

The drivers for the association between youth justice and OOHC are highly complex. They include the child’s abuse or maltreatment and their experience in OOHC. In addition, it is important to consider the impact of individual risk factors (e.g. trauma or mental health difficulties), social risk factors (e.g. family poverty) and contextual risk factors (e.g. social disadvantage) (AIHW 2016; Bollinger et al., 2017; Malvaso et al., 2016).

There have been sustained increases in child protection reports and substantiations during the past decade. This growth has been driven by changes in community attitudes to parenting, greater visibility of child protection, growth in the child population, professional reporting and awareness driven by the Royal Commission into Family Violence. A particularly strong driver of the increase in notifications between 2011-12 and 2015-16 related to changes in policing practices regarding the use of the L17 (family violence risk assessment). Until recently, this meant that when a child was present at such an incident, police routinely notified child protection through these forms. However, between 2015-16 and 2016-17 the proportion of child protection reports coming from police declined due to improved targeting and increased use of referral services in response to these incidents.

***Child FIRST (Child and Family Information, Referral and Support Teams)*** *links vulnerable children, young people and their families into the relevant services they need. Timely identification and targeted intervention with children and families at risk is critical to minimise the negative impacts on children and young people’s safety, stability and development. Effective early intervention can substantially improve outcomes for vulnerable children, young people and families, including reducing the progression into statutory child protection services.*

*Each Child FIRST across Victoria provides a central referral point to a range of community-based family services and other supports within each of the Child FIRST catchment areas.*

*Child FIRST, as the access point for family services, is progressively transitioning to The Orange Door.*

*The* ***Orange Door*** *was recently established to provide an easier and more coordinated way for women, children and young people who are experiencing family violence, and families who need assistance with the care, development and wellbeing of children and young people to access the services they need to be safe and supported.*

*The Orange Door provides a visible contact point, advice based on the latest risk assessment tools and best available information, and coordinates connection to services and support.*

*The Orange Door engages with and plans interventions for perpetrators of family violence, keeping them in view, holding them accountable for their actions and changing their behaviour.*

*Statewide coverage is planned by the end of 2021.*

Child protection reports in Victoria have increased from 38,675 in 2006-07 to 110,961 in 2016-17. However, the growth in reports slowed in 2016-17 with four per cent more reports in 2016-17 than in the year before (2015-16). Reports had previously increased by 17 per cent (from 2014-15 to 2015-16) and 12 per cent (from 2013-14 to 2014-15) (AIHW 2008, 2018c).

The *Children, Youth and Families Act 2005* (the Act) requires that the State provides all possible support to families and intervenes only to the extent necessary to protect a child from harm. Where it is assessed that a child is in need of protection, the Children's Court may order that a child be placed in OOHC. The Act explicitly requires that children be placed within their kinship network where possible. Subject to the type of protection order made, the Secretary of the DHHS will assume varying levels of parental responsibility and decision making for the child. In all instances the Secretary must have regard to the best interests of the child as the paramount consideration and make provision for their physical, intellectual, emotional and spiritual development in the same way a good parent would. This is achieved through case planning that will, in most circumstances where a child is placed in OOHC, pursue reunification of the child with their family in the first instance. Where this cannot be achieved within legislated time frames, the Secretary is required to seek alternate permanent care arrangements for the child. A permanent care order transferring parental responsibility to the child’s permanent carer is the preferred outcome. A long-term care order can also provide the child with a carer until they are 18 years of age, but with the Secretary retaining ultimate parental responsibility.

The proportion of reports substantiated, defined as circumstances where a child has experienced (or is currently at risk of) significant harm as a result of abuse or neglect, has remained fairly stable over the decade. In 2006-07 around 17.7 per cent of reports were substantiated. From 2007 to 2017, the proportion of reports substantiated fluctuated between 13.7 per cent and 17.7 per cent. Since 2006-07, there has been a 141 per cent increase in the number of child abuse or neglect substantiations in Victoria. In 2016-17, there were 15,488 children subject to a child abuse or neglect substantiation, up from 6,588 in 2006-07[[59]](#footnote-60) (AIHW 2008, 2018c). This trend has been evident for both Aboriginal and non-Aboriginal children in Victoria. During the past decade the number of substantiations relating to Aboriginal children increased by 167 per cent compared to 131 per cent for non-Aboriginal children.

The type of abuse substantiated has changed in the past decade. In 2016-17, ‘emotional abuse’ accounted for around 70 per cent of substantiations (up from 43 per cent in 2006-07), while ‘neglect’ fell from 16 per cent to four per cent. This reflects a change in case recording, tying the basis for substantiation more closely to the grounds set out in the Act. Grounds most commonly used for the harm to a child as a result of neglect are emotional or psychological, which is then reported nationally under ‘emotional abuse’. The Act does not include a ground of neglect. Neglect may result in significant harm under other grounds. Other grounds in the Act include significant harm as a result of physical injury, sexual abuse or to physical development or health. The proportion of substantiations attributed to sexual abuse increased during the decade from seven per cent to 10 per cent, while the proportion of substantiations attributable to physical abuse fell from 35 per cent to 16 per cent (AIHW 2008, 2018c).

Perhaps unsurprisingly, the increase in substantiations has coincided with an increase in children living in OOHC. On 30 June 2017, there were 10,312 children[[60]](#footnote-61) in OOHC in Victoria (AIHW 2016-17), up from 5,052 on 30 June 2007 (AIHW 2006-07), an increase of 104 per cent. Of these, 8,212 (79.6 per cent) were non-Aboriginal and 2,091 were Aboriginal (20.3 per cent). Aboriginal children represent 1.5 per cent of the child population aged zero to 17 years (ABS 2016 Census), and around 20 per cent of children in OOHC. Since 2006-07, there has been a more than three-fold increase (234 per cent) in the number of Aboriginal children in OOHC (626 Aboriginal children at 30 June 2007). This compares to around a 90 per cent increase in the number of non-Aboriginal children in OOHC. Over the decade, the rate of Aboriginal Victorians in OOHC care per 1,000 children has increased from 47.8 to 95.9. The equivalent national rate for Aboriginal children increased from 36.1 to 58.7 during the same period (AIHW 2008, 2018c).

The overrepresentation of Aboriginal children in OOHC occurs in the context of previous policies that caused significant harm to Aboriginal Victorians and the ongoing repercussions of colonisation. Assimilation policies, forced child removals and intergenerational trauma are all contributing factors in the ongoing overrepresentation of Aboriginal children in care (AIFS 2017). Additional contributing factors, which are often closely intertwined with those mentioned above, include higher rates of social and economic disadvantage and underrepresentation in universal prevention and early intervention services (Lewis et al 2017).

Cultural plans are now required for all Aboriginal children in OOHC. According to DHHS' record keeping system, at 30 December 2017, there were 1,614 Aboriginal children in care for more than 19 weeks, the period prescribed for the development of a cultural plan. Of these children 24.4 per cent had an endorsed plan.[[61]](#footnote-62) These plans are important for maintaining the connection between children and their culture during periods when they are at risk of losing that connection. This can prove to be a significant protective factor for these children’s health and wellbeing.

The Aboriginal Child Placement Principle governs child protection services in relation to placement of Aboriginal children who are unable to live safely with their parents’ family. It was established to support stronger connections between Aboriginal children in child protection and their family, community and their cultural identity. The principle sets out placement options for Aboriginal children in order of preference:

* the child’s extended family and kinship networks
* the child’s Aboriginal community
* with other Aboriginal carers
* with non-Aboriginal carers.

*A kinship worker has been working with child protection to help find a family for two siblings residing in care. The maternal family did not want to be involved. The children’s father had limited information about his biological family and despite his strong desire to connect with his family, efforts to date had been unsuccessful.*

*When interviewing the father about his memories, the father spoke about an aunt. Follow up occurred with an Aboriginal agency, and a local elder and discovered the father had a large extended family. When contact was made with the aunt, she said she was aware of the children’s situation but hadn’t known how to get in touch. The aunt is now in telephone contact with the eldest child, and it is hoped that this relationship, and a relationship with the other child, will continue to grow. Workers are liaising with Births, Deaths and Marriages to help the father find out more about his family.*

For the first time in 2016-17, the proportion of Victorian Aboriginal children (77.9 per cent) being placed with an Aboriginal carer, relative or in Aboriginal residential care surpassed the national figure (67.6 per cent) (AIHW 2018c). This was a large increase on the 2015-16 result of 58.4 per cent (AIHW 2017c). This was the first time the proportion of Victorian Aboriginal children being placed in line with the Aboriginal and Torres Strait Islander placement principle had exceeded 60 per cent since 2007-08 (67.9 per cent).

Aboriginal children do better when connected to culture and every Aboriginal child must have the opportunity to learn, practice, thrive and pass on their culture.

*It is well recognised that Aboriginal Community Controlled Organisations (ACCOs) are best placed to provide support not only from a cultural and spiritual perspective but also because they are able to provide many of the fundamental health and community services a child and their family or carer needs to maintain community connectedness.*

*The* ***Transitioning Aboriginal Children to ACCOs initiative*** *seeks to have 100 per cent of Aboriginal children on contractible orders in care case managed by ACCOs by the end of 2021. This involves the transfer of resources, targets, and funding from community service organisations and DHHS to ACCOs, as well as enabling the safe transition of children and their carers to ACCOs. The initiative has established enduring partnerships between government, community service organisations and ACCOs.*

The number of children in home-based care has doubled between 2006-07 and 2016-17, from 4,674 at 30 June 2007 to 9,820 at 30 June 2017. This represents a 2.7 percentage point increase (92.5 per cent in 2007 to 95.2 per cent in 2017) in the proportion of children in the OOHC system that are in home-based care.

Table 29 Proportion of Victorian children (aged 0-17) in out of home care, by placement type, 2010 to 2017. Source: Australian Institute of Health and Welfare, Child Protection Australia.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Placement type** | **30-Jun-10** | **30-Jun-12** | **30-Jun-14** | **30-Jun-16** | **30-Jun-17** |
| Foster care | 40.8 | 34.9 | 27.7 | 15.9 | 15.2 |
| Relatives/kin | 40 | 45.6 | 50.3 | 56.4 | 49.7 |
| Third-party parental care |  |  |  | 20 | 28.3 |
| Other home-based care | 10.5 | 11.1 | 14.7 | 2.8 | 2.0 |
| Total home-based care | 91.3 | 91.6 | 92.7 | 95 | 95.2 |
| Residential care | 8.3 | 7.7 | 6.7 | 4.5 | 4.3 |
| Independent living | 0.4 | 0.6 | 0.6 | 0.4 | 0.5 |

Children in home-based care are more likely to have only one placement. Through an OOHC outcomes tracking survey, case managers reported that 42 per cent of children in home-based care had only had one placement, compared to seven per cent in residential care placements (DHHS 2017b). Overall, 39 per cent of children in OOHC have had one move, 44 per cent have had between two and five placements, 11 per cent have had between six and 10, five per cent have had between 11 and 20 placements and one per cent have more than 21 (Ibid.). Placement stability helps children to keep friendships, maintain relationships with services, remain engaged with school and continue with community activities (Beauchamp 2014). Placement instability is associated with poor educational, employment and psychological outcomes and affects a person’s ability to maintain relationships (Johnson et al 2011).

*In line with the* ***Roadmap for Reform*** *and the new child and family system framework, DHHS is strengthening home-based care, and transforming residential care to a time-limited intensive support response that focuses on early intervention to help children recover from the effects of trauma and neglect. A new kinship care model has been implemented to support Victoria’s largest cohort of carer households. Targeted Care Packages are used to unify children and young people with their families, preventing entry into and supporting transition out of residential care.*

*To develop alternatives to residential care, DHHS is testing innovative models including professionalised foster care and an intensive support service with integrated mental health for young people who have experienced significant trauma.*

*Over 2016-17 and 2017-18, the daily average number of children in residential care has trended down, with a two per cent reduction from 1 July 2016 to 30 June 2018.*

# 4.0 Inclusive and enabling communities

The impact of communities on children’s health and wellbeing

## Key facts

**Communities play a significant role in the health and wellbeing of children, providing them with the strength, support and resources that they need, as well as a positive environment that enables children to flourish.**

A supportive community for children, with trusted adults and support in times of need, contributes to a happy and healthy childhood. In 2017, around 94% of Victorian families reported they had access to support in times of need.

*Having a trusted adult is an important protective factor for children, providing a role model and reducing the likelihood of them engaging in risky behaviours.*

While most school aged children in Victoria reported having a trusted adult in 2016, older students and those from single-parent families were less likely to do so.

**Table 30 Victorian students (Years 5, 8 & 11) with a trusted adult, 2016. Source: Victorian Student Health and Wellbeing Survey, 2016.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Statewide** | **Couple-parent** | **Single-parent** | **Year 5** | **Year 8** | **Year 11** |
| 2016 | 69% | 75% | 66% | 75% | 65% | 64% |

Providing the physical infrastructure that children need is another vital ingredient to an inclusive and enabling community. In 2017, almost nine in ten Victorian families reported having good access to parks and playgrounds.

*When children have good access to parks and playgrounds, it offers them better opportunities for physical activity.*

Although most Victorian families do have parks and playgrounds close by, those from the most disadvantaged backgrounds are much less likely to have good access than those from more affluent families.

**Table 31 Victorian families who believe their children (aged 0-12 years) have good access to parks and playgrounds, 2017. Source: Victorian Child Health and Wellbeing Survey, 2017.**

| **Cohort** | **Proportion of children** |
| --- | --- |
| Statewide | 89% |
| Metro | 93% |
| Rural | 79% |
| Couple parent families | 90% |
| Single parent families | 85% |
| SEIFA quintile 1 (most disadvantaged) | 76% |
| SEIFA quintile 3 | 87% |
| SEIFA quintile 5 (least disadvantaged) | 96% |

When children enjoy a safe living environment, they are more likely to engage and participate in social and academic activities. In 2017, more than nine in ten Victorian families believed that the communities they lived in were safe.

*Feeling safe is a key precursor to health and wellbeing. Conversely, unsafe communities are associated with risky behaviours.*

While 98% of children under 13 years in the least disadvantaged areas reportedly live in safe neighbourhoods, this dropped to 81% in the most disadvantaged areas.

**Table 32 Victorian students (Years 5, 8 and 11) living in disorganised\* communities who have ever smoked tobacco or used illicit drugs, 2016. Source: Victorian Student Health and Wellbeing Survey, 2016.**

|  |  |  |
| --- | --- | --- |
| **Community disorganisation** | **Proportion of students who have ever smoked tobacco** | **Proportion of students who have ever used illicit drugs** |
| Students living in a disorganised community | 50.2% | 55.8% |
| Students not living in a disorganised community | 33.3% | 28.9% |

\**Survey defined disorganisation through student responses to questions about how safe they feel, the presence of fights, and crime in their neighbourhood.*

*Young people in contact with the youth justice system are more likely than their peers to come into contact with the criminal justice system as an adult.*

In 2016-17, a total of 2,822 young Victorians were found guilty of an offence, down from 6,633 in 2008-09.

**Table 33 Australian young people (10-17) under supervision, rate per 10,000, community and custodial supervision, states and territories, 2016-17. Source: Australian Institute of Health and Welfare, 2017.**

| **State/Territory** | **Non-Aboriginal** | **Aboriginal** |
| --- | --- | --- |
| Victoria | 11 | 148 |
| New South Wales | 9 | 154 |
| Queensland | 12 | 203 |
| Western Australia | 11 | 294 |
| South Australia | 8 | 214 |
| Tasmania | 16 | 59 |
| Australian Capital Territory | 15 | 182 |
| Northern Territory | 6 | 134 |
| Australia | 11 | 184 |

*Young people in custody are among the most vulnerable in the community, with many facing challenges related to mental health, disability and homelessness.*

More than half of young people in the youth justice system had prior interactions with child protection services, while over a third had accessed mental health services.

**Table 34 Young people receiving youth justice orders who have engaged with DHHS services, Victoria, 2015-16. Source: Armytage and Ogloff, 2017.**

| **Interaction with Department of Health and Human Services** | **Males** | **Females** |
| --- | --- | --- |
| Previous involvement with child protection | 48% | 69% |
| Received alcohol and drug services | 46% | 45% |
| Received mental health services | 31% | 41% |
| Received disability services | 7% | 4% |

## Introduction

Another particularly important environmental factor in a child’s healthy development is the community. A strong community provides a family with strength, resources and services to draw upon in times of need (Department of Victorian Communities (DVC) 2006). This is particularly important during stressful periods and times of major change. A strong community can reduce parental stress and support good parenting, which has positive ramifications for children’s outcomes (Ibid. Kohen et al 2008). For example, a strong social network and community can support mothers during pregnancy, reducing the probability of depression and risky behaviours. A strong and healthy community environment can also provide role models for young children and resources that improve safety, learning and social connectedness (Leventhal and Brooks-Gunn 2000). More affluent neighbourhoods are associated with increased learning outcomes (Ibid.). Research suggests healthy communities with high-quality facilities promote social connections, encourage recreation and involvement in sporting and artistic activities (DVC 2006). Conversely, a less supportive and fragmented community environment with poor perceptions of safety and a lack of access to transport and heightened socioeconomic disadvantage can be harmful to a child and family (Australian Social Inclusion Board (ASIB) 2010; Leventhal and Brooks-Gunn 2000; Kohen et al 2008). That is why in order to understand how Victoria’s children are faring, it is important to understand more about our communities, including the physical and social environments in which we live.

This chapter will be broken into three parts that each highlight different elements of communities that are important to the wellbeing of children and families including: types of social support they can draw on within their communities; the physical environment and transport access; and community safety. Looking at all of these aspects of communities provides a comprehensive understanding of the support networks and environments surrounding Victorian children and their families.

## 4.1 Community support and the social environment

Families that have adequate support networks and structures in times of need generally have higher levels of economic, physical and mental health outcomes than those without, which has implications for children living within these family structures. The social environments we live in are vital to our health and wellbeing. Respectful relationships focus on promoting respect, positive attitudes and behaviours to build healthy relationships, resilience and confidence. Embedding a culture of respect and equality in young people leads to positive impacts on their mental health, relationships with peers and adults, and long-term developmental outcomes.

### 4.1.1 Support in times of need

The VCHWS provides insights into the support networks of young Victorian families. According to the survey, the proportion of Victorian families with children under 13 years of age who report being able to get help in times of need has remained fairly stable since 2006. In 2017, around 94 per cent of children were living in families that could access support in times of need. While there were no characteristics that were associated with substantially poorer social connectedness, there was still a slight social gradient to the measure. Families from the most disadvantaged quintile of households (87 per cent), single-parent families (90 per cent) and parents of children listed on a Health Care Card (91 per cent) were the least likely to be able to get support from families and friends in times of need.

### 4.1.2 Young people who have a trusted adult in their life

A child having a trusted adult from outside their immediate family, who they can turn to if needed, is another important factor that promotes positive wellbeing. Relationships held with peers and trusted adults support the development of executive functioning, self-regulating behaviours, and the ability to cope with manageable threats, all fundamental to building resilience (NSCDC 2015). Resilience, the ability to adapt and function positively in the face of adversity, equips children and young people with perseverance through times of stress. It is through these positive relationships from outside a young person’s immediate family that the community can promote children’s health and wellbeing.

According to the VSHAWS, seven in 10 students in Victoria report having a trusted adult in their life. Students in Year 5 are more likely to have a trusted adult than adolescents. Language background and family type were the family characteristics that were most strongly associated with having a trusted adult. Students from an English speaking background (71 per cent) are much more likely than students from other language backgrounds to report having a trusted adult in their life (59 per cent). For students from other language backgrounds this marked a decline from the already low 2014 survey result of 64 per cent. Students from single-parent families (66 per cent) were also less likely to have a trusted adult in their life compared to those in couple-parent families (75 per cent).

Table 35 Proportion of Victorian students (Years 5, 8 and 11) with a trusted adult in their life, by family type, year level and language background, 2016. Source: Victorian Student Health and Wellbeing Survey, 2016.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Statewide** | **Couple parent** | **Single parent** | **Year 5** | **Year 8** | **Year 11** | **LBOTE** | **English** |
| 2016 | 69% | 75% | 66% | 75% | 65% | 64% | 59% | 71% |

While most families and children in Victoria are well supported, there is a minority who require additional help. Both indicators highlight that the families that most commonly experience greater social isolation are those facing higher levels of socioeconomic disadvantage.

***Respectful Relationships*** *supports schools and early childhood education settings to promote respectful relationships, positive attitudes and behaviours, and to teach children how to build healthy relationships, resilience and confidence.*

*Victoria’s Royal Commission into Family Violence recognised the critical role that schools and early childhood education settings have in creating a culture of respect and gender equality to change the story of family violence for future generations. The Commission recommended respectful relationships education be introduced into every government school from Prep to Year 12, and be delivered through a whole-school approach.*

*In response to this recommendation, more than 1000 government, Catholic and independent schools are participating in the Respectful Relationships initiative, which also includes professional learning for up to 6,000 early childhood educators in Victorian government-funded kindergarten programs.*

### 4.1.3 Adults who thought multiculturalism definitely made life in their area better

Victoria has a proud history of multiculturalism. As outlined earlier in this report, more than 28 per cent of Victorian residents were born overseas and many more come from families that have recently migrated. The attitudes of Victorians towards multiculturalism impacts on this large group of Victorians’ feelings of safety and their ability to participate in society.

The Victorian Population Health Survey provides some insights into Victorian's opinions about the impact of multiculturalism on their life. In 2016, 76.6 per cent of Victorians reported that multiculturalism had made their life better, at least sometimes. This was a slight increase on the 2015 result of 75.7 per cent (DHHS 2018b).

### 4.1.4 Voluntary work

Volunteering supports individuals’ health and wellbeing through a range of mechanisms, including growing support networks, improving self-esteem and linking people with career paths (DVC 2006). It can be used as a measure of the strength of a community. In 2016, around 19 per cent of Victorians over the age of 15 years had participated in voluntary work, which was the same as the proportion of Australians engaging in voluntary work (PHIDU 2016b). In regional Victoria, residents were more likely to have engaged in voluntary work (24 per cent) than in Melbourne (18 per cent). West Wimmera (45 per cent) and Buloke (40 per cent) had the highest proportion of volunteer residents over 15 years of age (PHIDU 2016; ABS 2015b).

## 4.2 Healthy, accessible and enabling communities

Economic opportunities, access to services and the quality of the physical environment have a substantial impact on health and wellbeing (Butterworth 2000). Societies both rich and poor are judged by the quality of their population’s health, how fairly this is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of poor health (World Health Organisation (WHO) 2008). This is apparent in a variety of ways. For example, parental and community perceptions of danger are influenced by the physical, socioeconomic and cultural features of neighbourhoods. Neighbourhoods that enable higher levels of social interaction through their design, including through spaces such as parks, playgrounds and play spaces, are associated with less danger and improved wellbeing (Francis et al. 2012, 2017).

In addition, access to close affordable transport has widespread benefits for the health and wellbeing of children and young people. This includes promoting active lifestyles and contributing to improved mental health. Research indicates that patrons of public transport will, on an average trip, accumulate around seven times more incidental exercise than private motorists, contributing substantially to the daily recommended physical activity level needed to minimise the risk of obesity (Socialdata Australia 2000). In particular, for children and young people, access to transport is also a key enabler of social interactions and access to employment opportunities.

*The Victorian Government has established nine* ***Regional Partnerships*** *and six* ***Metropolitan Partnerships*** *across Victoria. The Partnerships are a way for local communities to engage directly with state and local governments, and advise the Victorian Government of their top priorities for jobs, services and infrastructure across the region. The Partnerships provide their communities with a platform to improve outcomes and economic opportunities for children and young people.*

*Partnership priorities are already starting to make a difference to the lives of young people. Following advocacy from the Barwon Regional Partnership, the Victorian Government funded the expansion of The Geelong Project to four more government secondary schools, centralising youth support and delivering pre-crisis help. The Victorian Government has also funded increasing demands for Early Start Kindergarten, helping the Western Metropolitan Partnership improve participation in early childhood education for socially disadvantaged families.*

### 4.2.1 Physical environment

One measure of a community’s physical environment is found in the VCHWS, which asks parents of children aged zero to 12 years about access to parks and playgrounds. Eighty nine per cent of Victorian children had access to good parks and playgrounds in 2017. Between 2006 and 2017 each survey has reported increases in the proportion of children living in neighbourhoods with access to good parks and playgrounds. Interestingly, parents of children in rural areas are less likely to report having access to good parks and playgrounds than parents in metropolitan areas. The most pronounced differences relate to children living in disadvantaged communities, who report significantly poorer access to parks and playgrounds. In 2017 there was a 20.5 percentage point gap between the proportion of children in the most disadvantaged quintile of communities (75.7 per cent) who reported good access to parks and the proportion of children in the least disadvantaged quintile of communities (96.2 per cent). This is a similar gap to the 2006 survey, with access for children in both quintiles improving slightly over the intervening period. Children from single-parent families and children listed on a Health Care Card are also less likely to have access to these spaces.

Table 36 Proportion of children (aged 0-12 years) living in neighbourhoods with access to parks, playgrounds and play spaces, by SEIFA IRSD quintile, Victoria, 2006 and 2017. Source: Victorian Child Health and Wellbeing Survey, 2006 and 2017.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Q1** | **Q2** | **Q3** | **Q4** | **Q5** |
| 2006 | 73% | 76% | 83% | 84% | 93% |
| 2017 | 76% | 83% | 87% | 92% | 96% |

The food environment, inside and outside of the home, influences a children’s dietary intake. Unhealthy foods and drinks are readily accessible in large portion sizes. The ‘super-sizing’ of convenience foods means that, for just 12 per cent more in price, one can consume 23 per cent more energy, 25 per cent more fat and 38 per cent more sugar (DHHS 2016a). The density of fast food outlets is four times that of green grocers/supermarkets in eight mapped Victorian LGAs and up to six times more in some suburbs.

These food options are often relatively inexpensive and heavily promoted, with advertising often targeting children. The current food environment is a major contributor to poor diets due to disproportionate access, affordability and promotion of discretionary foods. One-fifth of Australians eat dinner out or have takeaway for dinner more than five times a week (DHHS 2016a). Unhealthy choices dominate in other everyday settings too such as at the checkout of supermarkets, in convenience stores and at train stations on the way to and from school.

In addition, Australian children are exposed to high levels of advertising and promotion of unhealthy food and drinks. There is clear evidence that children’s exposure to unhealthy food marketing negatively influences their food choices and is contributing to increasing rates of overweight and obese children (WHO 2010; Lumley, Martin & Antonopoulos 2012).

*The* ***Growing Suburbs Fund*** *contributes to meeting critical local infrastructure needs for communities in Melbourne's changing and fast-growing outer suburbs. It enables the Victorian Government to respond to the pressures being experienced by interface communities by providing funds for local infrastructure projects that improve liveability and resilience. Projects funded by the Growing Suburbs Fund that benefit children include early education, learning and training infrastructure, and sport, recreation and leisure facilities that serve several purposes. Examples of past projects include:*

* *Growth Corridor District Playground in Cardinia Shire Council;*
* *Sunbury Warm Water Pool in Hume City Council;*
* *Bridge Road Regional Play Space in Melton City Council;*
* *Greater Beveridge Community Centre (including kindergarten rooms and maternal and child health rooms) in Mitchell Shire Council;*
* *Waterfall Gully Preschool Expansion Project in Mornington Peninsula Shire Council; and*
* *Truganina East Integrated Family Learning Centre in Wyndham.*

### 4.2.2 Transportation

As highlighted at the beginning of this section, access to public transport is particularly important for young people. As children go through adolescence and develop independence, they rely on public transport and non-motorised transport to meet friends, go to school, engage in community life and access employment opportunities. This is particularly true as more and more families have caregivers in full-time employment.

Data on public transport access shows clear disparities between regional and metro areas. On average, 75 per cent of the populated area of metropolitan LGA in Victoria is within walking distance of public transport. However, in regional Victoria, the figure falls to around 22 per cent. In addition, the disparity between metropolitan and regional Victoria is evident if LGAs are ordered by the proportion of the populated area that is within a 20-minute walk of public transport, with services at least every 20 minutes. On this metric, the top 25 LGAs are located in Melbourne and 24 of the bottom 25 LGAs are in regional Victoria. This is expected due to the impact of distance in regional areas however it is important to consider access to services and its relationship to equity.[[62]](#footnote-63)

More disadvantaged areas across Victoria, particularly in Melbourne, have worse access to public transport than less disadvantaged areas. Looking at access to public transport by SEIFA quintile illustrates this fact. Across Victoria, 48 per cent of populated areas in LGAs in quintile one (most disadvantaged) were within walking distance of public transport. However, 72 per cent of populated areas within quintile five (least disadvantaged) were within walking distance of public transport. The social gradient was evident in metropolitan areas in Victoria (Q1 – 70 per cent and Q5 – 83 per cent) and in regional areas (Q1 – 24 per cent and Q5 – 37 per cent).[[63]](#footnote-64) [[64]](#footnote-65)

Within regional Victoria, larger population centres generally have better access to public transport. Among regional LGAs, the five most populous regional LGAs are all in the top 10 regional LGAs for walking access to public transport with services at least every 20 minutes. However, in Melbourne the pattern is different. Rapidly growing LGAs with large populations on the urban fringe of Melbourne, such as Casey, Wyndham and Whittlesea, suffer from poorer levels of access to frequent public transport, while LGAs in central Melbourne with smaller populations have better access to transport.[[65]](#footnote-66)

Another measure of access to transport is the proportion of households without a car. This is particularly important in areas experiencing greater isolation due to rurality or a lack of public transport. In Victoria in 2016, around 7.9 per cent of households had no car (PHIDU 2018b). This is similar to the Australia wide result of 7.5 per cent. Outside of Melbourne and Geelong, only 5.3 per cent of households did not have a car (Ibid.).

## 4.3 Neighbourhood safety

Safety is an important precursor to learning, health and wellbeing. Evidence has shown that when children and young people feel safe they are more likely to attend, engage and participate fully in their school and broader community (MacKay 2012; VicHealth 2015; Legge 2018; Carver, Timperio & Crawford 2008). There is also evidence suggesting that a lack of community safety is a risk factor for depressive symptoms in children (Stirling, Toumbourou & Rowland 2015).

Most Victorian communities are very safe. Results from the 2017 VCHWS show that more than nine in 10 parents (of children aged zero to 12 years) perceive their neighbourhood to be safe. Parents in rural areas are slightly more likely to perceive their neighbourhoods as safe. However, the survey shows that socioeconomic factors can reduce parents’ perceptions of community safety.

Parents from more disadvantaged living situations report feeling less safe than those in more affluent environments. In 2017, while 98 per cent of children under the age of 12 years living in the least disadvantaged areas were in neighbourhoods their parents perceived to be safe, this fell to around 81 per cent of children (aged zero to 12 years) living in the most disadvantaged quintile of families.[[66]](#footnote-67) This is down from 88 per cent in 2013 and 87 per cent in 2006 and 2009. Children in single-parent families and those listed on a Health Care Card are also less likely to live in neighbourhoods that their parents perceive as safe. In 2017, around 93 per cent of children in couple-parent households were in safe communities compared to 88 per cent of children in single-parent households. Children listed on a Health Care Card were also less likely to be living in safe neighbourhoods (86.5 per cent) than those not listed on a Health Care Card (94.4 per cent). These results highlight that, while Victorian parents from all walks of life report high levels of community safety, families facing greater socioeconomic disadvantage are less likely to perceive their neighbourhoods as safe.

Table 37 Proportion of Victorian children (aged 0-12) living in neighbourhoods that their parents perceive as safe, SEIFA IRSD quintile, 2006 and 2017. Source: Victorian Child Health and Wellbeing Survey, 2006 and 2017.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Q1** | **Q2** | **Q3** | **Q4** | **Q5** |
| 2006 | 87% | 92% | 94% | 96% | 98% |
| 2017 | 81% | 89% | 91% | 94% | 98% |

### 4.3.1 Community disorganisation and reported crimes committed against young people

Exploring crime and unsociable behaviours in communities helps to illustrate the impact of community disorganisation on children’s health and wellbeing. Children or young people who have been victims of crime or trauma have the potential to develop serious vulnerabilities in various facets of their lives, including their interpersonal relationships, learning and mental health. Perceptions of danger can act as barriers to children and young people participating in health promoting behaviours, in particular by restricting children from undertaking active methods of transport, such as walking and cycling, or independent free play in public spaces without adult accompaniment (Crawford et al. 2015, 2017; Legge 2018).

In 2016–17 there were 12,806[[67]](#footnote-68) reported crimes committed against children (under 18 years of age). Over the last five years, there has been an increase in the number of crimes with child victims – an increase of almost 2,000 reported crimes since 2012–13. That growth has been driven by an increase in reported crimes against the person, which are by far the most common reported offences committed against children and young people.[[68]](#footnote-69)

In each of the past five years, girls have been more likely to be victims of crime than boys. For example, in 2016-17 there were 5,918 reported crimes committed against boys and 6,852 against girls. This equates to 16 per cent more reported crimes committed against young females than males.[[69]](#footnote-70)

Most children grow up in communities they and their parents perceive to be safe. However, it is clear that some children are victims of crime and live in unsafe communities. The VSHAWS asks students in Years 5, 8 and 11 about disorganisation in their communities. The survey defines disorganisation through a combination of students’ feelings of danger, the presence of physical fights and drug crime. Across Victoria in 2016, around 23.2 per cent of students were living in communities characterised as disorganised. This was a similar proportion to the survey’s result two years earlier.[[70]](#footnote-71)

Crime and a lack of safety in a community can be a negative influence on the wellbeing of children. Exploring correlations between community disorganisation and risky behaviours highlights the association between crime and unsafe neighbourhoods and children’s wellbeing. For example, children living in disorganised communities (where they feel unsafe, there are physical fights and drug crime) were more likely to have ever smoked a cigarette, more likely to have tried illegal drugs and more likely to have experienced psychological distress. While resilience could help protect children from unhealthy community environments, children exposed to these environments are less likely to report high levels of resilience. In 2016, only 19.6 per cent of children who said their community was disorganised also reported high levels of resilience. However, 59.1 per cent of children living in communities that did not exhibit the characteristics of disorganisation reported high levels of resilience.[[71]](#footnote-72) Crime, fighting and feelings of a lack of safety in neighbourhoods appear to correlate with increases in the probability that children engage in risky behaviours and experience psychological distress.

### 4.3.2 Youth custody and crime

*The* ***Embedded Youth Outreach Project*** *(EYOP) is a pilot program that sees a police officer paired with a youth worker to support engagement with young people coming into contact with police at two sites in the north-western and south-eastern suburbs of Melbourne. The EYOP team provides support for police interactions with young people and engages with young people in the field or at a police station to assess their needs and provide support and referral. The project aims to link young people and their families with community-based supports to address their needs and reduce their likelihood of further contact with police. The EYOP operates outside of business hours, reflecting the time of day during which police most commonly encounter at-risk young people.*

Another way of understanding community safety, particularly in relation to the experiences of young people, is by looking at reported crimes committed by young people. Only a small number of young people in Victoria are involved with the criminal justice system. However, those that do come into contact with the youth justice system are more likely than their peers to come into contact with the criminal justice system as an adult.

In 2016-17, a total of 2,822 young people were found guilty of an offence, a reduction of 3.7 per cent on the previous year, evidencing a significant and continuing downward trend since 2008-09 when a total of 6,633 young people were found guilty of an offence (Children’s Court of Victoria 2018).

*At 14 years of age, Damien\* was charged with theft and burglary for offences committed at a bicycle shop. At court, he was referred to the* ***Children’s Court Youth Diversion Service*** *for an assessment, which indicated Damien was disengaged from education due to a history of poor academic performance and bullying.*

*The Diversion Coordinator developed a plan with Damien, which included goals to improve his attendance at school, engage in counselling with a mental health support service and write a letter of apology to the victim.*

*During the adjournment period, the Diversion Coordinator referred Damien to the student Health and Wellbeing Support Officer. The Support Officer assisted Damien to access tutoring, return to school on a part-time basis and participate in a mechanics program to inspire him to continue his education. When Damien returned to court, he had completed all the goals of his plan and the court discharged his offences, resulting in a non-discloseable criminal record.*

*\* Name has been changed*

*The* ***Youth@Risk Taskforce*** *of the Inner Gippsland Children and Youth Area Partnership (IGCYAP) is working to improve outcomes for children and young people at risk of entering the justice system. Evidence demonstrates early intervention can maintain young people’s connection with education and support better outcomes.*

*The IGCYAP used data from the local Child FIRST agency, DET, DHHS, Department of Justice and Regulation and Victoria Police to understand the experiences of young people at risk and how their families have interacted with services. A deep dive into the experiences of five children (from birth to ages 10 to 14 years) and four families showed that each had significant contact with the service systems. Key findings included:*

* *Education: no child made a successful transition from primary to secondary school, with all exiting before the end of Year 7, and many of the absences from school in primary and secondary school were correlated with incidents of family violence*
* *Family services: school attendance increased and reported family violence was significantly reduced when family services were involved with the family*
* *Child Protection: all children had multiple reports to child protection (total reports equated to one report every six months of a child’s life), and all had contact with Child Protection within the first year of their life*
* *Family Violence: high numbers of family violence incidents reported to Victoria Police, with many of the children’s offending occurring close to a family violence incident*
* *Parental offending: all children’s parents had been subject to a Correctional Order with the Department of Justice and Regulation (now known as the Department of Justice and Community Safety).*

*The findings from this data analysis have driven the development of three local strategies:*

* *• Reboot: focused on developing targeted responses for up to 30 children aged 10 to 14 years who are at risk of entering the justice system*
* *• Dads Do Matter: an eight-week parenting program targeting 32 men on community correctional orders who are fathers of children aged 10 years and under*
* *• Wonthaggi Multi-Agency response: a coordinated and targeted referral process for young people.*

*Through this work, children and young people are being provided with wrap-around supports and their participation in school has increased. The impacts that are expected from this work are epitomised in one 12-year-old boy, ‘Harry’ who was referred to Reboot in December 2017 after entering kinship care. Through the program, Harry, his grandmother, his care team, his mentor and the school advisers meet fortnightly to work on positive strategies at home and school. Since participation in Reboot, Harry’s participation in school has increased and he has not presented with further challenging behaviours.*

#### 4.3.2.1 Young people under Youth Justice Supervision

In Victoria, the majority of young people under supervision on an average day were male (85.5 per cent). This proportion was higher among those in custody (94.7 per cent) than those supervised in the community (83.6 per cent) (AIHW 2018g). Most young people under supervision on an average day were aged 14 to 17 years (67 per cent). About three per cent of young people under supervision in Victoria were aged 10 to 13 years of age, and 30 per cent were aged 18 years and over (AIHW 2018g). The proportion of Victorian young people who returned to supervision within a year of being released increased between 2013-14 and 2014-15. In 2013-14, around 40 per cent of young people aged 10 to 16 years who were released from sentenced supervision returned within 12 months. This increased to nearly 45 per cent in 2014-15 (Productivity Commission 2018b).

Ms Penny Armytage and Professor James Ogloff AM delivered the Youth Justice Review and Strategy: Meeting needs and reducing offending in August 2017. This was the first independent and system-wide review of Victoria’s youth justice system in 17 years. The Victorian Government has accepted all 126 recommendations from the Review in full or in principle, and work is underway to implement reforms arising from the recommendations.

The Review found that many young people in youth justice (both in the community and in custodial centres) have complex needs, and data suggests their needs are becoming more complex over time.

Many young people engaged with the youth justice system exhibit one or more of the following complicating characteristics:

* socioeconomic disadvantage
* intergenerational trauma and grief
* childhood abuse
* exposure to criminal activity committed by parents or siblings
* disrupted education
* high levels of disability, cognitive impairment, language and communication delays
* high levels of mental health concern, drug and alcohol disorders and foetal alcohol syndrome
* high levels of family conflict, unstable accommodation and homelessness (Armytage & Ogloff, 2017).

The AIHW found that in Victoria in 2016-17, the rate of Aboriginal young people aged 10 to 17 years under supervision on an average day was 148 per 10,000, compared with 11 per 10,000 for non-Aboriginal peers (AIHW 2018g). This means that in Victoria, Aboriginal young people aged 10 to 17 years were about 14 times as likely as non-Aboriginal young people to be under supervision on an average day. In comparison to other jurisdictions, Victoria’s ratio of Aboriginal young people under supervision was the second lowest.

Victoria has much to gain by finding new and innovative ways to address overrepresentation and deliver culturally appropriate programs. Tailoring interventions to individual needs allows participants to engage appropriately with interventions for greatest effect.

The Koori Youth Justice Program provides community-based early intervention and young people in pro-social activities with the community to reduce their risk of re-offending, such as site visits and camps, and programs connecting young people to culture, to engage classes. It also includes delivering relevant programs, cultural and community activities in school through providing relevant cultural supports and assistance, such as homework assisting Aboriginal young people who are at risk from disengaging from school to remain of entering, or re-entering the criminal justice system. Early intervention assistance includes prevention initiatives, and culturally safe support for Aboriginal young people who are at risk of re-offending.

The Government has made significant investment and is implementing a range of initiatives across youth justice to prevent offending, to reduce overrepresented groups from entering the system and to ensure the availability and delivery of effective interventions and services. This includes:

* $12.9 million to continue the Children’s Court Youth Diversion Service to keep offending behaviour from escalating and to support rehabilitation.
* $11.5 million to develop a new integrated case management framework across youth justice community services as well as youth justice custodial centres, and to assess the risks and needs of every young person in youth justice.
* $3.8 million for the creation of a new Custodial Classification and Placement Service to review the security risk of all young people in custody to ensure they are appropriately and safely placed.
* $18.7 million to provide additional health and mental health services to young people in custody, to support their health and rehabilitation.
* $1.3 million for a strategy to reduce the overrepresentation of Aboriginal young people in youth justice.
* $10.8 million for targeted interventions to address Aboriginal overrepresentation, including expanding the Koori Youth Justice Program, establishing a dedicated Aboriginal Youth Justice Taskforce to examine the care of Aboriginal young people in youth justice and increasing the number of Aboriginal custodial workers in youth justice.
* $2.5 million to reinstate and expand structured day programs across both youth justice precincts.
* $8.8 million to deliver a suite of new evidence-based Youth Offending Programs and psychosocial programs for young people in custody and under community supervision.
* $15 million for a whole-of-government approach to address youth offending, including to provide culturally responsive initiatives.
* $288 million for a new fit-for-purpose youth justice facility at Cherry Creek.
* $58 million to repair, strengthen and fortify both youth justice centres.
* $79 million to build an additional 68 secure custodial beds across the system and a further $73 million to operate the new units.

# 5.0 Physical and mental health

A holistic discussion of children’s health and wellbeing

## Key facts

**Good mental and physical health early in life is intrinsically important and proven to lead to better outcomes later in life.**

Children who are happy, healthy and confident are better able to fully engage in their environment, helping them to fulfil their potential.

*Most Victorian children are faring well.*

Three in four students report being satisfied with their lives, while almost nine in ten report good, very good or excellent health.

However, the proportion of children with an emotional, developmental or behavioural difficulty has risen to one in ten in 2017.

**Table 38 Victorian Students in Years 5, 8 and 11 who are happy and healthy, Victoria, 2016. Source: Victorian Student Health and Wellbeing Survey, 2016.**

| **Year** | **Children who report being satisfied with their lives** | **Children who report their health being good, very good or excellent** |
| --- | --- | --- |
| 2016 | 75% | 87% |

**Table 39 Victorian children (aged 6 months - 12 years) with an emotional, developmental or behavioural difficulty. Source: Victorian Child Health and Wellbeing Survey, 2006-2017.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Statewide** | **Couple-parent family** | **Single-parent family** |
| 2006 | 4.0% | 3.1% | 9.5% |
| 2017 | 10.1% | 7.7% | 22.2% |

Monitoring protective factors such as nutrition and physical activity provides insight into the physical and mental health of children and young people.

*The proportion of children who are physically active has declined to around six in ten, and is lower for those in metropolitan areas.*

Meanwhile, over 30 per cent of 5-17 year olds in Victoria are overweight or obese. Younger children (aged 5-11) are overweight or obese at higher rates.

**Table 40 Children (aged 5-12) who are physically active for over 60 minutes daily, Victoria. Source: Victorian Child Health and Wellbeing Survey, 2006-2017.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Statewide** | **Metro** | **Rural** |
| 2006 | 71% | 70% | 74% |
| 2017 | 59% | 58% | 63% |

**Table 41 Children (aged 5-17) who are overweight or obese, Victoria, 2014-15. Source: Australian Bureau of Statistics, cat no 4364.0, 2015.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **5-7 years** | **8-11 years** | **12-15 years** | **16-17 years** | **5-17 years** |
| 2014-15 | 34.3% | 34.5% | 26.8% | 26.4% | **30.9%** |

Certain risky behaviours, such as smoking and drinking, are important indicators of the current and future health and wellbeing of young people.

*Behaviours like smoking, drinking and drug taking are strongly associated with negative impacts on physical and mental health.*

While overall rates have reduced slightly, children from single-parent families are more likely to have engaged in risky behaviours than those from couple-parent families.

**Table 42 Victorian students in Year 8 and 11 who report ever engaging in risky behaviours, 2016. Source: Victorian Student Health and Wellbeing Survey, 2016.**

| **Family type** | **Smoking** | **Consuming alcohol** | **Illicit drug use** |
| --- | --- | --- | --- |
| Statewide | 10% | 55% | 12% |
| Couple-parent family | 8% | 54% | 10% |
| Single-parent family | 15% | 64% | 18% |

*Engaging in unsafe sexual activity is another potentially risky behaviour that can impact the health and wellbeing young people.*

Just under one in six Victorian students report having ever had sex, and a quarter of those students report always using condoms.

**Table 43 Victorian students in Years 8 & 11 who report ever having had sex, Victoria, 2016. Source: Victorian Student Health and Wellbeing Survey, 2016.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Statewide** | **Couple parent family** | **Single parent family** |
| 2016 | 15% | 13% | 21% |

**Table 44 Sexually active Year 8 and 11 students who report always using condoms, Victoria, 2016. Source: Victorian Student Health and Wellbeing Survey, 2016.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Statewide** | **Metro** | **Rural** |
| 2016 | 27.5% | 25.7% | 33.0% |

Families’ use of hospitals, including presentations at emergency departments, indicate some of the trends in the health and wellbeing of children and young people.

*The rise of allergies among young people over recent years shows changing immunity and general physical health.*

Anaphylaxis hospitalisations among 10 to 17-year-olds have risen sharply, particularly for 15 to 17-year-olds, who are now hospitalised at almost seven times the rate of a decade ago.

**Table 45 Rate of anaphylaxis hospitalisations (per 100,000) among 10 to 17-year-olds, Victoria. Source: Victorian Admitted Episodes Databases, 2005-06 to 2016-17.**

|  |  |  |
| --- | --- | --- |
| **Year** | **10-14 years** | **15-17 years** |
| 2005-06 | 9.0 | 14.0 |
| 2006-07 | 9.6 | 25.0 |
| 2007-08 | 10.6 | 21.3 |
| 2008-09 | 12.1 | 32.8 |
| 2009-10 | 13.6 | 31.1 |
| 2010-11 | 16.4 | 27.6 |
| 2011-12 | 13.0 | 41.6 |
| 2012-13 | 13.2 | 19.0 |
| 2013-14 | 19.9 | 38.1 |
| 2014-15 | 26.7 | 52.9 |
| 2015-16 | 37.0 | 74.4 |
| 2016-17 | 44.7 | 93.6 |

*While not all children who attempt self-harm will attend hospital, presentations to hospital for self-harm provide insights into prevalence.*

From 2006-2016, the number of Victorian females aged between 10 and 17 presenting to hospital for self-harm increased from 679 to 1112 and the number of males increased from 174 to 327.

**Table 46 Rate of self-harm emergency department presentations among 10 to 17-year-olds, Victoria. Source: Victorian Admitted Episodes Database; Victorian Emergency Minimum Dataset, 2006-2016.**

|  |  |  |
| --- | --- | --- |
| **Year** | **Males** | **Females** |
| 2006 | 63.3 | 260.4 |
| 2007 | 69.9 | 212.9 |
| 2008 | 66.1 | 209.0 |
| 2009 | 84.9 | 206.2 |
| 2010 | 75.6 | 219.2 |
| 2011 | 82.9 | 231.0 |
| 2012 | 96.1 | 306.2 |
| 2013 | 97.0 | 400.9 |
| 2014 | 108.1 | 435.1 |
| 2015 | 96.8 | 390.4 |
| 2016 | 112.7 | 404.1 |

The provision of high-quality and easily accessible health services is key to combatting issues around physical and mental health.

*When families are unable to access basic health services, this has significant consequences for their health and wellbeing.*

The proportion of parents with access to services has risen since 2006, although a gap remains between metro and rural areas.

**Table 47 Children (aged 0-12) with access to basic health services, Victoria, 2006 and 2017. Source: Victorian Child Health and Wellbeing Survey, 2006-2017.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Statewide** | **Metro** | **Rural** | **On a Health Care Card** | **No Health Care Card** |
| 2006 | 87.7% | 91.2% | 78.6% | 84.9% | 88.7% |
| 2017 | 93.3% | 95.8% | 85.6% | 91.8% | 93.8% |

*Understanding whether children and young people access health services is an important measure of service utility.*

Around 14% of Australian children aged four to 17 experience a mental disorder. Around 75% of mental health conditions occur before the age of 25.

**Table 48 Proportion of Victorian young people (aged 0-24) using MBS subsidised mental health services, 2011-12 and 2016-17. Source: Report on Government Services, 2011-12 to 2016-17.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **0-4 years** | **5-11 years** | **12-17 years** | **18-24 years** | **Total** |
| 2011-12 | 0.8% | 4.8% | 6.9% | 8.4% | 5.6% |
| 2016-17 | 1.1% | 7.8% | 10.9% | 12.2% | 8.5% |

## Introduction

Children’s physical and mental health are individually important, interrelated and central to their overall wellbeing. A child’s physical wellbeing impacts their mental health, just as their psychological wellbeing affects their physical health. A healthy child is better able to engage with their education, make friends and enjoy their life (AIHW 2016a). Healthy young people are also more likely to flourish into healthy and happy adults. They are able to participate in their community, are better prepared to enter the workforce and provide a positive contribution to society.

Children’s health is shaped by complex interactions between genetics, individual characteristics, a range of environmental factors and their access to services. Longitudinal research on Victorian children found that those who flourish later in life tend to have childhoods characterised by strong family relationships, strong relationships with peers, better adjustment to life at school, better control over their emotions, a less emotionally reactive temperament and an interest in working for and being involved in the community (Vassallo & Sanson 2013). International research suggests that socioeconomic factors account for up to 40 per cent of all influences on health, health behaviours 30 per cent, clinical care 20 per cent and the physical environment 10 per cent (British Academy 2014).

Rapid technological change during the past century is one factor that has had a significant impact on children’s health. These advances have led to significant improvements in living standards and wellbeing. Medical advancements have improved the understanding and treatment of countless illnesses. Vaccines have curtailed diseases that once ruined children’s lives. In addition, communications technology has enabled children to make social connections in a way that was once impossible. Technology has enabled children to access vast amounts of information that unlocks lessons about the world around them. However, there are also challenges and problematic aspects to technological development. Indeed a range of modern health problems, explored earlier in this report and later in this chapter, are related to the way people interact with technology.

Most Victorian children are happy and healthy by national and international comparisons. However, there is a clear social gradient to health outcomes (State of Victoria 2015). While children from all walks of life can experience poor health outcomes, inequities related to socioeconomic factors are evident, including those related to family circumstances and community disadvantage explored earlier in this report. These circumstances that make a group of Victorian children significantly more vulnerable to experiencing poorer health and wellbeing outcomes, also often mean these children have the fewest protective resources to draw on. And as this report shows, when this heightened vulnerability is combined with experiences of trauma, health outcomes evidently suffer.

The Adverse Childhood Experiences Study surveyed thousands of adult Americans, who had undertaken a medical evaluation, to understand the impact of different types of abuse and traumatic experiences during childhood (Felitti et al. 1998). The study looked at experiences of abuse, incarcerated relatives, family violence, mental illness in the family and familial substance abuse. It found a relationship between these experiences and risky behaviours, substance abuse, psychological issues and physical illness (Anda et al. 2002, 2004; Chapman, Dube & Anda 2007; Felitti et al. 1998). For each additional negative experience, there was a multiplier effect on the probability of experiencing a range of poor health and wellbeing outcomes. Problematically, research suggests that these experiences rarely occur on their own (Chapman, Dube & Anda 2007). These adverse experiences in childhood were shown to have serious long-term health implications. For example, compared to people with zero adverse experiences, people exposed to four or more were four to 12 times more likely to experience alcoholism, abuse drugs, experience depression and commit suicide. Moreover, they were two to four times more likely to smoke, rate their health as poor and have a sexually transmitted infection (Felitti et al. 1998). This highlights the lasting influence of childhood experiences in people’s lives.

This chapter explores the physical and mental health outcomes of Victorian children, with a particular focus on the most vulnerable. This includes: key protective factors that support positive health outcomes; risky behaviours and other factors that detract from children’s health; an overview of Victorian children’s health; trends in a few important physical health indicators; common mental disorders; and access to common Victorian health services.

## 5.1 Protective factors

### 5.1.1 Resilience

As noted earlier in this report, resilience is defined as the ability to function competently in the face of challenges, adversity or stress (DHHS 2017h). It includes the capacity to cope and recover from difficult or traumatic circumstances and to adapt and grow from disruptive experiences (Hunter 2012). Young people who are psychologically resilient are more likely to respond constructively to challenges and difficulties they face in their lives.

Resilience implies autonomy (sense of personal agency), relatedness (positive connections with others) and competence (feeling capable or masterful) (DHHS 2017h). High levels of resilience are an important protective factor for health and wellbeing, especially during the significant transitions of adolescence and early adulthood.

Victorian students’ resilience, measured through the VSHAWS, was statistically stable between 2014 and 2016. In 2016, 68.8 per cent of students across Years 5, 8 and 11 reported high levels of resilience. The survey shows that younger students are more resilient than their older peers. Year 5 students (72 per cent) reported higher levels of resilience in 2016 than Year 8 (66 per cent) or Year 11 (68 per cent) students.

High levels of resilience are associated with lower levels of psychological distress. In 2016, nine per cent of students who reported high levels of resilience in VSHAWS also reported psychological distress. Conversely, 42 per cent of students who reported low levels of resilience also reported psychological distress.

Being bullied was associated with lower levels of resilience as were risky behaviours such as drinking and smoking. Around 14 per cent of students with low levels of resilience reported ever having smoked cigarettes, compared to eight per cent of students with high levels of resilience.

Table 49 Proportion of Victorian students (Years 5, 8 and 11) with high and low levels of resilience, by self-reported psychological distress and experience of bullying, 2016. SOURCE: VSHAWS 2016, DET analysis.

|  |  |  |
| --- | --- | --- |
| **Level of resilience** | **Experiencing psychological distress** | **Being bullied** |
| Low resilience | 41.7% | 65.4% |
| High resilience | 9.0% | 38.8% |

### 5.1.2 Nutrition

Consuming nutritious foods in line with the Australian Dietary Guidelines is essential to the normal growth, physical and cognitive development and general daily functioning and wellbeing of children (NHMRC 2013). Good nutrition supports children’s learning and has a range of benefits for students’ performance at school, including improved concentration.

It also reduces the risk of both short-term and long-term health conditions such as nutrient deficiencies, constipation, type 2 diabetes, heart disease and cancers (Ibid., Better Health Channel 2017). Introducing nutritious foods and limiting unhealthy foods at a young age can help children create and maintain healthy eating habits later in life. On the other hand, eating discretionary or “junk” foods (foods and drinks high in energy, saturated fat, and added sugars and salt) can have a range of negative impacts on children and young people’s health, including tooth decay, weight issues, type 2 diabetes, hypertension, heart disease and some cancers. Refer to Section 4.2.1 for discussion of the food environment.

Many Victorian children have low intakes of important core foods such as fruit, vegetables, dairy and wholegrains. In 2011-12, 88 per cent of Victorian children (two to 18 years of age) did not consume enough vegetables and 25 per cent did not consume enough fruit each day (DHHS 2016a). The mean daily calcium intake for Victorian children was 789 mg, with many older children (from nine to 18 years of age) falling short of recommendations (1000 – 1300mg per day) (ABS 2015a; NHMRC 2017).

The daily recommendation for fruit consumption is between one or two serves per day, depending on the age of the child (NHMRC 2013). The results from VCHWS show that young children from socioeconomically disadvantaged backgrounds are slightly less likely to eat the daily recommended amount of fruit. In 2017, 73 per cent of children aged between four and 12 from the most disadvantaged quintile of households ate the recommended amount of fruit, up from 70 per cent in 2013. In comparison, 78 per cent of children from the least disadvantaged areas in Victoria met the daily fruit intake recommendation. Similarly, 72 per cent of young children from single-parent families met the recommendation compared to 78 per cent of children from couple families. Due to changes in the guidelines in 2013, these results are not comparable to results from earlier surveys.

VCHWS also collects data on children’s vegetable intake. The daily recommendation for vegetables is between 2.5 and 5.5 serves per day, depending on the age of the child (NHMRC 2013). The 2017 survey showed that around four per cent of Victorian children aged under 13 years ate the recommended amount of vegetables every day. Children from single-parent families were more likely to meet the vegetable intake recommendation than children in couple-parent families (six per cent compared to three per cent respectively).

Table 50 Proportion of Victorian children (aged 0-12) who eat daily recommended amounts of fruit and vegetables, 2013 and 2017. SOURCE: VCHWS, 2013 and 2017.

|  |  |  |
| --- | --- | --- |
| **Year** | **Meeting daily intake guidelines for fruit consumption** | **Meeting daily intake guidelines for vegetable consumption** |
| 2013 | 73.2 % | 2.9 % |
| 2017 | 76.7 % | 3.8 % |

The Australian Health Survey quantified young Victorians’ energy intake from discretionary foods in 2011-12. The survey showed that the average Victorian child (two to 18 years of age) receives 38 per cent of their daily energy from these foods and drinks (ABS 2015a). Older children (aged 14 to 18) received 41 per cent of their daily energy from discretionary foods and were about 60 per cent more likely to drink sugary drinks than children aged four to 13 years (Ibid.). Overall, around 40 per cent of Victorian children reported drinking soft drink in the day before the survey (Ibid.). The mean daily sodium intake in 2011-12 was 2,450 mg, well above what is needed (200 – 920mg per day) (ABS 2015a; NHMRC 2017).

Nutrition is an often overlooked or under-recognised factor in mental health. The link between diet and mental health is well-established for adults and evidence is growing for the relationship between both healthy and unhealthy diet patterns and mental health and emotional/behavioural problems in adolescents and children (O’Neil, Quirk & Housden 2014). The quality of a person’s diet has been shown to be associated with adolescent mental health in both cross-sectional and prospective Australian studies, with improvements in diet quality being associated with improvements in mental health (Jacka et al. 2011).

### 5.1.3 Sleep

Sleep is critical to both physical and mental health and adequate sleep is an important indicator of health and wellbeing in children (Chen et al. 2006). Sleep helps with concentration, memory and allowing the body to regenerate and protect against illness (Potter & Weiler 2015; Solan 2017; Sleep Health Foundation 2011). Sleep deprivation can increase the risk of depression, anxiety and low self-esteem as well as affect academic performance (VicHealth 2018b; Better Health Channel 2018c).

Recommendations for the amount of sleep people need vary by age: newborns should sleep for between 14 and 17 hours; infants between 12 to 15 hours; toddlers between 11 and 14 hours; pre-schoolers between 10 and 13 hours; primary school-aged children between nine and 11 hours; and teenagers between eight and 10 hours (Sleep Health Foundation 2015). Adolescents are naturally inclined to go to bed later and wake up later which can conflict with school timetables (VicHealth 2018b).

The use of computers, phones and watching television can negatively impact on sleep. This is because the blue light emitted from electronic devices can delay the release of sleep-inducing chemicals, increase alertness and alter the body’s internal clock (National Sleep Foundation 2017). A recent VicHealth study found that teenagers slept an average extra 21 minutes per night if they stopped using their smart-phones an hour before bed. The study found that caffeine consumption is increasing amongst teens and negatively impacting on sleep. In addition, the study reported that a good family environment is associated with improved sleep quality while conflict is related to sleep problems.

VicHealth’s study found that many young Australians have problems with sleep even if these challenges do not meet the diagnostic criteria for a sleep disorder. It found that adolescents are only getting between 6.5 and 7.5 hours of sleep on school nights rather than the recommended eight to 10 hours (VicHealth 2018b).

Results from the VSHAWS also suggest that many Victorian students have problems with sleep. In 2016, 49 per cent of all students reported some problems with their sleep. Older students (56 per cent in Year 11) were more likely to report sleep problems than younger students (45 per cent in Year 5). More females (53 per cent) reported problems than males (46 per cent). Students in single-parent families (57 per cent) were also more likely to report sleep problems than students in couple-parent families (48 per cent). All of these results have increased slightly since the 2014 survey.

For some Victorian students the challenges of sleeping at night translated to difficulty staying awake in class. In 2016, 21 per cent of students who reported having a sleep problem also reported falling asleep at least once during class in an average week.

This increased to 33 per cent among Year 11 students, down from 36 per cent in 2014. Around 26 per cent of students in single-parent families, who reported having a problem with their sleep, reported falling asleep in class at least once in an average week.[[72]](#footnote-73)

### 5.1.4 Physical activity

There is a wealth of research documenting the short and long-term benefits of regular physical activity. For children and young people in particular, physical activity and exercise promotes healthy growth and development, maintains healthy weight and reduces the risk of disease. Studies have also shown that exercise improves sleep and concentration and can alleviate the severity of mental health issues, such as depression and anxiety.

The VCHWS shows declining levels of physical activity among children aged between five and 12. In 2017, 59 per cent of these children were reportedly undertaking at least 60 minutes of moderate to vigorous intensity physical activity every day, down from 71 per cent in 2006. Children in couple-parent families (60 per cent) were slightly more likely to engage in this level of physical activity than children in single-parent families (56 per cent). There is no clear social gradient to physical activity with children in the lowest SEIFA quintile reporting the highest physical activity result of any quintile (63 per cent).

According to the VSHAWS, levels of physical activity among older students are declining. The 2016 survey found that around 23 per cent of students in Victoria exercise for at least 60 minutes every day, meeting national guidelines, down from 26 per cent in 2014. The 2016 survey showed that males (29 per cent) were more likely to meet the guidelines than females (17 per cent), and physical activity declined sharply with year level (33 per cent of students meeting the guidelines in Year 5, compared with 20 per cent in Year 8 and 12 per cent in Year 11).

Table 51 Proportion of Victorian students (Years 5, 8 and 11) who are physically active for one hour every day, by Year level, 2014 and 2016. Source: Victorian Student Health and Wellbeing Survey, 2014 and 2016.

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Year 5** | **Year 8** | **Year 11** |
| 2014 | 32.4% | 17.3% | 11.9% |
| 2016 | 33.0% | 20.0% | 12.0% |

VicHealth analysis shows that sports participation drops suddenly at age 15. While 67 per cent of 10 to 14-year-olds were reportedly playing sport, the figure dropped to 29 per cent among 15 to 19-year-olds (VicHealth 2017). Participation rates among girls were significantly lower than boys at all age stages, with 50 per cent of five to nine-year-old and 10 to 14-year-old girls taking part in organised sport, compared to more than eight in 10 boys in both age groups (VicHealth 2016).

There is evidence that people with a disability are less likely to get an adequate amount of exercise than their non-disabled peers (Department of Health (DoH) 2011). While there is a lack of data on exercise levels of Victorian children with a disability, a 2012 Australian survey illustrates this fact. Among children aged five to 17 with a moderate to mild disability, 67 per cent had participated in exercise in the past 12 months (ABS 2014). This was higher among primary school aged children (73 per cent) than children aged 13 to 17 years (66 per cent). Children with a profound to severe disability were less likely to have exercised in the previous 12 months (58 per cent).

### 5.1.5 Importance of connection to culture and community for Aboriginal children

There is a growing body of evidence that shows a strong link between connection to culture and improved health and wellbeing of Aboriginal people (Colquhoun & Dockery 2012; Dockery 2009, 2010; Wexler 2009). The cultural dislocation and intergenerational trauma caused by colonisation as well as subsequent family dislocation, cultural disconnection and associated loss of land, language and lore have all had significant adverse outcomes for Aboriginal people’s health and wellbeing (DHHS 2017c). These factors continue to contribute to greater prevalence of poverty and family violence among Aboriginal families as well as the overrepresentation of Aboriginal children in child protection and youth justice. While social determinants of health such as poverty, parental education, employment and housing impact on all individuals, cultural connection is one social determinant of Aboriginal people’s health that is not captured in traditional definitions.

The National Aboriginal and Torres Strait Islander Social Survey collects, among other things, information on aspects of Aboriginal people’s cultural connection. The survey asks participants about their main language spoken at home, whether they identify with a clan, tribal or language group and whether they have been involved in a range of selected cultural events, ceremonies or organisations in the past 12 months. In 2014-15, 38 per cent of Aboriginal children aged between three and 17 years in Victoria reported that they identified with a clan, tribal or language group, up from 29 per cent in 2002 (ABS 2018e).

In addition, around 56 per cent reported that they had been involved in a cultural event, ceremony or Aboriginal organisation in the previous year, up from 44.8 per cent in 2002 (Ibid.). In 2014-15, 48 per cent of all Australian Aboriginal children reported identifying with a clan, tribal or language group and 71 per cent reported involvement in a cultural event, ceremony or organisation in the previous 12 months (Ibid.). The proportion of Victorian Aboriginal children who reported speaking an Aboriginal language at home cannot be reported,[[73]](#footnote-74) however across Australia the figure was just under eight per cent. The loss of Aboriginal languages in Victoria is a contributing factor to this lack of local data.

***Marrung*** *is a 10-year integrated plan spanning the early childhood, schools and training and skills sectors to ensure Aboriginal learners realise the benefits of the Education State reform agenda, so that every Victorian has the opportunity to succeed in life, regardless of background, place or circumstance.*

*Underpinned by the principle of Aboriginal self-determination, Marrung was developed in partnership with the Aboriginal community, including the Victorian Government’s principal partner in Aboriginal education, the Victorian Aboriginal Education Association Incorporated.*

*Marrung’s vision is Victoria as a place where the rich and thriving cultures, knowledge and experience of our First Nations peoples are celebrated by all Victorians.*

*Marrung also seeks to ensure our universal service systems are inclusive, responsive and respectful of Aboriginal people at every stage of their learning and development journey, so that every Aboriginal person can achieve their potential, succeed in life and feel strong in their cultural identity.*

A number of initiatives are being implemented so that learning environments are more inclusive places, not just for Aboriginal learners but for all Victorians. This includes Cultural Understanding and Safety Training, which provides all Government school staff with a better understanding of Aboriginal culture and the needs of their Aboriginal students and families; and the Aboriginal Languages Program Training Initiative, which will increase the number of Aboriginal teachers of Victorian Aboriginal languages in kindergartens and schools.

DET also collects data on cultural safety and inclusion in Victorian schools. The 2017 August Schools Census showed that:

* 1,010 (66.4 per cent) schools flew the Aboriginal and/or Torres Strait Islander flag at any time throughout the year
* 1,203 (79.1 per cent) schools had an Acknowledgement of Country at School Assemblies and/or at special events
* 791 (52 per cent) schools celebrated National Reconciliation Week and 738 (48.5 per cent) schools celebrated National Aboriginal and Islanders Day Observance Committee Week
* 408 (26.8 per cent) schools had a sign acknowledging the Traditional Owners
* 101 (6.6 per cent) schools had least one Aboriginal person on its School Council (110 Aboriginal people in total).
* 1396 (91.8 per cent) schools incorporated Aboriginal perspectives in the curriculum. 41.6 per cent of these schools involved Aboriginal community and/or parents in the development and/or delivery.

In 2017, eight Victorian schools taught the Victorian Curriculum F-10 – Victorian Aboriginal Languages. While a greater number of schools report teaching an Aboriginal language, some of them do not meet DET requirements of a language program. They are often Aboriginal Culture programs that include some language. It is important to note that schools must follow strict protocols if they wish to establish a Victorian Aboriginal Language program. The protocols state that the subject can only be offered with the permission and support of the local Aboriginal community. Aboriginal Languages are important because students learn much more than an Aboriginal language. They learn about the world’s oldest cultures, the practices that allowed those cultures to survive through the millennia and a different way of viewing the world. Language is also important, particularly for Aboriginal people, because it helps shape a person’s identity and is important for passing on cultural knowledge. There is evidence that language and culture support positive outcomes in health, education and employment (Standing Committee on Aboriginal and Torres Strait Islander Affairs 2012).

The 2017 Attitudes to School Survey (AtoSS) showed that Aboriginal students in Victorian government schools had a slightly lower degree of connectedness to their school (62.1 per cent endorsement, compared to 66.1 statewide). In line with statewide results for government school students this figure of connectedness is higher in primary school and drops in early secondary school for Aboriginal students (80.4 per cent endorsement for Years 4 to 6 compared to 48.1 per cent endorsement for Years 7 to 9). Promisingly, Aboriginal students have a similar degree of connectedness to the statewide average for Years 4 to 6 and Years 10 to 12.

## 5.2 Risky behaviours and factors that negatively impact health

### 5.2.1 Young smokers

Children and young people living in homes with relatives who smoke increases their chance of passive smoking, which is associated with many of the health consequences associated with smoking. The risks of respiratory illnesses, such as asthma, bronchitis and pneumonia, are particularly elevated for children (Better Health Channel 2018a).

There have been significant increases in the proportion of young children living in smoke-free homes in Victoria. The 2017 VCHWS found that 82 per cent of children under 13 years of age were living in a smoke-free home, up from 68 per cent in 2006. Children living in regional Victoria, children from single-parent families and children on health care cards were more likely to be exposed to tobacco but there have been improvements for every group identified in the survey. Exposure to smoke in the home continues to have a fairly steep social gradient, with children in more disadvantaged households more likely to be exposed.

Table 52 Proportion of Victorian children (aged 0-12) living in a smoke-free home, by SEIFA IRSD quintile, 2006-2017. SOURCE: VCHWS 2017; DET Internal Analysis.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Q1** | **Q2** | **Q3** | **Q4** | **Q5** |
| 2006 | 55.5% | 59.1% | 65.0% | 68.6% | 81.3% |
| 2009 | 67.8% | 66.0% | 73.5% | 76.6% | 83.7% |
| 2013 | 70.7% | 76.7% | 79.4% | 80.7% | 89.9% |
| 2017 | 65.5% | 72.2% | 79.7% | 85.0% | 91.4% |

People who begin smoking at a young age not only risk short-term health consequences such as respiratory and non-respiratory effects, addiction to nicotine and risk of other drug use, but are more likely to create a habit that will continue into adulthood. Studies have found that adolescent smokers can show early signs of heart disease, have a resting heart rate two to three beats faster per minute than non-smokers and are at greater risk of lung cancer (WHO 2018a).

According to VSHAWS, in 2016 around 10 per cent of Victorian students responded that they had ever smoked a cigarette, up from eight per cent in 2014. Year 11 students were much more likely to have smoked than Year 8 or Year 5 students (28 per cent, eight per cent and one per cent respectively). However, fewer Year 11 students had tried cigarettes than in 2014, when 35 per cent reported ever having smoked.

Smoking among children in Australia is low and declining. A study from 2014 suggested the proportion of students aged 12 to 15 that had smoked in the previous month was lower than at any other point since monitoring commenced in 1984 (VicHealth 2017). According to the report on smoking in Australian secondary schools, the overall rate of current smoking (smoked in previous seven days) among children aged 12 to 17 was 5.1 per cent, with males (5.4 per cent) slightly more likely to smoke than females (4.9 per cent) (White & Williams 2016). Older children were more likely to smoke although rates were still low with 12.1 per cent of 17-year-olds defined as current smokers (that is smoked in the week before the survey) (Ibid.).

In 2014, the proportion of current smokers (smoked in previous seven days) aged 12 to 17 in Victoria was slightly higher at six per cent (Williams et al 2016). Similar to the national trend, younger students were less likely to smoke. However, in contrast to the Australia-wide findings, the study found that Victorian females smoked more than males. VSHAWS demonstrates that regular smoking is low and declining. Among Year 11 students who had ever tried smoking, 15 per cent had smoked in the past month, down from 20 per cent in 2014. Only three per cent of the Year 8 students, who had ever tried a cigarette, reported smoking in the previous month.

However, young people in OOHC and children with a mental illness are much more likely to smoke regularly. In 2016, an OOHC outcomes tracking survey completed by case managers reported that 22 per cent of young people over the age of 10 and 39 per cent of young people aged 15 to 17 in OOHC smoked tobacco (DHHS 2017b). Of the group that smoked tobacco over 10 years of age, 80 per cent smoked every day and a further 12 per cent smoked four to six days a week. The proportion of young people who smoked (aged 10 years and over) increased to 65 per cent in residential care (Ibid.). A survey conducted in 2013-14 found that 24 per cent of Australian children (aged 13 to 17) with a major depressive disorder had smoked in the past 30 days (Lawrence et al. 2015). Among children with other mental disorders, 24.1 per cent had smoked in the past 30 days. This is compared to 4.1 per cent of children in the same study with no mental disorder who had smoked in the previous 30 days.

There are also higher smoking rates among people with a disability. A report by the AIHW found that people between 15 and 64 years of age with a severe or profound disability were twice as likely to smoke as people without a disability (AIHW 2016a). Importantly for the purposes of this report, 41 per cent started smoking every day before the age of 18 compared to 23 per cent in the general population (Ibid.).

### 5.2.2 Young drinkers

National guidelines for alcohol consumption recommend that not drinking alcohol at all is the safest choice for young people under 18 years of age. Youth alcohol consumption can interfere with the healthy development of the human brain, particularly for children under 15 years of age. Alcohol is also associated with increased risk of injuries, violence and self-harm and can lead young people to engage in more risky or antisocial behaviour (DoH 2013a). The Australian Temperament Project, a longitudinal study of Victorian children, found that heavier use of alcohol, tobacco and other drugs in adolescence was predicted by individual characteristics, such as involvement in antisocial behaviour, being more outgoing and thrill-seeking, being male, family characteristics such as maternal smoking and drinking, and their relationships, including lower attachment to family and poorer quality friendships (Vassallo & Sanson 2013).

In 2016, 55 per cent of students who responded to the VSHAWS had drunk alcohol, down from 60 per cent in 2014. Older students are more likely to drink alcohol, as are students in single-parent families and those living in regional areas. In 2016, 70 per cent of Year 11 students reported ever having drunk alcohol. However, there was a reduction between 2014 and 2016 across all recorded population groups.

Table 53 Proportion of Victorian students (Years 5, 8 and 11) who have ever consumed alcohol, 2014 and 2016. Source: VSHAWS, 2014 and 2016.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Statewide** | **Metro** | **Rural** | **LBOTE** | **English** |
| 2014 | 60.0% | 56.0% | 69.0% | 42.0% | 62.0% |
| 2016 | 55.0% | 52.0% | 62.0% | 40.0% | 58.0% |

However, between 2014 and 2016 there was an increase in the proportion of students that were binge drinking. In 2016, among the Year 11 students who had ever tried alcohol, 41 per cent had consumed five or more alcoholic drinks in one session in the previous two weeks, a 10 per cent increase since 2014. In 2016, 15 per cent of Year 8 students who had ever tried alcohol reported having consumed more than five alcoholic drinks in the previous two weeks, up from eight per cent in 2014. This pattern of more students engaging in heavy drinking was evident across all recorded population groups including students in both metropolitan and regional areas as well as those in single-parent and couple-parent families.[[74]](#footnote-75)

In a similar pattern to smoking among adolescents, young people with a mental illness are more likely to drink alcohol (Lawrence et al 2015). In 2013-14, drinking rates among young people with a major depressive disorder were as follows: 65.3 per cent aged 13 to 17 had ever drunk alcohol; 34.3 per cent had drunk alcohol in the past 30 days; and 27.6 per cent had consumed more than four drinks in a row in the past 30 days (Ibid.). For young people without a major depressive disorder the corresponding figures were 33.8 per cent (ever drunk), 15.4 per cent (drunk in past 30 days), and 10.1 per cent (drunk more than four drinks in a row in the past 30 days) (Ibid.). Adolescents with other mental health conditions also had higher rates of drinking than the general population but these were lower than those with a major depressive illness.

The 2016 OOHC outcomes tracking survey found much higher rates of regular alcohol consumption. Case managers reported that 35 per cent of Victorian 15 to 17-year-old young people in OOHC regularly consume alcohol (DHHS 2017b), almost four times more than the national average (ABS 2015c).

Children in contact with the youth justice system are also more likely than other children to engage in risky drinking. Among children and young people sentenced or on remand in 2015-16 in Victoria (Parliament of Victoria 2018b):

* ten per cent had a history of alcohol misuse
* sixty six per cent had a history of both alcohol and drug misuse
* twelve per cent offended while under the influence of alcohol but not drugs
* fifty eight per cent offended under the influence of both alcohol and drugs.

### 5.2.3 Young drug users

Illicit drug use can not only have immediate consequences for a young person’s health and wellbeing, but establishing these kinds of behaviours from a young age can have harmful lasting impacts later in life.

According to the Victorian Student Health and Wellbeing Survey the proportion of Year 8 and Year 11 students that have tried illicit drugs is increasing. In 2016, 17 per cent of students reportedly had tried any illicit drug, an increase of 13 per cent in two years. Older students are more likely to have tried drugs than younger students. In 2016, 26 per cent of Year 11 students reported having tried an illicit substance compared to 11 per cent of Year 8 students. In 2016, 12 per cent of students had tried marijuana including 23 per cent of Year 11 students. Around 4.5 per cent of Victorian students had tried ecstasy, amphetamines or hallucinogens, including 7.6 per cent of Year 11 students and 2.6 per cent of Year 8 students. Children from single-parent families are more likely to have tried illicit drugs than children in couple-parent families.

Table 54 Proportion of Victorian students (Years 8 and 11) who have ever used illicit drugs, 2014 and 2016. Source: VSHAWS, 2014 and 2016.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Statewide** | **Couple-parent** | **Single-parent** | **Year 8** | **Year 11** |
| 2014 | 13.0% | 10.0% | 19.0% | 5.0% | 24.0% |
| 2016 | 12.0% | 10.0% | 18.0% | 5.0% | 23.0% |

Young people with a mental illness are more likely to have taken drugs than other young people (Lawrence et al 2015). In 2013-14, 28.8 per cent of Australian young people aged 13 to 17 years who reported having a major depressive illness had ever used cannabis, 13.1 per cent had smoked marijuana in the past 30 days, 16.1 per cent had ever used other drugs and 6.1 per cent had used other drugs in the previous 30 days (Ibid.). The corresponding figures for young people aged 13 to 17 years without a disorder were 8.7 per cent, 3.5 per cent, 2.7 per cent and 0.9 per cent (Ibid.).

Drug use is also more common among young people in OOHC than the general population. An outcomes tracking survey completed by case managers in 2016 showed that 28 per cent of 14 to 17-year-olds were reported to have used illicit drugs in the previous 28 days (DHHS 2017b).

A recent review of Victoria’s youth justice system shows drug and alcohol use is a problem for young people on youth justice orders. In 2015-16, 45 per cent of the females and 46 per cent of the males engaged with the youth justice system had received drug and alcohol services over their lifetime (Armytage & Ogloff 2017).

### 5.2.4 Sexual health

Supporting young people with their sexual and reproductive health is important. Research shows that most young people in Years 10 to 12 in secondary school are sexually active. Most teenagers are not practising safer sex (such as using condoms), leading to concerns around unplanned pregnancies and sexually transmitted infections (STIs).

Sexual health literacy and awareness among young people is mitigated by the intersections of a range of factors including, but not limited to: all gender expressions and experiences; developmental ages and stages; disabilities; cultural and ethnic identities; across different geographic settings; sexual orientations; and religious affiliations. Additionally, technology and social media is changing the way young people communicate and connect with others, impacting upon how relationships are brokered and maintained.

Young people need to know about safer sex, including information about contraception, prevention of STIs, sexual behaviours that increase risk, regular STI screening and treatment. Young people need accurate information about sex to negotiate sexual activity and relationships safely and responsibly.

Technological change has resulted in challenges related to children’s sexual health. One such challenge is sexting, the practice of sharing nude or near nude images or videos. A study conducted with 1,593 Australian children (aged eight to 13) and 1,424 teens found around a third of teens had some experience of sexting within the 12 months before June 2017 (UK Safer Internet Centre, University of Plymouth, Netsafe & Office of the eSafety Commissioner 2017). This includes being asked, asking, sharing or showing nude or near nude images. The study found 15 per cent of all teens had received an image or video of someone nude or nearly nude (Ibid.). The practice can cause psychological and reputational harm to children and, in Australia, it can lead to a person being charged and potentially registered as a sex offender, which can have long-term consequences (Ibid.; Kids Help Line 2018).

A survey of 1,372 Australian 16 to 29-year-olds found that 40 per cent had ever sent or received a sext (Yeung et al 2014). The study found that lower levels of education, greater number of sexual partners, inconsistent condom use with a regular partner and risky alcohol consumption were all independently related to sexting (Ibid.). Another study exploring the attitudes of 469 young people aged 15 to 29 years found that more permissive attitudes to sexting were associated with lower sexual health knowledge and inconsistent condom use with casual partners (Lim et al 2016).

Online pornography is another children’s health challenge. With smart devices becoming widely available, the way children are accessing pornography and the role it is playing in their sexual literacy is changing. Research suggests that children and young people are accessing pornography at increasing rates, particularly teenage boys (Lim et al. 2017; Campo 2016). The effects of frequent viewing can be reinforcing harmful gender stereotypes and contributing to unhealthy and sexist views of women and sex (Ibid.). In addition, research suggests overexposure to pornography could support the development of attitudes that condone violence against women (Ibid.). This is particularly problematic given the proliferation of increasingly violent content (Ibid.). It can contribute to unrealistic understandings and expectations about sex and the types of sexual behaviours that are normal.

The VSHAWS shows that only a small proportion of Victorian young people are sexually active. In 2016, 15 per cent of students (in Year 8 and Year 11 combined) reported having had sex, a similar figure to the 2014 survey. This was significantly more likely for older students, with 29 per cent of Year 11 students reporting having had sex compared to six per cent of Year 8 students. In 2016, 21 per cent of young people from single-parent families reported having had sex compared to 13 per cent of young people in two-parent families. Young people from an English-speaking background were more likely to have had sex than those from a culturally and linguistically diverse family. More males reported having had sex than females. Most sexually active Victorian Year 11 students start having sex at 15 years of age.

The survey showed that among sexually active Victorian teens only 28 per cent always used a condom, similar to the 27 per cent in 2014. Students from language backgrounds other than English were less likely to report always using a condom (18 per cent) than those from an English-speaking background (30 per cent). Young people in regional areas were more likely to always use a condom than their peers in metropolitan areas (33 per cent to 26 per cent).[[75]](#footnote-76)

Occasional or inconsistent condom use increases the risk of acquiring STIs. In 2017, there were 919 notifications of an STI reported to DHHS among Victorians aged 15 to 17 years, representing a population rate of 429.8 per 100,000. Ninety per cent of the 919 notifications were for chlamydia infections.

The notification rates for STIs have fluctuated over the past decade, with the current rate continuing the decline from the peak in 2012 of 744 per 100,000. For young Victorians aged 15 to 17 years, females are more likely to diagnose and report with an STI than Victorian males. In 2017, the overall STI rate per 100,000 Victorian females aged 15 to 17 years was 669.2, compared to the male rate of 200.3. Both the female and male rates have been falling since 2012, however they are slightly higher than rates a decade ago (rates of 587.9 and 82.2 respectively in 2007).

Rates of chlamydial infection are the highest for any STI and follow the same pattern as the overall population rate, increasing from 2006 to 2011-2012 and then subsequently falling. The rate of chlamydial infection among Victorian females aged 15 to 17 years (625.2 per 100,000) is nearly four times higher than for Victorian males aged 15 to 17 years (160 per 100,000).[[76]](#footnote-77)

Table 55 STI notification rates per 100,000 young people (aged 15 to 17 years), by gender, 2006-2017, Victoria. Source: DHHS, data request.

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Statewide** | **Male** | **Female** |
| 2006 | 282.3 | 85.2 | 484.1 |
| 2007 | 331.2 | 82.2 | 587.9 |
| 2008 | 421.7 | 127.2 | 724.6 |
| 2009 | 461.4 | 173.1 | 764.6 |
| 2010 | 603.2 | 216.2 | 1001.9 |
| 2011 | 741.0 | 253.6 | 1251.4 |
| 2012 | 744.0 | 270.7 | 1235.2 |
| 2013 | 623.6 | 238.6 | 1032.4 |
| 2014 | 565.7 | 216.7 | 932.1 |
| 2015 | 482.4 | 211.7 | 766.2 |
| 2016 | 453.2 | 199.3 | 716.2 |
| 2017 | 429.8 | 200.3 | 669.2 |

Another possible consequence of unprotected sex is pregnancy. Pregnancy during a young person’s teen years can impact significantly on schooling and postnatal depression is common for young mothers (Price-Robertson 2010; Morehead & Soriano 2005). These mothers and their children often experience poorer health outcomes and a range of economic challenges (Morehead & Soriano 2005). The teen (under 20 years of age) birth rate in Victoria in 2016 was 1.5 per 100, down from 2.8 in 2006. Some groups have significantly higher teenage birth rates. Eleven per cent of Aboriginal mothers in 2016 were teenagers, down from 18 per cent in 2006. The proportion of teenage mothers in regional Victoria (2.9 per cent) remains more than double the proportion of teenage mothers in metropolitan Victoria (1.03 per cent). The Victorian teen birth rate for mothers born outside of Australia (0.5 per cent) is lower than for Australian born mothers (2 per cent).[[77]](#footnote-78)

### 5.2.5 Sedentary behaviours

Research on the impact of electronic media has suggested health implications and negative outcomes that correlate with the duration and content of viewing. Research suggests that engaging with excessive screen time is associated with developmental risks in children and young people (including issues in sleep, obesity, executive functioning and aggression) (Radesky & Christakis 2016). A study of Canadian children found that even when controlling for socioeconomic variables, health status and body mass index, television viewing was significantly associated with physical inactivity (Koezuka et al. 2006). A systematic review of 232 studies including 983,840 participants found a dose response between increased sedentary behaviour and negative health outcomes (Tremblay et al. 2011). This included body composition, fitness, self-esteem, pro-social behaviour and academic achievement (Ibid.). There is evidence showing that reducing sedentary behaviour is associated with lower health risks among young people, in particular, decreasing daily television viewing from above two hours (Ibid.). However, other studies suggest the relationship between screen time and physical activity is less direct. These studies argue that reducing screen time will not motivate children to exercise (Kardefelt-Winther 2017).

Information technology is used in most Australian homes, with 97 per cent of households with children under 15 years of age having access to the Internet. These homes have an average of seven electronic devices (AIFS 2018). Young people (aged between 15 and 17 years) are the highest users and, in 2014-15 spent around 18 hours per week online (ABS 2018d).

Parents report through the VCHWS that around 18 per cent of children (5 to 12 years of age) exceed the recommended amount of daily screen time. Children living in areas with the higher levels of socioeconomic disadvantage are more likely to exceed the recommended screen time limit.

Table 56 Proportion of Victorian children (aged 5 to 12 years) exceeding 2 hour daily screen time recommendation, by SEIFA IRSD quintile, 2006 to 2017. Source: VCHWS, 2006 to 2017.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Q1** | **Q2** | **Q3** | **Q4** | **Q5** |
| 2006 | 21.2% | 22.4% | 19.3% | 17.9% | 15.8% |
| 2009 | 21.6% | 22.1% | 19.6% | 17.9% | 15.0% |
| 2013 | 24.1% | 19.0% | 19.0% | 17.6% | 14.2% |
| 2017 | 25.7% | 27.6% | 16.1% | 14.6% | 16.4% |

Older students completing the VSHAWS report higher levels of electronic media usage. Among Year 5, 8 and 11 students in 2016, around 68 per cent reported exceeding the two-hour daily recommendation, up from 61 per cent in 2014. Females (66 per cent) were less likely to exceed the daily recommendation than males (70 per cent). However, the biggest difference was between age groups. Eighty-three per cent of Year 11 students use electronic media for more than two hours a day compared to 50 per cent of Year 5 students.

### 5.2.6 Racism

Racism is damaging to both mental and physical health. People experiencing greater socioeconomic disadvantage are more likely to experience racism. The greater the frequency of racist experiences, the worse the health outcomes (DHHS 2017c). Racism has been shown to increase the probability of experiencing psychological distress, depression, anxiety, post-traumatic stress disorder, psychosis and substance abuse disorders (Berger & Sarnyai 2015; Paradies et al. 2015). Research has also highlighted links between racism and conditions such as cardiovascular disease (Lewis et al. 2014), hypertension (Dolezsar et al. 2014), poor self-reported health (Paradies & Cunningham 2012), obesity (Cozier et al. 2014), adult-onset asthma (Coogan et al. 2014) and cancer (Taylor et al. 2007).

The Speak Out Against Racism study explored the prevalence of racial discrimination among Victorian children (Priest et al, in preparation). The study spoke to more than 2,500 children from Years 5 to 9 from a wide variety of backgrounds about specific instances of racial discrimination from their peers, their teachers and in the broader community. The study showed that around 38 per cent of Victorian children had experienced some form of racial discrimination with peers being the most common source. Twenty-six per cent of students reported being called insulting names by other students, seven per cent reported their teacher unfairly put them in a lower ability class and 12 per cent reported being told that they did not belong in Australia. Based on the survey responses, secondary school students were more likely to have experienced some form of racial discrimination than those in primary school. The responses showed that Southeast Asian students were most likely to have experienced racial discrimination (70 per cent), while Anglo students were least likely (24 per cent). Around 45 per cent of Aboriginal students and 66 per cent of African students reported any experience of racial discrimination (Ibid.).

***Speak Out Against Racism (SOAR)*** *is a whole-of-school approach that aims to foster effective bystander responses to racism and racial bullying in schools. SOAR spans six mutually reinforcing elements:*

* *Teacher training and development*
* *Curriculum and classroom materials*
* *Student support and development*
* *Parent and community involvement*
* *School policies and guidelines*
* *Monitoring and reporting of student performance and racial discrimination*

*A culturally diverse primary school located in the outer suburbs of Melbourne participated in SOAR. They value their cultural diversity and while they do not believe racism is a major issue at their school, they are aware of its significance for many of their students and families in the wider community.*

*At the start of SOAR, teachers attended two professional learning workshops which gave them knowledge, tools and confidence to deliver the SOAR lessons and activities to their students. Through the program students learnt about racism and its effects on individuals and schools, and what strategies they can use to ‘speak out against racism’.*

*After the program ended, the students reported they really enjoyed taking part in the program, particularly as they were given a safe space to share their ideas, opinions and experiences. They reported feeling braver and more confident in themselves when they experienced or witnessed racism. The school’s ‘Team SOAR’ student-led group are very enthusiastic about their role in finding ways to raise awareness about addressing racism in their school and community.*

### 5.2.7 Bullying

Bullying is a critical issue for children and young people. Bullying is repeated verbal, physical, social or psychological aggressive behaviour directed towards a person or group considered to be less powerful, with the intention of causing distress, fear or harm (DET 2017). The effects of bullying can impact victims, perpetrators and bystanders, ranging from immediate psychological and physical risks to long-term personal, social and educational complications. For children, bullying often occurs at school. This can have a severe negative impact on children’s wellbeing.

The AtoSS shows that bullying is worst in the middle years of school. In 2017, 20 per cent of Victorian government school students in Years 7 to 9 reported being bullied, up from 18 percent the previous three years. This was higher than the proportion of Years 5 and 6 students reporting bullying (19 per cent) and Years 10, 11 and 12 students (12 per cent). Since 2014, reported bullying in primary school has increased (from 14 per cent) and declined in the senior years (from 16 per cent). As shown in the table below, Aboriginal students and students from low socioeconomic areas are more likely to experience bullying than their peers.

Table 57 Proportion of Victorian government school students (Years 5 -12) who report being bullied, 2015-17. Source: AtoSS, 2015 to 2017.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year Level** | **2014** | **2015** | **2016** | **2017** |
| 5 to 6 | 13.8 | 15 | 14.8 | 18.9 |
| 7 to 9 | 18.4 | 18 | 17.6 | 20.1 |
| 10 to 12 | 16.1 | 15.6 | 15.7 | 11.9 |

Table 58 Proportion of Aboriginal Victorian government school students (Years 5 -12) who report being bullied, 2015-17. Source: AtoSS, 2015 to 2017.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year Level** | **2014** | **2015** | **2016** | **2017** |
| 5 to 6 | 20.6 | 22 | 23.4 | 23.7 |
| 7 to 9 | 26.3 | 26.2 | 25.7 | 27.8 |
| 10 to 12 | 31.70 | 25.7 | 27.5 | 22.1 |

Table 59 Proportion of disadvantaged Victorian government school students (Years 5 -12) who report being bullied, 2015-17. Source: AtoSS, 2015 to 2017.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year Level** | **2014** | **2015** | **2016** | **2017** |
| 5 to 6 | 15.2 | 17.4 | 18.2 | 21.3 |
| 7 to 9 | 20.5 | 19.8 | 19.8 | 22.1 |
| 10 to 12 | 17.1 | 16.8 | 16.7 | 13.8 |

The VSHAWS asks Years 5, 8 and 11 students about the frequency and type of bullying they have experienced. In 2016, 17 per cent of students in this survey reported being bullied most days. This was highest among Year 8 students (19 per cent), followed by Year 5 students (16 per cent) and Year 11 students (15 per cent). Students from a non-English language background (19 per cent) were more likely to be bullied than their English background peers (17 per cent). Twenty per cent of students in single-parent families reported being bullied regularly compared to around 16 per cent of students from couple-parent families. The most common types of bullying reported were: teasing (72 per cent); being left out (32 per cent); rumours being spread about them (20 per cent); and physical threats (17 per cent).

Correlations between students who reported bullying and their other survey responses show associations between lower levels of resilience and higher psychological distress. The majority (65 per cent) of students who reported low levels of resilience also reported being bullied while 39 per cent of students with high levels of resilience were also bullied. However, among students who reported not being bullied the pattern reversed, 28 per cent of students reported low levels of resilience and 57 per cent of students reported high resilience levels. In addition, 28 per cent of students who reported being bullied also said they were experiencing psychological distress. However only nine per cent of students who reported no bullying said they were experiencing psychological distress. This suggests a possible double-edged sword whereby bullying could be associated with increased psychological distress and diminished protective resources.[[78]](#footnote-79)

Additional research illustrates that LGBTI students experience significantly more bullying than their non-LGBTI peers and the majority of this occurs at school. An Australian study found that 61 per cent of LGBTI young people report experiencing verbal homophobic abuse, 18 per cent physical homophobic abuse, and 69 per cent other types of homophobic abuse (Hillier et al. 2010). Around 80 per cent of respondents experienced this abuse at school (Ibid.). Several other Australian studies have found bullying based on sexuality and diverse gender expressions to be widespread (Rigby & Johnson 2016; Robinson et al. 2013). Students report that the effects of this bullying include difficulty concentrating in school, missing class, missing school, lower academic achievement, hiding at recess and lunch, not using the change rooms and/or toilets and dropping out from school (Hillier et al. 2010).

Further discussion of bullying in schools can be found in Section 4.4, which explores the relationship between student safety, internalising behaviours and learning outcomes.

*The $9.5 million* ***Victorian Anti-Bullying and Mental Health Initiative*** *aims to prevent and respond to bullying in Victorian schools.*

*The initiative brings together existing programs and resources with new investment to help schools address bullying in all its forms. This includes the Bully Stoppers online toolkit, which provides evidence-based advice for school leaders, teachers, parents and students; and Safe Schools, which supports schools to create a safe and inclusive environment for LGBTI young people, with a focus on building the capability of school staff.*

*Additional investment provides every school in Victoria with the opportunity to access the eSmart Schools cyber safety program delivered by the Alannah and Madeline Foundation to help combat cyberbullying. The Victorian Government also committed to addressing racist bullying in schools, building a culture of respect and boosting the capacity of teachers to work with students from all backgrounds. New Bully Stoppers resources focused on preventing and responding to racist bullying are under development.*

#### 5.2.7.1 Experiences of cyber bullying amongst young people

Advances in communication and information technology have opened the door for a modern form of bullying, with significant consequences for children’s health and wellbeing. Cyberbullying and traditional bullying are related and often co-occur, however, cyberbullying has distinct features. For example, while both involve repeated acts of intentional aggression, perpetrators of cyberbullying are able to bully large numbers of people anonymously, and victims can be bullied at any place or time, even when they are at home (Pingault & Schoeler 2017). The internet and social media platforms enable people to reproduce gossip and send a message to an entire friendship group (Kowalski et al. 2014). In addition, the lack of verbal, non-verbal and social cues in an online conversation makes it easier to offend a person (Ibid.). Along with a lack of social mores moderating conversation, there is rarely a person who can step into online environments to stop aggressive or hurtful behaviour (Ibid.). Compounding these factors the Internet is somewhat permanent with messages and pictures posted often permanently stored online and users having the ability to download content (Ibid.).

A meta-analysis of studies looking at the effects of cyberbullying shows small to moderate associations with a range of mental health outcomes. People who report high levels of cyberbullying were more likely to report high levels of stress, suicidal ideation, depression, anxiety, loneliness, somatic symptoms, conduct and emotional problems, drug and alcohol use, reduced life satisfaction and self-esteem (Kowalski et al 2014). While causal relationships cannot be established, cyberbullying is associated with adverse mental health outcomes (Pingault & Schoeler 2017).

The VSHAWS reports on instances of cyberbullying among Years 5, 8 and 11 students. In 2016, 33 per cent reported instances of cyberbullying in the 30 days prior to the survey, up from 29 per cent in 2014. In a similar trend to the 2014 survey, in 2016 cyberbullying was more commonly experienced among Year 11 students (41 per cent), followed by Year 8 students (36 per cent) and Year 5 students (25 per cent). There was a difference between students in one-parent (39 per cent) and two-parent families (31 per cent).

## 5.3 Overall Health

Children’s health is a strong determinant of cognitive development, academic and educational achievement, and associated with positive future outcomes (Biddle & Asare 2011). Early patterns of health and wellbeing behaviours can have lifelong impacts. A child or young person’s quality of life has a major impact on health and wellbeing, holding the potential to influence participation and engagement in activities within the school and broader community.

The vast majority of Victorian children are healthy and report high levels of satisfaction with life, as reported through VSHAWS and VCHWS. In 2016, 75 per cent of students reported feeling satisfied with their life and 87 per cent reported their health as good, very good or excellent. Students from non-English backgrounds reported lower levels of satisfaction and health. However, the largest difference in life satisfaction and health was between young people living in couple families and single-parent families. Eighty per cent of students living with both parents were satisfied with their life compared to 67 per cent of children living with one parent. Students living in one-parent families were less likely to rate their health positively (84 per cent), compared with their peers from couple families (90 per cent).[[79]](#footnote-80) Parents also report that most Victorian children have good overall health. In 2017, 97 per cent of children aged zero to 12 years were reported to be healthy.[[80]](#footnote-81)

## 5.3.1 Prevalence of mental disorders

Among children and young people, mental health and substance use disorders are the leading cause of disability worldwide (Erskine et al. 2015). Mental ill health contributes to nearly half of the burden of disease in young people (Headspace 2011). It has been identified as the leading concern among young Australians (Mission Australia 2017). A recent study found six of the top 10 reasons for referring a child to a paediatrician were mental health issues (Hiscock et al. 2017).

Around 75 per cent of adult mental disorders occur before the age of 25 years and around 50 per cent before the age of 14 years (Kessler et al. 2005, 2007; Hiscock et al. 2018). Due to the age of onset of these conditions, poor mental health can often disrupt a young person’s education and their transition into employment. A longitudinal study illustrated that mental ill health in early adulthood has long-term consequences including reduced workforce participation, lower income and lower living standards at age 30 years (Gibb et al. 2010).

The environments in which children grow also impact on their development. Risk factors to a child’s mental wellbeing include harsh parenting, parental substance use and poor housing (CCCH 2018a). Focusing on a child and their family’s resilience and social connectedness is important to protect children during challenging periods (Ibid.). There is also evidence that intervening early with treatment leads to improved outcomes and the prevention of future mental health problems (Access Economics 2009). This is important given the research showing that severe mental disorders are often preceded by less severe mental health problems (Headspace 2011).

The most recent study of the prevalence of mental disorders among Australian children found that around 14 per cent of Australians aged between four and 17 years had experienced a mental disorder in the previous 12 months (Lawrence et al. 2015). The study found that most mental disorders were not severe. It found that 59.8 per cent were classed as mild disorders, 25.4 per cent were moderate disorders and 14.7 per cent were categorised as severe mental disorders. Teenagers were more likely to experience severe mental disorders. The study found that males were more likely to have experienced mental disorders than females in the 12 months leading up to the survey. It also found that while prevalence did not change for boys as they get older, older females were more likely than younger girls to have experienced a mental disorder (10.6 per cent for four to 11-year-olds and 12.8 per cent for 12 to 17-year-olds) (Ibid.).

Aboriginal Victorians are more likely to experience poorer mental health than their non-Aboriginal peers. Data on the prevalence of mental disorders among Victorian Aboriginal children is not available. However, given research shows that three quarters of mental disorders occur before the age of 25 years, high rates of mental illness in the adult Aboriginal population suggest that mental health difficulties would be more common among Aboriginal children than the rest of the population. Indeed, research suggests that differences in the mental health of Aboriginal and non-Aboriginal Australians begin at a young age (Jorm et al. 2012). In 2012-13 around 12 per cent of Aboriginal Australians reported feeling depressed or having depression as a long-term condition (AIHW 2016a). In 2014-15 the age-standardised rate[[81]](#footnote-82) of hospitalisations for mental and behavioural disorders among Aboriginal Australians was 1.8 times the rate for non-Aboriginal Australians, 2,827.4 per 100,000 and 1,602.5 per 100,000 respectively (Productivity Commission 2016).

Children in child protection experience considerably worse mental health outcomes than the general population. A 2016 OOHC outcomes tracking survey completed by case managers reported that 22 per cent of children and young people in OOHC showed signs of some kind of mental health condition, including six per cent with a formal diagnosis. Case managers reported around 37 per cent of children in OOHC showed signs of experiencing trauma during or immediately prior to their placement (DHHS 2017b).

Same-sex attracted and gender diverse Victorians also experience significantly higher rates of mental health conditions than heterosexual Victorians. A survey of 859 trans and gender diverse young people (14 to 25 years of age) found that 74.6 per cent of trans young people have been diagnosed with depression and 72.2 per cent with anxiety (Strauss et al 2017). Data on LGBTI people of all ages in Australia suggests that they are four to five times more likely to experience a major depressive episode than the general population (Rosenstreich 2013). Aboriginal LGBTI Victorians are also at increased risk of experiencing mental illness (State of Victoria 2017).

Children in contact with the youth justice system are also more likely to be experiencing difficulties with their mental health. Service use among these children is a good proxy indicator for prevalence of mental health conditions. In 2015-16, around 41 per cent of female and 31 per cent of male Victorian young people engaged with the youth justice system were using DHHS or public mental health services (Armytage & Ogloff 2017).

*The Victorian Government recognises that young people in youth justice have complex health and rehabilitation needs. It is critical that appropriate interventions and services are available to support them and address their risk of offending.*

*When young people first enter a youth justice custodial centre, they receive a health screen and mental health assessment within 24 hours of admission and a comprehensive health assessment by a general practitioner within 72 hours.*

*These assessments determine their health needs and inform the development of a targeted treatment plan for their time in custody. Supports provided through this treatment plan aim to address primary and mental health and include:*

* *mental health interventions such as mental health nursing and psychiatry services*
* *assistance with health needs through medical clinics and nursing services*
* *dental, optometry, physiotherapy and other allied health services.*

### 5.3.2 Experiences of psychological distress amongst young people

Young people experiencing high levels of psychological distress are at greater risk of depressive and anxiety disorders (Lawrence et al. 2015). The VSHAWS reports on psychological distress among Victorian students. In 2016, just under 18 per cent of students in Victoria reported psychological distress, up from 16 per cent in 2014. Females (23 per cent) were more likely to report psychological distress than males (13 per cent). Young people in couple-parent families (17 per cent) were less likely than those in single-parent families to report high levels of psychological distress (24 per cent). A greater proportion of older students (20 per cent in Year 8 and 26 per cent in Year 11) report psychological distress than their younger peers (11 per cent in Year 5). LGBTI young people report higher levels of psychological distress, with the highest rates among young men aged between 16 and 24 years of age (Rosenstreich 2013).

In 2014-15, 37 per cent of Aboriginal Victorians over the age of 18 years experienced psychological distress. This is more than the 29 per cent that reported high or very high distress levels in 2004-05 (Productivity Commission 2016). While these statistics are not about Victorian Aboriginal children, they remain illustrative given research previously outlined in this report that the majority of mental illnesses begin during adolescence.

### 5.3.3 Social and emotional health and difficulties

A sense of social and emotional wellbeing is developed through complex interactions between an individual’s characteristics and their environment, including experiences in their home, school and community. Social and emotional wellbeing is important because it focuses on a child’s personal strengths rather than simply the absence of mental illness and takes into account the child’s physical, social and material environment (Hamilton and Redmond 2010). Improved social and emotional skills have been shown to be associated with improved academic achievement (Durlak et al 2011).

Between 2006 and 2017 there has been a significant increase in the proportion of children reported to have emotional, developmental or behavioural difficulties. The 2017 VCHWS reported that 10.1 per cent of children covered in the survey reportedly had an emotional, developmental or behavioural difficulty. This figure has increased in each survey since 2006 when the figure was reportedly four per cent of children. Children from single-parent families are reported to be substantially more likely to have emotional, developmental or behavioural problems than children living in couple families and the gap has widened during the past decade, from a little more than six percentage points in 2006 to a little more than 14 percentage points in 2017. In 2017, 22.2 per cent of children from single-parent families were reported to have these difficulties compared to 7.7 per cent of children in couple families. Children on a Health Care Card fare even worse with 24 per cent of these children reportedly experiencing emotional, behavioural or developmental problems. Further analysis of Victorian children’s emotional and behavioural difficulties is in Section 6.1.3.

Table 60 Proportion of Victorian children (aged 0-12) who have an emotional, developmental or behavioural difficulty, by concession status, 2006-2017. Source: VCHWS 2017; DET Internal Analysis.

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Statewide** | **On Health Care Card** | **Not on Health Care Card** |
| 2006 | 4.0% | 8.4% | 2.4% |
| 2009 | 4.9% | 11.5% | 2.6% |
| 2013 | 7.1% | 18.7% | 3.5% |
| 2017 | 10.1% | 24.0% | 5.6% |

### 5.3.4 Special Health Care Need and disability

Children and young people with special health care needs have chronic developmental, physical, behavioural or emotional conditions, which require support from services to a degree not usually needed by that age group. In 2016, 18 per cent of students in the VSHAWS reported having a special health care need. Females were significantly more likely to report a special health care need (22 per cent) compared with males (13 per cent), and Year 11 students (22 per cent) were more likely to report a special health care need than Year 8 students (15 per cent). These results were similar to the previous survey in 2014.

People with a disability generally experience worse health and wellbeing outcomes than the general population. While data on young Victorians with a disability is sparse, a national survey of 15 to 64-year-old Australians with a disability found significantly lower workforce participation than the general population, higher levels of unemployment and lower weekly earnings (ABS 2016). As discussed earlier in this report, the survey also found Australians with a disability were significantly less likely to finish school. People with a disability are more likely to report poor to fair health than the general population (35 per cent compared to five per cent) (VicHealth 2012). They are also more likely to report chronic health problems and poorer mental health outcomes (Ibid.). Younger Australians with a disability were more likely to experience discrimination than older people with a disability, with around 21 per cent of 15 to 24-year-olds reporting unfair treatment in the 12 months before the survey compared to two per cent of people over 65 years of age (ABS 2015d).

A survey from 2012 provides some insights into the family situation and social participation of Australian children with a disability. It found that around 34 per cent of Australian children with a disability lived in one-parent families, compared to around 18.4 per cent of other children (ABS 2014). The survey found that in the past three months 90 per cent of Australian children (aged five to 17 years) with a disability had a visit from family/friends, 67.6 per cent had a telephone call with family/friends, 28.1 per cent had done art/craftwork and nine per cent reported engaging in another activity. Around eight per cent reported not engaging in any of the above activities (Ibid.).

The survey also asked about the proportion of children experiencing learning difficulties, challenges fitting in socially and communication issues. These challenges were all generally more pronounced among younger children and those with a severe or profound disability. Around 45 per cent of children aged between five and 12 years with a disability reported experiencing learning difficulties compared to 40 per cent of children with a disability aged between 13 and 17 years (ABS 2014). Around 38 per cent of five to 12-year-olds and 30 per cent of 13 to 17-year-olds with a disability reported difficulties fitting in socially (Ibid.). Around 30 per cent of five to 12-year-olds and 23 per cent of 13 to 17-year-olds with a disability reported challenges with communication (Ibid.).

Children in youth custody are more likely to have a disability than children in the general population. Around 11 per cent of the children and young people sentenced or on remand in 2015-16 were registered with a disability (Parliament of Victoria 2018b). However, this is likely to be an underrepresentation given that under reporting is common. A report from England comparing neurodevelopment disorders among the general population and young people in custody, seen in the table below, illustrates the increased vulnerability and added health needs that children in the youth justice system experience.

Table 61 Prevalence rates of neurodevelopment disorders among young people in England. Source: Chitsabesan et al 2012.

| **Neurodevelopmental disorder** | **Reported prevalence rates among young people in the general population (per cent)** | **Reported prevalence rates among young people in custody (per cent)** |
| --- | --- | --- |
| Learning disabilities | 2 – 4 | 23 – 32 |
| Dyslexia | 10 | 43 – 57 |
| Communication disorders | 5 – 7 | 60 – 90 |
| Attention deficit hyperactive disorder | 1.7 – 9.0 | 12 |
| Autistic spectrum disorder | 0.6 – 1.2 | 15 |
| Traumatic brain injury | 24.0 – 31.6 | 65.1 – 72.1 |
| Epilepsy | 0.45 – 1.00 | 0.7 – 0.8 |
| Foetal alcohol syndrome disorder | 0.1 – 5.0 | 10.9 – 11.7 |

*Luka is a 14-year-old boy, with* ***Autism and Intellectual Disability****. He lives at home with his parents and siblings Ellie and Max. Luka attends a special school but finds many of the learning tasks difficult. His communication is limited. He finds it hard to express himself and make friends at school and often spends school lunchtime by himself.*

*Over the last eight months, Luka became increasingly aggressive, more volatile and unpredictable. He stopped doing chores, bathing and changing his clothes. He started having ‘melt downs’ - he would lash out, scream, break things, sometimes hitting or kicking others. His parents found his behaviour harder to manage as he was getting bigger and stronger. His teachers also struggled and he was once suspended from school.*

*Max and Ellie, Luka’s brother and sister, were afraid and were avoiding him. Luka was also injuring himself, banging his head and punching walls. His family were in a constant state of hyper-arousal, worried about the next ‘melt down’ and possible harm.*

*Luka’s family were desperate and his parents were worried about how to protect their other two children. They became reclusive, too scared to go out in public. Things were so desperate that his parents started to consider the possibility of relinquishing Luka into care.*

*Luka’s teacher suggested referral to the* ***Alfred Child and Youth Mental Health Service, Mental Health Intellectual Disability Initiative-Youth Service****. Luka and his family were initially seen by the Paediatric Registrar in order to rule out any organic cause to changes. A multidisciplinary assessment was completed that included: psychiatry, neuropsychology and psychology, speech pathology, occupational therapy, social work, special education and family peer work.*

*Assessment resulted in:*

*• Diagnosis of Generalised Anxiety/Major Depressive Disorder - Luka commenced medication*

*• A behavioural approach applied to understand triggers for Luka’s behaviour and to coach more adaptive responses*

*• Awareness of Luka’s communication needs - his family developed methods to communicate more effectively and Luka developed techniques to better express his needs and preferences*

*• Identification of Luka’s sensory processing strengths/sensitivities so that sensory stimuli could be adapted and modulated to his needs*

*• A system of care being established that engaged and co-ordinated services – these included disability support, re-establishing respite and support for carers.*

*After four months, Luka’s behaviour has steadily improved. While his mood still fluctuates, outbursts are occurring less often. His family report their stress levels have dropped, his siblings are less fearful of him and have resumed their regular games of backyard cricket. His teacher is also more equipped with strategies that enhance Luka's ability to complete classroom activities.*

*Overall Luka’s family say their hope for the future has returned along with their ability to manage Luka’s mental health needs.*

## 5.4 Common physical conditions

### 5.4.1 Dental Health

Healthy teeth and gums in childhood supports good dental health in adulthood. A range of preventative factors reduce decay and the likelihood of needing a filling, and improve long-term dental health, such as regular visits to a dentist, exposure to fluoride in drinking water and toothpaste, brushing, flossing and a healthy diet (DHHS 2018c, Spencer et al. 2018). Oral health is also influenced by behavioural factors, including smoking and alcohol consumption (Productivity Commission 2017). Losing teeth can cause pain, as well as affect a child’s smile which has an impact on social interactions and self-esteem (Bönecker et al. 2012; Rodd et al. 2011). Dental decay has functional effects, such as on chewing and speech, educational effects, such as absenteeism, and psychological effects, such as increased irritability and difficulty sleeping (AIHW 2018d; Bönecker et al. 2012; Brennan, Spencer & Roberts-Thomson 2008; Jackson et al. 2011; Rodd et al. 2011). Among young adults in Victoria, dental conditions are the leading cause of potentially preventable hospitalisations (DHHS 2018c; Rogers et al. 2018).

Data from the VCHWS shows that while there are some clear inequalities in oral health for children under 13 years of age, outcomes across Victoria have improved slightly. In 2017, 17.7 per cent of children covered in the survey had a filling. This represented a slight improvement on the 2006 result (20 per cent). However, despite improvements for all measured groups of children, inequalities remain. Children living in regional Victoria (22.6 per cent) are more likely to have a filling than those living in metropolitan areas (16.1 per cent). Children in single-parent families also remain more likely than those in couple parent families to have a filling (16.4% compared to 23.7%). Children living in socioeconomically disadvantaged areas were also remain more likely to have a filling than their peers living in more advantageous circumstances.

Access to high quality, timely dental care is important for reducing preventable dental hospitalisations, higher long-term health care costs and improving the quality of life of Victorians. However, for many Victorians dental care can be prohibitively expensive.

*The Victorian Government’s public dental services are provided through the Royal Dental Hospital in Melbourne and 83 clinics across Victoria to support access, particularly among people who cannot afford private dental care. All children aged zero to 12 years are eligible as well as young people aged 13 to 17 years who hold a healthcare concession card or who are dependents of concession card holders. Children and young people aged zero to 17 years with a Health Care Card or who are dependants of concession card holders can access services free of charge. A flat fee of $33 is charged for the treatment of children aged under 12 years that do not hold a health care concession card. Children are provided with the next available appointment.*

*The Commonwealth’s Child Dental Benefits Schedule provides benefits for basic dental services for children aged two to 17 years. Families in receipt of the Family Tax Benefit Part A are eligible to access up to $1,000 over a two calendar year period for a variety of dental care for their child, including examinations, x-rays, cleaning, fissure sealing, fillings, root canals and extractions. This benefit cannot be used for orthodontic, cosmetic dental work or dental work provided in a hospital.*

Another measure that provides further clarity about children’s oral health is the rate of potentially preventable dental hospitalisations (PPDH). The rate among Victorian children and young people aged zero to 19 years is stable at 4.3 per 1,000 population over the decade. The rate for Victorian children under four years of age who live in regional Victoria has improved, from 13.4 per 1,000 population in 2000-01 to 5.0 in 2016-17. This is now only slightly higher than the rate of PPDH for Victorian children under the age of four living in metropolitan areas of 4.1 per 1,000. The rates for most other age groups in metropolitan and regional areas have been stable or increased slightly among older children. Among children aged five and nine years living in metropolitan areas the rate has increased since 2000. In 2016-17 there were 7.3 PPDH per 1,000 Victorian children in metropolitan areas aged between five and nine years, up from 4.1 in 2000-01. This compares to 10.3 per 1,000 Victorian children in regional areas aged between five and nine years (stable since 2000-01 when the rate was 10.2).[[82]](#footnote-83) According to Victoria’s Chief Health Officer, the reductions in rural areas are most likely because of the extension of water fluoridation in rural Victoria from 2006 (DHHS 2018c).

Table 62 Potentially preventable dental hospitalisation rates per 1,000 population, by age group, metropolitan Victoria, 2000-2017. Source: DHHS, Victorian Health Information Surveillance System.

|  |  |  |
| --- | --- | --- |
| **Year** | **0-4 years** | **5-9 years** |
| 2000-01 | 3.3 | 4.1 |
| 2001-02 | 5.9 | 6.0 |
| 2002-03 | 3.2 | 4.9 |
| 2003-04 | 5.2 | 6.4 |
| 2004-05 | 4.5 | 7.1 |
| 2005-06 | 5.4 | 6.4 |
| 2006-07 | 3.9 | 5.7 |
| 2007-08 | 3.7 | 6.5 |
| 2008-09 | 3.7 | 6.6 |
| 2009-10 | 3.7 | 7.6 |
| 2010-11 | 4.4 | 7.4 |
| 2011-12 | 4.1 | 6.9 |
| 2012-13 | 3.0 | 5.8 |
| 2013-14 | 3.3 | 6.6 |
| 2014-15 | 3.7 | 6.8 |
| 2015-16 | 4.6 | 7.6 |
| 2016-17 | 4.1 | 7.3 |

Table 63 Potentially preventable dental hospitalisation rates per 1,000 population, by age group, rural Victoria, 2000-2017

|  |  |  |
| --- | --- | --- |
| **Year** | **0-4 years** | **5-9 years** |
| 2000-01 | 13.4 | 10.2 |
| 2001-02 | 13.2 | 12.4 |
| 2002-03 | 12.3 | 10.7 |
| 2003-04 | 12.6 | 12.1 |
| 2004-05 | 11.6 | 12.8 |
| 2005-06 | 11.6 | 12.4 |
| 2006-07 | 9.6 | 13.2 |
| 2007-08 | 9.4 | 13.4 |
| 2008-09 | 7.6 | 14.5 |
| 2009-10 | 7.5 | 14.0 |
| 2010-11 | 6.9 | 12.8 |
| 2011-12 | 6.5 | 13.2 |
| 2012-13 | 5.9 | 11.8 |
| 2013-14 | 5.4 | 11.5 |
| 2014-15 | 5.2 | 11.2 |
| 2015-16 | 5.3 | 10.8 |
| 2016-17 | 5.0 | 10.3 |

There is a social gradient to rates of PPDHs among Victorian children and young people. Among Victorian children and young people aged between zero and 19 years who are in the SEIFA quintile of highest disadvantage, the rate of PPDH per 1,000 population was 5.4 in 2016-17. The rate per 1,000 population for Victorian children in the quintile of least disadvantage was 4.3 in 2016-17. The difference between the two quintiles has remained between one and two PPDHs per 1,000 population since at least 2000-01. The difference between the most disadvantaged and least disadvantaged children in Victoria is most pronounced in the five years to nine years age group (Q1 10.7 and Q5 – 6.7).[[83]](#footnote-84)

A Victorian study has shown that access to dentists, community water fluoridation and SES are independently associated with PPDHs. The study showed that children aged zero to four years residing in a postcode without fluoridated water had on average 59 per cent higher rates of PPDHs than those with access to fluoridated water (Rogers et al. 2018). It also found that children with the lowest levels of access to oral health professionals had 65 per cent higher rates than those with the highest access. Children living in the most disadvantaged SES quintiles had 57 per cent higher rates of PPDHs than children in the most advantaged quintiles. The study also found that the Victorian rate of PPDHs among children under four years of age has declined at the same time as the proportion of Victorians that have access to fluoridated drinking water has increased (Ibid.). Around 90 per cent of Victorians have access to fluoridated water (DHHS 2018c).

### 5.4.2 Asthma

Asthma is a chronic respiratory condition caused by the narrowing of airways due to inflammation. People experience shortness of breath, tightness in the chest and wheezing. Asthma can negatively impact people’s physical, social and emotional wellbeing, particularly for those who do not manage the condition well. According to a survey conducted in 2014-15, people with asthma are more likely to rate their health as fair or poor and less likely to rate their health as very good or excellent (AIHW 2018a). Asthma caused approximately 421 deaths across Australia in 2015 (Ibid.).

Asthma medication generally consists of preventative inhalers, taken regularly to reduce the probability of an attack, and a reliever puffer, taken when someone begins to have an attack. Asthma is considered well managed when a person experiences few symptoms and uses the reliever less than three times per week. A 2012 study of nearly 2,300 Australians aged over 16 years with asthma, found that 45 per cent of these people did not have the condition well controlled and more than half of these people did not use a preventer (AIHW 2018a). However, in 2011-12, 40.9 per cent of children aged zero to 14 years had an asthma action plan, the highest proportion of any age group (Ibid.).

The AIHW reports Australia-wide on children aged between zero and 14 years with asthma. According to its data from 2014-15, more boys (12.3 per cent) have asthma than girls (9.5 per cent) (AIHW 2018a). The report says that in 2012-13, 14.6 per cent of Aboriginal Australian children aged zero to 14 years had asthma compared to 9.3 per cent of non-Aboriginal children in that age group (Ibid.)

Parent reported data from the 2017 VCHWS found that 12.1 per cent of Victorian children aged up to 12 years had asthma. It found the condition was more common among children in rural areas than metropolitan areas, among children in single-parent families compared to children in couple families, and children on a health care card. Statewide results were similar to the 2006 survey. However, the 2017 results show a higher proportion of children from single-parent families have asthma than a decade ago.

Asthma can, in severe cases, require hospitalisation. In 2016-17, there were 5,491 hospitalisations for children (zero to 17 years) in Victoria. This included 3,026 children aged between zero and four years (down from 3,244 in 2005-06), 1,636 children aged between five and nine years (up from 1,183 in 2005-06), 618 children aged between 10 and 14 years (up from 422 in 2005-06) and 211 children aged 15 to 17 years (up from 192 in 2005-06).[[84]](#footnote-85)

The rate of hospitalisations for children aged between zero and four years per 100,000 population has decreased significantly during the past decade. In 2006-07, the rate for children in this age group was 1064.6 per 100,000 population. In 2016-17, the rate had fallen to 753.2. Rates for children aged 10 to 14 years and 15 to 17 years have increased slightly during the decade but are much lower than the zero to four years age group.[[85]](#footnote-86)

Table 64 Asthma hospitalisation rate per 100,000 population, by age group, Victoria, 2006-2017. SOURCE: DHHS, VAED.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year** | **0-4 years** | **5-9 years** | **10-14 years** | **15-17 years** |
| 2006-07 | 3,429 | 1,444 | 493 | 180 |
| 2007-08 | 3,824 | 1,149 | 429 | 139 |
| 2008-09 | 4,001 | 1,037 | 400 | 143 |
| 2009-10 | 3,964 | 1,415 | 496 | 178 |
| 2010-11 | 3,936 | 1,446 | 577 | 235 |
| 2011-12 | 3,902 | 1,515 | 496 | 204 |
| 2012-13 | 3,503 | 1,183 | 371 | 141 |
| 2013-14 | 3,842 | 1,526 | 467 | 151 |
| 2014-15 | 3,634 | 1,535 | 488 | 149 |
| 2015-16 | 3,298 | 1,605 | 488 | 154 |
| 2016-17 | 3,026 | 1,636 | 618 | 211 |

### 5.4.3 Allergies

The most sudden and severe form of an allergic reaction is anaphylaxis, which if untreated can be fatal. Medication, food and insect venom are the three main causes of anaphylaxis. In children food allergies are the most common cause, responsible for more than 80 per cent of hospital presentations (DoH 2013b).

Hospital data shows more Victorian children are affected by anaphylaxis than previously. In 2016-17, there were 687 hospitalisations of children due to anaphylaxis in Victoria, up from 200 in 2005-06. This included: 259 hospitalisations of children aged zero to four years; 139 hospitalisations of children aged five to nine years; 157 hospitalisations of children aged 10 to 14 years; and 132 hospitalisations of children aged 15 to 17 years.[[86]](#footnote-87)

While in the past, children from zero to four years have been more likely than children in other age groups to be hospitalised for anaphylaxis, this is no longer the case. The table below shows that the rate per 100,000 population for children aged between 15 and 17 years has increased much faster than any other age group during the past four years. Children aged between 15 and 17 years have a much higher rate of hospitalisation for anaphylaxis than other age groups. While the number of hospitalisations remains fairly low, the growth in the rate of hospitalisations for children aged between 15 and 17 years is concerning.[[87]](#footnote-88)

Table 65 Anaphylaxis hospitalisations rate per 100,000, by age group, Victoria, 2006-2017. Source: Victorian Agency for Health Information data request.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year** | **0-4 years** | **5-9 years** | **10-14 years** | **15-17 years** |
| 2006-07 | 120 | 55 | 32 | 34 |
| 2007-08 | 120 | 37 | 35 | 29 |
| 2008-09 | 115 | 51 | 40 | 45 |
| 2009-10 | 102 | 61 | 45 | 43 |
| 2010-11 | 125 | 72 | 54 | 38 |
| 2011-12 | 124 | 74 | 43 | 57 |
| 2012-13 | 122 | 64 | 44 | 26 |
| 2013-14 | 174 | 96 | 67 | 52 |
| 2014-15 | 197 | 152 | 91 | 73 |
| 2015-16 | 232 | 136 | 130 | 105 |
| 2016-17 | 259 | 139 | 157 | 132 |

The growth in these hospital admissions among children has coincided with an increase in hospitalisations for allergic reactions to food. In 2016-17, there were 567 hospital admissions due to anaphylactic shock caused by adverse reactions to food, a 250 per cent increase on the 162 hospitalisations in 2005-06. This increase has been largely driven by a growing rate of allergies among children aged 15 to 17 years.[[88]](#footnote-89)

Table 66 Anaphylactic shock due to adverse food reaction hospitalisations rate per 100,000 population, by age group, Victoria, 2006-2017. SOURCE: Victorian Agency for Health Information data request.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year** | **0-4 years** | **5-9 years** | **10-14 years** | **15-17 years** |
| 2006-07 | 33.8 | 12.6 | 6.0 | 13.2 |
| 2007-08 | 28.3 | 7.5 | 7.5 | 12.5 |
| 2008-09 | 28.7 | 11.2 | 6.9 | 16.0 |
| 2009-10 | 25.5 | 15.1 | 10.0 | 17.4 |
| 2010-11 | 30.1 | 15.9 | 10.6 | 14.5 |
| 2011-12 | 28.7 | 14.7 | 7.0 | 24.1 |
| 2012-13 | 26.8 | 14.3 | 9.0 | 11.0 |
| 2013-14 | 41.6 | 22.9 | 15.5 | 26.4 |
| 2014-15 | 47.1 | 34.4 | 21.7 | 36.2 |
| 2015-16 | 50.8 | 28.7 | 28.5 | 56.0 |
| 2016-17 | 56.5 | 31.3 | 35.9 | 65.9 |

### 5.4.4 Healthy weight

Weight issues for children and young people have short and long-term effects on physical and mental health and wellbeing. Overweight and obese young people are at an increased risk of developing physical problems, including chronic disease, while the impacts on mental health extend to social isolation, discrimination, bullying and peer problems (Griffths et al. 2006; Strauss 2000; Summerbell et al. 2005).

Overweight or obese children are at increased risk of adult obesity (Ferraro, Thorpe & Wilkinson 2003). About 80 per cent of obese adolescents will become obese adults (Better Health Channel 2013). In Victoria in 2014-15, 32 per cent of 10 to 14-year-olds, 31 per cent of five to 17-year-olds and 40 per cent of young people aged between 18 and 24 years were overweight or obese (AIHW 2018f, ABS 2015c). The proportion of Victorian children aged five to 14 years who were overweight or obese increased from 23 per cent in 2011-12 to 31 per cent in 2014-15 (AIHW 2018f). Weight issues are more common in children living in more disadvantaged areas (AIHW 2018f, VicHealth 2017).

Children with a major depressive disorder are significantly more likely to be underweight or obese. In 2013-14, a survey of Australian children found: 10.6 per cent of Australians with a major depressive disorder aged 11 to 17 years were underweight; 25.8 per cent were overweight; and 16.7 per cent were obese. The same survey found 5.3 per cent of children with no disorder in this age group were underweight, 20.5 per cent were overweight and 5.8 per cent were obese (Lawrence et al. 2015).

People with a disability are also more likely to be overweight. Data is not available on the proportion of Victorian children with a disability who are overweight. However, a report from 2010 found that 69 per cent of Australians with a severe or profound disability were overweight or obese compared to 58 per cent of people without a disability (AIHW 2010a).

### 5.4.5 Cancer

Cancer affects the lives of many Victorians. Thirty per cent of men and 25 per cent of women will develop cancer before the age of 75 (DHHS 2018c). Cancer in children and young Victorians is relatively rare with almost 60 per cent of tumours developing in people over 65 years of age (DHHS 2018c). However, the impact on children and young people is unique. Young people are more likely to survive cancer than older Australians, meaning that the years lived post-cancer and resultant lifelong impact from cancer is larger (AIHW 2018b). From 2003 to 2012, the five-year relative survival rate for all children diagnosed with cancer in Australia was 84 per cent, one of the best results compared with countries in North America and Europe (Cancer Council 2018a). For Australians aged 15 to 25 years who were diagnosed with cancer in 2016, the estimated lifetime cost is estimated to be $1.4 billion (Ibid.)

On average, every year in Australia around 750 children aged under 14 years are diagnosed with cancer (Cancer Council 2018a). Cancer is a general term for diseases that are characterised by cells growing beyond their normal boundaries, invading adjacent parts of the body and spreading to other organs (DHHS 2018c). The most common types of cancer in Australian children are Leukaemia (33 per cent of all cases), tumours of the central nervous system (25 per cent of cases) and lymphomas (accounting for 10 per cent of cases) (Cancer Council 2018a). Around 48 per cent of children diagnosed with cancer in Australia are under the age of four years (Ibid.). Incidence rates of childhood cancers in Australia increased by 35 per cent from 1983 to 2014 (Ibid.). This has resulted in Australia having the fifth highest incidence rate of childhood cancer in the G20 (Ibid.).

In Victoria in 2016 there were 200 children under 14 years of age and 273 young people aged between 15 and 24 years diagnosed with cancer (Thursfeld & Farrugia 2017). In the same year there were 23 children under 14 years of age and 18 young people between 15 and 24 years of age who died from cancer. Among Victorian children aged zero to four years, the average incidence rate per 100,000 population for the past five years was 21.4. For Victorian children aged between five and nine years the rate was 11.8 per 100,000, the rate for 10 to 14-year-olds was 13.7 and the rate for 15 to 19-year-olds was 22.5 per 100,000 population (Cancel Council 2018b).

## 5.5 Common mental disorders

The second Australian Child and Adolescent Survey of Mental Health and Wellbeing is the most recent comprehensive study providing information on prevalence of disorders and service use. Published in 2015, the survey includes information collected in 2013-14 from 5,500 randomly sampled families with children aged four to 17 years from across Australia (Lawrence et al. 2015). The survey included diagnostic modules, questions about Australia’s health care system as well as questions about children’s background, family characteristics and living situation. In total, 6,310 parents and carers responded and 2,967 young people aged 11 to 17 years completed a questionnaire (Ibid.). While the study pertains to Australian children, it is the highest quality and most recent survey. As such, it represents the most accurate depiction of the mental health of children in all states and territories. Given Victoria is one of the largest states, it is likely that results from the survey largely reflect the prevalence of mental disorders and experiences of young people with mental disorders in Victoria.

The study found that Attention Deficit Hyperactivity Disorder (ADHD) was the most common mental disorder in Australian children and adolescents in 2013-14, followed by anxiety disorders, major depressive disorder and conduct disorder (Lawrence et al. 2015). Mental disorders affect individuals in a variety of ways, and to varying extents. The severity of disorders was assessed by considering the impact on functioning at school, with family and with friends, and the personal distress that symptoms caused. Major depressive disorder had a greater impact on the functioning of children and young people than the other disorders. The rest of this section will explore these findings in greater detail.

### 5.5.1 Attention Deficit Hyperactivity Disorder

ADHD is a disorder that impacts children’s behaviour and development. It has three main symptoms, inattention, impulsivity and overactivity. While the cause of ADHD is still unknown, researchers suspect that contributing factors include neurophysiology, genetics, maternal smoking and drug use during pregnancy, exposure to lead, lack of early attachment to caregivers and childhood trauma (Better Health Channel 2012).

As noted above, ADHD was the most common mental disorder in children in 2013-14 (7.4 per cent). This was down on the prevalence reported in 1998 (9.8 per cent) (Lawrence et al. 2015). The most common type was inattentive (3.4 per cent), followed by hyperactive (1.2 per cent) and combined. Twice as many males were reported to have ADHD in the report (10.4 per cent compared with 4.3 per cent of females) (Ibid.). While adolescent females were less likely to suffer from ADHD, the proportion of males was similar between the four to 11 and 12 to 17 age groups. Around one in 10 children (10.5 per cent) experienced a severe level of distress from ADHD in at least one domain of school/work, friends, family and self (Ibid.). A higher proportion of children with ADHD experienced moderate (23.8 per cent) and mild (65.7 per cent) distress (Ibid.).

Increased prevalence of ADHD coincided with changes in family type. According to the study, 5.7 per cent of children aged four to 17 years in their original family[[89]](#footnote-90) had experienced ADHD in the 12 months prior to the survey (Lawrence et al. 2015). This is compared to 7.9 per cent in a stepfamily, 13.4 per cent in a blended family and 11.1 per cent in a single-parent family (Ibid.).

Other familial factors were also associated with higher prevalence of ADHD, including employment, income, parental education, area of residence and family functioning. Prevalence increased significantly when parents were unemployed. Prevalence was lowest for children in households in which both parents were employed (5.8 per cent) and highest when both parents were unemployed (15.6 per cent) (Lawrence et al. 2015). Prevalence more than doubled for children living in households earning less than $52,000 a year (11.7 per cent) compared to children living in households earning $130,000 or more per year (5.2 per cent) (Ibid.). It was higher outside of greater capital cities and worse for children living in families with poor family functioning. Almost 20 per cent of children aged four to 17 years living in households with poor family functioning had ADHD compared with five per cent of children living in families with very good family functioning (Ibid.).

### 5.5.2 Anxiety disorders

Anxiety disorders refer to a range of conditions characterised by feelings of persistent and excessive worry or fear that hampers daily life. This includes disorders such as social phobia, separation anxiety disorder, generalised anxiety disorder and obsessive-compulsive disorder.

Anxiety was the second most common mental disorder (6.9 per cent) (Lawrence et al. 2015). Separation anxiety disorder was the most common anxiety disorder in children aged four to 11 years (4.9 per cent) (Ibid.). Among adolescents, both social phobia and separation anxiety were equally common (3.4 per cent each), with generalised anxiety disorder almost as common (2.9 per cent) (Ibid.). Obsessive-compulsive disorder and social phobia had the largest proportion of cases with severe overall impact (31.8 per cent) (Ibid.). Overall, 18.7 per cent of anxiety disorders were classed as severe, 27.5 per cent moderate and 53.8 per cent mild (Ibid.).

Anxiety disorders were more common in stepfamilies and one-parent families than in original families. While 4.7 per cent of children in their original family had experienced an anxiety disorder in the 12 months before the study, this increased to 9.3 per cent of children living in a stepfamily and 12.9 per cent of children in a one-parent family (Lawrence et al. 2015).

Lower family income, parental education and joblessness were associated with higher prevalence of anxiety disorders among children and adolescents. In the 12 months prior to the survey, five per cent of children living in a household with a pre-tax income of $130,000 or more had experienced an anxiety disorder (Lawrence et al. 2015). This compared to 10.6 per cent of children living in a household with a pre-tax income of less than $52,000 per year (Ibid.). In relation to parental education levels, 5.3 per cent of children who had a parent with at least a bachelor degree had experienced an anxiety disorder in the 12 months before the survey, compared to 9.6 per cent of children whose parents’ highest level of education was Year 10 or below (Ibid.). Children living in jobless households were also significantly more likely to have experienced an anxiety disorder. While 9.8 per cent of children living with a single employed parent had experienced an anxiety disorder, 17.2 per cent of children living with a single unemployed parent had experienced an anxiety disorder in the 12 months before the survey (Ibid.). Anxiety disorders were also more common among families with poor family functioning compared to those with good or very good functioning.

### 5.5.3 Major depressive disorders

Major depressive disorder affects a person’s mood and is commonly associated with a loss of interest or pleasure and irritability. In order to be diagnosed with depression at least five symptoms must be present for a minimum of two weeks and the child must experience significant distress that interferes with school, home or social settings (Lawrence et al 2015).

The 12-month prevalence rate of major depressive disorder among four to 17-year-olds was 2.8 per cent (Lawrence et al. 2015). This was significantly higher among adolescents aged between 12 and 17 years (five per cent) than four to 11-year-olds (1.1 per cent) (Ibid.). Females were slightly more likely to experience depression than males. Depression had a severe impact on overall functioning in 42.8 per cent of cases (Ibid.). The impact was largest in the domains of school and self.

Similarly, family characteristics, such as income, education levels and functioning were all associated with changes in prevalence. Around 2.1 per cent of children in two-parent families experienced major depressive disorder compared to 5.5 per cent of children in single-parent families (Lawrence et al. 2015). While 3.8 per cent of children living in households with an annual pre-tax income of less than $52,000 had experienced a major depressive disorder in the previous 12 months, this fell to 1.8 per cent of children living in households with a pre-tax income of $130,000 or more (Ibid.).

### 5.5.4 Conduct disorders

Conduct disorder is persistent behaviour that is aggressive towards people or animals, destroys property, is deceitful, or seriously violates rules (Lawrence et al. 2015). It must violate the rights of others or societal norms. Common behaviours associated with conduct disorders are bullying, physical fighting and truancy.

The 12-month prevalence rate of conduct disorders among four to 17-year-olds was 2.1 per cent (Lawrence et al. 2015). This was almost identical whether the child was between four and 11 years of age or between 12 and 17 years of age (Ibid.). Around 19 per cent of cases were classified as severe, 22 per cent moderate and 59 per cent mild (Ibid.). Compared to other domains, conduct disorders were more likely to have a severe impact on the family domain than school, friends or self domains.

Single-parent family type, lower household income, lower levels of parental education, unemployment and poor family functioning were all associated with higher prevalence of conduct disorders. While the 12-month prevalence rate of conduct disorders among four to 17-year-olds living with two parents was 1.4 per cent, this increased to 4.8 per cent for single-parent families (Lawrence et al. 2015). Only 0.8 per cent of children living in a household with a pre-tax income of $130,000 or more per year had a conduct disorder. This increased to 4.3 per cent of children living in a household with an annual income of less than $52,000 (Ibid.).

### 5.5.5 Intentional self-harm in young people and suicide

Intentional self-harm includes a range of behaviours that cause direct and deliberate harm to oneself, including non-suicidal self-injury, suicidal behaviour and suicide. Self-injury may be inflicted via cutting, burns, punching or other methods. Common motivations for deliberate self-injury include emotion regulation and self-punishment (Martin et al. 2010). Measuring the problem, however, is challenging because there are difficulties in identifying intentional self-harm cases in hospital data. Some people may choose not to disclose that their injuries resulted from intentional self-harm, or may be unable to do so because of the nature of their injuries or because their motives were ambiguous (AIHW 2014).

A possibly sizeable, but ill-defined, proportion of hospital presentation and admission data for intentional self-harm cases is due to non-suicidal intentional self-harm. Intentional self-injury is stigmatised as attention-seeking and manipulative behaviour, which can make it difficult for people to seek help.

Higher rates of self-harm occur in women, and intentional self-injury rates are particularly high for young women aged 15–24 years (Victorian Injury Surveillance Unit (VISU), 2017). The predominant method is self-poisoning, usually with pharmaceuticals, followed by cutting. The 2015 Child and Adolescent Health Survey found self-harm was markedly higher in young people with major depressive disorder (Lawrence et al 2015).

The great majority of presentations at Victorian emergency departments relate to a physical health problem. Among mental health related presentations by children and young people, however, intentional self-harm is the most common presenting reason, accounting for 22.5 per cent of all mental health presentations in a recent seven year period (Hiscock et al 2018). There has been a marked increase in rates of Victorian children and young people presenting for self-harm at emergency departments. This may in part be due to improved awareness of self-harm among hospital staff and the community more broadly.

Intentional self-harm is uncommon in children and younger adolescents. Although there has been an increase in the rate of children aged 10 to 14 years making these presentations (from 49 per 100,000 to 100 per 100,000), this reflects an increase from 163 to 353 presentations per year across the state between 2006 and 2016.[[90]](#footnote-91)

Intentional self-harm is more common in older adolescents, particularly young women. The rate of presentations among 15 to 19-year-olds has increased from 345 per 100,000 in 2006 to 471 per 100,000 in 2016, and increases have occurred for both males and females.[[91]](#footnote-92) According to the Australian Child and Adolescent Survey of Mental Health and Wellbeing, almost two-thirds of adolescents who reported self-harm in the previous 12 months had self-harmed more than four times previously (Lawrence et al 2015). Cutting is most strongly associated with repetitive self-harm, and other risk factors include increasing age and a history of psychiatric treatment (Robinson 2017).

Table 67 Emergency Department self-harm presentation rates per 100,000, by age group, Victoria, 2006-2016. Source VISU/VEMD.

|  |  |  |
| --- | --- | --- |
| **Year** | **10-14 years** | **15-17 years** |
| 2006 | 49.1 | 338.8 |
| 2007 | 45.5 | 291.0 |
| 2008 | 38.0 | 291.8 |
| 2009 | 50.4 | 293.2 |
| 2010 | 44.2 | 305.9 |
| 2011 | 53.9 | 315.2 |
| 2012 | 73.6 | 395.8 |
| 2013 | 102.8 | 471.2 |
| 2014 | 112.5 | 515.1 |
| 2015 | 98.8 | 467.0 |
| 2016 | 100.5 | 507.9 |

Presentations for self-harm can be used as a proxy indicator for prevalence. However, the figures may be an underrepresentation of the number of cases as not all children who attempt self-harm will attend a hospital. Hospital admissions for self-harm, excluding same day separations, help provide detail on the number of particularly serious cases.

Rates of admission to hospital for self-harm, excluding same day separations, have increased slightly over the decade, particularly among females. Both the number and rate of admissions are higher for the older age group of 15 to 17-year-olds. The rate for 10 to 14-year-old Victorians has fluctuated, reflecting the relatively low numbers of admissions for this group. Between 2014 and 2016, there was an average of 90 admissions across the state per year for children aged 10-14 years for intentional self-harm.

Similarly, the rate of admissions for 15 to 19-year-old Victorians increased from 163 per 100,000 in 2006 to 217 per 100,000 in 2012, and then declined to 174 per 100,000 in 2016. The average annual number of admissions for this age group across the state in the period 2014-2016 was 606, and the vast majority were young women.[[92]](#footnote-93) A recent study of hospital-treated self-harm in Victoria for adults aged 15 years and over found that the female to male ratio for intentional self-harm was highest for 15 to 19-year-olds at 4.4:1. (VISU 2017). Young people who self-harm are at risk from the immediate physical injury (such as wounds, infections and organ damage) and the emotional impact (including feelings of shame, distress and depression).

In a 2016 outcomes survey, case managers reported that around 10 per cent of children in OOHC had attempted self-harm or harmed themselves in the previous 12 months. Around six per cent had hurt themselves, four per cent had attempted to hurt themselves and one per cent had attempted suicide (DHHS 2017b). Eighty-eight per cent of children who had hurt themselves or attempted to hurt themselves in the previous 12 months were 11 years or over (Ibid.). Among children aged 11 years or over, 17 per cent had self-harmed. Rates of self-harm were significantly higher in residential care (38 per cent) (Ibid.). Among Australian young people more generally, about one in 10 adolescents report self-harming at some point in their lives (Lawrence et al 2015).

In 2016, suicide was the leading cause of death of Australian children between five and 17 years of age (ABS 2017a). In the five year period 2012-2016, 11 children aged five to 14 years, and 68 young people aged 15 to 17 died by suicide in Victoria (Ibid.). The suicide rate for children aged five to 17 years and young people in Victoria is the lowest nationally at 1.7 per 100,000 population, and similar to the rates of New South Wales and South Australia (Ibid.). The Australian rate for Aboriginal children and young people between 2012 and 2016 was 9.8 deaths per 100,000 people, compared to 1.9 per 100,000 for non-Aboriginal children and young people (Ibid.).

In Victoria, the average annual number of suicides by Aboriginal people (of all ages) in the period 2009-2014 was less than 10 (Coroners Court of Victoria 2017). Calculating annual rates of suicide for low numbers of deaths within small populations is not reliable. Minor fluctuations in absolute frequencies can be magnified into major rate fluctuations that misrepresent what is actually happening. The available data suggest that the number of deaths by suicide of Aboriginal young people in Victoria is low.

In 2015, suicide accounted for around 33 per cent of all deaths of zero to 17-year-old Victorians (ABS 2017a). This was second only to transport deaths which accounted for 38 per cent of deaths. These were by far the two highest causes of child deaths in Victoria in 2015. The suicide rate of 10 to 17-year-old Victorians per 100,000 people increased from 2.4 in 2007 to 3.1 in 2015 (Ibid.). In 2007 this equated to 13 deaths of 10 to 17-year-olds and in 2015, 17 Victorian children died by suicide (Ibid.).

LGBTI Australians have significantly higher suicide and self-harm rates. A 2014 focus group survey of 1,032 young people between the ages of 16 and 27 years who identified as gender variant or sexuality diverse found that 41 per cent had thought about self-harm and 42 per cent had thought about suicide (Robinson et al 2013). In addition, 33 per cent of queer young people who participated in the survey had harmed themselves in the past, and 16 per cent had attempted to take their own lives (Ibid.). A national survey of 859 trans young people aged between 14 and 25 years found that around 80 per cent had self-harmed and 48 per cent had attempted suicide (Strauss et al 2017).

## 5.6 Access to health services

*The* ***Doctors in Secondary Schools program*** *is being delivered in 100 Victorian government secondary schools, providing access to youth-friendly primary care services to approximately 65,000 students. Each participating school has a fully fitted-out onsite general practitioner (GP) clinic, with a GP and nurse attending up to one day per week.*

*The program aims to improve accessibility of healthcare for adolescents, who have some of the lowest attendance rates of any population group. Low attendance rates are even more pronounced for young people experiencing social disadvantage, which is why this program is targeted at schools with higher levels of socioeconomic disadvantage. Half the schools participating in the program are located in regional Victoria, where families often face barriers to accessing healthcare. Another 25 participating schools are located in Melbourne’s growth areas and urban fringe to help meet demand for services created by Victoria’s unprecedented population growth.*

*At the end of December 2017, over 1,400 young people had one or more consultations with the GP, with 2,470 consultations overall. The majority of consultations were for mental health issues and physical health issues, and almost 568 referrals had been made to specialist services for further care.*

Australian children receive healthcare in a range of settings. This includes GPs, specialists, hospitals and community-based organisations. While Victoria has a strong health system that works well for most people, some young people face barriers to the care they need. These include waiting times, stigma, discrimination or lack of awareness regarding how or where to get the care. Lack of access to necessary healthcare services can lead to a deterioration of health and quality of life, as well as affect care outcomes (DHHS 2016b). Victorians with a disability are a group with particular challenges accessing timely and effective health care. According to VicHealth barriers include inadequate transportation, failure to provide assistance with communication and discriminatory attitudes among staff (VicHealth 2012).

The vast majority of Victorian children live in households that have access to basic health services. Results from the past four VCHWS illustrate that access to services is improving across Victoria. In 2017, more than 93 per cent of respondents to the survey said they had access to basic services, such as a health centre or medical clinic. This has increased in each survey since 2006 when 88 per cent of parents of children aged zero to 12 years lived in communities with access to basic services. This indicator has improved for every measured group during recent surveys. However, there remains a statistically significant difference between children living in rural areas and those living in metropolitan areas. In 2017, 85.6 per cent of children (aged zero to 12 years) living in families in rural areas had access to basic services, up from 78.6 per cent in 2006. In 2017, 95.8 per cent of children under 13 years of age living in metropolitan areas had access to basic services – up from 91.2 per cent in 2006. This shows that while all Victorian communities enjoy access to basic services and this is improving, families living outside of Melbourne continue to have poorer access to services.

According to the survey of Australian adolescent mental health around one in six (17 per cent) children and young people aged four to 17 years had used services for emotional or behavioural problems in the previous 12 months. Around 14.8 per cent had used health services, 11.5 per cent had used school services and 53.5 per cent used both health and school services (Lawrence et al. 2015). The survey showed that 56 per cent of four to 17-year-olds with a mental disorder had used services for emotional and behavioural problems in the previous 12 months (Ibid.). Service use was higher among children and adolescents with more severe disorders.

Most people seeking psychological help use Medicare Benefits Schedule (MBS) subsidised services. Administrative data on Victorian children and young people using MBS subsidised mental health services shows increasing usage. Overall, nearly seven per cent of Victorian children (zero to 17 years) used one of these services in 2016-17, up from four per cent in 2011-12. The proportion of children aged between five and 11 years using MBS subsidised mental health services increased from five per cent in 2011-12 to eight per cent in 2016-17. Victorian adolescent (12 to 17 years) service usage also increased, from seven per cent in 2011-12 to 11 per cent in 2016-17 (Productivity Commission 2018d).

### 5.6.1 Emergency Departments

Over the seven-year period to 2014-15, there were more than two-and-a-half-million presentations to emergency departments in Victoria by children and young people zero to 19 years of age. Nearly 98 per cent were for physical health problems and around two per cent were for mental health problems (Hiscock et al. 2018).

In 2016-17, children under the age of four years accounted for 178,680 presentations to Victorian emergency departments. Of these, 0.3 per cent were triaged as resuscitations, 9.4 per cent as emergency cases, 35.6 per cent as urgent, 47.1 per cent as semi-urgent and 7.6 per cent as not urgent. This was higher than any other age group and 97,000 presentations more than the five to nine years age group. From 2010-11 to 2016-17, children under four years of age accounted for 11 per cent of all emergency presentations. The most common diagnosis in 2016-17 for children under four years of age was viral infection, accounting for about 10 per cent of diagnoses for males and females. Acute bronchiolitis, croup, and infection of the upper respiratory tract were in the top five diagnoses for Victorian boys and girls under the age of four years, accounting for a further 11 per cent of diagnoses for girls and 14 per cent for boys. Seven out of the 10 most common diagnoses for Victorian children under the age of four stayed the same between 2006-07 and 2016-17. [[93]](#footnote-94)

In 2016-17, children aged between five to nine years accounted for 81,619 presentations to Victorian emergency departments. The most common diagnosis for Victorian boys and girls aged five to 11 years was abdominal, flank pain, cramps, and/or intestinal colic, accounting for six and seven per cent of cases respectively. In this age group, fractures of the wrist, hand, fingers, forearm and elbow accounted for a little more than eight per cent of cases among boys and nine per cent among girls. Eight of the most common diagnoses among five to 11-year-old boys in 2016-17 were the same as in 2006-07. Five of the top 10 diagnoses in 2016-17 were the same as 2006-07 for girls in this age group.[[94]](#footnote-95)

In 2016-17, the most common diagnoses for girls aged between 12 and 17 years was abdominal, flank pain, cramps and/or intestinal colic (eight per cent). This accounted for around four per cent of male cases for this age group. The most common diagnosis for 12 to 17-year-old males was fracture of the wrist, hand or fingers (eight per cent). Fractured wrists, hands, fingers, forearms, strained hands, sprained wrists and sprained knees were all in the top 10 diagnoses for 12 to 17-year-old boys accounting for a little more than 17 per cent of cases. Among girls aged 12 to 17 years, suicide attempt or ideation, suicide risk and depression accounted for nearly 5.6 per cent of presentations in 2016-17. Seven of the top 10 diagnoses for 12 to 17-year-old boys in 2016-17 were the same as in 2006-07. Among 12 to 17-year-old girls, five of the top 10 diagnoses in 2016-17 were the same as 2006-07.[[95]](#footnote-96)

### 5.6.2 Hospital presentation and separation data on mental illnesses

From 2008-09 to 2014-15, there were 52,359 mental health presentations to Victorian emergency departments by children and young people aged under 19 years. Stress-related, mood, and behavioural and emotional disorders together accounted for 40 per cent of mental health presentations, and the numbers of presentations for each of these reasons increased markedly during the seven-year study period (Hiscock et al. 2018).

Mental health presentations increased by 6.5 per cent per year from 2008-09 to 2014-15, and physical health presentations increased 2.1 per cent per year over the same period. Presentations for intentional self-harm increased from 1,412 to 2,157, an increase of 52.8 per cent (Hiscock et al. 2018). Mood disorder presentations increased from 658 to 1,259, a 91 per cent increase. Behavioural and emotional disorders increased from 473 to 866, an 83 per cent increase. Stress related disorders increased from 1054 to 1540, a 46 per cent increase. Psychoactive substance use was the second largest category over the seven-year period (22.3 per cent) (Ibid.).

Most children and young people in Victoria who need specialist mental health services receive treatment in the community. A small proportion require inpatient treatment for mental illness. In 2016-17, there were 1,835 hospitalisations of clients in child and adolescent mental health services in Victoria (DHHS 2017i).

# 6.0 Learning and education

Relationships between education and health and wellbeing

## Key facts

**Health, wellbeing and education are complementary and interrelated. Health and wellbeing are prerequisites for positive outcomes at school, and education is key to long-term health and wellbeing.**

Early childhood development is key to children’s success at school. In 2015, one in five Victorian children were assessed as being developmentally vulnerable at school entry.

*Developmental vulnerability at school entry is associated with poorer educational achievement years later.*

Linked data for Victoria shows that children who are developmentally vulnerable at school entry are half as likely to achieve in the top two bands in Year 5 NAPLAN Reading as those classified as on track.

**Table 68 Proportion of developmentally vulnerable children achieving in the top two bands for Year 5 NAPLAN Reading, by domain, Victoria, 2014. Source: Australian Early Development Census, 2009 and NAPLAN, 2014.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vulnerability status** | **Physical Health** | **Social Competence** | **Emotional Maturity** | **Language & Cognition** | **Communication** |
| Vulnerable | 19% | 16% | 22% | 6% | 12% |
| On track | 41% | 42% | 41% | 42% | 43% |

*Positive parenting in the early years fosters stronger relationships with children, can help mitigate the effects of poverty on development and enhances learning outcomes.*

Reading to children in the preschool years has a significant impact on their learning, and on Year 3 NAPLAN scores with 69% of Victorian children read to by a family member daily.

**Table 69 Children under five read to daily by a family member, Victoria, 2006 and 2017 by SEIFA quintile. Source: Victorian Child Health and Wellbeing Survey, 2006 and 2017.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Quintile 1** | **Quintile 2** | **Quintile 3** | **Quintile 4** | **Quintile 5** |
| 2006 | 64.6% | 57.2% | 67.1% | 66.1% | 83.4% |
| 2017 | 59.4% | 67.8% | 66.2% | 71.7% | 72.2% |

The nature of the school environment impacts not only on learning and education outcomes, but also on health and wellbeing – particularly around the mental health of young people.

Students’ engagement with school, and in particular, their relationship with their teachers, influences academic outcomes.

*Student engagement with school dips during the middle of high school, as evidenced by an increase in unapproved absences and a drop in connection to teachers.*

**Table 70 Proportion of government school students chronically absent (30+ days) by connection to school, Victoria, 2017. Source: Attitudes to School Survey, 2017 and Department of Education and Training administrative data.**

|  |  |  |
| --- | --- | --- |
| **Year Level** | **Students who feel connected to school** | **Students who do not feel connected to school** |
| Year 4-6 | 9.1% | 13.0% |
| Year 7-9 | 10.8% | 20.3% |
| Year 10-12 | 7.2% | 13.3% |

**Table 71 Victorian government school students who feel their teachers share concern / are an advocate. Source: Attitudes to School Survey, 2017.**

|  |  |  |
| --- | --- | --- |
| **Year Level** | **Teacher concern** | **Advocate at school** |
| Year 4 | 79.6% | 89.3% |
| Year 5 | 76.5% | 88.2% |
| Year 6 | 73.1% | 87.3% |
| Year 7 | 46.6% | 73.3% |
| Year 8 | 36.9% | 65.7% |
| Year 9 | 34.5% | 63.4% |
| Year 10 | 37.2% | 59.1% |
| Year 11 | 41.0% | 62.3% |
| Year 12 | 47.3% | 68.1% |

*When a poor school environment includes bullying, this can have a detrimental impact on wellbeing and educational achievement.*

The proportion of students experiencing bullying has increased in recent years and Aboriginal students are more likely than their peers to experience bullying.

**Table 72 Proportion of bullied and not bullied government school students in the top two bands for NAPLAN Reading, Victoria, 2017. Source: Attitudes to School Survey and NAPLAN, 2017.**

|  |  |  |
| --- | --- | --- |
| **Year level** | **Not bullied** | **Bullied** |
| Year 5 | 43% | 34% |
| Year 7 | 29% | 20% |
| Year 9 | 20% | 11% |

**Table 73 Proportion of bullied and not bullied government school students in the bottom two bands for NAPLAN Reading, Victoria, 2017. Source: Attitudes to School Survey and NAPLAN, 2017.**

|  |  |  |
| --- | --- | --- |
| **Year level** | **Not bullied** | **Bullied** |
| Year 5 | 13% | 19% |
| Year 7 | 15% | 22% |
| Year 9 | 24% | 34% |

Young people who finish school and go on to further education enjoy better health and employment outcomes.

*Young people who finish school are more likely to go on to further education and enjoy better mental health, are less likely to develop chronic illness and or suffer from social isolation.*

Victoria has high levels of school completion with approximately eight out of every ten Victorians either completing Year 12 or an equivalent qualification by age 19.

**Table 74 Post-school education destinations, Victoria, 2017. Source: On Track Survey, 2017.**

| **Post-school destination** | **Young people who did not finish Year 12\*** | **Year 12 completers\*** |
| --- | --- | --- |
| Apprenticeship/traineeship | 32% | 8% |
| Certificate/diploma | 19% | 13% |
| Bachelor degree | 1% | 54% |
| Total in education and training | 51% | 75% |

*\*Figures may not add up to total due to rounding*

*Higher levels of educational attainment provide better employment pathways, reducing economic and social disadvantage.*

Recent employment figures show that those with post-school qualifications are more likely to be employed than Year 12 non-completers.

**Table 75 Employment by highest level of education, Australia, 2016. Source: Australian Bureau of Statistics, cat no 6202.0, 2017.**

| **Educational attainment** | **Proportion of people employed** |
| --- | --- |
| Post-graduate degree | 86% |
| Bachelor degree | 84% |
| Diploma / Advanced Diploma | 82% |
| Year 12 | 72% |
| Year 11 | 61% |
| Year 10 and below | 54% |

*Wellbeing in early childhood makes a significant contribution to achieving educational excellence in school.*

To better understand how these domains are associated, departmental analysis linked early childhood health and wellbeing data to learning outcomes, and controlled for the influence of different demographic factors. The data linkage shows that as indicators of poor health and wellbeing accumulate prior to school entry, the influence on a child’s academic achievement in primary school compounds, creating even greater challenges.

Figure 1 Increase in likelihood of achieving in top two bands for NAPLAN Year 3 Numeracy (2017), by SEHQ health and wellbeing indicator (2014). Source: School Entrant Health Questionnaire, 2014 and NAPLAN 2017.

**1.5 x**

**1.1 x**

**1.5 x**

**5.7 x**

***Excellent health*** *versus good health*

***No speech difficulty*** *versus speech difficulty*

***Not witnessed violence*** *versus has witnessed violence*

***Excellent health, no speech difficulty, has not witnessed violence*** *versus good health, speech difficulty, has witnessed violence*

**Increase in likelihood of achieving in the top two bands for NAPLAN Year 3 Numeracy**

## Introduction

An appetite for lifelong learning is cultivated from an early age. Positive health and wellbeing is one of the building blocks that enables a child to fully engage with school life from the beginning, and to develop their individual skills and interests to the fullest potential. There is also considerable international evidence demonstrating the substantial effect of education on health. Education influences health through a range of complex mechanisms like income, access to health care and better employment opportunities.

Participation and engagement in education nurtures human development, social relationships and wellbeing and can promote positive choices and a healthy lifestyle. Education matters to health through the direct effect it has on learners, its impact on people’s choices and opportunities, and through its potentially transformative effect on families, workplaces, community and the wider society.

This chapter demonstrates the relationship between health and wellbeing and learning and education over three life stages; from the time before a child starts school, through their school life as a student, and a young person’s pursuit of life opportunities post school.

This approach reflects the importance of extrinsic factors, including supportive family environments and positive school climates, which encourage and motivate students to succeed through each stage of their education journey. These factors are closely connected to intrinsic factors, such as the resilience and motivation of individual students, which have a positive impact on student outcomes at the individual and cohort level. In other words, children play an active role in shaping their own experience at school; conversely, the school and home environments frame this experience as well. Understanding the interrelations between extrinsic and intrinsic wellbeing factors is crucial for understanding the experience of students at a school.

## 6.1 Developmental vulnerabilities in early childhood

The Victorian Government’s Lifting Our Game report (Brennan & Pascoe 2017) found that wellbeing in early childhood makes a significant contribution to achieving educational excellence in schools. It reported the growing evidence linking improved school readiness, due to children’s participation in high quality early childhood education, and lifted academic achievement (NAPLAN results and Programme for International Student Assessment (PISA) scores). High-quality early childhood education also has broader impacts beyond schooling, including associations with increased employment, income and financial security, improved health and wellbeing outcomes and reduced rates of involvement in crime.

Developmental vulnerabilities, such as physical and motor impediments or cognitive and socio-emotional issues, can affect all children (WHO 2018b). Certain children, however, are more prone to exhibit developmental issues at an early age. For example, AEDC results over time suggest that boys starting school are more likely than girls to be assessed by their teachers as developmentally vulnerable on one or more development domains.

Children who begin school with a developmental vulnerability can struggle to catch up to their peers as they progress through schooling. Accordingly, it is vital that children showing signs of such vulnerabilities are provided with the appropriate support from an early age. The impact of an undetected or untreated developmental issue can also exacerbate poor performance over time.

### 6.1.1 Developmental vulnerabilities and academic performance

In 2015, around 20 per cent of children starting school in Victoria had an identified developmental vulnerability in the AEDC. This had not changed over the past three censuses. In 2015, 42 per cent of Aboriginal children had a developmental vulnerability, down from 47 per cent in 2009. The proportion of children from socioeconomically disadvantaged areas with an identified developmental vulnerability remained stable around 32 per cent from 2009 to 2015 (Commonwealth of Australia 2016).

Analysis conducted by DET sought to understand the relationship between starting school with a developmental vulnerability (as determined through the AEDC and the SEHQ) on a child’s future literacy performance.

Tracking the same children (across all school sectors), linked from their AEDC data in Prep (2009) to their Year 3 and Year 5 NAPLAN Reading results, this analysis demonstrated that children assessed as vulnerable on one or more AEDC domains were less likely to achieve in the top two bands for Reading at Year 3 (31 per cent, compared with 58 per cent who were not vulnerable). This pattern continued into Year 5, with the difference most marked for children who were vulnerable on two or more domains at Prep. Fourteen per cent of children who were vulnerable on two or more domains achieved in the top two bands at Year 5, compared with 40 per cent who were not vulnerable.[[96]](#footnote-97)

### 6.1.2 Speech and language

Early speech and language difficulties are associated with lower academic achievement and issues with social and emotional wellbeing (Commonwealth of Australia 2014). Research has found significant associations between speech and language issues and a range of other challenges such as conduct problems, hyperactivity and issues with peers (DET 2016).

A Victorian study found that children with speech and language difficulties are more than three times as likely to demonstrate socioemotional and behavioural difficulties and those with these difficulties are more than 12 times as likely to report receptive language difficulties and six times more likely to report expressive language difficulties (Hughes, Sciberras & Goldfeld 2016). This study found that there were a range of familial and health factors that predicted comorbidity, including the child witnessing violence, parental mental illness, living in disadvantaged areas and parental educational attainment (Ibid.).

According to DET’s analysis, vulnerability on the language and cognitive skills domain in the AEDC is more strongly associated with poorer academic performance than any other domain. Compared to children that were on track in Prep, children identified as vulnerable in the language and cognitive skills domain were nearly five times less likely to achieve in the top two bands in Year 3 NAPLAN Reading. In Year 5, they were seven times less likely to be in the top two bands. The analysis highlights the importance of investing in children’s developmental capabilities in the earliest years, particularly their language and cognitive skills, providing the developmental foundations for future achievement.

Table 76 Proportion of Victorian students achieving in the top two bands for Year 3 NAPLAN Reading (2012) by AEDC vulnerability domain (2009). Source: Department of Education and Training internal analysis; AEDC 2009 and NAPLAN 2012.

|  |  |  |
| --- | --- | --- |
| **AEDC vulnerability domain** | **Vulnerable** | **On Track** |
| Physical Health | 30.10% | 56.65% |
| Social Competence | 27.85% | 57.98% |
| Emotional Maturity | 34.32% | 56.73% |
| Language and Cognition | 12.26% | 58.35% |
| Communication | 21.65% | 59.05% |

Table 77 Proportion of Victorian students achieving in the top two bands for Year 5 NAPLAN Reading (2014) by AEDC vulnerability domain (2009). Source: Department of Education and Training internal analysis; AEDC 2009 and NAPLAN 2014.

|  |  |  |
| --- | --- | --- |
| **AEDC vulnerability domain** | **Vulnerable** | **On track** |
| Physical Health | 19.34% | 40.73% |
| Social Competence | 16.13% | 41.91% |
| Emotional Maturity | 22.26% | 41.03% |
| Language and Cognition | 5.92% | 41.93% |
| Communication | 11.92% | 42.93% |

The SEHQ records parent’s concerns and observations about their child’s health and wellbeing as they begin primary school in Victoria. The questionnaire is run as part of the Victorian School Nursing Program and provides nurses with a clinical tool to assess the health and wellbeing of children entering primary school. Parental concerns with a child’s general development, or behavioural and emotional maturity, can be raised and assessed through the SEHQ.

In 2017, around 14 per cent of children starting primary school were reported to have a speech and language difficulty. This was higher among Aboriginal children (25 per cent), children in one-parent families (20 per cent), boys (19 per cent), children in regional Victoria (18 per cent) and children in areas of most disadvantage (15 per cent). These results were all similar to results from the previous two years.[[97]](#footnote-98)

Research shows that children in contact with the youth justice system are particularly likely to exhibit speech and language difficulties. Australian researchers completed a review of literature looking at speech and language challenges among young people in custody. This included a study of 50 young Victorian males on community orders, which found 52 per cent had a language impairment (Snow & Powell 2008). Another study by Snow and Powell in 2011 of one hundred 17 to 21-year-old Victorian males in custody found that 46 per cent had a previously unidentified language impairment and those with higher offending scores performed worse on language measures (Snow & Powell 2011). An Australian literature review also found that children in contact with the youth justice system were more likely to experience other conditions that negatively affect speech and language, including intellectual disability, mental health issues, trauma, and less supportive and interactive environments (Caire 2013).

Research suggests that there is a correlation between overexposure to digital media and lower levels of language development for young children. One study of nearly 900 children under the age of two years found that children using handheld digital devices were more likely to have delays in expressive speech (Ma et al 2017). Several correlation-based studies have found early media exposure is associated with poorer language development (Mendelsohn et al 2010; Linebarger and Walker 2005; Zimmerman et al 2007). There is also evidence suggesting that content (i.e. television with a stronger narrative) and the age of the child are important factors to consider (Linebarger and Walker 2005; Zimmerman et al 2007). Additional research suggests that in-person interactions with parents and parental language skills are important for children’s language development (Hanson 2017).

### 6.1.3 Emotional and behavioural difficulties

The Strengths and Difficulties (SDQ) component of the SEHQ enables the identification of children at risk of behavioural and emotional problems (Goodman 1997; Goodman, Meltzer & Bailey 1998; Goodman, Lamping & Ploubidis 2010). The SDQ, a behavioural screening questionnaire for four to 17-year-olds, includes questions on 25 psychological attributes that are divided between five scales: emotional symptoms, conduct problems, hyperactivity, peer problems and pro-social behaviour. Children identified with a relatively high SDQ score are considered as being at higher risk of clinically significant problems related to behaviour. Results from the 2017 SEHQ indicate that one in 20 (4.9 per cent) Victorian Prep children were identified as at high risk of significant behavioural problems when they started school. This rate has risen slightly when compared to 2015 (4.6 per cent). Rates of identification for Aboriginal or Torres Strait Islander children were nearly triple the rate of the general population, and those from a one-parent family over double the rate.

Beginning school with behavioural and emotional problems can have a negative impact on future academic achievement. Departmental analysis linking SEHQ data for Prep students (2010) to their Year 3 NAPLAN scores (2013) shows that children with these identified developmental issues:

* have lower average NAPLAN scores at Year 3 for both Reading and Numeracy;
* are more than three times as likely to be at or below the national minimum standard if they are high risk (compared to low risk); and
* are less likely to be in the top two bands if they are high risk (compared to low risk).

A more recent data linkage of SEHQ 2014 and NAPLAN 2017 reinforced these findings. DET analysis found that 59 per cent of children who started school at low risk of emotional and behavioural problems went on to reach the top two bands in Year 3 NAPLAN Reading, compared to 40 per cent of children at moderate to high risk of emotional and behavioural problems. In Year 3 Numeracy, 49 per cent of children at low risk of emotional and behavioural problems achieved in the top two bands, while 31 per cent of children at moderate to high risk of emotional and behavioural problems reached the mark.

**Table 78 Proportion of Victorian students in the top two bands for NAPLAN Year 3 Reading (2017) based on emotional and behavioural problems measured through the School Entrant Health Questionnaire (2014). Source: Department of Education and Training internal analysis; SEHQ 2014, NAPLAN 2017.**

| **Risk assessment for emotional and behavioural problems** | **Proportion of students in the top two bands** |
| --- | --- |
| Moderate to high risk | 40.10% |
| Low risk | 58.90% |

## 6.2 Family factors and achievement outcomes

Extrinsic factors, such as the family environment, impact on student achievement and provide important support during periods of significant change. The transition to begin school or moving from primary to secondary school are periods filled with opportunities and challenges, and parents have an important role in supporting children to flourish during these transitions. Attending to children’s social and emotional health during transitions will also provide them with skills that underpin their mental health in the short and long-term. Research is equally clear that the accumulation of risk factors in the family environment, such as family violence and financial hardship, can have a cumulative impact on children’s health and academic achievement (Cassen, Feinstein & Graham 2009; Shonkoff et al. 2012).

### 6.2.1 Home learning environment

The in-home learning environment has a significant impact on learning outcomes. The LSAC examined four dimensions of the home learning environment that are important to children’s development:

* home activities, including teaching songs, playing games and doing art
* frequency of reading to children
* number of books in the home
* out-of-home activities, such as visiting the library or zoo.

The study found associations between children’s home environment at age two to three years and their learning outcomes in Year 3 (Commerford 2015). Children’s performance in Year 3 NAPLAN Reading and Numeracy was related to the frequency of in-home activities and out-of-home activities. Their Year 3 NAPLAN performance was also related to being read to frequently and having more than 30 books in the home (Ibid.). Importantly, a stimulating home learning environment at a young age was equally beneficial to children regardless of their gender, socioeconomic position or family type (Ibid.).

A study of British children found that the home learning environment was highly influential. The study explored the impact of SES, maternal education, income and the home learning environment on achievement in literacy and numeracy. Results, summarised below, illustrate that the home learning environment had the strongest effect on achievement.

Table 79 Effect sizes for socioeconomic status, maternal education, income and the home learning environment at age five in a study of British children. Source: Melhuish et al., 2008.

|  |  |  |
| --- | --- | --- |
| **Factors influencing achievement** | **Literacy** | **Numeracy** |
| Socioeconomic status | 0.29 | 0.43 |
| Mother's education | 0.35 | 0.23 |
| Income | 0.31 | 0.28 |
| Home learning environment | 0.73 | 0.65 |

Reading to children is a key measure used to understand the home learning environment. From a young age it can be an important bonding experience for both carer and child. While this everyday activity can promote greater feelings of wellbeing, it can also provide a foundation for enhanced development. Reading to children has been found to have a significant positive effect on their reading and cognitive skills, and an effect on their later schooling outcomes (regardless of family background):

* children aged four to five years who are read to between three to five days a week demonstrate the same level of reading skills as a child six months older, and this impact nearly doubles for children read to six to seven days a week (i.e. the same effect as being almost 12 months older)
* children who are read to more frequently are also more likely to have higher NAPLAN scores in Year 3 (Reading and Numeracy, but more so for Reading) than those children who were read to less often (Kalb & van Ours 2013).

According to parent reports in the 2017 VCHWS, 68.9 per cent of Victorian children aged under five years are read to by a family member every day. For some children, this is less likely to occur. These include children living in metropolitan areas, from single-parent families and those listed on a Health Care Card. However, statewide results for 2017 are down from results in 2013 (69.6 per cent). For some areas, the decline is higher than others, most notably areas of least disadvantage.

Table 80 Proportion of Victorian children under five who were read to everyday by a family member, by SEIFA-IRSD quintile, 2013 and 2017. Source: VCHWS 2013, 2017.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Quintile 1** | **Quintile 2** | **Quintile 3** | **Quintile 4** | **Quintile 5** |
| 2013 | 61.2% | 63.3% | 68.0% | 69.1% | 77.9% |
| 2017 | 59.4% | 67.8% | 66.2% | 71.7% | 72.2% |

### 6.2.2 Family risk factors

***LOOKOUT Education Support Centres*** *build the capacity of schools, child protection case workers and carers to improve the educational outcomes of children and young people in the OOHC system. Each regional LOOKOUT Centre is led by an experienced school principal and is staffed by a team of education specialists, allied health professionals and a Koori Cultural Advisor.*

*The LOOKOUT Centres work in partnership with schools to enrol children, set targets, monitor and evaluate educational progress, and coordinate resources and activities to support the child’s education at school and at home. They focus on improving school attendance, engagement and achievement. They provide professional development for school staff, promote sector-wide understanding of issues affecting students in OOHC, provide advocacy and work to make schools more inclusive for all students.*

*LOOKOUT supports all children and young people in court-ordered OOHC, which is approximately 4,300 students aged five to 17 years, across all school sectors, on any given day in Victoria.*

On average, children exposed to family risk factors, such as addictions, abuse, mental illness or stress, demonstrate poorer outcomes at school. SEHQ-NAPLAN linkage shows that lower proportions of children whose parents responded ‘yes’ to their child being exposed to family risk factors went on to achieve in the top two bands of NAPLAN Reading and Numeracy in Year 3. The biggest differences in children reaching these higher levels and not reaching them were for those who witnessed violence, experienced abuse, or were exposed to addictive behaviour (such as alcohol or drugs). Findings from the most recent linkage (SEHQ 2014 to NAPLAN 2017) are discussed in Section 3.3.4.

Table 81 Proportion of Victorian students in the top two bands for NAPLAN Year 3 Numeracy (2017), by SEHQ response (2014). Source: SEHQ 2014 and NAPLAN 2017 data linkage.

|  |  |
| --- | --- |
| **SEHQ response** | **Proportion in top 2 bands for NAPLAN Numeracy** |
| Alcohol or drug problems in family | 36.7% |
| No alcohol or drug problems in family | 48.2% |
| Abuse to child | 36.8% |
| No abuse to child | 47.9% |
| Child witnessed violence | 32.1% |
| No violence witnessed | 48.3% |
| Parental mental illness | 45.5% |
| No history of parental mental illness | 48.0% |
| High to very high family stress | 45.2% |
| Low to medium family stress | 48.3% |

Poverty also has a large impact on developmental outcomes. However, the impact of poverty can be mitigated by positive parenting. A longitudinal study in Britain found that positive parenting was an important contributor to school achievement and mediator of experiences of disadvantage and poverty (Kiernan & Mensah 2011). The study reported that a child living in poverty with positive parenting was 38 per cent more likely to be developmentally on track than a child not in poverty with poor parenting (Ibid.). It also found that 58 per cent of children experiencing persistent poverty and positive parenting were on track, compared to 19 per cent of children experiencing persistent poverty and poor parenting (Ibid.).

*Lauren and Ryan live in kinship care with their grandparents. They had been removed from the care of their mother after experiencing neglect as a result of her drug use. The children are enrolled in and attending the same primary school. The school’s principal contacted the* ***LOOKOUT Centre*** *with concerns about the impact the children’s behaviours were having on the staff and students.*

*The two children were displaying behaviours of concern such as fighting, punching, kicking each other, screaming and throwing things, indicating a high level of trauma and emotional dysregulation.*

*LOOKOUT Learning Advisors worked intensively with teachers at the school to build their understanding of the impact of trauma on the behaviour of the children, and to develop strategies to help the children to better self-regulate.*

*One of the Learning Advisors continued visiting the school fortnightly, modelling reflective practice and planning approaches for the individual children. With an increased understanding of trauma and the underlying reasons for the children’s behaviour, the teachers became more empathetic, and embraced the notion of working collectively to address needs and taking responsibility for all children in their school community*.

## 6.3 Student health and wellbeing and school

A student’s overall sense of health and wellbeing significantly impacts their attitude to learning and academic achievement. Research shows that children who experience chronic illness in early childhood are less likely to be prepared for school, with this trajectory often continuing throughout the primary years (Goldfeld et al. 2015; Whiteford, Walker & Berthelsen 2013). Health also affects their ability to foster social relationships and develop a feeling of connectedness to school. Both aspects are important; while academic performance is a strong indicator of child and youth development, well-rounded development extends beyond formal learning to include forms of social networks and supports.

The AtoSS is an important tool in gathering responses from students in Victorian government schools (Years 4 to 12) to drive school improvement. It incorporates questions on different aspects of their school life and environment. Health and wellbeing aspects cover: bullying; levels of resilience and sense of confidence; and a sense of connectedness to school and respect for diversity. How a student responds to these factors of the AtoSS (negatively or positively) has been shown to have a relationship to both their engagement at school, and their academic performance.

### 6.3.1 Wellbeing and absenteeism

Students who miss large amounts of school are generally more disengaged, have poorer educational outcomes and are at a greater risk of leaving school early. Analysis of Victorian government school students who left school in Year 9 showed that they were absent 18 more days than students who stayed in school. The early leavers were absent for an average of 32 days in Year 9, while the students who stayed past Year 9 were absent for an average of 14 days in Year 9. Differences in absences were evident as early as Year 4.[[98]](#footnote-99)

Absences from school tend to rise once students reach secondary school. Sharp increases can be seen for Year 8 and Year 9 students, who are, on average, absent for the largest amount of days a year when compared to other year levels. This holds true for all absences, and those unapproved by the school or parent/carer of the student. In 2017, Year 9 students in government schools were on average absent from school for 23 days, which is equivalent to half a term.[[99]](#footnote-100)

Table 82 Mean number of absence days (total and unapproved) for Victorian government school students, Years Prep-12, 2017. Source: Department of Education and Training data.

|  |  |  |
| --- | --- | --- |
| **Year level** | **Average number of absence days (total)** | **Average number of absence days (unapproved)** |
| Prep | 15.9 | 4.2 |
| Year 1 | 15.8 | 4.5 |
| Year 2 | 15.4 | 4.6 |
| Year 3 | 15.0 | 4.8 |
| Year 4 | 15.4 | 5.0 |
| Year 5 | 15.6 | 5.4 |
| Year 6 | 16.4 | 6.1 |
| Year 7 | 16.9 | 5.2 |
| Year 8 | 20.9 | 7.1 |
| Year 9 | 23.2 | 8.5 |
| Year 10 | 20.3 | 7.8 |
| Year 11 | 17.3 | 7.2 |
| Year 12 | 15.7 | 6.7 |

*The* ***Navigator*** *program supports young people who are not attending school, and have significantly disengaged from education. The program provides intensive case management and assertive outreach support to disengaged learners and their families. Navigator is delivered by community agencies that work closely with schools and regional staff from DET.*

*Navigator supports young people who are facing a range of complex issues such as mental health problems, homelessness, alcohol and other drug use, and family violence. Young people aged 12 to 17 years are eligible for the service if they have attended school for less than 30 per cent of the previous term. Community sector organisations are funded to provide intensive case management supports to disengaged young people, working with their families and schools to identify their barriers to education, referring to specialist supports where required, and helping them to re-engage with education.*

Some students are absent more than others. On average in 2017, 13 per cent of Victorian government school students were absent for more than 30 days of school. This rate was higher for Aboriginal students (30 per cent) and students from schools of high disadvantage (19 per cent). Overall rates, and those for these two cohorts of students, have remained generally stable over recent years.[[100]](#footnote-101)

Lower levels of health and wellbeing can contribute to student absence from school. Examination of student responses to the AtoSS and their absences from school provide interesting insights. The results show that chronic absenteeism was more common among students reporting being bullied, providing not positive responses to their internal levels of resilience, sense of confidence and sense of connectedness. Students providing a not positive response to levels of respect for diversity within their school were also more likely to be chronically absent than those providing a positive response. The difference was more pronounced for Aboriginal students. This suggests that a lack of respect for diversity in a school could have a stronger relationship with chronic absenteeism for Aboriginal compared to non-Aboriginal students. It is important to note that relationships between absenteeism and the survey measures may underreport the relationship, as students who are absent for the survey are not included in the analysis.

Table 83 Proportion of government school students with chronic absences (30 days or more) by response to AtoSS respect for diversity factor, Victoria, 2017. Source: Department of Education and Training internal analysis; AtoSS 2017.

|  |  |  |  |
| --- | --- | --- | --- |
| **AtoSS response** | **Year 4 to 6** | **Year 7 to 9** | **Year 10 to 12** |
| Positive | 9.5% | 11.9% | 7.9% |
| Not positive | 12.6% | 18.0% | 12.5% |
| **Difference (percentage points)** | **3.1** | **6.1** | **4.6** |

Table 84 Proportion of Aboriginal\* government school students with chronic absences (30 days or more) by response to AtoSS respect for diversity factor, Victoria, 2017. Source: Department of Education and Training internal analysis; AtoSS 2017.

|  |  |  |  |
| --- | --- | --- | --- |
| **Atoss response** | **Year 4 to 6** | **Year 7 to 9** | **Year 10 to 12** |
| Positive | 23.1% | 29.4% | 27.4% |
| Not positive | 32.5% | 37.5% | 32.6% |
| **Difference (percentage points)** | **9.4** | **8.1** | **5.2** |

\*Note: small sample, caution should be used when interpreting these results

According to this analysis, the relationship between not positive responses to student health and wellbeing and absences from school is stronger for students in Years 7 to 9. The proportion of not positive responses to the above factors among chronically absent students is higher for these students than those in the Year 4 to 6 and Year 9 to 12 groups. The factor however that could be argued to be contributing the most to chronic student absence differs by year level; for younger students (in Years 4 to 6) it is negative responses to their confidence in themselves as a learner that is most prevalent among those who regularly miss school, for older students (Years 7 to 9 and Years 10 to 12) it is lower feelings of school connectedness.

A sense of connectedness to school not only fosters greater levels of student engagement, but is also linked to higher academic resilience and acts as a protective factor against risky health behaviours (Catalano et al. 2004).

Students generally become less connected to their school as they grow older. A key contributor to this reduction is puberty, given the many emotional and physical changes associated with adolescence, which can present both challenges and opportunities for young people (VicHealth 2017). In 2017 (and consistent with previous trends), students in Years 4 to 6 reported a high degree of connectedness to their school (82 per cent endorsement). Students in Years 7 to 9 and Years 10 to 12 reported a far lower degree of connectedness (56 and 53 per cent endorsement respectively). Rates are consistently lower for Aboriginal students (more noticeably in secondary school), however students from schools of greater disadvantage report similar results to the statewide results.[[101]](#footnote-102)

Table 85 Degree of connectedness to school by cohort, Attitudes to School Survey, 2017. Source: AtoSS 2017.

|  |  |  |  |
| --- | --- | --- | --- |
| **Cohort** | **Years 4-6** | **Years 7-9** | **Years 10-12** |
| Victoria | 81.70% | 56.01% | 52.82% |
| Aboriginal | 80.40% | 48.10% | 44.40% |
| Low SES | 82.27% | 54.71% | 53.30% |

*The* ***Navigator*** *model provides effective outreach to disengaged students by partnering with other community services to help students to re-engage in learning. This approach leverages local knowledge, connections and expertise within the community sector.*

*For example,* ***Mission Australia, the Navigator provider in Bayside Peninsula****, supported a disengaged 15-year-old male student whose learning had been disrupted by family violence, poor health and low self-esteem. The Navigator case worker was able to plan the student’s return to school by linking in services from Headspace as well as community legal and other support services, and by providing emergency relief support to the family. Through the support of Navigator, the young person is now enrolled in a school and is close to full-time attendance. His confidence and self-esteem have also grown significantly as a result of the support he has received through the program.*

### 6.3.2 Health, wellbeing and academic achievement

The accumulation of health adversities has been shown to be associated with incrementally worse outcomes. The LSAC analysed the health and achievement of eight and nine-year-olds (Quach et al. 2017). The study assessed children for physical health adversities, including being overweight, special health care needs, disability, poor global health and low physical-related quality of life. The study also looked at a range of psychosocial health adversities such as, behaviour problems, psychosocial health-related quality of life and sleep. It found that for each additional physical or psychosocial health adversity that a child experiences, their academic achievement in Year 3 and Year 5 fell incrementally (Ibid.). This association with lower academic achievement suggests that as health adversities accrue, they have a cumulative effect. This effect could manifest through a range of mechanisms, such as daily living activities, body functions and structures, social participation, and attendance at school (Ibid.).

Student wellbeing measures are more positive for students in primary school. At this stage of their school life, students are happy and engaged, and performance results follow suit: the proportion of students in the top two bands for NAPLAN are invariably higher for students in Year 3 and Year 5 than Year 7 and Year 9.

How wellbeing factors contribute to this story is however not straightforward. Although students who report (through the AtoSS) higher levels of wellbeing are more likely to be those who also achieve at higher academic levels (measured here as the top two bands of NAPLAN Reading), this is not always the case.

The following highlights a few anomalies, displaying student responses to the sense of confidence factor in the 2017 AtoSS (positive or not positive towards this factor) which were then mapped against their 2017 NAPLAN Reading performance.

Table 86 Government school student (Years 5, 7 and 9) responses to sense of confidence (AtoSS 2017) matched with 2017 NAPLAN Reading performance. Source: Department of Education and Training internal analysis; AtoSS 2017; NAPLAN 2017.

|  |  |  |  |
| --- | --- | --- | --- |
| **AtoSS response** | **Top two bands, Year 5** | **Top two bands, Year 7** | **Top two bands, Year 9** |
| Positive responses | 41.1% | 28.1% | 20.9% |
| Not positive responses | 26.2% | 26.9% | 17.6% |

This suggests that the relationship between feelings of student wellbeing (here the factor of sense of confidence) and students’ performance varies across different year levels. For example, higher proportions of students who responded positively to questions about their confidence achieved in the top two NAPLAN Reading bands. However, the relationship between positive wellbeing and achievement decreases as students get older. As seen above, there was a 14.9 percentage point difference between the proportion of students in the top two bands for NAPLAN Reading that were positive about their confidence compared to those that were not positive in Year 5. However, the difference in Year 9 was just 3.3 percentage points.

### 6.3.3 Accumulation of health and wellbeing difficulties

DET analysis highlights how the accumulation of risk factors is associated with progressively worse academic achievement. The analysis looked at SEHQ and NAPLAN results. Parents of children entering primary school are asked through SEHQ about their child’s family environment, health and development. These responses were linked to their child’s Year 3 NAPLAN Numeracy results. The analysis accounted for children’s gender, whether they live in a metropolitan area or regional Victoria, alcohol or drug problems in the family, speech and/or language difficulties (referred to in this section as speech difficulties), a child witnessing violence and a child’s general health. This enabled the analysis to more precisely look at how the development, health and family factors are associated with the child’s Year 3 NAPLAN outcomes; in particular, how these factors compound to have an effect that is stronger than each individual factor.

The analysis showed how speech difficulties, when combined with declining health and experiences of witnessing violence, reduced the probability of high academic achievement. On average, a child in excellent health was 1.1 times more likely to be in the top two NAPLAN bands in Year 3 Numeracy than a student in good health. A student with no speech difficulties and in excellent health was 1.5 times more likely to be in the top two NAPLAN bands in Year 3 Numeracy than a student with speech difficulties in excellent health. And, a student who has not witnessed violence was 1.5 times more likely to be in the top two bands than a student who had witnessed violence, when both students did not have a speech difficulty. However, on average, a student without speech difficulties, in excellent general health and who had not witnessed violence was 5.7 times more likely to be in the top two NAPLAN bands for Numeracy than a student with speech difficulties, in good general health and who had witnessed violence. This shows how these factors compound to produce associations that are stronger than each individual factor.

| Figure 2 Odds ratios for achieving in the top two bands in NAPLAN Year 3 Numeracy (2017), by SEHQ response prior to school entry (2014). Source: DET internal analysis.  **1.5 x**  **1.1 x**  **1.5 x**  **5.7 x**  ***Excellent health*** *versus good health*  ***No speech difficulty*** *versus speech difficulty*  ***Not witnessed violence*** *versus has witnessed violence*  ***Excellent health, no speech difficulty, has not witnessed violence*** *versus good health, speech difficulty, has witnessed violence*  **Increase in likelihood of achieving in the top two bands for NAPLAN Year 3 Numeracy** |
| --- |

The analysis also showed that declining health added to the effect of speech difficulties in reducing the probability of high academic achievement. On average, a child without speech difficulties is 1.5 times more likely to achieve in the top two bands for NAPLAN Numeracy than a child with speech difficulties, when they are both in excellent health. However, when each child is only in good general health, the child without speech difficulties is 2.1 times more likely to achieve in the top two bands for NAPLAN Numeracy than the child with speech difficulties.

Similarly, declining health combined with witnessing violence prior to school entry further reduced the probability of high academic achievement. For example, a child without speech difficulties is 2.5 times more likely to achieve in the top two bands for NAPLAN Numeracy than a child with speech difficulties when they have both witnessed violence and are both in excellent health. However, if both students reportedly have good general health and have both witnessed violence, then the student without a speech difficulty is 3.4 times more likely to be in the top two bands than the student with speech difficulties.

| Figure 3 Probability of a child without a speech difficulty versus a child with a speech difficulty reaching the top two bands of NAPLAN numeracy in Year 3 (2017), by characteristic/experience prior to school entry (2014). Source: DET internal analysis; SEHQ 2014, NAPLAN 2017.  The figure demonstrates the cumulative impact of speech difficulties, declining health and experiences witnessing violence at school entry on future academic achievement in Year 3. On average, a child without speech difficulties is 1.5 times more likely to achieve in the top two bands  than a child with speech difficulties, when they are both in excellent health. However, when each child is only in good general health, the child without speech difficulties is 2.1 times more likely to achieve in the top two bands than the child with speech difficulties. Witnessing violence prior to starting school further reduces the probability of high academic achievement. On average, a child without speech difficulties is 2.5 times more likely to achieve in the top two bands than a child with speech difficulties, when they have both witnessed violence and are both in excellent health. However, when both children have witnessed violence but are only in good general health, a child without speech difficulties is 3.4 times more likley to achieve in the top two bands than a child with speech difficulties. |
| --- |

It is worth noting that the number of children who have witnessed violence, have a speech and language difficulty and have lower levels of health is relatively low, compared to those who have not. In addition, witnessing violence, speech difficulties and lower levels of general health are more common among school entrants from disadvantaged areas in Victoria. While socioeconomic disadvantage underpins many of these health inequities, this analysis highlights the connection between these health and wellbeing challenges at school entry and NAPLAN achievement in Year 3, as well as the cumulative effect of these adversities.

## 6.4 How the school environment can influence and shape health and wellbeing

While a student’s health and wellbeing can impact on their engagement and performance at school, the environment within the classroom and school grounds can also have an impact on student health and wellbeing. This can be a positive impact, for example building strong social connections and rapport with teachers, or it can be negative, for example, the negative effects of schoolyard bullying. As a general rule, reports of health and wellbeing (in addition to engagement with school and academic achievement, demonstrating the linkages between the three) are more positive among primary school students when compared to those attending secondary schools.

### 6.4.1 Social engagement

For many students, school is a scene of social engagement, a chance to connect with peers and build a sense of identity within an inclusive environment. For the majority of Victorian students, this is achieved in their primary school years. However, the transition to secondary school proves challenging for many students, and maintaining higher levels of health and wellbeing becomes more difficult.

According to data collected through the AtoSS, students in Victorian government primary schools feel very connected to school. This falls dramatically upon entrance to secondary school, and positive responses continue to decrease through Year 9 and Year 10.

Table 87 Government school students' degree of school connectedness, Years 4-12, 2017. Source: AtoSS 2017.

|  |  |
| --- | --- |
| **Year level** | **Degree of connectedness** |
| Year 4 | 84.1% |
| Year 5 | 81.2% |
| Year 6 | 79.7% |
| Year 7 | 65.7% |
| Year 8 | 52.5% |
| Year 9 | 49.3% |
| Year 10 | 50.7% |
| Year 11 | 52.2% |
| Year 12 | 56.0% |

This can be for many reasons; for most students, secondary school environments are larger, more hectic, and further from home and the friends they made at primary school. It is also fair to say that the transition from childhood to adolescence brings with it significant physical, psychological and emotional change. These two transitions, from primary to secondary school and from childhood to adolescence, can go some way in explaining the trend we see above.

Promisingly, the responses of Victoria’s 15-year-old students in the 2015 PISA show that Victorian students have the highest levels of sense of belonging when compared to all other states and territories. While the majority of students responded positively to questions relating to their sense of belonging, one in four did not feel like they belonged at school, and one in five felt like an outsider.

While information is not available for individual states, there are some common trends at a national level. The following groups of students report a significantly greater sense of belonging than their counterparts:

* male students
* non-Aboriginal students
* students from metropolitan schools
* students from the highest socioeconomic quartile

Interestingly, Australian-born students were less likely to report feeling like they belong at school than foreign-born students.

Another key indicator of belonging is connection to peers. In 2016 in Victoria, around 92 per cent of students reported through the VSHAWS that they were connected to their peers. This was high in both metropolitan areas (91 per cent) and regional areas (94 per cent). Connection to peers was slightly higher among Year 11 students (94 per cent) compared to Year 5 students (90 per cent).

### 6.4.2 Support for positive health and wellbeing at school

A sense of belonging at school is an important contributor to a student’s overall health and wellbeing. This can be fostered through strong relationships with teachers and school staff, and improved through promotion of healthy behaviours throughout the school.

Levels of teacher concern reflect how responsive a teacher is to students’ academic, social and emotional needs. Not only does this aid in improving a student’s wellbeing, but can also support improved academic achievement. Student wellbeing and feelings of security can also be bolstered by having a teacher (or other adult) that they can rely on and who supports them at school.

Consistent with trends outlined above, younger students are more positive about the support they receive at school through their teacher’s level of concern and having an adult at school they can talk to about their problems. Interestingly, there is divergence between the two perceptions, indicating that while students feel that they have a supportive adult at school who isn’t their teacher, they are not as positive about their teacher being able to support them.

Table 88 Proportion of positive responses from government school students (Years 4-12) to questions regarding teacher levels of concern and having an advocate at school, 2017. Source: AtoSS, 2017.

|  |  |  |
| --- | --- | --- |
| **Year level** | **Teacher concern** | **Advocate at school** |
| Year 4 | 79.6% | 89.3% |
| Year 5 | 76.5% | 88.2% |
| Year 6 | 73.1% | 87.3% |
| Year 7 | 46.6% | 73.3% |
| Year 8 | 36.9% | 65.7% |
| Year 9 | 34.5% | 63.4% |
| Year 10 | 37.2% | 59.1% |
| Year 11 | 41.0% | 62.3% |
| Year 12 | 47.3% | 68.1% |

School is also a place where children receive formal instruction to develop their health literacy. Health and Physical Education is a core component of the Victorian curriculum. It provides students with a foundation for lifelong participation in physical activity. Children are also taught about healthy living, which includes fitness, healthy body weight, psychological wellbeing and cognitive abilities. Students are helped to develop the skills and knowledge required to access, critically analyse and apply information about health and health care. Schools also help promote positive behaviours in relation to social interactions, relationships, sexual behaviours, drugs and alcohol and bullying, as well as things like road and water safety.

*The Victorian Government recognises the importance of student health and wellbeing and its role as an enabler of learning outcomes. The 2018-19 Victorian State Budget invested $65.5 million in student health and wellbeing initiatives. This includes $8.2 million over four years to extend mental health support in schools, and $0.8 million to extend the suicide prevention pilot in 2019.*

*This builds on the $9.5 million investment in the* ***Victorian Anti-Bullying and Mental Health Initiative*** *launched in February 2018. The mental health components of this initiative support school communities to effectively identify and intervene early to address the mental health needs of their students. DET has partnered with Headspace to deliver this mental health support, which includes one-on-one student counselling sessions for students in Victorian government secondary schools, SAFEMinds and suicide risk continuum training across Victorian schools, and psychological support sessions for Student Support Services staff. This investment is designed to increase the availability of mental health support for students, improve mental health outcomes and assist students in finding the right support as appropriate.*

### 6.4.3 Expulsions

Expulsions from school can have serious and lasting impacts on the student involved, their family and potentially the wider community. In 2017 there were 285 expulsions from Victorian government schools. A recent investigation by the Victorian Ombudsman into Victorian government school expulsions found that while expulsions are relatively rare, for those young people expelled it can have a profound and detrimental impact (Victorian Ombudsman 2017). The Ombudsman found that children in OOHC, students with disabilities and Aboriginal students were all overrepresented in the cohort of expelled students. The Ombudsman also raised concerns about reports of ‘informal expulsions’ that do not follow Departmental policy. As school exits of this nature are not consistently recorded it is not possible to accurately report on or estimate how many occur each year.

*DET has implemented a suite of reforms in response to recommendations from the Ombudsman’s report on Victorian government school expulsions. Reforms include greater oversight of vulnerable cohorts of students at the regional level, a requirement for principals to seek the Secretary’s approval to expel students aged eight or less, a strengthened focus on procedural fairness, and a strengthened voice for affected students and principals at key points in the process. In addition, there is a stronger focus on ensuring all available interventions and supports for students have been exhausted prior to an expulsion being considered, including exploring conflict resolution options, where appropriate. Greater support is provided to principals and families during and following an expulsion through a new, dedicated point of contact on expulsions in each region working with local area teams.*

### 6.4.4 Student safety

Students must feel safe at school in order to thrive. A recent study surveyed 1,221 Victorian primary school students across 43 schools to analyse the link between bullying and mental health (Bayer et al 2018). It found that children who reported being frequently bullied (29 per cent of the 8 to 9-year-olds surveyed) also reported behaviours associated with internalising disorders (including depression, withdrawal, anxiety and loneliness). Instances of internalising symptoms were also confirmed by the children’s parents.

Responses to the AtoSS demonstrate students in the middle of secondary school are less positive about levels of respect for diversity and the way schools manage bullying. Older students (from Year 7 onwards) are less likely to report that their school handles bullying and harassment appropriately and also less likely to report that people are treated fairly and diversity is respected. Positive responses for both factors are lowest amongst Year 9 students, with an upward trend for students in Years 10 to 12 (AtoSS 2017). Additional survey data and research outlined in section 5.2.7 highlights that some students are more likely to experience bullying than others, including students from a language background other than English, those from one-parent families and same-sex attracted and gender-diverse students (Hillier et al. 2010; Rigby & Johnson 2016; Robinson et al. 2013).

Table 89 Proportion of positive responses from government school students (Years 4-12) to questions regarding management of bullying and respect for diversity, 2017. Source: AtoSS, 2017.

|  |  |  |
| --- | --- | --- |
| **Year level** | **Managing bullying** | **Respect for diversity** |
| Yr 4 | 83.0% | 83.5% |
| Yr 5 | 80.6% | 80.7% |
| Yr 6 | 79.1% | 77.6% |
| Yr 7 | 64.4% | 55.1% |
| Yr 8 | 53.8% | 42.9% |
| Yr 9 | 51.2% | 41.0% |
| Yr 10 | 53.8% | 43.6% |
| Yr 11 | 57.8% | 48.7% |
| Yr 12 | 63.1% | 54.3% |

Analysing students’ responses to AtoSS and their NAPLAN outcomes shows a strong relationship between bullying and achievement. Students in Years 5, 7 and 9 who reported not being bullied were significantly more likely to achieve in the top two bands of NAPLAN Reading than their peers who reported being bullied. In addition, those who reported being bullied were significantly more likely to be in the bottom two bands than those who had not been bullied.

Table 90 Proportion of Victorian government school students in the top and bottom two bands of NAPLAN reading by response to AtoSS bullying measure. Source: Department of Education and Training analysis of AtoSS and NAPLAN.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AtoSS response** | **Year 5:**  **Top two bands** | **Year 5:**  **Bottom two bands** | **Year 7:**  **Top two bands** | **Year 7:**  **Bottom two bands** | **Year 9:**  **Top two bands** | **Year 9:**  **Bottom two bands** |
| Not Bullied | 42.6% | 12.7% | 29.1% | 15.0% | 20.0% | 23.6% |
| Bullied | 33.6% | 18.7% | 20.1% | 22.4% | 11.2% | 33.8% |

## 6.5 Post-school pathways

Whether or not young people complete school, and whether they pursue further education and training has a significant influence on lifelong health and wellbeing outcomes. The improved employment and income prospects of more highly educated individuals mean that they are less likely to be exposed to hazardous workplace environments, and can afford better access to healthcare, healthy food, and other positive lifestyle factors. Education also influences health and wellbeing through a number of behavioural mechanisms, including greater participation in health promoting behaviours, more positive social interactions and greater civic engagement (OECD 2006).

In Australia and internationally, qualifications at the bachelor’s degree level and higher have been found to be associated with a greater likelihood of people exercising regularly (Baum & Ma 2007) and living longer with less chance of developing chronic illness such as diabetes, obesity and heart disease (Winkleby, Fortmann & Barrett 1990). Higher education qualifications have also been found to be associated with reduced risk of social isolation (Heise & Meyer 2004).

Victorian findings have also shown that non-completion of secondary school is not only associated with lower earnings over the course of a person’s lifetime, but also with poorer physical and mental health, and higher mortality rates (Black 2007). Recent Victorian Population Health Surveys have found that when compared with the average Victorian, those who did not complete high school, were unemployed or had a total household income of under $40,000 were more likely to report fair or poor health (DHHS 2017g).

For these reasons, school completion rates and access to post-school educational pathways have significant implications for public health and health equity across demographics (Cohen & Syme 2013). In 2016, people with higher levels of educational attainment were more likely to be employed, which is strongly associated with long-term health and wellbeing. More than 80 per cent of people whose highest qualification was a bachelor’s degree were employed, compared with 54 per cent of people whose highest qualification was Year 10 or below (AIHW 2017b). While this rate has been fairly stable for those with higher qualifications, people with lower levels of educational attainment were less likely to be employed in 2016 than in 2008. This highlights the growing importance of school and post-school education to long-term economic wellbeing.

***Career education*** *is one of the key building blocks for lifelong success. Through the 2018-19 Victorian State Budget, the Victorian Government has invested $109 million over four years, and $26.7 million in ongoing funding to redesign career education.*

*This funding package will enable a suite of initiatives making stronger connections between school and future careers, and will give students the skills and knowledge to effectively navigate multiple and complex careers throughout their lives. Under these reforms, career education will start early, introducing students to initial learning and decision-making processes in Year 7, and will provide students with better opportunities to see and experience different jobs. Career education will also be made a priority, with more trained careers practitioners to support all government secondary schools.*

### 6.5.1 Year 12 or equivalent successful completion rates

Victoria has high levels of school completion with approximately eight out of every 10 Victorians either completing Year 12 or an equivalent qualification by age 19 years (Productivity Commission 2018a). These outcomes, however, are not equal for all young people, with disadvantaged cohorts significantly less likely to finish school.

Over the past decade the gap in school completion rates between Aboriginal and non-Aboriginal Victorians has been reduced, but remains significant. In 2006, around 56 per cent of Aboriginal Victorians aged between 20 and 24 years had a Year 12 or equivalent qualification compared to 86 per cent of non-Aboriginal Victorians (Productivity Commission 2018c). In 2016, this had increased to 71 per cent and 90 per cent respectively. Similarly, the rate of completions for lower SES students has persistently remained below that of higher socioeconomic demographics (Ibid.).

Table 91 Proportion of Victorian students completing Year 12 or equivalent, by socioeconomic status, 2012-2016. Source: Productivity Commission, 2018a.

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Low SES** | **Medium SES** | **High SES** |
| 2012 | 72% | 79% | 86% |
| 2013 | 75% | 80% | 85% |
| 2014 | 76% | 82% | 86% |
| 2015 | 76% | 82% | 86% |
| 2016 | 76% | 79% | 84% |

### 6.5.2 Young people engaged in full time education and/or work

In 2017, an estimated 80 per cent of Victorians who had completed Year 12 in the previous year were fully engaged in either study or work. For young people who had left school without completing Year 12 the rate of full engagement in either study or work was much lower, at 56 per cent (Productivity Commission 2018a).

For this 2016 cohort of Year 12 completers, those of higher SES were more likely to be engaged in further education in 2017, and were more likely to be engaged in a bachelor’s degree as opposed to an apprenticeship, certificate or diploma level qualification as compared to their lower SES peers. Young people who fail to engage in school, work or further education and training are exposed to significant risks, including school failure, unemployment, risky health behaviours, mental health problems, social exclusion, and economic and social disadvantage over the longer term.

Table 92 Exit destinations for 2016 Year 12 completers by socioeconomic status quartile (SEIFA). Source: On Track, 2017.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Exit destination** | **Lowest**  **quartile** | **Low-medium**  **quartile** | **Medium quartile** | **High**  **quartile** |
| Bachelor degree | 44% | 47% | 53% | 64% |
| Other qualification | 25% | 23% | 22% | 17% |
| Employed | 23% | 23% | 19% | 16% |
| Not in education or training | 8% | 7% | 6% | 4% |

***Head Start*** *is a new model for school-based apprenticeships and traineeships where students can complete an extra year of school to finish as a fully-qualified apprentice or trainee. During this extra year they spend more time doing important, paid, on-the-job training, giving them the opportunity to graduate ready for work. Head Start will deliver an estimated 1,700 apprenticeships and traineeships across Victoria over four years from 2019.*

# 7.0 Within Victoria

A focus on place

## Introduction

Sociological research recognises that the place in which a child grows up has a substantial influence on that child’s outcomes later in life. Locational characteristics – including the relative accessibility of health and education services in a given area, possibilities for local employment, and other area-based measures of social and economic disadvantage – shape the opportunities and challenges that children encounter. Accordingly, Victorian children are exposed to varying degrees of advantage and disadvantage, depending on where they grow up.

The *2016* *State of Victoria’s Children Report* used the concept of place as a framework for understanding the health and wellbeing outcomes of children across different Victorian jurisdictions. The report found that place can be an enabling factor for child development, particularly when children are advantaged through access to high quality services, nurturing home environments and genuine engagement with their communities. However, place can also be seen as a constraint on development, particularly in areas of concentrated disadvantage, which are characterised by ongoing risks to health and wellbeing, lower levels of educational achievement and more limited employment opportunities.

The first part of this chapter considers how place and disadvantage are related, examining measures of socioeconomic differences across Victorian Local Government Areas (LGAs). The second part consolidates reporting on outcomes for children in non-metropolitan areas, relative to their peers in metropolitan Melbourne. The third part considers the socioeconomic impact of place, reporting on outcomes for children who grow up in areas with the highest levels of disadvantage in terms of income, educational attainment and employment.

As seen in previous sections of this report, the risks associated with socioeconomic and environmental constraints can accumulate over time, particularly in communities with higher levels of socioeconomic disadvantage. Place-based interventions, which recognise the complex interrelations between developmental factors across Victorian jurisdictions, are one way to address these forms of locational disadvantage.

## 7.1 Measuring disadvantage by place

The Socio-Economic Indexes for Areas (SEIFA) are used to measure and compare socioeconomic conditions within different geographical regions, enabling a place-based snapshot of relative advantage and disadvantage across particular areas of Australia. SEIFA is comprised of four summary measures:

* Index of Relative Socio-economic Disadvantage (IRSD)
* Index of Relative Socio-economic Advantage and Disadvantage
* Index of Economic Resources
* Index of Education and Occupation.

Each index aims to capture a slightly different aspect of relative disadvantage and is constructed using different variables. For example, the IRSD is constructed by measuring factors such as household income, educational attainment and employment outcomes within a given area; the Index of Relative Socio-economic Advantage and Disadvantage, meanwhile, incorporates factors of advantage such as internet speed, which may offset the levels of disadvantage reported within the area.

SEIFA data can be reported against different types of geographical area, including Census Collection District, Statistical Local Area, LGA and Postal Area. This SEIFA-informed approach represents a method of understanding location-based differences within Victoria, which builds upon more generic distinctions between metropolitan and non-metropolitan areas.

Areas in proximity to the Greater Melbourne region are more likely to fall within the lower SEIFA-IRSD quintiles. However, there are certain areas within metropolitan Melbourne which are classed in the highest SEIFA-IRSD quintile.

### 7.1.1 Victorian LGAs by relative socioeconomic disadvantage

Table 93 List of LGAs in each SEIFA-IRSD quintile, Victoria. Source: PHIDU, 2018.

| **SEIFA IRSD Quintile** | **Local Government Areas** |
| --- | --- |
| Quintile 5 (least disadvantage) | Kingston, Monash, Maroondah, Knox, Whitehorse, Banyule, Macedon Ranges, Manningham, Port Phillip, Glen Eira, Queenscliffe, Surf Coast, Stonnington, Booroondara, Bayside, Nillumbik |
| Quintile 4 | Casey, Darebin, Wyndham, Melbourne, Moorabool, Moreland, Hobsons Bay, Mansfield, Moyne, Indigo, Cardinia, Mornington Peninsula, Moonee Valley, Yarra, Golden Plains, Yarra Ranges |
| Quintile 3 | West Wimmera, Warrnambool, South Gippsland, Whittlesea, Southern Grampians, Towong, Greater Geelong, Melton, Alpine, Maribyrnong, Mount Alexander, Hepburn, Murrindindi, Baw Baw, Mitchell, Frankston |
| Quintile 2 | Pyrenees, Gannawarra, East Gippsland, Colac-Otway, Campaspe, Bass Coast, Buloke, Wellington, Strathbogie, Wodonga, Corangamite, Ballarat, Horsham, Greater Bendigo, Wangaratta |
| Quintile 1 (most disadvantage) | Central Goldfields, Greater Dandenong, Brimbank, Latrobe, Mildura, Northern Grampians, Yarriambiack, Ararat, Loddon, Hindmarsh, Hume, Swan Hill, Glenelg, Greater Shepparton, Moira, Benalla |

## 7.2 Comparing metropolitan and rural outcomes

### 7.2.1 Early childhood health considerations in rural Victoria

Achieving a healthy start in early childhood involves a number of factors, which are ultimately connected to the goal of creating a nurturing and positive home environment that is most conducive to a child’s health and development. Locational factors, particularly the relative proximity and access to health services, can inform a child’s chances of achieving a healthy start in this sense. Meanwhile, exposure to environmental toxins, such as second-hand smoke, can prove detrimental to a child’s long-term health and wellbeing.

Metropolitan and regional child cohorts experience differing levels of tobacco exposure early in life. Mothers in regional Victoria are more likely to smoke than those in metropolitan areas – in 2016, the smoking during pregnancy rate in regional Victoria was 14.5 per cent, which was down from 17.9 per cent in 2011. This compares to 7.2 per cent of mothers in metropolitan areas that smoked during pregnancy in 2016.[[102]](#footnote-103) 84.1 per cent of children in metropolitan areas were reported as living in a smoke-free home, compared to 75.4 per cent of children in rural areas.[[103]](#footnote-104)

Table 94 Proportion of Victorian pregnant mothers that smoke, by location, 2011 and 2016. Source: Department of Education and Training internal analysis; VCHWS, 2017.

|  |  |  |
| --- | --- | --- |
| **Location** | **2011** | **2016** |
| Metro | 10% | 7% |
| Rural/regional | 18% | 15% |

Outside the metropolitan areas of Melbourne, children and families navigate different challenges in terms of accessing health and education services. In 2017, 85.6 per cent of children aged zero to 12 years in rural Victoria were reported as having access to basic services, compared to 95.8 per cent of children living in metropolitan areas. For both cohorts, however, reported access to services has improved since 2006 – from 78.6 per cent in rural areas and 91.8 in metropolitan areas.[[104]](#footnote-105)

In 2017, 75.8 per cent of children in rural areas were reported as attending a MCH Centre for a 3.5-year check, compared to 67.8 per cent of children in metropolitan areas. However, participation in this service has declined for both metropolitan and rural cohorts contributing to a statewide decrease – from 74 per cent of all Victorian children in 2015 to 69.9 per cent in 2017.[[105]](#footnote-106)

### 7.2.2 Family and Community Characteristics

Despite the challenges that may emerge in more remote areas, positive outcomes can be observed in rural Victoria on a number of family health and wellbeing measures. In 2016, 82 per cent of students in rural areas described their family functioning as healthy, compared to 79 per cent of metropolitan students.[[106]](#footnote-107) However, parents in rural areas are more likely to report ‘high’ or ‘highest’ levels of family stress than parents in metropolitan areas (11 per cent of rural parents compared to eight per cent of metropolitan parents).[[107]](#footnote-108)

Notably, children in rural areas were more likely to be read to daily by a family member than children in metropolitan areas (75.8 per cent in rural areas, compared to 66.8 per cent in metropolitan areas).[[108]](#footnote-109) This indicates that children’s early literacy outcomes, supported by strong familial and community connections, often thrive outside of metropolitan areas.

However, further comparisons from the 2017 VCHWS speak to the socioeconomic challenges faced by families in Victoria’s regions. On the issue of food insecurity, 9.7 per cent of respondents in rural areas reported that they had ‘run out of food’ at least once in the preceding year, compared with 6.2 per cent of respondents in metropolitan areas. Similarly, on issues of financial insecurity, 16.2 per cent of respondents in rural areas reported that they would be ‘unable to raise $2000 in an emergency’, compared to 9.9 per cent of metropolitan respondents.[[109]](#footnote-110)

### 7.2.3 Education and health outcomes

According to parent reports, 90.4 per cent of children in rural areas were enrolled in an accredited preschool or kindergarten program prior to entering Prep, compared to 87.7 per cent of children in metropolitan areas.[[110]](#footnote-111) At age 16, 82.5 per cent of children in non-metropolitan areas were enrolled full-time in secondary school, compared to 87.4 per cent of children in metropolitan areas (PHIDU 2018c).

Children assessed as having speech and language difficulties are more than three times as likely to develop social-emotional and behavioural difficulties compared to children without language difficulties (Hughes, Sciberras & Goldfeld 2016). According to parent reports, 17.8 per cent of school entrants in non-metropolitan areas were reported as having difficulties with speech and language, compared to 12.7 per cent of students in metropolitan areas.[[111]](#footnote-112)

There are positive and negative outcomes in relation to the health of children living outside of Melbourne. Children in rural areas aged five to 12 years were more likely to be active for more than one hour per day, compared to children in metropolitan areas (62.8 per cent in rural areas, compared to 58.2 per cent in metropolitan areas).[[112]](#footnote-113) In 2017, 59.8 per cent of Prep-aged children in rural areas were reported as having visited a dentist in the preceding 12 months, compared to 51.8 of metropolitan children.[[113]](#footnote-114) However, according to parent reported data, 15.2 per cent of children in rural areas have regular asthma, compared to 11.1 per cent of children from metropolitan areas.[[114]](#footnote-115)

## 7.3 Location-based disadvantage

Although SEIFA-IRSD quintiles aggregate socioeconomic factors for a particular area, the experience of individuals within a given area can differ – families can thrive in areas of relatively high disadvantage, while others may experience hardship in more advantageous environments. Almost 10 per cent of children living in low income welfare dependent families are reported as living in the least disadvantaged areas.

Certain disparities in outcomes become more pronounced when viewed through this socioeconomic lens. For example, in the most disadvantaged areas, only 65.5 per cent of children were reported as living in a smoke-free home, compared to 91.4 per cent of children from areas with the least disadvantage. Families based in the most disadvantaged areas of Victoria are less likely to own a car. In 2016, 9.7 per cent of dwellings in the highest SEIFA-IRSD quintile were reported as having no car, compared to 6.3 per cent of dwellings in the lowest quintile (PHIDU 2018c). And as the below indicates, reported instances of food insecurity and financial insecurity were more frequent in areas ranked within the higher SEIFA-IRSD quintiles.[[115]](#footnote-116)

Table 95 Proportion of Victorian children (aged 0-12) who experienced food and financial insecurity, by SEIFA-IRSD quintile, 2017. Source: Department of Education and Training internal analysis; VCHWS, 2017.

|  |  |  |
| --- | --- | --- |
| **SEIFA Quintile** | **Food insecurity** | **Financial insecurity** |
| Quintile 1 | 13.5% | 25.6% |
| Quintile 2 | 9% | 15.3% |
| Quintile 3 | 9.2% | 16.3% |
| Quintile 4 | 6.4% | 8.1% |
| Quintile 5 | 2.7% | 4.2% |

Infant mortality rates are often worse among socioeconomically disadvantaged populations. In 2007, the rate in the areas of the lowest SES in Victoria was 5.4 deaths per 1,000 births, and the rate in the highest was 3.7. In 2016, this disparity was still apparent, with an infant mortality rate of 3.2 in Victoria’s lowest SES communities and 2.1 in the highest SES communities (AIHW 2017a).

The rate of youth participation in education services differs substantially, according to the socioeconomic profile of particular areas. Across Victoria, for children aged three to four years located within the highest SEIFA-IRSD quintile (most disadvantaged areas), only 36.9 per cent of children were enrolled in preschool, compared to 55.1 per cent of children in the least disadvantaged areas. This gap was more pronounced in metropolitan Melbourne (PHIDU 2018c). Similarly, the percentage of students enrolled in secondary school at age 16 years was higher in areas with the least disadvantage. In 2016, 91.6 per cent of children aged 16 years from the least disadvantaged areas were enrolled in secondary school, compared to 80.4 per cent of students from the most disadvantaged areas (PHIDU 2018c).

Unsurprisingly, relative socioeconomic conditions impact the access to government services reported by families. In the most disadvantaged areas, 4.8 per cent of young people aged 16 to 24 years reported receiving an unemployment benefit, compared to 0.8 per cent of young people in areas with the least disadvantage. Around 22 per cent of households within the most disadvantaged areas were reported as receiving rent assistance from the Australian Government, compared to eight per cent of households in the most advantaged areas. In the most disadvantaged areas of Victoria, 22.4 per cent of children aged under 15 years were reported to be in jobless families in 2016, compared to 4.6 per cent of children from the least disadvantaged areas. (PHIDU 2018c)

In areas of most disadvantage, 15.5 per cent of school entrants were reported as having difficulties with speech and language, compared to 11.5 per cent of students in the least disadvantaged areas. In areas of highest disadvantage, the proportion of school entrants at high risk of developmental and/or behavioural problems has increased over time, from 15.8 per cent in 2015 to 16.7 per cent in 2017. In 2017, 48 per cent of Prep-aged children in areas of highest disadvantage were reported as having visited a dentist in the preceding 12 months, compared to 59.4 per cent of children in the least disadvantaged areas.[[116]](#footnote-117)

Sociological research recognises that the place in which a child grows up has a substantial influence on that child’s outcomes later in life – not all children in Victoria have access to the same opportunities (Skattebol & Redmond 2018). Recognising these differences, and developing policy solutions that address the specific life challenges faced by families across different regions of Victoria, is an important strategy for improving overall health and wellbeing outcomes in the state.

# 8.0 Conclusion

The 2017 State of Victoria’s Children report sets out evidence on the health and wellbeing of Victorian children. The evidence presented highlights the complexities and interrelated nature of the factors affecting a child’s development and ability to live a fulfilling life. This report shows how the communities in which children live, the families that nurture them, the schools they attend, and personal characteristics shape their experiences, opportunities and health.

There is much to celebrate about living in Victoria. The vast majority of Victorian children are happy and healthy. They live in a place where they can access high-quality, publicly funded healthcare. Victorian young people enjoy supportive families and safe communities. They have friends that they can rely on during difficult periods. They attend school regularly and are able to go on to take advantage of life’s opportunities. There are also some promising trends in relation to Aboriginal Victorians. These include significant improvements in the proportion of children attending early childhood education and engaging with MCH Services. In addition, the Aboriginal perinatal mortality rate decreased significantly and is now in line with the non-Aboriginal rate.

The report highlights a variety of opportunities and challenges rooted in the fast-paced technological changes occurring in Victoria. Developments in medicine and other fields have undoubtedly benefitted the health of millions of Australians, while the internet and communication technology have unlocked possibilities and opportunities that seemed unfathomable not long ago. However, this has not come without challenges, particularly for the health and wellbeing of children. Mobile phones, social media and email mean that Victorians are constantly connected to one another. This unlimited connectedness is not without its own issues, including cyber-bullying and sexting. There are also possible connections between increasing screen time and lower levels of physical education.

The report illustrates that health inequities among Victorian children continue to be predominantly driven by social disadvantage. While any child can experience periods of poor health, those living in families which are more vulnerable to financial stress or in areas of concentrated disadvantage are at greater risk of illness and poorer life outcomes.

Indeed, evidence in this report shows that children experiencing social and economic disadvantage are more likely to engage in risky behaviours. These children are often likely to have fewer protective resources to draw on and are less likely to engage with key services designed to support them. The report also highlights that these challenges can permeate across generations, creating pockets of entrenched disadvantage.

When social disadvantage occurs alongside parental substance abuse, family violence and/or child abuse, the cumulative impact on a child’s wellbeing can be devastating. Research presented in this report has found that traumatic experiences rarely occur in isolation. As they accumulate, so does the probability that children will engage in behaviours that harm their health and experience a range of physical and mental illnesses. Problematically, it is often children in families who face the most difficult circumstances that are least likely to engage with services that help prevent harm. While services that intervene after a traumatic event are important, they do little do alleviate the harm inflicted on a child.

However, the report does not contend that these factors or adversities are deterministic. Many children who experience social disadvantage or face seemingly insurmountable adversity are able to flourish and lead happy lives. The State of Victoria’s Children report attempts to provide a guide to policy makers, illustrating the children that are most vulnerable to poor health and wellbeing outcomes. It also provides an evidence base that can support the development of effective interventions that enable every Victorian child to have the opportunity to succeed and enjoy their lives.

# Acronyms

**ABS** Australian Bureau of Statistics

**ACCO** Aboriginal Community Controlled Organisations

**ACECQA** Australian Children’s Education and Care Quality Authority

**ADHD** Attention Deficit Hyperactivity Disorder

**AEDC** Australian Early Development Census

**AIFS**  Australian Institute of Family Studies

**AIHW**  Australian Institute of Health and Welfare

**AtoSS**  Attitudes to School Survey

**CCCH**  Centre for Community Child Health

**CMY** Centre for Multicultural Youth

**DET**  Department of Education and Training

**DDH**  Developmental Dysplasia of the Hip

**DHHS** Department of Health and Human Services

**DoCS**  Department of Community Services

**DoH**  Department of Health

**DPC**  Department of Premier and Cabinet

**ECEC**  Early Childhood Education and Care

**ESK**  Early Start Kindergarten

**HILDA** Household, Income and Labour Dynamics in Australia

**KAS**  Key Ages and Stages

**LBOTE**  Language Background Other Than English

**LGBTI**  Lesbian, Gay, Bisexual, Trans and Intersex

**LGA**  Local Government Area

**LSAC**  Longitudinal Study of Australian Children

**MBS**  Medicare Benefits Schedule

**MCH**  Maternal and Child Health

**NAPLAN**  National Assessment Program of Literacy and Numeracy

**NATSEM** National Centre for Social and Economic Modelling

**NHMRC**  National Health and Medical Research Council

**NQS**  National Quality Standards

**NSCDC**  National Scientific Council on the Developing Child

**OECD**  Organisation for Economic Co-operation and Development

**OOHC** Out-of-Home Care

**PHIDU**  Public Health Information Development Unit

**PISA**  Programme for International Student Assessment

**PPDH**  Potentially Preventable Dental Hospitalisations

**SEIFA**  Socio-Economic Indexes for Areas

**SEIFA-IRSD** Socio-Economic Indexes for Areas Index of Relative Socio-economic Disadvantage

**SDQ**  Strengths and Difficulties Questionnaire

**SEHQ** School Entrant Health Questionnaire

**SES**  Socioeconomic Status

**VAED**  Victorian Admitted Episodes Dataset

**VAGO**  Victorian Auditor-General's Office

**VCHWS**  Victorian Child Health and Wellbeing Survey

**VISU**  Victorian Injury Surveillance Unit

**VSHAWS**  Victorian Student Health and Wellbeing Survey

**WHO** World Health Organisation

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# Endnotes

1 Departmental of Education and Training’s (DET’s) Maternal and Child Health (MCH) 2006-07 to 2016-17

2 DET, 2017

3 Victorian Child Health and Wellbeing Survey (VCHWS), 2017

4 Victorian Student Health and Wellbeing Survey (VSHAWS), 2016

5 VCHWS, 2017

6 Data sourced from a request to the Department of Economic Development, Jobs, Transport and Resources (DEDJTR)

7 Ibid.

8 VCHWS, 2017

9 VSHAWS, 2016

10 Ibid.

11 Ibid.

12 Ibid.

13 VCHWS, 2017

14 Ibid.

15 Data sourced from a request to the Victorian Agency for Health Information (VAHI)

16 Data sourced from a request to the Victorian Injury Surveillance Unit (VISU)

17 DET internal analysis

18 VCHWS, 2017

19 DET internal analysis

20 DET internal analysis of Attitudes to School Survey (AToSS) responses and attendance data, 2017

21 DET internal analysis of the School Entrant Health Questionnaire (SEHQ) (2014) and NAPLAN results (2017)

22 DET internal analysis of AToSS responses and NAPLAN data, 2017

23 Analysis of On Track survey, 2017

24 SEHQ, 2017

25 VCHWS, 2017

26 VSHAWS, 2016

27 Data sourced from request to VAHI

28 SEHQ, 2017

29 VCHWS, 2017

30 Ibid.

31 SEHQ, 2017

32 These results are pooled for three years and reported for rolling triennia due to the small number of Aboriginal perinatal deaths in any single year.

33 VAHI

34 Data sourced from request to VAHI

35 Ibid.

36 VCHWS, 2017

37 Ibid.

38 Since 2015 a number of MCH service providers have migrated to a new record system. Difficulties transitioning to this system have affected the reporting of breastfeeding data. As such, breastfeeding data has been limited to 2015.

39 DET MCH data

40 Ibid.

41 Ibid.

42 Ibid.

43 Data sourced from the Australian Immunisation Record

44 Ibid.

45 DET MCH data

46 Ibid.

47 Ibid.

48 Data is sourced from DET data collections

49 Median weekly income has been calculated using Family Income (FINF) from the ABS Census Table Builder, 2006 and 2016.

50 VCHWS

51 Ibid.

52 Ibid.

53 According to Palermo et al: “The Victorian healthy food basket is a list of 44 core foods (fruit, vegetables, meat, milk and milk products, breads and cereals) and non-core foods (margarine, oil, sugar) commonly consumed by families … that meet the nutritional requirements of reference families for a fortnight”. For method see Palermo, C., Wilson, A., 2007. Development of a healthy food basket. Australian and New Zealand Journal of Public Health Vol 31(4) p360-363.

54 VSHAWS, 2016

55 VCHWS, 2017

56 DET analysis of the 2016 VSHAWS

57 Data sourced from request to the Crime Statistics Agency

58 DET MCH data

59 AIHW reports prior to 2008-09 reported on children aged 0 to 16 years and from 2009-10 onwards, figures refer to children aged 0-17.

60 The total number of children includes those whose Indigenous status was unknown

61 The Department of Health and Human Services (DHHS) believes this is a significant under-count of endorsed plans. Recent changes to policy and practices meant that cultural plans needed to be reloaded into the system. Many plans could not be uploaded to the system due plans exceeding to file size limits leading to an undercount of endorsed plans.

62 Data sourced from request to the DEDJTR

63 Ibid.

64 The low number of LGAs in quintile 1 in metropolitan areas and the low number of LGAs in quintile 5 in regional areas means that these results should be interpreted with caution.

65 Ibid.

66 VCHWS, 2017

67 The total number of reported crimes includes persons of unknown sex

68 Data is sourced from the Crimes Statistics Agency

69 Ibid.

70 Data is sourced from the 2014 and 2016 VSHAWS

71 Linked data sourced from DET analysis of the 2016 VSHAWS

72 VSHAWS, 2016

73 This figure has not been reported due to a high relative standard error (higher than 50 per cent).

74 VSHAWS, 2014 and 2016

75 VSHAWS, 2016

76 Data sourced from request to DHHS

77 Data sourced from request to VAHI

78 DET analysis of VSHAWS, 2016

79 VSHAWS, 2016

80 VCHWS, 2017

81 A method of adjusting a crude rate to account for the effect of differences in population age structures

82 Data sourced from the Victorian Health Information Surveillance System

83 Ibid.

84 Data sourced from request to VAHI

85 Ibid.

86 Ibid.

87 Ibid.

88 Ibid.

89 “Original family” is defined in the report by Lawrence et al., 2015 as a family that has at least one child living with their natural, adoptive or foster parents, and no step children.

90 Data sourced from a request to VISU

91 Ibid.

92 Ibid.

93 Data sourced from request to DHHS

94 Data sourced from request to VAHI

95 Ibid.

96 DET internal analysis

97 SEHQ, 2017

98 DET data

99 Ibid.

100 Ibid.

101 AToSS, 2017

102 Data sourced from request to VAHI

103 VCHWS, 2017

104 Ibid.

105 SEHQ, 2017

106 VSHAWS, 2016

107 SEHQ, 2017

108 VCHWS, 2017

109 Ibid.

110 SEHQ, 2017

111 Ibid.

112 VCHWS, 2017

113 SEHQ, 2017

114 VCHWS, 2017

115 Ibid.

116 SEHQ, 2017

1. Departmental of Education and Training’s (DET’s) Maternal and Child Health (MCH) 2006-07 to 2016-17 [↑](#footnote-ref-2)
2. DET, 2017 [↑](#footnote-ref-3)
3. Victorian Child Health and Wellbeing Survey (VCHWS), 2017 [↑](#footnote-ref-4)
4. Victorian Student Health and Wellbeing Survey (VSHAWS), 2016 [↑](#footnote-ref-5)
5. VCHWS, 2017 [↑](#footnote-ref-6)
6. Data sourced from a request to the Department of Economic Development, Jobs, Transport and Resources (DEDJTR) [↑](#footnote-ref-7)
7. Ibid. [↑](#footnote-ref-8)
8. VCHWS, 2017 [↑](#footnote-ref-9)
9. VSHAWS, 2016 [↑](#footnote-ref-10)
10. Ibid. [↑](#footnote-ref-11)
11. Ibid. [↑](#footnote-ref-12)
12. Ibid. [↑](#footnote-ref-13)
13. VCHWS, 2017 [↑](#footnote-ref-14)
14. Ibid. [↑](#footnote-ref-15)
15. Data sourced from a request to the Victorian Agency for Health Information (VAHI) [↑](#footnote-ref-16)
16. Data sourced from a request to the Victorian Injury Surveillance Unit (VISU) [↑](#footnote-ref-17)
17. DET internal analysis [↑](#footnote-ref-18)
18. VCHWS, 2017 [↑](#footnote-ref-19)
19. DET internal analysis [↑](#footnote-ref-20)
20. DET internal analysis of Attitudes to School Survey (AToSS) responses and attendance data, 2017 [↑](#footnote-ref-21)
21. DET internal analysis of the School Entrant Health Questionnaire (SEHQ) (2014) and NAPLAN results (2017) [↑](#footnote-ref-22)
22. DET internal analysis of AToSS responses and NAPLAN data, 2017 [↑](#footnote-ref-23)
23. Analysis of On Track survey, 2017 [↑](#footnote-ref-24)
24. SEHQ, 2017 [↑](#footnote-ref-25)
25. VCHWS, 2017 [↑](#footnote-ref-26)
26. VSHAWS, 2016 [↑](#footnote-ref-27)
27. Data sourced from request to VAHI [↑](#footnote-ref-28)
28. SEHQ, 2017 [↑](#footnote-ref-29)
29. VCHWS, 2017 [↑](#footnote-ref-30)
30. Ibid. [↑](#footnote-ref-31)
31. SEHQ, 2017 [↑](#footnote-ref-32)
32. These results are pooled for three years and reported for rolling triennia due to the small number of Aboriginal perinatal deaths in any single year [↑](#footnote-ref-33)
33. VAHI [↑](#footnote-ref-34)
34. Data sourced from request to VAHI [↑](#footnote-ref-35)
35. Ibid. [↑](#footnote-ref-36)
36. VCHWS, 2017 [↑](#footnote-ref-37)
37. Ibid. [↑](#footnote-ref-38)
38. Since 2015 a number of MCH service providers have migrated to a new record system. Difficulties transitioning to this system have affected the reporting of breastfeeding data. As such, breastfeeding data has been limited to 2015. [↑](#footnote-ref-39)
39. DET MCH data [↑](#footnote-ref-40)
40. Ibid. [↑](#footnote-ref-41)
41. Ibid. [↑](#footnote-ref-42)
42. Ibid. [↑](#footnote-ref-43)
43. Data sourced from the Australian Immunisation Record [↑](#footnote-ref-44)
44. Ibid. [↑](#footnote-ref-45)
45. DET MCH data [↑](#footnote-ref-46)
46. Ibid. [↑](#footnote-ref-47)
47. Ibid. [↑](#footnote-ref-48)
48. Data is sourced from DET data collections [↑](#footnote-ref-49)
49. Median weekly income has been calculated using Family Income (FINF) from the ABS Census Table Builder, 2006 and 2016. [↑](#footnote-ref-50)
50. VCHWS [↑](#footnote-ref-51)
51. Ibid. [↑](#footnote-ref-52)
52. Ibid. [↑](#footnote-ref-53)
53. According to Palermo et al: “The Victorian healthy food basket is a list of 44 core foods (fruit, vegetables, meat, milk and milk products, breads and cereals) and non-core foods (margarine, oil, sugar) commonly consumed by families … that meet the nutritional requirements of reference families for a fortnight”. For method see Palermo, C., Wilson, A., 2007. Development of a healthy food basket. Australian and New Zealand Journal of Public Health Vol 31(4) p360-363. [↑](#footnote-ref-54)
54. VSHAWS, 2016 [↑](#footnote-ref-55)
55. VCHWS, 2017 [↑](#footnote-ref-56)
56. DET analysis of the 2016 VSHAWS [↑](#footnote-ref-57)
57. Data sourced from request to the Crime Statistics Agency [↑](#footnote-ref-58)
58. DET MCH data [↑](#footnote-ref-59)
59. AIHW reports prior to 2008-09 reported on children aged 0 to 16 years and from 2009-10 onwards, figures refer to children aged 0-17 [↑](#footnote-ref-60)
60. The total number of children includes those whose Indigenous status was unknown [↑](#footnote-ref-61)
61. The Department of Health and Human Services (DHHS) believes this is a significant under-count of endorsed plans. Recent changes to policy and practices meant that cultural plans needed to be reloaded into the system. Many plans could not be uploaded to the system due plans exceeding to file size limits leading to an undercount of endorsed plans. [↑](#footnote-ref-62)
62. Data sourced from request to the DEDJTR [↑](#footnote-ref-63)
63. Ibid. [↑](#footnote-ref-64)
64. The low number of LGAs in quintile 1 in metropolitan areas and the low number of LGAs in quintile 5 in regional areas means that these results should be interpreted with caution. [↑](#footnote-ref-65)
65. Ibid. [↑](#footnote-ref-66)
66. VCHWS, 2017 [↑](#footnote-ref-67)
67. The total number of reported crimes includes persons of unknown sex [↑](#footnote-ref-68)
68. Data is sourced from the Crimes Statistics Agency [↑](#footnote-ref-69)
69. Ibid. [↑](#footnote-ref-70)
70. Data is sourced from the 2014 and 2016 VSHAWS [↑](#footnote-ref-71)
71. Linked data sourced from DET analysis of the 2016 VSHAWS [↑](#footnote-ref-72)
72. VSHAWS, 2016 [↑](#footnote-ref-73)
73. This figure has not been reported due to a high relative standard error (higher than 50 per cent) [↑](#footnote-ref-74)
74. VSHAWS, 2014 and 2016 [↑](#footnote-ref-75)
75. VSHAWS, 2016 [↑](#footnote-ref-76)
76. Data sourced from request to DHHS [↑](#footnote-ref-77)
77. Data sourced from request to VAHI [↑](#footnote-ref-78)
78. DET analysis of VSHAWS, 2016 [↑](#footnote-ref-79)
79. VSHAWS, 2016 [↑](#footnote-ref-80)
80. VCHWS, 2017 [↑](#footnote-ref-81)
81. A method of adjusting a crude rate to account for the effect of differences in population age structures [↑](#footnote-ref-82)
82. Data sourced from the Victorian Health Information Surveillance System [↑](#footnote-ref-83)
83. Ibid. [↑](#footnote-ref-84)
84. Data sourced from request to VAHI [↑](#footnote-ref-85)
85. Ibid. [↑](#footnote-ref-86)
86. Ibid. [↑](#footnote-ref-87)
87. Ibid. [↑](#footnote-ref-88)
88. Ibid. [↑](#footnote-ref-89)
89. “Original family” is defined in the report by Lawrence et al., 2015 as a family that has at least one child living with their natural, adoptive or foster parents, and no step children [↑](#footnote-ref-90)
90. Data sourced from a request to VISU [↑](#footnote-ref-91)
91. Ibid. [↑](#footnote-ref-92)
92. Ibid. [↑](#footnote-ref-93)
93. Data sourced from request to DHHS [↑](#footnote-ref-94)
94. Data sourced from request to VAHI [↑](#footnote-ref-95)
95. Ibid. [↑](#footnote-ref-96)
96. DET internal analysis [↑](#footnote-ref-97)
97. SEHQ, 2017 [↑](#footnote-ref-98)
98. DET data [↑](#footnote-ref-99)
99. Ibid. [↑](#footnote-ref-100)
100. Ibid. [↑](#footnote-ref-101)
101. AToSS, 2017 [↑](#footnote-ref-102)
102. Data sourced from request to VAHI [↑](#footnote-ref-103)
103. VCHWS, 2017 [↑](#footnote-ref-104)
104. Ibid. [↑](#footnote-ref-105)
105. SEHQ, 2017 [↑](#footnote-ref-106)
106. VSHAWS, 2016 [↑](#footnote-ref-107)
107. SEHQ, 2017 [↑](#footnote-ref-108)
108. VCHWS, 2017 [↑](#footnote-ref-109)
109. Ibid. [↑](#footnote-ref-110)
110. SEHQ, 2017 [↑](#footnote-ref-111)
111. Ibid. [↑](#footnote-ref-112)
112. VCHWS, 2017 [↑](#footnote-ref-113)
113. SEHQ, 2017 [↑](#footnote-ref-114)
114. VCHWS, 2017 [↑](#footnote-ref-115)
115. Ibid. [↑](#footnote-ref-116)
116. SEHQ, 2017 [↑](#footnote-ref-117)