The state of Victoria’s children 2010
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Ministerial foreword

Victoria is home to more than 1.2 million children and young people, representing 22.5 per cent of Victoria’s population. The environment in which these children and young people live, learn and grow has changed significantly over the past few decades. So too have the challenges they face.

The State of Victoria’s children 2010 investigates ten areas of crucial importance to the healthy development of children and young people, bringing together a range of data from Victorian government departments and from state, national and international research. This report is a valuable resource to support planning and policy decisions for Victoria as a whole and for Victorian communities.

The Victorian Government is committed to providing the best possible start in life for children and young people and to continuing to support them as they transition to adulthood, becoming healthy, confident and productive members of the community. Government commitments, initiatives and programs that support children, young people and their families are noted in this report, demonstrating what is already being achieved across the state.

The end result is that, while recognising our considerable achievements, this report will provide a solid foundation for future action in improving outcomes for Victoria’s children, young people and their families.

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

This report brings a new dimension to monitoring outcomes for Victorian children, young people and their families. Building on what has been learned from evidence in previous State of Victoria's Children reports, this edition provides an in-depth look at key issues that continue to warrant further investigation. It draws together new and existing Victorian datasets to tell a more in-depth story about how children, young people and their families are faring.

This approach provides a new opportunity to look at associations across outcome areas. It enables us to go beyond the previously identified data sources for discrete indicators and draws together the best available evidence and research to enable a solid interrogation of Victorian issues in a national and international context. It also enables an initial exploration of the associated risk and protective factors for key outcomes.

This fifth edition of the annual The State of Victoria's Children series is intended to provide government and the community with a sound basis for future action in improving outcomes for Victorian children, young people and their families, and it continues to advance efforts in monitoring outcomes by Victorian Government departments.

Measuring outcomes for Victorian children, young people and their families

This edition continues to reflect the ecological model of the Victorian Child and Adolescent Outcomes Framework, which acknowledges that families and communities are fundamental in shaping outcomes for children and young people. This model (further described in Chapter 1) places the child or young person at the centre, surrounded by the important aspects of their environment and, most importantly, their families, communities and the wider society.

It continues to draw heavily on the Victorian Child and Adolescent Monitoring System (VCAMS), a comprehensive monitoring system that enables measurement and reporting against the outcomes for Victorian children and young people articulated in the above framework. VCAMS comprises 150 evidence-based indicators (or measures) of how Victorian children and young people are faring. Data for these indicators are sourced from across Victorian Government departments, from the Australian Bureau of Statistics and from VCAMS surveys (including the first Victorian Adolescent Health and Wellbeing Survey, and the 2009 Victorian Child Health and Wellbeing Survey). Technical information about the nature of these data collections is provided in the introduction and the sources of data used are detailed within each chapter. More detailed discussion of data sources and analytical techniques are presented in the accompanying Technical Report and Data Compendium (published online).

More recently, the annual Families Statement reflects the Victorian Government's commitment to the health, wellbeing and prosperity of Victorian children and their families. The 2011 Victorian Families Statement: Starting the discussion on what matters to families identified the key challenges facing Victorian families and set the broad directions of government focus and priorities which begin to address some of the challenges identified in this report. Further, the first Victorian Public Health and Wellbeing Plan 2011–2015, outlines opportunities to promote the health of children and families. This report provides a significant evidence base to guide directions of the Victorian Government and the broader community in further improving the outcomes for children, young people and their families.
Report preview and structure

The scope of this report is children aged 0–17 years, in line with the definition of child under the *Child Wellbeing and Safety Act 2005*. Unless otherwise stated, the term 'children' throughout this report refers to those aged 0–12 years and the term 'young person' refers to those aged 12–17 years.

This report is the first in *The State of Victoria's children* report series to take an issues-based approach as distinct from reporting against each of the VCAMS indicators. This issues-based approach was considered important because it enabled a more rigorous and lengthy discussion against a group of topics that continue to warrant a better understanding. As such, the report is structured around the key themes, with a chapter dedicated to each theme. Selection of the issues for inclusion was informed by evidence from the previous reports and also informed by new data collections.

The report starts with an overview of the Victorian population of children, young people and their families, with a detailed discussion of demographic and social characteristics to set the scene for the subsequent chapters on:

- healthy weight
- oral health
- social and emotional wellbeing
- mental health
- sexual and reproductive health
- substance use
- engagement with learning
- safety
- parents promoting health and development
- families, communities and social support.

Key Victorian Government initiatives relevant to each theme are listed within each chapter and also noted here in the Executive Summary, this includes new initiatives and commitments and programs in place.

In keeping with the Victorian Child and Adolescent Outcomes Framework, Chapter 13 provides a brief commentary about how children and young people are faring against 35 distinct outcomes. Although most of the outcome areas are covered in the preceding chapters, this at-a-glance overview chapter summarises recent trends and also facilitates comparisons with previous reports.

Data sources used in this report

This report draws on over 20 different datasets, further described in the Introduction. These include administrative data sources from across Victorian Government, Victorian surveys conducted by research organisations on behalf of Victorian Government (such as the Victorian Child Health and Wellbeing Survey and the Victorian Adolescent Health and Wellbeing Survey, conducted by the Centre for Adolescent Health) and national surveys conducted by the Australian Bureau of Statistics (such as the National Health Survey and the Survey of Education and Work). The source of each data item is detailed in the body of each chapter. All surveys used in this report have been developed by child and adolescent experts and incorporate questions and scales with national and international validity to measure key indicators. Statistical rigour has also been applied to the sampling methodology, to weighting of survey results and to analysis and reporting of findings. Additional information about the data sources, including survey methodology, analytical techniques and representativeness of the survey data, is presented in the accompanying online Technical Report and Data Compendium.

Victorian children, young people and their families

Victoria is home to 1.2 million children and young people aged 0–17 years, making up 22.5 per cent of the total Victorian population. These children and young people live in approximately 570,000 families. Most children and young people (71.8 per cent) live in metropolitan areas of the state and the remaining 28.2 per cent in regional areas. They are also a diverse group, with about one in five from a culturally and linguistically diverse (CALD) background and a small proportion (1.1 per cent) of Aboriginal background.
Healthy weight

Overweight and obesity are related to a wide range of poor health and wellbeing outcomes and there is strong evidence that overweight children are more likely to be overweight as adolescents and subsequently as adults. While most Victorian children and young people are of a healthy weight, a significant proportion is overweight or obese (based on physical measurements; 12.4 per cent of 2 year olds, 15.4 per cent of 3–4 year olds and 25.3 per cent of children aged 5–17 years).

Nutrition (including breastfeeding) and physical activity are key factors in promoting healthy weight. Half of Victorian infants are fully breastfed at 3 months, reducing as the infant gets older (to 36.9 per cent of 6 month olds). One in three Victorian children aged 5–12 years (33 per cent) and one in five Victorian young people aged 12–17 years (19 per cent) eat the recommended serves of fruit and vegetables daily.

Over half (55.4 per cent) of Victorian children aged 1–12 years rarely if ever have sugar-based drinks (improved from 41.5 per cent in 2006). However, over one third consume fast food at least once a week (34.3 per cent) and two in three have fried potato-chip products (including chips, French fries, wedges and crisps) at least once a week (66.8 per cent). As children get older, they are less likely to meet the recommended daily serves of fruit and vegetables.

Children are also less likely to do the recommended level of physical activity (at least one hour a day) as they get older, and are more likely to spend two hours or more each day using electronic media. Sixty per cent of Victorian children aged 5–12 years are physically active for at least one hour per day, compared to just 12 per cent of young people aged 12–17 years. Almost one in five children aged 5–12 years spend two hours or more each day using electronic media (18.8 per cent), compared to nearly three in five young people aged 12–17 years (58.7 per cent).

Gender and socioeconomic differences are notable factors in promoting healthy weight and healthy eating. Gender differences in physical activity and healthy eating increase with age, with young men more likely to be physically active and young women more likely to eat the recommended serves of fruit and vegetables. Socioeconomic differences are observed in relation to nutrition and sedentary activities, but not in relation to physical activity.

Recent Victorian research suggests a slight decline in the proportion of preschool children who are overweight or obese. However, childhood and adolescence are particularly important times to promote the value of healthy weight and healthy eating and exercise habits.

Key Victorian Government initiatives

**Commitments and new initiatives**

- Early intervention programs to help vulnerable parents with child rearing
- *The Premier’s Active Families Challenge* and *Ride2School*
- Establish a *Victorian Healthy Eating Advisory Service*
- $40 million in new preventative health initiatives for children including:
  - A new statewide policy for Health Promotion for Children and Young People
  - Preventative Community Model across 14 LGAs
  - Victorian Prevention and Health Promotion Achievement program for schools and early childhood settings
- *Victorian Breastfeeding Action Plan* to help services and the community promote and support breastfeeding

**Programs in place**

- The School Canteens and Other School Food Services Policy
- Mandated timetabling for sport and physical education in schools
- *Healthy Eating Programs* and VELS-based nutrition curriculum in Government schools
- *Victorian Aboriginal Nutrition and Physical Activity Strategy 2009–14*
- Evaluation of *Kids-Life* early intervention pilot projects for overweight children in three regions
- Broader child, family and community health services
- Healthy Weight/BMI – MCH Program.
Oral health

Oral health is an important component of having a good quality of life. Australia was ranked seventh for the oral health of its children and young people among the Organisation for Economic Cooperation and Development (OECD) countries, but despite this high ranking oral health continues to be a significant problem for many children and young people. Over a quarter (27.3 per cent) of Victorian children aged 5–12 years have experienced toothache at some stage. Nearly one in six Victorian young people aged 12–17 years (16.4 per cent) reported experiencing toothache either sometimes or often.

Over a quarter (26.6 per cent) of Victorian children aged 5–12 years have had tooth filling(s). One in 10 (11.7 per cent) have had at least one tooth extracted and one in 14 (7.1 per cent) have had dental treatment in hospital under general anaesthetic. Tooth fillings, tooth extractions and hospital dental treatment also occur more frequently in children from areas of most socioeconomic disadvantage and from regional areas of Victoria.

Since 2004–05, the rate of hospitalisations for dental-related conditions in Victorian children aged four years and younger has been declining (especially in regional areas decreasing from 86 to 56 hospitalisations per 10,000 between 2004–05 and 2009–10). However, at the same time, rates for 5–9 year olds have been increasing (more so in regional areas, from 87 children per 10,000 to 97 per 10,000).

Oral diseases and tooth decay are mostly preventable through proper nutrition, daily oral health care (such as tooth brushing), regular visits to a dental professional and the use of fluoride. Two thirds of Victorian children (66 per cent) and young people (67.4 per cent of young) brush their teeth twice a day. Seven in 10 parents of Victorian children aged 7 years and younger assist their children to brush their teeth at least once a day (68.8 per cent).

Most Victorian children receive some fluoride through normal tooth brushing (92.6 per cent) and most drink fluoridated tap water; however, 21.7 per cent of regional children drink tank/rain water (i.e. non-fluoridated) as their usual source of drinking water.

Almost all Victorian children have visited a dentist on at least one occasion by the age of 12. While children are more likely to have visited the dentist as they get older, the proportion of 5 year old children who have never visited a dentist is concerning (26.6 per cent). More than half of Victorian young people age 12–17 years visit a dentist at least once a year and most report that they can access dental services if needed (90.4 per cent).

Children and young people from regional areas of Victoria, areas of most socioeconomic disadvantage and those of Aboriginal background appear to have significantly poorer oral health outcomes than other Victorian children and young people.
Social and emotional wellbeing

Social and emotional wellbeing (SEWB) is a multifaceted concept that is reflected in the thoughts, feelings and behaviours of children and young people. While there is no single definition of SEWB, it is usually associated with positive physical health outcomes, positive peer relationships and achievement in school. Children with low levels of SEWB are more likely to have difficulty at home and in their peer groups and to experience negative emotions, antisocial behaviours and disengagement from learning.

In their first year of primary school, most Victorian children are developmentally ‘on track’, as measured by the Australian Early Development Index (AEDI). However, a small but sizable proportion is developmentally vulnerable on the social competence domain (8.4 per cent) and/or the emotional maturity domain (8.3 per cent).

Around 5 per cent of Victorian children aged 5–6 years experience emotional or behavioural difficulties and are considered to be at high risk of significant clinical problems. Around 7 per cent of children are also considered to be at a high risk in terms of hyperactivity or conduct problems at school entry.

Six in 10 Victorian young people aged 12–17 years (61.1 per cent) report a high level of social and emotional functioning, defined as having a sense of autonomy and personal agency/power, positive connections with others and feeling confident and capable. Furthermore, most Victorian young people report being satisfied with the quality of their lives (77.1 per cent).

Body image in young people is one important aspect of social and emotional wellbeing discussed in this report. More than one in three Victorian young people (34.4 per cent) report as being concerned about gaining weight or getting fat.

Females are more likely than males to have positive social and emotional wellbeing across childhood and adolescence, but this is reversed for body image, where females are significantly more likely to be negatively concerned about weight gain than males (51.4 per cent compared to 17.7 per cent).

A range of factors, both individual and environmental (in the home, school and community), are associated with promotion of SEWB in children and young people, in particular, positive family, peer and teacher relationships. Children and young people from the more disadvantaged areas are less likely to have positive social and emotional wellbeing.
Mental health

Mental ill-health is the largest single contributor of disability burden in the Australian population. Mental health problems among children and young people can seriously disrupt or impede their school, work, social and family experiences. There are limited data on the actual prevalence of mental health problems or disorders among Victorian children and young people but the most recent data shows that thirteen per cent of Victorian young people (age 12–17 years) report very high levels of non-specific psychological distress (this is not the same thing as a clinical diagnosis). Serious psychological distress is more common among female young people and among those living in socioeconomically disadvantaged areas.

A small proportion of Victorian young people suffer from an eating disorder (2.4 per cent, consistent with national and international data), with a higher proportion of females than males.

The rate of registration with public specialist mental health services by young Victorians aged 12–17 years of age has remained relatively stable over the past five years, at a rate of 6.9 per 1000 population in 2004 and 6.8 in 2009. Females have a consistently higher rate than males at all ages in adolescence.

Over the period 2007–09, there were 1547 hospital admissions and 1604 hospital Emergency Department (ED) presentations by young people for self-harming injuries. Hospital treatment for self-harming injuries was more prevalent for older than younger adolescents, and more prevalent for females than males.

Self-reported data from Victorian young people (12–17 years) indicates that 14.1 per cent have used or believe they have a need of mental health professionals. However, a quarter of these young people feel they cannot access mental health services if needed, with perceived barriers including cost, confidentiality and accessibility.

Risk factors for mental health problems in children and young people include unstable family relationships, family conflict, family violence, lack of social support and poverty. Protective factors identified in the research include nurturing and secure family relationships, positive and rewarding school environments, connectedness to schools and communities, positive personal achievements, pro-social peer group and friends.

Key Victorian Government initiatives

Commitments and new initiatives

- Mental Health Professional Learning Program for the education workforce
- Enhancing and expanding Headspace services at selected sites across Victoria
- 150 additional Primary Welfare Officers
- Professional Development opportunities for teachers to address challenging behaviours
- Targeted mental health and suicide prevention initiatives for gay, lesbian, bisexual and transgender young people
- Community-based eating disorder treatment services
- Enhanced and expanded community mental health services
- Central coordination of inpatient beds, with boost in bed capacity, including additional PARC beds
- Improved housing access and innovative housing models
- Support for workforce participation
- Research into mental illness

Programs in place

- Headspace services
- Eating Disorders Strategy
- Student Support Services Program for school students
- Student Welfare Coordinators and secondary school nurses
- Primary School Nursing Program
- Child and Adolescent Mental Health Service in Primary Schools
- School Focused Youth Service
- Scholarships for Graduate study in Mental Health for the Teaching professions
- Priority access to mental health services for children in Out-of-Home Care
- Youth Justice mental health initiative.
Sexual and reproductive health

The timing of first sexual intercourse and the context in which it occurs has important implications for health. Australian young people are engaging in their first sexual activity at a younger age than in the past and may be at higher risk of unplanned pregnancy and sexually transmitted infections, as well as a range of other poorer health and life outcomes.

By age 12 years most Victorian young people have started pubertal development, and by 17 years almost all have reached or are nearing reproductive maturity. Females reach sexual maturity earlier than males.

Less than one in 20 Victorian young people aged 12–14 years (4.7 per cent) report being sexually active (having had sexual intercourse). However, more than one in five Victorian young people aged 15 to 17 years report being sexually active (22.4 per cent). Young people in rural and regional Victoria and young people from low socioeconomic areas are significantly more likely to be sexually active.

Three in four (74.7 per cent) sexually-active young people in Victoria report always using at least one form of contraception (including a condom, contraceptive pill or other method) during sexual intercourse. Over half of sexually-active Victorian young people report always using a condom (58.1 per cent), with condom use more common for younger adolescents. Young people with low levels of social and emotional wellbeing are less likely to always use condoms. The rates of notified sexually transmitted infections (STIs) in Victorian young people have been consistently increasing over the past decade, with chlamydia being the most prevalent, although it is unclear how much these rates reflects a true increase in prevalence or better reporting. Older adolescents, females and those from regional areas are more likely to have a diagnosed STI. Immunisation rates are high for Hepatitis B among Victorian young people (74.7 per cent) and for the human papilloma virus (HPV) among Victorian young women (72.8 per cent).

Most young people have poor knowledge about STIs (with the exception of HIV/AIDS). Commonly reported sources for information about sexual and reproductive health (nationally) include mothers, female friends and school-based health programs.

On average, about 10 babies are born per 1000 Victorian women aged 19 years and younger, a fertility rate consistently lower than the national teenage fertility rate. The rate of births to teenage women is consistently higher in regional Victoria compared to metropolitan Victoria.

Key Victorian Government initiatives

Commitments and new initiatives
- Catching On Early primary school sexuality education professional learning for teachers and school nurses
- Targeted support to schools to promote health and safety of same-sex attracted and gender diverse groups

Programs in place
- HPV and Hepatitis B vaccination for children in Year 7
- Comprehensive P–10 sexuality education curriculum and policy support to all schools
- School nurses in secondary schools
- Local initiatives to support the National BBV and STI strategy
- Family Planning Victoria safe sex and blood-borne infections youth education programs
- Specific youths sexual health and Health and education assessments for children in out of home care (OHC)
- Sexual health and sexuality education for children and young people in OHC policy
- Innovative Health Services for Homeless Youth program
- Sexual Assault Services for children.
**Substance use**

Alcohol, tobacco and illicit drugs are major causes of preventable injury, disease and death in Australia and patterns of substance use in adolescence can have profound influences on substance use or misuse in adulthood.

One in four Victorian young people aged 12–17 years report having smoked tobacco at least once. Of the 11.5 per cent of Victorian young people who smoked over the last year, nearly one in three (29.9 per cent) smoked regularly, with more than half of these regular smokers smoking on a daily basis (16.9 per cent). However, the proportion of Victorian young people who are regular smokers has decreased over the past decade.

Alcohol consumption in Victorian young people is more common than tobacco smoking, with three in five (59.8 per cent) having drunk alcohol at least once and almost two in five consuming alcohol over the past month (37.7 per cent). Rates of recent binge drinking are much higher among older adolescents (29.7 per cent of 15–17 year olds compared to 8.9 per cent of 12–14 year olds). Alcohol consumption is higher among young people in rural and regional Victoria. Almost three quarters of Victorian young people aged 15–17 report ease of access to alcohol. Most young people are aware of risk of harm from regular drinking.

A small number of Victorian young people report having used illegal drugs. The most common drug used is cannabis (marijuana) (9.6 per cent report use on at least one occasion), a much smaller proportion (2.8 per cent) has used other illicit drugs at least once and 7.5 per cent have sniffed glue or chromed at least once. Ecstasy use among 16–17 year olds in Victoria has increased between 1996 and 2008, but use of cannabis and other hallucinogens has declined. One in five Victorian young people aged 12–17 years report ease of access to cannabis and one in 10 report it is easy to get other drugs.

Family factors (such as parental styles and quality of family relationships, parental attitudes to substances, parental substance use, and parental monitoring and supervision) and peer substance use were strong influences on young people’s choices or behaviours related to substance use.

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**Key Victorian Government initiatives**

**Commitments and new initiatives**

- Expansion of a range of drug, alcohol, health and rehabilitative services for youth justice clients
- Koori Youth Healing Service
- In-depth research project to test innovative secondary drug education program for future statewide implementation
- Introduction of the ‘Secondary Supply’ (SS) legislation banning the supply of alcohol to minors in a private residence without parental consent
- Community Education Campaign to inform the community about the SS legislation

**Programs in place**

- Comprehensive P–12 drug education curriculum and policy support to all schools
- Secondary school nurses and Student Welfare Coordinators
- School Focused Youth Service
- Drug education professional learning for primary and secondary teachers
- *Victorian Alcohol and Drug Prevention and Treatment Strategy*
- Drug Diversion by Police
- Alcohol and drug treatment services for young people
- Koori Alcohol Action Plan
- Alcohol and drug youth consultants to child protection
- Drug and alcohol services for young people in secure welfare accommodation
- *Innovative Health Services for Homeless Youth* program.
Engagement with learning

Young people who disengage with learning and, as a result, leave formal learning environments at an early age are more likely to experience poorer health and social outcomes in early adulthood and in later life.

Victorian children and young people have a high level of engagement with formal education from an early age and this continues well into their twenties.

The proportion of Victorian children attending a kindergarten program in the year before formal schooling reached 95.1 per cent in 2010. Based on data from the Australian Early Development Index (AEDI), most children (79.8 per cent) are developmentally on-track at school entry. Apparent retention rates from Years 10 to 12 (across all schools) have remained steady over the past four years. A high proportion of 19 year olds have attained Year 12 or an equivalent qualification (79.8 per cent), with a number of young people also continuing education into their twenties to reach this level of qualification.

Nearly half of Year 12 completers in Victoria went on to university in 2010 (48.5 per cent) and more than a quarter continued on to other non-school education and training (26.3 per cent). In Victoria, 15–19 year olds are less likely to be not engaged in full-time education or full-time employment than nationally (12.7 per cent in Victoria compared to 16.4 per cent nationally). However, Victorian early school leavers are more likely to be looking for work or not in full-time education or employment (21.2 per cent in 2010) compared to Year 12 completers (5.9 per cent in 2010).

Overall school participation rates are high, but data for Victorian Government schools show school absences peak in Year 9 and are also higher in regional schools. Over a quarter (28.1 per cent) of Victorian young people (all schools) report skipping school at least once in the past month and this is also more likely to occur in more disadvantaged areas.

Many factors influence and indicate how well children and young people engage with learning, ranging from personal and emotional factors to school and family factors. More than half of Victorian young people report always or often enjoying school (56.3 per cent); with a further 28.9 per cent sometimes enjoying school.

Key Victorian Government initiatives

Commitments and new initiatives

- Combat Bullying/Cyberbullying
- Enforce Truancy Laws
- Establish seven Youth Partnership demonstration sites to address the needs of vulnerable young people
- Pilot effective models education provision for disengaged young people and enable funding flexibility
- Renewed Education commitment for children and young people in Out-of-Home Care, including health and education assessments and appointment of a learning mentor
- Transitions for Students with Disabilities
- Additional Primary Welfare Officers
- Expand VET in schools to widen subject and career choices
- Increased funding for Victorian Training Guarantee exemption places
- Reintroduction of TAFE concession fee places for diploma or advanced diploma courses.

Programs in place

- Transition: A Positive Start to School
- Sharing our Journey
- Victorian Early Years Learning and Development Framework implementation
- Curriculum options for senior secondary students, including VCAL, VETiS, apprenticeships and traineeships
- Student Welfare Coordinators
- A range of flexible learning options to re-engage disengaged students
- Local Learning and Employment networks
- Alternative settings
- Local Learning and Employment Networks
- National Partnership on Youth Attainment and Transitions Career Development Services
- Wannik Aboriginal Education Strategy
- Parent promotion of child development and learning – MCH Program.
Of concern, however, are the 14 per cent of Victorian young people who report rarely if ever enjoying school. Almost half (49.2 per cent) of Victorian young people aged 12–14 years and four in 10 (39.7 per cent) of those aged 15–17 years report having experienced bullying. Of particular concern is the 15.2 per cent of all 12–17 year olds who report having been bullied or harassed at school on most days, with a higher proportion of males (18.2 per cent) than females (12.2 per cent).

Measures of many school engagement factors in Victorian Government schools have shown a gradual improvement over the past five years, in student motivation, school connectedness, teacher support and effectiveness, and students’ perception of school safety. However, consistent with other research evidence, a number of indicators suggest that engagement with learning for some young people declines in the middle years of schooling, particularly in Year 9. These include measures related to students’ learning motivation and confidence, connectedness to peers, perception of school safety, and classroom behaviors.
Safety

A secure and safe physical and social environment is critical to the emotional wellbeing and the healthy development of children and young people, and safety can be understood as a necessary pre-condition for health. In this context, safety issues relating to unintentional injuries and deaths; harm from violence and crime; and the antisocial and criminal behaviours of children and young people themselves are discussed.

Unintentional injuries and deaths

From 2007 to 2009, there were almost a quarter of a million (244,610) Emergency Department (ED) presentations and a further 50,000 hospital admissions for unintentional injury among Victorian children and young people (aged 0–17 years). The most common recorded cause of injury was falls and the most frequently recorded location of these injuries was at home, followed by school or public buildings. Males are more at risk of unintentional injury, particularly those aged 12 to 17 years.

Unintentional injury deaths in Victorian children and young people have been declining over a 10-year period. Most of these deaths were caused by transport injuries (58.8 per cent), followed by drowning (13.8 per cent).

Victims of crime and abuse

Crimes perpetrated against a child or young person can have a disproportionate and lasting effect on the victim. Many young victims do not report crimes to the police for a complex range of reasons. From reported data, the 2009–10 rate at which Victorian children and young people (aged 0–17 years) were victims of crime is 9.1 per 1000 children and young people. Females are slightly more likely to be victims of crime and the rate is highest among older young people (aged 15–17 years). The most commonly reported crimes where the victims are children and young people are physical assaults, theft and sexual assaults.

Key Victorian Government initiatives: Safety

**Commitments and new initiatives**

- Strengthen Victoria’s youth justice system and create clearer pathways into prevention and rehabilitation programs by significantly expanding the Youth Justice Group Conferencing program and increasing the number of youth justice workers to supervise community based orders and the community component of court orders
- Expansion of bail supervision pilot program for young offenders
- Early intervention programs to help vulnerable parents with child rearing
- Enforcing truancy laws
- Stamping out bullying
- Establish seven Youth Partnership demonstration sites to address the needs of vulnerable young people
- Community Crime Prevention Program supporting local action to address local crime issues

**Programs in place**

- Victorian Police Early Intervention Pilot Program
- Youth Support Service to lower risk of youth offending
- Youth Justice Services to address youth offending including:
  - Forensic interventions/health services
  - Youth Justice Community Support Service
  - Koori Youth Justice Program
- Counselling and support for women and children experiencing family violence
- Sexual Assault Services for children
- Treatment programs for young people displaying inappropriate sexual behaviour
- Range of services to address risk taking behaviours among vulnerable young people
- Child Witness Service providing support to children required to give evidence in court
- Safe from injury and harm – MCH Program.
Over the three year period 2007–09 there were 3049 ED presentations and a further 1271 hospital admissions for assaultive injury in Victorian young people aged 12–17 years. Assaults using bodily force accounted for 60 to 70 per cent of hospital treatments, followed by assault injuries caused by blunt and sharp objects. The number of sexual assaults reported to police where the victim was a child or young person has been decreasing over recent years in Victoria. However, current national data suggests that a large proportion of sexually-active young people have experienced ‘unwanted sex’ where they were pressured or coerced (38 per cent of females and 19 per cent of males).

Antisocial and criminal behaviour

In comparison to other states and territories, Victoria has a low youth crime rate and has the lowest number per capita of young people detained in custody. Current Victorian legislation has a strong diversionary approach. Given certain conditions, Victoria Police may issue a caution to a young person under the age of 17 years. The rates of Victorian young people receiving a caution have remained relatively stable over the past five years, and 80 per cent of those cautioned had not reoffended within one year.

A small minority of Victorian young people engage in antisocial behaviours and relatively fewer go on to become persistent or serious offenders. Based on self-reported data by Victorian young people (aged 12–17 years), one in 14 (7.2 per cent) have attacked someone else to seriously hurt them, males are more likely to have done so as are those from more disadvantaged areas. One in five young males have reported carrying a weapon (not further defined) on at least one occasion.

Recorded police data show that, of all crimes committed in Victoria since 2005–06, the proportion committed by someone aged 10 to 17 years has been increasing (9.8 per cent in 2009–10). Higher rates of crimes are committed by males and by those in regional areas.
Parents promoting health and development

Parents play a fundamental role in promoting the health and development of their children from pregnancy, childhood, through to adolescence.

The majority of mothers did not smoke tobacco during pregnancy (81.3 per cent) and almost 40 per cent did not consume alcohol during pregnancy. However, almost one in five Victorian children were exposed to tobacco during pregnancy (18.3 per cent) and mothers of three in five Victorian children drank some alcohol during pregnancy (59.7 per cent). A sizeable proportion of children were exposed to binge drinking before their mothers realised they were pregnant (18.9 per cent). Notably, children from high income families were more likely to have been exposed to alcohol prior to birth.

Almost nine in 10 Victorian parents (87.4 per cent) placed infants on their back to sleep, in accordance with guidelines to minimise the risk of Sudden Infant Death Syndrome (SIDS). Half of Victorian infants are fully breastfed at 3 months, reducing to 36.9 per cent at 6 months. Almost all Victorian infants receive maternal child health (MCH) checks at birth (99.8 per cent in 2009–10) and, although the participation rate decreases as children age, more than three in five receive their 3.5 year check (63.1 per cent). Most Victorian parents immunise their children, with the immunisation rate at above 92 per cent at ages 1–2 years, decreasing to 87.2 per cent at school entry.

Three quarters (76.4 per cent) of 1–4 year olds are read to every day by a family member, so assisting their child’s early learning and development. Parental role modeling may promote healthy eating habits in children; however, less than half (47.7 per cent) of Victorian parents consume the recommended daily serves of fruit and less than one in ten (7.3 per cent) consume the recommended daily serves of vegetables. About two thirds of Victorian parents do the recommended weekly amount of exercise week (at least 30 minutes of moderate intensity exercise at least five days per week).

Most Victorian children (74.8 per cent) and young people (74 per cent) live in a smoke-free household. The majority of Victorian children are protected by their parents from sun exposure during the summer months (81.7 per cent), although this is more the case for babies and young children than older children.

Key Victorian Government initiatives

Commitments and new initiatives

• Cradle to Kinder an intensive ante and post-natal support service for vulnerable pregnant women
• Stronger support for telephone advice from the MCH line and Parentline
• Funding boost to Australian Breastfeeding Association to provide support for new mothers
• Victorian Breastfeeding Action Plan
• Implement the Victorian Public Health and Wellbeing Plan 2011–2015
• SmallTalk program.

Programs in place

• Ban of smoking in vehicles carrying children
• HPV and Hepatitis B vaccination for babies
• Pertussis (whooping cough) vaccination for parents
• A new parent vaccination program to protect babies from whooping cough by vaccinating parents
• Promotion of smoking reduction strategies by health and early childhood practitioners
• Enhanced Maternal and Child Health Service for vulnerable families
• Best Start networks of early childhood services, parents and local governments
• Regional Parenting Services
• In Home Support for higher-need Aboriginal families
• Parent support or parenting programs for families affected by alcohol or drug use
• General early childhood services that support capable parenting
• Integrated Family Services for vulnerable families
• Funding the Victorian Aboriginal Community Controlled Health Organisation to support pregnant Aboriginal women to stop smoking
• Early identification of mothers with post-natal depression and mental illness in the perinatal period through the Perinatal Emotional Health Program (PEHP) and universal screening
• Mother Baby Units offer consultation and support to MCH and Enhanced MCH nurses.
Families, communities and social support

Families

Of all the factors that can affect outcomes for Victorian children and young people, families are by far the most important and influential. Nine in 10 Victorian children (89.9 per cent) live in families with healthy family functioning, characterised by family members discussing feelings, making joint decisions and supporting, trusting and accepting each other. Eight in 10 young people (83.1 per cent) report living in families with healthy family functioning which, for this group, is measured as being free from aggressive behaviours and having a good system to manage adolescents’ school and social lives.

Nearly four in 10 Victorian children have been exposed to a significant stressful event by the time they start school (e.g. the death of a family member, parental divorce, or an illness of their parents or siblings), with Aboriginal children and those from one-parent families more likely to have been exposed to multiple stressors. A history of parental mental illness is experienced by 3.5 per cent of children by the time they start school and 2.4 per cent come from a family where there are alcohol or drug problems. One in 10 Victorian parents (10.8 per cent) with dependent children consume alcohol at levels that are at risk of short-term harm on at least a weekly basis.

Children and young people can be subjected to harm and abuse in their own home. The rate of substantiated child abuse has decreased from 2005–06 to 2009–10 (from 6.5 to 5.7 per 1000). In these family situations there is a complex interplay between family violence, mental health problems, substance use and child abuse.

The incidences of family violence in which a child or young person was present accounted for around 40 per cent of all family violence incidents reported to the Victoria Police between 2005–06 and 2009–10. Of the 35,720 reported family violence incidents in 2009–10, a total of 14,870 children and young people aged 16 years and younger experienced these incidents. The number of children identified as ‘aggrieved family members’ (i.e. as victims) in finalised family violence intervention order applications in Victoria has increased dramatically, from 5310 in 2003–2004 to a total of 15,399 in 2007–08, due largely to legislative and practice changes.

The number of family violence incidents where the perpetrator was a young person (aged 10–17 years) has increased from 274 incidents in 2004–05 to 479 in 2009–10, though the overall number of family violence incidents also rose during this period, partially owing to strategies employed by the government to increase reporting and improve police responses.

Key Victorian Government initiatives

Commitments and new initiatives

- Stronger support for parents through telephone advice from MCH line and Parentline
- Parenting Strategy
- Primary Welfare Support Officers
- Cradle to Kinder an intensive ante and post-natal support service for vulnerable pregnant women
- Funding for Childrens Protection Society to provide intensive childcare for at risk children
- Preventing Violence Against Women program. New evidence based initiative targeting community, families men, women, boys and girls to build equitable, respectful organisations communities and relationships to prevent violence against women and children
- Smalltalk program
- Expanded Early Start Kindergarten
- Appoint an independent Children and Young Persons Commissioner.

Programs in place

- Universal Maternal and Child Health (MCH) service
- Enhanced MCH for higher need families
- Families where a Parent has a Mental Illness (FaPMI) strategy implementation includes training and support to mental health services. Foster links with Child FIRST, to increase the family focus of services
- The BEACON Project leads a family-focused approach in Alcohol and Other Drug services through training and clinical leadership
- Concessions and reduced charges for low-income families or young people
- Child Witness Service providing support to children required to give evidence in court
- Strong Culture, Strong People, Strong Families – Towards a safer future for Indigenous families and communities (10 year plan)
- Specialist programs for Aboriginal children and families that support culturally appropriate child protection responses.
Communities and social support

Communities further influence outcomes at the family, child and young person level, including through social support, access to local services and amenities, and opportunities to participate in community decisions and activities. Social support can help families deal with challenging life events and help the family feel an overall sense of belonging and trust. Nearly nine in 10 Victorian families with children have access to support networks, with 95.2 per cent of the children in families with relatives or friends who could take care of them or their parents if needed.

Around nine in 10 Victorian young people report having a special person in their lives who they can turn to when having problems, and seven in 10 report having a trusted adult in their lives.

Most children and young people are reported to live in neighbourhoods that are clean and have basic shopping facilities and services, but less than half of Victorian young people (48.3 per cent) report that their neighbourhood has good recreational facilities. While the majority of Victorian young people (73.4 per cent) report as living in neighbourhoods with close affordable public transport, more than one in eight (14.1 per cent) do not and, of these young people, most (76 per cent) indicate that lack of local public transport has impacted on their ability to meet their school, work, social or health goals. The majority of children (79.4 per cent) and young people (85.6 per cent) in Victoria feel safe in their communities, at home, walking around their neighbourhood and on public transport.

Most young people report that there are sporting teams available in their community (81.3 per cent), with less reporting having community services and volunteering opportunities (62.9 per cent) or youth groups (61.7 per cent). Those young people in more disadvantaged areas are less likely to report that their communities offer all these services and opportunities. Regarding community decision-making, 61 per cent of young people feel that adults in their neighbourhood pay attention to what they say, and 47.1 per cent feel they can help decide on activities in their neighbourhoods.

The Victorian Government provides a range of family support services and programs to vulnerable children, young people and their families. These children and young people are likely to experience greater challenges because their development has been affected by the experience of multiple risk factors and/or cumulative harm. There has been a steady increase in the number of families and children accessing family services since 2005–06, reaching a total of 29,000 cases involving 63,000 children in 2009–10.
Emerging issues and trends

Overall, the findings of this report continue to show that the majority of Victorian children, young people and their families are faring well; they display positive characteristics and protective factors and generally fare better than their national counterparts. However, there are a number of recurring themes across each of the chapters in the report that warrant further consideration.

Socioeconomic disparities

Across almost all issues we continue to see socioeconomic disparities. Children, young people and families from disadvantaged backgrounds fare less well on many measures where this analysis has been undertaken. Some examples include that they are:

- less likely to be a healthy weight and meet fruit and vegetable intake guidelines
- more likely to have poorer oral health, as indicated by more reported fillings and extractions and lower use of dental services
- more likely to have emotional and behavioural problems that are of concern
- more likely to be developmentally vulnerable at school entry
- more likely to experience bullying, to have skipped school or to have been suspended
- more likely to have been involved in antisocial or criminal behaviour
- more likely to be exposed to tobacco in the home.

Regional differences

While this is a statewide report, in many cases analysis has been included to enable comparisons between children, young people and their families in metropolitan and regional (non-metropolitan) Victoria. There are a number of key outcome areas where children and young people in metropolitan Victoria fare better, including across sexual health, school attendance, oral health, and are less likely to engage in substance use. However, those living outside of metropolitan Victoria have a better perception of their neighbourhood and community safety, with young people more likely to report social support and opportunities to be involved in the local community. It should be noted, however, that these analyses do not distinguish between those in regional centres and those in more rural or remote areas.

Gender differences

As frequently documented in research, and as further identified in this report, there are differences in outcomes for males and females and they display different strengths and face different challenges across a range of outcome areas. Females generally fare better on measures of oral health, unintentional injury, aspects of engagement with learning, and are less likely to engage in antisocial behaviour. Males tend to fare better on a range of mental health outcomes.
Co-occurrence of risk taking behaviours and compound disadvantage

Taking an issues-based approach to this year’s report has enabled a more detailed look at the co-occurrence of risk-taking behaviours among Victorian young people and families who face multiple risk factors or experience compound disadvantage. The co-occurrence of multiple risk-taking behaviours by the same young people is evident in the published literature. However, through the use of findings from the Victoria-wide survey of 10,000 young people, for the first time, this report has demonstrated the co-existence of multiple risk-taking behaviours in the same groups of Victorian young people. For example, there are strong associations across different types of substance use (tobacco, alcohol and other drugs) among Victorian young people and, in a small but significant group, substance use is also associated with other high-risk behaviours, such as unsafe sex, antisocial behaviour and even criminal behaviour (such as carrying a weapon or assaulting another person).

There is also strong evidence that some Victorian families experience multiple risk factors. In 2009, approximately 65 per cent of families using the Victorian Government-funded Early Parenting Assessment and Skill Development Services (PASDS) had four or more risk factors, including mental illness, family violence, substance use, being teenage mothers, financial stress, insecure housing, and/or infant or parent disabilities.

The analyses included in this report are by no means exhaustive of the wealth of available data and there are opportunities to further explore these issues through ongoing analyses of VCAMS surveys and program data from across Victorian Government departments.

Next steps

This report further advances efforts in monitoring outcomes for children, young people and their families by Victorian Government departments. Through the thematic approach, it has enabled a more rigorous discussion against issues that continue to warrant a better understanding. It highlights where Victorian children, young people and their families continue to do well or have seen recent improvements; however, it also identifies where more attention is needed; where there are disparities across population groups or sections of the state; and the complexity of compound disadvantage that a number of Victorian families experience. In addition, while the Victorian Government has one of the most advanced and comprehensive systems to monitor and report against outcomes for children and young people, the report also draws attention to gaps that remain in our monitoring system and research base.

This report is not the final step in understanding how children and young people are faring. It is expected to not only provide a base for future action in monitoring, research and evaluation but to drive program planning and policy development at all levels of government and service provision. This report is intended to form part of ongoing dialogues among program planners and policy-makers across government, among local government areas and community service organisations and among researchers and practitioners.

Future State of Victoria’s Children reports will continue to evolve and advance as Victoria’s monitoring system grows and improves. Rigorous reporting against the VCAMS indicators will take place online, enabling these reports to take a more investigative and innovative approach focusing on particular issues, places and population groups. The importance of local data is also recognised and, where available, these data will also be published in the VCAMS Community Profiles for each local government area and through online reporting. This combined approach of state and local reporting and additional investigative analyses will provide a solid foundation to support evidence-informed decision-making.
Introduction
Chapter 1
Introduction

The environment in which Victoria’s children and young people live, learn and grow has changed significantly over the past few decades. Economic, social and political changes have directly impacted upon a number of demographic patterns within the population. These transitions can be observed in changes to family size and composition, parental working patterns, and rates of birth, death and marriage. Other changes have been experienced via the mass engagement of children and young people with globalised consumer culture, technology, communications and social media.

In the context of these changes, both in Australia and internationally, a growing body of evidence suggests that the future outcomes of children and young people depend largely upon the support and guidance they and their families receive during their formative years. This awareness has led to the formulation of new evidence-based strategies to support children, young people and their families for the benefit of the entire community.

The State of Victoria’s Children Report 2010 is the fifth in a series of annual reports that discuss the status of the health, development, learning, safety and wellbeing of Victorian children and young people. How Victorian children and young people are faring is primarily the responsibility of their families, including their parents and carers, who have the most powerful influence over their lives. However, communities, schools, non-government organisations, local governments, and the Victorian and Commonwealth Governments also have a responsibility to contribute to positive outcomes for children and young people.

This report considers the outcomes framework for Victorian children and young people, relevant findings from the previous reports, and new information available in a Victorian context to present a detailed discussion of key themes and issues. It therefore differs from preceding reports in that it seeks to present an in-depth discussion of key outcomes for young people, including the context in which they occur and the factors influencing these outcomes. In addition, a new evidence base is provided on which to draw for community and government planning, policy-making and program development.

The report’s focus is on outcomes for children and young people aged 0–17 years in Victoria. Throughout, the term ‘child’ is used to denote children aged 0–12 years and the term ‘young people’ used to denote those aged 12–17 years, unless otherwise specified.

The audience for this report includes government, policy-makers, the media, those involved in planning and delivering services, advocacy groups and the general public (including families with children and young people themselves). It is intended to inform a wide range of people about how Victorian children and young people are faring and to lead discussion on the factors influencing important outcomes for them and their families.
Childhood and adolescence are critical periods for the formation of healthy and productive adults. There has been significant government interest, focus and investment in achieving the best outcomes for children and young people over the past decade. Through the Council for Australian Governments (COAG), a series of national partnerships have been formed, which focus on improving outcomes in schooling, early childhood, and youth engagement in education and post-school transitions to further education, training and employment.

Systematic monitoring of child outcomes is fundamental to the capacity of government to make sound choices. Key policy recommendations by the Organisation for Economic Cooperation and Development (OECD) in relation to improving child outcomes assert that the statistical invisibility of children needs to end and that data (ideally internationally comparable data) needs to be collected across all stages of the child’s life-cycle and across all dimensions of wellbeing in order to inform policy. Victoria is recognised as a national leader in systematically identifying, measuring, monitoring and reporting on outcomes for children and young people.

More recently, the annual Families Statement reflect the Victorian Government’s commitment to the health, wellbeing and prosperity of Victorian children and their families. The 2011 Victorian Families Statement: Starting the discussion on what matters to families identified the key challenges facing Victorian families and set the broad directions of government focus and priorities, including secure income and a manageable household budget, access to quality education, health and disability services, safe and friendly neighbourhood and communities, and support of rural and regional Victoria.

Further, the first Victorian Public Health and Wellbeing Plan 2011-2015, released in September 2011, recognises the importance of investment in positive early childhood development. The plan outlines opportunities to promote the health of children and their families in key settings including local communities, workplaces, early childhood and education settings, and health services. In addition, the plan outlines action areas to protect health, to keep people well and to strengthen preventative healthcare.

This report provides a significant evidence base to guide directions of the Victorian Government and the broader community in further improving the outcomes for children, young people and their families.

Key national and international policy directions relating to children and young people

- Coalition of Australian Governments (COAG), National Partnership Agreement on Early Education, 2008
- Smarter Schools National Partnerships, 2008
- Early Childhood Development Strategy – Investing in the Early Years, 2009
- Early Years Learning Framework, 2009
- Youth Attainment and Transitions National Partnerships, 2009
Measuring outcomes for Victorian children, young people and their families

Victorian Child and Adolescent Outcomes Framework

The Victorian Child and Adolescent Outcomes Framework was developed in the context of the Child Wellbeing and Safety Act 2005 to support the required functions of the Children's Services Coordination Board and to provide an evidence-based structure for ongoing monitoring and reporting of child and adolescent outcomes to inform planning and policy decisions.

The framework (see Figure 1.1) incorporates a life-course perspective from pregnancy through to transition to adulthood. It brings together the interrelated domains of health, safety, learning, development and wellbeing, and reflects an ecological model of childhood and adolescence. This model seeks to understand the relationships between a child’s wellbeing and development and the environment in which they live. Children develop through their interactions with their immediate family and friendship environment, and through the interactions between their family environments and larger social and community environments. The child or young person is at the centre, surrounded by the important aspects of their environment and, critically, their families, their communities and the wider society.

Figure 1.1: The Victorian Child and Adolescent Outcomes Framework
The framework creates a common foundation from which to develop government policies and programs and to set goals in relation to children and young people. It aims to both identify and describe the 35 most important outcomes for Victoria’s children and young people and for our communities and society.

Through the development of this framework, four priority population groups of Victorian children and young people were identified. The best available evidence suggests that these groups face more complex challenges than other Victorian children and young people and require additional monitoring efforts to better understand their needs. The priority groups are:

- Aboriginal children
- Children living with a disability or developmental delay
- Recent or high-need immigrant children
- Children suffering chronic disadvantage (including those in Out-of-Home Care within the child protection system, homeless young people or those in the juvenile justice system).

A comprehensive monitoring system

The Victorian Child and Adolescent Monitoring System (VCAMS) is the comprehensive monitoring system that enables measurement and reporting against the outcomes for Victorian children and young people articulated in the above framework. It comprises 150 evidence-based indicators (or measures) of how Victorian children and young people are faring. Data for these indicators are mainly sourced from across Victorian Government-funded services, surveys produced by the Department of Education and Early Childhood Development (DEECD) and the Australian Bureau of Statistics (ABS).

VCAMS was developed to help improve the outcomes of children and young people through the use of evidence and data in decision-making. Importantly, the ongoing ‘monitoring’ of these outcomes means that information is available about how children are faring on these outcomes over time. Data from VCAMS are published at a state level in The State of Victoria’s Children annual reports, while local level data have been made available through a series of Community Profiles (both published by DEECD). In 2012, the VCAMS will be released online (at www.education.vic.gov.au) to provide access to the most recent information about the VCAMS system’s 150 indicators. This new capacity to publish the most up-to-date data online for each of the VCAMS indicators will provide an opportunity to refocus and streamline the future content of The State of Victoria’s Children reports.
Report scope and structure

Of the four previous annual series of reports published (2006–09), the first three have provided a comprehensive overview of the general population of Victorian children and young people, while the 2009 report focused on Aboriginal children, young people and their families.

This 2010 report takes a different approach to previous editions, through its in-depth focus on key issues for Victorian children, young people and their families as informed by findings of previous reports and significant advances in VCAMS data collections. It intentionally goes beyond reporting of information about discrete indicators for children and young people and moves towards an examination, explanation and discussion of these outcomes. The focus of the discussion within each theme has been shaped by literature reviews, consultation across Victorian Government and, where possible, consultation with leading academics.

Risk and protective factors

Where possible, ‘risk and protective factors’ are discussed throughout to help understand relevant outcomes for Victorian children, young people and their families. It seeks to identify common and important risk factors (things that are predictors or increase the probability of future negative or adverse outcomes) and protective factors (things that moderate or mitigate the influence of risk factors). These risk and protective factors occur across environments in which children and young people live: the social (family, peer group, school or community), the economic and the physical environments.

Many risk and protective factors are modifiable and able to be altered by a child, young person or their family (e.g. poor diet as a risk factor for obesity), but some are specific to the child and unable to be changed (e.g. the child’s sex). Understanding the risk and protective factors for specific outcomes can assist policy-makers and other planners to design services, programs or interventions that account for these influences. Importantly, having specific risk factors does not guarantee that a child or young person will eventually have a negative outcome or engage in negative behaviour; rather, they are factors that, through their influence on a child’s life, can increase the probability or likelihood of these outcomes occurring. No single risk or protective factor causes a particular outcome.
Evidence base

This report is based on a synthesis of evidence regarding outcomes for children, young people and their families and the risk and protective factors known to influence those outcomes. The report maximises the utility of new and existing VCAMS data sources, including the first adolescent health and wellbeing survey (HOWRU) conducted through VCAMS. However, it goes beyond previously defined VCAMS data sources to integrate the best available data and research from the most recent sources to inform the discussion of each key issue.

This report draws on over 20 different datasets, further described in the Introduction. These include administrative data sources from across Victorian Government, statewide surveys conducted by research organisations on behalf of Victorian Government (such as the Victorian Child Health and Wellbeing Survey, Victorian Adolescent Health and Wellbeing Survey, branded HOWRU for administration) and national surveys conducted by the Australian Bureau of Statistics (such as the National Health Survey and the Survey of Education and Work). The source of each data item is detailed in the body of each chapter. Survey data all surveys used here have been developed by subject matter experts and incorporate questions and scales with national and international validity to measure key indicators. Statistical rigour has also been applied to the sampling methodology, to weighting of survey results and to analysis and reporting of findings.

Data sources used in the report include:

- Victorian Adolescent Health and Wellbeing Survey (HOWRU, 2009)
- Victorian Child Health and Wellbeing Survey (VCHWS, 2006 and 2009)
- Australian Early Development Index (AEDI, 2009)
- School Entrant Health Questionnaire (SEHQ, 2009, 2010)
- Australian Secondary Students’ Alcohol and Drug Survey (ASSAaD, 2008)
- Administrative data from across Victorian Government departments including:
  - Children and young people as victims and offenders of crime
  - Hospitalisations and emergency presentations
  - Attitudes to school
  - School attendance
  - Early childhood service utilisation
  - Notifications of sexually transmissible infections
  - Family violence incidents
  - Child protection substantiations
- Australian Bureau of Statistics (ABS) Census (2006), demographic data and national surveys
- Major national and Victorian research
- Literature reviews of most up-to-date evidence against the key themes

More information about the data sources and technical methods used in this report is presented in the accompanying online technical report. Detailed data used in this report, including detailed analytical results and associated statistics, will also be available in the online data compendium.

Readers are encouraged to refer to the online technical report and data compendium to assist in the understanding of the data presented in this report.
Report structure

In taking an issues-based approach, the report has enabled a more rigorous and lengthy discussion against a group of topics that continue to warrant a better understanding. As such, the report is structured around the key issues, with a specific chapter dedicated to each.

This report comprises 14 chapters (see following table), including this introduction (Chapter 1), a demographic overview of Victoria's children, young people and their families (Chapter 2); followed by 10 themed chapters. The report concludes with a summary of how Victoria's children are faring in 2010 on the 35 outcomes areas from the Victorian Child and Adolescent Outcome Framework (Chapter 13), followed by a concluding chapter containing the next steps (Chapter 14).

Key Victorian Government initiatives relevant to each theme are listed within each chapter and also noted in the Executive Summary, this includes new initiatives and commitments and programs in place.

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<td>The issues associated with good oral health in Victorian children and young people are discussed. The prevalence of oral health problems and the key factors known to promote oral health in children are examined, including oral care (e.g. tooth brushing), preventive dental care, treatment of problems by dentists and the use of fluoride.</td>
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<td>5</td>
<td>Social and emotional well-being</td>
<td>This chapter looks at the positive social and emotional wellbeing in Victorian children and young people, and the available information about positive social and emotional wellbeing and negative child behaviour (associated with poor social and emotional wellbeing). The relationship between positive body image and social and emotional wellbeing is also explored.</td>
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<td>6</td>
<td>Mental health</td>
<td>Mental ill health, including mental health problems and disorders in Victorian children and young people are discussed, and information is provided on the prevalence of important mental disorders and mental problems in Victorian children and young people and the use of mental health services.</td>
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<td>Sexual and reproductive health</td>
<td>Sexual and reproductive health issues in Victorian children and young people are presented, relating to puberty and reproductive development, drawing on information on Victorian young people's sexual activity. Issues around sexual safety (including the prevention of unwanted pregnancy and the contraction of sexually transmitted infections), sexual health knowledge and use of health services are also discussed.</td>
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26 The state of Victoria's children 2010
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<td>Substance use</td>
<td>The use of substances, including tobacco, alcohol, illicit drugs and other substances by Victorian young people are examined. The prevalence of tobacco smoking, consumption of alcohol (including binge drinking) and use of illicit drugs (with a focus on cannabis) are discussed alongside information relating to where young people access these substances. Information about young people and their parents’ attitudes to tobacco smoking, alcohol consumption and use of drugs is also presented.</td>
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<td>9</td>
<td>Engagement with learning</td>
<td>A discussion on how well Victorian children and young people are engaged with learning, particularly in formal educational settings. It considers individual factors for children and young people influencing their engagement with learning, such as behavioural, cognitive and emotional factors. Broader risk and protective factors influencing engagement with learning, including the impact of their parents, peers (through both friendships and bullying), teachers, school and the broader community, are also explored.</td>
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<td>10</td>
<td>Safety</td>
<td>Selected aspects of safety for Victorian children, young people and their families are covered, focusing on three key issues: the prevalence of preventable and accidental injuries to children and young people, the prevalence of antisocial or criminal behaviour by Victorian young people, and issues associated with Victorian children and young people being the victims of crime. Specific issues relating to harm occurring to children and young people through sexual assault and assault are also discussed.</td>
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<td>11</td>
<td>Parents promoting child health and development</td>
<td>Selected aspects of parental behaviour promoting health, development and wellbeing in Victorian children and young people are discussed, focusing on antenatal care and early childhood health, immunisation and the prevention of vaccine preventable illnesses, the prevention of sun-related damage, exposure to tobacco smoke within the home, and the early engagement of children in reading.</td>
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<td>12</td>
<td>Families, communities and social support</td>
<td>Issues relating to family functioning and family social supports for Victorian children and young people are examined. The key factors known to promote positive family functioning, including social support, participation in communities, and characteristics of neighbourhoods of children, as well as government services provided to vulnerable families, are considered. Issues of family violence and child abuse are also examined.</td>
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<td>Emerging trends across the report and a discussion of the next steps in monitoring and in utilising the report findings.</td>
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Chapter 1

References


Victoria’s Children, Young People and their Families
In line with the ecological model of the Victorian Child and Adolescent Outcomes Framework, outcomes for children and young people are influenced by a wide range of factors, including family, community and the wider society. In considering outcomes for children and young people in Victoria, it is important to contextualise and understand the size, distribution and composition of the population of Victorian children and young people, as well as the characteristics of their parents and families.

There are 1.2 million children and young people aged 17 years or younger living in Victoria, making up 22.5 per cent of the Victorian population. Most (71.8 per cent) live in metropolitan areas of the state and the remaining 28.2 per cent in regional areas.

Victoria’s children and young people are also a diverse group. About one in five is from a culturally and linguistically diverse (CALD) background and a small proportion (1.1 per cent) is of Aboriginal background.

While most Victorian children and young people experience very good overall health, a sizable proportion has special health care needs (14.5 per cent of children and 15.3 per cent of young people).

The majority of Victorian children and young people live in couple families, with over one in 10 living in lone-parent families (12.2 per cent of children and 13.1 per cent of young people).

The majority of children aged 12 years or younger (60.2 per cent) live in families with sufficient economic resources (annual household income of over $60,000 per annum). Of concern, however, one in 16 children live in families with annual household income less than $20,000 per year (6.1 per cent).

In a 2009 survey of Victorian children aged 12 years or younger (VCHWS 2009), over half of the mothers (59.7 per cent) and 88.3 per cent of fathers report they were in employment (including self-employment); 33.6 per cent of mothers and 4.1 per cent fathers in full-time home duty; and a very small proportion of parents report they were unemployed (1.4 per cent of mothers and 3.6 per cent of fathers).

Nearly eight in 10 Victorian children live in families who own, or are purchasing through a mortgage, their own home (78.1 per cent). The remainder are renting accommodation through the private rental market (15.9 per cent) or through public housing options (4.7 per cent). Over nine in 10 Victorian families with young children agree that their home meets their family’s general housing needs (92.3 per cent), leaving 7.7 per cent who think these needs are not being met.

Eight in 10 Victorian parents of children aged 0–17 years self-report their general health as being ‘excellent’ or ‘good’ (81.4 per cent), and two in 10 as being ‘fair or poor’ (18.5 per cent).

More than one in 10 parents of Victorian children aged 0–17 years (12.1 per cent) are under serious psychological distress and are at high or very high risk of a diagnosable mental illness or disorder. One in five parents of Victorian children aged 0–17 years have been diagnosed with depression or anxiety at some stage in life (23.3 per cent). They were more likely to suffer a mental health problem or disorder if they were unemployed and/or had low levels of income or education.
This chapter provides an overview of the most recent information about the number, growth, composition, locality and diversity of Victorian children and young people aged 17 years and younger. Information about important factors associated with their families is also examined.

In this report, data from two DEECD surveys – the 2009 Victorian Adolescent Health and Wellbeing Survey (HOWRU) and the 2009 Victorian Child Health and Wellbeing Survey (VCHWS) – are used to supplement previously published Census data from the 2006 Census of Housing and Population to provide a more recent picture of the demographic characteristics of Victorian children, young people and their families. The aim of these large population surveys is to be representative of the Victorian population and to enable reliable reporting on the characteristics of the population, as well as on a broad range of health and wellbeing outcomes. While the results from these two surveys are robust enough to be used for this purpose, to ensure the accuracy and consistency of reporting, comparisons are also made with similar information from the 2006 Census in this chapter (further information about these surveys is provided in the online technical report).

What is the total population of Victoria’s children, young people and their families?

The 2009 population estimates from the Australian Bureau of Statistics (ABS) state that there were approximately 1.2 million children and young people (645,000 males and 594,500 females) aged 17 years or younger living in Victoria. They represented nearly a quarter (24.1 per cent) of all children and young people aged 17 years and younger in Australia; and made up 22.5 per cent of the entire Victorian population, a proportion that is consistent with (albeit slightly lower than) that within the populations of other states and territories (ABS 2009a).

The total population of children and young people aged 0–17 years in Victoria is expected to grow from the current 1.2 million people to 1.6 million by 2056. However, the proportion of children and young people is expected to decrease steadily over the next half century in line with increased life expectancies and the ageing of the Victorian population (from the current 22.5 per cent to 19.5 per cent by 2056) (see Figure 2.1).

Figure 2.1: Population projections for Victorian children aged 0–17 years, 2011–56

Where do Victoria's children and young people live?

Consistent with the distribution of overall population in Victoria, most Victorian children and young people live in metropolitan areas of the state, with 874,000 (71.8 per cent) living in metropolitan areas compared to 344,000 (28.2 per cent) living in regional areas (see Figure 2.2). The concentration of children and young people is still largest near Melbourne and the surrounding area, with very small numbers of children and young people in more remote areas across the state (see Figure 2.3).

Figure 2.2: Distribution of population aged 0–17 years in each age group across metropolitan and regional Victoria, at 30 June 2009

Source: ABS Preliminary Estimated Resident Population by Single Year of Age, Sex and Statistical Local Areas of Victoria (unpublished), July 2009

Much of the information provided in this report compares the outcomes for children and young people living in metropolitan areas of Victoria to those living in regional areas. Regional and metropolitan areas in this report are based on government administrative regions. Metropolitan Victoria includes four metropolitan regions (Eastern, Southern, Western and Northern metropolitan regions), while regional Victoria comprises five non-metropolitan regions (Barwon South West, Gippsland, Grampians, Hume and Loddon Mallee).

However, there are some important distinctions to be made between the experiences, opportunities, and outcomes of children and young people living in regional cities (e.g. Geelong or Warrnambool) and those living in rural or more remote regions (e.g. Sea Lake in the Wimmera). Certainly those children, young people and their families living in larger towns or regional cities have significantly easier access to community and health services, educational institutions and social opportunities than those living in more remote regions. Given these differences in the populations of children and young people in regional areas, it is reasonable to consider that, while the information provided in this report is often presented in terms of outcomes for children and young people from metropolitan areas versus an aggregate of regional areas, there may be a greater disparity between metropolitan areas and small rural townships and areas.
How diverse are Victoria’s children and young people?

While children and young people are discussed in this report as a ‘group’ of the Victorian population, there are important differences within the population of children and young people, which can affect how they experience and respond to many of the risk and protective factors encountered.

Importantly, the health, development, learning, safety and wellbeing outcomes may differ according to the sub-group to which the child or young person belongs, such as children and young people from CALD backgrounds, including refugee children, and Aboriginal children and young people.

According to the ABS Census of Population and Housing 2006, there are approximately 13,000 Aboriginal children and young people in Victoria, making up 1.1 per cent of the total population of children and young people. Over half of Victoria’s Aboriginal children and young people live in regional areas of the state (56 per cent), with the remainder (44 per cent) living in metropolitan areas. An in-depth focus on outcomes for Victorian Aboriginal children was provided in The State of Victoria’s Children 2009: Aboriginal children and young people in Victoria.
According to more recent information from the 2009 Victorian Child Health and Wellbeing Survey (VCHWS) and the 2009 Victorian Adolescent Health and Wellbeing Survey (HOWRU), 5.4 per cent of 0–12 year olds and 12.9 per cent of 12–17 year olds were born overseas, with 18.5 per cent of 0–12 year olds and 23.6 per cent of 12–17 year olds speaking a language other than English at home (see Figure 2.4).

The results from VCHWS 2009 and HOWRU 2009 are broadly consistent with the information from the most recent ABS Census of Population and Housing 2006. The Census 2006 suggests that, in 2006, under a quarter of all Victorians were born overseas (23.8 per cent). Furthermore, around 20 per cent of Victorian children and young people spoke a language other than English at home (compared with 13.6 per cent of all children and young people in other states and territories). The most common languages other than English spoken at home by Victorian children aged 12 years or younger were Indian languages (2.6 per cent), Italian (2.5 per cent), Greek (1.8 per cent) and Arabic (1.7 per cent).

Refugee children are also an important component of the CALD sub-group. Although they make up a very small group in the population of Victorian children and young people, overall they face significant and pervasive challenges that affect their health, development, learning, safety and wellbeing. Of the 17,064 people who entered Victoria on humanitarian grounds in the period 2002–07, nearly half were children or young people aged 17 years or younger (47.8 per cent). Refugee children and young people living in Victoria are most likely to be Sudanese (21.9 per cent), Burmese (21.2 per cent), Afghanistani (15.3 per cent) or Iraqi (13.6 per cent) (Victorian Government 2009).

What is the overall health status of Victoria’s children and young people?

Most Victorian children experience very good overall health, with 98.5 per cent of the Victorian children aged 12 years or younger reported by their parents in VCHWS 2009 as having good, very good or excellent general health; while 89.2 per cent of the Victorian young people aged 12–17 self-reported in HOWRU 2009 survey as having ‘good health’. These two surveys show that a sizable proportion of Victorian children and young people have special health care needs (14.5 per cent of children aged 12 and under, and 15.3 per cent of young people aged 12–17 years). These are children who are reliant on medication, some form of physical, developmental, behavioural or emotional functional limitation (though they may or may not fall into the definition of having a disability); and are likely to use more health services than other children.
A considerable number of Victorian children and young people live with a disability, although it is difficult to provide accurate estimates because of debate surrounding the definition of a disability and identification problems even where a definition is agreed. There is very limited information on the prevalence of disability among children and young people in Victoria. The most recent information available from the 2003 Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers estimated that nationally 8 per cent of children have a disability and that the Victorian figure is slightly lower at 7 per cent (accounting for 67,170 children) (Victorian Government 2009). In this survey, disability is defined as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities.

In Victoria, reports by parents of children in their first year of primary school in the 2009 School Entry Health Questionnaire indicate that 4.4 per cent of children aged 5–6 years had a disability (including intellectual, developmental or learning disability) in 2009. In addition, a number of Victorian children are classified as ‘developmentally vulnerable’ through the Australian Early Development Index (AEDI), which measures five areas (or ‘domains’) of development in children, including physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge. These five domains are closely linked to the predictors of good adult health, education and social outcomes. Around one in five Victorian children (20.2 per cent) are considered developmentally vulnerable on one or more of the AEDI domains at entry to school. A small, but still significant proportion of children (10 per cent) are developmentally vulnerable on two or more domains (see Chapter 9 for further discussion).

What types of families do Victorian children and young people live in?

Family structure has been demonstrated to be important for a range of immediate, short-term and long-term outcomes for the health, development, learning, safety and wellbeing of children and young people.

The 2006 Census of Population and Housing showed that there were approximately 570,000 families with children aged 17 years or under in Victoria. In a 2010 survey of 9302 Victorians aged 11–24 years, conducted by Mission Australia, 98.7 per cent of 11–14 year olds and 95.6 per cent of 15–19 year olds indicated that they live with their families.

The 2009 VCHWS and HOWRU surveys estimate that more than one in 10 Victorian children (12.2 per cent) and young people (13.1 per cent) live in lone-parent families (see Figure 2.5).

![Figure 2.5: Distribution of Victorian children aged 0–17, by family type, 2009](image)

According to the 2006 Census, lone-parent families are much more likely to be headed by a mother than a father. The 2009 VCHWS and HOWRU surveys estimated that among Victorian children and young people who live in lone-parent families, most live in one headed by their mother (89.5 per cent of children aged 12 years or younger and 86 per cent of young people aged 12–17 years).

(Chapter 12 discusses family structure, the characteristics of families with healthy family functioning and social support).
To what resources do Victorian families have access?

The economic and social resources available to a child or young person have been demonstrated to be critical predictors, both as risk or protective factors, towards a broad range of outcomes for children and young people. These resources include financial resources, such as family income and parental employment associated with the capacity to access economic resources; and human resources, such as parental education and knowledge.

Family income

The amount of income available is of higher importance than other sources. Household income is closely linked with, and reflects, other measures of socioeconomic status of children and young people, such as parent education and employment. Access to higher income has been associated with better outcomes for children and young people; conversely, children and young people in families with limited incomes can face significant challenges in having their needs met.

The most recent ABS Household Income and Income Distribution 2008–09 (ABS 2009b) estimated that the average (median) level of gross household income in Victoria was $1286 weekly (equivalent to $66,872 yearly). To reflect this in the report, the cut-off point has been chosen at $60,000 of annual gross household income to divide the population into two comparable family groups in analysing VCHWS 2009 data.

Figure 2.6: Annual gross household Income of Victorian families of children aged 0–12 years, 2009

Source: VCHWS 2009, DEECD

Figure 2.6 indicates that the majority of children aged 12 years or younger (60.2 per cent) live in families with access to sufficient economic resources (over $60,000 per annum). Of concern, however, are the 6.1 per cent of children living in families with access to less than $20,000 per year. Given the inflation factor, this is generally consistent with data from the 2006 Census of Population and Housing showing that over half of Victorian families with aged 0–17 years had incomes of greater than $1000 per week (equivalent to 52,000 per annum); and 7.4 per cent of the families lived with a weekly income under $350 (equivalent to $18,200 per annum) (Victorian Government 2010).

While dependent children rely on their parents to provide the necessities in life, families are also the main source of income for most young people. A 2010 survey by Mission Australia of 9302 Victorian young people aged 11–24 years found that parents and family were their main source of income for 94.7 per cent of 11–14 year olds and 70.5 per cent of 15–19 year olds (Mission Australia 2010). Unsurprisingly, older adolescents were more likely to report employment as an additional source of income (22 per cent of 15–19 year olds).
Employment status of parents

Information on the employment status of parents of Victorian children is available from the VCHWS 2009 (see Figure 2.7). Of the mothers who responded to the survey, over half (59.7 per cent) indicated that they were in employment, including 11 per cent who were self-employed, contrasting with 68.2 per cent and 20.1 per cent of fathers, respectively.

Figure 2.7 Employment status, parents of Victorian children aged 0–12 years, 2009

A considerable proportion of mothers indicated that they were engaged in home duties (33.6 per cent), an expected result given their likely role as primary carers of children in the 0–12 age range, with only 4.1 per cent of the fathers classifying themselves as such.

Only a very small proportion of parents indicated that they were unemployed (1.4 per cent of mothers and 3.6 per cent of fathers). Of the employed mothers, most (73 per cent) indicated that their employment was permanent and ongoing. Of note is the discrepancy between the numbers of mothers and fathers engaged in casual work – 20 and 6.5 per cent, respectively (see Figure 2.8).

Figure 2.8: Employment type of parents of Victorian children aged 0–12 years who are in employment, 2009

Source: VCHWS 2009, DEECD
**Education level of parents**

Education level of parents, in particular the education level of mothers, has been shown to be a significant protective factor towards many different outcomes for children and young people. Evidence suggests that the higher the education level of the mother, the more likely it is that a child will have positive outcomes.

VCHWS 2009 indicated that the majority of Victorian children aged 0–12 years (84.2 per cent) are cared for by mothers with an education level equivalent to, or exceeding, Year 12 (see Figure 2.9).

The 2006 Census of Population and Housing showed that 26.4 per cent of couple families in Victoria with children live in households where neither parent has completed Year 12 or equivalent. Significantly, this rises to more than half (56.3 per cent) in Victorian one-parent households (Victorian Government 2009).

**Figure 2.9: Highest level of education of mothers of Victorian children aged 0–12 years, 2009**

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Per cent</th>
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<tbody>
<tr>
<td>University or other tertiary degree</td>
<td>41.4</td>
</tr>
<tr>
<td>TAFE/trade certificate or diploma</td>
<td>24.3</td>
</tr>
<tr>
<td>Completed high school (i.e. year 12)</td>
<td>18.5</td>
</tr>
<tr>
<td>Not completed high school</td>
<td>15.8</td>
</tr>
</tbody>
</table>

*The majority (98 per cent) of survey respondents in the survey are biological parents of child, of whom 83.2 per cent are mothers of the child.

Source: VCHWS 2009, DEECD

**Socioeconomic status (SES) and financial hardship**

Hardship experienced due to shortage of money is perhaps a more direct measure of how Victorian families are faring in relation to their economic resources. Two measures of socioeconomic status (SES) are used throughout this report in analysing and comparing outcomes of sub-population groups of Victorian children and young people: household income and the Socioeconomic Index for Area (SEIFA) Index of Relative Socioeconomic Disadvantage (IRSED) (produced by the ABS, based on the 2006 data from the 2006 Census of Population and Housing). The Index has been used as a proxy of SES measure in the analyses where there are no other SES data available. It is derived from the attributes of a small geographic area, such as low income, low educational attainment, high unemployment, jobs in relatively unskilled occupations and other variables indicative of disadvantage. The higher a geographic area’s value on the index, the less disadvantaged that area is compared with other areas. Areas can also be grouped into quintiles based on their IRSED scores to provide groupings by level of disadvantage, with quintile one being the most disadvantaged, and quintile five, the least disadvantaged. It is, however, recognised that the use of the SEIFA Index data is imperfect because of its incurrence and since it is an area-based, not household-based measure.

Of note, 26 per cent of children and 24.3 per cent of young people within Victoria live in areas of high socioeconomic advantage, compared to the 16.2 per cent of children and 18.5 per cent of young people who live in the most disadvantaged neighbourhoods (Figure 2.10). These are the children and young people whose families are more likely to undergo financial hardship.
While VCHWS 2009 showed that most children in Victoria (86.7 per cent) come from families who can raise $2000 within two days if an emergency arises, this still leaves over 10 per cent of Victorian children in families who have limited access to emergency funds. Similarly, although the majority of Victorian young people did not report directly experiencing hardship due to a shortage of money (97 per cent) in HOWRU 2009, a small number of those aged 12–17 years (1.4 per cent) did.5

What is the housing situation of Victorian families?

Housing situation of families has important influences on outcomes for children and young people. A range of aspects relating to housing are known to affect children's outcomes, including housing instability or homelessness, frequent ‘moving’ by the family, overcrowding in the home, housing stress (paying more than 30 per cent of household income on housing costs) and locality.

Housing stability

Stability of housing has been shown to be an important influence on outcomes for children and young people. While owning your own home is not a guarantee of housing stability, home ownership is considered to be the most stable form of housing, followed by rental accommodation in the private sectors and public housing.

VCHWS 2009 suggests that most Victorian children live in families who own or are purchasing through a mortgage their own home (78.1 per cent). The remainder are renting accommodation through the private rental market (15.9 per cent) or through public housing options (4.7 per cent) (see Figure 2.11). The survey also shows that the majority (92.3 per cent) of Victorian families with children aged 12 years or younger agree that their home meets their family’s general housing needs, leaving 7.7 per cent who believe their needs are not being met.6
These findings are roughly consistent with the 2006 Census of Population and Housing, which showed that most Victorian families (with children) (75.1 per cent) either fully owned or were purchasing their home, with 3.2 per cent in state authority housing (public housing). Of note, were the marked differences in tenure type for Aboriginal families and lone and two-parent families. The highest proportion of families with children in public housing was Aboriginal lone-parent families. Aboriginal families were also less likely to be home owners than non-Aboriginal families (ABS 2006).

Housing stress

When housing costs are high, people have less residual income to spend on other essential items. Households that spend more than 30 per cent of their incomes on housing expenses, particularly in the bottom two household income quintiles, are considered to be in ‘housing stress’. Lone-parent and low-income families with young children are the most likely to experience housing stress (Gabriel et al. 2005).

The 2006 Census of Population and Housing showed that the majority of families spend less than 30 per cent of income on housing. Households with the highest incomes ($4000 or more per week) are more likely than other households to spend smaller proportions of their income on housing, particularly compared to households with the lowest incomes weekly income $349 or less. In general, the lower the household income, the greater the proportion the spent on housing costs (Victorian Government 2009, p. 145).

How healthy are Victorian parents?

The health and wellbeing of parents and main carers has been demonstrated to have important influences on outcomes for children and young people. Eight in 10 Victorian parents of children aged 0–17 years self-report that their general health being ‘excellent’ or ‘good’ (81.4 per cent), and two in 10 (18.5 per cent) as ‘fair or poor’ (see Figure 2.12).

The health of the mother before, during and immediately after pregnancy is critical to ensuring a child’s maximal health, development, learning, safety and wellbeing outcomes throughout life (see further discussion in Chapter 11 on parent-promoted health and development). In particular, poor parental mental health is a risk factor for a range of negative child and adolescent outcomes. (See Chapter 12 on family functioning and Chapter 6 on mental health for further discussions of the impact on parental mental health on outcomes for children and young people).

Figure 2.12: Self-reported health status of parents of Victorian children and young people, 2008^  

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^Parents with dependent children aged 0–18 years;  
*Indicates data are not statistically significantly different across different income categories at 95 per cent confidence intervals.  
Source: Victoria Population Health Survey (VPHS) 2008, Victorian Department of Health
Furthermore, Figure 2.14 shows that almost one in five parents of Victorian children aged 0–17 years has been diagnosed with depression or anxiety at some stage of life (23.3 per cent). They were more likely to suffer a mental health problem or disorder if they are females, unemployed, and/or have low levels of family income or education (see Figures 2.13 and 2.14). Poor mental health of parents co-existing with other risk factors, such as low family income and low level of parent education, often leads to poor outcomes for children and young people.

*Parents with dependent children aged 0–18 years.
*Based on the Kessler 10 (K10) scale, combined categories of high and very high level of psychological distress.
Source: VPHS 2008, Victorian Department of Health
Chapter 2
Endnotes

1. See *The State of Victoria’s Children 2010: Data Compendium* (Table A2.1) for detailed data.

2. See *The State of Victoria’s Children 2010: Data Compendium* (Table A2.2) for detailed data.

3. Note that the definition of disability in this survey is not the same as ABS definitions of core activity limitation or disability; see *The State of Victoria’s Children 2010: Data Compendium* (Table A2.3) for detailed data.

4. Socioeconomic Index for Areas (SEIFA) – Index for Relative Socioeconomic Disadvantage (IRSED) data have been matched with the postal codes in data from VCHWS 2009 and HOWRU 2009 surveys by using the 2006 ABS Postal Area (POA) data. Inaccuracy and mismatch could occur as: 1) the ABS POA is only an approximation of postcode, and 2) the 2006 POA may not capture some new postcodes developed after 2006 in Victoria. For example, there are 367 sample observations in HOWRU 2009 that are not matched into the SEIFA IRSED.

5. Total does not add up to 100 per cent as 1.6 per cent of the young people surveyed did not answer the relevant question.

6. See *The State of Victoria’s Children 2010: Data Compendium* (Table A2.4) for detailed data.
Chapter 2

References

- (2009b), Household Income and Income Distribution, Australia: Detailed tables, 2007–08 (Table1.1B). Cat. No. 6523.0. ABS, Canberra.
Healthy Weight
Healthy Weight

Overweight and obesity are directly related to a wide range of poor health outcomes for children and young people, impacting on their overall health and wellbeing. Overweight children are likely to become overweight adolescents. Childhood and adolescence are particularly important times to promote the value of healthy weight, eating and exercise habits.

While most Victorian children and young people are within the healthy weight range, a considerable proportion are overweight or obese (12.4 per cent of 2 year olds, 15.4 per cent of 3.5 year olds and 25.3 per cent of children aged 5–17 years).

Maintaining a nutritious diet is a key factor in promoting healthy weight. The World Health Organisation (WHO) and the National Health and Medical Research Council (NHMRC) both recommend fully breastfeeding of infants until six months of age. Adequate consumption of fruit and vegetables and limited consumption of sugary and fatty foods and drinks are important dietary considerations in maintaining a healthy weight.

The proportion of Victorian infants fully breastfed has remained relatively stable over the last decade, with around half of Victoria’s infants being fully breastfed at 3 months, which decreases to 37 per cent by the time infants reach 6 months of age. Women with a university degree or higher are significantly more likely to have breastfed their child for 6 months or more.

One in three Victorian children (33 per cent) and one in five young people (19 per cent) eat the recommended serves of fruit and vegetables each day.

Over half of Victorian children (55.4 per cent) rarely if ever consume sugary drinks (improved from 41.5 per cent in 2006). However, over one third eat fast food at least once a week (34.3 per cent) and two in three have fried-potato products (including chips, French fries, wedges and crisps) at least once a week (66.8 per cent). Regular consumption of sugary drinks, fast food and fried-potato products is significantly more common for children from families with lower household income (less than $60,000 per year) than for those from families with higher household income ($60,000 per year or higher).

Being physically active is a key factor in promoting a healthy weight. The NHMRC recommends that children and young people aged 5–18 years should have at least one hour of physical activity per day. Time spent in ‘sedentary’ activities, such as watching television or using the internet, should be limited to less than two hours a day.

Six in 10 Victorian children aged 5–12 years (60.3 per cent) are physically active for at least one hour per day, with nearly two in 10 spending two hours or more each day using electronic media (18.8 per cent). Children are less likely to do this amount of daily physical activity as they get older and more likely to spend two hours or more each day using electronic media. Around one in eight Victorian young people are physically active at least one hour each day (12.3 per cent), and six in 10 spend two or more hours daily using electronic media (58.7 per cent).

There are complex interrelationships between the many aspects of a child’s life influencing the body weight. Promoting healthy weight requires effort, not just by individuals, but by their families, communities and the wider society.
This chapter examines the issue of healthy weight in Victorian children and young people. Issues explored are the main influences on promoting and maintaining a healthy weight, including physical activity and limited sedentary (inactive) behaviours, diet and nutrition and the role of families and parents in promoting healthy weight.

Over the past few decades, the number of overweight or obese people has increased dramatically in developed countries, including Australia. Establishing patterns of good eating and physical activity in childhood helps ensure that children and young people maintain a healthy body weight before they enter adulthood, thus providing the best start for optimum physical and mental development. It also helps reduce the risks of serious health and social problems associated with being overweight or obese later in life.

Maintaining a healthy weight is about getting a suitable balance between the amount and the types of food we consume and the amount of physical activity we undertake, which is right for our individual biological make-up. However, this seemingly simple choice for people to ‘choose’ healthy options is influenced by many complex factors, ranging from genetic and biological make-up of an individual, to family and educational environments and broader community and cultural influences. The marketing and growth of the fast food industry and increased sedentary lifestyles (such as an increasing reliance on cars as the primary means of transport and a wider use of electronic media, including digital television, internet and computer games) are also considered to be important factors contributing to overweight or obesity in the past few decades.

The Australian National Preventative Health Strategy acknowledges the complexity of the social, cultural and economic factors influencing healthy weight and has identified strategies to reduce overweight and obesity through working with individuals and families, state and local governments, health care providers (including maternal and child health services), communities, schools, workplaces, the food and beverage industry and the advertising industry (National Preventative Health Taskforce 2009). Figure 3.1 shows a conceptual map of these complex interrelationships between potential determinants of overweight and obesity in children.

Figure 3.1: The complex web of potential determinants of overweight and obesity in children

Source: Monasta et al. 2010

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This document is part of a larger text on Healthy Weight.
Healthy weight

Why is having a healthy weight important?

A child who is overweight at 2 years has a greater than 50 per cent chance of being overweight by adolescence, a tendency that will continue into adulthood. (Choudhary et al. 2007:111)

Overweight and obesity are related to a wide range of poor health outcomes, such as cardiovascular disease (including stroke), Type 2 diabetes, some cancers, osteoarthritis, kidney and gall bladder diseases, respiratory diseases (such as asthma) and musculoskeletal problems. Moreover, overweight and obesity often cause ‘comorbidities’ (where people suffer from two or more of these conditions at the same time) and have been proven to substantially decrease life expectancy. In addition, overweight and obesity can lead to social discrimination and stereotyping, isolation, peer problems and can significantly reduce self-esteem and social and emotional wellbeing.

(See Chapter 5 for an in-depth discussion of children and young people’s social and emotional wellbeing).

Key policy directions relating to healthy weight for children and young people

- World Health Organisation (WHO), Global Strategy on Diet, Physical Activity and Health, 2004
- Population-based Prevention Strategies for Childhood Obesity, 2009
- Global Strategy for Infant and Young Child Feeding, 2003
- National Physical Activity Recommendations for:
  - Children 0–5 years, 2010;
  - Children 5–12 years, 2004;
  - Young People 12–18 years, 2004
- National Health and Medical Research Council (NHMRC), Dietary Guidelines for Children and Adolescents, 2003

Key Victorian Government initiatives: Healthy weight

Commitments and new initiatives

- Early intervention programs to help vulnerable parents with child rearing
- The Premier’s Active Families Challenge and Ride2School
- Establish a Victorian Healthy Eating Advisory Service
- $40 million in new preventative health initiatives for children including:
  - A new statewide policy for Health Promotion for Children and Young People
  - Preventative Community Model across 14 LGAs
  - Victorian Prevention and Health Promotion Achievement program for schools and early childhood settings
- Victorian Breastfeeding Action Plan to help services and the community promote and support breastfeeding

Programs in place

- The School Canteens and Other School Food Services Policy
- Mandated timetabling for sport and physical education in schools
- Healthy Eating Programs and VELS-based nutrition curriculum in Government schools
- Evaluation of Kids-Life early intervention pilot projects for overweight children in three regions
- Broader child, family and community health services
- Health Weight/BMI – MCH Program.
For many people, being overweight or obese starts in childhood. Strong evidence suggests that children who are overweight during their childhoods are more likely to continue to gain weight and to be overweight by the time they are adolescents. Obese children are more likely than children of healthy weight to become obese adults, leading to the earlier development of chronic diseases, such as cardiovascular disease and diabetes. Given the pattern of weight gain from childhood to adolescence, and then into adulthood, childhood to adolescence is a particularly important time to promote healthy weight, eating and exercise habits and to identify and treat weight gain before they progress to adult obesity.

Children and young people are commonly characterised as ‘underweight’, ‘healthy/normal weight’, ‘overweight’ or ‘obese’ depending on their Body Mass Index (BMI) score and age (Lobstein et al. 2004). The BMI calculates a person’s body weight as a proportion of body height (squared). Information that uses ‘measured’ BMI (where a child’s weight and height have been physically measured) is more accurate than information where height and weight is ‘reported’ by parents or young people themselves. (Information using 'measured' weight and also 'self-reported' weight is presented in this chapter).

A recent systematic 23-year review (1985–2008) of research measuring Australian children's height and weight found that the proportion of Australian children and young people who were classified as overweight and obese had remained stable over the past decade, at between 21–25 per cent of all children and young people (Olds et al. 2010). The National Secondary Students’ Diet and Activity (NaSSDA) survey 2009–10 provides the most recent information on the prevalence of overweight and obesity among Australian secondary school students. It was based on a nationally representative sample of 12,188 secondary school students from Years 8–11. Information about the BMI of these young people was based on measured rather than self-reported body heights and weights of the survey respondents.

The NaSSDA survey 2009–10 estimates that, overall, 71.6 per cent of all students are within the healthy weight range; just under one in four students are overweight (18.2 per cent) or obese (5.5 per cent). These results are similar to those from the ABS National Health Survey 2007–08. The NaSSDA survey also highlights evidence of a strong influence of socioeconomic factors, with the prevalence of overweight and obesity significantly higher among students from areas of low socioeconomic status (SES) (27 per cent) compared to those from areas of medium SES (23 per cent) and areas of high SES (19 per cent).

Do Victorian children and young people have healthy weights?

_There are now an estimated 1.5 million young people under the age of eighteen in Australia who are overweight or obese._ *(Australian Government Healthy Weight 2008)*

Information from multiple sources indicates that the majority of Victorian children and young people are within the healthy weight range. The best available information about the body weights of Victorian preschool-aged children comes from a study by Nichols et al. (2010), which analysed the BMI data collected by nurses during Victorian Maternal Child Health consultations. Information of a total of 129,266 children aged 2 years and 96,164 children at 3.5 years from across 41 different local government areas across Victoria has been used in this study.

It found that a considerable proportion of young children were overweight or obese, consistently higher for 3.5 year olds than 2 year olds over this period (15–19 versus 12–14 per cent, respectively). Nonetheless, it found that the overall proportion of children who were overweight or obese decreased over the study period (see Figure 3.2). The study also found that children were more likely to be a healthier weight if they were female and if they were from a family with a higher socioeconomic status.
Factors that promote healthy weight in children and young people:
- A nutritious diet low in ‘energy dense’ foods and drinks
- Increased physical activity
- Limited sedentary behaviour
- Parents having healthy weights and lifestyles

Figure 3.2: Prevalence of overweight and obesity in 2 and 3.5 year old Victorian children, 1999–2007

Source: Nichols et al. (2010)
Using measured BMI scores, the most recent ABS National Health Survey 2007–08 (ABS 2009) estimated that the proportion of Victorian children and young people who were overweight or obese were similar to the national rate (19.2 per cent are overweight in Victoria versus 17.1 per cent nationally; and 6.1 per cent are obese in Victoria compared to 7.8 per cent nationally).

There is also parent-reported information available about the weight status of Victorian children when they start primary school (at age 5 or 6 years) (see Figure 3.3). The majority of Victorian children (90.6 per cent) were identified as being ‘healthy weight’ by their parents, with only 2.1 per cent as being overweight. This is in stark contrast to the information from the 2010 Nichols et al. study, which estimated that around 15 per cent of this cohort (children aged around 3–4 years in 2007) was overweight or obese.

There is also recent self-reported information about the weight status of Victorian young people from HOWRU 2009. Figure 3.4 shows that, overall, 61.7 per cent of young people rated their weight status as ‘about right’. However, a significant number of young people rated themselves as ‘overweight’ (23.1 per cent), which is similar to the proportion of children and young people classified as overweight by the ABS National Health Survey (25.3 per cent).

Figure 3.3: Parent-reported prevalence of overweight and obesity of Victorian children aged 5–6 years, by population groups, 2010.

Source: School Entry Health Questionaire (SEHQ) 2010, DEECD

Figure 3.4: Prevalence of self-reported overweight and obesity of Victorian young people aged 12–17 years, 2009

Source: HOWRU 2009, DEECD
Analysis of this information also shows that there are important differences between groups of Victorian young people on how they report their weight status. Notably, female young people in Victoria were more likely to report themselves as ‘overweight’, whereas males were more likely to report themselves as ‘underweight’. This finding is not unsurprising given the different gender patterns of body image and satisfaction. (Chapter 5 provides a further discussion of body image).

Physical activity

Why is physical activity important for children and young people?

Physical activity is one of the key influences on maintaining a healthy weight, and therefore preventing overweight and obesity and the related development of chronic diseases. While physical activity is critical to healthy weight, it is also valuable in the long term in protecting against some cancers, strengthening the musculoskeletal system and reducing the chances of developing osteoporosis (a disease of low bone-mineral density). Physical activity is known to have a positive impact on mental health and wellbeing, including reducing stress, anxiety and depression.

Two aspects are important when discussing the impact of physical activity on Victorian children's and young people's weight:

- amount, frequency and vigour of physical activity
- amount of time spent in inactivity or sedentary activity.

(Sedentary activities are important as they are often undertaken at the expense of physical activity).

Cultural and social changes have driven changes in the amount of physical activity children and young people undertake. The explosion of multimedia, including digital television, the internet (social media), computer games and other electronic media, encourages more time in sedentary behaviour and less time physically active.

Physical activity guidelines for children and young people:

Children and young people aged 5–18 years should have at least one hour of moderate-to-vigorous physical activity every day and should not spend more than two hours a day using electronic media for entertainment (such as computer games, watching television or using the internet).

Infants, toddlers and preschoolers aged 5 years or younger should not be sedentary, or kept restrained or inactive for more than one hour at a time, with the exception of sleeping (Australian Government 2004a, 2004b).

Nationally, the NaSSDA survey 2009–10 shows that around 15 per cent of secondary school students met the daily physical activity recommendations. It found that male students were more likely than female students to engage in recommended levels of physical activity (22 per cent versus 8 per cent). Of all students, 71 per cent reported spending more than two hours using electronic media for entertainment on an average school day, while 83 per cent reported spending this amount of time using electronic media for entertainment on the weekend. Males were more likely than females to exceed the recommended time spent on electronic media recreation, on both school days and on the weekend.
How many Victorian children and young people are physically active?

Information from recent DEECD surveys show that 60.3 per cent of Victorian children (aged 5–12 years) are meeting the national physical activity recommendations and having at least one hour of physical activity every day. However, as the child ages, activity levels appear to drop off dramatically, with only 12.3 per cent of young people aged 12–17 years getting sufficient physical activity each day (see Figure 3.5).

There is also a difference between male and female children and young people in physical activity patterns. Males are more likely to meet the physical activity guidelines than females, and this difference becomes even more pronounced once they reach adolescence (see Figure 3.5).

**Figure 3.5: Proportion of Victorian children and young people who meet the Australian physical activity guidelines, by age group and sex, 2009**

Not surprisingly, there is an inverse relationship between the amount of physical activity children and young people undertake, and their amount of sedentary activity (spending two or more hours each day using electronic media).

Figure 3.6 indicates that over half (58.7 per cent) of all young people aged 12–17 years use electronic media for two or more hours each day, in contrast to 18.8 per cent of children aged 5–12 years. Males, regardless of their age, are more likely than females of the same age to spend two or more hours each day using electronic media.

**Figure 3.6: Proportion of Victorian children and young people who spend two or more hours per day using electronic media, by age group and sex, 2009**

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Source: HOWRU 2009, DEECD; VCHWS 2009, DEECD
Nutrition

How important is a nutritious diet for healthy weight in children and young people?

Nutrition is critical to health and wellbeing outcomes from birth. Maternal health and nutrition before and during pregnancy, and then early infant nutrition (particularly breastfeeding) are important factors in promoting optimal physical growth and mental development, disease prevention and lifelong health. There are three aspects of nutrition that are particularly important when considering healthy weight in Victorian children and young people: breastfeeding, consumption of fruit and vegetables, and consumption of sugary drinks (including fruit juice) and fatty foods.

The World Health Organisation (WHO) and the NHMRC in Australia, which stipulate the nutritional requirements of infants, recommend fully breastfeeding infants until the age of six months, with continued breastfeeding along with complementary feeding to 2 years of age and beyond. (Fully breastfed infants are those who have breast milk as their main source of nourishment, and include those that have only breast milk, and those infants who are predominantly breastfed but may also have water). There is convincing evidence that breastfeeding provides a range of immediate, short and long-term nutritional, health, social and economic benefits both to the child and the wider community. There is also growing evidence to suggest that children are less likely to be overweight or obese if they were breastfed as babies (House of Representatives 2007).

NHMRC outlines the recommended daily intake of fruit and vegetables for children and young people (see Table 3.1). Fruit and vegetables are a significant source of vitamins and minerals, dietary fibre, complex carbohydrates and folic acid, essential for optimal physical and mental development in children and young people.

Table 3.1. National Health and Medical Research Council (NHMRC) dietary guidelines for consumption of fruit and vegetables by children and adolescents, 2003

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Recommended number of serves per day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fruit</td>
</tr>
<tr>
<td>4–7</td>
<td>One (1)</td>
</tr>
<tr>
<td>8–11</td>
<td>One (1)</td>
</tr>
<tr>
<td>12–18</td>
<td>Three (3)</td>
</tr>
</tbody>
</table>

Eating sufficient quantities of fruit and vegetables daily and limiting the amount of high sugar, high salt and high fat foods (e.g. cakes, biscuits, crisps, fried chips and other ‘fast food’ that are often energy dense) and sugary drinks (e.g. cordial, soft drinks, sports drinks and fruit juices) are fundamental to a healthy diet in childhood and adolescence and the key influences on maintaining a healthy weight. Excessive consumption of sugary drinks has been linked to childhood obesity and poor oral health.

(See Chapter 4 for a further discussion on the link between diet and oral health).

The NaSSDA survey 2009–10 shows that, nationally, 24 per cent of secondary school students reported meeting the recommended daily requirement of four or more serves of vegetables; 41 per cent) students reported eating the recommended three or more daily serves of fruit. When combined, only around 14 per cent of students reported meeting both the vegetable and fruit dietary recommendations. Furthermore, the survey found that 30 per cent consumed four or more cups of soft drink, cordials and sports drinks (excluding diet varieties) per week.
How many Victorian children and young people have nutritious diets?

The proportion of Victorian infants fully breastfed at 3 and 6 months of age has remained fairly stable over the last decade. Figure 3.7 shows that around half of Victorian infants are fully breastfed at age 3 months, but the rate drops to around 37 per cent by 6 months, well below the WHO and NHMRC recommendations.

Figure 3.7: Proportion of infants fully breastfed* at age 3 and 6 months, Victoria

Evidence from VCHWS 2009 indicates that the duration of breastfeeding is influenced by the mother’s education level (Figure 3.8). Victorian infants whose mothers have university-degree qualifications are more likely to be breastfed for six months or longer than infants whose mothers have lower-level qualifications. There is currently no reliable means to compare Victorian rates with overall national rates of breastfeeding, due to varying definitions of breastfeeding in data collections in the states and territories. However, recent commentary by the Australian Institute of Health and Welfare (AIHW 2009) suggests that declining rates of breastfeeding as infants get older is consistent across Australia.

In terms of fruit and vegetable intake, the most recent available data indicates that only 33 per cent of children and 19 per cent of young people eat the recommended number of daily serves, consistent for both males and females. The proportion of Victorian children and young people eating the recommended serves decreases as the child ages (see Figure 3.9).

Figure 3.8: Duration of fully breastfeeding of Victorian children aged under 2 years, by mother’s highest level of education, 2009

*The fully breastfed rate is the combined rate of exclusively breastfed and predominantly breastfed. An exclusively breastfed infant receives only breast milk with no other liquids or solids except vitamins, mineral supplements or medicines. A predominantly breastfed infant receives breast milk and water, water-based drinks, fruit juice or oral rehydration salts but no breast milk substitutes or solids.

Source: Victorian Maternal and Child Health Annual Reports, DEECD

Evidence from VCHWS 2009 indicates that the duration of breastfeeding is influenced by the mother’s education level (Figure 3.8). Victorian infants whose mothers have university-degree qualifications are more likely to be breastfed for six months or longer than infants whose mothers have lower-level qualifications. There is currently no reliable means to compare Victorian rates with overall national rates of breastfeeding, due to varying definitions of breastfeeding in data collections in the states and territories. However, recent commentary by the Australian Institute of Health and Welfare (AIHW 2009) suggests that declining rates of breastfeeding as infants get older is consistent across Australia.

In terms of fruit and vegetable intake, the most recent available data indicates that only 33 per cent of children and 19 per cent of young people eat the recommended number of daily serves, consistent for both males and females. The proportion of Victorian children and young people eating the recommended serves decreases as the child ages (see Figure 3.9).

Figure 3.8: Duration of fully breastfeeding of Victorian children aged under 2 years, by mother’s highest level of education, 2009

*Indicates data are not statistically significantly different at 95 per cent confidence intervals.

Source: VCHWS 2009, DEECD
The majority of young children rarely if ever consumed sugary drinks (64.9 per cent of children aged 1–4 years); however, as children get older, they are more likely to start consuming at least one cup of sugary drink per day (see Figure 3.10). Overall, 55.4 per cent of Victorian children aged 1–12 years rarely if ever consume sugary drinks. In comparison with the information collected from the same survey in 2006, this suggests an overall increase in the number of children who do not drink sugary drinks (41.5 per cent in 2006 compared with 55.4 per cent in 2009) (DEECD 2010).

The consumption of sugary drinks among Victorian children differs according to family household income and residential areas of children or families (Figure 3.11). Children from families with lower levels of household incomes (less than $60,000 per year) are significantly more likely than those from households with higher incomes to consume sugary drink on a daily basis (51.7 per cent compared with 40.8 per cent). In addition, children who live in regional areas of state are more likely than those in metropolitan areas to have sugary drink daily (48.5 versus 42.7 per cent, respectively).
Not surprisingly, the same general patterns of consumption of sugary drinks by Victorian children apply to their consumption of fatty foods (e.g. take-away fast foods and also fried ‘chips’). According to VCHWS 2009, close to two thirds (66.8 per cent) of all Victorian children aged 12 or under eat fried-potato products (including chips, French fries, wedges, and crisps) at least once a week, with the rate higher among 5–12 year olds (71.9 per cent).\(^1\) Children from families with lower levels of household income are more likely to do so four or more times a week (10.7 per cent) than children from families with higher levels of household income (7.3 per cent). Children living in regional Victoria are more likely to have fried-potato products at least once a week (72.3 per cent) than children living in metropolitan locations (64.7 per cent)\(^2\). (see Figure 3.12).

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**Figure 3.11:** Daily consumption of sugary drinks*, of Victorian children aged 1–12 years, by annual gross household income and area of residence, 2009

* Sugary drinks are defined in the survey as soft drinks, fruit juice, cordials, or sports drinks. One cup = 250ml; one can of soft drink = 1.5 cups.

Source: VCHWS 2009, DEECD

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* Includes chips, French fries, wedges and crisps.

Source: VCHWS 2009, DEECD
Relationship between physical activity and nutrition

For the purpose of this report, a further analysis has been undertaken to examine the relationships between nutrition and physical activity among Victorian young people aged 12–17 years using data from HOWRU 2009. The results suggest that young people’s behaviours related to healthy diet and physical activity differ depending on their age, gender and socioeconomic situation:

- Females are more likely than males to eat the recommended daily serves of fruit and vegetable and spend less than two hours using electronic media.
- Males are more likely than females to meet the recommended guidelines in terms of physical activity.
- Young people from the least socioeconomically disadvantaged areas are more likely than those from the most socioeconomically disadvantaged areas to meet the recommended daily serves of fruit and vegetable guidelines and are more likely to spend more than two hours per day using electronic media.
- Younger adolescents (aged 12–14 years) are more likely than older adolescents (aged 15–17 years) to meet the daily physical activity guidelines and spend less than two hours per day using electronic media.

Further, the results show that having a healthy diet and being physically active co-occur in the same population of young people. Young people who meet both physical activity and electronic media use guidelines are more likely than those not meeting either guideline to have a healthy diet (meet the dietary recommendations). On the other hand, young people who meet the daily fruit and vegetable guideline are more likely than those not meeting the guideline to be physically active or spend less time on electronic media.

Families promoting healthy weight

What role do parents and families have in promoting healthy weight for children and young people?

There is increasing evidence about the ways in which parents, carers, siblings and other family members influence healthy weight, physical activity and nutrition in children and young people. In particular, the following family factors are considered to be important:

- parents’ knowledge, values and beliefs about food
- role-modelling of positive nutrition and physical activity by parents and siblings
- child–parent interactions around, and about, food and physical activity
- parenting styles and supports (see Chapters 11 and 12 for further discussion about parent and family influences on outcomes for children and young people)
- the family socioeconomic situation (including parents’ educational, occupational and employment status) (see Chapters 2 and 12 for further discussion about the influence of family resources on outcomes for children and young people)
- the security of access to food (i.e. food security, or the stability of access to food and types of food).

National Physical Activity Guidelines: Active Australia 2003 recommends that adults engage in at least 30 minutes of moderate intensity physical activity at least five days per week. In terms of Victorian parents’ physical activity habits, data from the 2008 Victorian Population Health survey shows that just over two thirds of Victorian parents with children under 18 years do the recommended amount of physical activity (66.8 per cent).

The NHMRC Dietary Guidelines for Australian Adults 2003 recommends that adults eat at least five serves of vegetables and two serves of fruit each day. Data from the Victorian Population Health Survey 2008 show that only 47.7 per cent of Victorian parents with children under 18 years of age consume the recommended serves of fruit every day. Only 7.3 per cent of these parents have the recommended daily amount of vegetables (see Figure 11.8 in Chapter 11).
Endnotes

1. See detailed data in The State of Victoria’s Children and Young People 2010 Data Compendium (Table A3.1).

2. The detailed results of this logistical regression analysis are presented in The State of Victoria’s Children and Young People 2010 Data Compendium (Table A3.2).
Chapter 3
References


Chapter 3

References


• (2002). Global strategy on diet, physical activity and health.


Chapter 4

Oral Health
Oral health is an important component of having a good quality of life. Poor oral health can adversely affect a range of different outcomes for children and young people.

One of the key symptoms of poor oral health is tooth decay, which can be treated through filling or removing decayed teeth. Oral diseases and tooth decay are believed to be almost entirely preventable through proper nutrition, daily oral health care (such as tooth brushing), regular preventive visits to a dental professional, and the use of fluoride. One in four Victorian children aged 5–12 years (26.6 per cent) have had their teeth filled, 11.7 per cent have had one tooth or more extracted, and 7.1 per cent have had dental treatment under a general anaesthetic in hospital.

Since 2004–05, the rate of hospitalisations for dental related conditions in Victorian children aged four years and younger has been declining (especially in regional areas, from 87 to 56 hospitalisations per 10,000 between 2004–05 and 2009–10). However, at the same time, rates for 5–9 year olds have been increasing (more so in regional areas, from 86 to 97 children per 10,000 population).

Around nine in 10 Victorian children aged 5–12 years (91.1 per cent) have ever visited a dentist, and over six in 10 Victorian young people visit the dentist at least once a year (65.3 per cent of females versus 60.6 per cent of males).

Nearly eight in 10 Victorian young people (79 per cent) usually see a dentist for a preventive health check (with only 18.7 per cent usually attending to seek treatment for a problem). Nine in 10 Victorian young people (90.4 per cent) report that they can access dental services if needed.

Two thirds of Victorian children (66 per cent) and young people (67.4 per cent of young) brush their teeth twice a day. Seven in 10 parents of Victorian children aged 1–7 years assist their children to brush their teeth at least once a day (68.8 per cent).

Seven in 10 Victorian children receive fluoride by drinking fluoridated tap water (68.9 per cent), and most receive some fluoride through normal tooth-brushing with toothpaste containing fluoride (92.6 per cent). However, 21.7 per cent of regional children report drinking tank/rain water (which is non-fluoridated) as their usual source of drinking water.

There is clearly disparity in oral health outcomes of children and young people between metropolitan and regional Victoria. Socioeconomic influences are also apparent in oral health outcomes of Victorian children and young people. Tooth fillings, tooth extractions and hospital dental treatment occur more frequently in children from most disadvantaged areas and from regional areas of Victoria. They are also significantly less likely to engage in oral health prevention activities, such as tooth brushing, using fluoridated toothpaste, seeing a dental professional and using fluoridated water.
Oral health – the overall health of the whole mouth, including the teeth, gums, jaw and oral cavity – is an important component of having a good quality of life. Poor oral health can negatively affect a range of different outcomes for children and young people.

Among the Organisation for Economic Cooperation and Development (OECD) countries, Australia was ranked seventh for the oral health of its children and young people in 2002 (AIHW 2010). Despite Australia’s relatively high ranking in child oral health internationally, oral health continues to be a significant problem for many children and young people, particularly those from regional areas, Aboriginal and Torres Strait Islander children, adolescent males, children from lone-parent households, children and young people living with a disability and those from socioeconomically disadvantaged backgrounds.

In 2008–09, $6.7 billion dollars was spent on dental services (both treatment and prevention) in Australia, 61.5 per cent of which was paid for directly by individuals because most dental services (90.4 per cent) are supplied by private dentists in Australia (AIHW 2010).

Many lifestyle risk factors for poor oral health (such as poor diet) are also risk factors for chronic diseases, such as cardiovascular disease and diabetes, some cancers and chronic respiratory diseases. Improving risk factors for poor oral health may have additional benefits by also improving outcomes in other health areas in the long term.

One of the key symptoms of poor oral health is tooth decay. However, oral diseases and tooth decay are believed to be almost entirely preventable through proper nutrition, daily oral health care (such as tooth brushing), regular preventive visits to a dental professional and use of fluoride.

This chapter discusses issues relating to the oral health of Victorian children and young people, including the prevalence of poor oral health, then looks at how Victorian children and young people fare on the factors known to promote oral health, including tooth brushing, visiting a dental professional and use of fluoride.

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


### Programs in place

- Water Fluoridation
- Evidence-based Oral Health Promotion Resource
- Dental Program targeted to areas of high needs
- Dental Employment Program, Rural Dental Practitioners and Mobile Dental Units
- Oral Health Capacity Building
- Oral Health Component – MCH strategy
- Smiles 4 Miles Award Program

### Key Victorian Government initiatives: Oral health

**Commitments and new initiatives**

- Evidence based Oral Health Promotion Resource (2011) to support policy development and program implementation
- Healthy Families, Healthy Smiles – Early Intervention Oral Hygiene and Health Program

**Programs in place**

- Evidence-based Oral Health Promotion Resource
- Dental Employment Program, Rural Dental Practitioners and Mobile Dental Units
- Dental Program targeted to areas of high needs
- Oral Health Capacity Building
- Oral Health Component – MCH strategy
- Smiles 4 Miles Award Program
Oral health in children and young people

The foundations for good oral health are laid even before a child is born. Tooth development begins in utero, with teeth ‘buds’ becoming present within the gums of the embryo from around five weeks gestation. Once born, most children will ‘cut’ their first tooth within their first year of life. All of their primary (deciduous) teeth will usually have emerged by age 3, and at around 6 years children will begin to lose their primary teeth, which will be replaced by permanent (adult) teeth. All permanent teeth have usually emerged by the time a young person is aged 13, with the exception of their wisdom teeth, which usually emerge between 17 and 21 years.

What is the overall oral health status of Victorian children and young people?

In VCHWS 2009, parents of Victorian children aged 12 years and under report that almost all children have good, very good or excellent oral health (94.9 per cent). Similarly, the majority (81 per cent) of 12–17 year old Victorian young people report in HOWRU 2009 having good, very good or excellent oral health (see Figure 4.1). However, a significant proportion of young people (15.7 per cent) indicated they had only ‘fair or poor’ oral health compared with younger 1–12 year olds (5 per cent). This decline in oral health as a child ages is consistent with trends across Australia.

More males reported having fair or poor oral health compared to their female counterparts (18.9 per cent versus 12.4 per cent for the 12–17 year olds and 5.9 per cent versus 4.1 per cent for the 1–12 year olds). More children and young people from areas of the most socioeconomic disadvantage than those from areas of the least of socioeconomic disadvantage reported having fair or poor oral health (19.5 per cent compared to 13.7 per cent for the 12–17 year olds and 6.9 per cent compared to 4.2 per cent for the 1–12 year olds) (see Figure 4.1).

Figure 4.1: Oral health status of Victorian children and young people, by age, sex and areas of socioeconomic status (SES), 2009

<table>
<thead>
<tr>
<th></th>
<th>Excellent/very good</th>
<th>Good</th>
<th>Fair/poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Pop. 1–12 yrs (^)</td>
<td>17.8</td>
<td>37.1</td>
<td>45.1</td>
</tr>
<tr>
<td>Male 1–12 yrs (†)</td>
<td>17.8</td>
<td>37.1</td>
<td>45.1</td>
</tr>
<tr>
<td>Female 1–12 yrs</td>
<td>23.0</td>
<td>46.9</td>
<td>30.1</td>
</tr>
<tr>
<td>Most disad. 1–12 yrs</td>
<td>23.0</td>
<td>46.9</td>
<td>30.1</td>
</tr>
<tr>
<td>Least disad. 1–12 yrs</td>
<td>16.4</td>
<td>35.3</td>
<td>48.3</td>
</tr>
<tr>
<td>All Pop. 12–17 yrs</td>
<td>12.4</td>
<td>37.9</td>
<td>50.6</td>
</tr>
<tr>
<td>Male 12–17 yrs</td>
<td>12.4</td>
<td>37.9</td>
<td>50.6</td>
</tr>
<tr>
<td>Female 12–17 yrs</td>
<td>52.1</td>
<td>39.0</td>
<td>9.9</td>
</tr>
<tr>
<td>Most disad. 12–17 yrs</td>
<td>13.7</td>
<td>33.8</td>
<td>52.6</td>
</tr>
<tr>
<td>Least disad. 12–17 yrs</td>
<td>31.6</td>
<td>33.8</td>
<td>34.6</td>
</tr>
</tbody>
</table>

*Rated by parents of the children in VCHWS 2009.
†Self-reported status by students in HOWRU 2009.
*Indicates data are not statistically significantly different across the SES groups and between males and females at 95 per cent confidence intervals.
Source: HOWRU 2009, DEECD and VCHWS 2009, DEECD
To what extent do Victorian children and young people experience symptoms of poor oral health? *There is a significant concentration of dental conditions in the 2–10 year old range. This is primarily to do with the difficulties of managing more complicated dental treatment with young children in a dental clinic chair and the preference of dentists to carry out these treatments using a general anaesthetic.*

(Victorian Government 2007: vii)

Further understanding of the oral health of Victorian children can be achieved by looking at information on the usual reasons children visit the dentist, the incidence and frequency of toothache, the incidence of teeth fillings and teeth extractions and the number of dental treatments in hospital.

VCHWS 2009 indicates that over a quarter (27.3 per cent) of all 5–12 year old Victorian children have experienced a toothache at some stage, with the proportion significantly higher in regional areas (35.2 per cent) than for children living in metropolitan areas (24.1 per cent). In HOWRU 2009, the majority of young Victorian young people report rarely if ever having experienced a toothache (75.7 per cent). However, 16.4 per cent of young people reported experiencing toothache either sometimes or often. This proportion is similar to the rate in which Australian adults reported experiencing toothache in the past 12 months (15.1 per cent) (AIHW 2007).

HOWRU 2009 suggests that, of those young people aged 12–17 years who have ever attended a dentist, most visited for routine preventive consultations. Nearly one fifth (18.7 per cent) usually attended for treatment of an oral health problem, while the remaining four fifths (79.0 per cent) usually attended for a preventive check-up (see Figure 4.2).

Consistent with the self-reported rate of poorer oral health, young people from areas of the most socioeconomic disadvantage are significantly more likely to attend a dentist for treatment (26.1 per cent), compared with those from areas of the least disadvantaged areas (12.4 per cent) (see Figure 4.2).

Figure 4.2: Usual reason for visiting a dentist, young people aged 12–17 years, by areas of socioeconomic status (SES), Victoria, 2009

Over a quarter (26.6 per cent) of Victorian children aged 5–12 years have had their teeth filled; 11.7 per cent have had their teeth extracted; and 7.1 per cent also have had dental treatment under a general anaesthetic in hospital (see Figure 4.3). Consistent with the research evidence that oral health declines with age, more older children (aged 9–12 years) have had teeth filled (38.6 per cent), extracted (17 per cent) and had dental treatment under a general anaesthetic in hospital (8.2 per cent) compared with younger children (aged 5–8 years) (14.3, 6.2 and 5.9 per cent, respectively). Tooth fillings, tooth extractions and hospital dental treatment also occur more frequently in children from low socioeconomic areas and from regional areas of Victoria (see Figure 4.3).
Other information related to the oral health status of Victorian children and young people comes from records of hospital treatments. Ambulatory Care Sensitive Conditions (ACSC) are complaints for which hospitalisation is thought to be preventable if appropriate primary care treatment, prevention and early intervention strategies were received. Admissions to hospital for tooth decay and related causes are considered to be an ACSC, as appropriate oral health care should avoid the need for hospital-based treatment of dental problems. In 2004–05, ACSC for children aged 9 years or younger in Victoria accounted for 95 per cent of all hospital admissions for tooth decay and related causes in this age group (Victorian Government 2007).

Figure 4.3: Proportion Victorian children aged 5–12 years who have had dental treatments by age groups, location and areas of socioeconomic status (SES), 2009

<table>
<thead>
<tr>
<th>Location</th>
<th>All</th>
<th>5–12 yrs</th>
<th>9–12 yrs</th>
<th>5–8 yrs</th>
<th>Metropolitan</th>
<th>Regional</th>
<th>Least disad. areas</th>
<th>Most disad. areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>SES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least disad. areas</td>
<td>5.7</td>
<td>6.4</td>
<td>7.1</td>
<td>5.9</td>
<td>9.5</td>
<td>9.7</td>
<td>8.7</td>
<td>7.1</td>
</tr>
<tr>
<td>Most disad. areas</td>
<td>7.1</td>
<td>8.2</td>
<td>11.7</td>
<td>14.3</td>
<td>16.2</td>
<td>14.5</td>
<td>9.7</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Source: VCHWS 2009, DEECD. The overall rate of hospital admissions for dental-related conditions in Victorian children and young people has remained steady, at under 50 hospitalisations per 10,000 children, depending on the age of the child. The rate for children aged 4 years and younger has been declining between 2004–05 and 2009–10 (especially in regional areas, decreasing from 87 to 56 hospitalisations per 10,000 children as shown in Figure 4.4). However, at the same time, rates for children aged 5–9 years have been increasing (more so in regional areas, from 86 to 87 children per 10,000).

Various reasons may contribute to changes in the rates of hospital treatment for tooth decay in Victorian children. The progressive fluoridation of water supplies in regional areas since 2004 could explain the decrease in hospital admissions for young children under 4 years in regional areas (detailed discussion on water fluoridation takes place later in this chapter). Limited access to private dental professional in regional areas of Victoria might also impact on these rates of dental treatments performed in hospitals. Age-appropriate dental practices might also have an impact on these figures (e.g. needing to immobilise very young children through general anaesthetic to perform treatment). However, there is no substantiated explanation for the increase in admissions for 5–9 year olds.
Figure 4.4: Hospital separations due to tooth decay (dental caries and related causes), Victorian children and young people aged 0–17 years

*Including dental conditions under IDC codes of K02, K03, K04, K05, K06, K08, K12, K13, K098 and K099, and excluding dental conditions under K00, K01, K07, K091, K092, K10, K11, K14 and K09.

Source: Victorian Admitted Episodes Data (both public and private hospitals); ABS Preliminary Estimated Resident Population by Single Year of Age, Sex and Statistical Local Areas of Victoria 2010 (unpublished).

Promoting oral health in children and young people

The oral health of children in Australia greatly improved from the mid-1960s to the mid-1990s, largely due to progressive fluoridation of water supplies and oral health promotion activities (Spencer 2004).

Multiple factors help promote and maintain good oral health in children and young people, generally relating to appropriate diet and food intake, regular tooth brushing, regular dental check-ups, and the use of fluoride. Factors compromising oral health in children and young people include the frequent consumption of sugary foods and drinks, drinking alcohol and smoking tobacco. (Chapter 3 provides a detailed discussion of the consumption of sugary drinks in Victorian children, while further discussion of substance use by Victorian young people can be found in Chapter 8). Some diseases also predispose children and young people to poor oral health (e.g. HIV/AIDS, diabetes and bulimia) and some medical treatments (the use of antibiotics, chemotherapy and radiotherapy and medicines that cause dry mouth commonly prescribed for depression, anxiety, hypertension and acne) can impact negatively on oral health.

Do the tooth brushing routines promote and maintain oral health?

Brushing teeth twice a day (morning and night), in a manner that suitably cleans the teeth and gums, is a protective factor for maintaining good oral health. Around seven in 10 Victorian children (66 per cent) and young people (67.4 per cent) brush their teeth twice a day. Those from the most socioeconomically disadvantaged areas are significantly less likely to brush their teeth twice a day than those from the least disadvantaged areas. For example, 69.8 per cent of children and 72.4 per cent of young people in the least disadvantaged areas brush their teeth twice per day, compared to children and young people from the most disadvantaged areas (60 and 64.6 per cent, respectively) (see Figure 4.5).

Female young people aged 12–17 years in Victoria are also significantly more likely to brush their teeth twice daily (76.4 per cent) than males of the same age (58.6 per cent). (See Data Compendium for detailed data). The lower rates of tooth brushing in adolescent males and children and young people from lower socioeconomic areas are consistent with the poorer oral health status of these groups of Victorian outlined earlier in this chapter.
Not only is it important that teeth and gums are brushed twice daily, but teeth need to be brushed adequately to remove plaque for the prevention of gum disease and tooth decay. The Victorian Government recommends that parents help their children in brushing their teeth until age 7 years to ensure teeth are cleaned adequately and to regulate the amount of fluoride that the child swallows (see the Better Health Channel at www.betterhealth.vic.gov.au).

VCHWS 2009 indicates that over half (68.8 per cent) of all parents of Victorian children aged 7 years or younger help their children to brush their teeth at least once a day. However, only one third (33.9 per cent) of parents assist with tooth brushing for the recommended twice a day (see Figure 4.6). There is a significant decline in the proportion of parents who do so as a child ages; so while 83 per cent of children aged 4 years or younger have their parents assist with their tooth brushing (at least once a day), only 50.3 per cent of the parents of 5–7 year old children provide this help. Of significant concern are the 7.9 per cent of children aged 1–4 years and the 31.5 per cent of children 5–7 years in Victoria whose parents have never assisted them in brushing their teeth (see Figure 4.6).
Do Victorian children and young people use dental services?

*Early dental visits should be expected to reduce the child’s future dental risk – leading to improved oral health and reduced oral health costs. Because untreated dental disease increases in severity and necessitates more extensive and costly treatment secondary to postponing care, timely intervention has great potential to reduce overall costs associated with dental treatment in preschool children.* (Lee Bouwens et al. 2006)

Having regular oral health checks by a qualified dental practitioner is a key protective factor in the maintaining good oral health. Dental professionals (dentists or oral health therapists) have a vital role in promoting oral health, fostering the ability of a child, young person or their parents to manage and control oral health. Their services are also important in the early identification and treatment of tooth decay and oral disease.

There is evidence to suggest that the earlier a child has their first preventive dental visit, the less likely they will need restorative or emergency treatments and the greater the chance that the child will continue to see a dental professional for preventive visits.

Information on visits to private dental services is not routinely collected in Victoria or Australia. While information on children’s visits to Victorian public dental services is collected, the data do not provide a representative picture of dental treatment for all Victorian children due to the eligibility requirements relating to family income for public services. Consequently, the majority of the information available about dental treatments in children and young people in Victoria presented in this chapter comes from the two DEECD surveys, HOWRU 2009 and VCHWS 2009.

HOWRU 2009 suggests that most Victorian young people visit the dentist at least twice a year (41.6 per cent of female and 34.4 per cent of male young people). Young people from the most socioeconomically disadvantaged areas were significantly less likely to have seen a dentist at least twice a year (46.3 per cent) than young people from the least disadvantaged areas (32.4 per cent) (see Table 4.1).

Nine in 10 Victorian children aged 5–12 years (91.1 per cent) have seen a dentist at some stage in the past, with children from least disadvantaged areas more likely to have done so than children from more disadvantaged areas (89.9 per cent) (see Figure 4.7). Furthermore, Victorian children are more likely to visit the dentist as they get older, with almost all children (99 per cent) having been to the dentist by age 12 years. Of concern, however, is the proportion of primary school-aged children (26.6 per cent of 5 year olds) who have never seen a dentist (see Figure 4.8).

### Table 4.1: Frequency of visiting a dentist of Victorian young people aged 12–17 years, by sex and socioeconomic status (SES)*, 2009 (per cent)

<table>
<thead>
<tr>
<th>FREQUENCY</th>
<th>SEX</th>
<th>SES AREAS</th>
<th>Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Most disadvantaged</td>
</tr>
<tr>
<td>At least twice a year</td>
<td>34.4</td>
<td>41.6</td>
<td>32.4</td>
</tr>
<tr>
<td>Once a year</td>
<td>26.2*</td>
<td>23.8*</td>
<td>23.7*</td>
</tr>
<tr>
<td>Once in every 2 years</td>
<td>8.2*</td>
<td>7.4*</td>
<td>6.4*</td>
</tr>
<tr>
<td>Longer than 2 years</td>
<td>10.1</td>
<td>7.7</td>
<td>9.7*</td>
</tr>
<tr>
<td>Don’t know/unknown</td>
<td>21.2*</td>
<td>19.6*</td>
<td>27.8</td>
</tr>
</tbody>
</table>

*Data needs to be interpreted with caution given the large numbers of respondents where frequency of visiting the dentist is unknown.

*Indicates data are not statistically significantly different between males and females at 95 per cent confidence intervals.

Source: HOWRU 2009, DEECD
Figure 4.7: Use of dental services, Victorian children aged 5–12 years, by areas of socioeconomic status (SES), 2009

Source: VCHWS 2009, DEECD

Figure 4.8: Proportion of Victorian children who have used dental services, by age, 2009

Source: VCHWS 2009, DEECD
Nearly nine in 10 Victorian young people (86.6 per cent) report as needing dental services, with 90.4 per cent reporting that can access a dentist if needed (see Figure 4.9). Of concern, however, is the remaining 9 per cent of Victorian young people who do not see a need for dental services (for health promotion, prevention or treatment), and who reported they were unable to access a dentist if needed (8 per cent).

In line with most of the data on oral health outcomes for Victorian young people presented in this chapter, young males are significantly less likely than young females to report a need for, or have used, dentist services (84.5 compared with 88.8 per cent of females of the same age). Similarly, young people from the most socioeconomically disadvantaged areas are significantly less likely to report they 'need', or have used, dentist services than those from the least most socioeconomically disadvantaged areas (81.4 compared to 92.1 per cent, respectively); moreover, they are also significantly less likely to report that they can access dental services when needed (88.9 versus 93.1 per cent, respectively)(see Figure 4.9).

A number of factors may contribute to the difficulties in accessing dental services, including limited access to public dental services and the cost of private dental services. These obstacles are not limited to Victoria or to children and young people, and are experienced across Australia for all population groups.

Figure 4.9: Proportion of Victorian young people aged 12–17 years who need dental services, by sex and areas of socioeconomic status (SES),8 2009

<table>
<thead>
<tr>
<th>Need dental health services (*)</th>
<th>Can access dental health services if needed (†)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male*</td>
<td>Yes</td>
</tr>
<tr>
<td>Female*</td>
<td>No</td>
</tr>
<tr>
<td>Most disad.</td>
<td></td>
</tr>
<tr>
<td>Least disad.</td>
<td></td>
</tr>
<tr>
<td>All pop.</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10.4</td>
</tr>
<tr>
<td>Female</td>
<td>7.6</td>
</tr>
<tr>
<td>Most disad.</td>
<td>13.3</td>
</tr>
<tr>
<td>Least disad.</td>
<td>5.1</td>
</tr>
<tr>
<td>All pop.</td>
<td>9.0</td>
</tr>
<tr>
<td>Male</td>
<td>7.6</td>
</tr>
<tr>
<td>Female</td>
<td>9.0</td>
</tr>
<tr>
<td>Most disad.</td>
<td>9.8</td>
</tr>
<tr>
<td>Least disad.</td>
<td>5.9</td>
</tr>
<tr>
<td>All pop.</td>
<td>8.0</td>
</tr>
</tbody>
</table>

^ Those who reported having used or been identified in needing dental health services by young people themselves or their family members.
† Among those who reported having used dental health services and/or having been identified in needing dental health services by young people themselves or their family members.
* Indicates data are not statistically significantly different across the two categories at 95 per cent confidence intervals.
Source: HOWRU 2009, DEECD
How many children and young people use fluoride?

*Water fluoridation is a safe, effective public health measure that benefits everybody in the community regardless of age, gender, income or education level. Water fluoridation has been deemed one of the ‘Ten greatest public health achievements of the twentieth century’ by the United States Centres for Disease Control.*

(Victorian Government 2007)

Fluoride significantly decreases tooth decay by improving the structure of tooth enamel and reverses the decay process in early tooth decay. Fluoride can be applied through topical treatments (such as the use of fluoridated toothpaste and mouthwashes) and through systemic interventions (such as including small amounts of fluoride in water supplies). *(Table 4.2 lists recommended usage for children by age).* Fluoridated water provides dental benefits to both children and adults, but provides the greatest benefit when an individual has life-long exposure.

### Table 4.2: Victorian Government guidelines on use of fluoride toothpaste for children

<table>
<thead>
<tr>
<th>Age</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18 months</td>
<td>Should have their teeth cleaned by an adult, using water and no toothpaste. A health professional, however, may recommend the use of low-fluoride children’s toothpaste in some cases.</td>
</tr>
<tr>
<td>8 months – 5 years</td>
<td>Should have their teeth cleaned by an adult, using a pea-sized amount of low-fluoride children’s toothpaste smeared over the toothbrush. A health professional, however, may recommend the use of standard fluoride toothpaste in some cases.</td>
</tr>
<tr>
<td>6 years and over</td>
<td>6 years and over A standard fluoride toothpaste should be used.</td>
</tr>
</tbody>
</table>


### Figure 4.10: Type of toothpaste used (Victorian children age 1–12 years), by area of residence, 2009

Source: VCHWS 2009, DEECD

Most Victorian children receive some fluoride through normal tooth brushing with fluoridated or low fluoride children’s toothpaste (92.6 per cent; *(see Figure 4.10)*). However, a few parents (2.3 per cent of children) choose to use non-fluoride toothpastes. Parent-assisted tooth brushing can also assist to reduce the amount of fluoride swallowed by their children by encouraging them to spit excess toothpaste into the sink and rinse.
Victorian children and young people can also obtain fluoride through fluoridated drinking water. Artificial water fluoridation has progressively occurred across Victoria since 1962. By 2010, 90 per cent of Victorians had fluoridated water supplies, either through natural or artificial fluoridation. Australia’s National Oral Health Plan includes a goal to extend fluoridation around Australia. However, due to the widespread use of tank water (particularly in regional areas of Victoria), bottled or filtered water, some Victorian children and young people still do not have access to fluoridated drinking water in a systematic way. This is especially the case in regional areas, where 21.7 per cent of children drink tank/rain water (non-fluoridated) as their usual source of drinking water (see Figure 4.11).

Figure 4.11: Usual source of drinking water, Victorian children age 1–12 years, by area of residence, 2009

Source: VCHWS 2009, DEECD
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Endnotes

1. Socioeconomic Index for Areas (SEIFA) — Index for Relative Socioeconomic Disadvantage (IRSED) (developed by the Australian Bureau of Statistics based on data from the 2006 Census of Population and Housing) has been used as a proxy of SES measure in the analyses where there are no other SES data available. It is derived from the attributes of a small geographic area, such as low income, low educational attainment, high unemployment, jobs in relatively unskilled occupations and other variables indicative of disadvantage. The higher a geographic area’s value on the index, the less disadvantaged that area is compared with other areas.

Areas can also be grouped into quintiles based on their IRSED scores to provide groupings by level of disadvantage, with quintile 1 being the most disadvantaged, and quintile five, the least disadvantaged. It is, however, recognised that the use of the SEIFA Index data is imperfect because of its incurrence and since it is an area-based, not household-based measure. Furthermore, the SEIFA IRSED data have been matched with the postal codes in data from VCHWS 2009 and HOWRU 2009 surveys by using the 2006 ABS Postal Area (POA) data. Inaccuracy and mismatch could occur as: 1) the ABS POA is only an approximation of postcode, and 2) the 2006 POA may not capture some new postcodes developed after 2006 in Victoria. For example, there are 367 sample observations in HOWRU 2009 that are not matched into the SEIFA IRSED.

2. See detailed data in The State of Victoria’s Children and Young People 2010 Data Compendium (Table A4.1)

3. ibid
4. ibid
5. ibid
6. ibid
7. ibid
8. ibid.
Chapter 4

References

• (2010a). Fact Sheet: Dental checks – 0 to 6 years. Victorian Department of Health, Melbourne.
Social and emotional wellbeing (SEWB) is a multifaceted concept encompassing both individual capacities and social competencies. Because of the complex developmental stages that children and young people experience from birth through to 17 years of age, how their social and emotional wellbeing is reflected in their behaviours, thoughts, feelings and abilities differs across the ages. As such, no single ‘measure’ of social and emotional wellbeing can be used for all children and young people.

In VCHWS 2009, eight in 10 Victorian children aged 4–12 years demonstrated normal emotional and behavioural responses (83.5 per cent), with one in 18 (5.4 per cent) considered to have emotional or behavioural responses that are ‘of concern’.

In their first year of primary school, most Victorian children are developmentally ‘on track’, as measured by the Australian Early Development Index (AEDI) on social competence and emotional maturity. A small but sizable proportion is developmentally vulnerable on the social competence domain (8.4) and/or the emotional maturity domain (8.3 per cent).

Within the 2010 School Entry Health Questionnaire (SEHQ), the Strengths and Difficulties Questionnaire (SDQ) is used to assess different aspects of Victorian children behaviours at the beginning of primary school. As assessed by the SDQ, most Victorian children do not have overall behavioural and emotional difficulties (87.0 per cent); however, a small proportion have these difficulties to a degree of high risk of significant clinical problems (4.3 per cent).

In HOWRU 2009, six in 10 of Victorian young people aged 12–17 years (61.1 per cent) demonstrated ‘positive social and emotional functioning’, defined as having a sense of autonomy and personal agency/power, positive connections with others and feeling confident and capable.

How people report on their overall life satisfaction or happiness is a common measure used to assess social and emotional wellbeing. In HOWRU 2009, most Victorian young people aged 12–17 reported they were satisfied with the quality of their lives (77.1 per cent).

Across childhood and adolescence, those from socioeconomically disadvantaged backgrounds are less likely to have positive social and emotional wellbeing.

A focus in this chapter is the issue of body image in young people and how this relates to positive social and emotional wellbeing. More than one in three Victorian young people (34.4 per cent) reported being concerned about gaining weight or getting fat. This concern is significantly more common among females than among males (51.4 versus 17.7 per cent). The proportion of females who reported having concerns of gaining weight appears to increase with their age (57 per cent among 15–17 year olds compared to 46.3 per cent among 12–14 year olds).

Factors influencing the SEWB of Victorian children and young people can be represented by an ecological model, where the following factors combined contribute to SEWB outcomes:

- environmental context, involving positive adults, peers and programs in schools, homes and communities
- social and emotional strengths, involving resilience skills and attitudes supporting emotional regulation and behavioural control
- learning capabilities, such as confidence, persistence, organisation and cooperation
- social skills and values.
The social and emotional wellbeing of children and young people is reflected in their behaviour, thoughts and feelings. However, the complex developmental stages that they move through from birth through to 17 years of age mean that there can be no one single constant measure for all children and young people. For instance, aggressive tantrums in a toddler may be seen as normal behaviour at that developmental stage, yet the same aggression in an older adolescent might be a sign of poor social and emotional wellbeing.

While there is no single definition of social and emotional wellbeing, it is usually associated with positive physical health outcomes, positive peer relationships, school readiness and achievement in school. In childhood and adolescence it sets the foundation to successfully manage the challenges of life as an adult. Conversely, children and young people with low SEWB levels are more likely to have difficulties at home and in their peer groups at school and often experience negative emotions (depression, worry, stress), negative behaviours (such as bullying), academic underachievement and disengagement from learning.

Poor social and emotional wellbeing can manifest in a range of negative behaviours, feelings and thoughts. Although it may eventuate into a mental problem or disorder in a small number of children and young people, SEWB is not the same as having a mental health problem or disorder. *The prevalence of mental problems or disorders that can appear in childhood and adolescence, such as anxiety disorders and depression, are discussed in detail in Chapter 6.*

This chapter examines the social and emotional wellbeing of Victorian children and young people, including the factors that are known to positively influence their wellbeing. Individual characteristics associated with social and emotional wellbeing include the ability to manage and appropriately express emotions and stress, regulate behaviour, maintain confidence and exhibit resilience when faced with challenges. It is also about developing new skills and social competencies, including understanding and appropriately identifying and responding to emotions in other people, having social skills and forming strong and positive relationships.

The second half of this chapter focuses on the issue of body image in young people and how this relates to positive SEWB. Body image is how people think, feel about and evaluate their own body. Positive body image has been linked to high self-esteem (particularly for females) and may act as a protective factor against some mental health concerns (such as depression). Positive body image is an important aspect of positive social and emotional wellbeing in young people.
Measures of social and emotional wellbeing

A range of relevant measures relating to both positive and negative concepts of social and emotional wellbeing are included in this chapter. Positive measures tend to focus on personal strengths and capabilities, but measures of poor social and emotional wellbeing (focusing on problems, deficits or inadequacies) are more frequently used as indicators.

How well are Victorian children and young people faring on measures of social and emotional wellbeing?

Recent information on positive social behaviour in Victorian children aged 4–12 years indicates that the majority of children of this age group have normal emotional and behavioural responses (83.5 per cent), with only a small minority (5.4 per cent) classified as having emotional or behavioural responses that are ‘of concern’. Males (6.7 per cent) and those living in families with relatively few financial resources (7.6 per cent) are significantly more likely to have emotional or behavioural difficulties that are of concern than females or those living in families with more income (see Figure 5.1).

Figure 5.1: Parent-reported emotional or behavioural difficulties*, Victorian children aged 4–12 years, by sex and annual household income, 2009

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Under $60K</th>
<th>$60k or more</th>
<th>4–12 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per cent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>80.5</td>
<td>86.6</td>
<td>77.2</td>
<td>88.2</td>
<td>83.5</td>
</tr>
<tr>
<td>Borderline</td>
<td>6.7</td>
<td>6.6</td>
<td>4.0</td>
<td>4.7</td>
<td>5.4</td>
</tr>
<tr>
<td>Of concern</td>
<td>5.2</td>
<td>3.8</td>
<td>7.6</td>
<td>4.7</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Information from HOWRU 2009 indicates that over half of Victorian young people (61.1 per cent) reported to have a high level of social and emotional functioning (see Figure 5.2). In this measure, a high level of social and emotional functioning means that young people have a sense of autonomy and personal agency/power, positive connections with others and feel confident and capable. Older adolescents aged 15–17 years (62.9 per cent), females (64.9 per cent) and young people living in the least socioeconomically disadvantaged areas (67.1 per cent) were significantly more likely to demonstrate positive social and emotional wellbeing.

One common measure used to assess social and emotional wellbeing is how people report on their overall life satisfaction or happiness. In HOWRU 2009, most Victorian young people aged 12–17 report they were satisfied with the quality of their lives (77.1 per cent). Female young people (12.0 per cent), older adolescents aged 15–17 years (13.6 per cent) and young people living in the most disadvantaged areas (12.1 per cent) were significantly more likely to report that they were dissatisfied with their lives (see Figure 5.3).

*Information is based on parent reporting. Related questions in the survey are based on the Strengths and Difficulties Questionnaire (Goodman 2001). Scales ranged 0–32: normal 0–13, borderline 14–16, of concern 17–40.
Source: VCHWS 2009, DEECD

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*Information is based on parent reporting. Related questions in the survey are based on the Strengths and Difficulties Questionnaire (Goodman 2001). Scales ranged 0–32: normal 0–13, borderline 14–16, of concern 17–40.
Source: VCHWS 2009, DEECD
Figure 5.2: Proportion of Victorian adolescents aged 12–17 who have positive psychological development*, by age, gender and areas of socioeconomic status (SES), 2009

*Ryan and Deci (2001) developed a 21-point scale, which assesses autonomy, competence and relatedness, from which a 9-point Basic Psychological Needs Scale. Source: HOWRU 2009, DEECD

Figure 5.3: Proportion of Victorian young people aged 12–17 years who were satisfied with the quality of their life, by age group, sex, and areas of socioeconomic status (SES), 2009*

*Based on self-report from young people. About 12 per cent of the survey respondents did not answer the relevant question, and the non-response rate is particularly higher (14.7 per cent) in the younger age group (12–14 year olds), and those from the most disadvantaged areas (13 per cent). Source: HOWRU 2009, DEECD
The Australian Early Development Index (AEDI) measures five areas (or ‘domains’) of development in children in their first year of primary school, as reported by the child’s school teacher, including physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge.

AEDI results are reported as average scores, ranging 0–10 on each of the five domains. Children who score below the tenth percentile (in the lowest 10 per cent) of the national AEDI population are classified as ‘developmentally vulnerable’. These children demonstrate a much lower than average ability in the developmental competencies measured in that domain. The AEDI provides an overall indication of the proportion of Victorian children who are developmentally vulnerable on these measures.

Most Victorian children are ‘on track’ on the overall AEDI measure of social competence or emotional maturity, with less than one in 10 Victorian children developmentally vulnerable on overall social competence (8.4 per cent) or emotional maturity (8.3 per cent).3

Figure 5.4 further shows the proportion of Victorian children who are developmentally vulnerable on the sub-domains of social competence. The social competence domain in the AEDI measures how well children are doing overall in their social development, such as their ability to get along with other children and their approach to learning and readiness to explore new things. Figure 5.5 further shows the proportion of Victorian children who are developmentally vulnerable on the emotional maturity sub-domains (including their pro-social and helping behaviour, and any behaviour that is anxious or fearful, aggressive, hyperactive or inattentive).

Notably, males are more likely than female children to be developmentally vulnerable on most of these sub-domains. Children from the most socioeconomically disadvantaged areas are more likely than those from the least socioeconomically disadvantaged areas to be developmentally vulnerable on all sub-domains (see Figures 5.4 and 5.5).

Figure 5.4: Proportion of Victorian children developmentally vulnerable on the AEDI social competence sub-domain, by areas of socioeconomic status and sex, 2009*

* AEDI results are reported as average scores, ranging 0–10 on each of the five domains. ‘Vulnerable’ are those who score below the tenth percentile (in the lowest 10 per cent) of the national AEDI population. These children demonstrate a much lower than average ability in the developmental competencies measured in that domain.

Source: Australian Early Development Index (AEDI) 2009; DEECD Analysis

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### Table: Proportion of Victorian children developmentally vulnerable on the AEDI social competence sub-domain, by areas of socioeconomic status and sex, 2009*

<table>
<thead>
<tr>
<th>Area</th>
<th>Least disad.</th>
<th>Most disad.</th>
<th>Girls</th>
<th>Boys</th>
<th>All children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readiness to explore new things</td>
<td>5.7</td>
<td>12.5</td>
<td>4.2</td>
<td>9.0</td>
<td>8.3</td>
</tr>
<tr>
<td>Approaches to learning</td>
<td>5.0</td>
<td>11.4</td>
<td>4.7</td>
<td>10.7</td>
<td>7.5</td>
</tr>
<tr>
<td>Responsibility and respect</td>
<td>3.6</td>
<td>11.8</td>
<td>4.0</td>
<td>11.3</td>
<td>7.5</td>
</tr>
<tr>
<td>Overall social competence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6.0</td>
</tr>
</tbody>
</table>

* AEDI results are reported as average scores, ranging 0–10 on each of the five domains. ‘Vulnerable’ are those who score below the tenth percentile (in the lowest 10 per cent) of the national AEDI population. These children demonstrate a much lower than average ability in the developmental competencies measured in that domain.

Source: Australian Early Development Index (AEDI) 2009; DEECD Analysis
In the 2010 School Entry Health Questionnaire (SEHQ), the Strengths and Difficulties Questionnaire (SDQ) is used to assess different aspects of Victorian child behaviours at the beginning of primary school, including pro-social behaviour, hyperactivity, emotional symptoms, peer problems and conduct problems (Goodman 2001). The hyperactivity scale measures a range of child behaviour, including restlessness, impulsiveness and concentration span. The emotional scale measures a range of negative emotions, such as sadness, fear and worries. The peer problems scale measures the child’s peer relationships, including not having friends, being picked on, playing by themselves or not being liked by other children. The conduct problem scale measures a child’s tendency to display negative behaviours when interacting socially with other children and adults. The pro-social behaviour scale measures positive social behaviours.

As assessed by the SDQ, most Victorian children do not have overall social and emotional difficulties (87.7 per cent) and a small proportion have social and emotional difficulties that are at high risk of significant clinical problems (4.3 per cent). Children from lone-parent families, those from the most socioeconomically disadvantaged areas and Aboriginal children are more likely to have social and emotional difficulties and are at high risk of significant clinical problems (see Figure 5.6). A small proportion of Victorian children have problems associated with their emotions (5.4 per cent), conduct (6.8 per cent), hyperactivity (6.7 per cent), peer problems (8.4 per cent) and difficulties with pro-social behaviour (3.3 per cent). Children from lone-parent families, those from the most socioeconomically disadvantaged areas and Aboriginal children are generally more likely to have these problems or difficulties (see Table 5.1).
Figure 5.6: Social and emotional behaviours in Victorian children aged 5–6 years, by sex and areas of socioeconomic status, 2010*

* Scales based on Strengths and Difficulties Questionnaire (SDQ), which are completed by parents of children starting school. SDQ scores range between 0–10, with 0–3 being Normal category and 5–10 being ‘Abnormal’ category (i.e. at a high risk of significant clinical problems).

Source: SEHQ 2010, DEECD

Table 5.1: Proportion of Victorian children aged 5-6 years who social and emotional difficulties at a high risk of significant clinical problems, by different aspect of behaviours, 2010*

* Scales based on Strengths and Difficulties Questionnaire (SDQ), which are completed by parents of children starting school. SDQ scores range between 0–10, with 0–3 being Normal category and 5–10 being ‘Abnormal’ category (i.e. at a high risk of significant clinical problems).

Source: SEHQ 2010, DEECD
Factors that promote social and emotional wellbeing

A range of factors related to individual and environmental characteristics have been associated with the promotion of social and emotional wellbeing in children and young people. Figure 5.7 outlines the many factors influencing child and adolescent social and emotional wellbeing (Bernard et al. 2007). Factors specific to the individual child can influence their social and emotional wellbeing, such as particular cognitive styles, learning styles, innate skills and abilities and temperament.

Positive family functioning is a key factor in promoting social and emotional wellbeing in children and is an important measure of how a family operates as a complete unit. Family factors are also critical to the development of positive social and emotional wellbeing in children and young people, which in turn is closely linked to their parents’ or primary caregivers’ SEWB. As a child develops through adolescence, and becomes more independent and responsible for their own actions, their social and emotional wellbeing becomes more distinct from that of their parents and family.

There is strong evidence to suggest that a range of aspects of family functioning are of particular importance, including parenting styles, parental stressors, family conflict and parental mental health. The available resources of a family can also promote or hinder positive family functioning. These resources include not only economic or financial resources, but also social resources, such as the support that they can draw on from family or extended family members, friends and the broader community. (Further discussion of the influence of families on outcomes for children and young people can be found in Chapter 12).
Figure 5.7: Environmental and personal factors contributing to children and young people’s social and emotional wellbeing (SEWB)

Environmental Factors

**Community**
- Positive adult–young person relationships
- High expectations communicated for achievement and behaviour
- Opportunities for positive peer interaction
- Places/activities that accommodate young person’s interests
- Opportunities for young person to interact with the community
- Provision for young person’s safety
- Communication of values and social–emotional capabilities.

**Family and home**
- Positive parent–child relationship
- Healthy and safe family environment
- High expectations communicated for achievement and behaviour
- Provision of activities that accommodate young person’s interests
- Providing young person with responsibility and involvement in decision-making
- Interest and involvement in child’s education
- Providing child with motivation (internal and external) for what is being learned
- Communication of values and social/emotional capabilities.

**School**
- Positive teacher–student relationship
- High expectations communicated for achievement and behaviour
- Provision of classes and activities that accommodate student interests
- Providing students with responsibility and involvement in decision-making
- Being sensitive to student’s gender, culture and home background
- Providing motivation (internal/external) for what student is learning
- Communication of values and social/emotional capabilities in classes and activities
- Provision of quality curriculum and pedagogy that provides multiple opportunities for student to be successful.

Personal Factors

**Cognitive**
- General intellectual capabilities
- Meta-cognitive thinking skills
- Cognitive styles
- Cognitive, language and non-verbal abilities
- Prerequisite academic knowledge

**Social-emotional**
- Resilience – rational attitudes and coping skills supporting emotional regulation and behavioural control
- Positive social orientation – social skills and values
- Positive work orientation – work confidence, persistence, organisation and cooperation.

**SEWB INDICATORS**
- ACHIEVEMENT
- SOCIAL
- EMOTIONAL
- BEHAVIOURAL

Source: adapted from Bernard et. al. 2007)
The witnessing of family violence (e.g. towards a parent) by children and young people has long-term psychological, emotional and behavioural consequences for them, including anger, trauma, sadness, shame, guilt, confusion, helplessness and despair, which impacts on their overall social and emotional wellbeing. *Chapter 12 includes a detailed discussion of family violence in Victorian families.*

The social and emotional wellbeing of parents is a known factor for a broad range of outcomes for children and young people. In particular, there is consistent evidence to suggest that children and young people with a parent with a mental health problem face a significantly higher risk of poorer outcomes. Children with a parent with a mental illness also face a higher risk of developing a mental illness themselves. *(See Chapter 2 for a more detailed discussion of the mental health and wellbeing of Victorian parents).*

The school environment is also seen as an influential factor in promoting positive social and emotional wellbeing in children and young people. Aspects of importance include the culture of the school, the supportiveness of the environment, school ‘morale’, classroom and peer behaviours, bullying or other negative behaviours and leadership within the school. *(Chapter 9 provides a detailed discussion of how these factors can influence a young person’s capacity to engage with learning in an effective way).*

**Body image and social and emotional wellbeing**

What is body image?

A range of factors influence body image, including body weight, height and shape, their skin colour, facial features, their religious or ethnic background (particularly if associated with a specific appearance) and any physical disability or limitation.

Positive body image has been linked to high self-esteem (particularly for females) and may act as a protective factor against some mental health concerns (such as depression). Positive body image then is an important aspect of positive social and emotional wellbeing in young people.

The term ‘body dissatisfaction’ is used to describe the feelings a young person has when they have a negative view of their appearance and are not satisfied with their body image. Having a poor body image can seriously impact on an individual’s social and emotional wellbeing and be a factor in the development of poor self-esteem, negative moods, unhealthy weight and diet behaviours and social isolation. In extreme cases, negative body image is a contributing factor to the development of eating disorders, depression and anxiety disorders *(for further discussion of these disorders, see Chapter 6).*

Why is body image important for children and young people?

Adolescence is a critical time for many physiological, social, cognitive and psychological changes, when a person’s identity, beliefs, value systems and social skills take form. It is also a period when the rapid and often extreme developmental physical changes created by puberty are often at odds with the cultural ideal of beauty, particularly for females. Young people are acutely aware of their physiological changes and are particularly vulnerable to social and cultural influences on their developing self-image. Research has found that exposing young people to images of the cultural ideals of beauty can lead to the development of poor body image and lower social and emotional wellbeing, although not all young people are affected in the same way.
The development of poor body image is also associated with the personality of the individual (such as perfectionism and excessive concern with what other people think); their interactions and level of support from people around them, such as friends, siblings, parents and teachers; and their immediate social environment.

There is some evidence to suggest that children are experiencing body image issues (such as body dissatisfaction and dieting) at an increasingly earlier age. Moreover, it appears that gender influences the development of positive body image, with females being more likely to develop body dissatisfaction than males.

Body weight is also a factor influencing the development of positive body image, with the further a person’s actual or perceived weight and body shape is from their ideal body image, the more likely they are to develop a poor body image.

A 2010 study by Mission Australia found that 28 per cent of Victorian 11–14 year olds and 33.5 per cent of 15–19 year olds rated body image as the issue of most personal concern. This was the issue of highest concern to all young people in Victoria (ahead of family conflict and coping with stress) (Mission Australia 2010).

Do Victorian young people have a positive body image?

More than one in five Victorian young people (23.3 per cent) said their body weight was very important when asked how important it was to how they feel about themselves in HOWRU 2009. Females were more likely than males to rate it so, with 31.3 per cent of females compared to 15.3 per cent of males rating their weight as very important (see Figure 5.8).

Figure 5.8: Victorian young people aged 12–17 years reported ratings of importance of their weight in how they felt about themselves as a person, 2009

Source: HOWRU 2009, DEECD
Furthermore, one third of young people reported being concerned about gaining weight or getting fat (34.4 per cent) (see Figure 5.9). This concern is significantly more common for adolescent females than males (51.4 versus 17.7 per cent). Females were more likely to report a larger degree of concern than males, with 21.2 per cent of females reporting as very or extremely worried compared with 4.8 per cent of males.

**Figure 5.9**: Victorian young people aged 12–17 years who reported feeling afraid of gaining weight or become fat, by severity of feeling and sex, 2009

The proportion of females who report having concerns about weight gain appears to increase with their age (57 per cent among 15–17 year olds compared to 46.3 per cent among 12–14 years olds). The severity of this concern also increases with age; for example, 25.6 per cent of 15–17 year old females reported they were very or extremely concerned about weight gain in contrast to 17 per cent of females aged 12–14 years (see Figure 5.10). The frequency of feelings of concern also increases as they age; for example, 18.5 per cent of females aged 15–17 years reported worrying about their weight every day or almost every day compared to 11.4 per cent of the 12–14 years olds (see Figure 5.11).

**Figure 5.10**: Victorian females aged 12–17 years who reported feeling afraid of gaining weight or become fat by severity of concern, by age group, 2009

*Indicates data are not statistically significantly different at 95 per cent confidence interval between the two age groups.

Source: HOWRU 2009, DEECD
Figure 5.11: Victorian females aged 12–17 years who reported feeling afraid of gaining weight or become fat, by frequency of feelings and age group, 2009

*Indicates data are not statistically significantly different at 95 per cent confidence interval between males and females.
Source: HOWRU 2009, DEECD
1. Positive Psychological Development (PPD) refers to an adaptive and healthy state of social and emotional functioning. It is indicated by perceptions of autonomy (sense of personal agency), relatedness (positive connections with others) and competence (feeling capable or masterful). Ryan and Deci (2001) developed a 21-point scale, which assesses autonomy, competence and relatedness, from which a 9-point Basic Psychological Needs Scale has been developed and was used within the HOWRU survey.

2. Socioeconomic Index for Areas (SEIFA) – Index for Relative Socioeconomic Disadvantage (IRSED) (developed by the Australian Bureau of Statistics based on data from the 2006 Census of Population and Housing) has been used as a proxy of SES measure in the analyses where there are no other SES data available. It is derived from the attributes of a small geographic area, such as low income, low educational attainment, high unemployment, jobs in relatively unskilled occupations and other variables indicative of disadvantage. The higher a geographic area’s value on the index, the less disadvantaged that area is compared with other areas. Areas can also be grouped into quintiles based on their IRSED scores to provide groupings by level of disadvantage, with quintile one being the most disadvantaged, and quintile five, the least disadvantaged.

It is, however, recognised that the use of the SEIFA Index data is imperfect because of its incurrence and since it is an area-based, not household-based measure. Furthermore, the SEIFA IRSED data have been matched with the postal codes in data from VCHWS 2009 and HOWRU 2009 surveys by using the 2006 ABS Postal Area (POA) data. Inaccuracy and mismatch could occur as: 1) the ABS POA is only an approximation of postcode, and 2) the 2006 POA may not capture some new postcodes developed after 2006 in Victoria. For example, there are 367 sample observations in HOWRU 2009 that are not matched into the SEIFA IRSED.

3. See detailed data in *The State of Victoria’s Children and Young People 2010: Data Compendium* (Table A5.1).

4. See note 2.

5. See note 2.
References

Evidence base about social and emotional wellbeing


Evidence base about body image and social and emotional wellbeing

At different stages in life, people are more susceptible to the development of mental health problems or disorders. This vulnerability is heightened at times of major life changes, including the transition from childhood to adolescence, and adolescence to adulthood and in old age. Mental health problems or disorders can seriously disrupt or impede school, work, social and family experiences of children and young people.

Mental health is closely linked with social and emotional wellbeing but it is only one aspect of overall social and emotional wellbeing (see Chapter 5 for discussion of social and emotional wellbeing in children and young people). Over one in 10 Victorian young people aged 12–17 years (13 per cent) reported (in HOWRU 2009) very high levels of non-specific psychological distress, with a higher rate for older adolescents (15–17 years), females and young people from families of socioeconomic disadvantage.

Consistent with international and national evidence, a small proportion of Victorian young people have an eating disorder (2.4 per cent), with a higher proportion for females (3.1 per cent) than for males (1.6 per cent).

The proportion of children and young people aged 10–17 years registered with a Child and Adolescent Mental Health Service (CAMHS) in Victoria remained relatively stable over the past five years, with a rate of 6.9 per 1000 population in 2004 and 6.8 in 2009. Females have a consistently higher rate than males at all ages in adolescence.

Hospital treatment for self-harming injuries in Victorian children and young people was more prevalent for 15–17 year olds (accounting for 82 per cent of all admissions and 80 per cent of emergency department presentations) compared to the 12–14 year olds, and more prevalent for females than males regardless of their age range.

The rates in hospital admission and ED presentation for self-harming in Victorian young people aged 12–17 years have been consistently lower than in young adults aged 18–24 years. However, both rates in young people aged 12–17 years have increased over the past decade.

Australia wide, suicide deaths in young people 12–24 years of age accounted for one fifth of all deaths of young people of this age group in 2004. In Victoria, there were 14 suicide deaths among young people aged 12–17 years in 2007. Self-reported data from Victorian young people (12–17 years) indicate that 14.1 per cent have used, or believe they have a need for, mental health professionals. However, a quarter of those young people feel they cannot access mental health services if needed. Perceived barriers include cost, confidentiality and accessibility.

Children and young people who are at a heightened risk of developing mental health problems or disorders often have an increased likelihood of experiencing other multiple risk factors or socioeconomic disadvantages. Risk factors for mental health problems in children and young people include unstable family relationships, family conflict, family violence, lack of social support and poverty. Protective factors identified in the research include nurturing and secure family relationships, positive and rewarding school environments, connectedness to schools and communities, positive personal achievements, pro-social peer group and friends.
The World Health Organisation (WHO) (2003) estimated that worldwide up to 20 per cent of children and young people suffer from a disabling mental problem. In Australia, nearly half of adults (45.5 per cent), equivalent to about 7.3 million people, have experienced a substance use, anxiety or affective disorder at some stage throughout their lives (Slade et al. 2009). The child and adolescent component of the ABS National Survey of Mental Health and Wellbeing in 2000 found that, in Australia, 14.1 per cent of young people aged 4–17 years had a mental health problem (Sawyer et al. 2000).

Mental ill health is the largest single contributor of disability burden in the Australian population. The study by Boston Consulting Group (2006) estimated that it accounted for 70 per cent of the disease burden in Australian young people. Mental health problems or disorders can seriously disrupt or impede their school, work, social and family experiences of young people. It is important to intervene early in attempt to prevent greater burden of disease in adulthood.

Mental health is not just the absence of a mental problem. WHO (1999) describes it as a state of emotional and social wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively or fruitfully, and can contribute to his or her community. While mental health is closely linked with positive social and emotional wellbeing, it is only one aspect of it (see Chapter 5 for discussion of social and emotional wellbeing in children and young people). Children and young people with emerging mental health issues often have fluctuating or unclear symptoms and multiple difficulties, which make a clinical diagnosis of a mental disorder difficult. As such, this chapter examines the issues relating to both mental health problems and disorders in children and young people, but does not differentiate ‘problems’ from ‘disorders’ unless otherwise stated.

Key policy directions for mental health

- Australian Government, National Mental Health Policy 2008
- Fourth National Mental Health Plan 2009–14
- National Action Plan on Mental Health 2006–11
- Living is For Everyone (LIFE) Framework 2008

Key Victorian Government initiatives: Mental health

**Commitments and new initiatives**

- Mental Health Professional Learning Program for education workforce
- Enhancing and expanding Headspace services at selected sites across Victoria
- 150 additional Primary Welfare Officers
- Professional Development opportunities for teachers to address challenging behaviours
- Targeted mental health and suicide prevention initiatives for gay, lesbian, bisexual and transgender young people

**Programs in place**

- Headspace services
- Eating Disorders Strategy
- Student Support Services Program for school students
- Student Welfare coordinators and secondary school nurses
- Primary School Nursing Program
- Community-based eating disorder treatment services
- Enhanced and expanded community mental health services
- Central coordination of inpatient beds, with boost in bed capacity, including additional PARC beds
- Improved housing access and innovative housing models
- Support for workforce participation
- Research into mental illness

- Child and Adolescent Mental Health Service in Primary School
- School Focused Youth Service
- Scholarships for Graduate study in Mental Health for the Teaching professions
- Priority access to mental health services for children in Out-of-Home Care
- Youth Justice mental health initiative
Mental health problems in childhood and adolescence

More than 75 per cent of all severe mental health and substance use problems commence before the age of 25, with the first episode of serious mental illness most likely to occur in the period from 16–25 years.

(Victorian Mental Health Reform Strategy 2009–2019)

Mental health problems can impede a child or young person’s thinking, emotions, behaviour and/or social abilities and can cause concern or distress. These problems might be of a short duration (e.g. in response to life stressors such as the death of a parent) or of longer duration. They may develop into a mental disorder (a clinically diagnosable illness) that significantly interferes with a child or young person’s thinking, emotions, behaviours and/or social abilities. Common mental disorders in Australian children and young people include depression, anxiety, conduct disorders, substance use disorders and, to a lesser degree, eating disorders and psychosis.

Mental disorders emerge in a developmental sequence in children and young people:

- Attachment and developmental disorders usually emerge in infancy and early childhood (birth through to 3 years).
- Behavioural disorders, anxiety and mood disorders can emerge from preschool to mid-adolescence.
- Eating disorders are more likely to emerge in late childhood through to mid-adolescence.
- Substance use disorders generally have their onset in early to mid-adolescence.
- Adult-type psychosis disorders generally emerge in mid-to-late adolescence.

A range of mental problems can arise during childhood and adolescence. Some manifest as ‘problems’, including challenging or disruptive behaviours, impaired cognition (thinking) and social disturbances (e.g. high psychological distress), while others are diagnosable disorders (including conduct disorders, eating disorders, substance use disorders and psychosis).
Psychological distress

Psychological distress is often measured using the Kessler 10 scale in community surveys of mental health (Kessler et al. 2002). This scale measures non-specific psychological distress asking people completing the survey about a range of negative emotional states they may have experienced over the past month. It is not a diagnostic tool to determine if a person has a particular mental disorder (such as depression or schizophrenia). However, there is a strong association between very high scores on the Kessler 10 scale and the current diagnosis of a mental disorder. Thus, very high scores suggest (but do not diagnose) the presence of a diagnosable mental disorder in a person.

Using the Kessler 10 scale, HOWRU 2009 suggests that a significant proportion (13 per cent) of Victorian young people aged 12–17 years have very high levels of psychological distress. Serious psychological distress is significantly more common in older adolescents, young females and young people from families living in the areas of most socioeconomic disadvantage (see Figure 6.1).

Figure 6.1: Proportion of Victorian young people with very high levels of psychological distress*, by age groups, sex and area of socioeconomic status (SES), 2009

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Male</th>
<th>Female</th>
<th>All pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>12–14 yrs</td>
<td>14.1</td>
<td>9.1</td>
<td>11.2</td>
</tr>
<tr>
<td>15–17 yrs</td>
<td>12.3</td>
<td>9.1</td>
<td>13.0</td>
</tr>
<tr>
<td></td>
<td>8.2</td>
<td>7.2</td>
<td>8.4</td>
</tr>
<tr>
<td></td>
<td>14.3</td>
<td>14.3</td>
<td>13.2</td>
</tr>
</tbody>
</table>

*Psychological distress was derived from the Kessler 10 scale (K10) (Kessler et al. 2002). Adolescents are defined as under very high levels of psychological distress if their K10 scores are equal to or greater than 30.

Conduct disorders

Challenging behaviour in primary school-aged children is common and often normal in relation to the developmental stages of children. However, when this behaviour significantly interferes with the child’s social and emotional development and wellbeing the child may be at risk of developing a conduct disorder. (See Chapter 5 for a discussion on the prevalence of behavioural difficulties in Victorian children). Conduct disorders are behavioural disorders characterised by a pattern of repetitive behaviour where the rights of others or social norms are violated, including verbal and physical aggression, cruel or destructive behaviour to others and animals, lying, truancy, vandalism or theft.

Estimates vary, but some suggest that approximately 7 per cent of Australian children have abnormal behaviour, 6.1 per cent have attention problems and 5.2 per cent have problems with aggression (Sawyer et al. 2000). Recent information about the prevalence of diagnosed conduct disorders in Victorian children is not available; however, a Victorian Government early action program estimated that in 2001 approximately 17 per cent of children and young people attending Victorian child and adolescent mental health services (CAMHS) presented with a conduct disorder (Victorian Government 2006).
Depression
The child and adolescent component of the National Survey of Mental Health and Wellbeing in 2000 found that one in 20 young people aged 13–17 years (4.8 per cent of males and 4.9 per cent of females) had a depressive disorder (Sawyer et al. 2000). There is no more recent data available on the prevalence of depressive disorders in Victorian children and young people.

Autism Spectrum Disorders
Autism Spectrum Disorders (ASDs) are developmental disorders causing significant impairments in social interactions, often associated with unusual behaviours and interests. ASDs commonly include Autistic Disorder and Asperger’s Syndrome and are much more common in males than females. While the actual number of Australian children with ASDs is unknown, recent information about Victorian children suggests that the rate of diagnosis of ASD (or suspected cases of ASD) may be 27 cases per 10,000 children aged 0–6 years (Victorian Government 2009a). This is generally consistent with international studies; however, a recent Australian study estimated the prevalence of ASD for Australian children aged 6–12 years in 2003–04 to be 62.5 per population of 10,000 (MacDermott et al. 2006).

Anxiety
Anxiety-related disorders are the most common emotional problems in children and there is good evidence to suggest that the onset of many adult anxiety disorders have their origins in childhood and adolescence. There are no reliable estimates of the prevalence of anxiety problems or disorders in Australian children or young people; however, information from the National Survey of Mental Health and Wellbeing 2007 indicate that 14.4 per cent of Australian adults had experienced an anxiety disorder in the previous 12 months (ABS 2008).

Substance use disorders
Substance use disorders are clinically diagnosable illnesses relating to the consumption of alcohol or drugs at levels that result in impaired control over the use of these substances and continued use despite significant psychological and physical problems. (See Chapter 8 for a discussion of alcohol, tobacco and illicit drugs and other substances use by Victorian young people). At least 30 per cent of public mental health patients also experience harmful drug and alcohol use and up to 50 per cent of people with severe mental problems living in the community also have alcohol and drug use problems. Over 75 per cent of substance use disorders commence before the age of 25 (Victorian Government 2009b).

Eating disorders
The onset of eating disorders, the most common of which are Anorexia Nervosa and Bulimia Nervosa, usually occurs in late childhood and early adolescence and are more common in young females. Eating disorders are characterised by abnormal patterns of eating, weight controlling behaviour and disturbed or abnormal perceptions of body shape, size and weight. They tend to be chronic, fluctuate in severity of symptoms and can last for years, and are often associated with a range of other mental health problems and disorders, including depression and anxiety, substance use, chronic physical health complications and suicide. Poor body image (see Chapter 5) is a risk factor for the development of eating disorders.

A 2007 longitudinal study suggests that around 10 per cent of young Victorian women (who did not have a diagnosed eating disorder) reported that they experienced at least two symptoms associated with anorexia or bulimia at some point between adolescence and young adulthood (Patton et al. 2007).
Surveys in developed Western countries have generally found prevalence rates of around 0.5 per cent for anorexia nervosa and 1 per cent for bulimia nervosa in females aged 15–24 years. In contrast rates for ‘partial syndromes’ have been around 3–5 per cent (Johnson-Sabine et al. 1988; Rastam et al. 1989).

Figure 6.2 suggests that only a small proportion of young people in Victoria suffer from an eating disorder (2.4 per cent), with a higher proportion for females than males. This information is broadly consistent with international and national evidence suggesting that only a small proportion of children and young people suffer from eating disorders and that more females have these disorders than males.

Figure 6.2: Proportion of Victorian adolescents who have an eating disorder,*^ 2009

*Adolescents have partial syndrome anorexia and/or bulimia, which are based on Branched Eating Disorder Test developed by Centre for Adolescent Health. See end note 3 for detailed criteria for partial syndrome anorexia and bulimia.

^While the information presented in the figure should be interpreted with caution (given the large numbers of young people who did not respond to the relevant questions in the survey).

Source: HOWRU 2009, DEECD

Psychosis

An estimated 40 per cent of people affected by a psychotic disorder had their first symptoms of their disease manifest before the aged of 20 years and with a peak onset age of between 15 and 25 years of age for males (Australian Government 2004). Early psychosis can affect a person’s beliefs, thoughts, feelings and behaviours and can cause someone to misinterpret or confuse what is going on around them. Young people who are experiencing psychotic symptoms, such as hearing voices, are referred to as having a ‘psychotic episode’. Effective treatments are readily available for psychotic illnesses. The earlier treatment is started, the quicker and more successful the recovery. With appropriate treatment most young people recover; however, for some psychosis can become an episodic problem throughout their life. There are no data available on the prevalence of psychosis in Victorian young people for this report.

For a small number of young people, mental health problems and disorders lead to self-harming behaviours, including suicide.
**Self-harming and suicidal behaviours**

Self-harm refers to a range of behaviours that range from mild self-injuries as a response to emotional pain to more extreme and severe behaviour, such as suicide. It is recognised as a behaviour in its own right, distinct from attempted suicide, because it can include deliberate destruction or damage to one’s own body without suicidal intentions.

Although the self-harming hospital admission rate for young people aged 12–17 years has been consistently lower than that for young adults aged 18–24 years, it has increased over the past decade. The rate for young people aged 12–17 years in Victoria has risen from a rate of 70 per 100,000 young people in 2000 to 83 per 100,000 in 2009, although the rate for young adults aged 18–24 years has been stable over the same period (see Figure 6.3).

**Figure 6.3: Rate of self-harm hospital admissions for Victorian young people, by age group, 2000–09**

![Graph showing the rate of self-harm hospital admissions for Victorian young people, by age group, 2000–09.](image)

*Source: VAED (excluding same day admissions) 2000–2009; VISU Analysis*

Similarly, the number of emergency department (ED) presentations for self-harming injuries for Victorian young people aged 12–17 years has been consistently lower than that for young adults aged 18–24 years. However, the number of ED presentations for young people aged 12–17 years has increased over the past decade. In contrast, the number of self-harm ED presentations in young adults aged 18–24 years showed a declining trend from 2001 to 2008 (see Figure 6.4).

**Figure 6.4: Self-harm hospital ED presentations (non-admissions) for Victorian young people, by age group, 2000–09**

![Graph showing the number of self-harm hospital ED presentations for Victorian young people, by age group, 2000–09.](image)

*Only 28 hospitals that contributed data to VEMD over the whole decade were included in the analysis. Rates are not calculated for ED presentations because numerator data are not complete. Source: VEMD 2000–09*
Table 6.1 provides further information about hospital-treated self-harming injuries by Victorian young people in 2007–09. During this three-year period, there were 1547 hospital admissions and 1604 hospital emergency department (ED) presentations by young people who had self-harmed.

The most common form of self-harming behaviour for young people aged 12–17 years was poisoning (78.1 per cent of admissions and 38 per cent of ED presentations), followed by injuries caused by cutting with a sharp object (16 per cent of admissions and 35.2 per cent of ED presentations). As such, self-harm injuries most commonly treated were poisoning effects and open wounds. The most common location in which 12–17 year olds harmed themselves was their own home (45.6 per cent of hospital admission cases and 60 per cent of ED presentation cases).

Hospital treatment for self-harming injuries was more prevalent for 15–17 year olds, accounting for 82.2 per cent of all admissions and 80.2 per cent of all ED presentations for self-harming injuries for 12–17 year olds. Females accounted for majority of hospital treatment for self-harming injuries (80.7 per cent of all hospital admissions and 70.8 per cent of all ED presentations for 12–17 year olds) (see Table 6.1).

**Table 6.1: Self-harm hospital treated injury, aged 12–17, Victoria, 2007–09**

<table>
<thead>
<tr>
<th>Major causes of injury</th>
<th>Admissions Number</th>
<th>%</th>
<th>ED Presentations Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
<td>1208</td>
<td>78.1</td>
<td>610</td>
<td>38.0</td>
</tr>
<tr>
<td>Sharp object</td>
<td>247</td>
<td>16.0</td>
<td>565</td>
<td>35.2</td>
</tr>
<tr>
<td>Hanging</td>
<td>39</td>
<td>2.5</td>
<td>3</td>
<td>0.3</td>
</tr>
<tr>
<td>Striking an object</td>
<td>45</td>
<td>2.9</td>
<td>98</td>
<td>6.1</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>0.4</td>
<td>95</td>
<td>5.9</td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nature of injury</th>
<th>Admissions Number</th>
<th>%</th>
<th>ED Presentations Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td>12</td>
<td>0.8</td>
<td>101</td>
<td>6.3</td>
</tr>
<tr>
<td>Open wound</td>
<td>209</td>
<td>13.5</td>
<td>480</td>
<td>29.9</td>
</tr>
<tr>
<td>Superficial injury</td>
<td>42</td>
<td>2.7</td>
<td>169</td>
<td>10.5</td>
</tr>
<tr>
<td>Dislocation, sprain and/or strain</td>
<td>1201</td>
<td>77.6</td>
<td>654</td>
<td>40.8</td>
</tr>
<tr>
<td>Systemic-poisoning/toxic effects</td>
<td>81</td>
<td>5.2</td>
<td>140</td>
<td>8.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Admissions Number</th>
<th>%</th>
<th>ED Presentations Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Road, street or highway</td>
<td>14</td>
<td>0.9</td>
<td>29</td>
<td>1.8</td>
</tr>
<tr>
<td>Home</td>
<td>705</td>
<td>45.6</td>
<td>963</td>
<td>60.0</td>
</tr>
<tr>
<td>School, public buildings</td>
<td>121</td>
<td>7.8</td>
<td>69</td>
<td>4.3</td>
</tr>
<tr>
<td>Residential institution</td>
<td>36</td>
<td>2.3</td>
<td>36</td>
<td>2.2</td>
</tr>
<tr>
<td>Other specified place</td>
<td>35</td>
<td>2.3</td>
<td>70</td>
<td>10.6</td>
</tr>
<tr>
<td>Unspecified place</td>
<td>636</td>
<td>41.1</td>
<td>333</td>
<td>20.8</td>
</tr>
</tbody>
</table>

**TOTAL** 1547 100% 1604 100%

Source: VAED (hospital admissions, including same day admissions), VEMD (ED presentations, non-admissions); VISU analysis
The number of young people who commit suicide is relatively low compared to the number who self-harm (AIHW 2008). The reasons why a young person attempts suicide are complex and interrelated, and evidence suggests that there are a variety of risk factors, warning signs and events that may in some cases precipitate suicidal thoughts or behaviours. Mental health problems or disorders are risk factors for self-harming behaviour and suicide, but they are not necessarily ‘causal’. What is known is that people with severe or persistent mental problems or disorders have a 10–15 times greater suicide risk than people with no mental health disorder, although the majority of people who have a mental problem or disorder do not experience suicidal thoughts or behaviour (Mendoza & Rosenberg 2010).

Some young people are at heightened risk of suicide, including young men, gay/lesbian, bisexual, transsexual or intersex young people, Aboriginal or Torres Strait Islander young people and those living in rural and remote areas of the country (Australian Government 2007; Mendoza & Rosenberg 2010). Young people with a heightened risk of suicide are those who:

- have a family history of suicide or suicidal behaviour
- have attempted suicide in the past
- have previously self-harmed
- are from socioeconomically disadvantaged areas (including those with low levels of education, unemployment or a history of imprisonment)
- have experienced abuse in childhood.

Suicide accounts for 16 per cent of all deaths of young people aged 15–19 years. Over 10 per cent of people with a severe mental illness commit suicide within 10 years of diagnosis. (Victorian Mental Health Reform Strategy 2009–2019)

The statistics on suicides are generally thought to be under-represented, because first, the social stigma associated with suicide probably deters its reporting and due to the way in which deaths are investigated and reported; and second, it can be difficult to determine if an individual acted deliberately to cause his or her death, therefore some deaths from suicide might be classified as accidental or caused by someone else.

In 2004, 14 per cent of all suicide deaths in Australia were by young people 12–24 years of age. Suicide accounted for one fifth of all deaths of young people of this age group (AIHW 2008). The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) reported a total of 14 suicide deaths among Victorian young people aged 12–17 years in 2007 (Victorian Government 2010b).

Risk and protective factors for mental health conditions and problems

The development of a mental health problem or disorder results from a complex interplay of factors. Children and young people who are at a heightened risk of developing mental health problems or disorders often have an increased likelihood of experiencing other multiple risk factors or socioeconomic disadvantages. They are more likely to have chronic health problems, be experiencing or have experienced childhood adversities (such as homelessness, family violence, trauma, abuse, neglect, having parents with a mental illness), in the youth justice system, and use/misuse substances. Nonetheless, even among children and young people who have many of these risk factors, it is not possible to predict which individuals will develop a mental health problem or disorder.

There are multiple protective factors that moderate the effect of risk factors and minimise the likelihood that individuals will experience mental health problems, mental illness or engage in suicidal behaviour. Like risk factors, protective factors can be short term or long term, rest with the individual or their community, and vary across the lifespan. (National Mental Health Policy 2008:14)
We know that risk factors for mental ill health act in a multiplicative way rather than an additive way, and that the effects of these risk factors are influenced by a number of protective and resilience factors. The way in which these factors interact will differ depending on the developmental age and specific circumstance of individual children and young people.

The mental health of parents is a known factor influencing a broad range of outcomes for children and young people, including acting as both a risk and protective factor for the development of mental problems and disorders in their children. In particular, there is consistent evidence to suggest that children and young people with a parent who has poor mental health face a significantly higher risk of developing a mental illness. (Chapter 2 provides further information and discussion on socioeconomic situations of families of Victorian children and young people, as well as their parents’ general health status, including mental health).

Around 17,000 children and young people have a parent with a severe mental illness who is registered as a Victorian public mental health patient. Children of parents with a mental illness are at greater risk of experiencing a mental health problem later in life; however, there is good evidence that early intervention programs can reduce risks. (Victorian Mental Health Reform Strategy 2009–2019)

The association between alcohol use and mental health in young people is thought to be reciprocal; that is, young people with certain mental illnesses (diagnosed or otherwise) are more likely to use substances and accelerate their use throughout their adolescence, while substance use can contribute to, and be a risk factor for, poor mental health or mental illnesses.

Alcohol use has been linked with deliberate acts of self-harm, with estimates being that about one third of all self-inflicted injuries and suicides in Australia are linked to alcohol consumption (NHMRC 2009). It is estimated that over half of all Victorians using alcohol and drug treatment services have a mental health problem (with many having anxiety and depression disorders) (Victorian Government 2007a). Young people with a dual diagnosis of mental illness and substance use face a number of issues that can complicate their treatment options, requirements and success. (Substance use patterns by Victorian young people are discussed in detail in Chapter 8).

What are the risk factors?
- Unstable family relationships
- Death of a parent
- Poor family functioning and poor parenting practices
- Family conflict or breakdown
- Experiencing or witnessing family violence
- Parental serious illness, including mental disorders or substance use disorders
- Lack of social support
- Physical illness or disability
- Psychological trauma (e.g. abuse, accidents, etc.)
- Poverty

What are the protective factors?
- Nurturing, affectionate and secure relationships with parents/families
- Positive and rewarding school environments
- Connectedness to schools and communities
- Positive personal achievements (such as academic or sporting achievements)
- Pro-social peer group and friends
- Positive or optimistic ‘temperament’
Prevention, identification and treatment of mental health problems and disorders

There is evidence that symptoms of behavioural problems typically occur during ages 2–4 years before the onset of a mental disorder. Intervening when difficulties or symptoms first appear may prevent problems from progressing or becoming more severe and thereby minimise the effect in the long term (Royal Australian and New Zealand College of Psychiatrists Report 2010).

Family doctors, school-based counsellors and pediatricians provide the services that are most often used by young people with mental health problems in Australia. It is estimated that 2 per cent of Australian children and young people have a severe mental health problem requiring a multidisciplinary, specialist mental health service (Sawyer et al. 2000).

There is also an opportunity to prevent or minimise the severity of mental health problems by providing support to children, young people and their families who are experiencing the known risk factors associated with the development of mental health problems (such as homelessness, family violence, and child abuse).

What treatment do Victorian children and young people receive?

Currently only one in four young persons experiencing mental health problems receives professional help— and only 50 per cent of those with the most severe problems. (Victorian Mental Health Reform Strategy 2009–2019)

Mental health support for children and young people is delivered through a range of community-based services, comprising primary care (GPs, allied health) services, maternal child health, community health, student support services, headspace (Australia’s National Youth Mental Health Foundation) and specialist mental health services.

Information from 2009 indicates that 14.1 per cent of Victorian young people report they have used or believe that they currently have a need for mental health professionals (including counsellors, psychologists or psychiatrist) (see Figure 6.5). This is similar to the rate of 13 per cent of young people who are under serious levels of psychological distress (see Figure 6.1). Moreover, there was a greater need for mental health services expressed by older adolescents aged 15–17 years (15.3 per cent) and by females (15.3 per cent). Among the young people who have used or believe that they currently have a need for mental health professionals, 26.9 per cent say that they are not able to access these services (see Figure 6.5). Of concern, less than one third (31.6 per cent) of young people who are under very high non-specific psychological distress have been identified as in need of mental health professionals, with 41.2 per cent of them saying that they cannot access services if needed (see Figure 6.6).

Figure 6.5: Proportion of Victorian adolescents who have used or need,¹ and feel they cannot access, mental health professionals,² by age group and sex, 2009

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¹ Includes those who used mental health services and whose family members or the adolescents themselves think that they need the services.

² Including counsellors, psychologists or psychiatrists.

Source: HOWRU 2009, DEECD
Most mental health care is delivered within community settings through primary health (GPs, community health services), supported by private allied health practitioners and psychiatrists. Often, children and young people’s mental health care is also supported through child and family welfare and school support services.

In the seven-year period 2000–01 to 2007–08, a total of 24,782 children and young people aged 10–17 years registered with a Child and Adolescent Mental Health Service (CAMHS) in Victoria, with 8.1 per cent (or 1998 registrations) having one hospital admission and 5.8 per cent (or 1426 registrations) more than one admission. The CAMHS registrations generally increase with age of Victorian children and young people (see Table 6.2).

Table 6.2: CAMHS registrations of Victorian Children and young people by hospital admissions and age of first registration, pooled data 2000–01 to 2007–08

<table>
<thead>
<tr>
<th>Age at first registration</th>
<th>No admissions Number</th>
<th>No admissions Per Cent (%)</th>
<th>One admission Number</th>
<th>One admission Per Cent (%)</th>
<th>More than one admission Number</th>
<th>More than one admission Per Cent (%)</th>
<th>Total registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 years</td>
<td>2,024</td>
<td>96.6</td>
<td>57</td>
<td>2.7</td>
<td>15</td>
<td>0.7</td>
<td>2,096</td>
</tr>
<tr>
<td>11 years</td>
<td>1,947</td>
<td>94.4</td>
<td>79</td>
<td>3.8</td>
<td>37</td>
<td>1.8</td>
<td>2,063</td>
</tr>
<tr>
<td>12 years</td>
<td>2,022</td>
<td>92.9</td>
<td>96</td>
<td>4.4</td>
<td>58</td>
<td>2.7</td>
<td>2,176</td>
</tr>
<tr>
<td>13 years</td>
<td>2,660</td>
<td>87.3</td>
<td>224</td>
<td>7.4</td>
<td>162</td>
<td>5.3</td>
<td>3,046</td>
</tr>
<tr>
<td>14 years</td>
<td>3,215</td>
<td>86.1</td>
<td>319</td>
<td>8.5</td>
<td>202</td>
<td>5.4</td>
<td>3,736</td>
</tr>
<tr>
<td>15 years</td>
<td>3,314</td>
<td>82.8</td>
<td>383</td>
<td>9.6</td>
<td>307</td>
<td>7.7</td>
<td>4,004</td>
</tr>
<tr>
<td>16 years</td>
<td>3,345</td>
<td>82.1</td>
<td>409</td>
<td>10.0</td>
<td>319</td>
<td>7.8</td>
<td>4,073</td>
</tr>
<tr>
<td>17 years</td>
<td>2,831</td>
<td>78.9</td>
<td>431</td>
<td>12.0</td>
<td>326</td>
<td>9.1</td>
<td>3,588</td>
</tr>
<tr>
<td>TOTAL</td>
<td>21,358</td>
<td>86.2</td>
<td>1,998</td>
<td>8.1</td>
<td>1,426</td>
<td>5.8</td>
<td>24,782</td>
</tr>
</tbody>
</table>

*Admissions are counted from their first registration date up to the end of May 2008.
Source: Victorian Department of Health
The rate of registration with public specialist mental health services by young Victorians aged 12–17 years has remained relatively stable over the past five years, from a rate of 6.9 per 1000 population in 2004 to 6.8 in 2009. Females have a consistently higher rate of registration with public mental health services than male young people at all ages in adolescence (see Figure 6.7).

**Figure 6.7:** Victorian mental health registrations per 1000 population for young people aged 12–17, by sex, 2004–09

Of the Victorian children and young people with mental problems who are hospitalised, the most common reasons for hospitalisation are mood disorders, neuroses, stress-related and somatoform disorders and mental health problems due to use of psychoactive substances (see Figure 6.8). There is a distinct difference in the rate and reasons for hospitalisation for females and males, with 40 per 10,000 females hospitalised for mood disorders compared to 14 per 10,000 males. Figure 6.9 indicates that the higher rates of hospitalisation of Victorian young people increase with age, with the rate for females increasing significantly around age 14 in comparison to males.

*Source: Victorian Admitted Episodes Data; ABS Preliminary Estimated Resident Population by Single Year of Age, Sex and Statistical Local Areas of Victoria, 30 June 2009 (unpublished).*

**Figure 6.8:** Diagnosis of psychiatric hospitalisations* of young people aged 12–17, by sex (pooled data), 2004–09

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*Source: CMI/ODS 20-02-2011; Victorian Department of Health*
Figure 6.9: Psychiatric hospitalisation rates* for Victorian young people aged 12–17, by age and sex (pooled data), 2004–09

*Data are based on principle diagnosis ICD 10 and may include ‘repeat’ admissions for the same individuals.
Source: Victorian Admitted Episodes Data; ABS Preliminary Estimated Resident Population by Single Year of Age, Sex and Statistical Local Areas of Victoria, 30 June 2009 (unpublished).

The overall hospitalisation rate for Victorian young people for mental health problems has decreased, from a rate of 14.8 per 1000 females aged 12–17 years in 2004 to 11.4 in 2009. The rate for males has similarly declined, from 8.5 per 1000 in 2004 to 5.5 in 2009 (see Figure 6.10). An increasing emphasis on community-based service delivery rather than a reliance on hospitalisation over the period has been a contributing factor to this increase.

Figure 6.10: Psychiatric hospitalisation rates* for Victorian young people aged 12–17 years, 2004–09

*Based on principle diagnosis ICD 10.
Source: Victorian Admitted Episodes Data; Preliminary Estimated Resident Population by Single Year of Age, Sex and Statistical Local Areas of Victoria, 30 June 2009 (unpublished).
Chapter 6
Endnotes

1. A partial syndrome of bulimia nervosa was defined as meeting at least two of the following three criteria:
   - Objective binging at least weekly for at least three months.
   - Use of any of the following for at least three months: self-induced vomiting at least once per week, laxative at least once per week, diuretics at least once per week, fasting (12 hours or longer) on four or more days per week, or vigorous daily exercise to control weight.
   - Report of body weight as very important to the adolescent's sense of self.

A partial syndromal anorexia for males (and females who have not started menstruating) was defined as meeting at least two of the following three criteria:
   - Very low body weight – defined as having a thinness grade 2 or 3
   - Intense fear of gaining weight or becoming fat when have low body weight (defined as thinness grades 1, 2 or 3 above).
   - Disturbance in the experience of body weight, size and shape when have low body weight (defined as thinness grades 1, 2 or 3).

A partial syndromal anorexia for females (who have started menstruating) was defined at meeting at least two of the following four criteria: Criteria 1, 2 and 3 as above, and 4: Have not had a menstrual period within the past 3 months (if not pregnant).
Chapter 6

References


Chapter 7

Sexual and Reproductive Health
Chapter 7
Sexual and Reproductive Health

Sexual and reproductive health encompasses the physical, social, emotional and psychological development of children into young people, and then into sexually and reproductively healthy adults. Adolescence is a critical time for physical maturation (puberty), development of sexual identity and the onset of sexual attraction and related behaviours. By age 12 years, most Victorian young people have started pubertal development; by age 17, the majority have reached or are nearing reproductive maturity. Females reach maturity earlier than males.

Less than one in 20 Victorian young people aged 12–14 years report being sexually active (having had sexual intercourse; 4.7 per cent). However, almost a quarter of Victorian young people aged 15 to 17 years report being sexually active (22.4 per cent). Young people in regional Victoria and young people from socioeconomically disadvantaged areas are significantly more likely to be sexually active. Three in four (74.7 per cent) sexually-active young people in Victoria report always using at least one form of contraception (including condoms, contraceptive pills or other methods) during sexual intercourse. The rate is consistent regardless of sex, age and area of residence of these young people.

Over half of all sexually-active Victorian young people report always using a condom (58.1 per cent), with condom use more common for younger adolescents. Over half of sexually-active young females report always using a condom during sexual intercourse (54.8 per cent), and one in three (33.9 per cent) report always using the oral contraceptive pill to protect against unplanned pregnancies.

The rates of notified sexually transmitted infections (STIs) in Victorian young people have been consistently increasing over the past decade, with chlamydia being the most prevalent, although it is unclear how much this reflects a true increase in prevalence. Older adolescents, females and those from regional areas are more likely to have a diagnosed STI. Immunisation rates are high for Hepatitis B among Victorian young people (74.7 per cent) and for the human papilloma virus (HPV) among Victorian young women (72.8 per cent).

On average, about 10 babies are born per 1000 Victorian women aged 19 years or younger, a fertility rate consistently lower than the national teenage fertility rate. The rate of births to teenage women is consistently higher in regional Victoria compared to metropolitan Victoria.

Most young people have poor knowledge of STIs (with the exception of HIV/AIDS). Young people display particularly poor knowledge of chlamydia. Most report to receive and trust information about their sexual and reproductive health from parents (particularly their mothers), female friends, and school-based sex education programs, health promotion pamphlets, websites and medical doctors.
Sexual and reproductive health covers more than how children physically mature through adolescence into adulthood, and their sexual activities or behaviours. It encompasses the physical, emotional, psychological and social sexual development of children into young people, and then into sexually and reproductively healthy adults.

*Sexual health is a state of physical, emotional, mental and social wellbeing related to sexuality, including the absence of disease, dysfunction or infirmity, a positive and respectful approach to sexuality and sexual relationships, the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence, and respect for the sexual rights of all persons.*

(World Health Organisation, 2002)

Adolescence is a critical time for physical maturation (puberty), development of sexual identity and the onset of sexual attraction and related behaviours. The most recent information about Victorian young people’s sexual and reproductive maturation, activities and knowledge comes from the 2009 HOWRU survey of Victorian young people aged 12–17 years and the Secondary Students and Sexual Health: Fourth National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health of young people in Years 10 and 12 at secondary school across Australia in 2008 (Smith et al. 2009). Information from both these sources relies on young people’s self-report. This is affected by how accurately young people portray their sexual activities and experiences when completing the surveys.

This chapter examines the issues around sexual and reproductive health of Victorian young people. Sexual development (including puberty) and sexuality issues are discussed, followed by information about Victorian young people’s sexual activities. Information about the fertility rate, contraceptive use, including protection against sexually transmissible infections (STIs), is discussed. Victorian young people’s knowledge of sexual and reproductive health and where they seek and receive sex education and health education are also examined.

### Key Victorian Government initiatives: Sexual reproductive health

#### Commitments and new initiatives

- **Catching On Early** primary school sex education professional learning for teachers and school nurses
- Targeted support to schools to promote health and safety of same-sex attracted and gender diverse groups

#### Programs in place

- HPV and Hepatitis B vaccination for children in Year 7
- Comprehensive P–10 sexuality education curriculum and policy support to all schools
- School nurses in secondary schools
- Local initiatives to support the National BBV and STI Strategy
- Family Planning Victoria safe sex and blood-borne infections youth education programs
- Specific youths sexual health and Health and education assessments for children in Out-of-Home Care (OHC)
- Sexual health and sexuality education for children and young people in OHC policy
- **Innovative Health Services for Homeless Youth** program
- Sexual Assault Services for children.
Development and sexuality

When do Victorian children start sexual development?

The onset of physical changes occurs at different ages and rates in individuals. Information from HOWRU 2009 indicates that most Victorian young people have started pubertal development by age 14 (94.5 per cent) (See Figure 7.1). By age 17 years, the majority have reached reproductive maturity (with 63.2 per cent in late pubertal stages and a further 24.9 per cent in post-pubertal maturation). Females reach reproductive maturity earlier than males, confirming national data (See Figure 7.2).

Figure 7.1: Pubertal development of Victorian adolescents, by single year of age, 2009*

*Puberty Category Scores were computed using the criteria of Crockett (1988, unpublished). See endnote 2 for details.

Source: HOWRU 2009, DEECD

Chapter 7

The state of Victoria’s children 2010
Figure 7.2: Pubertal development of Victorian adolescents, by age groups and sex, 2009

What is known about Victorian young people’s sexual and gender identity?

Sexual identity describes how a person identifies their own sexuality, while sexual attraction refers to the sexual emotions and feelings people have towards one another. The relationship between sexual identity, attractions and behaviours is not straightforward, particularly in young people.

Adolescence is a critical time for the emergence of sexual identity and attractions. Recent information from the Secondary Students and Health 2008: Fourth National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health suggests that the majority of young people report sexual attraction towards people of the opposite sex (91 per cent) (Smith et al. 2009). A further 6 per cent report being attracted to both males and females, a small proportion (1 per cent) report same sex attraction, and approximately 2 per cent of young people were unsure of their sexual identity.

Evidence suggests that gay/lesbian, bisexual, trans-sex and intersex (GLBTI) young people face significant challenges in relation to the development of their gender and sexual identities during puberty (Hillier et al. 2010). There is no available information about the experiences of Victorian young people who are questioning their assigned sex and the significant challenges they are likely to face while progressing through puberty and the development of their sexuality.
Sexual activity

What are the sexual experiences of Victorian young people?

Secondary Students and Health 2008: Fourth National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health found that most young people aged 15–18 years have had some form of sexual experience (such as deep kissing, sexual touching or oral sex), with fewer having had sexual intercourse (Smith et al. 2009).

Information from HOWRU 2009 suggests that more than one in five (22.4 per cent) of young Victorians aged 15–17 years have had sexual intercourse, with a smaller proportion (4.7 per cent) of younger adolescents having done so. Significantly more young people in regional areas of Victoria reported having had sexual intercourse (17.8 per cent) than those in metropolitan areas (11.4 per cent) (see Figure 7.3). In this survey, there were 16.6 per cent of survey respondents/students from Catholic schools, most of whom were not required to answer questions related to their sexual experience.

Figure 7.3: Proportion of Victorian young people aged 12–17 years who have had sexual intercourse,* by age group and area of residence, 2009

*In the HOWRU 2009 survey, there were 16.6 per cent of survey respondents/students from Catholic schools who were not required to answer questions related to their sexual experience. Therefore, data from this survey may underestimate the real proportion of sexually active young people in Victoria.

Source: HOWRU 2009, DEECD
When do Victorian young people become sexually active?

Contemporary young people are not only sexually active at a younger age, but may then experience a period of 10–20 years of sexual activity with a number of different partners before marriage or settling down with a life partner. This greatly increases the risk of unplanned pregnancy and STIs in young people today.

(Family Planning Victoria, Royal Women’s Hospital and Centre for Adolescent Health 2005:8)

International and Australian research suggests that many young people have sexual experiences (such as deep kissing or fondling) before engaging in actual intercourse. However, most research has focused on young people’s sexual behaviour (meaning intercourse) as this carries the highest risk of adverse outcomes (such as contracting STIs or pregnancy).

The age of initiation of sexual intercourse by Australian young people has been getting younger over the past three decades (Kang 2007). In HOWRU 2009, of those young Victorians who reported having experienced sexual intercourse, about one third say that their first ‘initiation’ into sexual intercourse was between the ages 12–14 years (33.7 per cent of sexually-active young people)(see Figure 7.4). This is consistent with international research that shows that most people in developed countries experience sexual initiation sometime during their adolescence.

The initiation of sexual intercourse prior to the age of 16 years has been associated with lower rates of contraceptive use, higher risk of contracting STIs, more sexual partners and teenage pregnancy. A concern over these outcomes is one rationale for characterising early sexual activity as ‘problem behaviour’ for young people (Family Planning Victoria et al. 2005).

Figure 7.4: Age of initiation of sexual intercourse, sexually-active Victorian young people aged 12–17 years, 2009

Source: HOWRU 2009, DEECD
Fertility

While being a ‘teenage parent’ does not necessarily mean that an individual or his or her children will experience adverse life outcomes, there is strong evidence that many young people who become parents while they are still adolescents face significant challenges throughout their lives. Support from extended families, friends and the wider community, including schools and other educational settings, can assist young people to successfully face these challenges while raising their children. (See Chapter 12 on families, communities and social support).

Do Victorian young people protect themselves against unplanned pregnancies?

HOWRU 2009 indicates that condoms and/or the contraceptive pill are the most commonly used methods by Victorian young people to protect themselves against unplanned pregnancies. Three in four (74.7 per cent) sexually-active young people in Victoria report always using at least one form of contraception (including condoms, contraceptive pills and/or other methods of contraception) during sexual intercourse. The proportion of young people who always use some form of contraception is consistent regardless of sex and age of the young person, and regardless of whether they are based in metropolitan or regional areas of Victoria (see Figure 7.5).

Figure 7.5: Proportion of sexually-active Victorian young people aged 12–17 years who reported always using contraceptives during sexual intercourse, by age group, sex and area of residence, 2009

Over half of the sexually-active female young people report always using a condom during sexual intercourse (54.8 per cent) and approximately one third (33.9 per cent) report always using the oral contraceptive pill to protect against unplanned pregnancies (see Figure 7.6 on page 118). These trends are similar to many other studies; however, the study-based data from Secondary Students and Health 2008: Fourth National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health found higher rates of contraceptive use, with 68 per cent of sexually-active young people always using condoms and 50 per cent using the pill to protect against pregnancy at their last sexual encounter (Smith et al. 2009).
How often does sexual activity by Victorian young people lead to pregnancy?

Given that approximately a quarter of Victorian young people aged 12–17 years are sexually active, it is a very small proportion of these young people whose sexual activities lead to pregnancy. The fertility or ‘birth’ rate for Victorian women aged 19 years or younger (or how many live births occur for every 1000 young women aged 19 years or younger) has been consistently lower than the national rate. The current rate for Victorian young people is 9.9 per 1000 young women, compared to 16.7 per 1000 for young women Australia wide (see Figure 7.7).

Figure 7.6: Use of contraceptives among sexually-active Victorian females aged 12–17 years, 2009

*Indicates data are not statistically significant different at 95 per cent confidence intervals.

Source: HOWRU 2009, DEECD

Figure 7.7: Age specific fertility (birth) rate of females aged 15–19 years*, Victoria and Australia compared, 2009

*Include births to mothers aged less than 15 years.

Source: ABS Births, 2007–09 (Cat. No. 3301.0)
The birth rate for young Victorian women has remained relatively stable (see Figure 7.8), with the rate significantly higher for those from regional areas than those from metropolitan areas. For example, in 2008, the birth rate for regional-based women aged 15–19 years was 16.7 live births per 1000 women, compared to 7.6 live births per 1000 metropolitan-based women of the same age.

Figure 7.8: Birth rate of Victorian females aged 15–19 years, by area of residence


Sexual safety

Risk-taking behaviour is common in many young people, but sexual risk-taking can have serious effects for young people, both short and longer term. Sexual safety in this report relates to protecting against sexually transmitted infections (STIs) through the consistent use of condoms, and through ensuring a safe environment and context in which sexual activity occurs – where sexual activity is not pressured and without the adverse influences of substance use. (Issues relating to unwanted sexual activity, sexual abuse and sexual assault of Victorian children and young people are discussed in Chapter 10).

Key policy directions relating to STIs

- National Hepatitis B Strategy 2010–2013
- Second National Sexually Transmissible Infections Strategy 2010–2013
- Third National Hepatitis C Strategy 2010–2013
- Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–2013

Do Victorian young people protect themselves against STIs?

Australia has seen a rise in the rate of many STIs over the past decade. Contracting a STI during adolescence can have significant effects on future sexual and reproductive health. Adverse outcomes include the development of cervical cancer (through contracting the human papilloma virus), infertility (through contracting chlamydia) and recurrent pain (e.g. herpes simplex virus) or chronic disease, disability and death through the contraction of blood-borne viruses, such as hepatitis or HIV/AIDS. STIs are the main preventable cause of infertility, particularly in women (Family Planning Victoria et al. 2005; Victorian Government 2006b).
Young people are a priority group in the National STI Strategy for 2010–2013, recognising that young people are at the greatest risk of contracting STIs due to their earlier sexual experience than previous cohorts of young people, higher rates of partner change, limited health literacy and barriers to health service access and use. There are some young people who are at greater risk of contracting a STI, including Aboriginal or Torres Strait Islander young people, homeless young people and those who are detained in the youth justice system (Australian Government 2010).

Consistent and correct use of condoms is the most effective means of preventing the transmission of STIs and blood-borne viruses. Recent information about sexually-active Victorian young people suggests that over half always use condoms (58.1 per cent) during sexual intercourse (see Figure 7.9); however, this leaves a large proportion who do not use condoms regularly (30.1 per cent) and a notable group (9.1 per cent) who report never using them. Condom use was more consistent with younger adolescents aged 12–14 years (63.6 per cent always use condoms) than with older adolescents (56.8 per cent).

This information about condom use by Victorian young people from HOWRU 2009 is consistent with that found in the Fourth National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health 2008, whereby nationally 50.8 per cent of young people in Years 10 and 12 reported always using a condom when having sex (Smith et al. 2009). One other way that young people can begin to protect themselves against STIs is through immunisation. In Victoria, immunisation is available for hepatitis B and also for the human papilloma virus (HPV) for females.
Hepatitis B is a blood-borne virus that in chronic cases causes long-term damage, mainly to the liver. Around three quarters of eligible Year 7 students have received the full course of hepatitis B vaccinations (74.7 per cent), with a higher rate for regional-based young people than metropolitan-based young people being fully vaccinated (77.4 per cent compared to 73.6 per cent) (see Figure 7.10).

Since 2006, immunisation has been available to protect against contracting HPV, the most prevalent viral STI in sexually-active people in Australia. In women, it can cause cervical cell abnormalities that can lead to cervical cancer. In 2009, the majority of eligible Year 7 female students in Victoria were fully immunised for HPV (72.8 per cent). Again, there were more regional-based females who were fully immunised (75.9 per cent) against HPV than metropolitan females (71.5 per cent) (see Figure 7.10).

Figure 7.10: HPV and hepatitis B immunisation rate of Victorian Year 7 students, by area of residence, 2009

Source: Victorian School Immunisation Program.

What is the rate of STIs in Victorian young people?

Information about STIs in Victorian young people is collected by the Department of Health as part of the mandatory reporting of some newly diagnosed STIs by medical doctors and laboratories (known as ‘notifications’). This means that the information about STIs in young people presented here only includes those young people who have been tested for, and confirmed, as having a STI. It does not include those young people who have a STI but have not been tested.

Young people have higher rates of STIs than older Victorians. There may be many factors that make young people more susceptible to STIs, including low partner STI treatment, lack of access to health services and sexual ‘risk-taking’ behaviour.

In 2008–09, there were 949 cases of young people aged 12–17 years diagnosed with a notifiable STI in Victoria (see Figure 7.11). Most notifications of STIs were for young people aged 16 and 17 years of age, a total of 767, accounting for 81 per cent of all the notifications for young people aged under 18 years. Following a consistent pattern since 2003–04, STIs are more prevalent in the older age groups of young people as they become more sexually active with age (see Figure 7.11).
The most common STIs are chlamydia, gonorrhoea and syphilis, with chlamydia being by far the most prevalent. Notified chlamydia cases in young people have been increasing yearly since 2003–04 (see Figure 7.12). The chlamydia increase in Victorian young people could be due to many factors, such as the increase of awareness about the disease within the general community and, consequently, increased numbers of people being tested; or it may be because of the greater sensitivity of the tests; or a genuine increase in prevalence.

Figure 7.11: Notifications of STIs among Victorian young people aged 12–17 years, by age, 2003–04 to 2008–09

Source: Notifiable Infectious Disease Surveillance System, Victorian Department of Health

Figure 7.12: Most common STIs among Victorian young people aged 12–17 years, by STI type, 2003–04 to 2008–09

Source: Notifiable Infectious Disease Surveillance System, the Victorian Department of Health
There is also evidence to suggest that female young people are more likely to have a STI than males. Since 2003–04, the rate of STI notifications in Victorian young people has steadily increased, doubling from 1.7 per 1000 Victorian young people aged 12–17 years in 2003 to 3.8 in 2008–09. Female young people consistently have a higher rate of STIs than males (see Figure 7.13). This trend is consistent across Australia, whereby young women have the highest prevalence of chlamydia notifications (Family Planning Victoria et al. 2005). This higher rate of infection in females is not unexpected, given that often chlamydia does not present with obvious symptoms with males. It may be only once symptoms are present in females that they seek medical care (and are therefore tested, diagnosed and the case ‘notified’). In addition, females are more likely to present to primary care facilities (including to gain access to contraceptives) and therefore may be more likely to be tested.

Figure 7.13: STI rates among Victorian young people aged 12–17 years, by sex, 2003–04 to 2008–09

Source: Notifiable Infectious Disease Surveillance System, the Department of Health; ABS Preliminary Estimated Resident Population by Single Year of Age, Sex and Statistical Local Areas of Victoria, 30 June 2009 (unpublished).

Young people living in regional areas of Victoria are more likely to have been notified as having an STI than young people living in metropolitan areas. The rate of STIs in regionally based young people has been consistently higher since 2003 than the rate of STI notifications for their metropolitan peers (see Figure 7.14). This may reflect the evidence presented earlier in this chapter that indicates more young people from regional areas are sexually active than their counterparts in metropolitan areas (see Figure 7.14).

Figure 7.14: Prevalence of STIs among Victorian young people aged 12–17 years, by area of residence, 2003–09

Source: Notifiable Infectious Disease Surveillance System, the Department of Health; ABS Preliminary Estimated Resident Population by Single Year of Age, Sex and Statistical Local Areas of Victoria, 30 June 2009 (unpublished).
Are Victorian young people sexually active under the influence of substances?

An analysis undertaken on the results of HOWRU 2009 further examined the relationships between a range of factors (behaviours and family situations) and unsafe sex (not using condoms) among Victorian young people. The results suggest that:

- Older adolescents (aged 15–17) are twice (1.8 times) as likely to have unsafe sex (not use condoms every time) compared to younger adolescents.
- Females are 1.4 times as likely to report having unsafe sex compared to males.
- Young people who have used illicit drugs are nearly twice as likely (1.8 times) to have unsafe sex compared to those who have never used illicit drugs.
- Young people who have low social and emotional wellbeing are 1.6 times more likely to have unsafe sex than those with higher levels of social emotional wellbeing.6

Further evidence indicates that over a fifth of sexually-active young people were under the influence of alcohol or drugs the last time they had sex (24.2 per cent in 2008) (see Table 7.1), with the numbers being higher for males than for females.

### Table 7.1: Sexually-active Australian students in Years 10 and 12 who reported being drunk or high the last time they had sexual intercourse, by sex, 2002 and 2008 compared

<table>
<thead>
<tr>
<th>SEX</th>
<th>Year 10</th>
<th>Year 12</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>29.9</td>
<td>23.6</td>
<td>27.3</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>23.1</td>
<td>17.9</td>
<td>14.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>26.3</td>
<td>20.1</td>
<td>20.2</td>
</tr>
</tbody>
</table>

Source: Smith et al. (2009)

A study based on the Fourth National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health 2008 found that sexually-active students who did not use condoms gave the following combination of reasons: sex just ‘happened’ (38.5 per cent), they trust their partner (31.4 per cent), they know their partner’s sexual history (27.1 per cent), they don’t like condoms (23.6 per cent), and their partner does not like condoms (20.6 per cent) (Smith et al. 2009).

Having sex under the influence of alcohol may cause young people to be uninhibited, leading to sexually risky practices. Conversely, it may also be possible that young people who engage in high-risk sexual behaviours and alcohol misuse have dispositional factors common to both sexual risk-taking and substance use.
Sexual health education

Most young people do not perceive themselves to be at risk of infection with an STI. However, young people’s sexual relations are often unplanned, sporadic and sometimes the result of pressure or the influence of alcohol or drugs. Sexual relations typically occur before adolescents have gained experience and skills in self-protection, before they have acquired adequate information about STIs, and before they can get access to health services and supplies (such as condoms).


While knowledge of STI transmission does not necessarily lead to the adoption of safer sex practices in young people, awareness and knowledge is a prerequisite for safer sexual behaviour.

What do Victorian young people know about STIs?

The Fourth National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health 2008 provides the most recent information about young people’s knowledge of STIs and diseases comes (see Table 7.2). In this survey, young people were asked a range of questions about their knowledge of various sexually transmitted diseases and infections. Their responses were collated into a composite knowledge score out of ten. There has been an improvement in knowledge about sexually transmitted diseases and infections by young people since 2002, with young women continuing to show consistently better knowledge than males. Knowledge of HIV is particularly high (a score of 9.3 out of 10 in 2008), but generally very poor regarding chlamydia, hepatitis (A, B and C) and human papilloma virus (HPV).

Table 7.2 Australian secondary students (Years 10 and 12) mean knowledge scores of sexually transmitted diseases and infections, by sex, 2002 and 2008*

<table>
<thead>
<tr>
<th>Knowledge type</th>
<th>Males</th>
<th>Females</th>
<th>2002</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV transmission</td>
<td>9.2</td>
<td>9.2</td>
<td>9.3</td>
<td>9.4</td>
</tr>
<tr>
<td>STI knowledge</td>
<td>5.5</td>
<td>6.7</td>
<td>6.7</td>
<td>7.5</td>
</tr>
<tr>
<td>Hepatitis knowledge</td>
<td>4.1</td>
<td>4.4</td>
<td>4.4</td>
<td>4.7</td>
</tr>
<tr>
<td>HPV knowledge</td>
<td>N/A</td>
<td>N/A</td>
<td>2.8</td>
<td>5.3</td>
</tr>
</tbody>
</table>

*Knowledge scores reflect a mean score derived from answers to questions related to knowledge. Scores can range from 0–10 with higher scores indicating better knowledge. Source: Smith et al. (2009).
Parents and teachers, with the support of the community, have the main responsibility for providing adolescents with the information they need to protect themselves from sexual and reproductive ill-health. Once informed, adolescents too can play an important role in passing on the information to their peers. (World Health Organisation, 2006)

Young people source information about sexual and reproductive health from a range of sources. The most commonly used sources of information for young people were their mothers (56 per cent) or a female friend (54.5 per cent), a school-based sexual health program (48.7 per cent), pamphlets (44.1 per cent), doctors (39 per cent) and websites (35.8 per cent). Interestingly, while the most ‘trusted’ source of information was doctors, with 73.3 per cent of young people saying they trusted sexual and reproductive health information from doctors, and one in four (39 per cent) reported using doctors as a source of information (see Table 7.3).

Table 7.3 Sources of information used by students for sexual health, Australia, 2008

<table>
<thead>
<tr>
<th>Source</th>
<th>Year 10 Used</th>
<th>Year 10 Trusted</th>
<th>Year 12 Used</th>
<th>Year 12 Trusted</th>
<th>TOTAL Used</th>
<th>TOTAL Trusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>28.4</td>
<td>69.5</td>
<td>51.7</td>
<td>78.2</td>
<td>39</td>
<td>73.3</td>
</tr>
<tr>
<td>Community Health Service</td>
<td>13.1</td>
<td>49.8</td>
<td>14.5</td>
<td>42.3</td>
<td>13.7</td>
<td>46.5</td>
</tr>
<tr>
<td>School Program</td>
<td>44.6</td>
<td>52.3</td>
<td>53.6</td>
<td>43.9</td>
<td>48.7</td>
<td>48.6</td>
</tr>
<tr>
<td>School counsellor</td>
<td>12.4</td>
<td>41.3</td>
<td>19.2</td>
<td>35.1</td>
<td>15.5</td>
<td>38.5</td>
</tr>
<tr>
<td>School nurse</td>
<td>13.7</td>
<td>40.9</td>
<td>17.8</td>
<td>33.8</td>
<td>15.6</td>
<td>37.8</td>
</tr>
<tr>
<td>Teacher</td>
<td>30.0</td>
<td>41.2</td>
<td>27.2</td>
<td>35.4</td>
<td>28.7</td>
<td>38.7</td>
</tr>
<tr>
<td>Other community worker</td>
<td>11.5</td>
<td>24.8</td>
<td>10.5</td>
<td>14.6</td>
<td>11.1</td>
<td>20.3</td>
</tr>
<tr>
<td>Youth worker</td>
<td>10.9</td>
<td>29.4</td>
<td>10.7</td>
<td>20.7</td>
<td>10.8</td>
<td>25.6</td>
</tr>
<tr>
<td>Media</td>
<td>30.4</td>
<td>23.3</td>
<td>39.7</td>
<td>20.8</td>
<td>34.6</td>
<td>22.2</td>
</tr>
<tr>
<td>Pamphlets</td>
<td>40.7</td>
<td>41.7</td>
<td>48.2</td>
<td>46.7</td>
<td>44.1</td>
<td>43.9</td>
</tr>
<tr>
<td>Internet web sites</td>
<td>34.3</td>
<td>27.7</td>
<td>37.5</td>
<td>20.6</td>
<td>35.8</td>
<td>24.6</td>
</tr>
<tr>
<td>Internet chat rooms</td>
<td>12.3</td>
<td>15.3</td>
<td>10.1</td>
<td>10.3</td>
<td>11.3</td>
<td>13.1</td>
</tr>
<tr>
<td>Mother</td>
<td>47.8</td>
<td>67.2</td>
<td>65.9</td>
<td>70.4</td>
<td>56.0</td>
<td>68.6</td>
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<td>51.4</td>
<td>36.1</td>
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<td>37.8</td>
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<td>55.3</td>
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</tr>
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<td>8.5</td>
<td>10.4</td>
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<td>12.6</td>
<td>6.1</td>
<td>6.0</td>
<td>11.6</td>
<td>9.7</td>
</tr>
</tbody>
</table>

Source: Smith et al. (2009)
In schools

There is currently no reliable information on the number of primary and secondary schools in Victoria providing sex education, but there is very strong evidence to suggest that sex education, and HIV programs in particular, help delay sexual activity for some young people and increase responsible sexual behaviour among those who do become sexually active (Family Planning Victoria et al. 2005).

In Victoria, sex education (or sexual health education) is covered in the Health and Physical Education key learning area in the secondary school curriculum, guided by a number of government policies. Schools may vary as to the format, frequency, content and quality of sex education taught. Primary school-based sexual and reproductive health education is thought to form the basis of secondary school sex education and may be important in terms of timing of information delivery and knowledge acquisition prior to the onset of sexual activity.

Health care providers

Health professionals are one of the key sources of information about sexual and reproductive health for young people, but only 39 per cent of young people report using doctors, 13.7 per cent use community health services and 15.6 per cent use school nurses to access information about sexual and reproductive health (see Table 7.3).

From their parents

Parents and family members are important sources of information about sexual and reproductive health. Communication about sexual issues can be challenging for both parent and child, and research shows that the most effective discussions about sexual and reproductive health and issues occur when the parent has significant knowledge, comfort, skills and confidence. There is evidence that risk-taking sexual behaviour in young people depends on the timing, frequency and quality of parent–adolescent communication about sexual and reproductive health. Effective communication about sex by parents can lead young people to postpone sexual intercourse, remain abstinent, have fewer sexual partners and consistently use contraceptives (Jerman & Constantine 2010).

Information from the Fourth National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health 2008 showed that almost half of the young people surveyed reported being confident talking to their parents about sex (47 per cent), contraception (52 per cent) and STIs (56.4 per cent) (Smith et al. 2009). Over half (56 per cent) of young people listed their mother as a source of sex information, 31.1 per cent listed their father, 13.3 per cent listed older brother/s and a further 18.1 per cent listed older sister/s (Table 7.3).
Chapter 7
Endnotes

1. While the National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health in 2008 survey is based on a national sample of 2926 young people in years 10 and 12 at secondary school (including 449 Victorian young people), the authors of the survey indicate that there are no significant differences between responses by Victorian young people and those in other states and territories. As such, national data are presented here to reflect trends in relation to Victorian young peoples’ sexual and reproductive health.

2. Pubertal development is assigned the following stages in response to specific questions on the HOWRU 2009 survey about growth of body hair, growth of facial hair, deepening of voice for males, growth of breasts for females and menstruation for females. Response options were: not yet started (1 point); barely started (2 points); definitely started (3 points); seems complete (4 points); I don’t know (missing). Yes on the menstruation item = 4 points; no = 1 point. Point values are averaged for all items to give a Pubertal Development Scale (PDS) score. Puberty Category Scores were computed using the criteria of Crockett (1988, unpublished) by totalling the scale values given above.

To compute Puberty Category Scores for males use body hair growth, voice change and facial hair growth as follows:

- Pre-pubertal = 3
- Early Pubertal = 4 or 5 (no 3-point responses)
- Mid-pubertal = 6, 7, or 8 (no 4-point responses)
- Late pubertal = 9–11
- Post-pubertal = 12

To compute Puberty Category Scores for female use body hair growth, breast development, and menarche as follows:

- Pre-pubertal = 2 and no menarche
- Early puberty = 3 and no menarche
- Mid-pubertal ≥ 3 and no menarche
- Late puberty ≤ 7 and menarche
- Post-pubertal = 8 and menarche

3. See above Endnote 2.

4. Sex questioning refers to an individual questioning the usefulness and validity of their current biological sex and assigned sex and includes people who see the categories of male/female as meaningless and those that feel that their sex does not align with the sex assigned to them at birth.

5. The detailed results of this logistical regression analysis are presented in the State of Victoria’s Children and Young People 2010 Data Compendium. For this analysis, ‘unprotected sex’ is defined as young people who reported not always using a condom.

6. Positive Psychological Development (PPD) refers to an adaptive and healthy state of social and emotional functioning. PPD is indicated by perceptions of autonomy (sense of personal agency), relatedness (positive connections with others) and competence (feeling capable or masterful). Ryan & Deci (2001) developed a 21-item scale which assesses autonomy, competence and relatedness. From this a 9-item Basic Psychological Needs Scale has been developed and was used within HOWRU 2009.
Chapter 7
References

- Family Planning Victoria, Royal Women's Hospital, Centre for Adolescent Health (2005). The Sexual and Reproductive Health of Young Victorians, Melbourne.
- Hillier, L., A. Turner, et al. (2005). Writing themselves in again – six years on: The second national report on the sexuality, health and well-being of same sex attracted young people, Australian Research Centre in Sex Health and Society, La Trobe University, Melbourne.


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Substance Use
Alcohol, tobacco and illicit drugs are major causes of preventable injury, disease and death in Australia. Adolescence is recognised as a critical time for experimentation and initiation into substance use, and patterns of substance use in adolescence can have profound influences on substance use or misuse in adulthood. Moreover, recent evidence indicates alcohol use and misuse has negative effects on the physical (including brain) development of young people.

The most recent information about Victorian young people’s substance use comes from the Victorian Adolescent Health and Wellbeing Survey (HOWRU 2009) and the Australian Secondary Students’ Alcohol and Drug (ASSAaD) Survey 2008 (Victorian results). Information from both these surveys relies on self-report by young people.

One in four Victorian young people aged 12–17 years report having smoked tobacco at least once. Of the 11.5 per cent of Victorian young people who smoked over the last year, nearly one in three (29.9 per cent) smoked regularly, with more than half of these regular smokers smoking on a daily basis (16.9 per cent). However, the proportion of Victorian young people who are regular smokers has decreased over the past decade. Four in five Victorian young people are aware of the health risks associated with smoking.

Alcohol consumption in Victorian young people is more common than tobacco smoking, with three in five (59.8 per cent) having drunk alcohol at least once, and almost two in five consuming alcohol over the past month (37.7 per cent). Rates of recent binge drinking are much higher among older adolescents (29.7 per cent of 15–17 year olds compared to 8.9 per cent of 12–14 year olds). Alcohol consumption is higher among young people in regional Victoria. Almost three quarters of Victorian young people aged 15–17 report ease of access to alcohol. Most young people are aware of the risk of harm from regular drinking.

A small number of Victorian young people report having used illegal drugs. The most common drug used is cannabis (marijuana) (9.6 per cent report use on at least one occasion); a much smaller proportion (2.8 per cent) has used other illicit drugs at least once; and 7.5 per cent have sniffed glue or chromed at least once. Data suggests that ecstasy use among 16–17 year olds in Victoria increased between 1996 and 2008 but use of cannabis and other hallucinogens has declined. One in five Victorian young people aged 12–17 years report ease of access to cannabis and one in 10 report ease of access to other drugs.

Poly-drug use, where a person uses more than one substance, either at the same time or at different times, can be associated with other high-risk behaviours, such as unsafe/unwanted sex, antisocial and even criminal behaviours (such as carrying a weapon or assaulting another person). There is strong evidence suggesting that family factors (such as parental styles and quality of relationships, parental attitudes to substances, parental substance use, parental monitoring and supervision) and peer substance use can have strong influence on young people’s choices or behaviours related to substance use.
This chapter examines the issue of substance use by Victorian young people. Patterns of tobacco smoking, alcohol consumption and illicit and licit drug use will be considered separately because each have significantly different (but interrelated) usage patterns, causes and effects for young people. The relationship between substance use and mental health problems will also be explored, and issues relating to family and peer influences on young people’s choices to try and use tobacco, alcohol and illicit drugs will also be discussed.

Substance use and misuse in Australia contributes to significant social and community problems and is a major cause of injury, disease and death. One estimate is that substance use costs Australia $55.2 billion a year in crime, health effects, loss of productivity, road accidents and fires (Collins & Lapsley 2008). Evidence suggests that it is licit substances (including tobacco and alcohol) and not illicit drugs (such as cannabis and heroin) that are responsible for most of the harm associated with ‘drugs’ within Australia.

As most people start experimenting with drugs (with tobacco, alcohol, cannabis and a small number with other substances) in adolescence, understanding patterns of substance use in adolescents is important to stemming problems associated with prolonged substance usage. This experimentation may occur in response to curiosity, peer pressure, family or other social influences. For most young people, it will not lead to serious or ongoing substance use or misuse problems. For the small number of young people who do develop substance misuse problems, their lives are often complicated by a range of issues, including leaving school early, unemployment, family conflict and breakdown, physical and mental health problems and/or housing insecurity and homelessness.

Key policy directions relating to substance use by young people

- World Health Organisation, Global Strategy to Reduce the Harmful Use of Alcohol, 2010
- National Health and Medical Research Council, Australian Guidelines to Reduce Health Risks from Drinking Alcohol, 2009
- The National Alcohol Strategy 2006–2011
- The National cannabis Strategy 2006–2011
- The National Tobacco Strategy 2004–2009
- Fourth National Mental Health Plan 2009–2014
- Victorian Mental Health Reform Strategy 2009–19

Key Victorian Government initiatives: Substance use

Commitments and new initiatives

- Expansion of a range of drug, alcohol, health and rehabilitative services for youth justice clients
- Koori Youth Healing Service
- In-depth research project to test innovative secondary drug education program for future statewide implementation

Programs in place

- Comprehensive P–12 drug education curriculum and policy support to all schools
- Secondary school nurses and Student Welfare Coordinators
- School Focused Youth Service
- Drug education professional learning for primary and secondary teachers
- Vic Alcohol & Drug Prevention and Treatment Strategy
- Introduction to the ‘Secondary Supply’ (SS) legislation banning the supply of alcohol to minors in a private residence without parental consent
- Community Education Campaign to inform the community about the SS legislation
- Drug Diversion by Police
- Alcohol and drug treatment services for young people
- Koori Alcohol Action Plan
- Alcohol and drug youth consultants to child protection
- Drug and alcohol services for young people in secure welfare accommodation
- Innovative Health Services for Homeless Youth program.
The most recent information about Victorian young people’s substance use comes from the Victorian Adolescent Health and Wellbeing Survey 2009 (HOWRU 2009) and the Australian Secondary Students’ Alcohol and Drug (ASSAaD) Survey 2008 (Victorian results) (VDH 2009). Information from both these studies relies on self-report by young people and, as such, the reliability of information presented in this chapter will be affected by how accurately young people have portrayed their substance use experience when completing these surveys. Furthermore, the main focus and survey methods (including the design of questionnaires, data collection and sampling procedures) of the two surveys differ to a large degree.

HOWRU is a survey of over 10,000 secondary school students in Years 7, 9 and 11 in Victoria, undertaken for the first time in 2009. This survey provides the opportunity to collect and examine a wide range of information of the health and wellbeing of young Victorians aged 12–17 years, including engagement with learning, family structure and functioning, health and personal experiences, school experience, substance use, access to services and perceptions of safety.

The Victorian ASSAaD Survey was part of a national study assessing substance use among secondary school students in Victoria. It is a paper-based survey that aims to provide prevalence estimates of the use of licit and illicit substances among secondary school students. A total of 4398 students in Years 7–12 took part in this survey, of whom 4267 were aged 12–17 years.

**Tobacco**

In recent years, Australia has seen a decline in smoking rates. However, tobacco smoking continues to be the major cause of preventable disease and death in Australian general population. Adolescence is a critical period in which some young people experiment with tobacco smoking, which may lead to ongoing use in adulthood, and the long-term subsequent health problems associated with it.

What are the problems associated with using tobacco for young people?

There are immediate health effects for young people who smoke tobacco, including shortness of breath, coughing and wheezing, reduced lung development and respiratory symptoms. The most critical effect of smoking by young people is the potential for nicotine addiction and the development of long-term smoking habits, which creates a higher risk of smoking-related cancers (the most notable of which are lung, larynx, mouth and pancreatic cancers) and illnesses that can result in death (e.g. heart disease and stroke, chronic obstructive pulmonary disease and emphysema). The more cigarettes smoked, and the greater the length of time spent regularly smoking, the greater the health risks.

How much do Victorian young people smoke?

Although it is of concern that some Victorian young people who smoke tobacco, including shortness of breath, coughing and wheezing, reduced lung development and respiratory symptoms. The most critical effect of smoking by young people is the potential for nicotine addiction and the development of long-term smoking habits, which creates a higher risk of smoking-related cancers (the most notable of which are lung, larynx, mouth and pancreatic cancers) and illnesses that can result in death (e.g. heart disease and stroke, chronic obstructive pulmonary disease and emphysema). The more cigarettes smoked, and the greater the length of time spent regularly smoking, the greater the health risks.

HOWRU 2009 suggests that about a quarter of Victorian young people aged 12–17 years have smoked a cigarette at some stage in their lives (24.6 per cent); a fifth had smoked in the last year (20 per cent); and a smaller proportion (11.5 per cent) had smoked in the past month (see Figure 8.1). These results are similar to information from the 2008 Victorian Department of Health Survey, which showed that less than one third of Victorian young people aged 12–17 years reported having ever smoked even a few puffs of a cigarette (28 per cent of females and 30 per cent of males) (VDH 2009).
The prevalence of smoking in young people increases with age: the older they are, the more likely they are to have smoked cigarettes ever (36.4 per cent of 15–17 year olds compared to 13.4 per cent 12–14 year olds who ever smoked cigarettes) (see Figure 8.1). These smoking patterns do not differ significantly according to sex, area of residence or socioeconomic status of Victorian young people. Of the 20 per cent who smoked a cigarette in the past year, 29.9 per cent smoked regularly (including 16.7 per cent who smoked every day). Older adolescents aged 15–17 years were more likely to smoke regularly (30.7 per cent, including 17.5 per cent daily) than younger adolescents aged 12–14 years (see Figure 8.2).

Figure 8.1: Prevalence of smoking cigarettes among young Victorian smokers, by age group, 2009

Source: HOWRU 2009, DEECD

Figure 8.2: Frequency of smoking cigarettes among young Victorian smokers over the past year, by age group, 2009

^Not regular smokers include those who smoked once or twice and those smoked once in a while over the year.
*Indicates data are not statistically significantly different across the different age groups at the 5 per cent error level (95 per cent confidence intervals). Source: HOWRU 2009, DEECD
Figure 8.3: Proportion of Victorian secondary school students aged 12–17 who are smokers,* 1984–2008

*Smokers includes current smokers (students who had smoked on at least one day in the past week) and committed smokers (students who had smoked on at least three of past seven days). Source: ASSAaD Survey 2008; VDH (2009)

Figure 8.4: Average number of cigarettes smoked per day by Victorian young people aged 12–17 years who ever smoked cigarettes, 2009^  

^Among those who reported smoking cigarettes over the last month prior to the survey. 
*Indicates data are not statistically significantly different across these three categories at 95 per cent confidence intervals. Source: HOWRU 2009, DEECD

How do Victorian young people access cigarettes?
Most Victorian young people acquire cigarettes from a variety of non-retail sources. Retail of tobacco is legislatively regulated in Australia and it is against the law for people under the age of 18 to purchase tobacco products. Consequently, according to the ASSAaD Survey 2008, nearly eight in 10 young people who smoke obtain cigarettes from non-retail means (79 per cent); with less than half of young people who smoke having obtained their last cigarette from friends (46 per cent) or someone else (16 per cent). About one fifth of young people who smoke reported having obtained cigarette from a retail source themselves (21 per cent) (VDH 2009).

Given that 61 per cent of Victorian students who had smoked a cigarette indicated that their last cigarette was given to them (by friends or others), it is not surprising that many also indicated in HOWRU 2009 that it was ‘easy’ to obtain cigarettes (44.6 per cent), with more older adolescents (aged 15–17 years) stating this than those younger (aged 12–14 years).1
What do Victorian young people think about smoking?

Knowledge, values, attitudes and beliefs have a significant impact on whether young people try cigarettes and continue to smoke. Information from HOWRU 2009 suggests that eight in 10 Victorian young people (84.3 per cent) are aware that there are health risks associated with smoking one or more packs of cigarettes per day; with more older adolescents than younger adolescents being aware of these harmful effects (87.7 versus 81.1 per cent) (see Figure 8.5). This is consistent with results from the ASSaD Survey 2008 (VDH 2009), which showed that more than 90 per cent of students agreed that smoking can harm your health.

**Figure 8.5:** Proportion of Victorian young people aware of risk of harm from heavy smoking,* by age group, 2009

![Bar chart showing the percentage of Victorian young people aware of risk of harm from heavy smoking by age group in 2009.](chart)

*Smoking one or more packs of cigarettes a day.

Source: HOWRU 2009, DEECD

While Victorian young people are aware of the health risks of smoking, a concerning number believe that smokers are usually more ‘popular’ than non-smokers (see Figure 8.6). The belief that smoking is associated with popularity is more prevalent in the younger age group than the older adolescents, regardless of the smoking status of the young person. There has been a significant decrease in the proportion of Victorian young people (in particular 12–15 year olds) who think that smokers are more popular than non-smokers from 1996 to 2008 (see Figure 8.6).

**Figure 8.6:** Proportion of Victorian secondary school students who agreed/strongly agreed that smokers are usually more popular than non-smokers, by age groups and smoking status,* 1996–2008

![Line chart showing the percentage of Victorian secondary school students who agreed/strongly agreed that smokers are usually more popular than non-smokers by age group and smoking status, 1996–2008.](chart)

*Smokers includes current smokers (students who had smoked on at least one day in the past week) and experimental smokers (students who had had at least a puff of a cigarette but who had not smoked in the past week). Source: ASSaD Survey 2008; VDH (2009)
What are the factors associated with smoking in Victorian young people?

There is a range of reasons why some young people smoke cigarettes, including their individual characteristics (such as their personality, sense of self, self-esteem and social competence), social context factors (such as the influence of friends, siblings and parents), and broader environmental factors (such as the availability of cigarettes and messages from the media and tobacco industry regarding smoking).

A further analysis using information from HOWRU 2009 examined the relationships between a range of factors (behaviours and family situations) and whether a young person is a regular smoker. The results indicate that those who:

- have drunk alcohol are 11 times as likely to smoke regularly than those who have not consumed alcohol
- have friends who smoke are nearly seven times as likely to smoke regularly than if their friends are non-smokers
- have used cannabis or other illicit drugs are six times as likely to be regular smokers than those who have not used drugs
- are unaware of the high risk of harm in heavy smoking (smoking one or more packs of cigarettes every day) are nearly three times more likely to smoke regularly than those who are aware of it
- report it ‘easy’ to access cigarettes are more than twice as likely to be regular smokers
- have parents not strongly against smoking are more than twice as likely to be regular smokers
- are exposed to smoking at home are twice as likely to be regular smokers than those who live in a smoke-free home.
- are sexually active are almost twice as likely to be regular smokers
- show low levels of connectedness to school are almost twice as likely to also be regular smokers than those who are engaged with school and learning.

### Factors associated with smoking in Victorian young people

- Has drunk alcohol
- Friends smoke
- Has used cannabis
- Perception of low or no risk of harm in smoking
- Live in metropolitan areas
- Easy access to cigarettes
- Exposed to smoking at home
- Parents not strongly against smoking
- Sexually active
- Disconnected from school
- Being female
Alcohol

What are the problems associated with drinking alcohol for young people?

The majority of Australian adults who regularly drink alcohol do so in moderation (Victorian Government 2008a). However, alcohol consumption is second only to tobacco smoking as a major cause of preventable illness and deaths in Australia’s general population.

The majority of Victorian young people do not regularly use or misuse alcohol, but a considerable proportion of Victorian young people experiment with alcohol and a smaller proportion also experience sporadic heavy or ‘binge’ drinking. The Australian guidelines on alcohol consumption advise against any alcohol consumption before the age of 17 years, and it is illegal for those under 18 to purchase alcohol.

The risk of harm occurring from drinking alcohol varies with age, sex and other biological characteristics of an individual, as well as the setting and context in which it is consumed. As adolescents’ bodies are continuing to mature, their physical immaturity (for example smaller body size) and their inexperience with alcohol can make young people more susceptible to the adverse effects of alcohol than adults. Alcohol use and misuse, and its disinhibiting effects, may cause young people to behave in ways that they would normally not.

There is strong evidence showing that the risks of accidents, injuries, violence, crime, risk-taking behaviour, self-harm and suicide are high among young people under 18 years of age who drink alcohol, with alcohol accounting for approximately 13 per cent of all deaths of young people aged 14–17 years in Australia (Chikritzhs et al. 2004). Alcohol is also a major factor in young people’s risky sexual behaviour (such as unsafe sex) and increased incidents of sexual coercion (see Chapter 7 for detailed discussion). A more dangerous consequence of long-term usage is alcohol dependence, which has a range of health, social and behavioural repercussions for individuals and their families.

How many Victorian young people have consumed alcohol?

While drinking alcohol on one occasion does not mean that the young person ‘drinks alcohol’ regularly, it does indicate an early age of exposure to alcohol. HOWRU 2009 shows that six in 10 Victorian young people have experienced alcohol (59.8 per cent). It is most notable that over half Victorian young people aged 15–17 years have drunk alcohol in the past month (52.3 per cent), compared to less than a quarter (23.8 per cent) of young people aged 12–14. Young people living in regional areas of Victoria are significantly more likely to have drunk alcohol than those in metropolitan areas (see Figure 8.7).

Information from other sources indicates the prevalence of drinking alcohol in young people may be significantly higher. For example the Victorian Department of Health Survey 2008 found that most young people had some experience with alcohol and that use of alcohol increased with age, from around 70 per cent of 12 year olds to around 95 per cent of 17 year olds (VDH 2009).

Many Victorian young people who do drink alcohol do so infrequently. Over half (54.8 per cent) had drunk alcohol once or twice in the past month, with 13.3 per cent reporting drinking 10 times or more in the past month (see Figure 8.8). The number of Victorian young people who had ever consumed alcohol declined in the period 1984–2008, regardless of age (VDH 2009).
Figure 8.7: Prevalence of alcohol consumption in Victorian young people, by age group and area of residence, 2009

Source: HOWRU 2009, DEECD

Figure 8.8: Frequency of alcohol consumption, Victorian young people aged 12–17 years who report ever drinking alcohol over the last month, 2009

Source: HOWRU 2009, DEECD

When do Victorian young people start drinking alcohol?

ASSAaD Survey 2008 shows that 68 per cent of Victorian 16 year old students who had drunk alcohol had their first full serve of alcohol between the ages of 13 and 15. Of concern, an additional 21 per cent of these 16 year olds indicated that they had their first full serve of alcohol at 12 years of age or younger. Information from this survey also indicates that the median age for consuming the first serve of alcohol is 15 years for Victorian young people; and that young people who consume their first drink before that age appear to engage in higher levels of alcohol consumption compared to those who delayed their first drink until they were at least age 15 (VDH 2009).
How much alcohol do Victorian young people drink?

The acute intoxication that results from binge drinking places young people at heightened risk of accidental injury, unwanted or unsafe sexual encounters, violence and drug use.

Recent information from HOWRU 2009 suggests that ‘binge drinking’ (drinking five or more drinks on one occasion) is a common form of alcohol consumption among Victorian young people; with almost one fifth of Victorian young people reported to have engaged in binge drinking in the past two weeks (19 per cent). It was significantly more common for older adolescents (29.7 per cent of 15–17 year olds) and those living in regional areas of Victoria (22.2 per cent)(see Figure 8.9).

Figure 8.9: Proportion of Victorian young people who reported binge drinking* in past two weeks, by age group and area of residence, 2009

* Binge drinking is defined in the HOWRU 2009 as 5 or more drinks in a row in the past two weeks.

Source: HOWRU 2009, DEECD

The average number of drinks consumed in the past week increases with age, with females drinking one per week at age 12 and increasing to an average of six drinks per week by age 17. Similar patterns are evident with males, who report drinking an average of four drinks per week at age 12, increasing to an average of nine drinks per week by age 17. From age 16, males drink significantly more drinks each week than females (see Figure 8.10). Binge drinking is significantly more common in older young people (those aged 18–24 years); however, patterns of alcohol consumption embedded prior to age 18 years are important precursors to drinking behaviour once a young person is at the legal age of drinking.

Figure 8.10: Average (mean) number of alcoholic drinks consumed in the past week by current drinkers* 12–17 years, by sex and age, 2008, Victoria

*Current drinkers: students who had used alcohol on any of the seven days prior to completing the survey (n = 981). Students who consumed more than 20 alcohol drinks on any day in the past week were excluded from analysis. Source: ASSAAd Survey 2008; VDH (2009)
How do Victorian young people access and consume alcohol?

*Students who drank at risk of short-term harm differed from those who did not in how they sourced alcohol and where it was consumed, and generally had a more positive attitude towards alcohol use.*

*(White & Smith, 2009: 60)*

The purchase of alcohol is legislatively regulated in Australia and recently introduced Secondary Supply legislation in Victoria now also prohibits the provision of alcohol to minors in a private residence without parental consent. Most Victorian young people report that they did not purchase their last alcoholic drink (85.2 per cent), with adolescents more likely to have reported purchasing alcohol (15.8 per cent) than younger adolescents (4.6 per cent). Young people living metropolitan areas (14 per cent) are more likely than those in regional areas to have purchased alcohol (8.7 per cent) *(see Figure 8.11).*

Victorian young people who did not purchase their last alcoholic drink report that the most common source of their last alcoholic drink was parents (37.2 per cent) and friends (23.3 per cent). Walk-in bottle shops (37.9 per cent), followed by supermarkets or other licensed liquor retailers (29.8 per cent) were the most common sources of alcohol for young people who report having purchased their last alcoholic drink.3

*Figure 8.11: Sources of last alcoholic drink reported by Victorian young people aged 12–17, by age group and area of residence, 2009*

Given that most Victorian young people obtained their last alcoholic drink from their parents or friends, it is not surprising to find that over half (55.1 per cent) indicate that it is ‘easy’ to access alcohol. The proportion of young people who report it to be ‘easy’ to obtain alcohol is significantly greater for older adolescents (73 per cent of 15–17 year olds) and for young people living in regional areas of the state (59.2 per cent) *(see Figure 8.12).* Consistent with the information that most Victorian young people obtain alcohol from their parents or friends, the most common places of consuming alcohol is at home, parties or friends’ houses *(see Figure 8.13).*

*Figure 8.12: Reported ‘ease’ of access to alcohol by Victorian young people, by age group and area of residence, 2009*
What do Victorian young people think about alcohol?

Knowledge, values, attitudes and beliefs have a significant impact on whether young people try alcohol, their pattern of drinking (such as binge drinking), and whether they progress to ongoing or regular use of alcohol into adulthood. HOWRU 2009 suggests that more than eight in 10 Victorian young people (85.1 per cent) are aware of the risk of harm from consuming one or two drinks of alcohol daily, with more older adolescents (87.8 per cent) reporting this understanding compared to younger adolescents (82.6 per cent) (see Figure 8.14).

ASSAaD Survey 2008 shows that a minority of Victorian young people were aware of the risks associated with binge drinking (five or more drinks in a row). In this survey, 39 per cent of Victorian students aged 12–17 years agreed that binge drinking was very dangerous; with younger students significantly more likely than older students to think so (46 per cent of 12–15 year olds compared to 23 per cent of 16–17 year olds). In 1996–2008 the proportion of Victorian young people who believe that binge drinking is dangerous has increased, regardless of age (from 20 to 23 per cent among 16–17 year olds and from 41 to 46 per cent among 12–15 year olds) (see Figure 8.15).
Information for the survey also indicates that the beliefs and attitudes towards alcohol differ with age among Victorian adolescents (see Table 8.1). Compared to the 12 year olds, the 17 year olds were significantly more likely to think that:

- getting drunk every now and then is not a problem (62 compared to 29 per cent)
- drinking is one of the best ways to relax (45 compared to 23 per cent)
- drinking is a good way of getting to know others (51 compared to 24 per cent)
- those who drink alcohol are more popular than non-drinkers (30 compared to 26 per cent).

Views about alcohol by young people in regional Victoria may also differ from those in metropolitan areas. Regional young people were more likely than their metropolitan peers to think that:

- getting drunk every now and then was not a problem (52 compared to 45 per cent)
- having a few drinks is one of the best ways to relax (40 compared to 32 per cent),
- drinking is a good way of getting to know others (44 compared to 33 per cent).

Table 8.1: Percentage of Victorian secondary students who agree/strongly agreed with attitude statements about alcohol use, by age, and area of residence, 2008.

<table>
<thead>
<tr>
<th>Alcohol attitude statements</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>Region Metro</th>
<th>Region Regional</th>
<th>All population 12-17 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting drunk every now and then is not a problem</td>
<td>29</td>
<td>36</td>
<td>47</td>
<td>53</td>
<td>58</td>
<td>62</td>
<td>45</td>
<td>52</td>
<td>47</td>
</tr>
<tr>
<td>Having a few drinks is one of the best ways of relaxing</td>
<td>23</td>
<td>27</td>
<td>33</td>
<td>40</td>
<td>42</td>
<td>45</td>
<td>32</td>
<td>40</td>
<td>35</td>
</tr>
<tr>
<td>Having a few drinks is one of the best ways of getting to know people</td>
<td>24</td>
<td>26</td>
<td>31</td>
<td>42</td>
<td>47</td>
<td>51</td>
<td>33</td>
<td>44</td>
<td>37</td>
</tr>
<tr>
<td>If someone doesn't have a few drinks then they're not really part of the group</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>People who drink alcohol are usually more popular than people who don't</td>
<td>26</td>
<td>22</td>
<td>29</td>
<td>30</td>
<td>37</td>
<td>30</td>
<td>28</td>
<td>31</td>
<td>29</td>
</tr>
</tbody>
</table>

What is the link between alcohol consumption and injuries in Victorian young people?

There is growing evidence of the specific risks of injuries (accidental or otherwise) associated with drug and alcohol use in adolescence. While the nature of the relationship is complex and not well understood, it has been suggested that there is interplay between substance use, risk-taking behaviours and injuries.

Drinking can increase the risk of injury by individuals engaging in riskier behaviour, exposing them to more hazardous circumstances, or reducing their perception or other biological responses to hazards.

Cases of young people being admitted to hospital for an alcohol-related injury were those that the hospital had identified as relating to the external cause of alcohol.
Table 8.2: Overview of hospital admissions due to alcohol-related injury and poisoning in Victorian young people aged 12–17 years, 2007–09

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ADMISSIONS</th>
<th>PERCENT (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>484</td>
<td>62.2</td>
</tr>
<tr>
<td>Female</td>
<td>294</td>
<td>37.8</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12–14 years</td>
<td>93</td>
<td>12.2</td>
</tr>
<tr>
<td>15–17 years</td>
<td>685</td>
<td>88.0</td>
</tr>
<tr>
<td>Major causes of injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>114</td>
<td>14.7</td>
</tr>
<tr>
<td>Transport</td>
<td>88</td>
<td>11.3</td>
</tr>
<tr>
<td>Poisoning</td>
<td>80</td>
<td>10.3</td>
</tr>
<tr>
<td>Cutting/piercing</td>
<td>34</td>
<td>4.4</td>
</tr>
<tr>
<td>Hit/struck/crushed</td>
<td>24</td>
<td>3.1</td>
</tr>
<tr>
<td>Fires/burns/scalds</td>
<td>8</td>
<td>1.0</td>
</tr>
<tr>
<td>Natural/environment/animals</td>
<td>7</td>
<td>&lt;1.0</td>
</tr>
<tr>
<td>Other unintentional</td>
<td>22</td>
<td>2.8</td>
</tr>
<tr>
<td>Intentional/self-inflicted</td>
<td>150</td>
<td>19.3</td>
</tr>
<tr>
<td>Intentional/inflicted by others</td>
<td>144</td>
<td>8.5</td>
</tr>
<tr>
<td>Other or undetermined intent</td>
<td>104</td>
<td>13.4</td>
</tr>
<tr>
<td>Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Road, street or highway</td>
<td>110</td>
<td>14.1</td>
</tr>
<tr>
<td>Home</td>
<td>187</td>
<td>24.0</td>
</tr>
<tr>
<td>School, public buildings</td>
<td>21</td>
<td>2.7</td>
</tr>
<tr>
<td>Trade or service area</td>
<td>48</td>
<td>5.9</td>
</tr>
<tr>
<td>Other specified place</td>
<td>54</td>
<td>6.9</td>
</tr>
<tr>
<td>Unspecified place</td>
<td>360</td>
<td>46.3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>778</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: VAED (hospital admissions, including same day admissions) 2007–09

Table 8.2 provides an overview of the analysis of the 778 hospital admissions due to alcohol-related injury in Victorian young people aged 12–17 years over the three-year period 2007–09. Males were more at risk for alcohol-related injury than females, accounting for 62 per cent of admissions. The admissions among young people aged 15–17 years accounted for around seven times of that among children aged 12–14 years (685 admissions compared to 93). Almost one quarter of the children and young people who were admitted to hospital for alcohol-related injuries were injured at home (24 per cent), while 14 per cent were injured on roads/streets/highways (see Table 8.2).

Data suggests that the rate of alcohol-related injury hospitalisation has increased over the past decade (see Figure 8.16). The hospitalisation rate due to alcohol-related injuries for Victorian young people aged 12–17 years has been significantly lower than that for young adults aged 18–24 year olds over the past decade. However, the hospitalisation rate for both age groups increased from 2000 to 2009 (from 26 to 36 per 100,000 for 12–17 year olds and from 89 to 107 per 100,000 for 18–24 year olds) (see Figure 8.16).

It is unclear whether this increase in rates of alcohol-related injury hospitalisations for Victorian young people reflects a ‘true’ increase in alcohol-related injuries occurring to young people or improved recording of alcohol within the hospital data sets.
What are the factors associated with alcohol consumption in Victorian young people?

A further analysis using information from HOWRU 2009 examined the relationships between a range of factors (behaviours and family situations) and if a young person had recently had an episode of ‘binge’ drinking. The results indicate that those who:

- report it ‘easy’ to access alcohol are nearly four times as likely to binge drink that those who report it more difficult to access alcohol
- have smoked cigarettes are nearly four times as likely to have had an episode of binge drinking than those who have not smoked
- have friends drinking alcohol are three times more likely to binge than those whose friends do not drink
- have parents not strongly against drinking alcohol are nearly three times more likely to binge drink than young people whose parents are strongly against it
- are sexually active are nearly three times more likely to binge drink as those who are not sexually active
- have used cannabis or other drugs are more than twice times as likely to have had an episode of binge drinking as those who have not used drugs
- report to have assaulted someone are just under twice more likely to binge drink
- report to have carried a weapon are more likely to binge drink
- think there is no risk of drinking alcohol are more likely to binge drink
- are older are more likely to binge drink than younger adolescents
- have siblings drinking are more likely to binge drink
- are in families categorised as having unhealthy family functioning are more likely to binge drink.

Factors associated with binge drinking in Victorian young people

- Easy access
- Smoked cigarettes
- Friends drinking alcohol
- Parents not strongly against drinking
- Any alcohol
- Sexually active
- Used cannabis or other illicit drugs
- Physically assaulted someone
- Aged older
- Ever carried a weapon
- Siblings drinking alcohol
- Perceives no great risk of harm from one or two drinks everyday
- Unhealthy family functioning

*Data includes cases of unintentional injury, intentional injury (self-harm and assault) and injuries of 'other or undetermined' intent.
Source: VAED (excluding same day admissions) 2000–09
Use of illicit drugs and misuse of licit drugs

The most commonly used illicit drug in Australia is cannabis (marijuana), followed closely by cocaine, and amphetamine-type stimulants such as ecstasy and ice. Licit substance use (e.g. sniffing paint, glue or petrol) and pharmaceutical drugs are used by young people to gain altered experiences in the same way that illicit drugs are used. Data on misuse of pharmaceutical drugs by young people are not available for inclusion in this report, but future surveys will include this information.

What are the problems associated with using and misusing drugs for young people?

The use of illicit drugs and misuse of licit drugs may contribute to a number of immediate, short and long-term health, economic and social problems, although the specific effects and problems may differ depending on the type of drugs.

Cannabis use can result in acute effects (e.g. impairment of reaction times, cognitive acuity and motor skills) or longer-term effects (including instigating and exacerbating psychotic illness and symptoms of schizophrenia). Long-term cannabis use has been linked to cancer, respiratory diseases and other illnesses. Use of ecstasy can result in increased heart rate, blood pressure and body temperature, which can result in stroke, heart problems or failure and kidney failure. Intravenous drug use increases the risk of contracting blood borne viruses.

Regardless of the specific illicit drug being used, common problems associated with illicit drug use by young people include:

- drug dependence
- instigating, complicating or exacerbating mental health problems or disorders
- aggression or violence
- unsafe sex
- social and economic disadvantage factors, such as leaving school early, unemployment and housing instability

Multiple substance use (poly-drug use), where a young person takes a combination of substances together (most often alcohol and illicit drugs), increases the risks of each individual drug taken.

How many Victorian young people have used illicit drugs and licit substance?

Information from ASSAaD Survey 2008 indicates that, for most types of drugs, there have been significant changes in the number of Victorian young people who have ever used drugs between 1996 and 2008. Lifetime usage of cannabis and other hallucinogens declined for Victorian young people in all age groups in 1996–2008. For younger adolescents aged 12–15 years, there was a decline in use of amphetamines (significantly for males), opiates and heroin and cocaine use (VDH 2009).

HOWRU 2009 shows that one in 10 Victorian young people (9.6 per cent) report having used cannabis; a smaller proportion (2.8 per cent) of young people report having used other illicit drugs; and 7.5 per cent have used inhalants (see Figure 8.17). The use of cannabis or other illicit drugs is more common among older adolescents (aged 15–17), whereas inhaling substances is more common among younger adolescents (see Figure 8.17). Males are more likely to use cannabis or other drugs than females, while females are more likely to use inhalants (see Figure 8.18).

Of note, is the significant increase in 1996–2008 in the number of 16–17 year olds (particularly females) who have reported to have used ecstasy (see Figure 8.19). While only small numbers of Victorian young people report having used ecstasy in 2008 (between 2–8 per cent, depending on age and sex), the proportion of young people using this drug has increased significantly for older adolescents (aged 16–17 years) and, in particular, for older females over the past decade.
Figure 8.17: Prevalence of illicit drugs and licit substance use among Victorian young people, by age group and drug type, 2009

- Ever used
- Used in past 30 days

Other illicit drugs, including cocaine, heroin and amphetamines.
Chroming is the practice of inhaling vapour from a chrome-based spray paint sprayed into a paper bag as a hallucinogen.

Source: HOWRU 2009, DEECD

Figure 8.18: Prevalence of illicit drugs and other substance use among Victorian young people, 2009

- Ever used
- Used in past 30 days

Other illicit drugs, including cocaine, heroin and amphetamines.
Chroming is the practice of inhaling vapour from a chrome-based spray paint sprayed into a paper bag as a hallucinogen.

Source: HOWRU 2009, DEECD

Figure 8.19: Proportion of Victorian young people who have ever used ecstasy in their lifetime, by sex and age group, 1996–2008

Source: ASSAaD Survey 2008; VDH (2009)
When do Victorian young people start using drugs?

Regular use of cannabis has been associated with the age of first initiation into drug use, with more regular users having first used the drug at earlier ages. HOWRU 2009 shows that over half of Victorian young people who have used drugs (57.8 per cent) report having tried drugs for the first time between ages 14 and 16 years.

How do Victorian young people access drugs?

Given cannabis is the most commonly used illicit drug by young people, it is not surprising that more young people (21.9 per cent) say it is ‘easy’ to obtain cannabis than those who say it is ‘easy’ to obtain other types of drugs (11.6 per cent). More older adolescents (aged 15–17) than the younger age group report it to be ‘easy’ to obtain both cannabis and other drugs, with more males than females of all ages doing so (see Figure 8.20).

Figure 8.20: Reported ‘ease’ of access to illicit drugs by Victorian young people, by age group and sex, 2009

Source: HOWRU 2009, DEECD
What do Victorian young people think about drugs?
ASSAaD Survey 2008 shows that the most common reasons for trying illicit drugs given by young people are curiosity and peer pressure. For young people who have not used them, the most common reasons given were concerns over health problems, observing negative experiences of other people and just not being interested. Notably, 16–17 year old young people in this survey are more likely than older young people (aged 18–24) to say that they have never tried drugs because of drug education at school or because of advertising on TV or elsewhere (VDH 2009).

In HOWRU 2009, when asked about their awareness of harm from cannabis use, most Victorian young people report that they are aware of a high risk of harm of using cannabis regularly (65.8 per cent). A considerably smaller proportion of young people believe that a high risk of harm can occur from using it once or twice (34.5 per cent). Females are more likely to report awareness of a high risk of harm from any cannabis use than male young people (see Figure 8.21).

Figure 8.21: Proportion of Victorian young people aware of risk of harm from using cannabis, by age group and sex, 2009

Factors associated with illicit drugs use in Victorian young people
- Aged older
- Being male
- Has ever smoked cigarettes
- Friend(s) using illicit drugs
- Has drunk alcohol recently
- Brother(s)/sister(s) ever used illicit drugs
- Parents not strongly against the use of cannabis
- Sexually active
- Perceive no great risk of harm in using cannabis once or twice
- Easy access to illicit drugs
- Disconnected from school
- Unhealthy family functioning

Evidence from ASSAaD Survey 2008 suggests that Victorian young people’s belief in the risk of drug use on mental health differs, depending on their own substance use experience. Of young people who have never used illicit drugs of any kind, a significant number (over 90 per cent) believe that the various drugs are dangerous to mental health. Those who had used drugs at least once were significantly less likely to believe that using illicit drugs regularly would be dangerous for their mental health, which was consistent for all types of drugs (VDH 2009).
What are the factors associated with using illicit drugs in Victorian young people?

Further analysis of HOWRU 2009 data examined the relationships between a range of factors (behaviours and family situations) and if a young person had ever used illicit drugs. Results indicate that those who:

• have smoked cigarettes are nearly nine times as likely to have used illicit drugs than those who never smoked
• with friends using illicit drugs are five times as likely to have used illicit drugs than those whose friends do not
• have consumed alcohol are nearly five times as likely to have used illicit drugs than those who have not
• have siblings using drugs are over three times more likely to have used illicit drugs than someone whose siblings do not
• are sexually active are nearly three time as likely to have used illicit drugs than those who are not
• think there is no great risk in using cannabis once or twice are more than twice as likely to have used illicit drugs than those who think there is a great risk of harm
• report it to be ‘easy’ to access drugs are nearly twice as likely to use drugs than those who find it more difficult
• are older adolescents are nearly twice as likely to use drugs than younger adolescents
• are male are nearly twice as likely to use drugs than females
• feel disconnected to school are more likely to use drugs than those who feeling connected to school.

Family and peer influences on substance use

There is strong evidence from both HOWRU 2009 and ASSaD 2008 to suggest that the aspects of family and peer groups influential in substance use by young people are parental styles and quality of relationships, parental attitudes to substance, parental substance use, parental monitoring and supervision, and peer use of substances.

The risk and protective factors associated with family and friends relevant to substance use in young people are often also relevant to a range of other outcomes in young people (such as engagement with school, sexual behaviour, social and emotional wellbeing). (See Chapter 12 for a detailed discussion of the influence of family functioning on outcomes for Victorian children and young people).

What do Victorian parents think about substance use by their children?

The attitude of parents towards substance use is associated with whether a young person also uses substances. The way in which families deal with a young person who is experimenting with smoking, drinking or using drugs can be critical to their ongoing substance use.

HOWRU 2009 shows that the majority of young people report their parents are strongly against substance use, with 88 per cent being against smoking cigarettes, 58 per cent against regular alcohol use and 93 per cent against cannabis use. Information from this survey also suggests that:

• Younger adolescents (12–14 years) are more likely than the older group (15–17 years) to report their parents being strongly against smoking cigarettes (89.6 per cent compared to 86.2 per cent) and regular alcohol use (44.5 per cent compared to 77.8 per cent).
• Parents’ attitude towards cannabis use is similar, regardless of the age of young people.
• Females are more likely than males to report their parents being strongly against substance use, including smoking cigarettes (89.1 per cent compared to 86.8 per cent, regular alcohol use (59.1 per cent compared to 56.9 per cent), and cannabis use (95 per cent compared to 91.1 per cent).
Do Victorian parents use substances?

Not allowing smoking within the home reduces the exposure of children and young people to harmful environmental tobacco smoke. Evidence suggests that infants and children exposed to second-hand smoke have an increased risk of premature death and disease (including from Sudden Infant Death Syndrome), increased frequency and severity of asthma and lower respiratory tract infections.

The majority of Victorian young people (74 per cent) are not exposed to tobacco smoke at home. However, young people are more likely to live in homes with people smoking in the house if they come from the most disadvantaged background or they are from lone-parent families (see Chapter 11 for detailed discussion).

Parental substance use (including illicit drug use and misuse of alcohol) can cause an array of problems within the family and for the young person, including instability or breakdown of family relationships, increased risk of abuse or neglect, and financial or housing strain for the family. These family problems can in turn heighten the risk of the young person experiencing other adverse events, such as leaving school early, developing antisocial behaviour and their own substance use. There is evidence that young people who have an alcohol dependent parent are at a greater risk of developing drug or alcohol problems.

There is evidence from ASSAaD Survey 2008 that the proportion of Victorian students who smoked increased if one or both parents smoking; for instance, of the 16–17 year old students whose parents are smokers, 26 per cent are current smokers compared to only 11 per cent of students whose neither parent smoked (see Figure 8.22).

Figure 8.22: Proportion of Victorian secondary school students aged 12–17 who smoke, by number of parents smoking, 2008*

<table>
<thead>
<tr>
<th>No parent smoking</th>
<th>One parent smoking</th>
<th>Both parents smoking</th>
<th>No parent smoking</th>
<th>One parent smoking</th>
<th>Both parents smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>86</td>
<td>29</td>
<td>61</td>
<td>38</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td>11</td>
<td>7</td>
<td>13</td>
<td>11</td>
<td>7</td>
<td>13</td>
</tr>
</tbody>
</table>

*Current smokers: students who had smoked on at least one day in the past week; experimental smokers: students who had had at least a puff of a cigarette but who had not smoked in the past week; never smokers: students who had not even had a puff of a cigarette.

Source: ASSAaD Survey 2008; VDH (2009)
Do Victorian parents monitor substance use?

Parents’ awareness of, and communication about, young people’s substance use has been demonstrated to have an impact on young people's substance use (particularly alcohol). Poorly monitored young people are more likely to begin drinking alcohol at a younger age, to drink more and to develop harmful patterns of drinking.

Evidence suggests that environments where there is minimal adult supervision and monitoring are more conducive to young people smoking, drinking or taking drugs. As adolescents mature, they tend to spend less time with their family than when they were young children and, consequently, there is a greater opportunity for them to consume these substances without the parental knowledge, permission or supervision.

The presence of adults to supervise young people drinking alcohol appears to affect the level of alcohol consumption in Victorian young people. Those who reported binge drinking in the past week were significantly less likely to consume their last drink under adult supervision (46 per cent) than those who did not report binge drinking (63 per cent) (VDH 2009).

What are the influences of friends on young people’s substance use?

The attitudes and activities of friends or peers can have a significant impact on young people's substance use. As discussed in previous sections, analyses based on data from HOWRU 2009 suggest that students who have a peer (sibling or friend) who use one substance (including smoking, binge drinking or illicit drug use) are more likely to use this substance than those without peers using it. The effects and influences of peers have been shown to mitigate the influence parents can have on alcohol and drug use.
Chapter 8
Endnotes

1. Detailed data are provided in *The State of Victoria’s Children and Young People 2010: Data Compendium* (Table A8.1).

2. The detailed results of this logistical regression analysis are presented in *The State of Victoria’s Children and Young People 2010 Data Compendium* (Table A8.2). Regular smokers includes those who smoke every day and those who smoke frequently but not every day.

3. The detailed results of this logistical regression analysis are presented in *The State of Victoria’s Children and Young People 2010: Data Compendium* (Table A8.3).

4. The detailed results of this logistical regression analysis are presented in *The State of Victoria’s Children and Young People 2010: Data Compendium* (Table A8.4).

5. Young people who exposed to both family conflict and poor family management. See Chapter 13 for detailed discussion.

6. The detailed results of this logistical regression analysis are presented in *The State of Victoria’s Children and Young People 2010: Data Compendium* (Table A8.5).

7. HOWRU 2009; see detailed data in *The State of Victoria’s Children and Young People 2010: Data Compendium* (Table A8.6).
Chapter 8
References


Chapter 9
Engagement with Learning

Young people who disengage with learning and, as a result, leave formal learning environments early may experience poorer outcomes in young adulthood and later life. Measures of engagement with formal learning are reviewed and associated individual, school and family factors are discussed.

Victorian children and young people have a high level of engagement with formal education from an early age and this continues well into their twenties.

The proportion of Victorian children attending a kindergarten program in the year prior to formal schooling reached 95.1 per cent in 2010. Based on data from the Australian Early Development Index (AEDI), most children (79.8 per cent) are developmentally on-track at school entry.

Apparent retention rates from Year 10 to 12 (across all schools) have remained steady over the past four years. A high proportion of 19 year olds have attained Year 12 or an equivalent qualification (79.8 per cent), with a number of young people also continuing education into their twenties to reach this level of qualification.

Nearly half of Year 12 completers in Victoria went on to university in 2010 (48.5 per cent) and more than a quarter continued on to other vocational training (26.3 per cent). In Victoria, 15–19 year olds are less likely to be not engaged in full-time education or full-time employment than nationally (12.7 per cent in Victoria compared to 16.4 per cent nationally). However, one in five early school leavers in Victoria are looking for work or not in full time education or employment (21.2 per cent in 2010).

Overall school participation rates are high, but data for Victorian Government schools show school absences peak in Year 9 and are also higher in regional schools. Over a quarter (28.1 per cent) of Victorian young people (all schools) report skipping school at least once in the past month and this is also more likely to occur in more disadvantaged areas.

Many factors influence and indicate how well children and young people engage with learning, ranging from personal and emotional factors to school and family factors.

More than half of Victorian young people (Years 7, 9 and 11 students) report always or often enjoying school (56.3 per cent); with a further 28.9 per cent sometimes enjoying school. Of concern, however, are the 14 per cent of Victorian young people who report rarely if ever enjoying school. Almost half (49.2 per cent) of Victorian young people aged 12–14 years and four in 10 (39.7 per cent) of those aged 15–17 report having experienced bullying. Of particular concern is the 15.7 per cent of all 12–17 year olds who report having been bullied or harassed at school on most days, with a higher proportion for males (18.2 per cent) than females (12.2 per cent).

Measures of many school engagement factors in Victorian Government schools have shown a gradual improvement over the past five years, such as student motivation, school connectedness, teacher support and effectiveness, and students’ perception of school safety. However, consistent with other research evidence, a number of indicators suggest that engagement with learning for some young people declines in the middle years of schooling, particularly in Year 9. These include measures related to students’ learning motivation and confidence, connectedness to peers, perception of school safety, and classroom behaviours.
Engagement with learning describes the extent to which children and young people interact with the opportunities and settings that can give them the increased knowledge and skills required to actively participate in society. It can occur in formal educational environments (e.g. within a kindergarten, school or training provider), or in informal learning settings (e.g. daily interactions with parents or other family members), but in both settings it is a life-long process. Engagement with learning is not about academic or vocational success, or a young person’s intelligence; rather, it involves how each individual participates in and maximises the opportunities for learning provided to them, regardless of their academic grades.

Young people who disengage with learning and, as a result, leave formal learning environments at an early age are more likely to experience difficulties associated with unemployment, poor health, substance abuse and incarceration. As well as the considerable personal costs to a child or young person of poor engagement with learning, there are also substantial costs to society in relation to health and community services.

Key policy directions relating engagement with learning for children and young people

- COAG, National Partnership on Youth Attainment and Transitions, 2009
- The Ministerial Council on Education, Employment, Training and Youth Affairs, Melbourne Declaration of Educational Goals for Young Australians, 2008
- Victorian Government (DEECD), Victorian Early Years Learning and Development Framework 2009
- Effective Schools are Engaging Schools: Student Engagement Policy Guidelines, 2009
- Victorian Training Guarantee, 2008

Key Victorian Government initiatives: Engagement with Learning

**Commitments and new initiatives**
- Combat Bullying/Cyberbullying
- Enforce Truancy Laws
- Establish seven Youth Partnership demonstration sites to address the needs of vulnerable young people
- Pilot effective models education provision for disengaged young people and enable funding flexibility
- Renewed Education commitment for children and young people in Out-of-Home Care, including health and education assessments and appointment of learning mentor
- Transitions for Students with Disabilities
- Additional Primary Welfare Officers
- Expand VET in schools to widen subject and career choices
- Increased funding for Victorian Training Guarantee exemption places
- Reintroduction of TAFE concession fee places for diploma or advanced diploma courses.

**Programs in place**
- Transition: A Positive Start to School
- Sharing our Journey
- Victorian Early Years Learning and Development Framework implementation
- Curriculum options for senior secondary students including VCAL, VETiS, apprenticeships and traineeships
- Student Welfare Coordinators
- A range of flexible learning options to re-engage disengaged students
- Local Learning and Employment Networks
- National Partnership on Youth Attainment and Transitions Career Development Services
- Wannik Aboriginal Education Strategy
- Parent promotion of child development and learning – MCH Program
Economic analyses of several early childhood interventions have demonstrated that, effective programs can repay the initial investment with savings to government and societal benefit. Investment in the early years and continued engagement in learning by children and young people makes good economic sense. Economist James Heckman (2008) and his colleagues have analysed early intervention studies to examine the origins of inequality and policies to alleviate it. Heckman concludes that early development sets the foundation for academic and life skills and early interventions benefit individuals, boost the productivity of the economy and can partially compensate for early adversity and that early skills support later skills and enhance the productivity of later investment in education. A good level of engagement with learning by children and young people is critical to ensure Australia can meet current and future skill shortages.

A range of factors act to promote or hinder engagement with learning. Personal factors influence engagement with learning, encompassing individual learning styles, motivations, emotional responses to school and behaviours. Characteristics of schooling or training environments also act to promote engagement with learning (such as the effectiveness of teachers and training staff, school or institutional culture and opportunities for young people to be included in extracurricular activities and school and training provider policy development). Importantly, social and family factors, such as the influence of peers, parents and the broader community, are also factors that can enhance or hinder a child's engagement with learning.

This chapter examines how well Victorian children and young people engage with learning in formal educational environments from birth through to age 17 years. It focuses on engagement with formal school learning because information related to non-school learning environments is very limited. How well Victorian children and young people are faring on specific measures of engagement with learning is also discussed, including participation in early childhood education and care; school readiness; student participation, attendance and absences; and retention and attainment rates. Information is also provided and discussed on the destinations of young people once they leave school. Risk and protective factors known to affect engagement with learning, including those relating to individual children and young people, their schools and their families, are also considered.

Measuring how well Victorian children and young people engage with learning

What is engagement with learning?

*Engagement is considered the primary theoretical model for understanding dropout and is necessary to promote school completion, defined as graduation from high school with sufficient academic and social skills to partake in post-secondary enrolment options and/or the world of work.*

(Appleton, 2008)

For the purposes of this report, engagement with learning describes the ways in which children and young people interact with the opportunities and settings in their lives that can provide them with increased knowledge and skills.

There is an important distinction between ‘engagement with learning’ and ‘student engagement’. In this chapter, engagement with learning refers to all aspects of interaction with learning by children and young people, whereas ‘student engagement’ is used to describe only the personal behavioural, cognitive and emotional components of these interactions in students. Student engagement commonly refers to the internal personal characteristics of an individual child or young person (as opposed to external family or community factors). These characteristics are made up of ‘behavioural’ factors, such as school attendance, effort and positive conduct; ‘cognitive’ factors, such as willingness, aspirations and self-confidence; and ‘emotional’ factors, such as interest, distress, boredom or curiosity. Because concepts of student engagement only relate to the child’s personal characteristics and do not routinely include influences of broader family, neighbourhood, community and environment, ‘student engagement’ is only one of many factors that reflect how well a child or young person is engaged with learning.

This chapter provides information on available measures of how well Victorian children and young people engage with learning, including their engagement and participation in early childhood education and care; school readiness, school participation, school absences and truancy; as well as their rates of school retention and Year 12 attainment.
How many children engage with early education and care settings?

The first and most important learning environment a child experiences is within their family home *(and the role of parents in promoting learning and development is discussed in Chapter 11)*. Outside their family home, the first learning environment many children experience is within a childcare environment. Childcare can be provided as informal care (provided by extended family, friends or babysitters) or as formal care (i.e. long day care, family day care or occasional care).

In Victoria, formal care environments, particularly day care centres, require staff to have formal qualifications in early childhood education and care. Landmark longitudinal studies, such as the Perry preschool project (Schweinhart 2005) and the Abecedarian program in the United States (Barnett & Masse 2007), have followed up on the long-term outcomes of children from preschool. These studies have demonstrated the significant impact that qualified early childhood educators can have upon preschool children in terms of their academic success and their longer-term outcomes, especially for children from low socioeconomic backgrounds. In the United Kingdom, the Effective Preschool and Primary Education (EPPE) Project has found that participation in a quality early childhood education and care program plays an important role in cognitive and social/behavioral outcomes through to age 11, particularly for disadvantaged children (Sylva et al 2008).

Figure 9.1 shows that almost one third (29.9 per cent) of all Victorian children aged 5 years or younger have experienced formal care environments and are therefore likely to receive a formal introduction to learning within these environments. Although those Victorian children not attending formal childcare may be receiving a suitable introduction to learning through their family, it is unclear if they receive an introduction to learning that is consistent with those received in environments with a qualified early childhood educator.

**Figure 9.1: Victoria children aged 0–5 years, by type of usual care, 2008**

> ^Formal care includes long day care, before/after school care, and family day care or occasional care.
> #Informal care includes children cared by relatives, such as grandparents, non-residential parents and siblings.
> Source: ABS *Childhood Education and Care, Australia, June 2008* (Cat. 44020002)

There are currently significant developments within the early years education and care sector within Australia that recognise the importance of consistent and high-quality education for young children. This includes the National Early Years Learning Framework and the Victorian Early Years Learning and Development Framework. The impact of these policies will include an increase in the number of weekly hours children spend in kindergarten programs and will require higher qualifications for educators and carers within formal care environments (including long day care centres and kindergartens).
The proportion of Victorian children attending a kindergarten program in the year prior to formal schooling has been consistently high over the past decade, reaching 95.1 per cent in 2010 (see Figure 9.2).

**Figure 9.2: Proportion of Victorian children who attended a 4 year old kindergarten program*, 2000–2010**

*Includes Victorian Government-funded kindergarten programs only.
Source: Kindergarten Program 2010, Statewide Report, DEECD

How well prepared are Victorian children to engage with learning at school?

A child is most likely to have positive engagement with learning if they are adequately prepared for school. Children enter developmental stages at different times, and different aspects of those developmental stages (i.e. physical, cognitive, social, emotional aspects) also occur at different rates in different children. However, the concept of ‘school readiness’ is no longer seen solely as a measure of individual child maturation, rather it is recognised that families, early childhood services, communities and schools are all interrelated components (CCCH 2007).

The importance of making a good transition to school is indicated by evidence that school readiness is predictive of later outcomes: children who are less ‘ready’ are less likely to excel academically, and are more likely to have behavioural and emotional problems, be retained in a grade or drop out of school.

(Edwards, Baxter et al. 2009:23)

The Australia Early Development Index (AEDI) is a key measure of children’s development as they enter school and is reflective of the experiences they have had before school. The AEDI measures five areas (or ‘domains’) of development in children, including physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge. These five domains are closely linked to the predictors of good adult health, education and social outcomes. Information is collected by teachers via checklists indicating whether a child is ‘on track’ or ‘developmentally vulnerable’ for each of these domains during the first full year of school.

Most Victorian children (79.8 per cent) do not have developmental vulnerabilities at the start of their primary schooling, but around a fifth of all Victorian children (20.2 per cent) are considered developmentally vulnerable on one or more of the AEDI domains at entry to school. A small, but still significant proportion of children (10 per cent) are developmentally vulnerable on two or more domains (see Figure 9.3).

Some groups of children in Victoria are at greater risk of poor engagement with learning outcomes, especially those that are developmentally vulnerable at school entry. In particular, almost half of Aboriginal and Torres Strait Islander children (42.5 per cent) and nearly one third of children living in the most socioeconomically disadvantaged areas (31.5 per cent) are considered developmentally vulnerable on one or more AEDI domains, boys being consistently more likely to be so than girls (see Figure 9.3).
What do we know about the school participation rates of Victorian children and young people?

The school participation rate measures the total number of students enrolled in school at the school census date as a proportion of the Estimated Resident Population (ERP) on 30 June in that year. Importantly, participation rates do not include students enrolled in formal learning environments other than schools, such as TAFE, other VET providers or universities.

Figure 9.4 indicates that there is an almost full participation rate of Victorian young people in school until the age of 16 years. It is at this time when some young people move to employment or other education and training options such as VET. Figure 9.4 also indicates more females than males stay in school until age 16 and 17 years. Among Victorian young people aged 15–19 years, over two thirds (76.5 per cent) are attending full-time education (including 57.4 per cent in school education and 19.1 per cent in tertiary education), with females more likely to participate in it than males. However, just under a quarter of Victorian young people (23.5 per cent) are not participating in full-time education (see Figure 9.5).

Figure 9.3: Percentage of Victorian children developmentally vulnerable on one or more and two or more of the AEDI domains, by Aboriginal status, sex and area of socioeconomic status (SES), 2009

* AEDI results are reported as average scores, ranging 0–10 on each of the five domains. ‘Vulnerable’ are those who score below the tenth percentile (in the lowest 10 per cent) of the national AEDI population. These children demonstrate a much lower than average ability in the developmental competencies measured in that domain.

Source: AEDI 2009; DEECD analyses

Source: ABS, Schools, Australia, 2009 (Cat. No. 4221.0)
What do we know about absence from school in Victorian students?

Information on school absences and reported truancy are indicators of engagement with learning in children and young people. While school absences can reflect absences due to student illness, they can also provide evidence of dissatisfaction or poor engagement with learning by students. Being absent from school without permission is otherwise known as ‘truancy’ or more colloquially as ‘wagging’ school.

In 2009, the average number of school absences in Victorian Government school students was fairly consistent across primary school children in both metropolitan and regional areas of Victoria, with between 14 and 15 days per year for primary school-aged children (see Figure 9.6).

Figure 9.5: Education participation of Victorian young people aged 15–19 years, by sex, 2009

Figure 9.6: Average days of absence of students in Victorian Government schools, by school location, 2009
In secondary school, absences were considerably higher in all years (except Year 12), compared to primary school. Absences peaked at Year 9 (with an average number of 24 school days absent for regional students and 22 for metropolitan students). Year 12 students registered the fewest number of absences in the secondary school years. These patterns of school absences in Victorian secondary school students are consistent with the national evidence, which suggests students in Years 8, 9 and 10 across Australia are generally less engaged with learning than those in other year levels.

HOWRU 2009 indicates that most Victorian young people do not wag school (71.9 per cent). However, over a quarter (28.1 per cent) of Victorian young people reported having wagged school for at least one day over the last month (see Figure 9.7). Young people who reported wagging school for three or more days over the month were more likely to come from the most socioeconomically disadvantaged areas. This indicates that, while many young people, regardless of background, may ‘experiment’ with wagging school, a larger proportion of young people from more disadvantaged backgrounds are likely to wag more often, suggesting increased disengagement with learning.

Consistent with other information indicating relatively poorer engagement with learning for the middle years of schooling (Years 7–9), Figure 9.7 also shows a greater proportion of young people in Years 9 and 11 reporting to have wagged school for three days or more in the past month than those in Year 7.

**Figure 9.7**: Days of school absence over a month^ because of skipping or wagging, Victorian young people aged 12–17 years, by school year level and area of socioeconomic status (SES), 2009

<table>
<thead>
<tr>
<th>Year level</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 7</td>
<td>75.9</td>
</tr>
<tr>
<td>Year 9</td>
<td>71.2</td>
</tr>
<tr>
<td>Year 11</td>
<td>68.7</td>
</tr>
<tr>
<td>Most disad.</td>
<td>66.7</td>
</tr>
<tr>
<td>Least disad.</td>
<td>75.3</td>
</tr>
<tr>
<td>Aged 12–17 yrs</td>
<td>71.9</td>
</tr>
</tbody>
</table>

^Over the last four weeks prior to the survey.

*Indicates data for students at Year 9 and Year 11 are not statistically significantly different at the 95 per cent confidence intervals

Source: HOWRU 2009, DEECD
What do we know about school retention rates?

Apparent retention rates show how many students remain in school at the end of Year 12 as a percentage of the total number of students enrolled in the previous years. They are considered a crude indicator of student retention, as they do not take into consideration students repeating a year or students transferring to other schools. Figure 9.8 indicates that apparent retention rates have remained relatively steady in Victoria over 2006–10, with higher rates for students in metropolitan areas and for females.

Figure 9.8: Victorian Years 10–12 apparent retention rates, by sex and area of residence, 2005–10

![Graph showing apparent retention rates]

^Include both government and non-government schools

Source: DEECD, February school census 2006–10
What do we know about Year 12 attainment in Victorian young people?

The Year 12 or equivalent attainment rate at age 19 is a measure of the proportion of 19 year old young people who have attained a Year 12 or equivalent qualifications in the school sector (including VCE, Victorian Certificate of Applied Learning (VCAL), International Baccalaureate, or VET Certificates level II or higher). Over the last decade since 2001, the Year 12 or equivalent attainment rate has been gradually increasing in Victoria, but it has been consistently higher for those living in metropolitan areas than those living in regional areas of the state (Figure 9.9).

Figure 9.9: Victorian Year 12 or equivalent attainment rate at age 19, by area of residence, 2001–09

![Graph showing Year 12 attainment rate by area of residence in Victoria, 2001–09.](image)

Source: Victorian Curriculum and Assessment Authority (VCAA) and Skills Victoria Administrative Data

In 2009, the Year 12 or equivalent attainment rate for 19 year olds was 79.8 per cent (see Figure 9.9); however, for a slightly older age group (the 20–24 year old population), this increases to 88.1 per cent (see Figure 9.10). This indicates that, while some young people may not attain a Year 12 or equivalent qualification by the age of 19, almost one in 10 continue to remain engaged with formal learning environments in order to reach this qualification level well into their twenties. Figure 9.10 indicates that the Year 12 or equivalent attainment rate for Victorian 20–24 year old young people has been consistently higher than the national rate.

Figure 9.10: Comparison of the proportion of the 20–24 year old Victorian and national population having attained at least Year 12 or equivalent, 2001–10

![Graph comparing Year 12 attainment rates for Victorian and national 20–24 year olds, 2001–10.](image)

Source: ABS Education and Work, Australia (6227.0), 2009
Destinations of Victorian school leavers

While engagement with learning is important throughout life, one of the most important outcomes of good engagement with learning for children and young people is that they are prepared to participate fully in society as an adult, either through pursuing further education and training, and/or participating in the workforce.

The On Track surveys conducted by the Department of Education and Early Childhood Development ascertain the post-school destinations of consenting Victorian students in the first half of the year after they leave school. In 2010, nearly half of those who complete Year 12 in Victoria continue to higher education in universities, 26.3 per cent continue on other vocational training (including TAFE/VET, apprentice and trainee programs), 19.2 per cent are in employment, with a small proportion (4.9 per cent) looking for work (see Figure 9.11). More female (51.5 per cent) than male (45.3 per cent) Victorian young people go to university, while more males (12 per cent) than females (5.2 per cent) go on to apprentice or trainee programs (see Figure 9.11).

Figure 9.11: Post-school education and training and employment destinations, Year 12 completers, Victoria, 2010

In Victoria, fewer young people aged 15–19 years are not engaged in full-time education or full-time employment (12.7 per cent or 46,300 young people) than the Australian average (16.4 per cent Australia-wide)(see Figure 9.12). The proportion of young Victorians not participating in full-time education or employment rose sharply during the period of the global financial crisis of 2008–09 and has only partly recovered in 2010.

There is a significant body of evidence demonstrating that, in comparison to school completers (i.e. those who finish Year 12) early school leavers generally face higher levels of unemployment, poorer health, greater risk of teen pregnancy, substance abuse and incarceration.
In 2010, 34.5 per cent (or 4,094 students) of the 11,882 students who started Years 10, 11 or 12 and left school before completing the year during 2009 provided responses for the 2010 On Track Early Leaver Survey. Almost 80 per cent of early school leavers surveyed continued to engage with informal or formal learning, either through an apprenticeship or traineeship (32.8 per cent), participating in TAFE/VET (20.1 per cent) or through employment (25.9 per cent). However, 21.2 per cent of early school leavers in Victoria were either looking for work, or not engaged in education, employment or training (see Figure 9.13).

In 2010, for the first time since 2003, the number of Victorian early school leavers who were enrolled in VET/TAFE (20.1 per cent) surpassed that of early school leavers who were looking for work (15.8 per cent) (see Figure 9.13). Factors that may be responsible for this include the impact of the global financial crisis in deterring young people from entering the workforce and the commencement of the staged implementation of Victorian Training Guarantee (VTG).

More male than female early school leavers were participating in apprenticeship or traineeships. Females were more likely than males to be employed and participating in TAFE/VET education (see Figure 9.13).
Figure 9.13: Destinations of Victorian early school leavers*, by sex, 2006–10

Disparities also exist between metropolitan and regional Victorian early school leavers. Early school leavers from regional areas are more likely to be in an apprenticeship or traineeship, but less likely to participate in TAFE/VET, be employed or looking for work than those living in metropolitan areas. There are also more early school leavers in metropolitan areas not in education, training or employment than those in regional areas (see Figure 9.14).

Figure 9.14: Destinations of early school leavers*, by area of residence, 2006–10

Regardless of sex and location, the number of early school leavers participating in TAFE/VET in Victoria has been increasing steadily since 2006 (14 per cent in 2006 compared to 20.1 per cent in 2010). The number of early school leavers participating in apprenticeships or traineeships has been in decline since 2006 (41.1 per cent in 2006 compared to 32.8 per cent in 2010) (see Figures 9.13 and Figure 9.14).
Personal factors that impact on engagement with learning

*If Australia is to achieve the target of 40 per cent set by the Bradley Review, then higher levels of participation and completion will be required of groups that have traditionally not attended university, at least in proportionate numbers. Among the key groups that will need to lift are those young people from low SES backgrounds and from remote locations.*

(Robinson, Lamb et al. 2010:51)

Children and young people’s personal factors (e.g. willingness to learn, motivation, personal aspirations and self-confidence) are key influences on, and indicators for, how well they engage with learning.

Since 2006, the Victorian Attitudes to School Survey has collected information on government school students in Years 5–12, in relation to their motivations and aspirations (measured as student motivation broadly). Data for 2006–2010 indicate that student motivation has been steadily increasing annually since 2006 in all year levels of secondary school.

Also derived from the Victorian Attitudes to School Survey, a measure of ‘learning confidence’ has been established through asking students questions relating to their confidence in learning and their perceptions of how good they believe they are at learning. Data on Victorian students’ learning confidence ratings for 2006–10 demonstrate a yearly increase, with female students rating more highly for learning confidence than males (see Figure 9.15).

**Figure 9.15: Learning confidence of Years 5–12 in Victorian Government schools, by sex, 2006–10**

Learning confidence and student motivation are closely related concepts influencing a child or young person’s engagement with learning. Ratings of learning confidence and student motivation are highest in Years 5 and 6 for Victorian children, but decrease dramatically to their lowest points in Years 9, 10 and 11. As with other measures of engagement with learning, there is an increase in Year 12 for learning confidence and student motivation (see Figure 9.16).
Educational aspirations in children and young people are not necessarily related to student motivation and learning confidence. This may be because educational aspirations can be significantly affected by the individual’s family, friends, school and community. The most common reason given by young people for remaining in formal education is their career aspirations (Lamb et al. 2004). Most young people consider learning at school to be ‘very’ or ‘quite’ important to their later life (61.6 per cent), with only 2.3 per cent indicating they think school is not important at all to later life (see Figure 9.17).

Figure 9.16: Learning confidence and student motivation, Years 5–12 students in Victorian Government schools, 2010

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Source: Victorian Attitudes to School Survey 2010, DEECD

Educational aspirations in children and young people are not necessarily related to student motivation and learning confidence. This may be because educational aspirations can be significantly affected by the individual’s family, friends, school and community. The most common reason given by young people for remaining in formal education is their career aspirations (Lamb et al. 2004). Most young people consider learning at school to be ‘very’ or ‘quite’ important to their later life (61.6 per cent), with only 2.3 per cent indicating they think school is not important at all to later life (see Figure 9.17).

Figure 9.17: Proportion of Victorian young people who think learning at school is important to later life, 2009

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Source: HOWRU 2009, DEECD
Most young Victorians have an expectation that they will complete Year 12 or higher education levels (94.7 per cent) (see Table 9.1). Female young people, those from metropolitan areas and those from the least disadvantaged areas have higher educational aspirations. More male young people, those from regional areas of Victoria and from most disadvantaged areas expect to attain a TAFE qualification, trade or apprenticeship as their highest level of education.

In their Australian study into junior secondary students’ perceptions on influences on their engagement with schooling, Campbell et al. (2009) argued that there is merit in giving students in the early years of secondary schooling more detailed and explicit career information as there appeared to be a strong relationship between student engagement with learning and educational aspirations. Information from HOWRU 2009 is consistent with this argument, as educational aspirations increase as students progress through secondary school; albeit, this may be due to those who are not planning to complete Year 12 already having left school at an earlier age.

Table 9.1: Highest level of education aspired to achieve by Victorian young people aged 12–17 years, 2009 (per cent)

<table>
<thead>
<tr>
<th></th>
<th>Less than Year 12</th>
<th>Year 12</th>
<th>TAFE/Trade/Apprenticeship</th>
<th>University</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5.9</td>
<td>10.0</td>
<td>22.3</td>
<td>60.9</td>
</tr>
<tr>
<td>Female</td>
<td>3.2</td>
<td>7.1</td>
<td>13.1</td>
<td>75.8</td>
</tr>
<tr>
<td><strong>Areas of residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metropolitan</td>
<td>3.9</td>
<td>7.8*</td>
<td>15.2</td>
<td>72.2</td>
</tr>
<tr>
<td>Regional</td>
<td>6.0</td>
<td>10.4*</td>
<td>23.8</td>
<td>59.1</td>
</tr>
<tr>
<td><strong>Socioeconomic status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most disadvantaged</td>
<td>4.8</td>
<td>8.6</td>
<td>20.3</td>
<td>65.6</td>
</tr>
<tr>
<td>Least disadvantaged</td>
<td>2.3</td>
<td>5.6</td>
<td>12.0</td>
<td>79.4</td>
</tr>
<tr>
<td><strong>All population</strong></td>
<td>4.5</td>
<td>8.6</td>
<td>17.8</td>
<td>68.3</td>
</tr>
</tbody>
</table>

*Indicates data are not statistically significantly different at the 95 per cent confidence intervals.
Source: HOWRU 2009, DEECD

**Influence of emotional factors on engagement with learning**

... less than one-half of early leavers have friends who think school is important, compared to four-fifths of graduates.

*(Lamb, Walstab et al. 2004:31)*

Emotional factors, such as levels of enjoyment, interest, boredom or frustration at school and in learning, are key influences on how engaged a child or young person is with learning. The Victorian Attitudes to School Survey collected information about ‘student morale’, ‘student distress’ and ‘student connectedness’ of government school students in Years 5–12. Student morale includes measures of positive emotions, such as being cheerful, relaxed and happy; while student distress includes measures of negative emotions, such as being tense, frustrated, depressed, uneasy and stressed. Student connectedness includes emotional aspects relating to how a student ‘feels’ about school.

Data from the Victorian Attitudes to School Surveys 2006–10 indicate that students’ connectedness to school has been progressively improving since 2006 all year levels of secondary schools (Years 5–12).

This survey also shows that student morale has been increasing and student distress has been decreasing at similar rates annually. As might be expected, there is an inverse relationship between student morale and student distress; that is, when student distress is high, student morale is low (see Figure 9.18).
Emotional factors relating to engagement with learning follow a similar pattern to cognitive factors affecting engagement with learning among Victorian students. Measures of student distress and student morale follow a similar pattern to measures of student motivation and learning confidence. The highest ratings (i.e. highest student morale and lowest student distress) are evident during primary school, decreasing steadily throughout secondary school and levelling off towards Year 12. This supports earlier evidence that engagement with learning decreases significantly between late primary school to around Year 9 in secondary school. Level of interest is critical in having a good engagement with learning. Three-quarters of young people rate their school subjects as being ‘interesting’. Young people are most likely to rate their school subjects as being ‘boring’ in Year 9 (see Figure 9.19). More than half of Victorian young people report enjoying school, but of concern are the 14 per cent who report rarely or never enjoying it (see Figure 9.20).
Friendships (social connections or connectedness) are known to be critical to children and of increasing importance to young people as they become more independent from their parents and families. Friendships with peers can either be factors for promoting or hindering engagement with learning.

Victorian students in government schools report high levels of 'connectedness' when asked about their connections with friends, with female students consistently reporting stronger degrees of connection to their peers than male students (see Figure 9.21). Consistent with measures on other emotional factors, social connections at schools are at their strongest in Year 6, and weakest in Years 9 and 10 (see Figure 9.22).
Figure 9.21: Perception of connectedness to peers by Years 5–12 students in Victorian Government schools, by sex, 2006–10*

*Connectedness to Peers measures the extent to which students feel socially connected and get along with their peers.
Source: Victorian Attitudes to School Survey 2006–10, DEECD

Figure 9.22: Connectedness to peers* by Years 5–12 students in Victorian Government schools, by school year level, 2006 and 2010

*Connectedness to peers measures the extent to which students feel socially connected and get along with their peers.
Source: Victorian Attitudes to School Survey 2006 and 2010, DEECD
How does student behaviour impact on engagement with learning?

The behaviour of individual children and young people, as well as their peers' behaviour, can act as risk and protective factors for engagement with learning. Along with truancy (as discussed earlier), the behaviour (and misbehaviour) of individual students can both indicate their level of engagement with learning as well as affect their peers' levels of engagement with learning. Equally, the behaviour of peers can negatively affect an individual's engagement with learning if that behaviour is disruptive, abusive or antisocial.

In the Victorian Attitudes to School Survey, government school students in Years 5–12 were asked to rate their peers' classroom behaviour in terms of how it affected their capability to learn. Classroom behaviour was defined as the extent to which other students are not disruptive in class. Trend data from 2006 to 2010 show an annual improvement in student perceptions of classroom behaviour (see Figure 9.23). This is supported by data from the School Staff Opinion Survey, indicating that teachers report that both individual student misbehaviour and classroom misbehaviour has been falling over the same period (see Table 9.2). Despite these apparent improvements in student behaviour, parents' perceptions of how well teachers manage student behaviour has remained steady for 2006–10 (see Table 9.2). Consistent with the pattern of poorer engagement with learning in the middle years of school (Years 7–9), classroom behaviour is also at its worst in Years 8, 9 and 10 (see Figure 9.23).

*Classroom Behaviour measures the extent to which other students are not disruptive in class.5
Source: Victorian Attitudes to School Survey 2006 and 2010, DEECD

Table 9.2: Parent and teacher reported student and classroom misbehaviour, Victoria, 2006–10

<table>
<thead>
<tr>
<th>Area of residence</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent-reported behaviour</td>
<td>Victoria</td>
<td>5.31</td>
<td>5.32</td>
<td>5.36</td>
<td>5.33</td>
</tr>
<tr>
<td>management (scale of 1–7)</td>
<td>Metropolitan</td>
<td>2.44</td>
<td>2.41</td>
<td>2.36</td>
<td>2.33</td>
</tr>
<tr>
<td>Teacher-reported student</td>
<td>Regional</td>
<td>2.51</td>
<td>2.51</td>
<td>2.48</td>
<td>2.52</td>
</tr>
<tr>
<td>misbehaviour* (scale of 1–5)</td>
<td>Metropolitan</td>
<td>20.07</td>
<td>19.47</td>
<td>18.84</td>
<td>18.16</td>
</tr>
<tr>
<td>Teacher-reported classroom</td>
<td>Regional</td>
<td>19.02</td>
<td>19.47</td>
<td>18.42</td>
<td>18.93</td>
</tr>
<tr>
<td>misbehaviour* (scale 1–100)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Negative variables therefore a lower score is a positive outcome.
Source: Victorian School Staff Opinion Survey; Victorian Parent Opinion Survey, DEECD
Suspension rates in school students can provide a measure of serious misbehaviour. Self-reported information from HOWRU 2009 indicates that a small proportion of young people aged 12–17 years (8 per cent) had been suspended in the past year (see Figure 9.24). Furthermore, of those young people who reported being suspended from school, 80.1 per cent were suspended only once or twice (see Figure 9.25). Suspensions occurred at a greater rate in male young people (10.8 per cent) and those from the most socioeconomically disadvantaged areas (10.3 per cent) (see Figure 9.24). For 9.2 per cent of males and 5.6 per cent of females who ever reported being suspended from school, behaviour issues can be considered significant, with more than six suspensions occurring for these young people within the past year (see Figure 9.25).

Figure 9.24: Proportion of young people who report having ever been suspended from school in the past year, by sex and area of socioeconomic status (SES), Victoria 2009

Source: HOWRU 2009, DEECD

Figure 9.25: Frequency of suspension from school among Victorian young people aged 12–17 years who report having ever been suspended from school over the past year, by sex, 2009

*Indicates data are not statistically significantly different between males and females at the 95 per cent confidence intervals.
Source: HOWRU 2009, DEECD

What do we know about children and young people’s safety at school?
It is generally agreed that bullying can be defined as the systematic abuse of power in interpersonal relations. It involves a more powerful person or group deliberately seeking to hurt or threaten an individual or group that is unable to defend themselves adequately. Typically, bullying involves a series of negative acts. Bullying may take a variety of forms, both direct, as in physically attacking someone or verbally abusing them, and indirect, as in unfairly excluding people, spreading rumours, or sending hurtful anonymous emails.

(Rigby & Griffiths, 2009:6)

Feeling safe with their peers can be a protective factor for good engagement with learning for children and young people; conversely, bullying by peers can be a risk factor for engagement with learning. Bullying includes physical and/or emotional violence, acts of exclusion and spreading rumours. It can occur either face to face or remotely, such as via the internet (e.g. through social network sites or emails). While using different definitions and measures, both HOWRU 2009 and VCHWS 2009 surveys collected information on the prevalence of bullying experienced by Victorian children and young people.

Information from the VCHWS 2009 indicates that more than three quarters of children aged 4–12 years do not experience bullying or harassment (76.5 per cent); although this means that almost a quarter (23.5 per cent) of children do experience them (see Figure 9.26).

Information from HOWRU 2009 indicates that the proportion of young people who report being bullied increases to almost half (49.2 per cent) by ages 12–14 years, dropping to 39.7 per cent for 15–17 year olds (see Figure 9.27). Of particular concern is the proportion of Victorian students aged 12–17 years bullied on most days, with almost one in five of males (18.2 per cent) and more than one in 10 females (12.2 per cent) reporting this.

Figure 9.26: Proportion of Victorian children aged 4–12 years who are picked on or bullied by other children or young people, by sex and annual household income,* 2009^*Gross household income before tax.

^Parents of children in the survey were asked whether the child has been picked on or bullied by other children. Source: VCHWS 2009, DEECD
Figure 9.27: Proportion of Victorian adolescents who reported being bullied,* by age group and sex, 2009

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Being bullied</th>
<th>Being bullied on most days</th>
</tr>
</thead>
<tbody>
<tr>
<td>12–14 yrs</td>
<td>49.2</td>
<td>16.9</td>
</tr>
<tr>
<td>15–17 yrs</td>
<td>39.7</td>
<td>13.4</td>
</tr>
<tr>
<td>Male</td>
<td>46.0*</td>
<td>18.2</td>
</tr>
<tr>
<td>Female</td>
<td>43.2*</td>
<td>12.2</td>
</tr>
<tr>
<td>All pop.</td>
<td>44.6</td>
<td>15.2</td>
</tr>
</tbody>
</table>

* Indicates data are not statistically significantly different between males and females at the 95 per cent confidence intervals.
^ Based on Gatehouse Bullying Scale.
Source: HOWRU 2009, DEECD

The Victorian Attitudes to School survey asks students in Years 5–12 in government schools questions relating to bullying and harassment by their peers, collated under the title ‘school safety’. In this measure, the higher the rating, the less bullying and harassment has been reported. Perceptions of school safety by students at all year levels have increased over 2006–10, with perceptions at their lowest in Years 8 and 9 (see Figure 9.28).

Figure 9.28: Perception of student safety* by Years 5–12 students in government schools, by school year level, 2006 and 2010

* Student Safety measures the extent to which students feel they are safe from bullying and harassment.
Source: Victorian Attitudes to School Survey 2006 and 2010, DEECD
School factors that impact on engagement with learning

The impact of school and other learning environment factors, such as teacher support and effectiveness, the school culture and student involvement in decision-making all have an impact on the degree to which children and young people engage with learning. The most common reason cited by young people for early school leaving is that they ‘did not like school’ (Lamb et al. 2004).

How do Victorian teachers promote engagement with learning?

Receiving positive acknowledgement from teachers for their school work or behaviour is considered a protective factor against early school leaving.

In the Victorian Attitudes to School Survey, students in Years 5–12 were asked about how empathetic and effective they thought their teachers. Trend information indicates that student perceptions of teacher empathy and teacher effectiveness are high and have been increasing over the period 2006–10 (see Figure 9.29).

Student perceptions of the degree to which their learning environment is stimulating (questions focusing on how interesting teachers are) increased in the past four years (see Figure 9.29). However, it must be noted that this information relates to student perceptions of teacher effectiveness, and does not necessarily provide an actual measure of teacher effectiveness in promoting engagement with learning.

Figure 9.29: Perception of teacher support and effectiveness by Years 5–12 students in Victorian Government schools, 2006–10

Source: Victorian Attitudes to School Survey 2006–10, DEECD
How does school culture promote engagement with learning?

The culture within a school is known to have an impact on engagement with learning. Aspects affecting school culture include having supportive leadership, good morale and a generally positive environment within classrooms and the broader school. Supportive leadership within a school can have a significant impact on teacher morale, plays a large part in school morale, and can ultimately have an impact on the level of engagement with learning experienced by the students within that school.

Victorian Government school staff were asked about the morale and leadership within their school as part of the Victorian School Staff Opinion Survey (see Table 9.3). There has been an increase in levels of school morale and supportive leadership between 2006 and 2010 regardless of location of the schools, with regional schools having consistent higher rankings for both measures than metropolitan schools (see Table 9.3).

Table 9.3: Victorian school staff reported supportive leadership and school morale in Victorian Government schools, 2006–10

<table>
<thead>
<tr>
<th>Location of schools</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Metropolitan</td>
<td>Regional</td>
<td>Metropolitan</td>
<td>Regional</td>
<td>Metropolitan</td>
</tr>
<tr>
<td>Supportive leadership (scale of 1–5)</td>
<td>3.78</td>
<td>3.91</td>
<td>3.86</td>
<td>3.86</td>
<td>3.84</td>
</tr>
<tr>
<td>School morale (scale of 1–5)</td>
<td>3.72</td>
<td>3.76</td>
<td>3.80</td>
<td>3.83</td>
<td>3.81</td>
</tr>
</tbody>
</table>

Source: Victorian School Staff Opinion Survey 2006–10, DEECD

How do students perceive their involvement in school decision-making?

Having opportunities to be involved in decision-making within a learning environment is considered to be an important element of how well a student engages with learning. Student involvement in decision-making ranges from having choices about learning activities within a classroom to participating in a student representative council and providing feedback on new curriculum options.

Recent information from HOWRU 2009 indicates that around half of Victorian young people aged 12–17 years (58.8 per cent) report having the chance to make decisions in their classroom. Younger students 12–14 years were more likely to report having the chance to be involved in decision-making than 15–17 year olds (64.1 compared to 53.1 per cent)(see Figure 9.30).

Figure 9.30: Proportion of Victorian young people who have the chance to help make decisions in their school classroom*, by age group, 2009

*Includes those who agree or strongly agree that ‘In my school, students have lots of chances to help decide things like class activities and rules’. Source: HOWRU 2009, DEECD
How do Victorian schools support student diversity?

State and Commonwealth governments allocate approximately $95 million annually to support programs for ESL (English as a second language) students, including new arrivals and students with refugee backgrounds or experiences.

The Department of Education and Early Childhood Development (DEECD) provides English language support through a variety of flexible learning options, comprising intensive English language schools, outpost and visiting outpost programs, isolated support, outreach services, bridging/transition programs, Multicultural Education Aides (MEAs), and interpreting and translating services. Additionally, students with refugee background or experience also have access to extended intensive English language programs through English language schools, refugee transition support initiatives (e.g. ESL coaches), out of school hours learning support and specialised Victorian Certificate of Applied Learning (VCAL) programs.

In 2010, 43,504 students from language backgrounds other than English were identified as eligible for ESL support, which includes 4790 new arrival students and 7253 students with refugee background or experience.

The Victorian Program for Students with Disabilities (PSD) is a targeted program providing schools with resources to support a defined student population with moderate to severe disabilities. In 2010, it supported approximately 3.7 per cent of the government school population across more than 90 per cent of government schools. This support was provided to more than 20,000 students, of whom over half (11,319 students or 56 per cent) are in mainstream schools, with 44 per cent (8,950 students) attending specialist schools.

How flexible are learning options in Victorian Government schools?

Engagement with learning is also promoted through ensuring a variety of flexible learning options available to accommodate the diversity of Victorian children and young people. Provision of a range of learning options maximises the chance of all children and young people to remain engaged with formal learning environments, at least until they complete Year 12 or its equivalent qualification (VET Certificate II or above). Such options must cater for the diversity within the general population of children and young people, including those at risk of disengaging from school and early school leavers.

Some of the alternative options for Victorian young people to complete Year 12 are to pursue the Victorian Certificate of Education (VCE), the Victorian Certificate of Applied Learning (VCAL), or the International Baccalaureate (IB) towards the end of their schooling.

There is also a need for multiple flexible learning options to assist children and young people at high risk of disengagement with school and those already disengaged from school (early school leavers). These options have to cover both outside school (some of which fall under the category of ‘alternate education’) and within government, independent and Catholic schools. Two of the existing options are Community VCAL and distance education. There are also multiple education providers catering for early school leavers, including Adult and Community Education (ACE), Technical and Further Education (TAFE), private providers, registered training organisations and community organisations. Vocational education and training (VET) is provided by schools, TAFE providers, ACE providers, agricultural colleges and other registered training organisations, and also via apprenticeships and traineeships.

As part of Victoria’s agreement to the National Partnership on Youth Attainment and Transitions, the Victorian Training Guarantee (VTG) provides an education and training entitlement for young people aged 15–24 years. First implemented in 2009, the VTG now provides a government-subsidised training place to any young person under 20 years, any applicant seeking a Foundation skills course, any applicant who is an Apprentice, or any applicant seeking a higher qualification than the highest qualification already held. From 1 January 2010, this was extended to 20–24 year olds for any government-subsidised qualification, which would result in the individual attaining a higher qualification, again subject to admission requirements and course availability. In 2009, 30.2 per cent of 15–19 year olds were enrolled VET courses, with 26.5 per cent enrolled in VET courses accredited under the Australian Qualifications Framework (see Figure 9.31).
The Department of Education and Early Childhood Development (DEECD) has developed guidelines to assist schools with students below the age of 15 seeking to attend an educational program in an Adult and Community Education (ACE) setting. Under these arrangements, students are enrolled in a government school, but attend the premises of the ACE provider to receive part or all of their education. However, numbers are unavailable, as the students are not formally enrolled with ACE providers, but merely attend ACE programs.

Since 2005, the proportion of disengaged youth (those who did not complete Year 12 and are currently unemployed) participating in ACE courses has been steadily increasing, from 3.1 per cent of all ACE enrolments in 2005 to 4.6 per cent in 2009 (see Figure 9.32).

Figure 9.32: Proportion of Victorian 15–19 year olds enrolled in ACE course that did not complete Year 12 and are currently unemployed, 2005–09

Source: Adult Community and Further Education Board, Department of Planning and Community Development
Family factors that impact on engagement with learning

Engaging families in the education of their children at home and at school is increasingly viewed as an important means to support better learning outcomes for children. When schools and families work together, children have higher achievement in school and stay in school longer. (Berthelsen & Walker, 2008:34)

There is significant evidence to suggest that behaviour, beliefs, expectations and socioeconomic and health situations of parents can significantly impact on children and young people's engagement with formal learning environments, including schools and early years programs.

Family factors influencing a child or young person's engagement with learning include the choice of school, the degree to which a parent becomes involved in the school community, how often and how well a parent reads to their child and the parents' experiences of their own school days.

Parents' long-term educational aspirations for their children are an important influence on a child or young person's engagement with learning and, potentially, that child or young person's own educational aspirations. As part of an analysis completed on information from the Longitudinal Study of Australian Children (LSAC), almost all Australian parents expected that their children would complete Year 12; while just 41 per cent expected that their child would complete a post-secondary qualification (Berthelsen & Walker 2008).

Parent involvement and contact with their child’s school is thought to be an important factor in fostering engagement with learning in children and young people. Such involvement includes formal parent–teacher meetings, attending formal and social school events, helping in class or on excursions, assisting with fundraising and joining school councils. Evidence indicates that Australian parental contact increases as household income increases; that is, families with higher incomes are more likely to be involved and engaged in school activities (Berthelsen & Walker 2008).

Parents' socioeconomic and health conditions are thought to the most pervasive impacts on children and young people's engagement with learning. Children and young people with parents who experience severe disadvantage (such as homelessness, abuse alcohol, illicit drugs or incarceration) are likely to experience follow-on effects, which impact on their capacity to engage with learning. This can also be true for some children with parents who have chronic health conditions and diseases, including mental illness. (Chapter 12 has further discussion about family functioning and the impact of multiple and chronic disadvantage on outcomes for children and young people).
Chapter 9
Endnotes

1. Students rank the following statements against their experiences on a scale from 1 (strongly disagree) to 5 (strongly agree): Doing well in school is very important to me; Continuing or completing my education is important to me; I try very hard at school; I am keen to do very well at my school.

2. See detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A9.1).

3. ibid.

4. Socioeconomic Index for Areas (SEIFA) – Index for Relative Socioeconomic Disadvantage (IRSED) was developed by the Australian Bureau of Statistics (ABS) based on data from the 2006 Census of Population and Housing. Each geographic area in Australia was given an IRSED score ranking the disadvantage of an area compared to other areas across Australia. Areas can also be grouped into quintiles based on their IRSED scores to provide groupings by level of disadvantage, with quintile 1 being the most disadvantaged, and quintile 5, the least disadvantaged. The SEIFA IRSED data have been matched with the postal codes in data from VCHWS 2009 and HOWRU 2009 surveys by using the 2006 ABS Postal Area (POA) data. Inaccuracy and mismatch could occur as: 1. the ABS POA is only an approximation of postcode, and 2. the 2006 POA may not capture some new postcodes developed after 2006 in Victoria. For example, there are 367 sample observations in HOWRU 2009 that are not matched into the SEIFA IRSED.

5. Students in the survey have been asked questions: Has anyone teased or called your names? Has anyone spread rumours about you? Have you been deliberately left out things? Have been threatened physically or actually hurt by another student?

6. Students rank the following statements against their experiences on a scale from 1 (strongly disagree) to 5 (strongly agree): I have been bullied recently at school; I have been teased in an unpleasant way recently at my school; Students are mean to me at this school; I have been deliberately hit, kicked or threatened by another student recently.
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Chapter 9

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Safety
Chapter 10

Safety

One of the most critical ways to monitor how Victorian children and young people are faring is through identifying, measuring and assessing risks to their safety. This chapter addresses safety issues related to unintentional injury and death, harm from violence and crime and antisocial and criminal behaviours of children and young people themselves.

From 2007 through 2009 there were almost a quarter of a million (244,610) Emergency Department (ED) presentations and a further 50,000 hospital admissions for unintentional injury among 0–17 year olds in Victoria. The most common recorded cause of injury was falls and the most frequently recorded location of these injuries was at home, followed by school or public buildings. Males are more at risk of unintentional injury, particularly those aged 12–17 years. Unintentional injury deaths in Victorian children and young people have been declining over a 10-year period. Most of these deaths were caused by transport injuries (58.8 per cent), followed by drowning (13.8 per cent).

Crimes perpetrated against a child or young person may have a disproportionate and lasting effect. Many do not report crimes to the police for a range of complex reasons. From reported data, the rate at which Victorian children and young people (age birth to 17 years) were victims of crime is 9.1 per 1000 children and young people in 2009–10. The most commonly reported crimes where the victims are children and young people are physical assaults, theft and sexual assaults.

Over a three-year period (2007–09) there were 3049 ED presentations and a further 1271 hospital admissions for assaultive injury in Victorian young people aged 12–17 years. The number of sexual assaults reported to police where the victim was a child or young person has been decreasing over recent years in Victoria. However, recent national data suggests that a large proportion of sexually-active young people have experienced ‘unwanted sex’, where they were pressured or coerced into having sex (38 per cent of females and 19 per cent of males).

A small minority of Victorian young people engage in antisocial behaviours and relatively few young people who are antisocial or commit crimes in their youth go on to become persistent or serious offenders. Based on self-reported data by Victorian young people (aged 12–17 years), one in 14 (7.2 per cent) have attacked someone else to seriously hurt them; males are more likely to have done so as are those from more disadvantaged areas. One in five young males have reported carrying a weapon (not further defined) on at least one occasion.

Recorded police data show that, of all crimes committed in Victoria since 2005–06, the proportion that are committed by someone aged 17 years or younger has been increasing (9.8 per cent in 2009–10). Higher rates of crimes are committed by males and by those in regional areas. In comparison to other states and territories, Victoria has a low youth crime rate and has the lowest number per capita of young people detained in custody. Current Victorian legislation has a strong diversionary approach. Given certain conditions Victoria Police may issue a caution to a young person under the age of 17 years. The rates of Victorian young people receiving a caution have remained relatively stable over the past five years, and 80 per cent of those cautioned had not reoffended within one year.

Antisocial and criminal behaviours co-exist, and often co-occur, with other multiple risk factors, including limited engagement with school; a history of family conflict/breakdown; a history of child abuse, neglect or mistreatment; family members involved in the criminal justice system; and having friends who engage in antisocial and criminal behaviours.
This chapter examines selected issues involving ‘safety’ for Victorian children and young people. It first examines risks to safety from preventable, unintentional injuries and deaths, along with the risk factors exposing children and young people to an increased chance of unintentional harm. It then looks at issues relating to children and young people as victims of crimes. Lastly, it examines safety issues associated with antisocial and criminal behaviours by young people themselves. Young people’s involvement in antisocial behaviour (whether they have been officially ‘caught’ by the police) and, more seriously, their criminal behaviour are examined alongside the risk and protective factors known to influence such behaviour.

Key policy directions for child and adolescent injury prevention

• National Youth Policing Model, 2010
• COAG, National Framework for Protecting Australia’s Children 2009–2020

Key Victorian Government initiatives: Adolescent safety

Commitments and new initiatives

• Strengthen Victoria’s youth justice system and create clearer pathways into prevention and rehabilitation programs by significantly expanding the Youth Justice Group Conferencing program and increasing the number of youth justice workers to supervise community based orders and the community component of court orders
• Expansion of bail supervision pilot program for young offenders
• Early intervention programs to help vulnerable parents with child rearing
• Enforcing truancy laws
• Stamping out bullying
• Establish seven Youth Partnership demonstration sites to address the needs of vulnerable young people
• Community Crime Prevention Program supporting local action to address local crime issues

Programs in place

• Victorian Police Early Intervention Pilot Program
• Youth Support Service to lower risk of youth offending
• Youth Justice Services to address youth offending including:
  • Forensic interventions/health services
  • Youth Justice Community Support Service
  • Koori Youth Justice program
• Counselling and support for women and children experiencing family violence
• Sexual Assault Services for children
• Treatment programs for young people displaying inappropriate sexual behaviour
• Range of services to address risk taking behaviours among vulnerable young people
• Child Witness Service providing support to children required to give evidence in court
• Safe from injury and harm – MCH Program.

Injuries

*The environments in which people live do much to determine injury risks and opportunities for injury prevention. The physical environment includes things such as roads, vehicles, buildings and the settings in which we live, work and play. These are often less safe that they could be, given better planning and design. Factors such as education, income and employment status comprise a socioeconomic environment which shapes opportunities for and knowledge about safety.*

Injuries are commonly classified according to whether they were deliberately inflicted, called intentional injuries, including harm (e.g. assault or suicide), or accidental, often called unintentional injuries (e.g. car accidents or falls from playground equipment). (Issues relating to intentional injuries of self-harm and suicide are discussed in Chapter 6 on mental health. Victorian children’s exposure to, or experience of, family violence and abuse are discussed in Chapter 12).

Hospitalisation, whether it be admission into hospital or being provided with medical care in an emergency department, are often considered ‘proxy’ measures of the severity of an injury. It is probable that many (though less severe) unintentional injuries in children and young people are also treated within the primary health care sector in Australia, such as by general practitioners (GPs).

More than 330,000 Victorians of all ages (six in every 100) were treated in hospitals for unintentional injury during 2009, including 97,205 hospital admissions and 233,586 emergency department (ED) presentations. Victorian children aged 0–14 years have the lowest hospitalisation rate compared to the general population (one in every 100). Conversely, they have the highest ED presentation rate compared to the general population (seven in every 100) (Victorian Injury Surveillance Unit, Monash University (VISU) 2011).

In terms of the severity of unintentional injuries, the death of a child or young person is obviously the gravest outcome. In 2006, the unintentional injury death rate was estimated at 23.6 per 100,000 Victorians of all ages. The rate per 100,000 was the lowest for children aged 0–14 years (3), rising in adolescents and young adults aged 15–24 years (14.5), and peaking in older adults (87.2) (VISU 2010).

Why are children and young people particularly vulnerable to unintentional injuries?

While most injuries to children and young people are unintentional, they are not necessarily random; hence there is a degree to which unintentional injuries can be predicted and thereby prevented. Most injuries can be prevented by identifying their causes, removing these causes or reducing children's exposure to them.

The risk of being unintentionally injured varies with age, with some periods of life, including early childhood and late adolescence, being times of high risk. As children grow from infancy to childhood and through to adolescence they progress through a number of developmental stages, each with physical, cognitive, emotional and social development aspects. The relationship between age and risk of unintentional injuries is not straightforward, because all aspects of the developmental stage at a given age are not always necessarily uniform across all individuals. However, generally speaking, the following developmental stages are important in terms of the increased vulnerability to specific types of unintentional injury:

- **infancy** (birth to around 1 year of age), where the child is highly dependent. The characteristic injury for infants is child abuse (or neglect).

- **early childhood** (around age 1–4 years), where the child begins to be mobile but lacks an understanding of, or ability to recognise hazards and risks. The characteristic injuries for toddlers and preschoolers are drowning, pharmaceutical poisonings and fire, burn/scald type injuries.

- **middle childhood** (age 5–9 years), where the child explores the world through play and schooling. The characteristic injuries for children in middle childhood are falls (e.g. from playground equipment).

- **late childhood to early adolescence** (age 10–14 years) where the child's increased independence, physical and social development occurs through school and sports. The characteristic injury for these children/young people is sports injuries.

- **mid to late adolescence** (age 14–17 years), where the emerging adult may experiment with risk-taking behaviours, such as drug and alcohol use, and high-risk sports. The characteristic injuries for these young people are transport accidents.
Regardless of developmental stage, the risk of hospitalisation or deaths from an unintentional injury is higher for some groups of children and young people. Most notably, at all ages, males are significantly more likely than females to suffer hospitalisation from injuries (unintentional or otherwise) or death. The difference in injuries between male and female children tends to vary with age and type of injury.

National data indicates that the rate of hospitalisations and death for unintentional injuries for Aboriginal and Torres Strait Islander people is over twice the rate for other Australians (Australian Government 2005). Children from socioeconomically disadvantaged backgrounds, children of lone parents, children from a large family or where there is parental drug or alcohol use, and children living in poor housing show a disproportionately high risk of injury leading to death or hospitalisation compared to other Australian children (ABS 2006; AIHW 2005).

What are the rates of hospital treatment for unintentional injuries among children and young people in Victoria?

Between 2007 and 2009, over 294,000 Victorian children and young people went to hospitals for treatment of unintentional injuries, including 82.9 per cent who were presented in hospital emergency departments (EDs) (without admissions) and the remaining 17.1 per cent who were hospitalised. Consistent with evidence that males are at a higher risk of injuries than females, more young males than young females aged 17 or younger were treated in Victorian hospitals or EDs for unintentional injuries. The rate of having medical treatment (in hospital or EDs) for unintentional injuries was the same for both males and females during infancy, but increases with age for males and decreases with age for females after infancy (see Figures 10.1 and 10.2).

Over one third of unintentional hospital admissions and ED presentations by Victorian children and young people were for injuries caused by falls (38.1 per cent of admissions and 40.1 per cent of ED presentations). Other common causes of unintentional injuries requiring hospital treatment were being hit, struck or crushed (14.9 per cent of admissions and 22.9 per cent of ED presentations) and transport accidents (14.1 per cent of the hospital admissions) (see Table 10.1).
It is unclear where around half of the unintentional injuries requiring hospital admissions for Victorian children and young people in 2007–09 actually occurred (55.4 per cent) or what activity was taking place at the time (50.9 per cent). Commonly known activities causing unintentional injury requiring hospital treatment were leisure activities (50.2 per cent of ED presentations), sports and recreational activities (21.4 per cent of hospital admissions and 13.8 per cent of ED presentations) (see Table 10.1). Common locations where unintentional injuries requiring hospital treatment are known to have occurred were in the home (16.8 per cent of admissions and 41.9 per cent of ED presentations), schools or public buildings (11.7 per cent of admissions and 13.8 per cent of ED presentations) and sports or athletic areas (10.2 per cent of ED presentations).

Table 10.1: Overview of unintentional injury hospital treatment among Victorian young people aged 0–17 years, 2007–09 (pooled data)

<table>
<thead>
<tr>
<th>Major causes of injury</th>
<th>ADMISSIONS*</th>
<th>ED PRESENTATIONS*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Per cent (%)</td>
</tr>
<tr>
<td>Fall</td>
<td>19,185</td>
<td>38.1</td>
</tr>
<tr>
<td>Hit/struck/crushed</td>
<td>7,510</td>
<td>14.9</td>
</tr>
<tr>
<td>Transport</td>
<td>7,095</td>
<td>14.1</td>
</tr>
<tr>
<td>Poisoning</td>
<td>1,577</td>
<td>3.1</td>
</tr>
<tr>
<td>Cutting/piercing</td>
<td>2,355</td>
<td>4.7</td>
</tr>
<tr>
<td>Natural/environment/animals</td>
<td>1,411</td>
<td>2.8</td>
</tr>
<tr>
<td>Fires/burns/scalds</td>
<td>1,076</td>
<td>2.1</td>
</tr>
<tr>
<td>Choking/suffocation</td>
<td>353</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Drowning/near drowning</td>
<td>103</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Machinery</td>
<td>201</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Explosions/firearms</td>
<td>66</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Other unintentional</td>
<td>9,410</td>
<td>18.7</td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure activity</td>
<td>3,814</td>
<td>7.6</td>
</tr>
<tr>
<td>Sports and recreation</td>
<td>10,753</td>
<td>21.4</td>
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<tr>
<td>Education</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Resting/sleeping/eating</td>
<td>1,287</td>
<td>2.6</td>
</tr>
<tr>
<td>Being nursed or under care</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Working (income or other types)</td>
<td>722</td>
<td>1.4</td>
</tr>
<tr>
<td>Other specified activity</td>
<td>5,872</td>
<td>11.7</td>
</tr>
<tr>
<td>Unspecified activity</td>
<td>27,894</td>
<td>55.4</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>8,466</td>
<td>16.8</td>
</tr>
<tr>
<td>Residential Institution</td>
<td>48</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Schools/public buildings</td>
<td>5,879</td>
<td>11.7</td>
</tr>
<tr>
<td>Sports/athletic areas</td>
<td>4,960</td>
<td>9.9</td>
</tr>
<tr>
<td>Road/street/highway</td>
<td>2,474</td>
<td>4.9</td>
</tr>
<tr>
<td>Trade/service area</td>
<td>514</td>
<td>1.0</td>
</tr>
<tr>
<td>Industrial/construction area</td>
<td>110</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Farm</td>
<td>264</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Place for recreation</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Other specified places</td>
<td>1,993</td>
<td>4.0</td>
</tr>
<tr>
<td>Unspecified places</td>
<td>25,634</td>
<td>50.9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>50,342</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Hospital admissions include same-day admissions. ^ED presentations include only non-admissions.
Source: Victorian Admitted Episodes Dataset (VAED); Victorian Emergency Minimum Dataset (VEMD); VISU analysis
What do we know about deaths from unintentional injuries among children and young people in Victoria?

Over the period of 2004–2006, 160 children and young people died as a result of unintentional injuries in Victoria. Significantly more males died (60.6 per cent) than females (39.4 per cent). Of all deaths, a significant proportion were those aged 15–17 years (43.1 per cent), followed by infants and very young children 0–2 years (16.9 per cent) (see Table 10.2).

Over half (58.8 per cent) of unintentional injury deaths were caused by transport injuries. Other common causes were drowning (13.8 per cent), poisoning (7.5 per cent), choking and suffocation (6.3 per cent) and fire/burns/scalds (3.8 per cent). The most common place of unintentional injury deaths for Victorian children and young people was on a road, street or highway (53.1 per cent), consistent with the information that most injury deaths were caused by transport injuries. However, 18.1 per cent of injury deaths to Victorian children and young people during 2004–06 occurred within the child’s home.2 This data is broadly consistent with that for the adult population aged 25–64 years, where the leading causes of unintentional injury deaths are transport, poisoning and falls (VISU 2010).

The death rate for unintentional injuries for Victoria’s children and young people aged 0–17 years has been declining over the past decade (see Figure 10.3). There has been a decrease from 1997 to 2006, from seven deaths to four deaths per 100,000.

Table 10.2: Unintentional injury deaths of Victorian children 0–17, by sex and age groups, 2004–06 (pooled data)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number</th>
<th>Per cent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>97</td>
<td>60.6</td>
</tr>
<tr>
<td>Female</td>
<td>63</td>
<td>39.4</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–2 years</td>
<td>27</td>
<td>16.9</td>
</tr>
<tr>
<td>3–5 years</td>
<td>15</td>
<td>9.4</td>
</tr>
<tr>
<td>6–8 years</td>
<td>15</td>
<td>9.4</td>
</tr>
<tr>
<td>9–11 years</td>
<td>10</td>
<td>6.3</td>
</tr>
<tr>
<td>12–14 years</td>
<td>24</td>
<td>15.0</td>
</tr>
<tr>
<td>15–17 years</td>
<td>69</td>
<td>43.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>160</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Australian Bureau of Statistics (ABS) Death Unit Record File; VISU analysis

Figure 10.3: Unintentional injury death rates for Victorian young people aged 0–17 years, by sex, 1997–2006

Source: Australian Bureau of Statistics (ABS) Death Unit Record File 1997-2006; VISU analysis
What factors are associated with injuries in Victorian children and young people?

Evidence (ABS 2006; AIHW 2005) suggests that particular factors increase the risk that a child will suffer or die from an unintentional injury, namely:

- being male
- being younger (0–4) and being older (15–17 years)
- coming from a socioeconomically disadvantaged background
- having a mother who is a younger age
- having a mother with lower levels of formal education
- coming from a large family (particularly if the child is the youngest of many siblings)
- use of alcohol.

A range of preventive measures are often needed to reduce the likelihood of an unintentional injury occurring. Prevention may include:

- home safety education, involving educating parents about risks commonly found in the home (e.g. hanging by curtain cords)
- safety devices/equipment (e.g. smoke alarms, bicycle helmets)
- modification of the home (e.g. cupboard locks or poisons in high cabinets)
- structural designs (e.g. standards for balconies and windows to reduce falls)
- legislation and regulation (e.g. child car safety seats).

Children and young people as victims of crime

Crime perpetrated against a child or young person, particularly at a critical developmental or transitional time, may have a disproportionate and lasting effect. Experiencing crime can divert an individual from their normal, healthy and productive development and adversely shape the direction of their life. They are at a higher risk of a range of negative developmental outcomes in the immediate and longer terms, including physical, social and emotional impacts.

While information presented relates to official crime statistics from Victoria police, it is important to note that children and young people can be victimised in a range of settings (including within their own homes) and incidents of harm against them may not be reported to the police. Information from other sources has therefore been included in this discussion to establish this broader context of crime and abuse against Victorian children and, young people and their families. (Victorian children’s exposure to, or experience of, family violence and abuse are discussed in detail in Chapter 12).

What do we know about general crimes and abuse against children and young people?

It is likely that a significant number of young people who experience crime or abuse do not report it to the police. There are complex and multiple reasons why children and young people might not formally report a crime or abuse. They may be reluctant to report a crime or abuse if the perpetrator is a parent or if the crime or abuse occurred within their own home or family situation. Children and young people may not report out of fear for their own safety or that of siblings, that they may be blamed for what has occurred or out of fear of possible family breakdown. Others may not understand what has happened to them as a crime, may not know how and where to report the crime and seek help, or be concerned about the effects of reporting a crime, especially if the perpetrator is known to them. Young crime victims who are already known to police or fear police for other reasons may be reluctant to seek police assistance.
Information from Victoria Police suggests that young people in regional areas are more likely than those in metropolitan areas of Victoria to be the victims of crimes. The overall victim rate of reported crime in 2009–2010 is 9.1 per 1000 Victorian children and young people. Older adolescents (aged 15–17 years) and females are more likely to report being victims of crime (see Figures 10.4 and 10.5).

Figure 10.4: Reported Victorian crime rates where victim was a young person aged 0–17 years (rate per 1000 young people), by area of residence and sex of victims, 2005–06 to 2009–10

Source: Law Enforcement Assistance Program (LEAP), Victoria Police; ABS Preliminary Estimated Resident Population by Single Year of Age, Sex and Statistical Local Areas of Victoria (unpublished), July 2009

Figure 10.5: Reported Victorian crime rates where victim was a young person aged 0–17 years (rate per 1000 young people), by age group of victims, 2005–06 to 2009-10

Source: Law Enforcement Assistance Program (LEAP), Victoria Police; ABS Preliminary Estimated Resident Population by Single Year of Age, Sex and Statistical Local Areas of Victoria (unpublished), July 2009
The most common reported crimes where victims are children or young people are physical assaults, theft and sexual assaults, accounting for a total of 85.7 per cent of all crimes against young people (see Figure 10.6).

Figure 10.6: Reported Victorian crime rates where victim was a young person aged 0–17 years, by crime category, 2009–10

How safe are Victorian children and young people from physical assault?

Victimisation for physical assault is complex. Males constitute the majority of victims of all physical assault, usually at the hands of other males (whether family members, peers, acquaintances or strangers). Females are usually assaulted by males known to them. The ABS Safety Survey 2005 found that, among population of all ages in Australia, 10 per cent of males and 4.7 per cent of females experienced physical violence in the 12 months prior to the survey period. Of those who experienced physical violence, 31 per cent of females were assaulted by a current and/or previous intimate partner, compared to 4.4 per cent of males (ABS 2008).

As indicated in Figure 10.7, the most common crime committed against Victorian children and young people that is reported to police is physical assault, with a total number of 3943 incidents reported in 2009–10. Table 10.3 provides details of assaultive injuries in young people aged 12–17 years treated in Victorian hospitals. Young people aged 15–17 years accounted for most of the assault-related injuries (82.1 per cent of admissions and 75.2 per cent of EDs). Males accounted for the majority of the hospital admissions and ED presentations, regardless of age.
Table 10.3: Overview of hospital-treated assaultive injury in young people aged 12–17 years, Victoria 2007–09

<table>
<thead>
<tr>
<th></th>
<th>ADMISSIONS (inc. same-day admissions)</th>
<th></th>
<th>ED PRESENTATIONS (non-admissions only)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Per cent (%)</td>
<td>Number</td>
<td>Per cent (%)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1062</td>
<td>83.6</td>
<td>2308</td>
<td>75.7</td>
</tr>
<tr>
<td>Female</td>
<td>209</td>
<td>16.4</td>
<td>741</td>
<td>24.3</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12–14 years</td>
<td>227</td>
<td>17.9</td>
<td>755</td>
<td>24.8</td>
</tr>
<tr>
<td>15–17 years</td>
<td>1044</td>
<td>82.1</td>
<td>2294</td>
<td>75.2</td>
</tr>
<tr>
<td><strong>Major causes of injury</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharp object</td>
<td>168</td>
<td>13.2</td>
<td>174</td>
<td>5.7</td>
</tr>
<tr>
<td>Blunt object</td>
<td>155</td>
<td>12.2</td>
<td>457</td>
<td>15.0</td>
</tr>
<tr>
<td>Bodily</td>
<td>781</td>
<td>61.4</td>
<td>2032</td>
<td>66.6</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>28</td>
<td>2.2</td>
<td>21</td>
<td>0.7</td>
</tr>
<tr>
<td>Neglect and maltreatment</td>
<td>16</td>
<td>1.3</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other</td>
<td>35</td>
<td>2.8</td>
<td>185</td>
<td>6.1</td>
</tr>
<tr>
<td>Unspecified</td>
<td>88</td>
<td>6.9</td>
<td>180</td>
<td>5.9</td>
</tr>
<tr>
<td><strong>Nature of injury</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fracture</td>
<td>415</td>
<td>32.7</td>
<td>417</td>
<td>13.7</td>
</tr>
<tr>
<td>Open wound</td>
<td>243</td>
<td>19.1</td>
<td>678</td>
<td>22.2</td>
</tr>
<tr>
<td>Intra cranial</td>
<td>157</td>
<td>12.4</td>
<td>135</td>
<td>4.4</td>
</tr>
<tr>
<td>Superficial</td>
<td>114</td>
<td>9.0</td>
<td>726</td>
<td>23.8</td>
</tr>
<tr>
<td>Internal organs</td>
<td>37</td>
<td>2.9</td>
<td>21</td>
<td>0.7</td>
</tr>
<tr>
<td>Dislocation/sprain/strain</td>
<td>13</td>
<td>1.0</td>
<td>286</td>
<td>9.4</td>
</tr>
<tr>
<td>Nerves/spinal cord</td>
<td>10</td>
<td>0.8</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Eye (exc. foreign body)</td>
<td>14</td>
<td>1.1</td>
<td>61</td>
<td>2.0</td>
</tr>
<tr>
<td>Muscles/tendon</td>
<td>28</td>
<td>2.2</td>
<td>104</td>
<td>3.4</td>
</tr>
<tr>
<td>Blood vessels</td>
<td>7</td>
<td>0.6</td>
<td>7</td>
<td>0.2</td>
</tr>
<tr>
<td>Systemic-poisoning/toxic effects</td>
<td>6</td>
<td>0.5</td>
<td>9</td>
<td>0.3</td>
</tr>
<tr>
<td>Other/unspecified</td>
<td>216</td>
<td>17.0</td>
<td>602</td>
<td>19.7</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Road/Street/Highway</td>
<td>113</td>
<td>8.9</td>
<td>605</td>
<td>19.8</td>
</tr>
<tr>
<td>Home</td>
<td>110</td>
<td>8.7</td>
<td>455</td>
<td>14.9</td>
</tr>
<tr>
<td>School/public buildings</td>
<td>126</td>
<td>9.9</td>
<td>512</td>
<td>16.8</td>
</tr>
<tr>
<td>Trade/Service area</td>
<td>121</td>
<td>9.5</td>
<td>89</td>
<td>2.9</td>
</tr>
<tr>
<td>Place for recreation</td>
<td>0</td>
<td>0.0</td>
<td>379</td>
<td>12.4</td>
</tr>
<tr>
<td>Sports/athletics areas</td>
<td>18</td>
<td>1.4</td>
<td>55</td>
<td>1.8</td>
</tr>
<tr>
<td>Other specified place</td>
<td>95</td>
<td>7.5</td>
<td>423</td>
<td>13.9</td>
</tr>
<tr>
<td>Unspecified place</td>
<td>687</td>
<td>54.1</td>
<td>531</td>
<td>17.4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1271</td>
<td>100%</td>
<td>3049</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: VAED (hospital admissions); VEMD (ED presentations); VISU analysis
Physical assaults using bodily force on young people account for 60–70 per cent of hospital treatments for assault-related injuries, followed by assault injuries caused by blunt objects. The most common types of injuries from assault include fractures, open wounds, superficial injuries and head injuries (Table 10.3).

While the location of the assault is not known for a significant number of hospital-treated injuries (54 per cent of admissions and 13.9 per cent of ED presentations), the most common known place was schools and other public buildings (32 per cent of hospital admissions and 39 per cent of ED presentations). Other common locations included trades and service areas, on the road/street/highway, recreational spaces and at home (Table 10.3).

**How safe are Victorian children and young people from sexual assault?**

*Sexual violence has a profound impact on physical and mental health. As well as causing physical injury, it is associated with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences. Its impact on mental health can be as serious as its physical impact, and may be equally long lasting. Deaths following sexual violence may be as a result of suicide, HIV infection or murder – the latter occurring either during a sexual assault or subsequently, as a murder of 'honour'. Sexual violence can also profoundly affect the social wellbeing of victims; individuals may be stigmatised and ostracised by their families and others as a consequence.*


Internationally, estimates by the World Health Organisation indicated that nearly one in four women experience sexual violence by an intimate partner and up to one third of adolescent females report their first sexual experience as being forced (WHO 2010). Sexual violence, whether this occurs in childhood or adult life, is associated with a range of negative long-term, physical, social and mental health outcomes (WHO 2002).

Sexual assault is any behaviour of a sexual nature that makes the victim feel uncomfortable, frightened or threatened. It is sexual activity that has not been agreed to, where another person uses physical or emotional force against the victim. Sexual assault is frequently perpetrated outside of the family in dating and other social settings as well as experienced in the context of family violence. Although females make up the majority of sexual assault victims, males are also victims of it.

In 2005–06, young people under the age of 24 years were the victims in 66 per cent of rapes and 90 per cent of other sexual offences reported to Victoria police. Of these, young women were the victims in 85 per cent of the rape reports and in 75 per cent of other sexual offences (Victoria Government 2009a). The number of sexual assaults reported to police where the victim was a child or young person has been decreasing over recent years (e.g. 2738 in 2009–10 compared to 3091 in 2005–06) (see Figure 10.7).

**Figure 10.7: Number of reported sexual assaults* in Victoria of young people aged 0–17 years, 2005–06 to 2009–10**

*Includes rape and non-rape sexual assaults.

Source: Law Enforcement Assistance Program (LEAP), Victoria Police
Sexual assault (often framed in survey questions as ‘unwanted sex’ or ‘unwanted sexual activity’) is common. Recent evidence suggests that a notable proportion of sexually-active young people has experienced ‘unwanted sex’, i.e. sexual activity where they were pressured or coerced into participating. The results of the Fourth National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health 2008 found that 38 per cent of female students and 19 per cent of male students in Years 10 and 12 had experienced unwanted sex (Smith et al. 2009).

The common reasons cited for unwanted sex occurring included being too drunk and being pressured by their partner. While these incidences of ‘unwanted sex’ may not necessarily be reported as sexual assault, it gives an indication that many young Victorian people (females in particular) experience sexual coercion and assault.

**Antisocial and criminal behaviour**

Antisocial behaviour is a generic term used in this report to refer to many behaviours (including violent behaviours) and non-violent norm and rule violations, including behaviour that is aggressive, harmful or destructive to property, people or the community in general. It may also include criminal acts (regardless of whether the young person is apprehended by the police). Therefore antisocial behaviours are considered in relation to behaviours where the young person has not been charged with an offence by the police. In contrast, criminal acts (where the young person has been charged by the police) are antisocial in nature but are differentiated from those where police were not involved.

A small minority of Victorian young people engage in antisocial behaviours, of whom a fraction who commit offences are charged by the police and become involved in the youth justice system. Relatively few young people who are antisocial or commit crimes in their youth go on to become persistent or serious offenders.

**What antisocial behaviour do Victorian young people engage in?**

Information on antisocial behaviours engaged in by Victorian young people is very limited. HOWRU 2009 collected self-reported information related to antisocial behaviours of Victorian secondary school students, including substance (particularly drug) use, assault and carrying a weapon. *(Chapter 8 on substance use provides a more in-depth discussion of the use of alcohol and illicit drugs by Victorian young people).* These selected antisocial behaviours reported by young people themselves may or may not be behaviours that have resulted in the police charging the young person with an offence. It must be noted that presenting information only on selected antisocial behaviours does not provide a comprehensive picture of the prevalence of antisocial behaviour in Victorian young people, nor does it ‘capture’ antisocial behaviour engaged in by young people not within the formal school system.

While the majority of Victorian young people have never carried a weapon (84.9 per cent), one in five of Victorian young males aged 12–17 years (22.9 per cent) report to have carried one at some stage in the past year. Young people in regional areas (17.9 per cent) and those in the most socioeconomic disadvantaged areas (16.9 per cent) were significantly more likely to report carrying a weapon in the past year *(see Figure 10.8).*

*Figure 10.8: Proportion of Victorian young people who report having ever carried a weapon* over the past year, by sex and area of residence and area of socioeconomic status (SES)† 2009

![Figure 10.8](image)

*There is no clear definition or specification on what is a weapon in the survey.*
Of those young people who reported to have carried a weapon in the past year, 56.2 per cent have done so on one or two occasions; however, one in five reported to have carried a weapon 10 times or more in the past year (25.5 per cent of males and 12.2 per cent of females) (see Figure 10.9). It should be noted that there is no clear definition or specification on what constitutes a weapon in the survey and no information is available to explain if those Victorian young people who carry a weapon do so for self-protection or with intent to harm others, due to peer pressure, or carrying it for another person.

Figure 10.9: Frequency of carrying a weapon among Victorian young people aged 12–17 years who report having ever carried weapon over the past year, by sex, 2009

<table>
<thead>
<tr>
<th></th>
<th>10 times or more</th>
<th>6 to 9 times *</th>
<th>3 to 5 times *</th>
<th>1 or 2 times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25.5</td>
<td>5.7</td>
<td>17.1</td>
<td>53.1</td>
</tr>
<tr>
<td>Female</td>
<td>4.3</td>
<td>17.1</td>
<td>35.7</td>
<td>56.3</td>
</tr>
<tr>
<td>All pop.12–17 yrs</td>
<td>12.2</td>
<td>6.5</td>
<td>16.8</td>
<td>56.2</td>
</tr>
</tbody>
</table>

* Indicates data are not statistically significant different between males and females at the 95 per cent confidence intervals.
Source: HOWRU 2009, DEECD

Self-reported information from young people in 2009 indicates that only a very small proportion (7.2 per cent) of Victorian young people aged 12–17 years of age have physically attacked another person (see Figure 10.10), with males, older adolescents aged 15–17 years and those from the most socioeconomically areas more likely to do so. Of this small proportion, most indicated that they have done so only on one or two occasions (75.6 per cent of those who have been physically violent). Of concern, about a quarter (24.4 per cent) of those young people who report to have been physically violent have done so on repeated occasions (three times or more).

Figure 10.10: Proportion of Victorian young people aged 12–17 years who report having ever attacked someone to seriously hurt them, by sex, age group and area of socioeconomic status (SES), 2009

<table>
<thead>
<tr>
<th></th>
<th>10.0</th>
<th>4.5</th>
<th>6.5</th>
<th>8.0</th>
<th>8.5</th>
<th>5.7</th>
<th>7.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12–14 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–17 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most disad.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least disad.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12–17 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Indicates data are not statistically significant different between the two age groups at the 95 per cent confidence intervals.
Source: HOWRU 2009, DEECD
What crimes do Victorian young people commit?

Importantly, a steady body of research findings has found that for many juveniles the criminal career is relatively short-lived and/or opportunistic; that is, most young people who come into contact with the juvenile justice system do not reoffend, irrespective of whether the offence was detected, prosecuted or processed.

(Drugs and Crime Prevention Committee, 2009)

Information from Victoria Police indicates that, of all the crimes recorded in Victoria since 2004, those aged 10–17 years are responsible for a small but significant proportion (9.8 per cent in 2009–10, LEAP data, Victoria Police). Although the rate of crimes committed by a young person aged 10 to 17 years in Victoria is lower compared to the overall crime rate in Victoria, it has been increasing since 2005–06 (from 53.5 per 1000 population to 65.3 in 2009–10). This increasing trend might reflect a true increase in the number of crimes committed by young people or an increase in the number of offences reported where young people were charged (see Figure 10.11).

Figure 10.11: Rates of crimes committed by offenders of all ages and by offenders aged 10–17 years, Victoria, 2005–06 to 2009–10

Source: Law Enforcement Assistance Program (LEAP), Victoria Police

Consistent with the overall population in Victoria, the most common crimes among young people are crimes against property (64.3 per cent of all youth crimes). However, young people are more likely than the general population to commit crimes against other person (19.1 per cent of crimes by young offenders compared to 12.4 per cent of crimes by offenders of all ages) (see Figure 10.12).

Figure 10.12: Crimes committed by offenders of all ages and by offenders aged 10–17 years by broad crime categories, Victoria, 2009–10

Source: Victoria Police – Law Enforcement Assistance Program (LEAP)
The crime rate is markedly higher among young males than among young female, and higher among older adolescents (aged 15–17 years) than among younger adolescents (aged 10–14 years). The youth crime rate is also higher in regional areas of Victoria than in metropolitan areas (although the numbers of crimes in regional Victoria is smaller than those in metropolitan areas). The rate of crimes has been increasing since 2005-06, regardless of their area of residence, age and sex (see Figures 10.13).

Figure 10.13: Victorian crimes committed by a young person aged 10–17 years, by sex and area of residence (rate per 1000 population), 2005–06 to 2009–10

Source: Victoria Police – Law Enforcement Assistance Program (LEAP)
What are the outcomes for Victorian young people involved in the youth justice system?

Young people who are cautioned, rather than charged, are less likely to have further contact with police than those who appear in court for their first offence. *(Victoria Police Child and Youth Strategy 2009–2013)*

In comparison to other states and territories, Victoria has a low youth crime rate and has the lowest numbers per capita of young people detained in custody (AIHW 2010).

In Victoria, children and young people aged 10–17 years who commit crimes may find themselves in contact with the youth justice system. This first contact is likely to be with the police, who may give a formal caution in an attempt to ‘divert’ the young person from further antisocial or criminal behaviour. Current legislation (Children, Youth and Families Act 2005) and previous policy directions have reflected a strong diversionary approach to responding to young people at risk of entering the youth justice system. This process of providing interventions early in a young person’s contact with the criminal justice system aims to reduce the likelihood of further contact with the system. The number of cautions given by Victoria police to young people aged 17 years or younger increased from 2005–06 to 2006–07 and then remained relatively stable over recent years, with a consistently higher number of males received cautions than females *(see Figure 10.14)*. Furthermore, recent estimations from Victoria Police indicate that 80 per cent of the young people who had received a caution had not reoffended within one year and 65 per cent had not reoffended after three years (Victoria Police 2009a).

Figure 10.14: Number of police cautions issued to Victorian young people aged 0–17 years, by sex, 2005–06 to 2009–10

For more serious offences, the police may charge the young person with an offence and the matter will go to court. If a young person has been found guilty of an offence or crime by the court, they may be sentenced to either (1) a period of detention in a Youth Justice Centre; (2) community-based supervision (including probation, youth supervision, and youth attendance); or (3) be given an unsupervised order (e.g. a monetary fine or a good behaviour bond). This process results in only the most serious and persistent offenders and those posing the most serious risk to society becoming youth justice clients.

The rate at which Victorian young people are under supervision (1.69 per 1000 on an average day) is significantly lower than that for all other states and territories and the Australian average (2.5 per 1000 young people) (AIHW 2010). The majority of Victorian young people under supervision orders have been placed on community-based supervision (a rate of 1.54 per 1000 on an average day), with a small number placed in detention (0.1 rate). Males make up the great majority of those under youth justice supervision on an average day (1242 out of 1392) *(see Table 10.4).*
What factors contribute to antisocial and criminal behaviour in Victorian young people?

*There is no one cause or single factor contributing to juvenile offending. Criminal and antisocial behaviour by young people, as with adults, is a complex phenomenon that is attributable to a range of intersecting and overlapping factors.*

*(Drugs and Crime Prevention Committee, 2009)*

There is a considerable body of research into the characteristics of young people who commit crimes, which suggests that young people who commit crimes tend to be those who are disadvantaged or vulnerable with multiple risk factors, including individual factors (e.g. sex and age); family factors (such as from socioeconomically disadvantaged backgrounds or having family members involved in criminal acts or exposure to family violence); and community factors (such as living in communities with high crime rates).

Individual factors, including the age at which a young person first comes into contact with the criminal justice system, are known to influence future offending behaviour. The younger the person is at first point of contact with the police, the more likely they are to reoffend. Young people aged under 14 years of age at their first police contact have a significantly longer involvement in the criminal justice system than those older at their first contact (Victoria Police 2009a).

In Victoria, a 2001 study into reoffending among young people in the youth justice system found that nearly half (41 per cent) of these young people had reoffended, with up to 61 per cent for those who had previously been on supervised orders (Victorian Government 2001). However, given the diversionary approach taken in Victoria to antisocial and criminal behaviour in young people, only the more serious or persistent offenders formally enter the youth justice system. Therefore, reoffending rates only take into account those young people who have been convicted of serious offences, which is likely to skew (i.e. artificially inflate) the recidivism (repeat offending) rates stated.
The relationship between alcohol, crime and violence is complex. While intoxication does not always lead to offending, it is estimated that 47 per cent of all assault offenders and 43 per cent of all assault victims, were intoxicated prior to the event. (Victoria Police, Child and Youth Strategy 2009–2013)

The use of substances, in particular alcohol and illicit drugs is a known risk factor for youth offending and antisocial behaviour.

One of the factors consistently demonstrated to influence young people’s antisocial and criminal behaviour is their connection to formal schooling and, in particular, their participation and retention in school. Poor academic achievement and disengagement with schooling may make it more likely for a young person to leave school early. This compounds other risk factors (such as financial hardship and lack of employment opportunities), which in turn link to youth offending behaviour (see Chapter 9 on engagement with learning for more information).

Family dysfunction, including family conflict and breakdown, are known to be contributing factors to young people being engaged in antisocial or criminal behaviour. In particular, there is very strong evidence that a history of abuse, neglect or maltreatment as a child is a risk factor for antisocial or criminal behaviour in adolescence. Child maltreatment is also a known risk factor for being a victim of or perpetrating intimate partner violence.

Having a parent or family member who has a history of offending or incarceration is known to be a risk factor for a young person engaging in antisocial and criminal behaviour. Information from Corrections Victoria indicates that 47.9 per cent of prisoners received into Victorian prisons in 2009 had dependent children aged 17 years or younger (Victorian Government 2010).

While negative family factors are associated with an increased likelihood of antisocial or criminal behaviour in young people, positive family factors (such as strong bonds and attachment to parents) have been demonstrated as ‘protective’ factors. Consistent and positive parenting, parental supervision and involvement in the child’s life and high-quality child–parent relationships have all been demonstrated to have a significant impact on reducing the likelihood of youth antisocial and criminal behaviour. (See Chapter 12 for further discussion of the influences families have on outcomes for Victorian children and young people).

How safe do Victorian children and young people feel?

Most Victorian children and young people are not victims of crime or abuse and most feel safe within their communities. While perceptions of safety do not necessarily equate to actual safety, they give a good indication of how confident and secure children, young people and their families feel in their neighbourhoods. Perceptions of safety are also important in relation to the levels of social support available to children, young people and their families (see Chapter 12 for discussion of family and community support).

The majority of young people (82.4 per cent) in Victoria feel safe in their communities. While most children and young people report feeling safe in their neighbourhoods, females (84.9 per cent), older adolescents aged 15–17 years (85.6 per cent), those living in regional areas of Victoria (84.2 per cent) and those from the least socioeconomically disadvantaged areas (87.1 per cent) are more likely to report feeling safe in their neighbourhoods (see Figure 10.15).
While most young Victorians report to feel safe in their neighbourhoods, their perceptions of safety are related to the time of day and where they are situated. They were significantly less likely to feel safe walking around their neighbourhood or being on public transport at night. Regardless of the location and time of day, male young people and those living in regional areas of Victoria were more likely to report feelings of safety regardless of location and time of day (see Table 10.5).

Table 10.5: Proportion of Victorian young people aged 12–17 years who feel safe in their neighbourhood, by location, time of the day and sex, 2009

<table>
<thead>
<tr>
<th>Sex</th>
<th>All pop.</th>
<th>AT HOME BY THEMSELVES</th>
<th>WALKING IN LOCAL AREA ALONE</th>
<th>ON PUBLIC TRANSPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12-17 yrs</td>
<td>During the day</td>
<td>After dark</td>
<td>During the day</td>
</tr>
<tr>
<td>Male</td>
<td>83.5</td>
<td>78.4</td>
<td>44.8</td>
<td>73.2</td>
</tr>
<tr>
<td>Female</td>
<td>81.5</td>
<td>75.5</td>
<td>23.4</td>
<td>69.6</td>
</tr>
<tr>
<td>Location</td>
<td>Metropolitan</td>
<td>81.2</td>
<td>75.6</td>
<td>31.3</td>
</tr>
<tr>
<td></td>
<td>Regional</td>
<td>85.5</td>
<td>80.2</td>
<td>41.0</td>
</tr>
<tr>
<td>All 12–17 year</td>
<td>82.5</td>
<td>77.0</td>
<td>34.1</td>
<td>71.4</td>
</tr>
</tbody>
</table>
Chapter 10
Endnotes

1. VISU analysis; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A10.1).

2. Australian Bureau of Statistics (ABS) Death Unit Record File; VISU analysis; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A10.2).

3. Socioeconomic Index for Areas (SEIFA) – Index for Relative Socioeconomic Disadvantage (IRSED) was developed by the Australian Bureau of Statistics (ABS) based on data from the 2006 Census of Population and Housing. Each geographic area in Australia was given an IRSED score ranking the disadvantage of an area compared to other areas across Australia. Areas can also be grouped into quintiles based on their IRSED scores to provide groupings by level of disadvantage, with quintile 1 being the most disadvantaged, and quintile five, the least disadvantaged. The SEIFA IRSED data have been matched with the postal codes in data from VCHWS 2009 and HOWRU 2009 surveys by using the 2006 ABS Postal Area (POA) data. Inaccuracy and mismatch could occur as: (1.) the ABS POA is only an approximation of postcode, and (2.) the 2006 POA may not capture some new postcodes developed after 2006 in Victoria. For example, there are 367 sample observations in HOWRU 2009 that are not matched into the SEIFA IRSED.

4. HOWRU 2009; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A10.3).

5. See note 3.

6. Offenders are usually referred to as ‘alleged offenders’.

7. Alleged offenders are persons who have allegedly committed a criminal offence and have been processed for that offence by either arrest, summons, caution or warrant of apprehension during the corresponding financial year, regardless of when the offence occurred.

8. Those persons who for legal or other reasons were apprehended but were not charged are also included. Persons are counted on each occasion they are processed and for each offence counted in recorded offences (e.g. a person processed on three occasions will be counted three times). Only the offence in recorded offences for which the offender has been processed is included.

9. Only the most serious offence which best describes a distinct course of criminal conduct is recorded in official crime statistics, even though an offender may be charged with other offences resulting from the one incident. For example, an offender carrying a firearm commits an armed robbery – only the offence of armed robbery is recorded although the offender would be charged with armed robbery and possession of a firearm.

10. The number of distinct courses of criminal conduct occurring within an incident will generally be one unless there is a break in time and/or location. For example, if an offender presents three valueless cheques to a teller only one offence would be recorded but if the three cheques were presented at different times or at different branches then three offences would be recorded.
Evidence base about injuries (intentional and unintentional in Victorian children, young people and their families)


Evidence base about antisocial behaviour, crime and victimisation of Victorian children, young people and their families


Parents Promoting Health and Development
Parents play a fundamental and influential role in promoting the health and development of their children from infancy, childhood, through to adolescence.

Parental influence is positive for the majority of Victorian children. However, the actions and behaviour of a proportion of parents does expose their children to health risks.

The mothers of around one in five Victorian children smoked tobacco at some point during pregnancy (18.3 per cent); while around three in five drank some alcohol during pregnancy (59.7 per cent). Notably, children from families with higher levels of household income were more likely to have been exposed to alcohol prior to birth. Of concern, 18.9 per cent of Victorian children were exposed to ‘binge drinking’ levels of alcohol before their mothers realised they were pregnant; and 2.4 per cent of children were exposed to binge drinking after the mother became aware of the pregnancy.

Most Victorian parents (87.4 per cent) placed infants on their back to sleep in accordance with recommended practice to reduce the risk of Sudden Infant Death Syndrome (SIDS).

The proportion of Victorian infants fully breastfed has remained relatively stable over the last decade, with around half of Victoria’s infants being fully breastfed at 3 months, which decreases to 37 per cent by the time infants reach 6 months of age.

Almost all Victorian infants receive maternal child health (MCH) checks at birth (99.8 per cent in 2009–10) and, while the participation rate decreases as children age, more than three in five receive their 3.5 year check (63.1 per cent). Most Victorian parents immunise their children, with the immunisation rate at above 92 per cent at the ages 1 and 2 years, decreasing to 87.2 per cent at school entry.

Less than half (47.7 per cent) of all Victorian parents consume the recommended serves of fruit every day and less than a tenth (7.3 per cent) of these parents consume the recommended serves of vegetables on a daily basis. About two thirds of Victorian parents do the recommended amount of exercise each week (66.8 per cent).

Over half of all Victorian children aged under 8 years are read to by a family member each day, with daily reading more likely to occur for preschoolers (76.4 per cent) than school-aged children (58.2 per cent of 5–8 year olds).

Most Victorian children (74.8 per cent) and young people (74 per cent) live in a smoke-free household. The majority of Victorian children are protected from sun exposure during the summer months (81.7 per cent), with babies and young children (aged 1–4 years) significantly more so than older children (aged 5–12 years).
In line with the ecological model of child development (outlined in Chapter 1), parents play a fundamental and influential role in promoting the health and development of their children in the immediate, short and longer terms. During infancy and childhood, parents and other main carers play a key role in directly supporting, assisting and teaching children about the world and encouraging them to grow into healthy and productive adults. As a child ages, particularly through adolescence, the influence of their parents and family can be reinforced (or challenged) by the increasing importance of friends and peer groups. The quality of the relationships between children and young people and their parents is a key protective factor that helps promote positive health and development outcomes. (Chapter 12 provides a detailed discussion of the role of the family and the family’s social network on outcomes for Victorian children and young people).

There are various ways in which parents promote health and development. This chapter focuses on a number of specific issues where parents have significant responsibility for promoting positive outcomes, including parental actions or behaviours in promoting optimal antenatal care, overall health and wellbeing in early childhood and in protection against environmental risk (such as environmental tobacco smoke and sun exposure).

Key Victorian Government initiatives: Parents promoting health and development

**Commitments and new initiatives**

- Cradle to Kinder an intensive ante and post-natal support service for vulnerable pregnant women
- Stronger support for telephone advice from the MCH line and Parentline
- Smalltalk program
- Funding boost to Australian Breastfeeding Association to provide support for new mothers
- Victorian Breastfeeding Action Plan

**Programs in place**

- Ban of smoking in vehicles carrying children
- HPV and Hepatitis B vaccination for babies
- Pertussis (whooping cough) vaccination for parents
- A new parent vaccination program to protect babies from whooping cough by vaccinating parents
- Promotion of smoking reduction strategies by health and early childhood practitioners
- Enhanced Maternal and Child Health Service for vulnerable families
- Best Start networks of early childhood services, parents and local governments
- Regional Parenting Services
- In Home Support for higher-need Aboriginal families
- Parent support or parenting programs for families affected by alcohol or drug use
- General early childhood services that support capable parenting
- Integrated Family Services for vulnerable families
- Funding the Victorian Aboriginal Community Controlled Health Organisation to support pregnant Aboriginal women to stop smoking
- Early identification of mothers with post-natal depression and mental illness in the perinatal period through the Perinatal Emotional Health Program (PEHP) and universal screening
- Mother Baby Units offer consultation and support to MCH and Enhanced MCH nurses.
Antenatal care

The health of the mother before, during and immediately after pregnancy and the health of the child in their first two years of life are critical to ensuring maximal health, development, learning, safety and wellbeing outcomes throughout the child’s life. Access to high-quality health care prior to, during, and after birth has been shown to be effective in promoting the health and development of both the mother and the child. Some of the key ways for mothers to promote their infants’ health and development is by abstaining from using substances such as alcohol or tobacco and by maintaining a healthy diet (including sufficient folate intake to prevent neural tube defects) during pregnancy.

A baby’s birth weight and survival through the first year of the life are internationally recognised indicators of the quality of antenatal care and the healthy lifestyles of the mother before and after the birth of her infant.

Are Victorian babies born at healthy weights?

A child’s birth weight is widely accepted as an important indicator of the overall health of an infant at birth. In Australia in 2008, the majority of infants (92.5 per cent) recorded normal birth weights (2500–4499 grams). However, 6.1 per cent of babies born with low birth weights, 1 per cent had very low birth weights and 0.4 per cent had extremely low birth weights (AIHW 2010a).

Low birth weight is attributed to infants being born pre-term (premature) or because they are small for their gestational age. These infants are at significantly higher risk of a range of poorer health outcomes, including greater chances of longer hospitalisation after birth, the development of disabilities, and increased risk of illness and death. It has been associated with a range of factors, including the mother’s physical characteristics (including size, age and ethnicity); use of alcohol, tobacco or drugs during pregnancy; her diet and overall health.

Most Victorian infants are born at a healthy weight (93.8 per cent of live births in 2008). This is consistent with recent 2010 data on the proportion of infants born of healthy weight across Australia (93.9 per cent) (AIHW 2010a). The proportion of Victorian infants with a low birth weight (including low, very low and extremely low birth weights) in 2008 is significantly higher for infants born to Aboriginal women (14.2 per cent) than those born to non-Aboriginal women (6.2 per cent) (see Figure 11.1).
Do Victorian mothers consume alcohol and tobacco during pregnancy?

One of the key factors influencing the birth weights of infants is the use of substances during pregnancy. The harmful effects of alcohol, tobacco and other drugs on foetal development are well established.

Smoking during pregnancy can lead to a number of significant, preventable threats to the health of the mother and child both before and after childbirth. Mothers who smoke during pregnancy increase the risk of premature birth, stillbirth, low birth weight and Sudden Infant Death Syndrome (SIDS). There are also additional long-term risks for the health of the child as they grow into adolescence and adulthood, such as increased chance of childhood obesity, high blood pressure and asthma.

The risks of drinking alcohol during pregnancy are primarily related to the potential consequences for the development of the foetal brain. Although there is uncertainty regarding the specific effects of low levels of alcohol consumption during pregnancy, evidence has shown that heavy alcohol consumption (either chronic daily use or ‘binge’ drinking) during early pregnancy is of greatest risk to the unborn infant. Additionally, a number of other factors can increase the risks associated with consuming alcohol during pregnancy. These include the stage of foetal development when alcohol is consumed, the pattern and timing of alcohol use and the use of other drugs in combination with alcohol. The Australian Guidelines to Reduce the Risks from Drinking Alcohol (2009) advise that the safest option is abstaining from any alcohol during pregnancy.

Recent information from the VCHWS 2009 suggests that most Victorian children aged under 2 years were not exposed to tobacco during pregnancy (81.3 per cent). However, nearly one in five (18.2 per cent) smoked before realising they were pregnant, and, of concern, 9.3 per cent of mothers smoked tobacco after they were aware of the pregnancy (see Figure 11.2). Education level appears to have an influence on whether a woman smokes during pregnancy (either before or after she realised she is pregnant). Victorian children whose mothers have a university degree are less likely to have been exposed to tobacco during pregnancy than those whose mothers have lower levels of education (see Figure 11.2).
Aiming to reduce the rate of smoking among pregnant women and the risk of smoking-associated adverse health outcomes for their babies, maternity service providers in Victoria have been required to provide smoking cessation advice, assistance and follow-up during routine antenatal care. In Victorian public hospitals where data is reported, most pregnant women received appropriate interventions in relation to smoking at their first antenatal visit prior to 20 weeks gestation; and the majority of women identified as smokers or recent quitters at their first antenatal visit were given further appropriate interventions in relation to smoking (see Figure 11.3).

Figure 11.3: Proportion of Victorian pregnant women given appropriate interventions in relation to smoking, 2003–04 to 2008–09

*The rate of all women given appropriate interventions in relation to smoking at their first antenatal visit prior to 20 weeks gestation.
#The rate of women who were identified as smokers or recent quitters at their first antenatal visit who attend clinic again prior to 20 weeks gestation and were given further appropriate interventions in relation to smoking.

Source: Department of Health, Victorian maternity services performance indicators, August 2010
Information from VCHWS 2009 indicates that around one third of Victorian children aged under 2 years were not exposed to alcohol during pregnancy (39.6 per cent). However, over half of children’s mothers (56.0 per cent) report to have consumed alcohol before they realised they were pregnant. Around one third (32.7 per cent) report drinking alcohol after realising they were pregnant (see Figure 11.4).

The level of annual family income appears to have an influence on the mother’s consumption of alcohol during pregnancy. Figure 11.4 indicates that Victorian children whose families have lower levels of annual household income (under $60,000 per year) were less likely to have been exposed to alcohol prior to birth (33 per cent never drank), compared to of children whose families had higher levels of income (32.4 per cent never drank). Significantly, children from higher income families were more likely to be exposed to alcohol during their pregnancy, even after the mother became aware of the pregnancy, compared to children from lower income families (39.5 per cent versus 19.2 per cent).

Figure 11.4: Proportion of Victorian children aged under 2 years whose mothers drank alcohol during pregnancy, by annual household income, 2009

Of those Victorian children who were exposed to alcohol before birth, most were not exposed to ‘binge’ levels of alcohol consumption (defined in VCHWS 2009 as consuming more than four standard drinks in a day). Given the evidence of the harmful effects of heavy drinking in the early stages of a pregnancy, it is of concern that around 16.7 per cent of Victorian children were exposed to heavy levels of alcohol before their mothers realised they were pregnant (presumably in the first 12 weeks of pregnancy)(see Figure 11.5). A further 2.4 per cent of children were exposed to binge drinking levels of alcohol after the mother became aware of the pregnancy. The rate of binge drinking by mothers before or after awareness of pregnancy is similar regardless of household income.

Figure 11.5: Proportion of Victorian children aged under 2 years whose mothers consumed alcohol at binge drinking level* during pregnancy, by annual household income, 2009

*These categories are not mutually exclusive; some women may have drank alcohol pre and/or post awareness.
Source: VCHWS 2009, DEECD

*Binge drinking if defined in VCHWS 2009 as consuming more than four standard drinks in one day.
^ These categories are not mutually exclusive; some women may have binge drank pre and/or post awareness
Source: VCHWS 2009, DEECD
Optimal health and wellbeing in early childhood

The pivotal role of parents in promoting the health and development of their children is well established. This is particularly so during infancy and childhood, where the parents’ actions and behaviour can assist or hinder their children’s healthy growth.

Key ways for parents to promote health and development for their children include using available health and medical services (such as maternal and child health services and immunisation programs); preventing health problems (through healthy sleeping habits, good oral care and healthy diets and exercise); and identifying problems early so that appropriate treatment, support and care can be provided.

Do Victorian parents promote healthy sleeping habits?

Sudden Infant Death Syndrome (SIDS) is the sudden and unexpected death of an infant under the age 1 year. Death usually occurs during sleep and is unable to be explained through medical examination or factors relating to the clinical history of the child. Despite considerable reductions in its incidence over the last decade, SIDS remains a major cause of death for infants in Australia, accounting for 22.1 per cent of the deaths of infants aged 28–364 days in Australia in 2007. It is ranked as the second major cause of infant deaths after deaths due to birth defects (43 per cent) (Victorian Government 2010a). Although the causes remain unknown, the Public Health Association of Australia (PHAA 2009) recommends five guidelines for parents to follow in order to reduce the risk of SIDS:

- placing infants on their backs to sleep from birth (as opposed to their stomach or side)
- providing a safe environment for sleep, with a safe cot, mattress and bedding
- ensuring that infants sleep with uncovered heads and faces
- avoiding infant exposure to tobacco smoke before and after birth
- placing infants in their own safe sleeping environment in the same room as the parents for the first 6–12 months of life.

Information from the VCHWS 2009 indicates that the majority of Victorian parents (87.4 per cent) place infants on their back to sleep in accordance with these SIDS recommendations.1

Do Victorian parents use maternal and child health (MCH) services?

The Victorian Maternal and Child Health (MCH) Service is a key element of the wider child and family health services offered to families in Victoria. It is a free, universal health service provided by a registered nurse for children from birth to school age and is jointly delivered by the Department of Education and Childhood Development (DEECD) and local governments. The aim of the MCH Service is to promote healthy outcomes for children, their mothers and families. This is achieved through a comprehensive approach to managing the physical, emotional and social factors affecting parents, families and communities. An enhanced MCH Service is also provided to children and families at a significantly higher risk of poor outcomes, such as parental substance use, physical disability of the child or if the parents are teenagers.

The MCH Service consists of a series of 10 consultations spaced from birth through to 3.5 years of age. These key visits comprise an initial home visit after birth, followed by office based consultations at 2, 4 and 8 weeks, 4 months, 8 months, 2 months, 18 months, 2 years and 3.5 years. Most Victorian parents use the MCH Service for regular health and development assessments of their children. While the service is universally offered to all Victorian children, participation in the key visits requires parents to independently book and attend appointments with an MCH nurse.

Nearly all infants in Victoria receive a MCH visit within their home within the first or second week of their lives (99.8 per cent in 2009–10)(see Figure 11.6). After the first visit, parents also continue to attend MCH appointments throughout their child’s early years. However, the MCH participation rate decreases as children age, from 95.4 per cent at 4 weeks of age to 63.1 per cent at 3.5 years. The participation in the Victorian MCH program has been consistent over the past decade.
Do Victorian parents immunise their children?

Immunisation is one of the most effective public health measures to protect children (and adults) from preventive communicable diseases, benefiting both individuals and the broader community.

The Commonwealth Government is responsible for setting the national immunisation agenda and the state and territory governments are responsible for its implementation. Under the Immunise Australia Program, the National Immunisation Program Schedule (NIPS) sets out the government-funded vaccines recommended (and funded) at different ages of a child’s life.

Parents can also help protect their older children from preventive communicable diseases through immunisation. Victorian children have a very high immunisation rate, with 92.1 per cent fully immunised at around age one year, 92.8 per cent at around age two, and 87.2 per cent by school entry in 2009–2010 (see Figure 11.7).

Figure 11.7: Proportion of Victorian children fully immunised,* by age group, 2006–07 to 2009–10

*A child is considered fully immunised if they have received all NIPS recommended vaccines at the appropriate age.

Source: Australian Childhood Immunisation Register
Do Victorian parents promote healthy diets and exercise behaviours?

There is increasing evidence about the ways in which parents influence healthy weight, physical activity and nutrition in children and young people. *(Chapter 3 provides a detailed discussion of healthy weight and the factors influencing healthy weight in Victorian children and young people)*.

The following family factors are considered to be important in promoting positive nutrition, physical activity behaviours and associated healthy weight in children and young people:

- parents’ knowledge, values and beliefs about food
- role modelling of positive nutrition and physical activity by parents and siblings
- child–parent interactions around, and about, food and physical activity
- parenting styles and supports *(see Chapter 12 for further discussion about parent and family influences on outcomes for children and young people)*
- the family socioeconomic situation (including parents’ educational, occupational and employment status) *(see Chapters 2 and 12 for further discussion about the influence of family resources on outcomes for children and young people)*
- and the security of access to food (i.e. food security or the stability of access to food and types of food).

Parents’ roles in promoting healthy diets begins from birth, with a focus on adequate nutrition through breastfeeding of infants. The proportion of Victorian infants who are fully breastfed has remained relatively stable over the last decade. Around half of Victoria’s infants are fully breastfed at 3 months, reducing to 37 per cent by the time they reach 6 months of age *(See Figure 3.7)*. These levels fall well below the World Health Organisation and National Health and Medical Research Guidelines that recommend exclusive breastfeeding until the age of 6 months.

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### National Immunisation Program Schedule (NIPS)

- **Birth** – *Hepatitis B*
- **2 months** – *Hepatitis B, Diphtheria, tetanus and acellular pertussis, Haemophilus influenzae type B, C and D, Inactivated poliomyelitis, Pneumococcal conjugate and Rotavirus*
- **4 months** – *Hepatitis B, Diphtheria, tetanus and acellular pertussis, Haemophilus influenzae type B, C and D inactivated poliomyelitis, Pneumococcal conjugate, Rotavirus*
- **6 months** – *Hepatitis B, Diphtheria, tetanus and acellular pertussis, Haemophilus influenzae type B and C, Inactivated poliomyelitis, Pneumococcal conjugate, Rotavirus*
- **12 months** – *Hepatitis B, Haemophilus influenzae type B & D, Measles, mumps and rubella, Meningococcal C (MenCCV)*
- **12–24 months** – *Hepatitis A (Aboriginal and Torres Strait Islander children in high risk areas)*
- **18 months** – *Varicella*
- **18–24 months** – *Pneumococcal polysaccharide and Hepatitis A (Aboriginal and Torres Strait Islander children in high risk areas)*
- **4 years** – *Diphtheria, tetanus and acellular pertussis, measles, mumps and rubella, inactivated poliomyelitis*
- **10–13 years** – *Hepatitis B, Varicella*
- **12–13 years** – *Human papillomavirus*
- **15–17 years** – *Diphtheria, tetanus and acellular pertussis*
The duration of breastfeeding is significantly tied to the education level of the mother, where mothers with university educations are more likely to fully breastfeed their babies for 6 months or longer (21.9 per cent) than women with lower levels of education (11.1 per cent)(see Figure 3. 8).

Parents also play an active role in promoting healthy diets for their children through providing appropriate food and dietary options. Role modelling of healthy eating habits is another key way that parents can promote healthy nutrition and healthy weights in their children. The Dietary Guidelines for Australian Adults developed by National Health and Medical Research Council (NHMRC) in 2003 recommend that adults eat at least five serves of vegetables and two serves of fruit each day.

The 2008 Victorian Population Health Survey (VPHS) indicated that under half (47.7 per cent) of all Victorian parents with children aged under 18 years consume the recommended serves of fruit every day. Less than a tenth (7.3 per cent) of these parents consume the recommended serves of vegetables on a daily basis. Mothers are significantly more likely to meet the fruit and vegetable recommendations than fathers (see Figure 11.8).

Figure 11.8: Proportion of Victorian parents meeting the recommended daily serves of fruit and vegetables,* by sex, 2008

Parents can also promote healthy weight by modelling healthy exercise activities for their children. The National Physical Activity Guidelines for Adults published by the Australian Government Department of Health and Ageing in 2005 recommend that adults engage in at least 30 minutes of moderate intensity exercise at least five days per week. VPHS 2008 indicates that about two thirds of Victorian parents with children under 18 years (66.8 per cent) do the recommended amount of exercise each week. Of note, Australian-born parents are more likely to meet the physical activity guidelines than those born overseas (70.2 per cent compared to 55.7 per cent, respectively)(see Figure 11.9).

Figure 11.9: Proportion of parents meeting the recommended levels of physical activity* each week, by annual household income and country of birth, Victoria, 2008

*Based on 2003 NHMRC Dietary Guidelines for Australian Adults aged 19 years and older, which recommend five serves of vegetables and two serves of fruit daily for adults to ensure a healthy diet.

*Based on the 1999 Australian Government Department of Health and Aged Care’s National Physical Activity Guidelines for Adults (persons aged 19 years and over), which recommend at least 30 minutes of moderate intensity activity on most, preferably all days.

Source: VPHS 2008, Victorian Department of Health
Do Victorian parents promote positive oral health?

Parents can promote positive oral health by assisting children and young people to have good oral hygiene habits (adequate fluoride intake and teeth brushing) and by taking them to the dentist for regular preventive checks.

Not only is it important that teeth and gums are brushed twice daily, but they need to be brushed adequately to remove plaque for the prevention of gum disease and tooth decay. It is currently recommended that parents help their children to brush their teeth until age 7 years to ensure teeth are cleaned adequately.

(Chapter 4 provides a detailed discussion of oral health outcomes for Victorian children and young people).

Early learning and development

The first and most important learning environment for young children is within their family home. Children rely on their parents to teach them about the world and help promote their ongoing engagement with learning.

Parents can assist in their children’s early learning and development within the home by engaging with their informal ‘learning’ activities, such as reading books together. They can also promote early learning by providing opportunities for their children to participate in formal early learning programs (including kindergarten). (Chapter 9 provides a detailed discussion of Victorian children’s engagement with formal and informal learning environments).

Do Victorian parents promote early learning at home?

Two major longitudinal studies, the Effective Pre-school and Primary Education (EPPE) Project in the United Kingdom and the Study of Early Child Care and Youth Development in the United States, have found that learning activities parents engage in with their children before school age (the early home learning environment) have a substantial impact on children’s social and cognitive development (Salmons et al 2007a; Salmons et al 2007b). For example, EPPE found that ‘The quality of the early years home learning environment (HLE) and parents’ (especially mothers’) qualification levels are the most important background factors relating to a child’s attainment in reading and mathematics at Year 5’.

In Victoria, the vast majority of parents report engaging in learning activities with their young children. The ABS Childhood Education and Care Survey 2008 reported on a range of informal learning activities which parents engaged in with their children over the week before the survey. Overall, 93 per cent of parents of 0 to 2 year old children and almost all (99 per cent) of 3 to 8 year old children report engaging in at least one of these activities with their child (activities included reading, telling a story, playing music, singing, dancing, sport, games and watching TV)(ABS 2009).
It is widely accepted that reading books at an early age is an influential factor in promoting children’s literacy development. There are a number of benefits of parents reading to their children. These include the development of positive associations with reading, greater understanding of language through contextualisation, improved listening skills and increased vocabulary skills.

VCHWS 2009 suggests that over half of all Victorian children aged under 8 years are read to by a family member each day. Daily reading to children is more likely to occur for preschoolers (76.4 per cent) than babies and school-aged children (see Figure 11.10).

Figure 11.10: Proportion of Victorian children who are read to by a family member every day, by age group, 2009

Do Victorian parents enroll their children in formal early learning?

In Victoria, formal care environments, particularly in kindergartens, require staff to have formal qualifications in early childhood education and care. Almost all eligible Victorian children are enrolled in a formal kindergarten program (95.1 per cent). This proportion has remained fairly stable over the past decade, suggesting that the majority of Victorian parents are actively promoting early learning and development by enrolling their 4-year-old children in formal kindergarten programs (see Chapter 9 for further discussion).
Protection against environmental risks

Parents play a pivotal role in protecting their children against harm or risks found in the environment. The most direct form of protection is the prevention of accidental injuries (see Chapter 10 for a detailed discussion on accidental injuries in children and young people). Parents can also promote the health and development of their children by protecting against two key environmental risks, damage caused by exposure to the sun and tobacco smoke.

Do Victorian parents protect their children against exposure to tobacco smoke?

There is strong evidence to suggest that exposure to tobacco smoke significantly increases the likelihood of developing a range of serious health problems and subsequent death. Environmental tobacco smoke, defined as smoke within a closed environment, such as a car or house, is an important factor in the incidence of SIDS. Exposure to it has been demonstrated to cause respiratory problems such as asthma, while it also increases the likelihood that children and young people will become smokers themselves. (Chapter 8 provides a detailed discussion of the smoking patterns of Victorian young people).

Most Victorian children (74.8 per cent) and young people (74 per cent) are not exposed to tobacco smoke at home (see Figures 11.11 and 11.12). Children are more likely to live in a smoke-free home if they live in metropolitan areas (77.1 per cent), come from high-income families (80.3 per cent), or if their parents’ education levels are university degree or equivalent (88.6 per cent) (see Figure 11.11). Young people are more likely to live in a smoke-free home if they live in couple families (78.4 per cent) or in the areas of the least socioeconomic disadvantage (81.2 per cent) (see Figure 11.12).

Figure 11.11: Proportion of Victorian children aged 0–12 years exposed to tobacco smoke at home, by area of residence, annual household income and parents’ education level, 2009

Source: VCHWS 2009, DEECD
Do Victorian parents protect their children against exposure to sun damage?

Exposure to sun damage during childhood increases the risks of developing skin cancers. Although it is not clearly understood why (beyond the usual risk of sun damage to an adult), it has been proposed that a child’s skin may be especially vulnerable to the effects of solar ultraviolet (UV) radiation. Recent international studies on sunburn show that the incidence of sunburn tends to increase through childhood and reaches a peak in adolescence (Lucas 2006).

In this context, the role of Victorian parents in reducing their children’s exposure to sun damage is particularly important. A number of strategies are promoted by the Victorian Cancer Council’s ‘Slip Slop Slap’ program to help protect children from sun damage when they are outside. These include:

- ensuring children and infants are well covered by sun-protective clothing
- applying Sun Protection Factor (SPF) 30+ sunscreen to areas of skin not protected by clothing at least 20 minutes before exposure to the sun, and reapplying every two hours when outdoors
- ensuring children and infants always wear suitable sun-protection hats (broad rimmed that shades their faces, necks and ears)
- keeping children and infants in the shade as much as possible
- protecting the eyes of children and infants with sunglasses.
The majority of Victorian children are protected from sun exposure during the summer months (81.7 per cent) (see Figure 11.13). Babies and younger children (aged 1–4 years) are significantly more likely to be protected from the sun by their parents than older children (aged 5–12 years). The most common forms of sun protection reported by Victorian parents are sun screen (89.6 per cent), hat (89.4 per cent) and covering with clothing (54.3 per cent), in line with the recommendations made by the Skin Cancer Council (see Figure 11.14).

Figure 11.14: Types of sun protection parents report usually using for their child (0–12 years), Victoria, 2009

*Parents were able to report more than one type.
Source: VCHWS 2009, DEECD
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Endnotes

1. VCHWS 2009; See detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A11.1).

2. ABS (2009) 4402.0 – Childhood Education and Care, Australia, June 2008 (Reissue), additional datacube.
References

Evidence base about parents promoting antenatal care

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References

- Evidence base about parents promoting child health.

• Public Health Association of Australia (PHAA) (2009). Public Health Association of Australia: Policy-at-a-glance – Sudden Unexpected Death in Infancy (SUDI) and Sudden Infant Death Syndrome (SiDS) Policy. PHAA, Canberra.


• (2010b). Fact Sheet: Dental checks – 0 to 6 years. Department of Health, Melbourne.


Evidence base about parents promoting early learning and development


Evidence base about parents protecting children against environmental risks.

- Department of Education and Early Childhood Development (2007, 29 November 2010). ‘Early Childhood Indicators: Decreased rate of children exposed to tobacco smoke in the home’.
Chapter 12
Families, Communities and Social Support

The ecological model of the Victorian Child and Adolescent Outcomes Framework recognises that individual children, young people and their immediate families sit within the broader context of extended families and friends, their communities and broader society. Of all the factors than can affect outcomes for Victorian children and young people, families are by far the most important and influential.

Nine in 10 Victorian children (89.9 per cent) live in families with healthy family functioning, characterised by family member discussing feelings, making joint decisions and supporting, trusting and accepting each other. Eight in 10 (83.1 per cent) young people live in families with healthy family functioning which, for this group, is measured as being free from aggressive behaviours and having a good system to manage adolescents' school and social lives.

Nearly four in 10 Victorian children have been exposed to a significant stressful event by the time they start school (e.g. the death of a family member, parental divorce, or an illness of their parents or siblings), and Aboriginal children and those from single parent families are more likely to have been exposed to multiple stressors. A history of parental mental illness is experienced by 3.5 per cent of children by the time they start school and 2.4 per cent come from a family where there are alcohol or drug problems. One in 10 Victorian parents (10.8 per cent) with dependent children consume alcohol at levels that are at risk of short-term harm on at least a weekly basis.

Children and young people can be subjected to harm and abuse in their own home. The rate of substantiated child abuse has decreased from 2005–06 to 2009–10 (from 6.5 to 5.7 per 1000). There is a complex interplay between family violence, mental health problems, substance use and child abuse.

The incidences of family violence in which a child or young person was present accounted for around 40 per cent of all family violence incidents reported to the Victoria Police between 2005–06 and 2009–10. Of the 35,720 reported family violence incidents in 2009–10, a total of 14,870 children and young people aged 16 years or younger experienced these incidents. The number of children identified as ‘aggrieved family members’ (i.e. as victims) in finalised family violence intervention order applications in Victoria has increased dramatically, from 5310 in 2003–04 to a total of 15,399 in 2007–08, due largely to legislative and practice changes, including changes to procedures, where children were previously likely to be included on their mother’s intervention order, and an increased awareness of the need to protect children separate from a parent at risk. The number of family violence incidents where the perpetrator was a young person (aged 10–17 years) has increased from 274 incidents in 2004–05 to 479 in 2009–10. However, the overall number of family violence incidents also rose during this period, partially owing to strategies employed by the government to increase reporting and improve police responses.

Communities further influence outcomes at the family, child and young person level, including through social support, access to local services and amenities, and opportunities to participate in community decisions and activities. Social support can help families deal with challenging life events and help the family feel an overall sense of belonging and trust. Nearly nine in 10 Victorian families with children have access to support networks, with 95.2 per cent of the children with relatives or friends who could take care of them or their parents if needed. Around nine in 10 Victorian young people report having a special person in their lives who they can turn to when having problems, with seven in 10 report having a trusted adult in their lives.

Chapter Summary
Most children and young people reported to live in neighbourhoods that are clean and that have basic shopping facilities and services, but less than half of Victorian young people (48.3 per cent) report that their neighbourhood has good recreational facilities. While the majority of Victorian young people (73.4 per cent) report living in neighbourhoods with close affordable public transport, more than one in 10 (14.1 per cent) do not and, of these young people, most (76 per cent) indicate that lack of local public transport has impacted on their ability to meet their school, work, social or health goals. The majority of children (79.4 per cent) and young people (85.6 per cent) in Victoria feel safe in their communities, at home, walking around their neighbourhood and on public transport.

Key policy directions relating to supporting families

- Australian Government, Social Inclusion Agenda 2011
- National Framework for Protecting Australia's Children 2009–2020
- Supporting Parents, Supporting Children: A Victorian Early Parenting Strategy 2010
- Victoria’s Plan to Prevent Violence against Women 2010–20
- Strategic Framework to Guide Continuing Family Violence Reform in Victoria 2010–2020

Key Victorian Government initiatives: Families, Communities and Social Support

**Commitments and new initiatives**

- Stronger support for parents through telephone advice from MCH line and Parentline
- Parenting Strategy
- Primary Welfare Support Officers
- *Cradle to Kinder* an intensive ante and post-natal support service for vulnerable pregnant women
- Funding for Childrens Protection Society to provide intensive childcare for at risk children

**Programs in place**

- Universal Maternal and Child Health (MCH) service
- Enhanced MCH for higher need families
- Primary School Nursing Program
- Integrated Family Services for vulnerable families
- Intensive family coaching and support for vulnerable families
- *Families where a Parent has a Mental Illness* (FaPMI) strategy implementation includes training and support to mental health services, fostering links with Child FIRST, to increase the family focus of services
- The BEACON Project leads a family-focused approach in Alcohol and Other Drug services through training and clinical leadership

- Preventing Violence Against Women program. New evidence based initiatives targeting community, families, men, women, boys and girls to build equitable and respectful organisations, communities and relationships to prevent violence against women and children
- *Smalltalk* program
- Expanded Early Start Kindergarten
- Appoint an independent Children and Young Persons Commissioner.

- Concessions and reduced charges for low-income families or young people
- Child Witness Service providing support to children required to give evidence in court
- *Strong Culture, Strong Peoples, Strong Families –* Towards a safer future for Indigenous families and communities (10 year plan)
- Specialist programs for Aboriginal children and families that support culturally appropriate child protection responses.
Most young people report there are sporting teams available in their community (81.3 per cent), with less reporting community services and volunteering opportunities (62.9 per cent) or youth groups (61.7 per cent), with those in more disadvantaged areas less likely to report as having all these things in their community. Regarding community decision-making, 61 per cent of young people feel that adults in their neighbourhood pay attention to what they say and 47.1 per cent feel they can help decide on activities in their neighbourhoods.

The Victorian Government provides a range of family support services and programs to vulnerable children, young people and their families. These children and young people are likely to experience greater challenges because their development has been affected by the experience of multiple risk factors and/or cumulative harm. There has been a steady increase in the number of families and children accessing to family services since 2005–06, reaching a total of 29,000 cases and a total of 63,000 children in 2009–10. The most common presenting issues for families accessing family support services include parenting, behaviour and mental health.

In line with the ecological model of the Victorian Child and Adolescent Outcomes Framework (VCAMS) (see Chapter 1), children's outcomes are influenced by many factors within the family, community and society. Therefore, there are many opportunities to improve outcomes, as well as challenges in better utilising these multiple spheres of influence in a more integrated and innovative way. Identification at the family or community level indicates the importance of these factors as 'determinants' or 'influencers' of child safety, health, development, learning or wellbeing (or in some cases, all of these).

Of all the factors than can affect outcomes for Victorian children and young people, families are by far the most important and influential. A 2010 survey by Mission Australia of 9302 Victorian young people aged 11–24 years found that 78.4 per cent ranked family relationships as what they valued most in their lives (Mission Australia 2010).

There are many different definitions used to describe a ‘family’. For the purposes of this report, a ‘family’ is the group of people usually living in the same dwelling and in which children are raised. The diversity of family types in Victoria has widened significantly over the past three decades with the emergence of non-traditional family types, such as families headed by a lone-parent, step or blended families and families headed by same-sex couples. The traditional ‘nuclear family’, in which the father is responsible for earning income and the mother is responsible for maintaining the home and tending to her children, is no longer experienced by many Victorian children.

The quality and extent of the relationships children, young people and their families have with their community and their community networks are also important. One of the ways in which families can access social support is through participation in their local communities. The participation of children, young people and their families in their local communities also builds the capacity of Victorian families, children and young people to shape the development of their communities and broader society in which they live.

The characteristics of the neighbourhood can act as risk and protective factors for outcomes for children. Key characteristics include access to services and amenities; opportunities for involvement in sport, recreation, and cultural activities; and opportunities for volunteering and taking part in local decisions.

This chapter examines issues relating to family functioning and family social supports for Victorian children and young people. An extreme aspect of unhealthy family functioning is family violence or child abuse. This chapter deals with the harm caused to children and young people from family violence and child abuse. The key factors known to promote positive family functioning, including social support, participation in communities, and characteristics of neighbourhoods of children are examined, as well as government services provided to vulnerable families.
Family functioning

Family functioning is a measure of how a family operates as a unit and how family members interact with each other. It reflects parenting styles, family conflict and the quality of the family relationship. The capacity of a family to function well affects the health and wellbeing of all family members, but is particularly important in promoting positive outcomes for children and young people.

Information from the 2009 Victorian Child Health and Wellbeing Survey (VCHWS) indicates that the majority of Victorian children live in families with healthy family functioning. In the VCHWS 2009, parents of Victorian children aged 12 years or younger were asked a range of questions about the relationships and interactions within their families. Based on the McMaster Family Assessment Device, family functioning in the VCHWS generally reflects whether a family discusses concerns, worries or fears; if family members are able to support, trust and accept each other, and whether the family unit has difficulty making decisions and planning.

The majority (89.9 per cent) of Victorian children live in families characterised as having healthy family functioning (see Figure 12.1); with a higher proportion (93.4 per cent) of children from high income ($60,000 or more annually) families classified as having healthy family functioning than those from low income (less than $60,000 annually) families (84.0 per cent). Of concern, however, 6.9 per cent of children live in families characterised as having unhealthy family functioning.

Using a different measure of family functioning derived from a different set of questions, data from HOWRU 2009 suggest that most Victorian young people aged 12–17 years live in families with healthy family functioning (83.1 per cent) (see Figure 12.2). The measure of family functioning in this survey focused on whether there were aggressive behaviours within the family (such as serious arguments, insulting and yelling), and whether parents have consistent rules monitoring adolescents’ school and social lives, including antisocial behaviours (such as substance use, carrying weapons and skipping schools).

Figure 12.1: Family functioning, Victorian children aged 0–12 years, by annual household income, 2009*

*Family functioning is based on the McMaster Family Assessment Device – General Functioning Scales (range 1.0–3.92). Healthy family functioning at scale range of 1–2; unhealthy family functioning at scales above 2).

Source: VCHWS 2009, DEECD
Figure 12.2 indicates that a significant proportion of young people (14.5 per cent) live in families with unhealthy family functioning. In this measure, unhealthy family functioning is characterised by families that have conflict (including serious arguments, yelling, and insults) and those that have poor family management (such as unclear rules and lack of supervision of children). Young people from couple families (85.9 per cent) were more likely than those from lone-parent families (77.5 per cent) to have families with healthy family functioning.

Figure 12.2  Family functioning, Victorian young people aged 12–17 years, by family type, 2009

Factors promoting positive family functioning

How a family functions is influenced by many factors, including the parenting styles, parents’ interaction and behaviour, the quality of the relationships between family members, family structure/type, economic resources, the types and frequency of stressful life events, parental health and social and emotional wellbeing, and the amount of social support they have available to them.

One of the most fundamental factors promoting positive outcomes in children and young people is the quality of the relationships they have with their parents or primary caregivers. Early ‘attachment’ or bonding between an infant and their parent or primary caregiver has been shown to have a profound effect on later outcomes during childhood, adolescence and adulthood, especially social and emotional wellbeing.

Parenting styles that are warm, consistent and responsive to a child’s age and developmental needs have been associated with positive family functioning and positive child outcomes. Parenting styles that are authoritative, harsh, abusive and controlling and parenting that is highly permissive or neglectful (with no boundaries provided to a child) have been associated with poor outcomes for children and young people. These parenting styles are considered to be ineffective parenting and have been linked to a range of poor outcomes for children and young people in all family types.

Factors that promote healthy family functioning

- Warm, responsible and consistent parental style
- Positive parental mental and physical health
- Marital harmony
- Attachment/bond of parents and children
- Absence of serious stressors
- Absence of conflict
- Absence of family violence or abuse
- Family social supports
- Attachment and participation in community life
- Sufficient family financial and economic resources

Source: HOWRU 2009, DEECD

*Young people who are exposed to both family conflict and poor family management.*

2 The state of Victoria’s children 2010
Positive family functioning is also related to how involved parents are with their children. Families that function positively are those where parents are available to their children (emotionally and physically), while consistently monitoring and supervising them, where they spend time directly engaged in activities with their children.

Family relationships are also important elements of family functioning. Harmonious relationships between parents, between parent and child and also between siblings have been shown to influence positive functioning of the family as a whole. Family functioning is a measure of how well the family is doing as a unit, not just the relationships between parents or between parents and children. The quality of relationships between all individuals in the family contributes to how well the family is functioning.

The economic resources that families have access to has been demonstrated to influence the way in which they function. There is mounting evidence about the negative impact that living in economic disadvantage has on various aspects of family functioning and subsequent outcomes of children and young people. Low socioeconomic status has been associated with a range of other risk factors, including parental mental ill health, parental low levels of education, low social support, inappropriate or unstable housing and housing in unsafe or under resourced neighbourhoods. Socioeconomic disadvantage is thought to influence family functioning by compromising quality parenting, parental social and emotional wellbeing and positive partner and friendship relationships. (Chapter 2 provides in detail information on financial, housing and health resources of Victorian families with children aged 0–17 years).

The overall health and wellbeing (including social and emotional wellbeing) of parents is a protective factor promoting positive family functioning and is associated with positive outcomes for children and young people. Parental illness can influence the ability of a parent to engage in positive parenting styles and increases the chance of neglect. (Chapter 2 provides discussion in detail on the health status, including mental health, of parents of Victorian children and young people).

Substance use (particularly alcohol) can have disruptive effects on family functioning. It has been demonstrated that children whose parents misuse substances are at a higher risk of neglect, physical and emotional abuse and low social and emotional wellbeing. It is a common factor in cases of family violence and child abuse.

**Substance use and misuse in parents of Victorian children and young people**

Based on the NHMRC 2001 guidelines, more than four standard drinks in any one day for women and more than six for men increase the risk of accident or injury (short-term harm). Further, more than two standard drinks per day for women (or 14 per week) and four for men (or 28 per week) increase alcohol-related disease risks (long-term harm).

Data from the Victoria Population Health Survey (VPHS) 2008 suggest that one in 10 Victorian parents (10.8 per cent) with dependent children consume alcohol at levels that are at risk of short-term harm on at least a weekly basis; furthermore, 3.1 per cent do so at levels of risk of long-term harm. Fathers (or stepfathers) are more likely than mothers (or stepmothers) to drink alcohol at levels putting them at risk of both long-term and short-term harm. In addition, Australian-born parents are more likely than overseas-born parents to drink alcohol at levels that place them at risk of harm (see Figure 12.3).
Figure 12.3: Proportion of Victorian parents who report drinking alcohol at the level of long-term and short-term risk of harm, \(^*\)\(^*\) by sex and Australian/overseas borne, 2008

![Chart showing proportion of Victorian parents at risk of long-term and short-term harm](image)

\*Parents with dependent children aged under 18 years.
\(^*\)Drinking levels are referred to in terms of the NHMRC 2001 guideline levels, which state that more than six standard drinks in any one day for men or more than four for women increases the risk of accident or injury (short-term harm); and more than four standard drinks per day/28 per week for men, or more than two per day/14 per week for women increases alcohol-related disease risks (long-term harm).

Source: VPHS 2008, Victorian Department of Health

Data from VPHS 2008 also show that the rate for long-term risky/high-risk drinking among Victorian parents increases with household income, with the highest proportion drinking alcohol at levels placing them at risk of harm among parents with annual household income over $80,000 (4.9 per cent).\(^3\)

### Life stressors

*High rates of exposures to adverse life events are associated with poorer outcomes for children, including anxiety and conduct problems. An accumulation of parental exposures to adverse events – such as a death or illness in the family, job loss, victimisation – is associated with increased parental irritability, and a deterioration of parenting practices.*

*(Zubrick et al. 2008: 8)*

High levels of stress during childhood (and particularly early childhood) can adversely affect a child’s ongoing learning, behaviour, physical and mental health. Every family deals with stress on a daily basis (e.g. lack of time in getting children to/from school, cooking dinner, homework, etc.), but certain events (such as divorce, death, new baby, illness of parents or siblings, parent lose job, and family violence and abuse), can place abnormal and significant levels of stress on a family and compromise positive family functioning.

Figure 12.4 indicates that 61 per cent of Victorian children aged 5–6 years had not experienced stressful events. However, of concern, 8 per cent of Victorian children live in families that were exposed to three or more of these stressors. In particular, children living in lone-parent families and Aboriginal children were significantly more likely to live in families exposed to multiple stress events. While many families may have the resources to deal with one of these serious stressful events, exposure to multiple stressful events is likely to further compromise family functioning.
The most common stress event was the death of a relative or friend (10.5 per cent), parents’ recent divorce or separation (8.5 per cent) and serious illness of a parent or sibling (4.1 per cent). There is also a small proportion of children aged 5–6 years and their parents who witness violence or experience abuse (see Figure 12.5).

Figure 12.5: Proportion of Victoria children aged 5–6 years and their parents who experienced family stress events, by stressor type, 2009

Source: SEHQ 2009, DEECD
Child abuse and family violence

Family violence, substance and alcohol abuse continue to be the key characteristics identified in families in the child protection system. Each of these risk factors, especially when experienced concurrently, significantly impact on parenting capacity and on the best interests of children.

(Victorian Government, Early Parenting Strategy, 2010: 14)

Abusive and traumatic experiences (including child abuse and family violence) during the early years of a child’s life has been demonstrated to affect longer-term outcomes, with consequences including behavioural and learning problems, substance use, antisocial and criminal behaviour, as well as poor physical and mental health.

Children and young people can be subjected to harm from crime, violence and abuse in their homes. Infants and toddlers are most likely to be subject of a child abuse investigation where child abuse is demonstrated in Victoria (Victorian Government 2010).

Recent information on the substantiated child abuse incidents (where incidents of child abuse were reported to, investigated and verified by the Department of Human Services) indicates a decrease in substantiated child abuse over the past five years (see Figure 12.6). In 2009–10, the rate of substantiated child abuse was 5.7 per 1000 children and young people, a decrease from 6.5 per 1000 in 2005–06. The rate of substantiated child abuse is consistently higher for children and young people living in regional Victoria. The most frequent types of abuse experienced by Victorian children and young people are emotional abuse (47 per cent of substantiated child abuse cases), physical abuse (37.4 per cent), neglect (7.8 per cent) and sexual abuse (7.8 per cent) (see Figure 12.7).

Figure 12.6: Substantiated child abuse (rate per 1000 population aged 0–17 years), by area of residence, Victoria, 2005–06 to 2009–10*

*Child protection notifications made to relevant authorities which were investigated and there was reasonable cause to believe that the child had been, was being, or was likely to be, abused, neglected or otherwise harmed. Substantiations may also include cases where there is no suitable caregiver, such as children who have been abandoned or whose parents are deceased.

Source: Client relationship Information System (CRIS) database, Victorian Department of Human Services

What is family violence?

Family violence is any behaviour that in any way controls or dominates a family member that causes them to fear for their own, or other family member's safety or wellbeing. It can include physical, sexual, psychological, emotional or economic abuse and any behaviour that causes a child to hear, witness, or otherwise be exposed to the effects of that behaviour.

(Victorian Family Violence Protection Act 2008)
There is a complex interplay between family violence, mental health problems, alcohol and drug use and child abuse. Children whose parents misuse substances are at a higher risk of neglect, physical and emotional abuse. Children exposed to both family violence and parental substance use may be at an even heightened risk of suffering abuse or harm. Experiencing direct child abuse, particularly physical, sexual and emotional abuse by parents and caregivers, also increases the likelihood of young males perpetrating violence during adolescence and adulthood.

Family violence is also recognised as a form of child abuse that can have long-lasting negative effects on children and young people. It can be direct through child abuse, or indirect through being a witness to, and experiencing, aggression and violence towards adults (usually against their mothers or other female caregivers). The ABS Personal Safety Survey 2005 found that 15 per cent of women reported having experienced violence by a previous partner since the age of 15 and, of these women, 59 per cent reported that violence had occurred during a pregnancy (ABS 2008).

The incidences of family violence in which a child or young person was present accounted for around 40 per cent of all family violence incidents reported to the Victoria Police between 2005–06 and 2009–10. Of the 35,720 reported family violence incidents in 2009–10, a total of 14,870 children and young people aged 16 years or younger experienced these incidents.4

The incidences of family violence in which a child or young person was present accounted for around 40 per cent of all family violence incidents reported to the Victoria Police between 2005–06 and 2009–10. Of the 35,720 reported family violence incidents in 2009–10, a total of 14,870 children and young people aged 16 years or younger experienced these incidents.4

The Family Violence Protection Act 2008 includes ‘causing a child to be exposed to family violence’ within its definition of family violence. Consistent with this, children and young people are now increasingly being recognised and recorded as victims (‘aggrieved family members’) rather than witnesses in family violence incidences. The number of children identified as ‘aggrieved family members’ (victims) in finalised family violence intervention order applications in Victoria has increased dramatically, from 5310 in 2003–04 to 15,399 in 2007–08 (Victoria Government 2009a).

There is also evidence to suggest that a small but notable proportion of family violence incidents reported to police are a result of actions by a young person. Figure 12.8 indicates an increase over the past five years in the number of family violence incidents where the perpetrator was a young person (an increase from 274 incidents in 2004–05 to 479 incidents in 2009–10). However, the overall number of family violence incidents also rose during this period, partially owing to strategies employed by the government to increase reporting and improve police responses. Of the small number of family violence incidents reported to police where the offence was committed by a young person, most incidents were committed by an older adolescent (aged 15–17 years of age) and by males.
The Victorian family Violence Database (Victorian Government 2009a) indicates that, overall, the rate at which a parent/step-parent reported violence from their adolescent child/step-child remained stable between 2005–06 to 2007–08. Nine per cent of all family violence incidents recorded by police and 4 per cent of all the aggrieved family members in finalised intervention orders involved parents as victims of violence from their adolescent children. Mothers were more likely to experience violence from their adolescent child/step child than were fathers, as seen in both police and courts data.

**Family social network**

*Some networks help people to get by on a day-to-day basis (filing gaps in childcare, looking after someone when that person is ill, providing small amounts of cash to make ends meet, or celebrating family or life landmarks). Other networks are important for getting ahead (providing information on jobs, education, training and opportunities for advancing one’s interests). In summary, social networks can provide social support, social influence, opportunities for social engagement and meaningful social roles as well as access to resources.*

*(Australian Social Inclusion Board, 2009)*
Extended family members and friendships are an important and often the most immediate form of support for children, young people and their families. They form the family’s ‘social network’, which can provide them with direct support and also link them in with other means of support. Other than people within their own immediate family, people in the family’s social network are often the first people that children, young people or parents turn to when they need support or in a time of crisis. Social support from family social networks helps children, young people and families to cope with stress, illness and challenging or difficult life events (e.g. death of a family member or loss of employment). It also helps the family feel an overall sense of belonging and trust.

How much social support is available to Victorian children and young people and their families?

One common measure of the social support available to a family is if it can access support in a time of crisis or emergency. Information about Victorian families in 2009 suggests that the majority have access to support networks. For instance, 86.7 per cent of Victorian children aged 0–12 years live in families where they could raise $2000 within two days in an emergency. However, lone-parent families (65.8 per cent) are significantly less likely to be able to raise this amount of money for an emergency than couple families (89.6 per cent). Similarly, in 2009, 95.2 per cent of Victorian children aged 12 years and younger live in families where they have relatives or friends who could take care of them or their parents in an emergency, with the proportion being similar regardless of family types and areas of residence.

A family’s social network is also important for young people to access support, either as part of their family or independently. A 2010 study by Mission Australia found that the top three support resources Victorian young people aged 11–19 years nominated were friends (86.2 per cent), parents (75.8 per cent), and relatives or family friends (61.6 per cent) for advice and support.

Information from the HOWRU 2009 indicates that most Victorian young people aged 12–17 years have a special person in their lives to whom they can turn to for advice when having problem (86.1 per cent). The majority of Victorian young people also reported having a trusted adult in their lives who they can turn to for advice when having problems (70.8 per cent). Females and young people from the areas of least socioeconomic disadvantage are more like to report having a trusted adult or a special person in their lives to whom they can turn for advice when having problems than young people from the most socioeconomically disadvantaged areas (see Figure 12.9).

Figure 12.9: Proportion of Victorian young people aged 12–17 years who have a trusted adult or a special person to whom they can turn to for advice when having problems, by socioeconomic status (SES) and sex, 2009

<table>
<thead>
<tr>
<th>SES</th>
<th>Male</th>
<th>Female</th>
<th>Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Least disad. areas</td>
<td>67.6</td>
<td>83.7</td>
<td>86.1</td>
</tr>
<tr>
<td>Most disad. areas</td>
<td>73.3</td>
<td>88.6</td>
<td>70.8</td>
</tr>
</tbody>
</table>

Source: HOWRU 2009, DEECD
Community influence and support

Social capital is a measure or value of social support within a community. It has three categories:

- **Bonding social capital** – a value given to relationships among people who share a common characteristic or interest (the family social network)
- **Bridging social capital** – a value given to relationships between similar groups/networks in society
- **Linking social capital** – a value given to relationships between individuals, groups and organisations at different ‘levels’ in society 2010–2020

One of the ways in which children, young people and their families can access social support is through the neighbourhoods and communities in which they live. Research into the influences of neighbourhoods on outcomes for children, young people and their families suggests that the neighbourhood’s characteristics (such as facilities, infrastructure, safety, cleanliness and transport) act as important factors for outcomes for children.

The extent of social support available to a family is considerably increased by participating in community organisations, such as local schools or other educational settings (e.g. through parent groups), sports or recreational activities (e.g. local AFL or netball club), leisure or social clubs, arts or cultural groups, and community organisations or religious organisations (e.g. local church or mosque). Participation in civic organisations can also be an avenue for support for families, such as being involved in a trade or technical association, political party, environmental or welfare group, volunteer organisation or consumer organisation, etc. Volunteering is also considered an important avenue for participation in the community, which helps individuals (through social support and skill development) and the broader community through the value it provides (e.g. providing telephone counselling at Lifeline or being part of the State Emergency Service).

‘Social capital’ is a measure of the extent of social support experienced within a neighbourhood or community. Essentially, the term means the value attributed to the social support available to an individual or family through relationships and interactions with friends, extended family, clubs and organisations and their community. Numerous studies have demonstrated that the higher the social capital within a community the better the outcomes for children and young people and their families living in that community.

In the same way, adolescent development, health and wellbeing are shaped by social capital. The importance of young people feeling supported by, and connected to, family, friends, school and community through opportunities to actively participate in the community is well documented in youth research. Access to community networks developed through young people’s active participation in public life (such as through their involvement in community events, arts, organised sport, organised groups and volunteering) provide them with important benefits, including emotional support, community contacts and resources.

Some population groups of Victorian children and young people face barriers in their active participation in community and social networks. These include gay/lesbian, bisexual, transsex and intersex (GLBTI) young people, and young people from socioeconomically disadvantaged background or those with different cultural and religious backgrounds.

For example, research shows that GLBTI young people are one of the most vulnerable groups of young people (Leonard & Marshall et al. 2010). Despite increasing legal and social recognition, they continue to be subject to much higher levels of violence, harassment and discrimination. Unlike young people who identify with other minority populations (including Aboriginal, ethnic and religious young people), GLBTI young people cannot be sure of support from their families or communities-of-identity and, for many, their families are a major sources of homophobic abuse. In addition, those living in isolated and small communities may face additional pressures due to ‘higher levels of homophobia, increased surveillance, and reduced access to relevant information, resources and services’.
How do Victorian children and young people participate in their communities?

Research indicates that including young people in meaningful decision-making at the family, school, community and broader societal level leads to increased individual and community wellbeing, connection and outcomes. This is because having a say in issues that affect them, their families, schools and communities contributes to young people feeling valued. Communities also benefit from young people’s participation as it generates positive attitudes, a sense of belonging, acceptance of diversity, improved feelings of safety, intergenerational understanding, opportunities for the development and sharing of new ideas and fostering future community leaders.

Victorian young people can participate in their communities in a variety of ways. Common methods of participation include arts and cultural activities and organised sports. Similar to the national rate, the participation rate in organised sport and/or dancing by Victorian children aged 5–14 years has increased, from 63 per cent in 2000 to 72 per cent in 2009 (see Figure 12.10).

**Figure 12.10:** Proportion of children aged 5–14 years participating in organised sport and/or dancing, Victoria and Australia compared, 2000–09

Nationally, the average number of hours that children spent participating in sport and/or dancing increased from 5.4 hours in 2000 to 5.8 hours in 2009. Most Australian children who did not participate in organised sport in 2009 were from lone-parent families where their parent was not employed (63 per cent of these children not participating) or were from couple families where both parents were unemployed (27 per cent of these children not participating) (ABS 2010).

Recent information suggests that Victorian young people are active within their communities. Most Victorian young people aged 12–17 years report that there are sporting teams (81.3 per cent) available in their communities; while over half of Victorian young people report that they have other community activities, such as youth groups (61.7 per cent) and scouting organisations (53.7 per cent) (see Figure 12.11). Young people in the most disadvantaged areas in Victoria are less likely to have these community activities than young people living in the least disadvantaged areas.
How do our children and young people feel about their communities?

Children’s perceptions of their local communities are key influences on the quality and nature of their engagement with communities. For example, children who feel safe in and positive about their local neighbourhoods are more likely to actively participate in local activities and more likely to feel able to travel around and make local connections (Victorian Government 2008).

In terms of being involved in their local community, Figure 12.12 shows that 61 per cent of Victorian young people believe that adults in their neighbourhood listen to what young people have to say, with young people living in the least disadvantaged areas more likely to report this. Moreover, nearly half of Victoria’s young people believe that they can help decide on activities in their neighbourhoods (47.1 per cent), with those from the least disadvantaged areas are more likely to report this.

Figure 12.12: Proportion of Victorian young people who believe they have the opportunity to have a say in issues, and decide on activities, that matter to them in their neighbourhood, by socioeconomic status (SES), 2009

Source: HOWRU 2009, DEECD
There is also evidence to suggest that people’s perception of safety within their neighbourhood is important to their sense of belonging and involvement in their local community. While perceptions of safety do not necessarily equate to actual safety, they give a good indication of how confident and secure children, young people and their families feel in their neighbourhoods. (Details relating to children and young people’s perceptions of neighbourhood safety are discussed in Chapter 10).

Around one fifth of Victoria’s young people report as living in neighbourhoods where there is crime (i.e. drugs/crimes or fights). Figure 12.13 indicates that 22.2 per cent of young people report crimes and/or drug-selling in their neighbourhood and 21.4 per cent report that their neighbourhood has fights. Young people living in areas of the most socioeconomic disadvantage are more likely to report neighbourhood crimes/fights than young people in areas of least disadvantage.

The quality, quantity and diversity of facilities in the local neighbourhood are important to outcomes for children, young people and their families. In particular, access to recreational, educational, health, transport, employment and social services within the community is important in providing high-quality social relationships between children, young people and their parents and the wider community in which they live.

The majority of Victorian children 0–12 years report that their neighbourhoods are clean (95.8 per cent), but fewer young people aged 12–17 agree (77.3 per cent). Around two thirds of Victorian children (68.6 per cent) and young people (69 per cent) live in neighbourhoods without heavy road traffic. Most Victorian children and young people live in neighbourhoods with basic shopping facilities (94.1 per cent of children and 79.9 per cent of young people). Similarly, most Victorian children (92 per cent) and young people (76.1 per cent) report that their neighbourhoods have basic services.8

Figure 12.13: Proportion of Victorian young people aged 12–17 years who live in a neighbourhood with fights and crime/drug-selling, by socioeconomic status, 2009

Source: HOWRU 2009, DEECD

Young people’s expectations about the amount and type of recreational opportunities and facilities available to them are very high. This is probably due to young people having a significant amount of leisure time coupled with being old enough to have a degree of independence with which to enjoy recreational activities away from their home. The information available on perceptions about recreational facilities is consistent with this, with under half of Victoria’s young people (48.3 per cent) perceiving their neighbourhood to have good recreational facilities (i.e. playgrounds, parks or gyms). This is in stark contrast to Victorian children (who are less independent), the majority of whom report that they live in neighbourhoods with good parks, playgrounds and play spaces (85.9 per cent).9
About two thirds of Victorian young people (73.4 per cent) live in neighbourhoods with close affordable public transport (Figure 12.14). Young people living in regional areas of Victoria and those living in the most socioeconomically disadvantaged areas are more likely to report having difficulty accessing public transport in their neighbourhoods. A significant proportion of young people (14.1 per cent) indicate that their neighbourhood did not have close, affordable public transport and, of these young people, most (76 per cent) indicate that the lack of local public transport has impacted on their ability to meet their goals (such as school, work, social or health goals).10

Figure 12.14: Proportion of young people who report having access to public transport in the neighbourhood, by area of socioeconomic status (SES) and area of residence, 2009

Source: HOWRU 2009, DEECD

Government services and support programs to vulnerable families

In Victoria, the Government provides a range of family support services and programs to promote the safety, stability and development of vulnerable children, young people and their families, and to build capacity and resilience for children, families and communities. The primary targets of these family support services are vulnerable children, young people and their families who are likely to experience greater challenges because the child or young person’s development has been affected by the experience of risk factors and/or cumulative harm. If not addressed, these problems may escalate and the child or young person may become involved with child protection services.

In 2005, Victorian Government introduced the Child FIRST program to provide integrated family services for vulnerable children. There has been a steady increase in the number of cases and children involved in the program since 2005–06, reaching a total of 29,000 cases and a total of 63,000 children in 2009–10 (see Figure 12.15).

Families accessing family support services often experience multiple risk factors. Over 2008–10, the main issues identified in the overall family service cases are families experiencing parenting difficulties (53.5 per cent of cases), followed by children experiencing behavioural difficulties (36.4 per cent) and mental health problems of family members (32.5 per cent). A significant proportion of families accessing services were also presenting with issues related to family violence (28 per cent) and child protection (21.7 per cent) (see Figure 12.16). Estimates from 2009 indicate that approximately 65 per cent of families using Victorian Government-funded early parenting assessment and skill development services (PASDS) have four or more risk factors, including mental illness, family violence, substance use, being teenage mothers, financial stress, insecure housing, and/or infant or parent disabilities (Victorian Government 2010).
While a relatively small number of Victorian families have these multiple disadvantages, the persistency and complexity of their disadvantage significantly increases the chances of their children having poor health, development, safety, learning and wellbeing outcomes in the immediate and longer terms.

The family support services play an important role in earlier intervention and diversion of vulnerable families or children from further risk factors and disadvantages.
1. The family conflict and poor family management scales in HOWRU 2009 are developed by the Communities That Care Youth Survey, Centre for Adolescent Health, based on risk and protective factor scales developed by Bond et al. (2000).

2. ibid.

3. See detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A12.1).

4. ibid. (Table A12.2).

5. Total data for 2009-10 excludes 3 young people for whom sex was not recorded.

6. VCHWS 2009; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A12.3).

7. ibid.

8. VCHWS 2009 and HOWRU 2009; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A12.4).

9. ibid. (Table A12.5)

10. HOWRU 2009; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A12.7).
Chapter 12

References


• Leonard, W., D. Marshall et al. (2010) Beyond homophobia: Meeting the needs of same sex attracted and gender questioning (SSAGQ) young people in Victoria. A policy blueprint. Monograph Series Number 75. The Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.


An Overview of how Victorian Children are faring in 2010
The Victorian Child and Adolescent Outcomes Framework provides a basis for systematically monitoring outcomes for Victorian children and young people across Victorian Government departments. The framework and the associated Victorian Child and Adolescent Monitoring System (VCAMS) are further described in Chapter 1 (see Figure 1.1).

Chapter 13
An overview of how Victorian children are faring in 2010

In keeping with the Victorian Child and Adolescent Outcomes Framework, this chapter provides brief commentary on how children and young people are faring against each of the 35 outcomes. While most of the outcome areas are covered across the discussion of key themes in the preceding chapters, this chapter enables an at-a-glance overview of recent trends against each outcome and also facilitates comparisons with previous reports. A comprehensive list of the indicators that have been agreed against each outcome and contextual information about the importance of each is published on the VCAMS website.

Outcome 1:
Do Victorian infants have optimal antenatal/infant development?

Foundations for adult health are laid in early childhood and even before birth. Poor circumstances during pregnancy are known to contribute to a range of childhood disabilities and medical conditions and to a propensity for ill health later in life.

Most Victorian infants are born at a healthy weight (93.8 per cent of live births in 2008), consistent with the national proportion of infants born of healthy weight (93.9 per cent). The proportion of infants with a low birth weight (including low, very low and extremely low birth weights) is significantly higher for infants born to Aboriginal Victorian women (around 14.2 per cent in 2008) than for those born to non-Aboriginal women (around 6.2 per cent in 2008). (See Chapter 11 for a more detailed discussion).

Most Victorian children are born without any birth defects (often called congenital abnormalities). A birth defect is a structural, genetic, functional, chromosomal or biochemical abnormality present when the child is born. The most common birth defects are Down Syndrome, heart defects or congenital dislocated hips. They can result in serious disabilities or death and can be a major reason for hospitalisation or medical treatment during infancy and childhood. The proportion of Victorian infants born with birth defects is very low, but has progressively increased over the past three decades (from 2.8 per cent in 1983 to 4.3 per cent in 2006).1

Sudden infant death syndrome (or SIDS) refers to the sudden and unexpected death of a child for no known cause. During the 1990s, the Sudden Infant Death Research Foundation introduced an extensive public education campaign that highlighted the association between face-down sleeping and SIDS. This campaign contributed to a marked national decline in the rate of SIDS. There were 115 infant deaths from SIDS in Victoria in 1990, compared with 28 in 2007 (Victorian Government 2010a). The infant mortality rate is measured by the number of deaths in infants aged under 1 year as a proportion of total live births. Over the past decade, the infant mortality rate in Australia has been relatively stable, with the Victorian rate being consistently lower than the national rate. In 2007, the infant mortality rate for Victorian infants was 3.8 deaths per 1000 births, compared with a rate of 4.2 deaths for Australia as a whole (Victorian Government 2010a).
The child mortality rate for children aged from birth to 4 years has been relatively stable between 2000 (95.7 per 100,000 children) and 2007 (99.6 per 100,000), with the rate higher for males than females (93.8 per 100,000 females compared to 105.1 per 100,000 males in 2007) (Victorian Government 2010a).

The mothers of two in 10 Victorian children smoked tobacco at some point during pregnancy (18.3 per cent), while six in 10 drank alcohol during pregnancy (59.7 per cent). (See Chapter 11 for further information).

Outcome 2:
Do Victorian children and young people have adequate nutrition?

Maintaining a nutritious diet (including breastfeading of infants, adequate consumption of fruit and vegetables and limited consumption of sugary and fatty foods) is a key factor in promoting healthy weight.

The proportion of Victorian infants who are fully breastfed has remained relatively stable over the last decade. Around half of Victoria’s infants are fully breastfed at 3 months, decreasing to 37 per cent by the time they reach 6 months of age. (See Chapter 11 for further information).

The National Health and Medical Research Council (NHMRC) (2003) provides guidelines on daily intake of fruit and vegetables for children and young people (see Table 3.1). One in three Victorian children (33 per cent) and one in five young people (19 per cent) eat the recommended serves of fruit and vegetables each day. More than half Victorian children (55.4 per cent) rarely if ever consume sugar-based drinks. Nonetheless, over one third have fast food at least once a week (34.3 per cent) and two in three eat fried-potato chip products (including chips, French fries, wedges and crisps) at least once a week (66.8 per cent). (See Chapter 3 for further information).

Outcome 3:
Are Victorian children and young people free from preventable diseases?

Immunisation is one of the most effective public health measures to protect children (and adults) from preventable communicable diseases, benefiting both individuals and the broader population through reduced infection rates.

Most Victorian parents immunise their children, with the immunisation rate above 92 per cent at the ages of 1 year and 2 years, decreasing to 87.2 per cent at school entry. (Further information about immunisation in Victorian children and young people is provided in Chapter 11).

In Victoria, when a person is diagnosed with a vaccine-preventable-illness, the ‘case’ is notified to the Department of Health. The most commonly notified illnesses for children and young people aged 0–17 years in 2009 were Bordetella Pertussis (or whooping cough) (917 cases), Varicella-Zoservirus (or chickenpox) (424 cases), Hepatitis B (59 cases) and measles (22 cases).

In 2009, there were 3244 cases of vaccine-preventable influenza notified to the Department of Health, a substantial increase from 384 in 2008 and 454 in 2007. This large increase in incidences of notifiable influenza in children and young people in Victoria in 2009 coincided with the H1N1 Influenza pandemic (swine flu).²

Outcome 4:
Do Victorian children and young people experience optimal social and emotional development?

Social and emotional wellbeing (SEWB) is a multifaceted and complex concept covering aspects relating to individual capacities and social competencies. In their first year of primary school, most Victorian children are ‘on track’ as measured by the Australian Early Development Index (AEDI) on social competence and emotional maturity. Around one in 12 are developmentally vulnerable in either the social competence domain (8.4 per cent) or the emotional maturity domain (8.3 per cent).

(Detailed discussion on the social and emotional wellbeing of Victorian children and young people is provided in Chapter 5).
Outcome 5:
Do Victorian children and young people have healthy teeth and gums?

Good oral health is known as a signifier of a good quality of life for children and young people. (Chapter 4 provides a comprehensive discussion on the oral health of Victorian children and young people).

Over a quarter (27.3 per cent) of Victorian children aged 5–12 years have experienced toothache at some stage. Nearly one in five young people aged 12–17 years (16.4 per cent) reported experiencing toothache either sometimes or often. This proportion is similar to the proportion of Australian adults who report having experienced toothache (15.1 per cent in the past 12 months). Over a quarter of Victorian children aged 5–12 years have had one or more tooth fillings (26.6 per cent), while one in 10 (11.7 per cent) have had a tooth extraction; and 7.1 per cent have had dental treatment in hospital under general anaesthetic.

The rate of hospitalisations for dental-related conditions in Victorian children aged 0–4 years has been declining (especially in regional areas, from 86 hospitalisations per 100,000 in 2004–05 to 56 per 100,000 in 2009–10). However, at the same time, rates for 5–9 year olds have been increasing (more so in regional areas, from 56 children to 97 per 100,000). Two thirds of Victorian children (66 per cent) and young people (67.4 per cent of young) brush their teeth twice a day. Seven in 10 parents of Victorian children aged 1–7 years assist their children to brush their teeth at least once a day (68.8 per cent).

There is clearly disparity in oral health outcomes between metropolitan and regional Victoria, with regional children appearing to have significantly poorer oral health outcomes.

Outcome 6:
Are Victorian children and young people of a healthy weight?

The development of healthy eating and physical activity patterns in childhood is important in ensuring children and young people maintain healthy weight in adulthood. Obese and overweight children and young people are faced with significantly higher risks of Type 2 diabetes, hypertension, cardiovascular diseases (including stroke) and some cancers.

While most Victorian children and young people are within the healthy weight range, a significant proportion are overweight or obese (12.4 per cent of 2 year olds, 15.4 per cent of 3.5 year olds and 25.3 per cent of children aged 5–17 years). (Healthy weight in Victorian children and young people is discussed comprehensively in Chapter 3).

Outcome 7:
Do Victorian children and young people enjoy optimal physical health?

The incidence of cancer in Victorian children and young people aged 0–19 years has been relatively stable over the decade, from a rate per 100,000 of 15.2 in 1998 to 18.1 in 2007.3

The Type 1 diabetes rate for Victorian children aged from birth to 14 years of age has increased marginally over the past decade, from a rate of 19.4 per 100,000 children in 2000 to 23.6 per 100,000 children in 2008, which is similar to the 2008 national rate (23.9 per 100,000).4

Outcome 8:
Do Victorian children and young people have optimal language and cognitive development?

The Australia Early Development Index (AEDI) measures a child’s language, cognitive and communication skills and general knowledge at entry to primary school. The majority of Victorian children aged 5–6 years (93.9 per cent) are ‘on track’ with their language and cognitive skill development at school entry, with 6.1 per cent being developmentally ‘vulnerable’. The majority of Victorian children (91.7 per cent) are ‘on track’ with their communication skills and general knowledge, while 8.3 per cent are developmentally vulnerable.1
Outcome 9:
Do Victorian children and young people have adequate exercise and physical development?

Being physically active is another key factor in promoting healthy weight (see detailed discussion in Chapter 3). Six in 10 Victorian children are physically active for at least one hour per day (60.3 per cent), with around two in 10 spending two hours or more each day using electronic media (18.8 per cent). As children get older, they are less likely to do this amount of daily physical activity and more likely to spend two hours or more each day using electronic media. Around one in eight Victorian young people (12.3 per cent) do an hour of physical activity each day, with almost six in 10 spending two hours or more using electronic media daily (58.7 per cent).

Outcome 10:
Do Victorian children and young people have positive behaviour and mental health?

In VCHWS 2009, eight in 10 Victorian children aged 4–12 years demonstrated normal emotional and behavioural responses (83.5 per cent), with one in 18 (5.4 per cent) considered to have emotional or behavioural responses that are ‘of concern’.

In their first year of primary school, most Victorian children are developmentally ‘on track’, as measured by the Australian Early Development Index (AEDI) on social competence and emotional maturity. A small but sizable proportion is developmentally vulnerable on the social competence domain (8.4) and/or the emotional maturity domain (8.3 per cent).

In HOWRU 2009, six in 10 of Victorian young people aged 12–17 years (61.1 per cent) demonstrated ‘positive social and emotional functioning’, defined as having a sense of autonomy and personal agency/power, positive connections with others and feeling confident and capable.

How people report on their overall life satisfaction or happiness is a common measure used to assess social and emotional wellbeing. In HOWRU 2009, most Victorian young people aged 12–17 reported they were satisfied with the quality of their lives (77.1 per cent).

Almost half of Victorian young people aged 12–14 (49.2 per cent) and four in 10 of those aged 15–17 years (39.7 per cent) report as experiencing bullying. Data from the Victorian Attitudes to School Surveys 2006–10 indicate that students’ connectedness to school has been progressively improving since 2006 across all year levels of secondary government schools (Years 5–12).

There are limited data on the real prevalence of mental health problems or disorders among Victorian children and young people. In HOWRU 2009 more than one in eight Victorian young people aged 12–17 years (13 per cent) reported very high levels of non-specific psychological distress. Serious non-specific psychological distress was significantly more common in older adolescents, females and young people from families of most socioeconomic disadvantage.

Consistent with international and national evidence, a small proportion of Victorian young people suffer from an eating disorder (2.4 per cent), with a higher proportion for females (3.1 per cent) than males (1.6 per cent).

Hospital treatment for self-harming injuries in Victorian children and young people was more prevalent for 15–17 year olds (accounting for 82 per cent of all admissions and 80 per cent of emergency department presentations) compared to 12–14 year olds, and more prevalent for females than males regardless of their ages.

Although rates in hospital admission and ED presentation for self-harming among Victorian young people aged 12–17 years have been consistently lower than that for young adults aged 18–24 years, both rates have increased over the past decade. (The prevalence of mental problems or disorders is discussed in detail in Chapter 6).
Outcome 11:
Are Victorian children and young people successful in literacy and numeracy?

Skills in literacy and numeracy are essential in daily life and are key to further educational opportunities and employment prospects.

A National Assessment Program – Literacy and Numeracy (NAPLAN) has been implemented across Australian schools annually since 2008. The yearly program aims to assess the literacy and numeracy achievements of students in Years 3, 5, 7 and 9 in order to monitor progress against national ‘standards’ expected of students in these year levels.

Based on the 2010 NAPLAN results (MCEECDYA 2011):

- Victoria, along with the ACT and NSW, is among the highest-performing jurisdictions in 2010, as in 2009 and 2008.
- In 2010, the Victorian average scores were above the national ones in 18 out of a total 20 measures, which include five domains (in Reading, Writing, Spelling, Grammar and Numeracy) for students at Years 3, 5, 7 and 9.
- The proportion of Year 3 Victorian students in the top achievement band is above the national average across all domains.
- The proportions of Years 5, 7 and 9 Victorian students in the top achievement band are either similar to, or above, other Australian jurisdictions across all domains.
- The 2010 results for Victoria in Years 3 and 7 Reading, Year 3 Writing and Year 5 Numeracy significantly improved from those in 2008.

Outcome 12:
Are Victorian children and young people safe from injury and harm?

A secure and safe physical and social environment is critical to the emotional wellbeing and the healthy development of children and young people. Safety can be understood as a necessary precondition for health.

Injuries are commonly classified according to whether they were deliberately inflicted (intentional injuries) or accidental (unintentional injuries). An estimated 90 per cent of all injuries are unintentional injuries.

The rate of unintentional injury hospital admissions (excluding same day admissions) among young people aged 0–17 years decreased over the decade (from 79 per 10,000 in 2000 to 66 per 10,000 in 2009). In contrast, the frequency of ED presentations increased from 53,351 in 2000 to 65,379 in 2009.

The death rate for unintentional injuries for Victoria’s children and young people aged 0–17 years has been declining over the past decade (from seven deaths to four deaths per 100,000 in 1997 to 2006). Consistent with the pattern in the adult population in Victoria, males aged 0–17 years are at a higher risk of injuries and injury-related deaths than females of the same age group.

Crime perpetrated against a child or young person, particularly at a critical developmental or transitional time, may have a disproportionate and lasting effect. Information from Victoria Police suggests that young people in regional areas are more likely than those in metropolitan areas of Victoria to be the victims of crimes. The overall victim rate of reported crime in 2009–10 was 9.1 per 1000 Victorian children and young people, decreasing from 9.9 per 1000 in 2005-06. Older adolescents (aged 15–17 years) and females are more likely to report being victims of crime.

The most commonly reported crimes in Victoria where victims are children or young people are physical assaults, theft and sexual assaults. These together account for 85.7 per cent of all crimes against children or young people.

(Chapter 10 contains extended discussion on the safety of Victorian children and young people).

In 2004, 14 per cent of all suicide deaths in Australia were by young people aged 12–24 years, accounting for one fifth of all deaths in this age group. In 2007, there were 14 recorded suicide deaths in young people aged 12–17 years in Victoria. (See Chapter 6 for further information).
Outcome 13:
Do Victorian young people have pro social teenage lifestyles and law-abiding behaviours?
In comparison to other states and territories, Victoria has a low youth crime rate and has the lowest number of young people per capita detained in police custody. Victorian young people aged 17 years or under are responsible for a small but notable proportion of crime (9.8 per cent in 2009–10), with more representation of young people in crimes against other people (15.1 per cent) and crimes against property (8.8 per cent) than other types of crime.
The number of cautions given by Victoria police to young people aged 17 years or younger has remained relatively stable over recent years, with a consistently higher number of males receiving cautions than females.
The rate of Victorian young people (aged 10 to 17 years) under supervision is significantly lower than all other states and territories. Data published in AIHW (2010a) show that the majority of those under supervision are under community-based supervision (a rate of 1.5 per 1000 population), with rates significantly higher among males. (Chapter 10 has detailed discussion on antisocial behaviours in Victorian children and young people).

Outcome 14:
Do Victorian young people have healthy lifestyles?
A healthy lifestyle during adolescence provides the basis for ongoing health into adulthood. (A detailed discussion of sexual and reproductive health is presented in Chapter 7 and substance use is discussed in Chapter 8).
In HOWRU 2009, a quarter of Victorian young people report having smoked tobacco at some stage (24.6 per cent). Of the 11.5 per cent who smoked over the last year, nearly one in three (29.9 per cent) report having smoked regularly, with more than half of these regular smokers smoking every day (16.9 per cent).
Alcohol drinking is more common than tobacco smoking in Victorian young people, with six in 10 (59.8 per cent) reporting having ever drunk alcohol, nearly four in 10 drinking alcohol over the past month (37.7 per cent), and one in five (19 per cent) reporting ‘binge’ drinking (where five or more alcoholic drinks are consumed on one occasion).
A small number of young people in Victoria reported having used illicit drugs, with cannabis (marijuana) being the most common (9.6 per cent). A much smaller proportion (2.8 per cent) have ever used other illicit drugs (including cocaine, amphetamine-type stimulants and heroin).
At least a quarter of Victorian young people aged 12–17 years have had sexual intercourse. Three in four (74.7 per cent) sexually-active young people in Victoria report always using at least one form of contraception (including condoms, contraceptive pills or other methods) during sexual intercourse.
Over half of all sexually-active Victorian young people report always using a condom (58.1 per cent), with condom use more common for younger adolescents. Over half of sexually-active young females report always using a condom during sexual intercourse (54.8 per cent), and one in three (33.9 per cent) report always using the oral contraceptive pill to protect against unplanned pregnancies.
Chlamydia is the most common form of notified sexually transmissible infection (STI) among Victorian young people. Older adolescents, females and those from regional areas are more likely to have a diagnosed STI. The rates of chlamydia in Victorian young people have been consistently increasing over the past decade, although it is unclear if this reflects a true increase in prevalence.
On average, about 10 babies are born per 1000 Victorian women aged 19 years or younger, a fertility rate consistently lower than the national teenage fertility rate. More young women in regional areas of the state give birth during their adolescence than their metropolitan peers.
Outcome 15:
Are Victorian young people able to rely on supportive adults?

The presence of a social network of families and friends is important for young people to access support at different times throughout adolescence. Supportive and trustworthy adults can play an important role in helping young people negotiate the challenges of becoming an adult. *(Chapter 12 gives a detailed discussion of the importance of a healthy family and social networks for Victorian children and young people).*

For advice and support, most Victorian young people aged 11–19 years turn to friends (86.2 per cent), parents (75.8 per cent), or relatives and family friends (61.6 per cent) *(Mission Australia 2010).* Nearly nine in 10 Victorian young people aged 12–17 years report having a special person in their lives who they can turn to when having problems (86.1 per cent), while seven in 10 report having a trusted adult in their lives (70.8 per cent). *(See Chapter 12 for further information).*

Outcome 16:
Do Victorian young people complete secondary education?

The successful completion of Year 12 or an equivalent qualification in the school sector provides a strong foundation for Victorian young people to move into the full-time workforce or go on to further education or training.

Most Victorian young people successfully complete Year 12 or an equivalent qualification. In 2009, the Year 12 or equivalent attainment rate for 19 year olds was 79.8 per cent, increasing to 88.1 per cent for the 20–24 year old population (consistently higher than the national average).

Over the last decade, the Year 12 or equivalent attainment rate at age 19 has been gradually increasing in Victoria. However, it has been consistently higher for those living in metropolitan areas of Victoria than for those living in regional areas since 2001.

Among Victorian young people aged 15–19 years, over two thirds (76.5 per cent) are attending full-time education, with an almost full participation rate of 15 year olds (97.7 per cent). The participation rate drops to 90.9 per cent at age of 16 when some young people move to employment or other education and training options. Over the last decade, the Year 12 or equivalent attainment rate has been gradually increasing in the state (79.8 per cent in 2009).

In 2010, nearly half of those who completed Year 12 in Victoria continued to higher education in universities, 26.3 per cent continued on to vocational training (including TAFE, VET, apprentice and trainee programs), and 19.2 per cent were in employment. A small proportion (4.9 per cent) were looking for work.

Early school leavers are more likely to be looking for work or not engaged in full-time education, employment or training (21.2 per cent) compared to Year 12 completers (5.9 per cent). There are fewer Victorian young people aged 15–19 years who are not engaged in full-time education or employment (12.7 per cent, or 46,300 young people) than the national average (16.4 per cent). *(Chapter 9 provides a detailed discussion of school retention, completion and early school leaving).*
Families

Outcomes 17:
Do Victorian parents lead healthy lifestyles?

Role-modelling of healthy lifestyles is a key way in which parents can promote healthy lifestyles in their children. (A detailed discussion of the ways in which parents promote health and development of their children is included in Chapter 11).

Two thirds of Victorian parents with children under 18 years (66.8 per cent) met recommended physical activity levels in 2008.

Less than half (47.7 per cent) of all Victorian parents with children aged under 18 years met the recommended daily serves of fruit and only 7.3 per cent have the recommended daily serves of vegetables. Mothers are significantly more likely to meet the fruit and vegetable recommendations than fathers. (Chapter 11 discusses the influence of parents in promoting health and development).

One in 10 Victorian parents with dependent children (10.8 per cent) drink alcohol at levels risking short-term harm on at least a weekly basis, with 3.1 per cent doing so at levels risking long-term harm.

Fathers are more likely than mothers to drink alcohol at levels putting them at risk of both long-term and short-term harm. The rate for drinking at long-term risk/high-risk among Victorian parents increases with household income.

Most Victorian children (74.8 per cent) and young people (74 per cent) live in a smoke-free household.

Outcomes 18:
Do Victorian parents promote their children’s health and development?

Parents play a fundamental and influential role in promoting the health and development of their children from infancy, childhood, through to adolescence.

Approximately nine in 10 Victorian parents (87.4 per cent) placed infants on their back to sleep, in line with medically recommended practice to reduce the risk of Sudden Infant Death Syndrome (SIDS).

Over half of all Victorian children aged 8 years and under are read to by a family member each day, occurring more frequently for preschoolers (76.4 per cent) than school-aged children (58.2 per cent of 5–8 year olds).

The majority of Victorian young children are protected by their parents from sun exposure during the summer months (81.7 per cent), babies and young children significantly more so than older children. (Chapter 11 provides a detailed discussion of parental influence on child health and development).

Outcome 19:
Do Victorian parents experience good mental health?

The overall health and wellbeing of parents, including social and emotional wellbeing and mental health, is a protective factor promoting positive family functioning. It is also associated with positive outcomes for children and young people.

According to VPHS 2008, more than one in 10 parents of Victorian children (12.1 per cent) were under serious psychological distress. Nearly one in four parents of Victorian children aged 0–17 years (23.3 per cent) have been diagnosed with depression or anxiety at some stage of their life. Parents are more likely to suffer a mental health problem or disorder if they are female, unemployed, and have low levels of family income or education. (Chapters 2 and 12 discuss the impact of parental mental health on outcomes for children and young people in detail).
Outcomes 20 and 21:
What are the levels of exposure to abuse, neglect, conflict and violence?
Abusive and traumatic experiences (including child abuse and family violence) during the early years of a child's life are known to affect longer-term outcomes for children.

The rate of child abuse in Victoria (as measured by the incidents of child abuse reported to, investigated and verified by the Department of Human Services) decreased between 2005–06 and 2009–10 (from 6.5 to 5.7 per 1000 children and young people).

The incidences of family violence in which a child or young person was present accounted for around 40 per cent of all family violence incidents reported to the Victoria Police between 2005–06 and 2009–10. Of the 35,720 reported family violence incidents in 2009–10, a total of 14,870 children and young people aged 16 years or younger experienced these incidents.

The number of children identified as 'aggrieved family members' (i.e. as victims) in finalised family violence intervention order applications in Victoria has increased dramatically, from 5310 in 2003–04 to a total of 15,399 in 2007–08, largely due to legislative and practice changes.

(Channel 12 has more information on children and young people experiencing family violence and abuse).

Outcomes 22:
Are Victorian families able to pay for essentials?
The economic resources available to a child or young person have been demonstrated to be a critical predictor of a broad range of outcomes.

The majority of children aged 12 years or younger (60.2 per cent) live in families with sufficient economic resources (annual household income of over $60,000 per annum). Of concern, however, one in 16 children live in families with annual household income under $20,000 per year (6.1 per cent).

In a 2009 survey of Victorian children aged 0–12 years (VCHWS 2009), over half of the mothers (59.7 per cent) and 88.3 per cent of fathers report they were in employment (including self-employment); 33.6 per cent of mothers and 4.1 per cent fathers in full-time home duty; and a very small proportion of parents report they were unemployed (1.4 per cent of mothers and 3.6 per cent of fathers).

The 2006 Census of Population and Housing showed that 26.4 per cent of couple families in Victoria with children living in households where neither parent has completed Year 12 or equivalent. Significantly, this rises to more than half (56.3 per cent) in Victorian lone-parent households (VCHWS 2009). Almost one in 20 Victorian families with children aged 12 years or younger (4.9 per cent) ran out of food on one or more occasions in the past 12 months and could not afford to buy more (VCHWS 2009 in Victorian Government 2009).

(Channel 2 provides a detailed discussion of the economic resources available to Victorian families).
Outcome 23: Do Victorian families have adequate family housing?

A range of aspects related to housing are known to impact on children's outcomes, including housing instability or homelessness, frequent 'moving' by the family, overcrowding in the home, housing stress (spending more than 30 per cent of household income on housing costs) and locality.

While owning a home is not a guarantee of housing stability, home ownership is considered to be the most stable form of housing, followed by rental accommodation in the public and private sectors. Nearly eight in 10 Victorian children live in families who own, or are purchasing through a mortgage, their own home (78.1 per cent). The remainder are renting accommodation through the private rental market (15.9 per cent) or through public housing options (4.7 per cent).

Over nine in 10 Victorian families with young children (92.3 per cent) agree that their home meets their family's general housing needs, leaving 7.7 per cent who feel their needs are not being met. (See Chapter 2 for further information).

Currently in Victoria, homelessness data is derived from the Supported Accommodation Assistance Program (SAAP), which provides transitional supported accommodation and related services to assist those who are homeless or at risk of homelessness. In 2008–09, among the 35,500 Victorians who received assistance from SAAP, 18.1 per cent (6400) were young people aged 19 years or younger. In addition, 23,100 accompanying children aged 17 years or younger received SAAP services in Victoria in 2008-09, which accounted for 19 per 1000 children and young people (AIHW 2010b).

Outcome 24: Do Victorian families have positive family functioning?

Family functioning is a measure of how a family operates as a complete unit and how family members interact with each other.

Nine in 10 Victorian young children (89.9 per cent) are in families characterised as having healthy family functioning in VCHWS 2009, where family members, particularly parents, are able to discuss feelings, to support, trust and accept each other, and to jointly make decisions.

Using a different measure of family functioning, HOWRU 2009 suggests that most Victorian young people aged 12–17 years live in families with healthy family functioning (83.1 per cent), where families are free from aggressive behaviours and have an effective system for managing adolescents’ school and social lives.

Around one in 10 Victorian children (10.5 per cent) have been exposed to a significant stressful family event by the time they start school (such as death of a family member, parents’ divorce, or illness of parents or siblings).
Communities

Outcome 25:
Is the Victorian community safe from environmental toxins?

The physical environment children and young people live in acts as both a risk and protective factor for their outcomes. Potential risks to the health of Victorian children and young people are cleanliness of neighbourhoods, air and water quality, and dangers associated with high ultraviolet radiation.

Nearly all Victorian children (95.8 per cent) and over three quarters of young people (77.3 per cent) report as living in clean neighbourhoods, but a small proportion do not (11.5 per cent of young people and 3.8 per cent for children). The majority of Victorian children (68.6 per cent) and young people (69 per cent) report living in neighbourhoods without heavy traffic. Nonetheless, nearly one third of children (31.3 per cent) and just under one fifth of young people (19.3 per cent) reported living in heavy traffic neighbourhoods. (See Chapter 12 for further information).

Recent data on air and water quality and solar ultraviolet radiation (UVR) in Victoria was provided in The State of Victoria’s Children 2009 (2010).

Outcome 26:
Do Victorian children and young people live in communities that enable them to build connections and draw on informal assistance?

Extended family members and friendships are an important and often the most immediate form of support for children, young people and their families. They form the family’s ‘social network’, which can provide them with direct support and also link them with other means of support.

One common measure of the social support available to a family is accessibility of support in times of crisis or emergency. Information about Victorian families in 2009 suggests that the majority have access to support networks. For instance, 95.2 per cent of Victorian children aged 12 years or younger live in families where they have relatives or friends who could take care of them or their parents in an emergency. Most Victorian young people aged 12–17 years have a special person in their lives who they can turn to for advice when having problem (86.1 per cent); while the majority also reported having a trusted adult in their lives who they can turn to for advice when having problems (70.8 per cent).

Most children and young people reported to live in neighbourhoods that are clean and that have basic shopping facilities and services, but less than half of Victorian young people (48.3 per cent) report that their neighbourhood has good recreational facilities.

(See Chapter 12 for a detailed discussion of the influence of social support on outcomes for Victorian children, young people and their families).
Outcome 27:
Do Victorian children and young people have access to local recreation spaces, activities and community facilities?

The quality, quantity and diversity of facilities in the local neighbourhood are important for outcomes for children, young people and their families.

Around nine in 10 Victorian children aged 0–12 years (85.9 per cent) live in neighbourhoods with good parks, playgrounds and play-spaces. Around half of Victorian young people aged 12–17 years (48.3 per cent) report that they have playgrounds, parks or gyms near their home.

Most Victorian children (92 per cent) and young people (76.1 per cent) report that their neighbourhoods have basic services and basic shopping facilities (94.1 per cent of children and 79.9 per cent of young people).

About seven in 10 Victorian young people (73.4 per cent) live in neighbourhoods with close affordable public transport. However, more than one in 10 (14.1 per cent) did not and, of these young people, most (76 per cent) indicate that the lack of local public transport has impacted on their ability to meet their school, work, social or health goals.

(Refer to Chapter 12 for a detailed discussion of the way in which the community environment influences social support and outcomes for children, young people and their families in Victoria).

Outcome 28:
What are the crime levels in the Victorian community?

The overall Victorian crime rate has been decreasing over the last decade, from nine crimes per 100 population in 2000–2001 to seven crimes in 2009–10. Over the same period, the number of recorded offences has also decreased by 19.3 per cent (Victoria Police 2010).

The majority of children (79.4 per cent) and young people (85.6 per cent) in Victoria feel safe in their communities. While most young Victorians report feeling safe in their neighbourhoods, their perceptions of safety are related to the time of day and where they are situated. They were significantly less likely to feel safe walking around their neighbourhood or being on public transport at night. Regardless of the location and time of day, male young people and those living in regional areas of Victoria were more likely to report feelings of safety regardless of location and time of day. (See Chapter 10 on safety for further information).

While perceptions of safety do not necessarily equate to actual safety, they give a good indication of how confident and secure children, young people and their families feel in their neighbourhoods. Perceptions of safety are also important in relation to the levels of social support available to children, young people and their families.

(See Chapter 12 for discussion of family and community support).
Society

Outcome 29:
Does Victoria have quality antenatal care?

Access to high-quality health care, before, during and immediately after birth has been shown to be effective in promoting the health and development of the mother and the child.

Smoking tobacco during pregnancy is a known risk factor for poor health and development outcomes, including low birth weight in infants. In 2008–09, 87 per cent of pregnant women who attended a Victorian public hospital for antenatal care during their first 20 weeks of pregnancy were given appropriate smoking cessation advice or intervention. Of these women who were identified as smokers or recent quitters when attending the antenatal care clinic, 78 per cent were given follow-up smoking cessation advice/support/interventions. (See Chapter 12 for further information).

The rate of caesarean deliveries has been increasing in many developed countries, with Australia having one of the highest rates in the world. There were 21,758 caesarean sections performed in Victoria in 2008, accounting for 30.5 per cent of women who gave birth, similar to the national rate (31.1 per cent). The rate has remained stable from 2006 (AIHW 2010c).

Outcome 30:
Do Victorian children experience early identification of child health needs?

Almost all Victorian infants receive a Maternal and Child Health (MCH) check at birth (99.8 per cent in 2009–10). After the first visit, parents continue to attend MCH appointments throughout the child's first few years of life. The MCH participation rate decreases as children age, from 95.4 per cent at four weeks of age to 63.1 per cent at 3.5 years. Participation in the Victorian MCH program has been consistent over the past decade, with parents more actively involved when their children are infants. (Chapter 11 provides a detailed discussion of the use of MCH services by Victorian families).

Around 90 per cent of students received an assessment by the primary school nurse, and the rate was fairly stable over the six year period 2002–07 for which data were available. The Primary School Nursing Program carries out follow-up assessments of children with previously identified health conditions to check progress and health gain. All children who were assessed as being in need of follow-up at the health assessment were followed up by the program.

Outcome 31:
Are high-quality early education and care experiences available in Victoria?

Other than within their family home, the first learning environment many children experience is within childcare environments (50.9 per cent of Australian children) (ABS 2008). Childcare can be provided as informal care (care provided by extended family, friends or babysitters) or as formal care (such as family day care, long day care or occasional care). In Victoria, formal care environments, particularly in day care centres, require staff to have formal qualifications in early childhood education and care.

Almost three in 10 Victorian children aged 5 years or younger (29.9 per cent) have experienced formal care environments with a qualified early childhood educator prior to school. The proportion of Victorian children attending a kindergarten program in the year prior to formal schooling has been consistently high over the past decade, reaching 95.1 per cent in 2010 (see Chapter 9 for further information).
Outcome 32:
Are there adequate supports to meet the needs of families with children with disabilities?

A considerable number of Victorian children and young people live with a disability, although it is difficult to provide accurate estimates because of debate surrounding the definition of a disability and identification problems even where a definition is agreed. There is very limited information on the prevalence of disability among children and young people in Victoria. The most recent information available from the 2003 Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers estimated that nationally 8 per cent of children have a disability and that the Victorian figure is slightly lower at 7 per cent (accounting for 67,170 children). Currently, there is no available data to reliably report on how services for children with a disability meet their needs or their families' needs.

Outcome 33:
Do Victorian children and young people attend and enjoy school?

Consistent attendance at both primary and secondary school provides the fundamental basis for children and young people to engage with learning the essential skills and knowledge needed for their successful transition into adulthood. (Chapter 9 provides a detailed discussion of engagement with learning in Victorian children and young people).

Measures of learning environment factors and personal cognitive and emotional factors for students in Victorian Government schools progressively improved in 2006–10. More than half of Victorian young people report always or often enjoying school (56.3 per cent); with a further 28.9 per cent sometimes enjoying school. However, of concern, 14 per cent of Victorian young people report rarely if ever enjoying school.

In Victorian Government schools, there are on average 14 absence days per year for each primary school student. The rate peaks in Year 9 to an average of 22 days and decreases across Years 10 to 12.

Outcome 34:
Do Victorian adult health and community services meet critical parenting needs?

The Victorian Government provides a range of family support services and programs to vulnerable children, young people and their families. These children and young people are likely to experience greater challenges because their development has been affected by the experience of multiple risk factors and/or cumulative harm. There has been a steady increase in the number of families and children accessing family services since 2005–06, reaching a total of 29,000 cases and 63,000 children in 2009–10. (See Chapter 12 for further information).

Information related to Victorian Primary School Nursing Program is discussed in Outcome 30.

Outcome 35:
Are there adequate supports for vulnerable Victorian young people?

A vital requirement for young people's health lies in their access to a range of health services when they are needed. The majority of young people report that they can access primary medical care, such as general practitioner (GP) services if needed (93.4 per cent), and the majority (83.7 per cent) see a local GP at least once a year.

Nine in 10 young people aged 12–17 years report that they can access dental services if needed (90.4 per cent), with six in 10 visiting the dentist at least once a year (65.4 per cent of females and 60.6 per cent of males).

One in seven Victorian young people (14.1 per cent) report they have used or believe that they currently have a need for mental health professionals (including counsellors, psychologists or psychiatrist).

Among the young people who have previously used, or believe that they currently have a need of, mental health professionals, 26.9 per cent feel that they are not able to access the services.

(Chapter 6 examines mental health issues and relevant data).
Chapter 13
Endnotes

1. Victorian Perinatal Data Collection Unit; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A13.1).

2. Notifiable Infectious Disease Surveillance System; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A13.2).

3. Victorian Cancer Registry 2010; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A13.3).

4. National Diabetes Registry; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A13.4).

5. Victorian Results for the Australian Early Development Index 2009; see detailed data in The State of Victoria’s Children and Young People 2010: Data Compendium (Table A13.5).
Chapter 13

References

This report presents the first consolidated analysis of issues of known importance for Victorian children, young people and their families. Building on the success of previous State of Victoria’s Children reports, it provides an in-depth look at key issues that continue to warrant further investigation and maximises the use of new and existing Victorian datasets to tell a more in-depth and comprehensive story than previous reports.

The strength of this approach is a new opportunity to look at associations across outcome areas. It enables us to go beyond the previously identified data sources for discrete indicators and draws together the best available evidence and research to enable a solid interrogation of Victorian issues in a national and international context and an exploration of the associated risk and protective factors.

This final chapter is not intended to summarise findings across all of the themes. These are set out at the beginning of each section and also in the Executive Summary; in addition, in keeping with the Victorian Child and Adolescent Outcomes Framework, a brief summary against the 35 outcomes has also been provided in Chapter 13. Rather, this section aims to highlight some of the emerging trends that have been identified, highlight where there are still gaps in our knowledge and outline opportunities to utilise the findings.

**Emerging issues and trends**

Overall, the findings of this report continue to show that the majority of Victorian children, young people and their families are faring well; they display positive characteristics and protective factors and generally fare better than their national counterparts. However, there are a number of recurring themes across each of the chapters in the report that warrant further consideration.

**Socioeconomic disparities**

Across almost all issues we continue to see socioeconomic disparities. Children, young people and families from lower socioeconomic backgrounds fare less well on many measures where this analysis has been undertaken. Some examples include that they are:

- less likely to be a healthy weight and meet fruit and vegetable intake guidelines
- more likely to have poorer oral health, as indicated by more reported fillings and extractions and lower use of dental services
- more likely to have emotional and behavioural problems that are of concern
- more likely to be developmentally vulnerable at school entry
- more likely to experience bullying, to have skipped school or to have been suspended
- more likely to have been involved in antisocial or criminal behaviour
- more likely to be exposed to tobacco in the home.
In this report, these analyses have predominantly been undertaken using annual household income where available or area-based measures of socioeconomic status from the Australian Bureau of Statistics’ Socioeconomic Indices for Areas (SEIFA). While these findings are consistent with evidence in the fields of child health and education, it should be noted that these are broad patterns observed through state-level analysis, and not all families with low income or living in low SES areas will necessarily have poorer outcomes.

Regional differences

While this is a statewide report, in many cases, analysis has been included to enable a comparison of how children, young people and their families are faring in metropolitan versus regional Victoria. There are a number of key outcome areas where children and young people in metropolitan Victoria fare better, including across sexual health, school attendance, oral health and are less likely to engage in substance use. However, outside metropolitan Victoria there are better perceptions of neighbourhoods and community safety, with young people more likely to report social support and opportunities to be involved in the local community. It should be noted that these analyses do not distinguish between those in regional centres and those in more rural areas. The next edition of this report will explore outcomes in rural and regional areas in more detail.

Gender differences

As frequently documented in research and as further identified in this report, there are differences in outcomes for males and females; they display different strengths and face different challenges across a range of outcome areas. Females generally fare better on measures of oral health, unintentional injury, aspects of engagement with learning, and are less likely to engage in antisocial behaviour. Males tend to fare better on a range of mental health outcomes.

Co-occurrence of risk taking behaviours and compound disadvantage

Taking an issues-based approach to this year’s report has enabled a more detailed look at the co-occurrence of risk-taking behaviours among Victorian young people and families who face multiple risk factors or experience compound disadvantage. The co-occurrence of multiple risk-taking behaviours by the same young people is evident in the published literature. However, through the use of findings from the large Victoria-wide survey of young people, this report, for the first time, has demonstrated the co-existence of multiple risk-taking behaviours in the same groups of Victorian young people. There are strong associations across different types of substance use (tobacco, alcohol and other drugs) among Victorian young people. Moreover, in a small but significant group substance use is also associated with other high-risk behaviours, such as unsafe sex, antisocial and even criminal behaviours (such as carrying a weapon or assaulting another person).

There is also strong evidence that some Victorian families experience multiple risk factors. In 2009, approximately 65 per cent of families using Victorian Government-funded Early Parenting Assessment and Skill Development services (PASDS) have four or more risk factors, including mental illness, family violence, substance use, being teenage mothers, financial stress, insecure housing, and/or infant or parent disabilities.

The analyses included in this report are by no means exhaustive of the wealth of available data and there are opportunities to further explore these issues through ongoing analyses of VCAMS surveys and program data from across Victorian Government departments.
Knowledge gaps

While this report demonstrates that Victoria continues to lead nationally in monitoring and reporting against child outcomes, it also identifies a number of limitations to our current monitoring efforts and areas where more information is required. For example, while the Victorian Adolescent Health and Wellbeing Survey (HOWRU 2009) has added significantly to what we know about how Victorian young people are faring, there are no time-series data yet available. Regular repetition of this data collection will enable the Victorian Government to track changes in adolescent health and wellbeing outcomes and contribute to assessing the effectiveness of policy and interventions.

Some of the monitoring challenges identified in this report include:

- No robust population data on the weight status of Victorian children and young people.
- A reliance on self-report for a true assessment of the oral health status of Victorian children and young people.
- Limited data on the actual prevalence of mental health problems or disorders among Victorian children and young people.
- It is not clear how much the continued increase in sexually transmitted infections (STIs) is an indication of an increase in prevalence or is due to more awareness and increased testing.
- Limited data available on the prevalence of disability among Victorian children and young people and the lack of data on outcomes for this priority population group.
- Key measures of engagement with learning are not consistently available across all education sectors.
- While there are on average 100,000 hospital treatments (Emergency Department presentations and admissions) for unintentional injury in Victorian children and young people per year, there may be many more that are treated within the primary health care sector. Further, for half of these injuries, the location and the activity engaged in at the time of injury are not specified.

Some of these gaps in our knowledge could be addressed through improvement of our existing data collections (in content, coverage and or quality) through linking existing data collections; however, some may require the development of new monitoring mechanisms and others require a more investigative research approach in the first instance. The report can therefore go a long way towards informing improvements to data collection and may also provide an initial framework for further analysis and research against some of these issues.
Next steps

This report further advances efforts in monitoring outcomes for children, young people and their families by Victorian Government departments. Through the thematic approach, it has enabled a more rigorous discussion against issues that continue to warrant a better understanding. It highlights where Victorian children, young people and their families continue to do well or have seen recent improvements. It also identifies where more attention is needed; where there are disparities across population groups or sections of the state; and the complexity of compound disadvantage that a number of Victorian families experience. Further, while Victorian Government departments have one of the most advanced and comprehensive systems to monitor and report against outcomes for children and young people, the report also draws attention to gaps that remain in our monitoring system and research base.

This report is not the final step in understanding how children and young people are faring. It is expected to not only provide a base for future action in monitoring, research and evaluation, but to drive program planning and policy development at all levels of government and service provision. It is intended to form part of ongoing dialogues among program planners and policy-makers across government, among local government areas and community service organisations and among researchers and practitioners.

Future State of Victoria’s Children reports will continue to evolve and advance as Victoria’s monitoring system grows and improves. Rigorous reporting against the VCAMS indicators will take place online, enabling these reports to take a more investigative and innovative approach focusing on particular issues, places and population groups. The importance of local data is also recognised and, where available, it will also be published in the VCAMS Community Profiles for each local government area and through online reporting. This combined approach of state and local reporting and additional investigative analyses will provide a solid foundation to support evidence-informed decision-making.