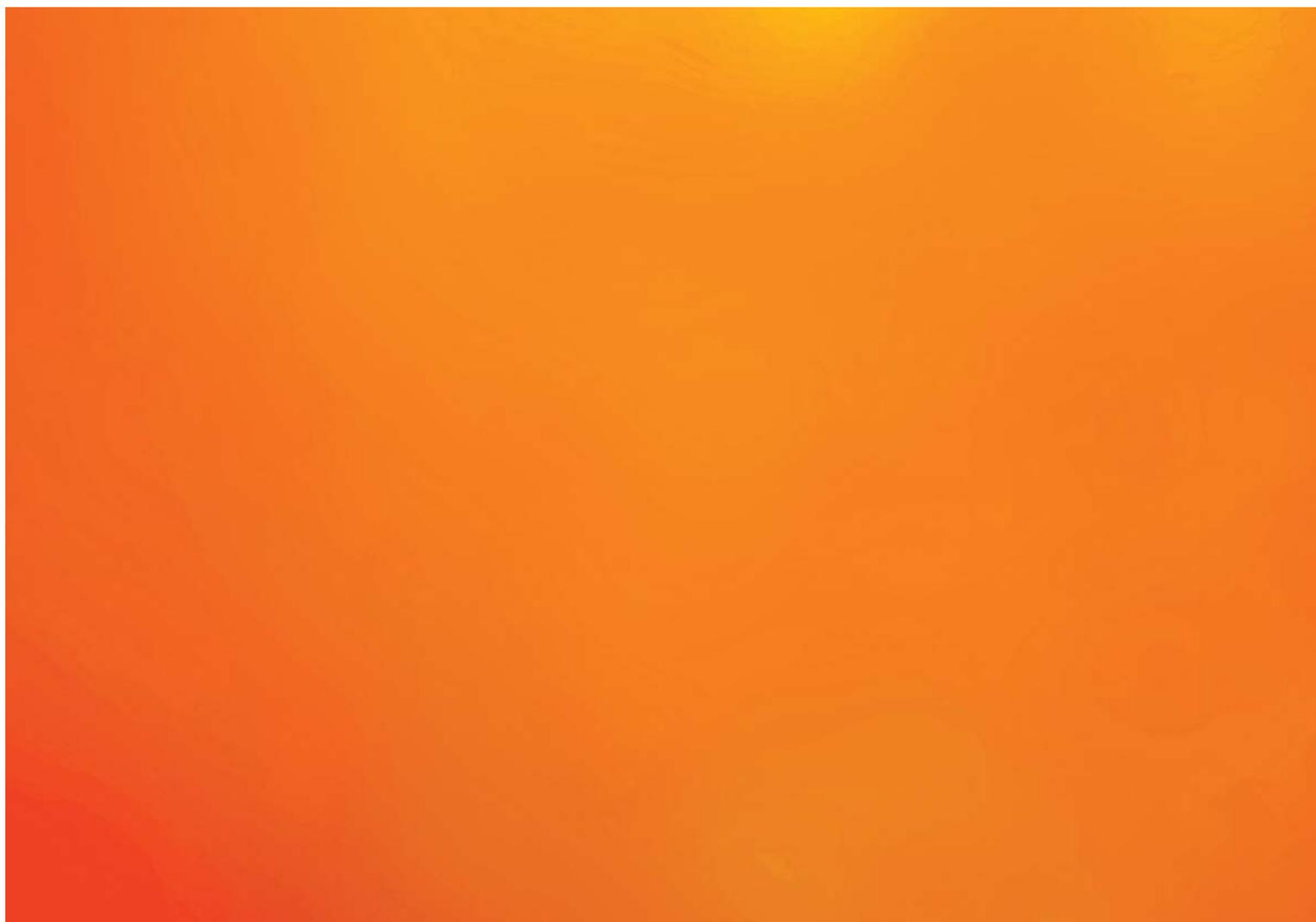


The state of Victoria's children report 2006

every child every chance





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Ministerial foreword

The Victorian Government is committed to giving children the best start in life and has made a real and continuing commitment to improving the wellbeing of children across the state. This commitment is reflected in the independent review of the Premier's Children Advisory Committee, in the appointment of a Minister for Children and an Office for Children, and in the introduction of the *Child Wellbeing and Safety Act 2005* and the *Children, Youth and Families Act 2005*.

The commitment is centrally reflected also in the production of this report on the wellbeing of Victoria's children. This is the first in a series of annual reports on Victoria's children and its publication represents an important milestone in the use of evidence to support and drive government planning and programs.

The State of Victoria's Children tells us how Victoria's children (aged zero-18) are faring based on the most-up-to date evidence of what matters in the lives of children and young people. This evidence has been used to create an Outcomes Framework of 35 key aspects of children's development. The report offers a high-level, yet comprehensive overview of the health, development, learning, safety and wellbeing of Victoria's children, focusing on outcomes for children and young people as a whole and on outcomes for children from four priority populations: Indigenous children, children with a disability, children from culturally and linguistically diverse backgrounds and children affected by chronic disadvantage. Comparative data on outcomes for children living in metropolitan and rural areas are also included.

In general, the report tells a good news story about how Victoria's children are faring. It shows that young Victorians are doing very well against a broad range of measures of health and wellbeing, safety, development and learning. Significant progress is being made towards the 'Growing Victoria Together' goals of high quality education and training for lifelong learning, high quality accessible health and community services and building friendly, confident and safe communities. This news is welcome and encouraging for all those who are committed to promoting and ensuring the wellbeing of children in Victoria.

On the other hand, the report alerts us, too, to some newly emerging health concerns affecting children and young people, such as obesity, eating disorders and mental ill health. It shows that not all children in Victoria are faring as well as broad statewide data suggest. The evidence shows there are inequalities in outcome for different groups of children, and clearly points to a need for policies to tackle these.

The comprehensive data that the report presents will allow the government to adapt and sharpen its focus on these areas of concern and on those children and families who are faring less well. With its focus on the outcomes that matter, the report will also provide an important resource for others, outside government, who are working to improve the life outcomes of children and young people.



Hon Sherryl Garbutt
Minister for Children
and Minister for Community Services

Acknowledgements

This report draws on a wide range of data from a variety of sources, including data held in the Department of Human Services, the Department of Education and Training, the Department for Victorian Communities, the Department of Justice, Victoria Police and the Australian Bureau of Statistics. We are grateful to all who provided this information.

We are also grateful to the following senior academics who contributed up-to-date data on their area of expertise for use in the report:

- Professor Jill Astbury from Victoria University
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- Professor Susan Sawyer from the Centre for Adolescent Health, Royal Children's Hospital and the University of Melbourne
- Professor Boyd Swinburn from Deakin University
- Associate Professor Melissa Wake from the Murdoch Children's Research Institute
- Professor Elizabeth Waters from Deakin University.

This report was prepared, under the direction of Michael White, in the Statewide Outcomes for Children Branch of the Office for Children, in the Victorian Government Department of Human Services.

The report was written by Dr Suzanne Hood, as principal author, with the support of Dr. Sharon Goldfeld, Pam Muth, Joyce Cleary, Atika Farooqui and Linda Hayes.

In introducing the Outcomes Framework the report draws on an unpublished paper by Don Siemon: 'Putting Children First: the Outcomes that matter'.

Ginnette Anile assisted with the production of Figures to be included in the report.

We owe a special thanks too, to Kerryn O'Rourke, who gathered data for the report while on placement with the Statewide Outcomes for Children Branch.

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Introduction

Every child every chance

The Victorian Government has recognised that children are in every sense our future. Already the government has introduced a number of initiatives that signal a real and continuing commitment to children in this state. In *Growing Victoria Together* the Victorian Government committed to improving the wellbeing of children and **every child every chance** is a response to that with far-reaching implications.

Internationally there is growing awareness that effective support for children and young people is vital for stability and prosperity in a rapidly changing social, educational and economic environment. It is also clearly demonstrated that appropriate support for children and families in the early years can pay considerable dividends for all communities.

Victoria has a long history of solid support for children and families, with a strong foundation of universal and specialist services. The challenge now is to ensure the results for all children are positive, relevant and timely.

Indicative of the importance of this endeavour, the Premier of Victoria, the Honourable Steve Bracks, has taken personal leadership. A thorough independent review through the Premier's Children's Advisory Committee, the announcement of a minister with responsibility for children and an Office for Children, and the release of the *Growing Victoria Together* and *A Fairer Victoria* policy documents have all set the foundation for a reappraisal of the entire system.

As a result of these initiatives, the Victorian Government has developed and adopted a vision and a way forward for the future of Victoria's children.

The vision for Victoria's children

The Victorian community's vision is for a Victoria in which every child thrives, learns and grows and is respected and valued to become an effective adult. This community is one in which the safety, health, development, learning and wellbeing of every child is protected and promoted throughout childhood.

It is also a Victoria in which:

- *Parents and families* are enabled to care effectively for their child and supported to act in his or her best interests.
- *Communities* recognise and respect children and young people, value their diversity and culture, and build connectedness and resilience among them and their families.
- *There is the right mix of places, professionals and high quality programs* to meet the changing needs of children, young people and families, provide opportunities, promote positive outcomes, intervene early and prevent harm.

From this vision, mechanisms and policies will be implemented to deliver better outcomes for Victorian children, families and our community.

The structure and the policies developed by the recently established Office for Children put the emphasis squarely on outcomes for children, with a focus on the child rather than the arrangement of services around them.

What we know

We are living through rapidly changing times and this can acutely affect children. In broad demographic terms, we are witnessing some key shifts that have considerable impact on communities, families and children (Stanley et al 2005). For example, falling birth rates, more families without children, increasing numbers of women in the workforce, workplace changes, and growing numbers of sole parent and blended families are all changing our society and will have a long term impact on Australian and Victorian children.

- We know from the statistical evidence that children in Victoria and generally in Australia are faring well in comparison with their peers across much of the world. On most available measures, the health and development of Victorian children is strong when compared with children internationally.
- All children are nevertheless vulnerable to illness and injury, especially in the early years, and there are newly emerging health concerns affecting children and young people, such as obesity, eating disorders and mental ill health.
- Not all children in Victoria are faring as well as statewide data might suggest. The evidence shows there are clear inequalities affecting different groups of children, and points to a need for policies to tackle these.
- All three strata of government in Australia and many non-government organisations are engaged in delivering services to children and families. The picture is complex and at times difficult to navigate, but state governments play a pivotal role in the provision of universal services.

Every child every chance: the Victorian Government response

Every child every chance is a child-centred approach to driving government policy and the services we put in place for children and their families. It begins with the establishment of an evidence base to tell us what is important and how our children are faring.

The Victorian Government has identified the 35 aspects of the safety, health, development, learning and wellbeing of children which matter most, according to our current knowledge of how children grow, thrive and succeed in the world. These are known as the Outcomes for Children.

Some of these outcomes are about the child itself; others are about their family, their community and the services and supports available.

Just as individual parents need to know how their child is progressing, the community needs to know how children are faring in all these aspects so we can plan effectively for the future.

Every child every chance – a comprehensive strategy

The government has identified that a coordinated approach across departments and agencies which focuses on children and their families is a fundamental tenet of this new policy agenda. The government recognises that this new structure and approach will take some time to entrench, and it is committed to it for the long term.

To achieve the goals set down in the 35 outcomes, the government will focus on actions that generate the maximum impact on the wellbeing of our children. These criteria will define the government's approach. They:

- may require some legislative change
- encourage greater interdepartmental effort across government
- guide the Victorian Government's program and spending priorities
- support the Victorian Government's discussion and negotiation with other levels of government: federal and local
- determine financial commitment to agencies working with children and families.

Two key mechanisms have been identified so far and are outlined here.

Understanding the State of Victoria's Children (aged zero to 18 years)

The aims of Understanding the State of Victoria's Children are to:

- continually update our knowledge of how children and young people are faring in Victoria
- identify where additional action may be required
- understand whether existing programs are helping and how they are helping
- effectively communicate this to the Victorian community.

This mechanism comprises data collection (in line with the outcomes framework), analysis, and online access to the data resource, as well as an annual published update which will give the community a snapshot of the health, development and wellbeing of Victorian children.

This robust evidence base, which will take account of shifting demographics, will be invaluable in the development of effective legislation, programs and service delivery, and in negotiations with federal and local levels of government. It will provide the backbone of evidence for decision-making within government, partnerships with non-government providers and other levels of government.

This report is the first annual report on the state of Victoria's children.

Legislation

Some new legislation has already been introduced in the form of the *Child Wellbeing and Safety Act 2005* and the *Children, Youth and Families Act 2005*. These two key pieces of legislation were enacted in late 2005. An extensive public information campaign is underway.

This new legislation sets out the principles that will guide our actions for all children, and particularly creates improved ways for responding to the needs of the most vulnerable children. For example, the *Child Wellbeing and Safety Act* sets out how the Children's Services Coordination Board will 'review annually and report to the Minister on the outcomes of government actions in relation to children, particularly the most vulnerable children in the community'.

The state of Victoria's children report

This is the first report on the state of Victoria's children to be produced by the Victorian Government. The report provides an overview of the wellbeing of Victoria's children and young people from the antenatal period to 18 years (zero to 18 years) within an outcomes framework that was developed by the Office for Children in the Department of Human Services, in collaboration with the Department for Victorian Communities and the Department of Education and Training. Further updates on the state of Victoria's children will be produced annually.

Measuring and reporting on the position and circumstances of children has a central role to play in efforts to improve children's lives and to ensure their rights under the United Nations Convention on the Rights of the Child (United Nations 1989). This report builds on similar initiatives elsewhere to monitor and document child wellbeing (Ben-Arieh & Goerge 2001). Within academic and policy circles there is also considerable interest in the development of social indicators to monitor the wellbeing of children and young people beyond measures of survival and basic needs, and new attention is being given to the question of how best to integrate the perspectives of young people themselves into the processes of wellbeing indicator development and reporting (Ben-Arieh 2005).

In *Growing Victoria Together: a vision for Victoria to 2010 and beyond* the Victorian Government has made a real and continuing commitment to improving the wellbeing of children across the state. By systematically identifying how Victoria's children and young people are faring, this report will highlight the areas where additional action is required in order to improve child wellbeing. In particular, it will identify where action is needed to address the inequalities in outcome experienced by children in four identified priority populations:

- Indigenous children
- children with a disability
- children from culturally and linguistically diverse backgrounds, including refugees
- children affected by chronic disadvantage, including children in out-of-home care.

The evidence suggests these groups of children are not faring as well as other children, that they face different or a particular set of problems, or that they are likely to require different approaches.

An outcomes framework as the basis for the report

The rationale for an outcomes approach

Much government activity aims to improve the lives or opportunities of the population or to reduce the prospect of future harm or suffering. This improvement is a change in an 'outcome' for the people involved—a measurable improvement in their health status, their income, their progress in education, or their subjective wellbeing.

Governments are increasingly aware of the range of ways in which public and private activity can intersect to impact on such outcomes. Action at a community level, as well as through services to individuals, can make a difference.

An outcomes focus is particularly valuable when dealing with a wide range of activities at a whole-of-government level or across a large population group. It allows government to connect to wide-ranging community expectations and to report back to the public on the success of the community's efforts as a whole and on the specific contribution of government activity.

Children and young people represent such a large population group, and childhood (including adolescence) is a life stage engaging most parts of government. A whole-of-government outcomes focus is essential when planning for children.

The development of the outcomes framework

We know a great deal from national and international research evidence about:

- the key circumstances and factors that impact on children and young people
- the challenges that children and young people may face
- the ways in which governments and the broader community can make a difference to children's lives and life chances.

The Office for Children has reviewed the evidence about the factors that make a real difference to children and young people and has identified 35 aspects of child health and wellbeing, learning and development and safety that are essential to our children's future. These aspects are known as the Outcomes for Children.

Child health implies not just the absence of disease, since some disease is part of life, but protection from damage or danger as a result of disease, whether physical or psychological.

Child development implies opportunities needed for growth, maturation and greater complexity in behaviour and interactions with others.

Child learning implies opportunities for interactions with others and discovery of the world, the acquisition of skills and understanding.

Child safety implies protection from unreasonable risk of injury, accident, harm or exploitation, and that the people involved in the care of children do not increase these risks.

Child wellbeing implies resilience, social confidence, secure cultural identity and protection from prolonged isolation, emotional trauma or exclusion.

However, children do not achieve these without the support of confident, capable parents, a strong community and a society which provides the services they need. For this reason the outcomes framework relates to both the individual child and their social and family context.

In line with the research evidence, each outcome area is:

- of known importance to children
- relevant to all or most children
- likely to respond to programs of intervention
- appropriate for government intervention or support.

Each outcome area has a number of associated indicators. The outcomes framework is set out in Figure A.

Figure A

The community

- Safe from environmental toxins
- Communities that enable parents children and young people to build connections, and draw on informal assistance
- Accessible local recreation spaces, activities and community facilities
- Low levels of crime in community



Supports and services

- Quality antenatal care
- Early identification of child health needs
- High quality early education and care experiences available
- Adequate supports to meet needs of families with children with a disability
- Children attend and enjoy school
- Adult health and community services that meet the needs of parents critical to parenting
- Adequate supports for vulnerable teenagers

The family

- Healthy adult lifestyle
- Parent promotion of child health and development
- Good parental mental health
- Free from abuse and neglect
- Free from child exposure to conflict or family violence
- Ability to pay for essentials
- Adequate family housing
- Positive family functioning



The child

- Optimal antenatal and infant development
- Optimal physical health
- Adequate nutrition
- Free from preventable disease
- Optimal social and emotional development
- Healthy teeth and gums
- Optimal language and cognitive development
- Healthy weight
- Adequate exercise and physical activity
- Positive child behaviour and mental health
- Successful in literacy and numeracy
- Safe from injury and harm
- Pro-social teenage lifestyle and law abiding behaviour
- Healthy teenage lifestyle
- Teenagers able to rely on supportive adults
- Young people complete secondary education





Use of the outcomes framework

The outcomes framework will provide a common basis for setting objectives and planning across the whole of government. It is reflected in *Future Directions*, the Government's action agenda for young Victorians. The framework will also be used in planning for the needs of young children in the years from birth to school.

The complete set of outcomes and indicators will provide the basis for the Victorian Child and Adolescent Monitoring System within the Office for Children. When fully operational this system will be an important resource for policy, planning, evaluation and research for government and non-government bodies.

At the time of writing, the Office for Children was continuing its work with other departments to develop and refine the outcome areas and the indicator lists. This work involves several complex elements, including identifying indicators in line with key selection criteria and working to ensure appropriate data are available to support each of the selected indicators. Where there are gaps, new data collection strategies are planned and some are underway.

The scope of this report

This first report focuses on those outcomes and indicators for which good and reliable data are available. It does not cover those outcomes and indicators that are still under development.

At present, it is easier to report on the kinds of measures that have traditionally been included in indicator sets (such as educational achievement and infant mortality) than on those kind of outcome areas that do not lend themselves so easily to quantifiable measurement (such as 'feeling valued by society' and 'cultural connectedness among Indigenous children and young people'). Also, while the report presents a range of data on parents' views (for example, their views about their local neighbourhoods and about their children's general health), it draws in a very limited way on children's own voices, views and experiences.

Also, while the report compares outcomes for children and young people in rural and in metropolitan areas, it does not provide analysis by Department of Human Service region or by Local Government Area, as the data systems required for this level of analysis are still under development.

Data sources

The report draws on a wide range of data from a range of sources, including data held by the Department of Human Services, the Department of Education and Training, the Department of Victorian Communities, the Department of Justice, Victoria Police and the Australian Bureau of Statistics. We were also able to draw on the knowledge and expertise of senior academics who contributed up-to-date information on their subject area for use in the report.

Two key sources of survey data include the School Entrant Health Questionnaire (1998–2004), which provides questionnaire data from parents about their concerns and observations relating to their children's health, and the Victorian Child Health and Wellbeing Survey (2006).¹

Further details of the School Entrant Health Questionnaire and the Victorian Child Health and Wellbeing Survey are attached in Appendices 1 and 2.

A developmental and ecological approach

In line with the outcomes framework, the report is focused on the whole of childhood: that is, on children and young people aged zero to 18 years. It reflects an ecological understanding, recognising that the course of childhood is affected by the contexts in which children live and grow: by their families and communities and by the availability of services and supports.

The focus on the child in the development of policy and practice represents an important shift in thinking, putting children at the centre of evidence gathering and the assessment of outcomes.

The report structure

The report is presented in four parts:

- Part 1: Victoria's children
- Part 2: The child
- Part 3: The environment
- Part 4: Principal findings.

¹ The Victorian Child Health and Wellbeing Survey used a computerised assisted telephone interview with primary caregivers of a randomly selected sample of 5,000 Victorian children aged zero to 12 years. The survey provides important information about many aspects relating to the health and wellbeing of Victorian children, including asthma, nutrition, oral health, child activities, child behaviour, family functioning and parental health.

Part 1: Victoria's children

Part 1 sets out some contextual information about the Victorian child (and adult) population and the characteristics of Victorian families.

Part 2: The child

This section reports on those broad outcome areas that are most immediately related to the child or young person. These areas are organised within three categories which reflect the community's aspirations for children:

- health and wellbeing
- development and learning
- safety.

Part 3: The environment

This section reports on those outcome areas that relate to the family, the community, and services and supports and have an impact on the health, development and wellbeing of children.

For each of the areas covered in Parts 2 and 3, the report will consider:

- What is the significance of or evidence base for the use of this outcome?
- What do we know about the circumstances for all children in Victoria?
- What issues are identified for children from the four priority groups (Indigenous children, children with a disability, children from culturally and linguistically diverse backgrounds, including refugees, and children affected by chronic disadvantage, including children in out-of-home care)?
- Are there differences in outcomes between children living in rural areas and those living in metropolitan areas?
- What does the evidence tell us about how Victoria's children are faring in comparison with other children nationally (and internationally)?

Part 4: Principal findings

This section includes an analysis and discussion of the main research findings, including their policy implications.

1. Victoria's children

1.1 Victoria's population

Victoria is the second most populated state or territory in Australia after New South Wales. It has a total population of 4,972,779, representing nearly a quarter (24.7 per cent) of the national population (Table 1.1).

Table 1.1: Population: Australia and the states and territories, 2004

State or territory	2004 population	Percentage of total population (%)
New South Wales	6,731,295	33.47
Victoria	4,972,779	24.73
Queensland	3,882,037	19.30
Western Australia	1,982,204	9.86
South Australia	1,534,250	7.63
Tasmania	482,128	2.40
Australian Capital Territory	324,021	1.61
Northern Territory	199,913	0.99
Other territories	2,670	0.01
Australia	20,111,297	100.00

Population as of 30 June 2004

Source: Department of Human Services calculations, based on Australian Bureau of Statistics 2005a

Geographical distribution

Nearly three-quarters (72.4 per cent) of Victoria's population lives in metropolitan Victoria and just over a quarter (27.6 per cent) lives in rural Victoria. Melbourne has a population of 3,600,080 and is the second most populated city in Australia (Table 1.2).

Table 1.2: Population: Australian cities

City	Population
Sydney	4,232,078
Melbourne	3,600,080
Brisbane	1,774,890
Perth	1,457,639
Adelaide	1,124,315
Canberra	323,645
Greater Hobart	202,138
Darwin	109,478

Population as of 30 June 2004

Source: Australian Bureau of Statistics 2005a

1.2 Victoria's child population

Victoria is home to 1,225,010 children and young people (aged zero to 18 years), representing just under a quarter (24.1 per cent) of the national child population.

While Victoria has the second highest child population of all the states and territories in terms of absolute numbers, it has the *second lowest* proportion of children (24.6 per cent) (Table 1.3).

Table 1.3: Number and percentage of children: Australia and the states and territories

State or territory	Number of children (aged zero to 18 years)	Percentage of children in total state or territory population (%)
New South Wales	1,688,073	25.1
Victoria	1,225,010	24.6
Queensland	1,015,630	26.2
South Australia	368,060	24.0
Western Australia	514,992	26.0
Tasmania	124,562	25.8
Northern Territory	62,229	31.1
Australian Capital Territory	81,603	25.2
Other territories	961	36.0
Australia	5,081,120	25.3

Population as of 30 June 2004

Source: Department of Human Services calculations, based on Australian Bureau of Statistics 2006, ABS data available on request

Geographical distribution

Although the majority of Victoria's children and young people live in metropolitan Victoria, children represent a greater proportion of the population in rural Victoria (Table 1.4).

Table 1.4: Number and percentage of children: Department of Human Services regions

Department of Human Services region	Number of children (aged zero to 18 years)	Percentage of regional population (%)
Hume	70,911	27.3
Loddon Mallee	81,307	26.9
Grampians	56,617	26.5
Gippsland	64,287	26.1
Barwon-South Western	89,694	25.6
Rural Victoria	362,816	26.4
North and West Metropolitan	351,429	24.1
Southern Metropolitan	279,825	23.9
Eastern Metropolitan	230,925	23.7
Metropolitan Victoria	862,179	23.9
Unincorporated Victoria	15	16.5
Total Victoria	1,225,010	24.6

Population as of 30 June 2004

Source: Department of Human Services calculations, based on Australian Bureau of Statistics 2005, ABS data available on request

Gender distribution

The gender distribution of Victoria's child population (48.8 per cent female and 51.2 per cent male) is consistent, at June 30 2004, with that of most states and territories and the national distribution.^{2,3}

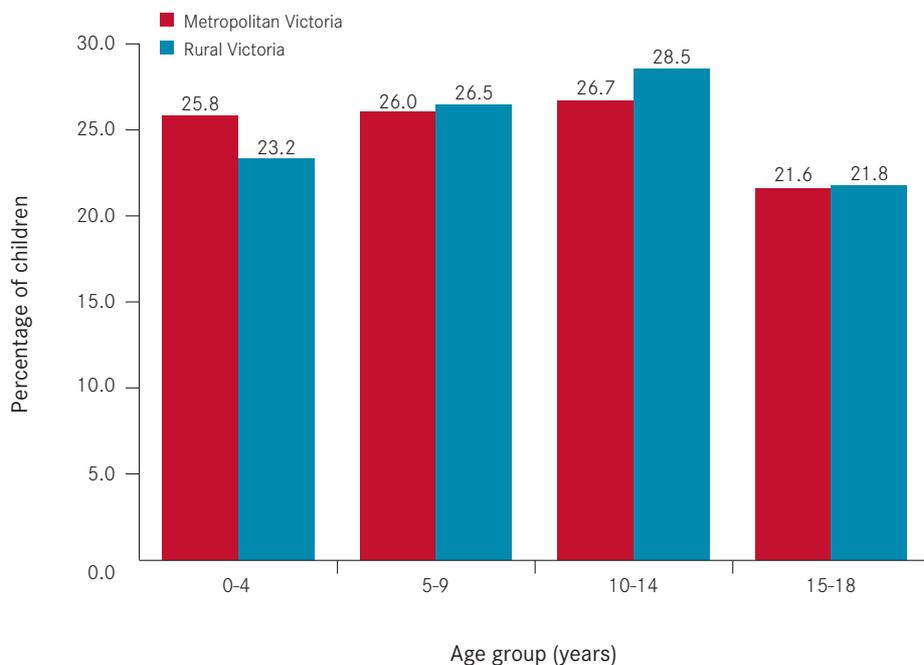
Age structure and distribution

Figure 1.1 illustrates the percentage of children and young people (aged zero to 18 years) in four age groups in rural and metropolitan Victoria. This shows rural Victoria has a smaller percentage of zero to four year-olds and a larger percentage of ten to 14 year-olds than metropolitan Victoria.

² With the exception of the 'other territories' (incorporating Jervis Bay, Christmas Island and Cocos or Keeling Islands) there are slightly more male children than female children in each state and territory.

³ Australian Bureau of Statistics 2005, ABS data available on request.

Figure 1.1: Percentage child population in each age group by area



Population at 30 June 2004

Source: Department of Human Services calculations, based on Australian Bureau of Statistics 2005, Australian Bureau of Statistics data available on request.

1.3 Projected changes in Victoria's population

Birth rates

Victoria has experienced a falling birth rate in recent decades, in line with most of the other Australian states and territories (Australian Bureau of Statistics 2005b-j).⁴ The total fertility rate⁵ of Victoria fell from 1.78 to 1.67 from 1993 to 2003 (Australian Bureau of Statistics 2005c) and is projected to fall further (to 1.63 in 2021) and then remain constant until 2051 (Australian Bureau of Statistics 2006, Series B).

Birth rates, together with changes in life expectancy, are key influences on both the *pattern of population growth* and the *age structure of the population*.

The pattern of population growth

While the total population of Victoria is projected to increase by almost 30 per cent over the next 45 years, Victoria's child population is projected to increase by only 0.25 per cent over the same period. By 2051, the child population of Victoria is expected to make up just 18.7 per cent of the total population (compared with 24.2 per cent in 2006) (Department of Human Services calculations based on Australian Bureau of Statistics 2005j).

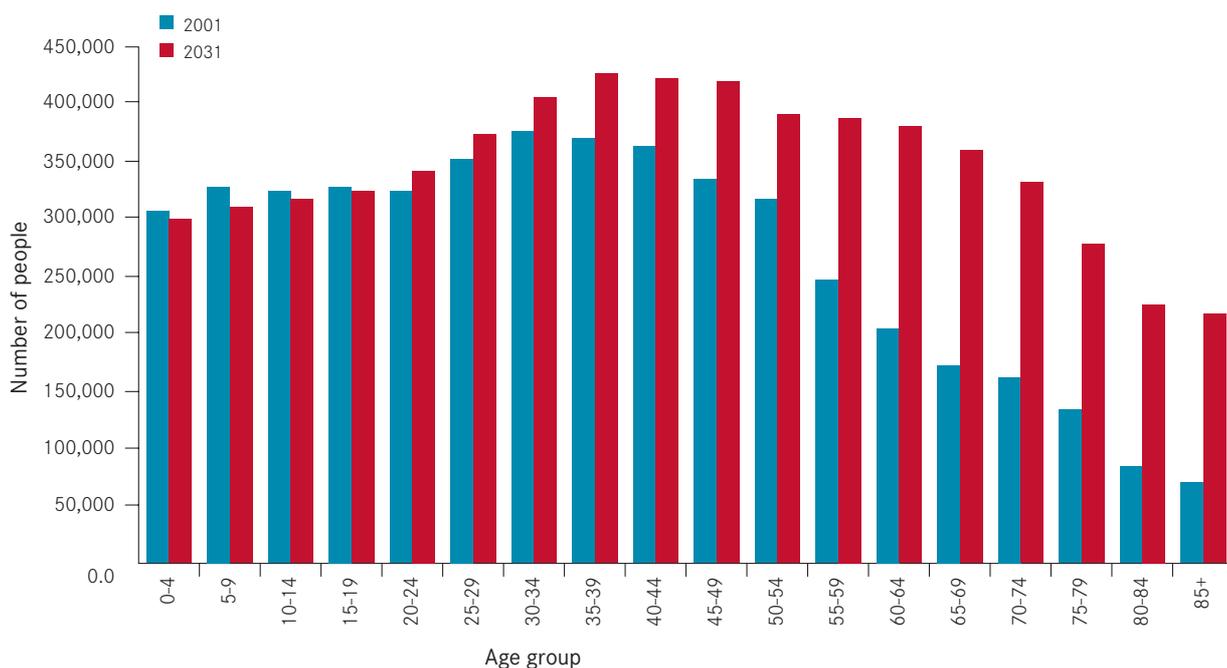
⁴ All other states and territories, with the exception of the Northern Territory, have also shown decreases.

⁵ Total fertility rate is defined as the average number of children a woman could expect to bear in her reproductive life, assumed to begin at age 15 years and end at 50 years.

The age structure of the population

Figure 1.2 illustrates the projected age structure of the Victorian population (2001–31). This shows a decline in the child population and marked increases over the same time period in the population aged 55 years and over.

Figure 1.2: Projected population of Victoria (2001–31) by five year age



Source: Department of Sustainability and Environment 2004

Rural/Metropolitan distinctions

Tables 1.5 and 1.6 give the total and child population projections (2011–51) for Melbourne and the rest of Victoria. These show that most of the projected population growth is in Melbourne. It is interesting to note that while the child population of Melbourne shows a small increase (of 7.3 per cent) the child population in the balance of Victoria *decreases* by 16.6 per cent.

Table 1.5: Projected total population: Melbourne and the rest of Victoria

	2011	2021	2031	2041	2051
Melbourne	3,872,918	4,253,367	4,591,846	4,850,887	5,041,126
Balance of Victoria	1,437,200	1,508,286	1,554,887	1,559,199	1,532,970
Victoria	5,310,118	5,761,653	6,146,733	6,410,086	6,574,096

Source: Australian Bureau of Statistics 2005j

Table 1.6: Projected child population: Melbourne and the rest of Victoria

	2011	2021	2031	2041	2051
Melbourne	867,504	877,579	899,161	916,031	926,232
Balance of Victoria	351,424	335,025	327,394	315,431	301,774
Victoria	1,218,928	1,212,604	1,226,555	1,231,462	1,228,006

Source: Australian Bureau of Statistics 2005j

1.4 Diversity in Victoria's population

The Indigenous population

In 2001 there was a total of 27,928 Indigenous people in Victoria (0.6 per cent of the total population).⁶ When compared with other states and territories Victoria has the lowest percentage of Indigenous people in the total population (Australian Bureau of Statistics 2003).

The Indigenous child population

There are marked differences between the age structure of the Indigenous population and that of the total population. Victoria's 13,111 children and young people aged zero to 18 years accounted for nearly half (46.9 per cent) of the total Indigenous population of Victoria in 2001. This is almost double the proportion of children and young people in the 2001 total population of Victoria (25.5 per cent).⁷

Distribution of the Indigenous population

In terms of population distribution, 48 per cent of the Indigenous population are in rural Victoria and 52 per cent are in metropolitan Victoria. This split is slightly larger among the Indigenous child population with 44.3 per cent of Indigenous children and young people in rural Victoria and 55.7 per cent in metropolitan Victoria (at June 2001).⁸

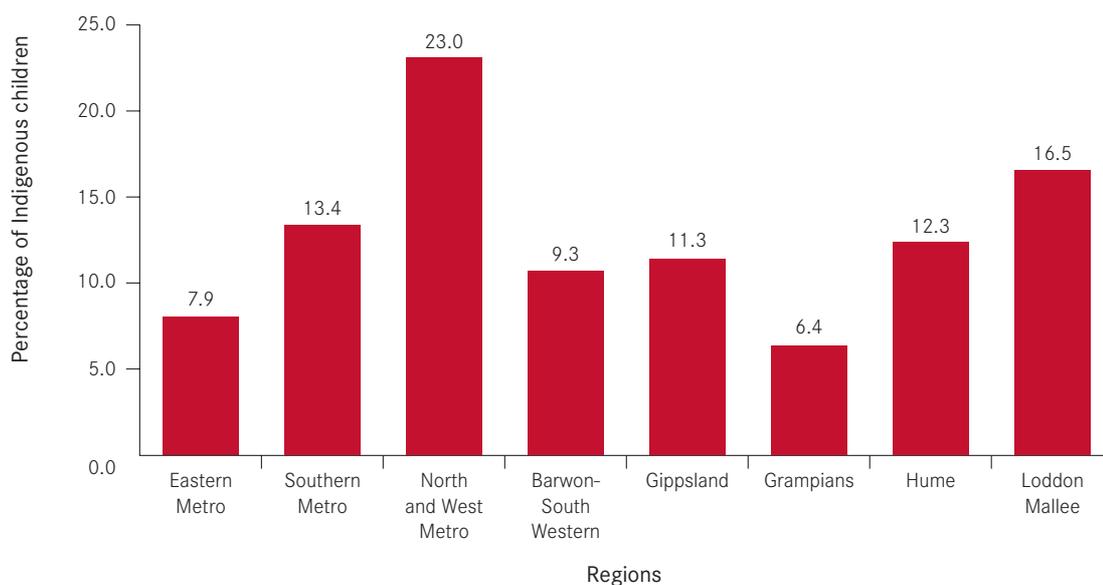
⁶ Australian Bureau of Statistics 2004, ABS data available on request.

⁷ Australian Bureau of Statistics 2004, ABS data available on request.

⁸ Australian Bureau of Statistics 2004, ABS data available on request.

Figure 1.3 presents the distribution of the total Indigenous child population across Department of Human Services regions (at June 2001). Most of Victoria's Indigenous child population is in the North and West Metropolitan Region (23.0 per cent).⁹

Figure 1.3: Distribution of Indigenous children across Department of Human Services regions



Population at 30 June 2001

Source: Department of Human Services calculations, based on Australian Bureau of Statistics 2004, ABS data available on request.

Place of birth

Based on the 2001 Census, 23.3 per cent of all Victorians and 6.7 per cent of children in Victoria were born overseas.¹⁰ The top stated countries of birth for all Victorians (after Australia) were the United Kingdom (4.4 per cent), 'born elsewhere overseas' (4.0 per cent),¹¹ Italy (1.9 per cent), Greece (1.24 per cent), Vietnam (1.22 per cent) and New Zealand (1.19 per cent) respectively.

The top stated countries of birth for children in Victoria (after Australia) were 'born elsewhere overseas' (1.8 per cent), New Zealand (0.76 per cent), the United Kingdom (0.57 per cent), China, Vietnam and the Philippines respectively.

⁹ Australian Bureau of Statistics 2004, ABS data available on request.

¹⁰ This does not include those for whom birthplace was not stated: 5.5 per cent of all Victorians and 7.7 per cent of children in Victoria.

¹¹ Includes 'inadequately described', 'at sea' and 'not elsewhere classified'

Figure 1.4 shows the percentage of the child population who were born outside Australia for all the states and territories.

Figure 1.4: Percentage of children, aged zero to 18 years, born overseas by state and territory



Population at 30 June 2001

Department of Human Services calculations based on Australian Bureau of Statistics 2004, ABS data available on request.

Languages spoken

Based on the 2001 Census, 19.8 per cent of all Victorians and 15.5 per cent of children in Victoria speak a language other than English at home.¹² The top languages spoken by all Victorians (after English) were Italian (3.2 per cent), Greek (2.6 per cent), Chinese (2.4 per cent, includes Mandarin, Cantonese and other Chinese languages), 'other' (2.17 per cent),¹³ Vietnamese (1.4 per cent) and Arabic (1.02 per cent, includes Lebanese) respectively.¹⁴

The top languages spoken by children and young people (after English) were Chinese (2.3 per cent, includes Mandarin, Cantonese and other Chinese languages), 'other' (also 2.3 per cent), Vietnamese (1.64 per cent), Greek (1.58 per cent), Arabic (1.36 per cent, includes Lebanese) and Italian (1.21 per cent) respectively.¹⁵

¹² This does not include those for whom language spoken was not stated: 4.7 per cent of all Victorians and 6.1 per cent of Victorian children.

¹³ Includes 'inadequately described', 'at sea' and 'not elsewhere classified'

¹⁴ Australian Bureau of Statistics 2006, ABS data available on request.

¹⁵ Australian Bureau of Statistics 2006, ABS data available on request.

Figure 1.5 shows the percentage of the child population aged zero to 18 years that speaks a language other than English at home, for all the Australian states and territories.

Figure 1.5: Percentage of children speaking language other than English at home



Population at 30 June 2001

Source: Department of Human Services calculations, based on Australian Bureau of Statistics 2004. ABS data available on request.

Refugee young people

The Centre for Multicultural Youth Issues provides information about young refugees in Victoria, derived from statistics from the Department of Immigration and Multicultural Affairs (The Centre for Multicultural Youth Issues 2006). This information shows that there were 1,117 youth arrivals (aged 12-25) to Victoria in 2005, under the government's Humanitarian Program.¹⁶

The majority of youth arrivals were from Africa (70.2 per cent), 20.3 per cent were from the Middle East, 9.3 per cent were from Asia and the Pacific and 0.2 per cent were from Europe. The majority of young Humanitarian arrivals settled in the outer southeastern and northwestern regions of Melbourne.

¹⁶ The government's Humanitarian Program is divided into an onshore and offshore stream. The offshore stream includes Refugee and Special Humanitarian Program visa holders. The Special Humanitarian Program has been established 'for people who have suffered discrimination amounting to gross violation of human rights.' Special Humanitarian Program holders may fit the United Nations definition of a refugee, (United Nations 1951) but are not tested against it. The onshore stream of the Special Humanitarian Program includes Temporary Protection/Humanitarian Visa holders (The Centre for Multicultural Youth Issues 2005).

The figures presented above give an indication of the numbers of children who make up two of the four priority groups that are a particular focus in this report: Indigenous children and children from culturally and linguistically diverse backgrounds.

Information about children with a disability follows. Information about children affected by chronic disadvantage is in section 3.1 (the family) and information about children in out-of-home care is in sections 2.2 (development and learning) and 2.3 (safety).

The prevalence of childhood disability

Information about the prevalence of childhood disability among children aged zero to 14 years is available from the Australian Bureau of Statistics. The Australian Bureau of Statistics defines disability as:

Any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities (Australian Bureau of Statistics 2004a).

There are four levels of core activity restriction: profound, severe, moderate and mild. Children with a disability can also have a core activity restriction if the disability limits their ability to some degree to perform tasks, such as self-care, mobility, communication and schooling.

The Australian Bureau of Statistics estimates that nationally 8 per cent of children have a disability and in Victoria the figure is slightly lower at 7 per cent (accounting for 67,170 children) (Australian Bureau of Statistics 2004a).

From research carried out in Australia, the United Kingdom and the United States of America, we know there is a strong association between childhood disability and low family income and that in Australia the rate of disability is higher among children living outside capital cities (Australian Institute of Health and Welfare 2004).

Children with special health care needs

The 2006 Victorian Child Health and Wellbeing Survey asked parents a series of questions to ascertain whether their child has special health care needs. The survey collected data on the proportions of children who are considered to be dependent on medication, regarded as having functional limitations, and reported to require or use more services (such as counselling and therapy) than is usual for children of their age.

Overall, 15.7 per cent of children were reported to have special health care needs. Nearly one in ten (9.3 per cent) of children were reported to be dependent on medication and to require or use more services (9.5 per cent). One in 25 (4.1 per cent) of children were regarded as having functional limitations.

Although boys and children living in rural areas appeared to have slightly higher health care needs than girls and children living in metropolitan areas, these differences were not statistically significant.

1.5 Family characteristics

According to the Family Characteristics Survey conducted by the Australian Bureau of Statistics (2003) there are approximately 612,600 families with children aged zero to 17 years in Victoria, encompassing approximately 1,133,800 children and young people. Families are classified as either 'couple families' or 'one parent families'. Couple families include intact, step and blended families and make up 82.1 per cent of Victoria's families. The remaining 17.9 per cent are one-parent families (including lone mother and lone father families). The number and percentage of children in each type of family are presented in Table 1.7.

Table 1.7: Number and percentage of children by family type, Victoria

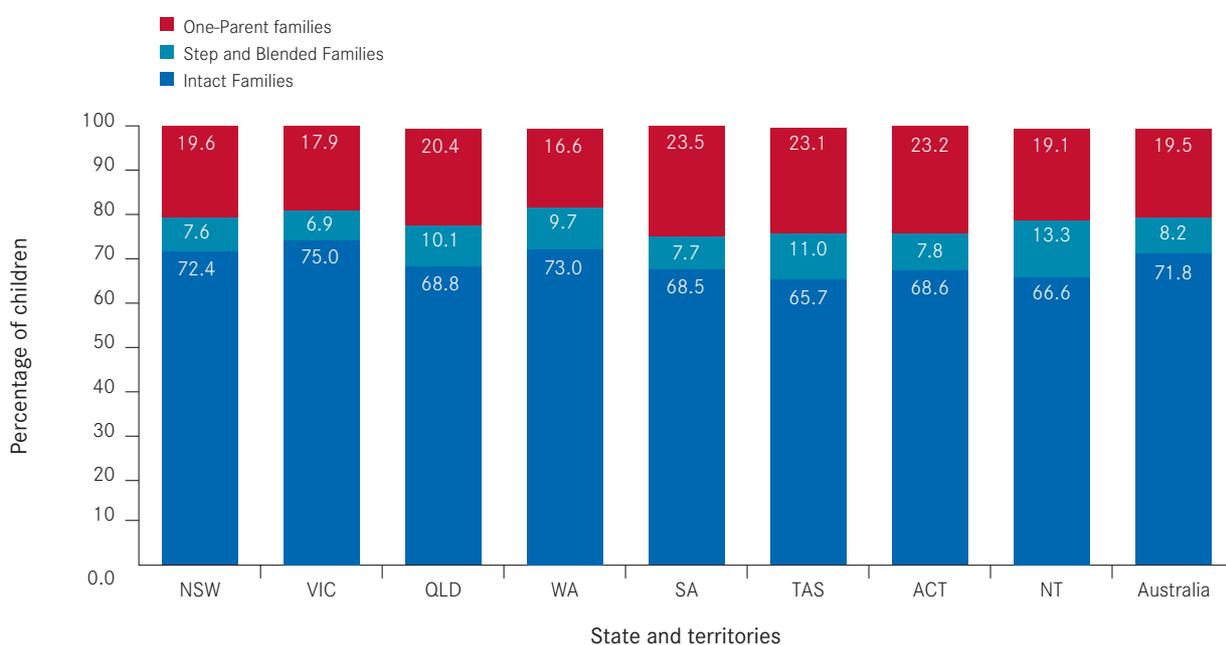
Family type	Number of children	Percentage of children (%)
Intact	850,600	75.0
Step	39,500	3.5
Blended	38,300	3.4
Total in couple families¹⁷	931,300	82.1
Lone mother	171,200	15.1
Lone father	31,300	2.8
Total in one parent families	202,500	17.9
Total	1,133,800	100

Source: Australian Bureau of Statistics 2004b

¹⁷ Includes 'other' couple families that are not classified as intact, step or blended. For example, grandparent couple families or families with only foster children present

Figure 1.6 shows the proportion of each family type as a percentage of the total number of families with children for each state and territory. This shows Victoria has the highest percentage of children and young people in intact families (75 per cent) and the lowest percentage of children and young people in step and blended families (6.9 per cent) when compared with the other states and territories.¹⁸ Figure 1.6 also shows Victoria has the second lowest percentage of children and young people in one-parent families (17.9 per cent).

Figure 1.6: Percentage of children, aged zero to 17, in each family type by state and territory



Source: Department of Human Services calculations based on Australian Bureau of Statistics 2004c

¹⁸ Northern Territory and the Australian Capital Territory have a relative standard error of 25 per cent to 50 per cent for step and blended families and these figures should be used with caution.



2. The child

2.1 Health and wellbeing

Health and wellbeing is a fundamental human right for all. Based on the Convention of the Rights of the Child (United Nations 1989), every child has the right to enjoy the highest attainable standards of health and to have an adequate standard of living for physical, mental, spiritual, moral and social development (Rigby et al. 2003). In addition to being a human right, child and youth wellbeing is crucial because it provides a basis for life outcomes.

A wide range of individual, familial, social, economic, neighbourhood, environmental and political factors affects children and young people's physical and mental health, with low socioeconomic status a key risk factor for poorer health outcomes (Australian Institute of Health and Welfare 2005).

The health of Australia's—and Victoria's—children has shown some marked improvements over the past 40 to 50 years on some of the traditionally and commonly used measures of child health. For example, death rates have continued to fall for almost all causes, and child death and disability arising from infectious diseases is much rarer than it was several decades ago (Stanley et al. 2005). However, the incidence of some physical illnesses (such as childhood diabetes) is increasing and new and pressing child health issues (such as mental ill health and obesity) are replacing some of the more traditional health concerns.

It is also clear that for some of Australia's children the recent advances in child health outcomes have been far less marked. Child poverty remains a significant impediment to child health and Australian children from less advantaged socioeconomic backgrounds continue to experience poorer health outcomes. Indigenous children have higher rates of low birthweight and of infant mortality than children from non-Indigenous groups (Steering Committee for the Review of Government Service Provision 2005). Research has also demonstrated that Indigenous adolescents experience substantial health inequalities compared with the general population (The Health of Young Victorians Study 1997, 2000, 2005).

In this section on the health of Victoria's children we cover issues relating to children's health at all ages from the antenatal period to the teenage years under the headings of 'health in the early years', 'staying healthy', 'healthy lifestyles', and 'mental health'.

The range of outcome areas covered in this section broadly relates to children and young people's physical and mental health; however, for the purposes of this report, we adopt a broad and holistic understanding of child health as 'a state of complete physical, mental and social wellbeing'. This definition encompasses the interconnectedness of all those varied factors that impact on child health (Australian Institute of Health and Welfare 2005) and it also reflects some of the key themes that emerge in children and young people's own accounts of what it means to be healthy.¹⁹ In line with this broad understanding of health, we focus on additional outcomes relating to children and young people's social and emotional health and development in subsequent sections of the report: 2.2 (development and learning) and 2.3 (safety).

¹⁹ For example, research in the United Kingdom highlights how children and young people link their sense of health and wellbeing with the quality of their social, emotional and physical environments (Healey 2002; Hood 2004).

Health in the early years

Outcome area: optimal antenatal and infant development

Associated indicators reported: low birthweight, infant mortality, sudden infant death syndrome

Research has demonstrated that the foundations of adult health are laid in early childhood and before birth (Wilkinson & Marmot 2003), and poor circumstances during pregnancy are known to contribute to a range of childhood disabilities and medical conditions and to a propensity for ill health in later life.

Under this outcome area of optimal antenatal and infant development, we consider three associated indicators: low birthweight, infant mortality and sudden infant death syndrome (known as SIDS).

Family and service factors that increase the risk for poorer outcomes (maternal smoking, misuse of drugs and alcohol, and inadequate antenatal care) and that can help to prevent adverse outcomes (folate supplementation) are considered in section 3.1 (the family) and section 3.3 (services and supports).

Low birthweight

Low birthweight is an indicator of the general health of a new baby and a key determinant of infant survival, health and development. Low birthweight babies are at greater risk of dying during the first years of life (Australian Institute of Health and Welfare 2004) and they also have a greater risk of hospitalisation, neonatal death,²⁰ physical and neurological complications and the development of psychosocial problems.

Low birthweight is defined as a birthweight of less than 2,500 grams and very low birthweight as a birthweight of less than 1,500 grams.²¹ Babies of low birthweight are more commonly born to families of low socioeconomic status, single mothers and Indigenous mothers (Australian Institute of Health and Welfare 2004).

In 2003, 6.3 per cent of all babies born alive in Australia were of low birthweight. This places Australia about in the middle compared with other Organisation for Economic Cooperation and Development (OECD) countries (Australian Institute of Health and Welfare 2006).

Low birthweight in Victoria

Table 2.1.1 shows the proportions of low birthweight and very low birthweight babies in Victoria from 1985 to 2004. The proportion (of low and very low birthweight babies) increased from 1985 to 2002, but has remained stable since then.

Table 2.1.1: Trends in low birthweight and very low birthweight as a proportion of all births, 1985–2004, Victoria

	1985	1990	1995	2000	2001	2002	2003	2004
Low birthweight (%)	5.5	6.0	6.5	6.7	6.7	7.0	6.9	6.8
Very low birthweight (%)	1.1	1.2	1.4	1.4	1.4	1.6	1.5	1.5

Source: Department of Human Services 2005

²⁰ Death of a live born infant within 28 days of birth

²¹ These definitions include both premature and full-term babies.

As Table 2.1.2 shows, babies born to Indigenous women are more than twice as likely to have a low birthweight than babies born to non-Indigenous women (15.3 per cent and 6.8 per cent respectively).

Table 2.1.2: Birthweight of Indigenous and non-Indigenous infants, Victoria, pooled data, 2003–04

Birthweight (grams)	Indigenous (%)	Non-Indigenous (%)
< 1,500	3.3	1.5
1,500–2,499	12.0	5.3
2,500–4,499	82.7	91.3
4500 +	1.9	1.9

Source: Department of Human Services 2005

This rate of difference is similar to that in some of the other Australian jurisdictions (Queensland, New South Wales) and in Australia as a whole (Table 2.1.3).²²

Table 2.1.3: Percentage of low birthweight for babies born to Indigenous and non-Indigenous mothers, selected jurisdictions, Australia, 2003

	NSW	Vic	Qld	WA	SA	NT	Australia
Indigenous mothers: percentage low birthweight	11.7	13.1	11.6	14.2	17.3	14.3	12.9
Non-Indigenous mothers: percentage low birthweight	5.7	6.4	6.1	5.9	6.2	6.8	6.1

Source: Derived from Laws & Sullivan 2005

Infant mortality

Infant mortality—a measure of the survival of children in their first year of life—is used internationally as a key indicator of hygiene and health conditions in a community (Australian Institute of Health and Welfare 2004). Infant mortality rates have shown a steady decline in Australia, falling by 93 per cent between 1912 and 2003; however, despite this fall, Australian infant mortality rates are at about the middle of the range compared with other OECD countries (Australian Institute of Health and Welfare 2006). There are also differences between the infant mortality rates of the Indigenous and the non-Indigenous populations and between the rates for children from different socioeconomic groups. For example, recent analysis using an area-based measure of socioeconomic position²³ has shown that children from the most disadvantaged areas are twice as likely to die as those from the least disadvantaged areas (Australian Institute of Health and Welfare 2006).

²² In South Australia and Western Australia babies born to Indigenous women are around three times more likely to be of low birthweight than babies born to non-Indigenous women.

²³ The analysis uses the Index of Relative Socioeconomic Disadvantage, which is based on data obtained from the Census. The index is derived from key characteristics of small areas, including the proportion of population with a low income, low educational attainment, jobs in relatively unskilled occupations or unemployed.

From 1999 to 2003 there were 13 deaths per 1,000 live births among Indigenous infants in Queensland, Western Australia, South Australia and the Northern Territory.²⁴ This infant mortality rate was nearly three times higher than that of non-Indigenous Australian infants (4.5 per 1,000 live births). It was also higher than the infant mortality rate in all but two of 29 other OECD countries (Australian Institute of Health and Welfare 2006).

Infant mortality in Victoria

In Victoria in 2004, the infant mortality rate was 3.3 per 1,000 live births (The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2005).²⁵ This can be compared with a national (Australian) rate for the same year of 4.7 per 1,000 live births (Australian Bureau of Statistics 2004).

Victoria is not able to report on the infant mortality rate of its Indigenous population; however, Table 2.1.4 shows that the perinatal²⁶ and neonatal mortality rates for babies born to Indigenous mothers are twice as high as those for babies born to non-Indigenous mothers.

Table 2.1.4: Mortality rate for babies born to Indigenous and non-Indigenous mothers, Victoria, pooled data, 1998–2002

Category	Indigenous/1,000	Non-Indigenous/1,000
Stillbirths	12.7	6.6
Neonatal deaths	7.5	3.4
Perinatal deaths	20.2	10.0

Source: Department of Human Services 2003

Sudden infant death syndrome

Sudden infant death syndrome (or SIDS) refers to the sudden and unexpected death of a child for no known cause.²⁷ The major risk factors that have been identified for SIDS include exposure to cigarette smoking during pregnancy and after birth, a prone sleeping position, over-wrapping and overheating (Eagar et al. 2005).

The Victorian Child Health and Wellbeing Survey collected data on the percentage of children in Victoria who were put on their back to sleep. These 2006 data are reported in section 3.1 (the family).

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 SIDS²⁸ from 1.87 per 1,000 live births in 1990 to 0.78 per 1,000 live births in 1995. The declining trend in SIDS deaths in Victoria is clearly illustrated in Figure 2.1.1.²⁹

²⁴ These are the only Australian states and territories for which coverage of Indigenous people in deaths data is considered sufficiently complete for statistical reporting.

²⁵ The most common cause of death for infants aged one month to 12 months was birth defects and genetic conditions (accounting for 28 deaths) followed by SIDS (18 deaths) and then conditions determined at birth, such as prematurity, birth asphyxia (15 deaths).

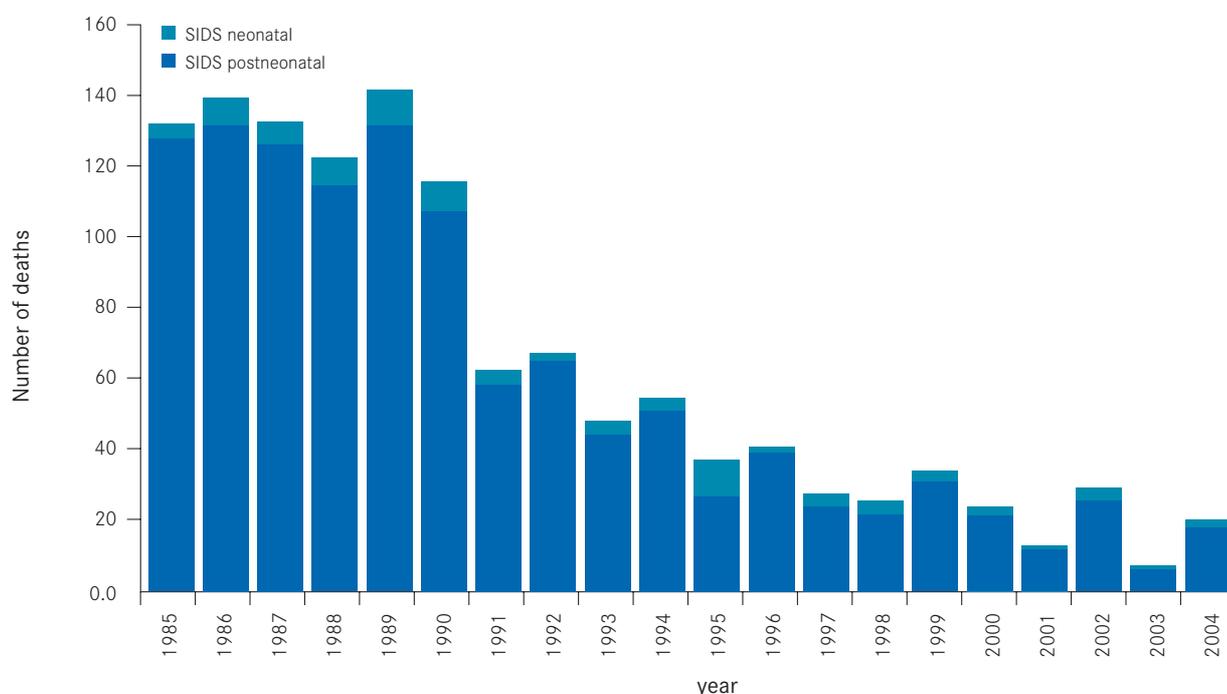
²⁶ Perinatal mortality measures the rate of stillbirths (fetal deaths of more than 20 weeks gestation or 400 grams) and neonatal deaths.

²⁷ SIDS is more specifically defined as 'the sudden unexpected death of an infant less than one year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of the death and the clinical history' (Krous et al. cited in The Consultative Council on Obstetric and Paediatric Mortality 2005).

²⁸ The rate of SIDS is expressed as the number of deaths classified as SIDS per 1,000 live births.

²⁹ A new classification of SIDS was adopted in 2004.

Figure 2.1.1: SIDS, neonatal and postneonatal infants, Victoria, 1985-2004



Source: The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2005

Health in the early years: summary of key findings

- The incidence of low birthweight and very low birthweight babies in Victoria is currently stable. Indigenous women are more than twice as likely to have low birthweight babies.
- Infant mortality rates are declining, although Australian rates are at about the middle of the OECD range.
- Perinatal and neonatal mortality rates for babies born to Indigenous mothers are twice as high as those for babies born to non-Indigenous mothers.
- SIDS deaths in Victoria (and nationally) have reduced markedly since 1990.

Staying healthy

Outcome area: free from preventable disease

Associated indicator reported: Full immunisation at one, two and six years of age

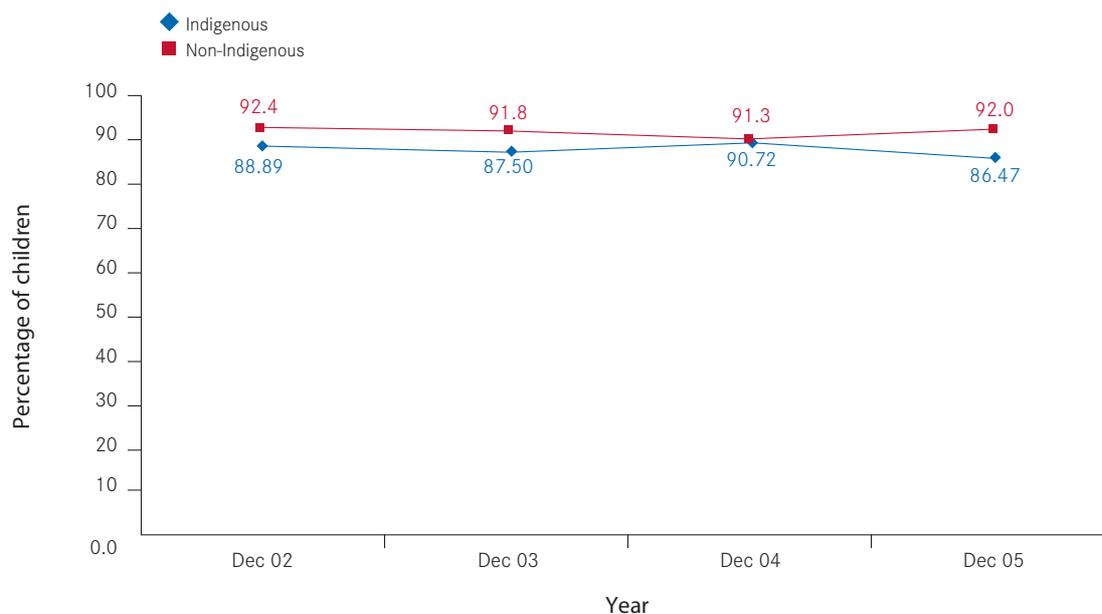
The Immunise Australia program specifies the recommended immunisation schedule for children. This program includes vaccination against diphtheria, tetanus, whooping cough, poliomyelitis, measles, mumps, rubella, haemophilias influenza type B (Hib), hepatitis B, meningococcal C and pneumococcal disease.

Immunisation against communicable diseases has been shown to reduce morbidity and mortality from a range of childhood diseases. Immunisation offers protection for individual children and also markedly reduces the rate at which these diseases circulate within the broader community. Evidence suggests that a minimum of 90 per cent vaccination coverage is required to interrupt the ongoing transmission of diseases (Australian Institute of Health and Welfare 2005).

In Victoria, the rates³⁰ of immunisation are marginally higher at all ages in rural areas than in metropolitan areas, although the percentage differences are very small.³¹

Figures 2.1.2 to 2.1.4 show the Victorian immunisation rates and trends for Indigenous and non-Indigenous infants and children at 12–15 months, 24–27 months and 72–75 months. Indigenous infants aged 12–15 months do not generally reach the 90 per cent minimum vaccination rate, and neither Indigenous nor non-Indigenous children reach the recommended minimum at 72–75 months.

Figure 2.1.2: Percentage of 12–15 month old infants fully immunised in each quarter in Victoria

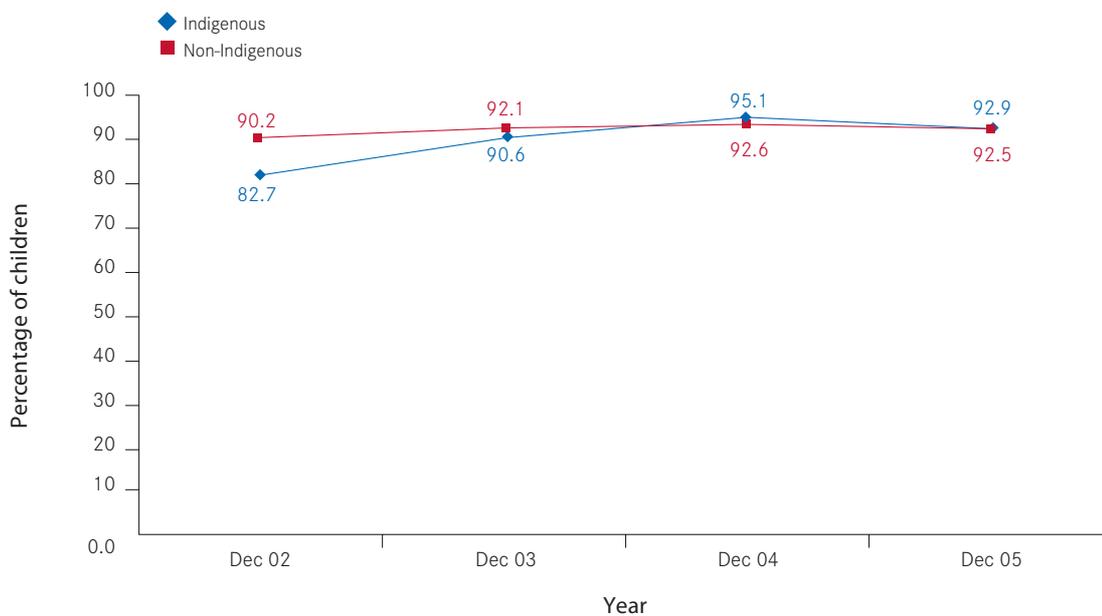


Source: Australian Childhood Immunisation Register

³⁰ The immunisation rate is expressed as the percentage of children who are fully vaccinated at one, two and six years of age.

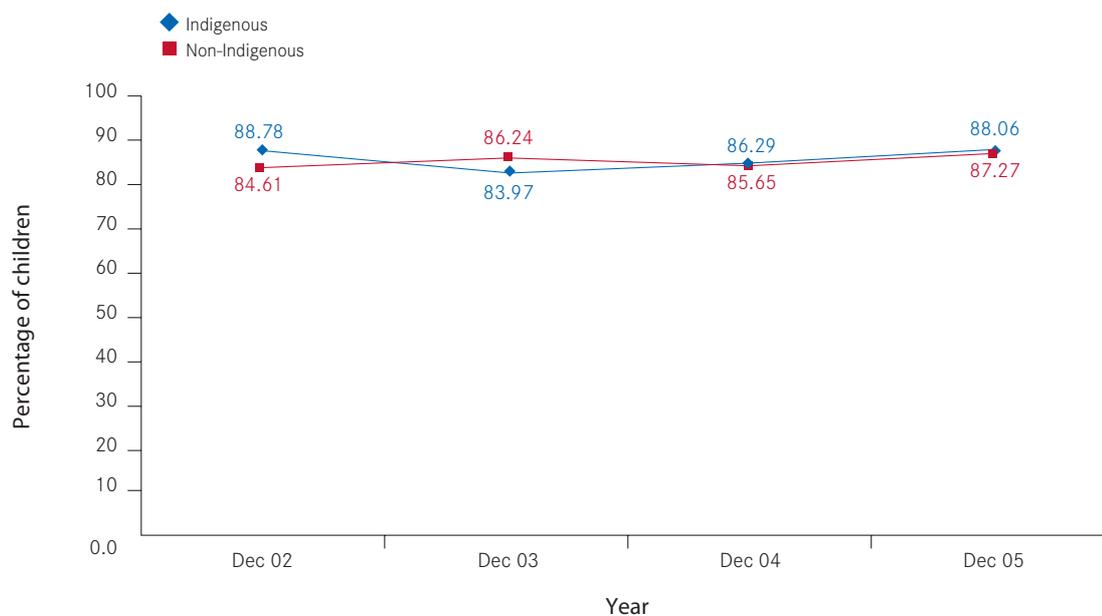
³¹ Source: Australian Childhood Immunisation Register

Figure 2.1.3: Percentage of 24–27 month old infants fully immunised in each quarter in Victoria



Source: Australian Childhood Immunisation Register

Figure 2.1.4: Percentage of 72–75 month old infants fully immunised in each quarter in Victoria



Source: Australian Childhood Immunisation Register

Outcome area: healthy teeth and gums

Associated indicators reported: decay-free dentition; decayed, missing or filled teeth; oral health behaviours

Good dental health in childhood contributes to good dental health in adulthood, with less decay and reduced loss of natural teeth. A range of preventive factors (water fluoridation, improved diet and oral hygiene, and regular brushing) contributes to child dental health.

Availability and affordability of dental health services may also influence the dental health of children (Australian Institute of Health and Welfare 2005).

The data we present here on child dental health are taken from the Victorian Child Health and Wellbeing Survey and the School Entrant Health Questionnaire.

Oral health status

Parents were asked in the Victorian Child Health and Wellbeing Survey to rate their child's oral health. Just over three-quarters of children (77.1 per cent) (aged six months to 12 years) were reported to have excellent or very good oral health; however, children living in rural areas had notably poorer oral health. As Table 2.1.5 shows, children living in rural areas were more likely than those living in metropolitan areas to have had toothache, a filling, dental treatment in hospital under general anaesthetic, or a tooth extracted because of a dental problem.

Table 2.1.5: Oral health status: children in rural and metropolitan areas

	Rural (%)	Metropolitan (%)	Victoria (%)
Child has (ever) had toothache	31.2	23.1	25.4
Child has (ever) had a filling	25.2	18.0	20.0
Child has (ever) had a tooth extracted	11.4	6.5	7.9
Child has (ever) had any dental treatment in hospital under general anaesthetic	7.2	3.1	4.2

Source: Victorian Child Health and Wellbeing Survey 2006

Oral health behaviours

The *Oral health guidelines for Victorians 2003* include the following recommendations for oral health:

- Drink plenty of tap water.
- Limit consumption and frequency of sugary drinks (milk or flavoured milks are preferable to sugary drinks).
- Teeth should be cleaned at least twice a day.
- Children should use low fluoride toothpaste from two to seven years of age.
- An adult should assist a child aged under seven years of age to brush his or her teeth.

Consumption of drinks

Most of Melbourne's water is fluoridated and most rural areas are not fluoridated. The survey found that children (aged two to 12 years) living in rural areas were much less likely to drink tap water than children living in metropolitan areas (53 per cent of children in rural areas usually drank tap water, compared with 74.8 per cent in metropolitan areas). The majority (76.7 per cent) of children aged two to 12 years drink more plain water than soft drinks.

Just over 60 per cent (60.9 per cent) of children aged one to 12 years drink more milk (including milk-based drinks and milk on cereals) than soft drinks. Not surprisingly, younger children appear to be more likely to drink more milk than older children (69.4 per cent of one to four year-olds, 58.7 per cent of five to eight year-olds, and 55.0 per cent of nine to 12 year-olds drink more milk than soft drinks).

Tooth cleaning

Seven in ten (70.4 per cent) of children (aged two to 12 years) used toothpaste twice a day or more. Older children were more likely than younger children to use toothpaste twice a day or more (56.8 per cent of two to four year-olds and 75.3 per cent of five to 12 year-olds used toothpaste twice a day or more).

Just under three-quarters (73.9 per cent) of children aged two to seven years were reported to use low fluoride toothpaste.

While the majority of parents said they actively assisted their children (under seven years of age) with toothbrushing, just under one-fifth of parents (18.2 per cent) reported they *never* did so (Table 2.1.6).

Table 2.1.6: Frequency of parental assistance with toothbrushing (for children aged six months to seven years)

	Never	Less than once a day	Once a day	Twice a day	More than twice a day	Tooth cleaning not yet started	Child does not have teeth	Total
Per cent	18.2	11.4	35	28.8	1.1	3.9	1.6	100

Source: Victorian Child Health and Wellbeing Survey 2006

Use of dental services

The survey found that children were more likely to have seen a private dentist at their last dental visit (64.1 per cent) than a dentist from the school dental service (27.1 per cent) or from other government or public dentist services³² (7.5 per cent).

Nearly one-third (30.2 per cent) of children (aged six months to 12 years) had never seen a dentist, and younger children were much more likely to have never seen a dentist than older children (71 per cent of one to four year-olds, compared with 13 per cent of five to eight year-olds and 1.3 per cent of nine to 12 year-olds).

Among children who had not seen a dentist in the last 12 months, the most common explanation for this (50.5 per cent of children) was that there was no reason to visit (for example, the child had healthy teeth and gums). The second most common reason was that the child was considered too young to need dental services (30.8 per cent). A minority of parents (4.7 per cent) identified cost as the main factor.

Indigenous children and dental services

Data from the School Entrant Health Questionnaire show that while parents of Indigenous children are more likely than parents of non-Indigenous children to have concerns about their children's teeth, Indigenous children are less likely than non-Indigenous children to have visited a dentist in the last one to two years (a total of 28.9 per cent of Indigenous parents had concerns about their children's teeth, compared with 18.5 per cent of non-Indigenous parents; 46.8 per cent of Indigenous children had visited a dentist, compared with 57.2 per cent of non-Indigenous children).

Outcome area: optimal health

Associated indicators reported: parent report of child health, asthma prevalence, parent report of asthma

Parent-report of child health

Parents (of children aged zero to 12 years) were asked in the Victorian Child Health and Wellbeing Survey to report on their children's general health.³³ Parents were asked to rate their child's general health as either 'excellent', 'very good', 'good', 'fair' or 'poor'.³⁴ The vast majority of Victorian children were described as being either in excellent (63.7 per cent) or very good health (25 per cent), and a minority of children were described as having good (9.3 per cent), fair (1.5 per cent) or poor (0.4 per cent) health (Table 2.1.7).

³² For example, a community health dental hospital

³³ In a broad sense, parents' assessments of their children's health can be regarded as a reliable indicator.

³⁴ This item has been used in child health surveys in New South Wales, Western Australia and South Australia, but there are no comparable Australian-wide data relating to parent report of child health.

Table 2.1.7: Victorian parental rating of general health of child

Rating	Total (%)
Excellent	63.7
Very good	25.0
Good	9.3
Fair	1.5
Poor	0.4
Total	100.0

Source: Victorian Child Health and Wellbeing Survey 2006

The survey found no statistically significant differences between the responses of metropolitan and rural parents about their children's general health;^{35,36} however, the health of children who had a health care card was much less likely to be rated as excellent (56.6 per cent of children who had a health care card had parents who rated their health as excellent compared with 66.4 per cent of children without a card).

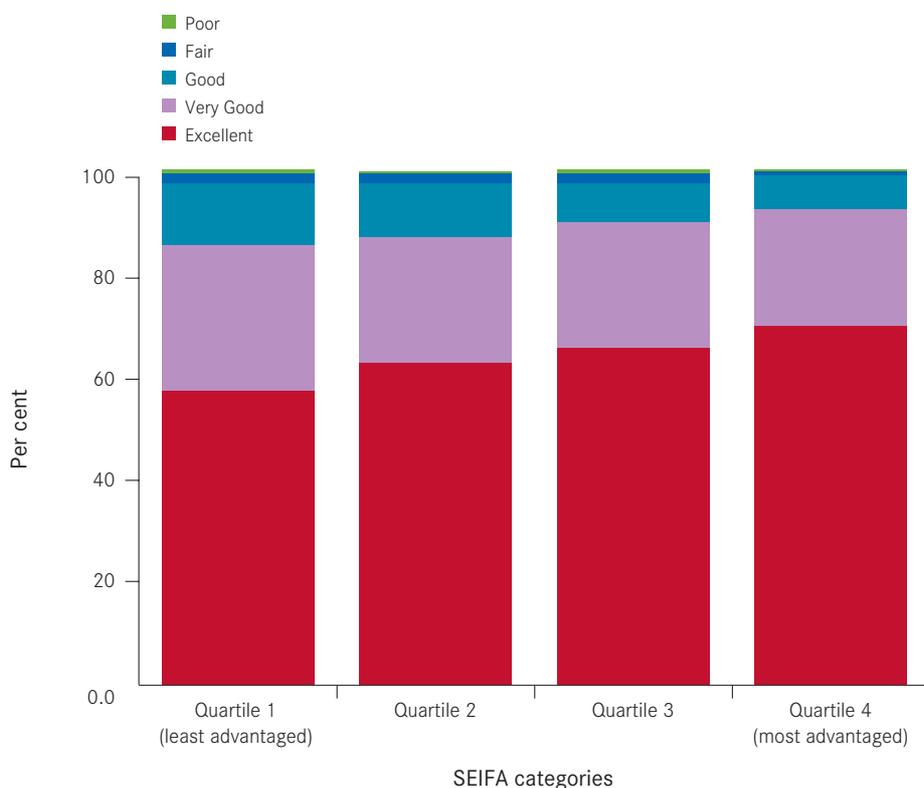
These findings are likely to reflect the importance of socioeconomic status as a key factor in influencing self-reported measures of health. The survey also found that children who were living in more socioeconomically advantaged areas were more likely than those living in disadvantaged areas to be given positive ratings of general health. This finding is represented in Figure 2.1.5 (this gives the children's general health status by Socio-Economic Indexes for Area (SEIFA) score).³⁷

³⁵ Research has shown that the health of people who live in geographically isolated areas of Australia is often poorer than that of people who live in major cities and other urban settings. Key reasons for this include the limited availability and access to health services for people in more remote areas and exposure to different health and environmental risks. The higher proportions of Indigenous people (who experience poorer health outcomes) in regional areas can also reduce the average health of the population in these areas (Australian Institute of Health and Welfare 2006).

³⁶ The Health of Young Victorians Study (HOYVS) (a school-based longitudinal study of the health and wellbeing of children and young people aged 5-18) found that children and young people in metropolitan areas were reported to have higher health and wellbeing than those in rural areas, although the differences were small.

³⁷ There are different SEIFA indexes. The index used here is the index of advantage/disadvantage. Produced by the Australian Bureau of Statistics, this is an index against which postcode areas can be scored on a continuum of advantage to disadvantage. While low values indicate areas of disadvantage (at the postcode level); high values indicate more advantaged areas. The SEIFA scores are based on data collected during the 2001 census.

Figure 2.1.5: General health status by SEIFA score



Source: Victorian Child Health and Wellbeing Survey 2006

Reports of child health from Indigenous parents

The total number of Victorian Child Health and Wellbeing Survey respondents who identified their child as of Aboriginal or Torres Strait origin was too low to allow for reporting of general child health ratings from the Indigenous population. However, data from the School Entrant Health Questionnaire show that more non-Indigenous (than Indigenous) parents reported their child as being 'generally healthy' (92.5 per cent of non-Indigenous parents reported that their child was 'generally healthy' compared with 88.4 per cent of Indigenous parents).

Asthma

Asthma is the leading cause of disease burden among children and is one of the most common reasons for children's visits to GP's and hospital admissions.

Asthma is caused by narrowing of the small air passages (breathing tubes or bronchi) of the lungs, resulting in a reduced airflow in and out of the lungs. This leads to wheezing, coughing and difficulty in breathing.

Diagnosis of asthma in the early years of life can be problematic and classification errors may be high in data for children of less than one year. Equally, assessing trends over time for asthma can be difficult because of changes in diagnostic criteria (Eagar et al. 2005).

Estimates of the prevalence of current asthma in Australian children, which are based on self-report, range from 14 per cent to 16 per cent and a higher proportion report recent wheeze. Asthma prevalence is high, by international standards, among Australian children (Australian Institute of Health and Welfare Australian Centre for Asthma Monitoring 2005).

Asthma prevalence in Victoria

Parent-report data from the Victorian Child Health and Wellbeing Survey show that 13.2 per cent of Victorian children (aged one to 12 years) have current asthma³⁸ and 23.3 per cent of children have experienced wheezing or whistling in the chest in the last 12 months.³⁹

Visits to general practitioners and hospitals

In the past 12 months, almost three in five children with current asthma had visited a general practitioner, and almost one in five had visited a hospital, because their asthma was worse or out of control.⁴⁰

Asthma management

Just over six in ten (62.6 per cent) of children with current asthma were reported to have an asthma action plan (written instructions of what to do if their asthma is worse or out of control).

Indigenous children and asthma

Parent-report data from the School Entrant Health Questionnaire suggest that parents of Indigenous children are more likely to report their child has asthma than parents of non-Indigenous children (26.5 per cent of Indigenous parents reported their child had asthma, compared with 20 per cent of non-Indigenous parents).

Victorian Child Health and Wellbeing Survey data related to special health care needs are presented together with Australian Bureau of Statistics data on the prevalence of childhood disability in Part 1 (Victoria's children).

Outcome area: [adequate nutrition](#)

Associated indicators reported: breastfeeding at three and six months; adequate availability of food; a balanced diet

Breastfeeding at three and six months

Breastfeeding has a range of positive effects on the survival, development and growth of babies. The mother's antibodies that are present in breast milk can protect a baby from disease while its own immune system is developing, and breastfeeding protects babies from many acute conditions and chronic diseases (Australian Institute of Health and Welfare 2005).

The Australian National Health and Medical Research Council recommends that infants are exclusively breastfed for the first six months of life (National Health and Medical Research Council 2003).

³⁸ Children with 'current asthma' are children who have been told by a doctor that they have asthma and have had symptoms of and/or have taken medication for asthma in the last 12 months.

³⁹ Boys and children living in rural areas are slightly more likely to have asthma, although the differences are not statistically significant (13.7 per cent of boys have asthma, compared with 12.7 per cent of girls; 14.6 per cent of rural children have asthma, compared with 12.7 per cent of metropolitan children).

⁴⁰ Some of these children made multiple visits to general practitioners or to hospitals.

Exclusively breastfed infants receive only breast milk (plus medication or vitamins as required).

Fully breastfed infants are defined as those who receive breast milk as their main source of nourishment. The definition includes infants who are exclusively breastfed (as defined above) and those who are predominantly breastfed (receiving breast milk and other fluids (for example, water) but no infant formula or solids).

Our findings, reported below, are based on three sources: data from the 2001 Australian Bureau of Statistics National Health Survey, data collected by the Victorian Maternal and Child Health Service, and the Victorian Child Health and Wellbeing Survey.

Breastfeeding in Australia

In Australia, the 2001 Australian Bureau of Statistics National Health Survey found that 87 per cent of infants aged zero to three years had been breastfed to some extent, with or without milk or milk substitutes; however, just over half (54 per cent) of the babies were fully breastfed at three months of age or less, and 32 per cent of babies were fully breastfed at six months of age or less (data reported in Australian Institute of Health and Welfare 2006, p. 14). These national figures appear to be very broadly similar to those available from Victoria (see later); however, considerable caution should be used when making comparisons between all three data sets (both national and Victorian).⁴¹

Breastfeeding in Victoria

Table 2.1.8 is based on the Victorian Maternal and Child Health Service data. The table shows the percentages of infants fully breastfed at three and at six months of age, by year, over a five-year period (2000–01 to 2004–05). At three months, around half of infants are still breastfed. By six months, this proportion is reduced to 40 per cent or less.

This table also shows a declining overall trend in breastfeeding across the five-year period.

Table 2.1.8: Percentage of women fully breastfeeding in Victoria: 2000–01 to 2004–05

	Infants fully breastfed at three months of age	Infants fully breastfed at six months of age
2000–01	53.1	40.1
2001–02	52.0	38.8
2002–03	50.6	37.9
2003–04	50.5	38.2
2004–05	48.5	37.0

Source: Victorian Maternal and Child Health Service data

The Victorian Child Health and Wellbeing Survey collected data from women about the feeding of their infants, including the proportion of women who reported ever breastfeeding and the proportions who reported full and exclusive breastfeeding.

A very high percentage (90.6 per cent) of all children aged under four years had been breastfed at some point.

⁴¹ Survey methods (such as those used in the Australian Bureau of Statistics National Health Survey and the Victorian Child Health and Wellbeing Survey) rely on respondents' recall of their breastfeeding behaviour. Data from the Victorian Maternal and Child Health Services relate to information collected from women who are attending the service.

Table 2.1.9 shows that nearly six in ten children (aged under two years) (57.9 per cent) are fully breastfed up to three months; however, the proportion of children who are fully breastfed at six months is more than halved (to 26.6 per cent).

Nearly half (48.3 per cent) of infants under two years are exclusively breastfed up to three months and the proportion who are exclusively breastfed up to six months is reduced by two-thirds (to 15.3 per cent).

Table 2.1.9: Percentage of children who are fully and exclusively breastfed up to three and six months

	Up to three months (%)	Up to six months (%)
Full breastfeeding	57.9	26.6
Exclusive breastfeeding	48.3	15.3

Source: Victorian Child Health and Wellbeing Survey 2006

Adequate availability of food

As part of the Victorian Child Health and Wellbeing Survey parents were asked whether there had been times in the last 12 months when they had run out of food and could not afford to buy more. Nearly 6 per cent (5.8 per cent) of children came from families where this was the case. Further details of these data are given in section 3.1 (the family).

A balanced diet

The survey also asked parents a series of questions about their child's nutrition. Key findings from these questions are included with the discussion of overweight and obesity in the following sub-section (healthy lifestyles).

Staying healthy: summary of key findings

- Indigenous infants in Victoria do not generally reach the minimum recommended level (90 per cent) of vaccination coverage at 12-15 months. Neither Indigenous nor non-Indigenous children reach the minimum level at 72-75 months.
- Children living in rural areas have poorer oral health than children living in metropolitan areas.
- Nearly one-third of children (aged six months to 12 years) had never seen a dentist (Victorian Child Health and Wellbeing Survey).
- Of Victorian children aged one to 12 years, 13.2 per cent have asthma.
- Parents of Indigenous children responding to the School Entrant Health Questionnaire were more likely (than parents of non-Indigenous children) to report that their child has asthma and less likely to describe their child as 'generally healthy'.
- Victorian parents rate the general health of their children very highly in the Victorian Child Health and Wellbeing Survey.
- Children living in more disadvantaged areas are less likely to be rated as being in excellent health by their parents (Victorian Child Health and Wellbeing Survey).
- Nearly six in ten children had been fully breastfed up to three months. The proportion that was fully breastfed at six months is almost half of this (Victorian Child Health and Wellbeing Survey).

Healthy lifestyles

Outcome area: **healthy weight**

Associated indicators reported: children overweight; children obese

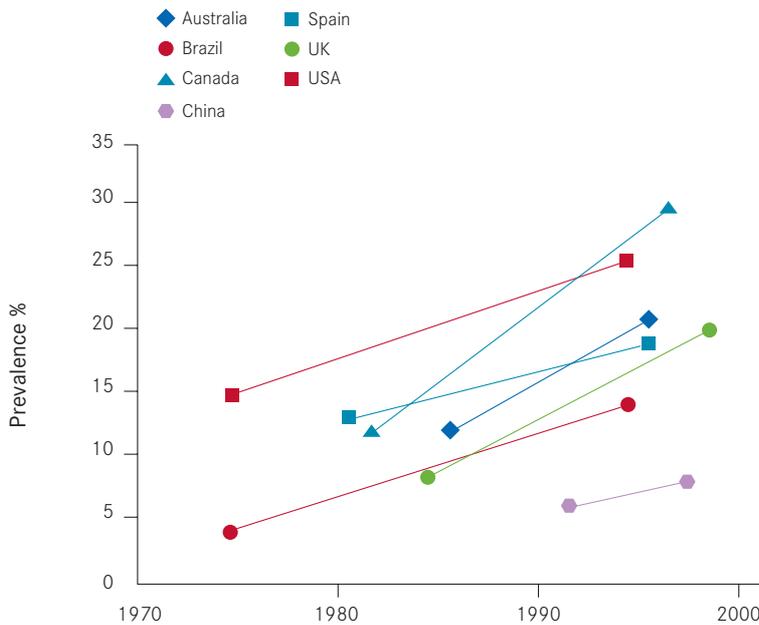
Outcome area: **adequate exercise and physical activity**

Associated indicator reported: level of physical activity

Childhood overweight and obesity in Australia⁴²

In Australia between 1985 and 1997, childhood overweight doubled and obesity trebled among children and young people aged seven to 15 years (Booth et al. 2003). Figure 2.1.6 illustrates rates of increase in overweight children internationally from the 1970s through to the late 1990s. This shows that although Australia does not have the highest rate of overweight children, its rate of increase is one of the steepest.⁴³

Figure 2.1.6: International trends in the prevalence of overweight, 1970–2000



Source: Lobstein et al. 2004, p. 18

⁴² Overweight and obesity are measured using BMI (body mass index). Children are classified as being overweight or obese if their BMI is greater than the cut-off point for their age.

⁴³ Recent research has shown that rates of prevalence of overweight children are increasing faster in Australia, than in the UK and the USA. Using extant nationally representative data, from seven countries, from 1971 to the present, the research has also shown that Australia is the only country where overweight has increased more among children than among adults (Popkin et al, unpublished).

Childhood overweight and obesity in Victoria

The evidence base for the burdens of overweight and obesity, while incomplete, also paints a picture of a very large and increasing problem of overweight and obesity for Victorian children. Indeed, overweight and obesity's high prevalence, multiple physical and psychosocial consequences (Lobstein et al. 2004) and long term persistence into adulthood (Margarey et al. 2003) mean that overweight and obesity are probably the single biggest threat to the health of Victorian children.

The diseases that obesity contributes to in adulthood are well documented and very expensive, particularly diabetes, cardiovascular diseases and musculoskeletal problems such as arthritis and chronic back pain (World Health Organization 2000). The Victorian Burden of Disease study (2005) has identified that overweight, low physical activity and low fruit and vegetable consumption together contribute 15.4 per cent to the 'risk factor burden' in the state (Department of Human Services 2005a).⁴⁴ Childhood overweight and obesity have a high risk of tracking into adulthood (Margarey et al. 2003). Obese children also carry greater immediate physical and psychosocial burdens, including significantly reduced health-related quality of life in the physical and social (rather than emotional and school) domains of functioning (Williams et al. 2005).

Prevalence

Information on the prevalence of childhood obesity over time is available from national nutrition surveys from 1985 and 1995. Since then Victoria has had to rely on small or regional surveys and information from the Longitudinal Study of Australian Children.

Preschool

Recent information about the prevalence of overweight and obesity in preschoolers is available from the first wave of Longitudinal Study of Australian Children data. These data are based on a nationally representative sample of four to five year-olds, including 1,200 from Victoria. Just over one in six (17.3 per cent) of the Victorian children were overweight and around one in 17 (5.7 per cent) were obese. Victorian preschoolers are slightly more likely than preschoolers from the whole Australian sample to be overweight or obese (23 per cent of Victorian children compared with 20.7 per cent in Australia).⁴⁵

Middle childhood

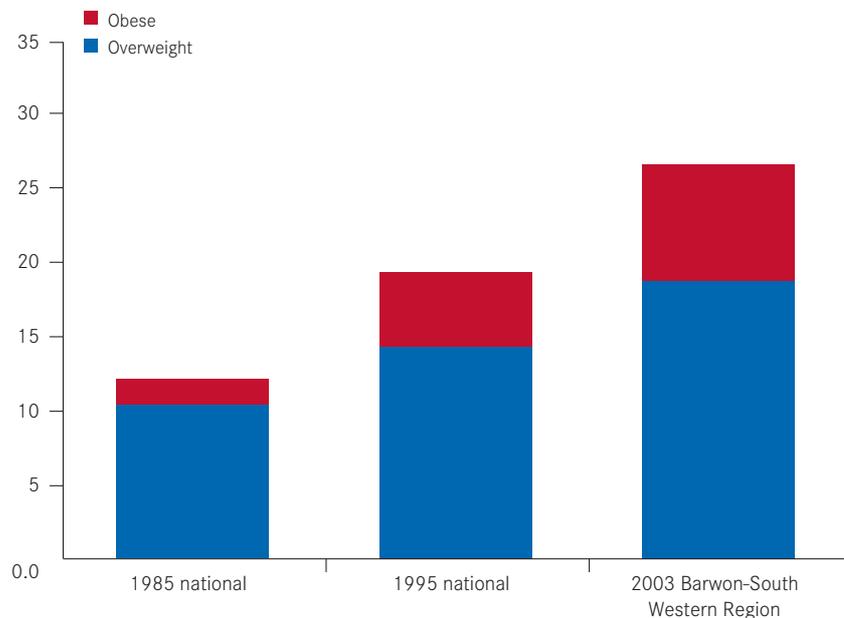
Figure 2.1.7 is based on comparable data for seven to 11 year-olds from the 1985 and 1995 national surveys (Margarey et al. 2003) and a 2003 survey from the Barwon–South West Region of Victoria (Sanigorski, in press).⁴⁶ The figure shows an increase in prevalence of overweight and obesity of about 1 per cent a year. This increase in prevalence means that approximately 10,000 Victorian children are entering the overweight or obese categories every year.

⁴⁴ In order to develop strategies to improve population health and allocate resources it is important to know the disease and injury burden for specific conditions and the burden associated with underlying risk factors that cause disease and injuries. The risk factor burden is a measure of the burden associated with these underlying risk factors (Department of Human Services 2005a).

⁴⁵ Victoria's prevalence was exceeded only by that of Tasmania (29.4 per cent) and was greater than that of South Australia (22.3 per cent), New South Wales (20.6 per cent), Northern Territory (19.4 per cent), Western Australia (19 per cent), Queensland (17.9 per cent) and the Australian Capital Territory (13.2 per cent) (Longitudinal Study of Australian Children data).

⁴⁶ A more recent survey from inner urban Melbourne (Gibbs, unpublished) shows that, for this multicultural community, the prevalence is even higher than for the Barwon–South West region (about 31 per cent versus 27 per cent).

Figure 2.1.7: Prevalence of overweight and obesity in seven to 11 year-olds: 1985–2003



Source: Data derived from Margarey et al. 2003 & Sanigorski, in press

Teenagers

Statewide Victorian data are not available for adolescents.

How can we explain the increasing prevalence of overweight and obesity?

The increasing prevalence of overweight and obesity is linked to changes in children's dietary intake, together with a shift towards more sedentary lifestyles with lower levels of physical activity.

Changes in children's dietary intake

The dominant pattern of change in Australian children's diet has been the increased consumption of energy-dense foods and drinks (that is, processed foods and snacks high in fat and sugar). Between the national surveys of 1985 and 1995, the total daily weight of food eaten by children did not change, whereas the energy density (and therefore total energy intake) increased by about 13 per cent (Cook et al. 2001).

Today's children live in an environment characterised by abundant 'obesogenic' foods. Of particular concern to the obesity epidemic are foods that are high in simple sugars (particularly sucrose and fructose), processed starch (particularly white flour) and fats (particularly saturated and trans fats). They are convenient and pleasurable to eat, may have addictive properties, and—with a substantial margin for profit—are heavily marketed.

Healthier foods (such as fruit and vegetables, fish, low fat meats, nuts and legumes) and drinks (such as low fat milk) are widely available in Victoria; however, these may be a less attractive option because of shorter shelf life, market vagary,⁴⁸ preparation requirements, lower immediate palatability of some foods, and less heavy marketing.

⁴⁸ Seasonal variation in availability, price and quality

The Australian National Health and Medical Research Council minimum guidelines for the recommended intake of serves of fruit and vegetables are given by age as follows: four to seven year-olds (one fruit, two vegetables), eight to 11 year-olds (one fruit, three vegetables), and 12 to 18 year-olds (three fruit, three vegetables).

National Health and Medical Research Council 2003

A balanced diet

The Victorian Child Health and Wellbeing Survey also identified some areas of concern for children's nutrition. For example, while nearly 90 per cent of children aged four to 12 years are meeting the minimum National Health and Medical Research Council daily recommended intake for fruit, only 38.6 per cent meet the minimum daily recommended intake for vegetables. The majority of children (aged 1-12 years) eat fries one to three times a week and 8 per cent eat fries more than three times a week. More than 10 per cent eat takeaway meals more than five times a month and just under one-quarter (23.3 per cent) of Victorian children (aged two to 12 years) drink more soft drink each day than water. While consumption of whole milk decreases with age, most nine to 12 year-olds still drink whole milk, rather than the recommended and freely available low fat variety.

Levels of physical activity

The Victorian Child Health and Wellbeing Survey shows that a high proportion (71 per cent) of Victorian children (aged five to 12 years) are meeting the recommended activity levels of at least one hour a day, although this is lower in girls and in older children. In New South Wales, the participation in sports and active pastimes seems to have increased since 1997 and this has been verified by increased physical fitness (Booth 2006); however, it is unclear whether the same trend is occurring in Victoria. A large proportion of Victorian children who live within two kilometres of school get driven there some (39 per cent) or all (37 per cent) of the time (Victorian Child Health and Wellbeing Survey 2006).

Are some groups of children more likely to be overweight or obese?

Children with a disability

Obesity can result in disability and disability can result in obesity (through barriers to exercise and ability to ingest nutritious foods and through changes in body composition and metabolism). There are no Victorian or Australian data specifically relating disability to overweight and obesity or nutrition; however, the 13.6 per cent of children participating in the Longitudinal Study of Australian Children reported to have special health care needs (which may be related to disability) had roughly the same prevalence of overweight, but twice the prevalence of obesity, as children without special health care needs.⁴⁹

Indigenous children

Minimal data are available for nutrition and obesity in Indigenous Victorian children.⁵⁰ In a large 2003 study involving 1,250 Aboriginal and 1,016 non-Aboriginal children attending 37 primary schools in New South Wales, the prevalence of obesity was similar in the two groups (Haysom et al. 2006).

⁴⁹ Although children with special health care needs ate slightly more vegetables and fruit, their intake of high sugar drinks and high sugar and fat foods was also higher. They were also breastfed on average for a shorter time than the children without special health care needs.

⁵⁰ Indigenous status was a risk factor for overweight and obesity in the preschoolers participating in the Longitudinal Study of Australian Children, but only 13 Indigenous children resided in Victoria.

Children from culturally and linguistically diverse backgrounds

According to the Longitudinal Study of Australian Children, preschoolers from a culturally and linguistically diverse background are 1.5 times more likely to be obese than preschoolers who are not from a culturally and linguistically diverse background.⁵¹ Fewer of the Longitudinal Study of Australian Children preschool-age children from a culturally and linguistically diverse background met the National Health and Medical Research Council guidelines for vegetable intake, although they drank fewer sweet drinks and ate less high sugar and high fat foods than the children who were not from a culturally and linguistically diverse background.

Chronic disadvantage

Chronic disadvantage has long been associated with overweight and obesity in adults, particularly women. This pattern is also seen in recent Australian studies of children (Booth 2006, Burke 2005, O'Dea 2003, Sanigorski, in press, Vaska & Volkmer 2004), although some older studies did not find such consistent relationships (Booth et al. 2001)^{52,53} The overwhelming finding from all studies is that childhood overweight and obesity prevalence rates are high right across the social gradient with the suggestion that the inequalities across the socioeconomic gradient are becoming more apparent with time.

Outcome area: [healthy teenage lifestyle](#)

Associated indicators reported: regular cigarette smoking, alcohol use, illicit drug use, adolescent mortality, births to teenage mothers

The greatest burden of disease for Victorian young people results from psychosocial problems, including mental disorders, tobacco, alcohol and other substance use, accidents and injury, sexually transmitted diseases and unwanted pregnancies (World Health Organization 2002; Mathers et al. 1999).

Victorian data relating to this outcome area are available from the Department of Human Services-commissioned study, *Improving the lives of young Victorians in our community* (Bond et al. 2000). Undertaken by the Centre for Adolescent Health in 1999, this school-based survey of risk and protective factors provides a detailed picture of psychosocial outcomes in students in years seven, nine and 11 at the state, metropolitan, non-metropolitan, local government area and Department of Human Services regional levels.

This study shows that young people who are recognised as having one risk behaviour (for example, tobacco smoking) are more likely to experience other risk behaviours. Also, the more risk factors in young people's lives (whether in the individual, family, school or community domains) the greater the likelihood of risk behaviours, whether they be substance use, mental disorder, risk of homelessness or antisocial behaviours.

⁵¹ Unpublished data also show that Victorian children from non-English speaking backgrounds and recent migrants from Africa have a higher prevalence of overweight/obesity (Gibbs, unpublished; Renzaho, in press).

⁵² For example, combined large datasets collected in 1997 from New South Wales, Victoria and South Australia school children did not show relationships between prevalence of overweight and obesity and social disadvantage.

⁵³ Longitudinal Study of Australian Children data show that a greater proportion of 2004 preschoolers from more disadvantaged backgrounds (as indicated by SEIFA Disadvantage Index quintile and maternal education) were overweight and obese. A general gradient of increasingly poor nutrition with increasing social disadvantage was also found in both the Longitudinal Study of Australian Children and the Victorian Child Health and Wellbeing Survey.

Cigarette smoking

Smoking is now considered a disease of childhood: 90 per cent of smokers commenced smoking in adolescence. The earlier the age of smoking initiation, the greater the likelihood of continued smoking into adult life. Adults in the lowest socioeconomic group have the highest rate of smoking.⁵⁴ In adolescence, there is no evidence that smoking initiation is associated with social disadvantage; however, those from higher socioeconomic groups are more likely to stop smoking as they mature.⁵⁵

Tobacco and alcohol (see later) are the most prevalent drugs used by young people in Victoria and there is increasing prevalence of use with age (Bond et al. 2000).

The *Improving the lives of young Victorians in our community* study found that, by year 11, 37 per cent of respondents had smoked cigarettes in the last 30 days.

Alcohol and illicit drug use

The *Improving the lives of young Victorians in our community* study found that rates of recent alcohol use in young people rose from 27 per cent in year seven to 47 per cent in year nine and 67 per cent in year 11.

Marijuana use also rose with age, increasing from 3 per cent of year seven students ever having tried marijuana to 40 per cent of year 11 students. Recent marijuana use rose from 1 per cent in year seven to 16 per cent in year 11.

In this school-based sample, more young people used ecstasy (3 per cent), solvents (6 per cent), amphetamines (2 per cent), cocaine (2 per cent), tranquillisers (6 per cent) and painkillers (8 per cent) than heroin (1 per cent).

There was greater use of alcohol and tobacco in non-metropolitan regions, similar reports of marijuana use in metropolitan and non-metropolitan regions, and greater use of other illicit substances from metropolitan regions.

Priority populations

There are inadequate data to allow for understanding of how the psychosocial risk profile might differ within the four priority populations in Victoria and more research on this is needed. Indigenous Australians are known to have higher rates of substance use, sexual abuse, earlier onset of sexual intercourse, and antisocial behaviours and to be disproportionately represented in youth justice settings, although there are few Victoria-specific data.

Young people in care have a significantly greater set of risk factors that are commonly coupled with fewer protective factors, placing them at far greater risk of poor health and life outcomes, including mental disorder (see also section 2.3 (safety)). Young people from culturally and linguistically diverse backgrounds, especially refugees who have experienced family and social disruption, violence and war, and poor engagement with education, are similarly at greater risk, although there are few Australian, let alone Victorian, data.

⁵⁴ Both in Victoria and elsewhere

⁵⁵ Delayed transition out of smoking has obvious health consequences because smoking is the single largest preventable cause of premature death and disease in Victoria. Delayed transition out of other risk behaviours, such as heavy alcohol use, have equally important repercussions, with alcohol dependency being increasingly recognised in young people, with significant social and health costs.

Children with a disability constitute a more complex pattern, given the different combinations of physical and intellectual disability that can occur. Higher rates of adjustment and mental disorder are well described, as are higher rates of sexual abuse. It had been previously thought that adolescents with chronic illness (such as asthma and diabetes) were less likely to participate in health risk behaviours, such as substance use. There is little evidence to support this. Indeed, there is increasing evidence of greater rates of substance use. Commonly these risk behaviours have a higher attributable risk in this population. For example, smoking and alcohol have a far greater attributable risk in those with diabetes than in otherwise healthy young people.

Births to teenage mothers

Teenage motherhood is associated with an increased risk of poor social, economic and health outcomes; however, it is important to recognise that not all teenage conceptions are unplanned or unwanted, and many teenage parents—and children of teenage parents—report positive experiences (Quinlivan 2004).

Teenage births in Australia

The rate of teenage births in Australia has remained relatively stable over recent years; however, the most recently available comparative data show that Australia is in the middle to upper range when compared with 27 other OECD countries. Australia's rate of 18.4 births per 1,000 women aged 15–19 years compares with rates of 2.9, 4.6 and 5.5 in Korea, Japan and Switzerland respectively and, at the other end of the range, with rates of 29.8, 30.8 and 52.1 in New Zealand, the United Kingdom and the United States of America (The United Nations Children's Fund 2001).

Within Australia, there are marked differences in the rates of teenage births between more rural and metropolitan areas. For example, research in New South Wales has identified a pattern of much higher rates in regional areas and lower rates in inner Sydney (Evans 2003). These geographical differences are largely explained by the higher rates of teenage births among Indigenous women, who are also more likely to be living in rural areas.

Teenage births in Victoria

The Victorian teenage birth rates at ages 15–17 and ages 18–19 are shown in Table 2.1.10. The table shows that among the 15–17 year age group the rate of births among Indigenous teenagers is more than eight times higher than that of non-Indigenous teenagers, and among the 18–19 year age group it is almost six times higher.

Table 2.1.10: Teen births, rate per 1,000, Victoria 2003–04

	All teens	Non-Indigenous teens	Indigenous teens
15–17 years	8.4	7.8	66.9
18–19 years	35.5	34.0	192.7

Source: Victorian Perinatal Data Collection Unit and Australian Bureau of Statistics 2001

It is unclear to what extent these differences relate to differing cultural practices and to the desire of Indigenous women to have their babies at an earlier age or to what extent they relate to poverty or a lack of access to contraceptive advice or abortion services (Evans 2003).

Healthy lifestyles: summary of key findings

- The prevalence of obesity is increasing in Australia and in Victoria and poses a key health threat to children.
- Childhood overweight and obesity prevalence rates are high right across the social gradient. Recent studies suggest an association between childhood obesity and low socioeconomic status.
- Children from culturally and linguistically diverse backgrounds and children with a disability may be more likely to be obese (Longitudinal Study of Australian Children).
- Alcohol and tobacco are the most prevalent drugs among young people who use drugs and there is increasing prevalence of use with age.
- There is greater use of alcohol and tobacco in non-metropolitan regions, similar reports of marijuana use in metropolitan and non-metropolitan regions, and greater use of other illicit substances in metropolitan regions.
- The rate of births among Indigenous teenagers is more than eight times higher than that among non-Indigenous teenagers for 15–17 year-olds and almost six times higher for 18–19 year-olds.

Mental health

Outcome area: positive child behaviour and mental health

Associated indicators reported: parent concern about child behaviour and emotion at school entry, child behaviour problems and adolescent mental health, bullying, adolescent self-harm

There are a number of definitional and methodological problems associated with measuring the prevalence of emotional, behavioural and mental health problems among children and young people. The definitions of such terms are problematic because these are clearly subjective states that vary across cultures and sub-groups of children and families (Australian Institute of Health and Welfare 2005). There are also difficulties in employing service-based data to estimate prevalence because many young people who are experiencing psychological difficulties may not come to the attention of mental health services (Stanley et al. 2005).

A distinction is commonly made in the terminology, however, between *mental disorders* and *mental health problems*. Mental disorders are defined by a set of symptoms that are typically associated with an impaired capacity to work, to engage with others and to deal well with the problems and challenges of everyday life. The term 'mental health problem' is commonly used to define a level of disturbance of concern to health practitioners, but one that does not necessarily meet all of the diagnostic criteria for a mental disorder, such as depression or anorexia nervosa.

The most recent national data about the prevalence of mental health problems among the child population is derived from the 1997 National Survey of Mental Health and Wellbeing. This suggests that as many as 14 per cent (or around one in seven) children aged four to 14 years in Australia have mental health problems: 15 per cent of boys and 14 per cent of girls. The most common complaints identified in the survey are somatic complaints and delinquent behaviour (data reported in Australian Institute of Health and Welfare 2005).

Our Victorian data on this outcome area are derived from the Victorian Child Health and Wellbeing Survey, from the Victorian School Entrant Health Questionnaire and from the Department of Human Services-commissioned study, *Improving the lives of young Victorians in our community* (Bond et al. 2000).

Parent concern about child behaviour and emotion at school entry

Data from the School Entrant Health Questionnaire show that 8.9 per cent of parents reported having concerns about their child's behavioural and emotional wellbeing. The parents of Indigenous children were more likely than the parents of non-Indigenous children to report such concerns (12.8 per cent and 8.9 per cent respectively).

Child behaviour problems

The Victorian Child Health and Wellbeing Survey collected information from parents about their children's mental health and behaviour using the Strengths and Difficulties Questionnaire (Goodman 2001). This questionnaire has been widely used within Australia and has good reliability and validity.

Data were obtained about the proportion of children aged four to 12 years scoring 'normal', 'borderline' or 'of concern' on each of five domains⁵⁶ (emotional symptoms, conduct problems, hyperactive behaviour, peer relationships and pro-social behaviour).

Results from this survey suggest that one in nine (11 per cent) children in Victoria have behaviour problems that are rated either 'borderline' or 'of concern'. Children in rural areas were more likely than those in metropolitan areas to have behaviour problems that were 'of concern'.⁵⁷

Bullying

Bullying can have a serious impact on the mental health of children and young people. Research in the United Kingdom has identified the most common effects as anxiety and depression, which can lead to intermittent or long absences from school, and poor self-esteem and withdrawal, which may lead to low participation, isolation and self-harm (Office for Standards in Education 2003; Smith et al. 1999).

Victorian parents were asked in the Victorian Child Health and Wellbeing Survey whether their child (aged four to 12 years) is picked on or bullied and whether their child often fights or bullies with other children. While a small minority of parents reported that it was 'certainly true' that their child is picked on or bullied (4.7 per cent), almost a fifth reported that this was 'somewhat true' (19.1 per cent). Parents were, perhaps unsurprisingly, less likely to say their child fights or bullies other children. Only 1.8 per cent of parents said this was 'certainly true' and 8.7 per cent of parents said it was 'somewhat true'.

Adolescent mental health

Mental disorders and mental health problems in adolescence affect participation in education and the workforce, are disruptive to relationships with family and friends, may affect personality development, and in some instances lead to death as a result of suicide or drug overdose (Beautrais et al. 1996). Adolescence is also the phase of life when adult mental disorders most commonly commence for the first time. Even where recovery has occurred, disruption to education and relationships may have long-term effects. As such, adolescence is an obvious phase for investment in prevention and early intervention.

Two kinds of mental disorders are found in adolescents: childhood onset (pre-pubertal) disorders and adolescent onset (post-pubertal) disorders. Childhood onset disorders that persist into adolescence include attention deficit hyperactivity disorder (ADHD) and conduct disorder. Adolescent onset disorders include substance use and abuse (see 'healthy teenage lifestyle'), depression and anxiety, schizophrenia and psychosis, and anorexia and bulimia nervosa.

⁵⁶ Using United Kingdom cut-off points (a total score of zero to 13 is defined as 'normal', a score of 14–16 as 'borderline' and a score of 17–40 as 'of concern').

⁵⁷ Among rural children, 8.1 per cent had behavioural problems that were 'of concern'. Among metropolitan children, 4.2 per cent had behavioural problems that were 'of concern'.

Who is most at risk?

It is clear that some groups of children and young people have higher rates of mental disorder. Identifiable groups with high rates of mental disorder include children of parents with a mental disorder (Department of Human Services, with VicHealth and beyondblue 2006). Other groups include young offenders, those in protective care, those in marginal accommodation and Indigenous youth. Young offenders who have served custodial sentences have a higher mortality rate, and this is principally due to the result of drug overdoses, suicide and accidents (Coffey et al. 2003; Coffey et al. 2004).

Prevalence

Around one in 12 adolescents in Australia has been estimated to have ADHD, with the problem at least three times more common in males (Sawyer et al. 2000), and around 3 per cent of teenagers fulfil the criteria for conduct disorder. Rates of antisocial behaviour and delinquency rise in early adolescence and typically those with childhood onset conduct disorder develop greater problems in adolescence.⁵⁸

Depression and anxiety are the most important health problems of adolescent women and depression and anxiety contribute much more than ADHD to the 'burden of disease' in the state.⁵⁹ Depressive disorder affects at least 5 per cent of young women before the age of 20 years, but depressive symptoms are much more common. Disorders that begin in adolescence commonly persist into adulthood so that the early adolescent rise in female depression largely accounts for the persisting higher rates of female depression through the reproductive years (Kessler 2003).

Psychotic disorders dramatically increase in incidence in the post-pubertal years, with the increase more marked in males than females. Around 1 per cent of males and a smaller proportion of females will have had an episode of psychosis before the age of 25 years.

Eating disorders are rarely seen in children before puberty. There is a marked female predominance of these problems from early adolescence. Anorexia nervosa has a peak age of onset around 14 years. The peak of bulimia nervosa appears a year or two later. Around 1 per cent of young women have a fully-fledged episode of anorexia nervosa and around 3 per cent have a fully-fledged episode of bulimia nervosa.

Adolescent self-harm

There is a strong relationship between self-harm and suicide, and deliberate self-harm (defined as ranging from a failed suicide attempt to scratches on the wrist) is probably the best predictor of suicide. Research in the United Kingdom has found that as many as one in 17 11–15 year-olds may have attempted to harm themselves (Bywaters & Rolfe 2002), and a study of self-harmers by a major children's organisation found that most linked their self-harming behaviour to life problems, including unwanted pregnancy, being bullied at school, not getting on with parents, parental divorce, rape, bereavement and entering care (Bywaters & Rolfe 2002).

⁵⁸ This worsening of conduct disorder appears to be more prominent in boys with delinquent and antisocial friends, suggesting that advancing pubertal stage brings either a change in peer group or a greater susceptibility to peer influence. The consequences of conduct disorder in later life include offending, personality disorder, violence and abuse.

⁵⁹ See footnote 46 for information about the burdens associated with injury and disease.

Victorian data

The *Improving the lives of young Victorians in our community* study found that the prevalence of deliberate self-harm was similar for both males and females, increasing to 5 per cent in year 11 and being more prevalent in metropolitan (6 per cent) than non-metropolitan (3.5 per cent) students. Victimization was more prevalent in younger students, and greater in non-metropolitan regions (45 per cent) than in metropolitan regions (37 per cent) (Bond et al. 2000).

Suicide in children under the age of 15 years is rare. For example, there were no deaths that were attributed to suicide among children of this age in Victoria in 2004 (The Consultative Council on Paediatric Mortality and Morbidity 2005). Some of the deaths in this age group, however, may occur in ambiguous circumstances and these may be classified as accidental when they are actually suicide. Threats of suicide and experiences of bullying in children under the age of 15 years need to be taken seriously (The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2005).

Data from the Australian Bureau of Statistics show that in Victoria in 2003 508 young people aged 15–18 years were admitted to hospital as a result of self-harm injuries. This represents a rate of 1.9 per 1,000 15–18 year-olds.⁶⁰

Self-harm was also the second highest cause of injury death among 15–18 year-olds in 2003, accounting for a total of 21 deaths.

Analysis of Australian Bureau of Statistics data⁶¹ by the Victorian Injury Surveillance Unit shows that the intentional self-harm injury death rate, among 15–18 year-olds, has decreased by 23% over the decade 1994/5 – 2003/04 from an average annual death rate of 7.5 per 100,000 persons in the period 1994/7 to 5.7 per 100,000 in 2001/04 (Clapperton and Cassell 2006).

Mental health: summary of key findings

- One in nine children in Victoria (aged four to 12 years) were shown by the Victorian Child Health and Wellbeing Survey to have behaviour problems that were either 'borderline' or 'of concern'.
- Children in rural areas and boys were more likely than those in metropolitan areas to have behaviour problems that were 'of concern'.
- Depression and anxiety are the most important health problems of adolescent women. Depressive disorder affects at least 5 per cent of young women before the age of 20 years, but depressive symptoms are much more common.
- Around one in 12 adolescents in Australia has been estimated to have Attention Deficit Hyperactivity Disorder, with the problem at least three times more common in males.
- While 4.7 per cent of Victorian parents reported that it was 'certainly true' that their child is picked on or bullied, almost one-fifth reported that this was 'somewhat true' (19.1 per cent).
- In Victoria in 2003 508 young people aged 15–18 years were admitted to hospital as a result of self-harm injuries (representing a rate of 1.9 per 1,000 young people aged 15–18 years).
- Self-harm was the second highest cause of injury death among 15–18 year-olds in 2003, accounting for a total of 21 deaths. However, the intentional self-harm injury death rate, among 15–18 year-olds, has decreased (1994/5–2003/04).

⁶⁰ In 2003, the population of 15–18 year-olds in Victoria was 265,258.

⁶¹ Analysis based on Australian Bureau of Statistics Death Unit Record File (ABS-DURF) July 1994–June 2004.

2.2 Development and learning

In this section we focus on child development and learning. Both learning and development are vital for children's health and wellbeing and studies show early indicators of learning and development are powerful indicators of life-long outcomes.

Healthy child development is commonly defined in terms of four areas: social, emotional, cognitive and physical. In this section we focus on a range of outcomes that are principally concerned with children's social, emotional and cognitive development. Aspects of physical development are primarily covered in section 2.1 (health and wellbeing).

By child learning we mean the activity of obtaining knowledge, understanding and skills. Child learning also implies opportunities for interactions with others and discovery of the world, the acquisition of skills and understanding.

Children from infancy through adolescence require a supportive and nurturing environment, both in the home and in care and educational settings, for optimal development, particularly for their social and emotional development. Family issues, such as parental mental illness, drug and alcohol use, unstable care arrangements or child physical or emotional abuse can all interfere with the process of healthy development, resulting in a range of adverse affects on the child and young person. However, it is important to recognise too that not all children who are affected by adverse circumstances in their childhood go on to experience difficulties in later life, and some children, particularly those who have experienced a range of protective factors, may be less at risk.

The section is divided into three broad areas. We look first at outcomes that are concerned with key aspects of childhood development in early and middle childhood, second at outcomes that are linked particularly to cognitive development in school-based learning, and third at outcomes that measure aspects of a pro-social teenage lifestyle and teenage behaviour.

Childhood development

There is a growing body of evidence in this country and internationally that shows that early childhood development sets the trajectory for later outcomes in adult life. Research has shown that investment in the early years—in the form of preschool care and education services—can have a positive effect on longer-term outcomes. We focus on this important area in section 3.3 (services and supports).

Other indicators that we consider here under the outcome area of optimal social and emotional development are stability of out-of-home care arrangements, and social and emotional development at school entry.

Outcome area: [optimal social and emotional development](#)

Associated indicators reported: stability of out-of-home care arrangements, social and emotional development at school entry

Stability of out-of-home care arrangements

Research has highlighted that children who are in the care of local authorities have poorer life chances in general than those who are not. Young people leaving care are more likely to have lower educational attainment, to be unemployed, to experience teenage parenthood, to have mental health problems, to be homeless and to be involved in the criminal justice system (Centre for Excellence in Child and Family Welfare 2005).

Research also points to some clear differences in the experiences of those young people leaving care who achieve positive outcomes and those whose outcomes are negative. As Figure 2.2.1 shows, many of the factors that are associated with positive outcomes concern the stability of children and young people's care and education arrangements.⁶²

Figure 2.2.1: Factors associated with a positive outcome for young people leaving care

- A stable and positive experience in care experienced through at least one long-term placement
- Attendance at fewer schools
- Completion of more schooling
- Encouragement to pursue further education
- Extended emotional and financial support from foster carers and previous workers
- Contact with family while in care or re-established after care
- Access to a mentor or advocate
- Life skills preparation and the teaching of independent living skills

Source: Research findings cited in Centre for Excellence in Child and Family Welfare 2005

Stability Reforms in Victoria

The Government's child protection reforms recognise that it is in most children's best interests to grow up experiencing stable, loving relationships with their parents. The new Children, Youth and Families Act requires community and departmental services to provide families with the widest possible assistance. Where children cannot live safely at home, the focus is on supporting families so that children can safely return home, as quickly as possible. This year's State budget provided \$27.45 million over four years to provide intensive support to families where children are removed. This is on top of \$52.33 million over four years to strengthen earlier intervention services, aimed at helping families before crises occur.

Unfortunately, it is not always possible for a child to be safely reunited with their families in timeframes that meet their developmental needs. The new legislation therefore sets maximum timeframes by which Child Protection must assess parental capacity, a child's developmental needs and whether ongoing attempts at reunification are in a child's best interests. These timeframes are shorter for very young children (12 months for children under 2 and 18 months for children aged 2–7). Where Child Protection assesses that ongoing attempts at reunification are not in a child's best interests, they will plan for the child's longer-term care away from home.

These legislative reforms are supported by initiatives aimed at strengthening out-of-home care services in Victoria. This year's budget provided \$22.4 million to provide training for carers, pilot a therapeutic model of foster care and support foster carers caring for children with complex behaviors. The Family and Placement Services Sector Development Plan spells out a ten-year action plan to ensure that out-of-home care can provide high quality and stable care for children who cannot live safely at home.

⁶² Research also points to the importance of resilience in helping young people to achieve positive outcomes when leaving care. However, there is a strong relationship between the characteristics of resilient young people and the factors that lead to positive outcomes. As the Centre for Excellence in Child and Family Welfare notes, 'the factors that promote positive outcomes for young people leaving care do so because they promote resilience within the young person' (Centre for Excellence in Child and Family Welfare 2005).

Social and emotional development at school entry

The Australian Early Development Index: Building Better Communities for Children Project is gathering key information about the developmental progress of Australian children over the first five years of their life. This project aims to measure the health and development of populations of young children in order to help communities assess how well they are doing in supporting children and their families (Centre for Community Child Health & Telethon Institute for Child Health Research 2005).

During 2004 and 2005 a total of 16,756 children were surveyed across five Australian states. Nearly half of these children (8,348) were from Victoria and Victoria had eight communities represented in the project. Using a teacher-completed checklist the Australian Early Development Index measured the developmental progress of the children within five domains: language and cognitive skills, physical health and wellbeing, communication skills and general knowledge, emotional maturity and social competence.

A recent report on the Australian Early Development Index implementation in Victoria gives the findings for children in Victoria (The AEDI National Support Centre 2006). This shows that the majority of Victorian children (69.2 per cent) were 'performing well' on one or more of the domains, 21.3 per cent of children were considered 'developmentally vulnerable' on one or more domains, and 10.3 per cent were considered to be 'developmentally vulnerable' on two or more domains. (Nationally, 65.1 per cent of children were 'performing well' on one or more of the domains, 22.6 per cent of children were considered 'developmentally vulnerable' on one or more domains, and 11.0 per cent were considered to be 'developmentally vulnerable' on two or more domains).

Childhood development: summary of key findings

- Seven out of ten (69.2 per cent) of the Victorian children surveyed by the Australian Early Development Index were 'performing well' on one or more of the domains. One in five (21.3 per cent) of the children were 'developmentally vulnerable' on one or more domains. These figures compare with national figures of 65.1 per cent and 22.6 per cent respectively.

School-based learning

Children and young people learn through a range of different experiences and in a range of contexts, including the home; however, this section of the report focuses on the importance of key outcomes that are linked to school-based learning at primary and secondary school. These are 'successful in literacy and numeracy', 'children attend and enjoy school', and 'young people completing Year 12 or its educational equivalent'.

Skills in literacy and numeracy are essential in daily life and are key to further educational opportunities and employment prospects. Children who express positive views about school are more likely to have higher educational aspirations and grades and complete their schooling. Year 12 completion (or its educational equivalent) has been shown to reduce the probability of unemployment, to increase workforce participation, and to increase wages throughout life.

In *Growing Victoria Together*, the Victorian Government has established a vision for 2010 and beyond. This vision identifies ten priority areas, including high quality education and training for lifelong learning. The government has established targets to measure progress towards this aim. They are:

- The proportion of Victorian primary students achieving the national benchmark levels for reading, writing and numeracy will be at or above the national average.
- By 2010, 90 per cent of young people in Victoria will successfully complete year 12 or its educational equivalent.
- The level of participation in vocational education and training of adults aged 25–64 years will increase.

The first two of these progress measures were used to measure outcomes for children within this report. The data we present here relate to children who are in the period of compulsory schooling (from age six to 15 years or prep to year nine); however, we also discuss the range of academic and vocational pathways that young people take after they have left school. (Data relating to care and education in the preschool years are provided in section 3.3 (services and supports).

We begin by giving some brief contextual information about the school system in Victoria. This provides background material for the outcomes data to follow.

The school system in Victoria

Victoria has a total of 2,306 schools (at February 2006). The majority of these (1,606 or 69.6 per cent) are government schools, 482 (20.9 per cent) are Catholic schools and the remaining 218 (9.5 per cent) are independent (Table 2.2.1).

Table 2.2.1 Victorian schools, February 2006

	Government	Catholic	Independent	All schools
Primary	1,213	378	55	1,646
Primary–secondary	48	13	131	192
Secondary	263	84	20	367
Special	78	7	12	97
Language	4	–	–	4
Total	1,606	482	218	2,306

Source: Department of Education and Training 2006

At February 2005 a total of 829,988 students were attending Victorian schools, including 539,952 (65 per cent) in government schools.

Outcome area: [successful in literacy and numeracy](#)

Associated indicator reported: percentage of students achieving national benchmarks

Statewide tests are administered in Victoria annually to assess the numeracy and literacy standards of Victorian primary school children in years three and five, and in secondary school (in year seven).

Achievement of children in Victoria

In 2004, the proportion of Victorian students achieving the national literacy benchmarks for years three, five and seven was at or above the national average.

Table 2.2.2 presents the percentages of children in Victoria (2004) achieving the national benchmarks for reading, writing and numeracy at years three, five and seven.⁶³ As the table shows, the percentage of students who were assessed as achieving at or above the national benchmarks for reading, writing and numeracy ranged between 85.8 and 97.1 per cent.

Table 2.2.2: Percentage of children in Victoria achieving the national benchmarks for reading, writing and numeracy, years three, five and seven (2004): all schools (error margins in brackets)

	Year 3	Year 5	Year 7
Reading	90.5 (±1.9)	87.6 (±2.1)	93.1 (±0.5)
Writing	97.1 (±0.1)	93.4 (±0.7)	96.0 (±0.7)
Numeracy	96.0 (±0.5)	94.7 (±0.7)	85.8 (±0.7)

Source: Ministerial Council on Education, Employment Training and Youth Affairs 2004

Sub-populations

Tables 2.2.3 to 2.2.5 provide the percentages of children in Victoria achieving the national benchmarks by gender and language background other than English (LBOTE), for children in year three (Table 2.2.3), year five (Table 2.2.4) and year seven (Table 2.2.5).

These tables show a clear pattern, which is consistent (with a few exceptions) across all subjects and the three age stages. In summary, girls generally achieve higher than boys⁶⁴ and children with a language background other than English achieve less well than students as a whole.

Table 2.2.3: Percentage of year three children achieving the national benchmarks, by gender, and LBOTE (2004): all schools (error margins in brackets)

	All students	Boys	Girls	LBOTE students
Reading	90.5 (±1.9)	88.2 (±2.3)	92.8 (±1.6)	86.7 (±2.5)
Writing	97.1 (±0.1)	96.3 (±0.2)	98.1 (±0.1)	94.5 (±0.1)
Numeracy	96.0 (±0.5)	95.4 (±0.4)	96.6 (±0.6)	92.8 (±0.7)

Source: Ministerial Council on Education, Employment Training and Youth Affairs 2004

LBOTE = language background other than English

⁶³ The achievement percentages reported include 95 per cent confidence intervals, so, for example, where the figure given is 96.0 per cent with 0.5 per cent in brackets, this means there is a 95 per cent chance that the true percentage lies between 95.5 per cent and 96.5 per cent.

⁶⁴ A significantly higher proportion of girls than boys achieved the national benchmark for reading, writing and numeracy in years three and five in 2004. In year seven, a significantly higher proportion of girls achieved the national benchmarks for reading and writing than boys, but there was not a significant difference between the proportion of boys and girls achieving the numeracy benchmark.

Table 2.2.4: Percentage of year five children achieving the national benchmarks, by gender, and LBOTE (2004): all schools (error margins in brackets)

	All students	Boys	Girls	LBOTE students
Reading	87.6 (± 2.1)	85.3 (± 2.4)	89.9 (± 1.8)	83.1 (± 2.7)
Writing	93.4 (± 0.7)	91.1 (± 0.9)	95.9 (± 0.5)	92.3 (± 0.7)
Numeracy	94.7 (± 0.7)	94.3 (± 0.7)	95.2 (± 0.8)	92.4 (± 0.9)

Source: Ministerial Council on Education, Employment Training and Youth Affairs 2004

LBOTE = language background other than English

Table 2.2.5: Percentage of year seven children achieving the national benchmarks, by gender, and LBOTE (2004): all schools (error margins in brackets)

	All students	Boys	Girls	LBOTE students
Reading	93.1 (± 0.5)	91.5 (± 0.6)	94.8 (± 0.5)	89.8 (± 0.9)
Writing	96.0 (± 0.7)	94.2 (± 1.1)	97.9 (± 0.4)	95.7 (± 0.8)
Numeracy	85.8 (± 0.7)	86.1 (± 0.7)	85.5 (± 0.8)	82.0 (± 1.1)

Source: Ministerial Council on Education, Employment Training and Youth Affairs 2004

LBOTE = language background other than English

Figure 2.2.2 shows the percentages of Indigenous and all children meeting the national benchmarks at years three, five and seven in 2004.

Figure 2.2.2: Percentage of Indigenous students and all students in Victoria achieving benchmarks, at years three, five and seven (2004): all schools⁶⁵

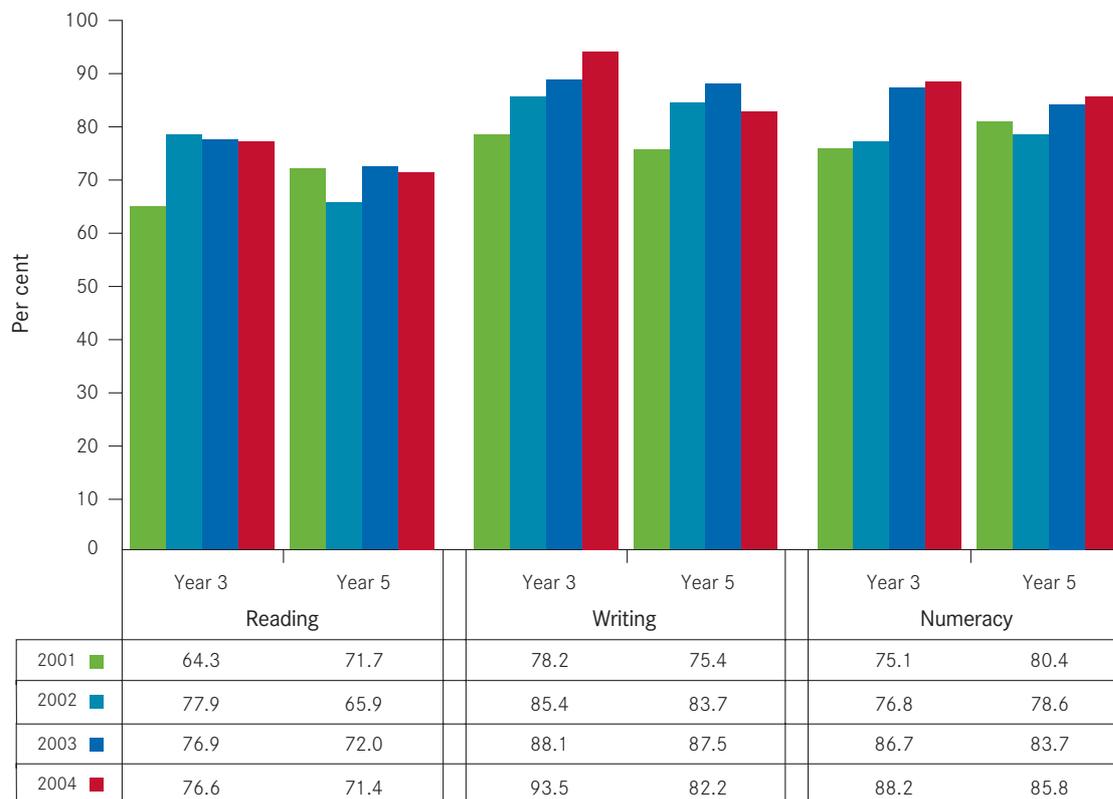


Source: Ministerial Council on Education, Employment Training and Youth Affairs 2004

The figure shows that in 2004 fewer Indigenous students, than all students, achieved reading, writing and numeracy benchmarks in years three, five and seven. While the results of Indigenous students remain behind those of non-Indigenous students, the performance of Indigenous students has generally improved since 2001. In particular, there was a significant improvement in year three reading, writing and numeracy between 2001 and 2004 (Figure 2.2.3).

⁶⁵ The achievement percentages shown in Figure 2.2.2 and Figure 2.2.3 include 95 per cent confidence intervals. For example, 80 per cent \pm 2.7 per cent means there is a 95 per cent chance the true percentage lies between 77.3 per cent and 82.7 per cent.

Figure 2.2.3: Percentage of year three and year five Indigenous students achieving the national benchmarks for reading, writing and numeracy, 2001–04



Source: Ministerial Council on Education, Employment Training and Youth Affairs, 2001; 2002; 2003; 2004.

The achievement of children and young people in out-of-home care

Comparative data on the educational achievement of children and young people in out-of-home care are available from the Department of Education and Training and the Department of Human Services.⁶⁶ The data were derived from an analysis of Curriculum Standards Framework benchmark data for a cohort of out-of-home care students (2003 and 2004) and a cohort of the general population of students (2001–04). Both cohorts comprised students in years prep to ten. Data for all students was collected at the end of each school year in December.^{67, 68}

The out-of-home care cohort displayed significant underperformance in comparison with expected levels of academic performance as determined by the Department of Education and Training standards and in comparison with the performance of the general student population; however, the performance data for the 2004 cohort of out-of-home care students were significantly better than those for the 2003 cohort.

⁶⁶ The data were gathered as part of a partnering agreement between the Department of Education and Training and the Department of Human Services ('School attendance and engagement of children and young people in out-of-home care').

⁶⁷ The analysis provided data for each key learning area on (1) proportional benchmarks (the proportions of students rated as beginning or lower, consolidating, established and better than established at the Curriculum Standards Framework level appropriate to their year) and (2) mean benchmarks.

⁶⁸ The 2004 benchmarks were developed from approximately 300,000 primary school student records and approximately 138,000 secondary college student records. For the out-of-home-care cohort the years prep to ten achievement data was collected for 1,136 students in 2003 and 1,146 students in 2004.

The performance of the out-of-home care cohort showed significant divergence from that of the general student population from year five onwards, with underperformance becoming more pronounced and the degree of difference increasing over the years.

Outcome area: children attend and enjoy school

Associated indicators reported: average rate of student attendance, connectedness to school, motivation to learn

Average rate of student attendance

Absenteeism from school is often associated with poorer educational outcomes for students; however, while absenteeism and poor learning outcomes are undoubtedly linked, it may be too simplistic to take the view that absenteeism is a cause of poor learning outcomes. As Mellor and Corrigan (2004) note, 'simply casting absenteeism as the cause of poor learning outcomes reflects a failure to consider deeper, more prescient, causes of both absenteeism and poor educational outcomes'.

Nationally, absenteeism rates are known to be higher among Indigenous children than non-Indigenous children. Mellor and Corrigan discuss how these high rates may be linked to disengagement from school and to high levels of mobility among Indigenous students and their families.

Data in Victoria on the average rate of attendance for students in government schools at years five, six, seven to ten, and 11 to 12⁶⁹ show that in 2004–05 the average rate of student attendance was 94 per cent in year five, 93 per cent in year six, and 91 per cent in years seven to ten. In secondary schools, the average rate of attendance in years 11 and 12 was 91 per cent.⁷⁰

Children and young people in out-of-home care

Recent data from the Department of Education and Training and the Department of Human Services show that children and young people in out-of-home care have higher rates of absence than the general population of students. In 2003, the average number of absent days per out-of-home care student (in years prep to ten) was 36.42 days, compared with an average in the general student population of 14.65 days. Nevertheless, the rates of absence of children and young people in out-of-home care showed a marked improvement from 2003 to 2004, dropping from an average of 36.42 days to 20.60 days.

Connectedness to school and motivation to learn

Surveys of parents, staff and students are undertaken to ascertain their view of how government schools are performing. In 2004, years five to nine students completed a questionnaire survey about their attitudes to school. The students were asked to rate their sense of connectedness to school and their motivation to learn on a five-point scale with high scores indicating high levels of connectedness⁷¹ and motivation to learn.

The overall responses of the children and young people were positive. The average 'connectedness' score for years five to nine students was 3.17. The average 'motivation to learn' score was 4.1.⁷²

⁶⁹ Source: Department of Education and Training 2004–05 annual report

⁷⁰ As these data relate to all absences (including illness, family holidays, parental choice) they do not provide a measure of 'truancy' or absence that is unauthorised.

⁷¹ The 'connectedness to school' statements provide a good measure of children and young people's enjoyment of school ('I enjoy the work I do at school'; 'I look forward to going to school'; 'Learning in my school is fun').

⁷² Source: Department of Education and Training 2004–05 annual report

Outcome area: completion of Year 12 or equivalent

As we have noted, year 12 completion is linked to improved employment outcomes. The government has set a target so that by 2010 90 per cent of young people in Victoria will have successfully completed year 12 or its educational equivalent. Every student should aim to complete year 12 or its equivalent in the vocational sector of a certificate II or above (such as an apprenticeship or traineeship) as a foundation qualification for stable and rewarding employment.

In 2004, 78.5 per cent of Victorians had completed year 12 or its equivalent or gained a qualification at Australian Qualifications Framework Level Two or above by age 19 years, and the proportion of young people achieving this outcome has shown an increasing trend since 1999. (These data relate to all students).

The target for completion of year 12 or equivalent mentioned earlier is measured nationally at age 20–24 years. This enables the capture of qualifications attained beyond school, such as apprenticeships or traineeships. This is also the target used for *Growing Victoria Together*.

Unpublished data from the Australian Bureau of Statistics Survey of Education and Work show that 85.0 per cent of Victorians aged 20–24 years had attained year 12 or a vocational certificate at the Australian Qualifications Framework Level Two or above in 2005. This has increased from 82.9 per cent in 1999 and is above the 2005 national average of 82.7 per cent.

More information about the pathways from school that young Victorian school leavers follow is available from the Victorian 'On Track' survey (Teese et al. 2005; Teese et al. 2006).⁷³

The survey found that in 2004 the rate of unemployment⁷⁴ for early school leavers was double the rate for year 12 completers. By 2005 early leavers were four and a half times more likely to be unemployed than year 12 completers.

Table 2.2.6 summarises the destinations of early school leavers and year 12 completers in 2005.

Table 2.2.6: Destinations of early leavers and Year 12 completers, 2005

	University %	VET Cert 4+ %	Entry Level VET %	Apprentice Ship %	Trainee Ship %	School Study %	Work p/t %	Work f/t %	Unemployed NLF %	Total %
Early school leavers (N = 1574)	0	4	9	34	6	2	16	12	18	100
Year 12 Completers N= 2121	34	14	5	9	7	0	16	12	4	100

Source: adapted from Table 3, in Teese et al (2006) (p.10)

⁷³ The survey follows the pathways of 30,000 Year 12 completers and 3,200 early leavers from the 2003 school year. Destination data were collected in 2004 and 2005 relating to education, training, employment and occupation. Information was also collected about the socioeconomic group of students and their Indigenous and language background other than English statuses.

⁷⁴ Or not being in the labour force

Indigenous students

Among year 12 completers surveyed in the first year of the study, Indigenous pupils were much less likely than non-Indigenous pupils to enrol in tertiary study, and they were much more likely to be employed, working as an apprentice or trainee, or unemployed (Teese et al. 2005).

Boys were more likely than girls to be early school leavers and early leaving was more common in lower socioeconomic status areas of Melbourne and throughout country Victoria;⁷⁵ however, the destinations of early leaving boys were likely to be more secure than those of early leaving girls. Early leaving boys were more likely to move into apprenticeships or full time employment.

Low achievement and disengagement from school were found to be major causes of early leaving. Early leavers who were unemployed blamed the job market (in two-thirds of cases) but also highlighted their lack of appropriate qualifications and training (59 per cent and 47 per cent respectively) (Teese et al. 2006).

Children and young people in out-of-home care

Data from the Department of Education and Training and the Department of Human Services show there is a high rate of movement of out-of-home care students to other schools in years ten and 11 (this is also true for year ten in the general student population). However, during year 12 the percentage of out-of-home care students who move to another school prior to completing the school year is significantly higher than for the general population (in 2003, 23.5 per cent of out-of-home care students moved to interstate schools and 23 per cent moved within the state, compared with 3.8 per cent and 9 per cent respectively of the general student cohort).^{76,77}

For the general student cohort moving during year 12, the primary exit destination was full time employment. Out-of-home care students were less likely to move into full time employment (11.8 per cent of out-of-home care students had a primary exit destination of full time employment in 2003, compared with 23.9 per cent of the general population).

For students completing year 12, alternative training or higher education providers were the primary exit destinations for both out-of-home care students and the general cohort.

It is of interest to note that a higher proportion of out-of-home care students moved on to university on completing year 12 than students in the general cohort (in 2003 46.6 per cent of out-of-home care students went on to Victorian universities, and 6.2 per cent went on to interstate universities, compared with 31.3 per cent and 1.25 per cent respectively of the general student population).

⁷⁵ Only one in ten early leavers in the On Track survey came from schools serving high socioeconomic status areas, whereas four in ten came from schools drawing on the two lowest socioeconomic status bands (Teese et al. 2005).

⁷⁶ The out-of-home care year 12 exit destination data was collected for 339 students in 2003. The total number in the 2003 statewide cohort is not known.

⁷⁷ The percentage of out-of-home care students who move to interstate schools is high. The reasons for this are not known and the data should be treated with caution.

School-based learning: summary of key findings

- In 2004, the proportion of Victorian students achieving the national literacy benchmarks for years three, five and seven was at or above the national average.
- Girls generally achieved higher than boys and children with a language background other than English achieved less well than students as a whole.
- Victorian children and young people score well in general on measures of 'connectedness to school' and 'motivation to learn'.
- While the results of Indigenous students remain behind those of non-Indigenous students, the performance of Indigenous students has generally improved since 2001. In particular, there was a significant improvement in year three reading, writing and numeracy between 2001 and 2004.
- Indigenous children have higher rates of absenteeism nationally than non-Indigenous children.
- In Victoria, comparative analysis of data from cohorts of students in out-of-home care and students in the general population shows that out-of-home care students achieve less well and have higher rates of absence than students in the general population.
- In 2005, 85 per cent of Victorians aged 20–24 years had attained year 12 or a vocational certificate at the Australian Qualifications Framework Level Two or above. This is above the national average of 82.7 per cent.
- Early school leaving is more common in lower socioeconomic status areas of Melbourne and throughout country Victoria.
- Comparative analysis shows that out-of-home care students in Victoria are more likely than students in the general population to move to another school prior to completing year 12. During year 12 a smaller proportion of out-of-home care students (than students in the general population) moved into full time employment. On completion of year 12 a higher proportion of out-of-home care students (than students in the general population) went on to university.

Teenage development and behaviour

Outcome area: [teenagers able to rely on supportive adults](#)

Associated indicators reported: connectedness with teachers, connectedness to school, experience of a trusted adult in life

Outcome area: [pro-social teenage lifestyle and law-abiding behaviour](#)

Associated indicators reported: leadership opportunities available to young people, school absence rates of ten to 14 year-olds

The teenage years mark an important period of transition from the relative dependence of childhood to the greater independence of young adulthood. While many young people experience an enjoyable adolescence, some who experience issues such as homelessness, substance abuse, violence and involvement in crime may require additional support (Department for Victorian Communities 2002). A continuing relationship with a significant and supportive adult—at home, at school or in the community—has been shown to be a key protective factor for teenagers who are facing other challenges in their life. Using a strength-based approach to engaging young people in local initiatives and leadership opportunities also supports their capacity to engage positively as a valued member of the community.

We have presented data on connectedness to school and on school absence rates (under the outcome area of children attend and enjoy school). Because of a lack of good data, at this stage we are not able to report on experience of a trusted adult in life or on leadership opportunities available to young people.

Young people and crime

During the course of their childhood, some children and young people become involved in criminal activities and become clients of the juvenile justice system. The majority of these children are involved in one-off, relatively minor events; however, the very small proportion of young people who engage in more serious and persistent crime may be the subjects of orders (such as community-based orders) or may have to serve sentences in juvenile detention (Australian Institute of Health and Welfare 2005).

In considering crime and young people it is important to remember, however, that:

- Most young people never commit a crime.
- Adults account for a much larger proportion of crime than young people.
- Young people are more likely than adults to be the victims of crime.

There is no single cause or precipitating factor for youth crime; however, as the Australian Institute of Health and Welfare notes (2005), risk factors (for youth crime) include family factors,⁷⁸ intelligence and school performance, truancy, the influence of peers, poverty and unemployment and substance abuse. Other risk factors include criminality in parents and siblings, child abuse and neglect and youth homelessness (Australian Institute of Health and Welfare 2005).

Juvenile justice in Australia and Victoria

The age of criminal responsibility in all Australian states and territories is ten years, meaning that ten is the youngest age at which a child may enter the criminal justice system for having committed (or allegedly committed) an offence (Australian Institute of Health and Welfare 2006). Victoria's juvenile justice legislation applies to young people aged ten to 17 years inclusive.

The juvenile justice system in Victoria has a strong emphasis on the diversion of young people away from the formal criminal justice system. This emphasis is reflected in the legislation and in the approach taken to working with young people from the initial point of contact with the police through to completion of any order imposed by the court (Department of Human Services 2006).⁷⁹

In Victoria, juvenile offenders are prosecuted under the *Children and Young Persons Act 1989*. This specifies the developmental needs of young people (as distinct from those of adults) and sets out the sentencing hierarchy and judicial processes that result in entry to the juvenile justice program (Howells et al. 2003). The key policy directions and the range of juvenile justice outcomes and services in Victoria are detailed on the next page.

⁷⁸ Family factors may include a lack of parental supervision, parental rejection, a lack of parental involvement and inconsistencies in discipline.

⁷⁹ The emphasis is also reflected in a unique sentencing option in Victoria called the 'dual track' system. Under this system an adult court can sentence a young person aged 18–20 years to a juvenile justice administered youth training centre custodial order as an alternative to a prison sentence.

Key policy directions in the Victorian juvenile justice system

The continued diversion of young people from entering or progressing through the justice system, including the legislation and the legislative age change, the provision of court advice, group conferencing, and central after-hours assessment and bail placement service

The effective management of young people to reduce offending through the provision of effective assessment processes (comprehensive client assessment and planning process - CAP), targeted and evidence-based interventions and case management systems through the implementation of the rehabilitation review, and the provision of transitional support services to reintegrate young people into the community

Continued development of approaches to address the over-representation of young Indigenous people in the justice system, including the development of the Children's Koori Court and the further development of the Koori Juvenile Justice Program and implementation of the Aboriginal Justice Agreement Phase 2 (AJA2)

Juvenile justice outcomes and services in Victoria

Pre-court/pre-sentence diversionary outcomes: informal caution/warning, formal caution, deferral of sentence; group conferencing

Does not involve juvenile justice program: dismiss the charge, fine, good behaviour bond, accountable undertaking

Involves juvenile justice program: supervised bail, community-based orders (probation, youth supervision order, youth attendance order), custodial remand, detention, supervised release on parole

Source: Australian Institute of Health and Welfare 2006

Outcome area: youth victims and perpetrators of crime

Associated indicators reported: cautions given to children and young people, children and young people in detention, children and young people on community or custodial orders

Cautions given to children and young people (aged ten to 17 years)

Cautioning is a pre-court diversion option that keeps offenders away from formal criminal processing. Our data on cautions are derived from Victoria Police crime statistics.

Cautions given are categorised into four groups: cautions given for crimes against the person,⁸⁰ cautions given for crimes against property,⁸¹ cautions given for drug-related crimes, and cautions given for other crimes.⁸²

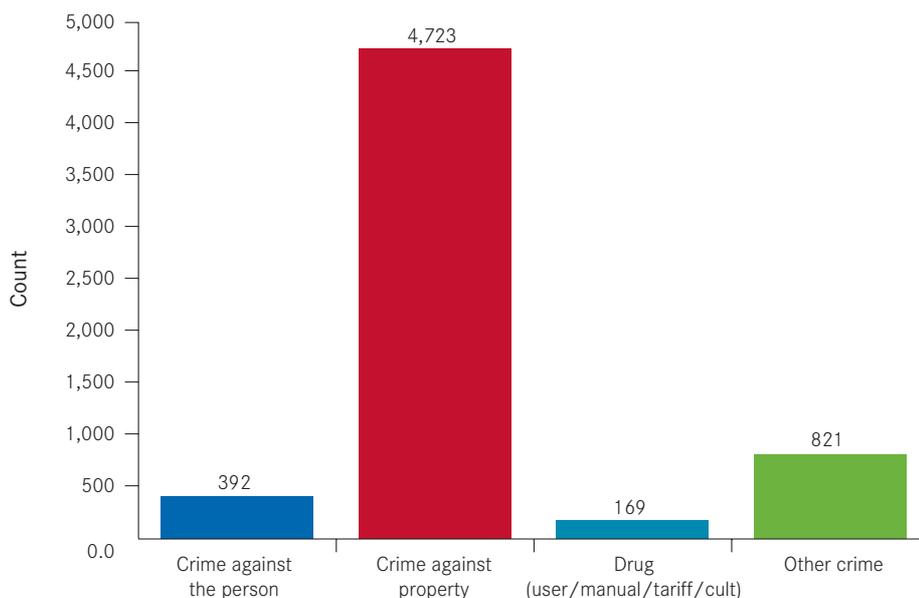
⁸⁰ Crimes against the person include homicide, rape, sex (non-rape), robbery, assault and assault or kidnap, with the largest proportion for assault.

⁸¹ Crimes against property include arson, property damage, burglary, deception and theft. Thefts make up the largest proportion of crimes against property and thefts from shops account for the largest proportion of thefts.

⁸² Other crimes include going equipped to steal, justice procedures, regulated public order, weapons/explosives, harassments, behaviour in public and 'other'.

Figure 2.2.4 shows the number of cautions given to children and young people, in Victoria, in each of the four categories.

Figure 2.2.4: Cautions given to children and young people (aged ten to 17 years), Victoria, 2004-05



Source: Victoria Police 2005

The figure shows that by far the largest numbers of cautions are for crimes against property (4,723 or 77.4 per cent). Other crimes account for the second largest group (821 or 13.4 per cent), followed by crimes against the person (392 or 6.4 per cent) and drug crimes (169 or 2.8 per cent).

Children and young people (aged ten to 17 years) in juvenile detention

Children and young people who are in juvenile detention are at particular risk of poor long-term life outcomes, including persistence into long-term offending (Australian Institute of Health and Welfare 2005).

Children and young people in detention: trends

Overall, the rates of children and young people in detention showed a declining trend across Australia from 1994 to 2004.

As Table 2.2.7 shows, rates are consistently lower in Victoria than in the rest of Australia.

Table 2.2.7: Rate⁸³ of detention of children and young people (aged ten to 17 years), Victoria and Australia, 2000–2004

	Rate of total persons in detention, Victoria	Rate of total persons in detention, Australia
2000	10.1 (52) ⁸⁴	31.3 (669)
2001	12.7 (66)	27.9 (604)
2002	10.9 (57)	25.0 (545)
2003	14.4 (76)	29.1 (640)
2004	11.7 (62)	25.5 (564)

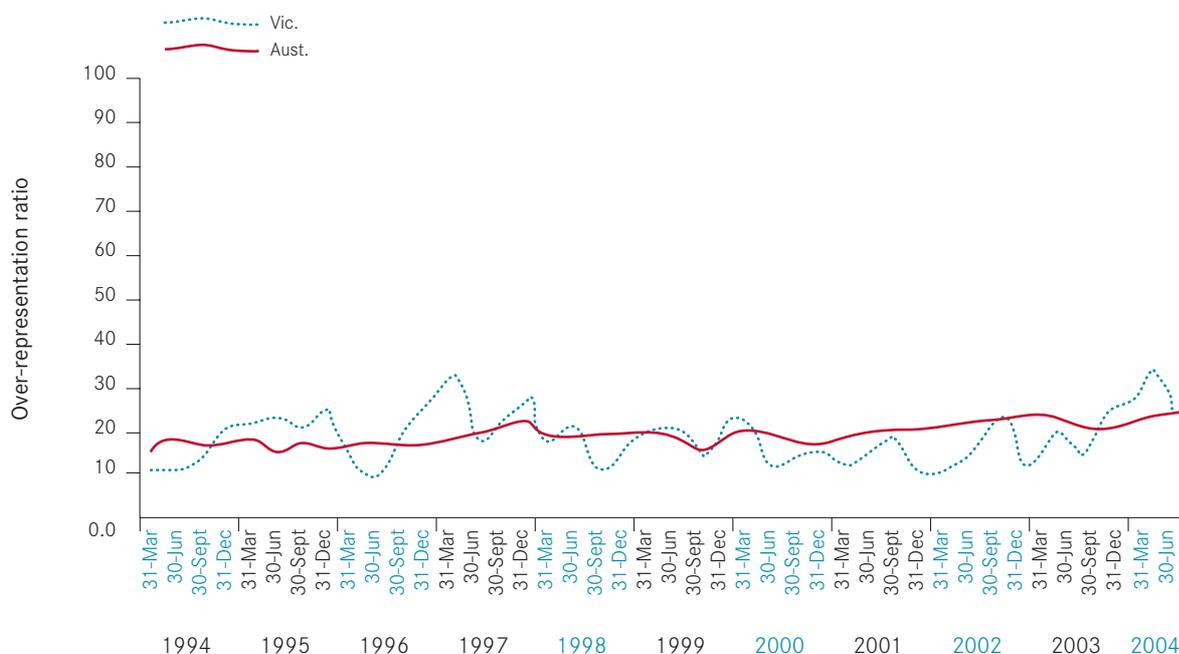
Source: Australian Institute of Criminology juveniles in detention data 1981–2004

Indigenous children and young people in juvenile detention

Indigenous children and young people are more likely to be in juvenile detention than non-Indigenous children and young people. Figure 2.2.5 shows the level of over-representation of Indigenous children and young people in detention in Australia and in Victoria from 1994 to 2004.

The figure shows that at 30 June 2004 Indigenous young people in Victoria were 20 times more likely to be detained.⁸⁵ Overall (across the entire period) the rate of over-representation of Indigenous children and young people in detention is lower in Victoria than in Australia as a whole.

Figure 2.2.5 Indigenous over-representation in juvenile detention in Victoria, 1994–2004



Source: Australian Institute of Criminology. Juveniles in detention data 1994–2004 (computer file)

⁸³ Per 100,000 relevant population

⁸⁴ Total numbers are given in brackets.

⁸⁵ In South Australia, Indigenous young people were also 20 times more likely to be detained. In Western Australia they were 52 times more likely, in New South Wales 30 times more likely, and in Queensland 23 times more likely to be detained.

Children and young people (aged ten to 19 years) on community and custodial orders

When a child or young person is convicted and formally sentenced by the Children's Court a range of sentencing options is available. We focus here on two kinds of juvenile justice orders: community-based orders and custody orders.

A community-based order requires a young person to adhere to court conditions (for example, mandatory reporting or participation in programs) while allowing them to remain with their family and other supports in the community.⁸⁶ A custody order requires a young person to serve some or all of their sentence in a juvenile justice custodial centre.⁸⁷

Tables 2.2.8 and 2.2.9 give a snapshot of the total numbers of Indigenous and of all young people on community and custody orders at 30 June from 2001–02 to 2004–05.

Table 2.2.8: Number of clients (aged 10–19) on community orders, Indigenous and all young people, at 30 June

Year	All children	Indigenous children
2002	779	83
2003	767	77
2004	699	80
2005	620	58

Source: Department of Human Services, Client Relationship Information System

Table 2.2.9: Number of clients (aged 10–19) on custody orders, Indigenous and all young people, at 30 June

Year	All children	Indigenous children
2002	139	16
2003	135	11
2004	111	17
2005	139	24

Source: Department of Human Services, Client Relationship Information System

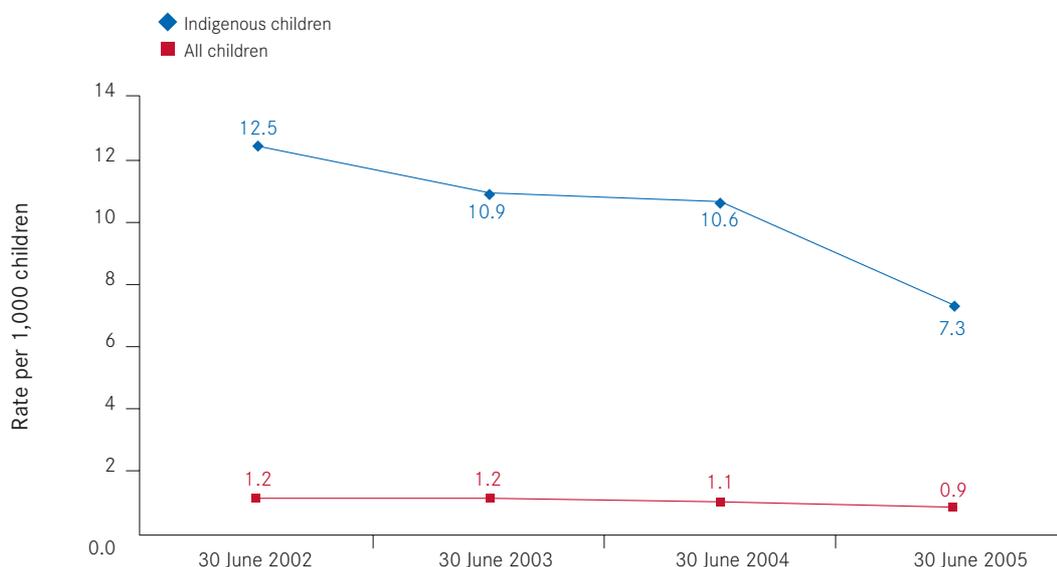
⁸⁶ There are three community-based orders: probation (the lowest level of supervised order), youth supervision orders and youth attendance orders (for young people aged 15 years or above on the day of sentencing).

⁸⁷ There are two custodial orders: youth residential orders (for young people aged ten years or more but under 15 years on the day of sentencing) and youth training centre orders (for young people aged 15 years or more but under 21 years on the day of sentencing).

Figures 2.2.6 and 2.2.7 are based on these data and show the rate of community and custody orders among Indigenous young people and all young people. Although the total numbers of Indigenous young people are small, the rate of community and custody orders is higher among Indigenous young people than it is among all young people.^{88,89}

The figures also show that while the rate of community orders has declined among Indigenous young people, the rate of custody orders has increased. In contrast to this, the rates of both types of order have remained stable among all young people across the period.

Figure 2.2.6: Rate of community orders in children aged ten to 19 years⁹⁰



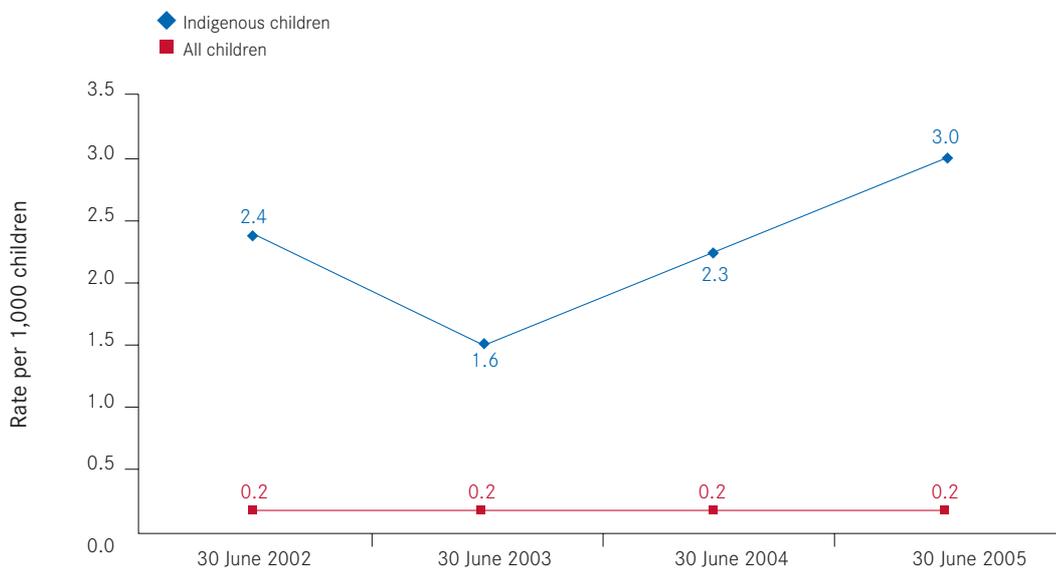
Source: Department of Human Services calculations based on data from Client Relationship Information System and Australian Bureau of Statistics 2002, 2003, 2004a, 2004b, 2005.

⁸⁸ The numbers of juvenile justice orders for all children and for Indigenous children are sourced from the Client Relationship Information System (CRIS). The number of orders is presented here as the rate per 1,000 of the relevant population. The rates are calculated using the following population bases as denominators: for Indigenous children, population data are taken from Australian Bureau of Statistics 2004a. High series estimates have been used. For all children, population data are based on the yearly estimated resident population produced by the Australian Bureau of Statistics.

⁸⁹ As noted previously, the age jurisdiction for the juvenile justice system is ten to 17 years. However, in order to fit with the Australian Bureau of Statistics 2004 publication (Australian Bureau of Statistics 2004a), which only provides estimates for five-year age groups (ten to 14 years and 15–19 years), the rates (and the corresponding numbers) presented are based on the ten to 19 year-old population.

⁹⁰ The calculations in Figure 2.2.6 and 2.2.7 use population estimates for the previous year, for example 2004 estimate used for 30 June 2005, because population estimates for the total population are published one year in arrears.

Figure 2.2.7 Rate of custody orders in children aged ten to 19 years



Source: Department of Human Services calculations based on data from Client Relationship Information System and Australian Bureau of Statistics 2002, 2003, 2004a, 2004b, 2005.

Young people and crime: summary of key findings

- Among children and young people aged ten to 17 years by far the largest numbers of cautions are for crimes against property.
- The rates of detention of children and young people aged ten to 17 years in Victoria are lower than national rates. Nevertheless, Indigenous young people in Victoria are 20 times more likely to be in detention than other children (as at 30 June 2004).
- Rates of custody and community orders are also higher among Indigenous young people.

2.3 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. However, the safety and security of children and young people can be compromised in a range of ways with a range of adverse affects.

By child safety we mean that children and young people are protected from unreasonable risk of injury or accident, harm or exploitation, and that the places and people involved in the care of children and young people do not increase these risks.

Injury and poisoning are leading causes of child and adolescent death and major causes of disability for children in Australia. Child abuse and neglect are known to have serious and adverse effects on children's present and future lives, and children who live in households where there is domestic violence can suffer serious emotional and psychological affects.

The quality of the local communities and the physical and social environment in which children and young people live can also adversely affect children and young people's health and wellbeing. They can be particularly affected, for example, by exposure to some pollutants and toxins, but also by crime and by fear of crime where their streets, schools and local neighbourhoods are perceived as unsafe.

This section on child safety is divided into two sections. In the first section (safe from injuries, harm and violence) we look at deaths and injuries to children and young people from both unintentional and intentional causes. We also focus on child abuse and on domestic violence. In the second section (safe from environmental toxins and from fear of crime) we look at issues relating to the quality of the environment (such as indoor and outdoor air quality) and at whether and to what extent parents perceive local neighbourhoods to be secure and safe.

Safe from injuries, harm and violence

Introduction

The data recording systems that are used to maintain information about injuries and deaths to children and young people commonly distinguish between injuries and deaths that are unintentional and injuries and deaths that are intentional and arise from self-harm or interpersonal violence.^{91,92}

Most injuries to children and young people are unintentional. The most prominent causes of these kinds of injuries are falls, poisoning, and road accidents, and causes tend to vary according to age, with poisoning most prominent for toddlers, falls for school-age children and road accidents for older young people.

⁹¹ Self-harm is discussed in 2.1 (health and wellbeing).

⁹² Some deaths or injuries are classified as 'other or undetermined intent'.

Childhood injuries can have significant and long-lasting effects on the development and wellbeing of the affected child, and disability or death from injury has a major impact on the child's family too; however, childhood deaths and morbidity as a result of injury are preventable and can be reduced through a range of strategies (Australian Institute of Health and Welfare 2005).⁹³

Adolescents are at increased risk of injury⁹⁴ and particularly young males. Research into injury consistently finds there is a higher rate of injury among young males than young females (Australian Institute of Health and Welfare 2003).

Outcome area: [safe from injury and harm](#)

Associated indicators reported: injury hospital emergency presentations, injury hospitalisations, injury deaths (including accidental drowning and road transport deaths)

Injury hospital emergency presentations (non-admissions)

Data from the Victorian Emergency Minimum Dataset show that in Victoria in 2003 there was a total of 68,902 injury hospital emergency presentations of zero to 18 year-olds. Six in ten (61 per cent) of these presentations were male.

The majority of these presentations (65,550 or 95.1 per cent) were for unintentional injuries. Among these, children aged zero to four years accounted for the largest proportion of presentations (28.9 per cent), followed by young people aged ten to 14 years (26.6 per cent), children aged five to nine years (22.8 per cent) and young people aged 15–18 years (21.6 per cent).

Injury hospitalisations

According to the Victorian Admitted Episodes Dataset, there was a total of 18,618 injury hospital admissions of zero to 18 year-olds in 2003. The rate (per 100,000) of admissions was also higher in males than in females, particularly in the two older age groups (ten to 14 years and 15–18 years).

Of the 18,618 injury hospital admissions, 17,328 (93.1 per cent) were for unintentional injuries.

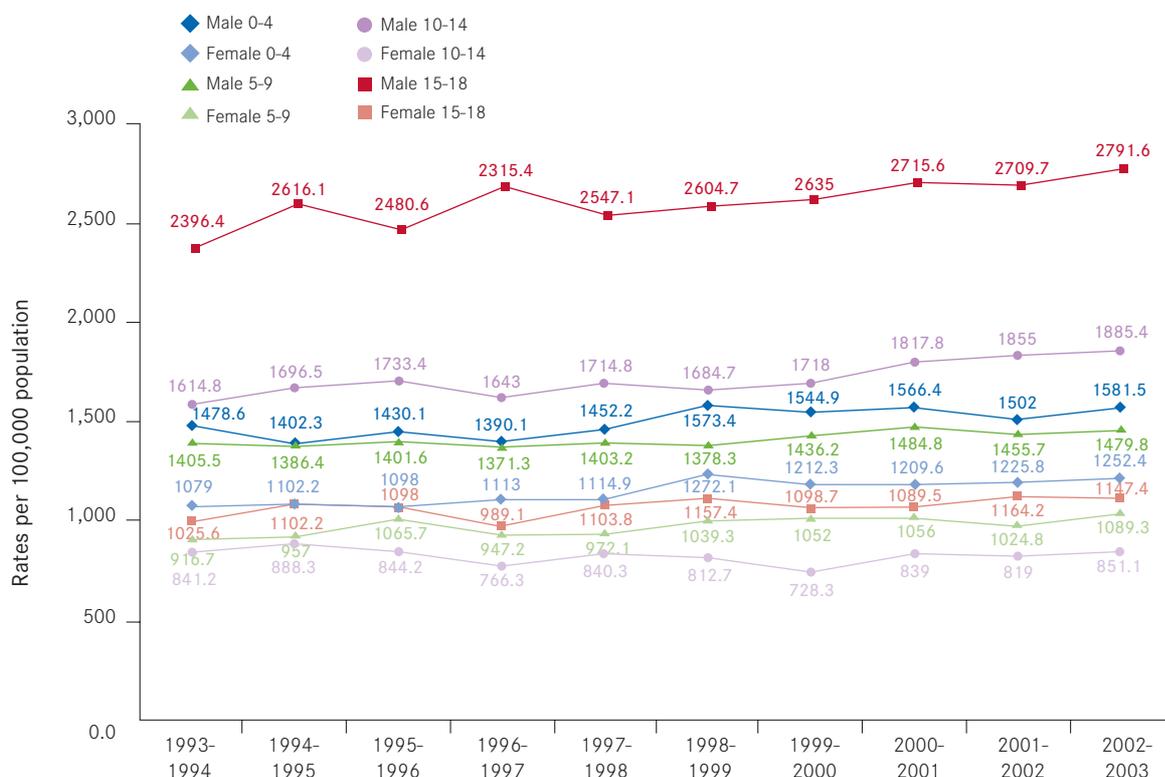
Figure 2.3.1 shows the rate of all injury hospital admissions by age and gender from 1993–94 to 2002–03. This clearly demonstrates the higher rates of admissions in males and in the two older age groups. The rate is notably higher among 15–18 year-olds and appears to show an upward trend over the ten-year period.⁹⁵

⁹³ These strategies include the use of child resistant closures to prevent poisoning, compulsory use of seatbelts in private vehicles, and pool fencing to prevent drowning.

⁹⁴ A key contributory factor to this is the increase in risk-taking behaviour at adolescence.

⁹⁵ The higher rate of admissions among the older age group is likely to reflect a pattern of more serious injuries (requiring admission) in older young people.

Figure 2.3.1: Yearly trends in children and young people's injury hospital admission rates by gender and broad age group, Victoria, 1993-94 to 2002-03



Source: Victorian Admitted Episodes Dataset, July 1993 to June 2003

Note: Excludes medical injury and late effects

Injury deaths

Data from the Australian Bureau of Statistics Death Unit Record File show there were 117 injury deaths of zero to 18 year-olds in 2003. The largest proportion of these (65 per cent) was among ten to 18 year-olds and the remainder (35 per cent) was among zero to nine year-olds.⁹⁶ Of these 117 deaths, 72.6 per cent were from unintentional causes.

The rate of injury deaths is higher among males than females in both age groups and almost double for males (than females) among ten to 18 year-olds (see Table 2.3.1).

Table 2.3.1: Crude rate⁹⁷ of injury deaths by gender and broad age group, Victoria 2003

	Males frequency	Males rate	Females frequency	Females rate	Total frequency	Total rate
0-9 years	23	7.2	18	5.9	41	6.5
10-18 years	51	16.8	25	8.6	76	12.7

Source: Australian Bureau of Statistics Death Unit Record File

⁹⁶ Two age groupings (instead of four) are used here because the number of deaths from injuries is small in comparison with the number of hospitalisations and emergency presentations.

⁹⁷ Per 100,000 population

Causes of injury⁹⁸

Injury hospital emergency presentations

Falls account for 35 per cent of all emergency presentations, followed by hitting, striking or crushing injuries (20 per cent). Other causes include cutting or piercing (8 per cent), transport accidents (5 per cent), fire, burn or scald (2 per cent), and other (29 per cent).

Hitting, striking and crushing injuries are the top cause of presentation for young people aged 15–18 years. Falls are the top cause among all other age groups.

Injury hospital admissions

Falls account for 40 per cent of all injury hospital admissions, followed by transport-related injuries (15 per cent), hitting, striking and crushing injuries (12 per cent), cutting or piercing (5 per cent), poisoning (5 per cent) and other (23 per cent).

Falls are the top cause of injury hospital admissions for all age groups.

Injury deaths⁹⁹

Transport accidents account for 46 per cent of all deaths, followed by self-harm (21 per cent), choking/suffocation (8 per cent), drowning (7 per cent), interpersonal violence (6 per cent) and other (13 per cent).

Transport accidents are the top cause of death among all age groups, accounting for 89 per cent of all injury deaths of five to nine year-olds, 48 per cent of all injury deaths of 15–18 year-olds, and 44 per cent and 31 per cent of all injury deaths of ten to 14 year-olds and zero to four year-olds respectively.

Among older young people aged ten to 14 years and 15–18 years, self-harm is the second most frequent cause of injury death. Among zero to four year-olds, the second most frequent cause is choking or suffocation.

Detailed tables describing the top five causes of injury hospital emergency presentations, injury hospital admissions, and injury deaths are in Appendix 3.

Trends in injury deaths

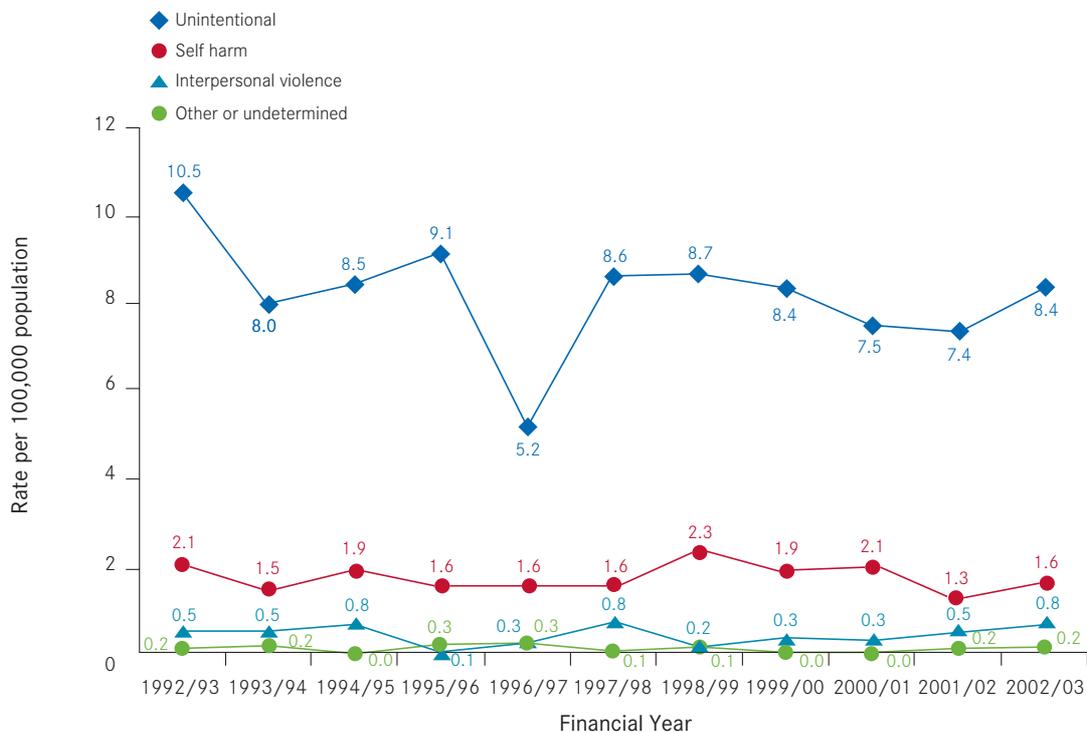
Figure 2.3.2 shows the yearly trend in injury deaths by intent from 1992–93 to 2002–03. This suggests there was a small decline in unintentional injury deaths among zero to 18 year-olds over the period.

Figure 2.3.3 highlights a more pronounced overall downward trend in the numbers of deaths of children aged zero to 15 years from unintentional injuries between 1991 and 2004. This difference in trend lines is probably related to the different age groups that are included in the data. (Figure 2.3.2 includes data relating to the zero to 18 year age group, whereas Figure 2.3.3 is based on the zero to 15 year age group).

⁹⁸ These data relate to all injuries, so while most are unintentional, injuries from self-harm, interpersonal violence and other or undetermined causes are included.

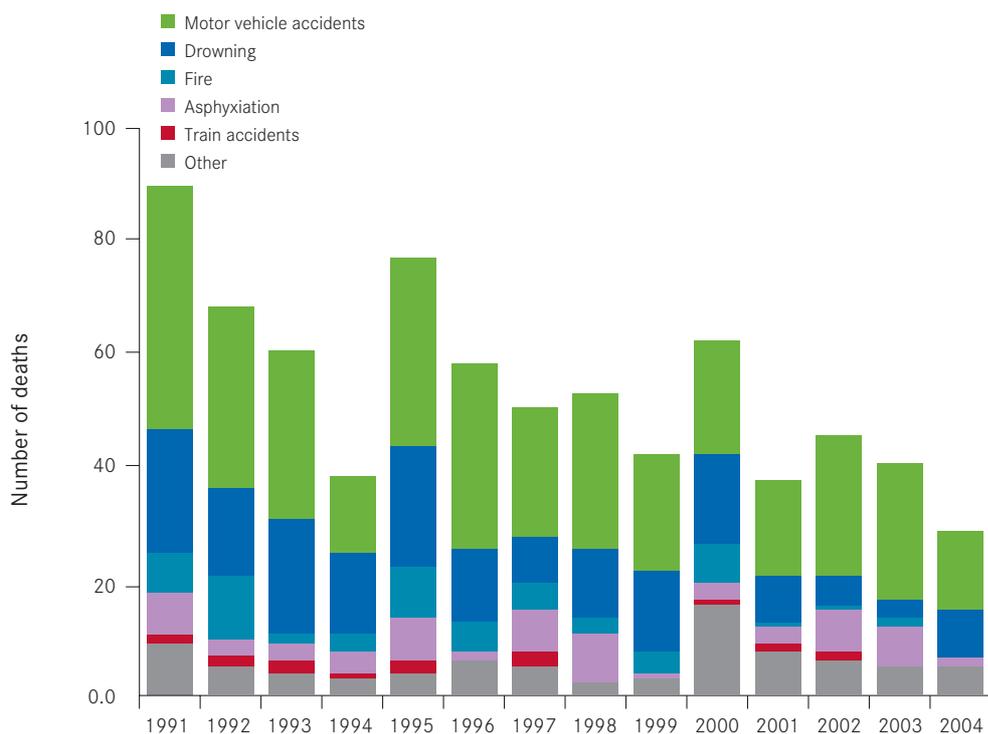
⁹⁹ The Consultative Council on Obstetric and Paediatric Mortality also publishes data on unintentional injury deaths of children and young people aged zero to 15 years. This shows that in 2004 there were 14 postneonatal and child deaths in Victoria due to motor vehicle accidents. There were also eight child deaths from drowning.

Figure 2.3.2: Yearly trends in children and young people's injury death rates by intent, Victoria, 1992-93 to 2002-03



Source: Australian Bureau of Statistics Death Unit Record File, July 1992 to June 2003
 Note: Excludes medical injury and late effects

Figure 2.3.3: Unintentional injury deaths, postneonatal infants and children, Victoria 1991-2004



Source: The Consultative Council on Obstetric and Paediatric Mortality 2005

Outcome area: free from abuse and neglect

Associated indicators reported: intentional injury death, notifications and substantiations, children on orders, children needing out-of-home care

Child abuse

Child abuse is commonly classified into groupings of physical and sexual abuse and emotional abuse and neglect; however, our understanding of what defines child abuse is culturally influenced and changes over time in response to societal attitudes and prevailing norms. In general, definitions of what constitutes child abuse have broadened over time so that some kinds of physical punishment that were once considered appropriate discipline for children may now be considered abusive (Australian Institute of Health and Welfare 2005).

The indicators we use here (intentional injury death, substantiation, re-notification, and the numbers of children on orders and in out-of-home care) offer some useful insights, individually and together, into the prevalence of child abuse as it is defined by current systems of child protection; however, child protection data apply in the main to children who have experienced severe and obvious forms of neglect. These data cannot give a full picture of the extent of abuse because some children who are experiencing abuse will not come to the attention of the child protection systems within community service departments (Australian Institute of Health and Welfare 2006).

Risk factors for child abuse

The majority of children who experience child abuse come from low income families that are affected by one or more of the following: substance abuse, mental health problems, intellectual disability and domestic violence. Poor parenting and isolation are other known risk factors for child abuse. Abuse is also more likely to occur in families where maltreatment has already occurred (Eagar et al. 2005).

Abuse and children with a disability

Children with a disability are known to be at a higher risk of abuse; however, no population-based Australian studies have ever been conducted on these children. Two United States national surveys underline the importance of this gap in Australian data. Crosse, Kaye and Ratnofsky (1995) found children with a disability were 1.7 times more likely to be maltreated and Sullivan and Knutson (2000a; 2000b) reported these children were 3.4 times more likely to be maltreated than other children.

Marginalised groups of children

Information is lacking on children on temporary protection visas who have no access to government support and on children living in detention.

Effects of child abuse

The development of children who are exposed to unsafe, abusive environments may be compromised in a range of ways. In infancy, they experience higher rates of attachment disorders, especially insecure, disorganised attachment, and developmental delay. In preschool and school they exhibit behavioural difficulties, including aggressive and hyper-reactive behaviours and conduct disorders; neuropsychological problems and poorer school performance; truanting and running away from home; and psychological difficulties, such as low self-esteem, depression, anxiety, dissociation, traumatic stress, eating disorders and social problems. Adverse health outcomes persist in the long term, and in adolescence and adulthood such children have higher rates of health risk behaviours, including unsafe sexual behaviours, harmful levels of tobacco and alcohol use and illicit drug use (Cummings & Davies 1994; Felitti et al. 1998; Kendall-Tackett 2002; Langsford et al. 2002; Edwards et al. 2003).

Intentional injury death

Children figure significantly as victims in family homicides in Australia. According to data presented at the Eighth Australian Institute of Family Studies Conference, of the 129 family homicides that occur on average in Australia each year, approximately 77 involve intimate partner homicides and 25 children are killed each year by a parent, with fathers, including stepfathers, responsible for 63 per cent of deaths (Mouzos & Rushford 2003). Data from the Australian Bureau of Statistics Death Unit Record File show there was a total of seven deaths in Victoria that were classed as 'inflicted by other' among children and young people aged zero to 18 years in 2003.

Notifications and substantiations

Reports to the Victorian Government Department of Human Services relating to concern about a child are termed child protection notifications. All notifications are assessed by the child protection services and either referred to appropriate support services (such as family support) or if appropriate, sent for child protection investigation or closed. A child protection notification is 'substantiated' where it is concluded that the child has been, is being, or is likely to be, abused, neglected or otherwise harmed (Australian Institute of Health and Welfare 2006).

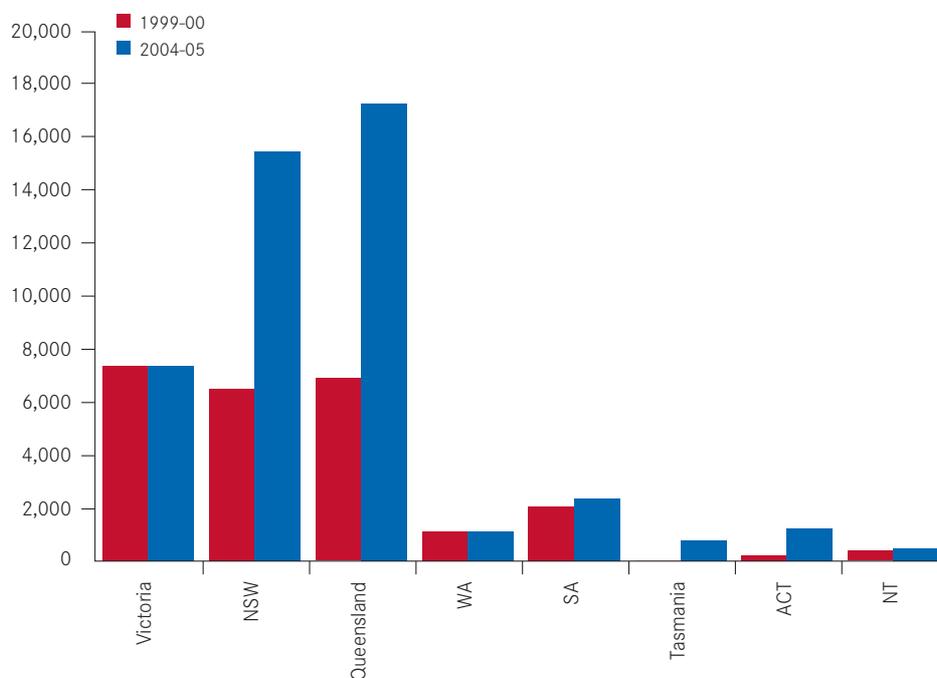
The number of child protection notifications more than doubled in Australia from 1999–2000 to 2004–05 (from 107,134 to 252,831). The number of substantiations also increased over the same period, although not by the same extent (from 24,732 to 46,154) (Australian Institute of Health and Welfare 2006). These trends may reflect some increases in the incidence of child abuse and neglect in the community or inadequate parenting causing harm to a child; however, they might be a reflection of a heightened awareness of child protection issues and policy decisions, including mandatory reporting (Australian Institute of Health and Welfare 2006).¹⁰⁰

Victoria does not show the same pattern of increases in substantiations as do many of the other states and territories (Figure 2.3.4).

Indeed, the total numbers of notifications and substantiations in Victoria have remained relatively stable (1999–2000 to 2004–05)(Table 2.3.2).

¹⁰⁰ In 1993 the Victorian Government proposed changes to the Children and Young Persons Act 1989 which would mandate specific professional groups to notify suspected cases of child abuse. In November 1993, doctors, nurses and police were mandated to report child physical and sexual abuse, and school teachers and principals were mandated in July 1994 (Australian Institute of Health and Welfare 2006, p. 71).

Figure 2.3.4: Number of child abuse substantiations by state and territory



Source: Australian Institute of Health and Welfare 2001; 2006

Table 2.3.2: Total number of notifications and substantiations in Victoria, 1999-00 to 2004-05

Year	Number of notifications	Number of substantiations
1999-00	36,805	7,359
2000-01	36,966	7,608
2001-02	37,976	7,687
2002-03	37,635	7,287
2003-04	36,956	7,412
2004-05	37,523	7,398

Source: Adapted from Tables 2.3 and 2.4 in Australian Institute of Health and Welfare 2006, p. 17 and 18

Family Support Innovations Projects in Victoria

Family Support Innovations Projects commenced in 2003 and will be expanded across the State by 2008-09. The projects aim to get earlier help to vulnerable children and families so as to avoid the need for later child protection involvement. Part of An Integrated Strategy for Child Protection and Placement Services (2002), these projects have been an important factor in the recent stabilisation of growth in demand for front-line child protection services in Victoria. This contrasts with the experience of most other Australian jurisdictions, which continue to experience strong growth in child protection demand.

The Family Support Innovation Project service approach is characterised by:

- The provision of a continuum of services tailored to meet the individual needs of the child and family
- Longer term and/or episodic support for children and families where chronic and/or complex needs are present
- Use of a child/youth centred, family focussed approach to ensure that outcomes for children/young people are at the centre of assessment, planning and intervention.

Substantiations and Indigenous children

Indigenous children are more likely than non-Indigenous children to be the subject of a substantiation in all the states and territories of Australia, with the exception of Tasmania. Victoria has the highest rate¹⁰¹ of Indigenous children who are the subject of a substantiation compared with all the states and territories (Australian Institute of Health and Welfare 2006).

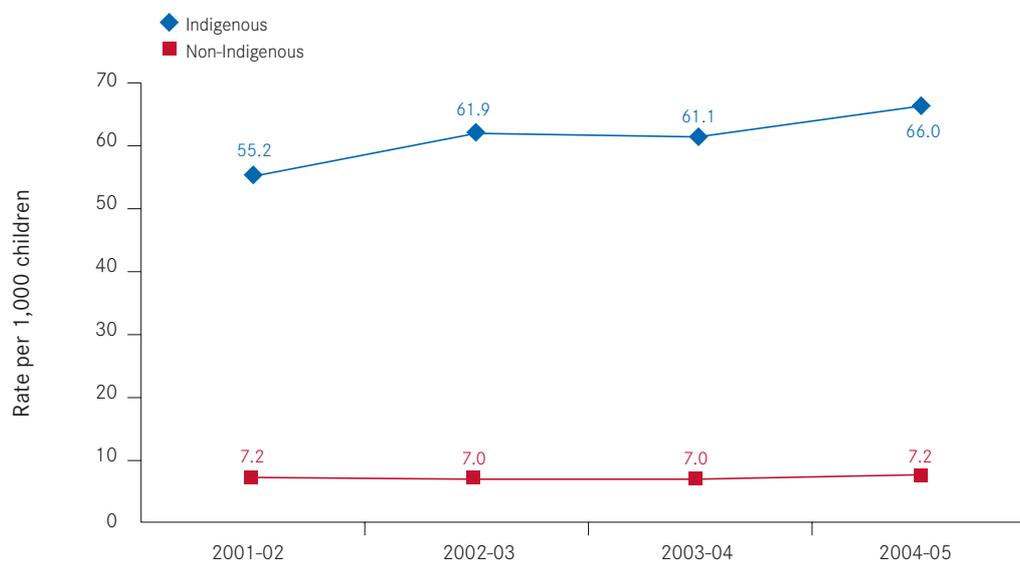
Although the rates of substantiation are much higher among Indigenous children in Victoria, it is important to note that the number of Indigenous children who are affected is small (in comparison with the number of all children). (This observation also relates to the comparative data reported later on re-notifications, children on orders and children needing out-of-home care). The relatively high rate of substantiation among Indigenous children in Victoria is a factor both of a small Indigenous child population and of work going on in Victoria to actively identify Indigenous children.

Figure 2.3.5 shows the rate of substantiations for Indigenous children and for all children (aged zero to 14 years) in Victoria over a four-year period (2001-02 to 2004-05).¹⁰² The figure shows the rate of substantiations among Indigenous children in Victoria is much higher than that among all children. The figure also shows that while the rate of substantiations among all children has remained stable, the rate of substantiations among Indigenous children appears to be increasing.

¹⁰¹ Per 1,000 children

¹⁰² The number of child protection substantiations for all children and for Indigenous children are sourced from the Department of Human Services Client and Service Information System (CASIS). The rates are calculated using the following population bases as denominators: for Indigenous children, population data are taken from Australian Bureau of Statistics 2004a. For all children, population data are based on the yearly estimated resident population produced by the Australian Bureau of Statistics (Australian Bureau of Statistics 2004b). On both occasions, the population data refer to the first year in the financial year period (for example, 2004-05 rates are calculated using the 2004 population estimates).

Figure 2.3.5: Rate of Child Protection substantiations among children aged zero to 14 years in Victoria¹⁰³



Source: Department of Human Services calculations based on data from Client and Service Information System and Australian Bureau of Statistics, 2002, 2003, 2004a, 2004b, 2005

¹⁰³ The calculations used in Figure 2.3.5 use population estimates for the first year in the financial year period, for example, 2004 estimates are used for the year 2004-05, because population estimates for the total population are published one year in arrears.

Programs aimed at reducing the over-representation of Indigenous children and families in the child protection system

Reducing the over-representation of Aboriginal children and families in the child protection system in Victoria is a major priority in the reforms of Child Protection. A number of programs have been developed and implemented in recent years to address the ongoing complex family issues that lead to the identification of Aboriginal children to child protection services. In order to provide Aboriginal families with the help that they need, the Government has provided funding to strengthen partnerships between Aboriginal organisations and mainstream child and family services and to build the capacity of Aboriginal organisations to directly deliver services to children and families.

Universal early childhood services: The participation of Aboriginal children in universal services is being promoted through the Koorie Early Childhood Education Program which supports participation in kindergarten, and innovative approaches from the Maternal and Child Health Service, for which Aboriginal children are an identified priority population group. In addition, new initiatives include Aboriginal Best Start projects, the Aboriginal In Home Support program and Koori Maternity Services. These initiatives are available to all families with young children in these areas and aim to improve the health, development, learning and wellbeing outcomes for children by improving access to culturally appropriate services, strengthening parenting capacity and building social connectedness.

Earlier intervention and prevention: More specialist support, to provide earlier intervention when families encounter difficulties and prevent child abuse and neglect, is provided through the Aboriginal Family Support Innovations Projects. These projects commenced in 2003 and Government will continue to work with agencies to build a robust Aboriginal family services sector across the State. New Child First teams will work in close partnership with local Aboriginal organisations to provide help to Aboriginal families earlier.

Child Protection and placement services: Since 2002 the Aboriginal Child Specialist Advice and Support Service has been funded to provide expert consultation and facilitate family involvement in decision-making whenever an Aboriginal child is notified to Child Protection. An evaluation of this service is underway, with a view to strengthening collaboration and service responses to families - to reduce re-notification rates. Cultural support plans are being implemented for all children in out-of-home care, to make sure that they remain connected to their culture and community. The Family Preservation and Restoration initiatives aim to prevent the need for children to be removed from their family and assist reunification as quickly as possible.

Children on orders

Children and young people may be placed on a care and protection order for a variety of reasons, including the child being the subject of a child protection substantiation, and there having been a serious and irretrievable breakdown in the relationship between the child and his or her parents.

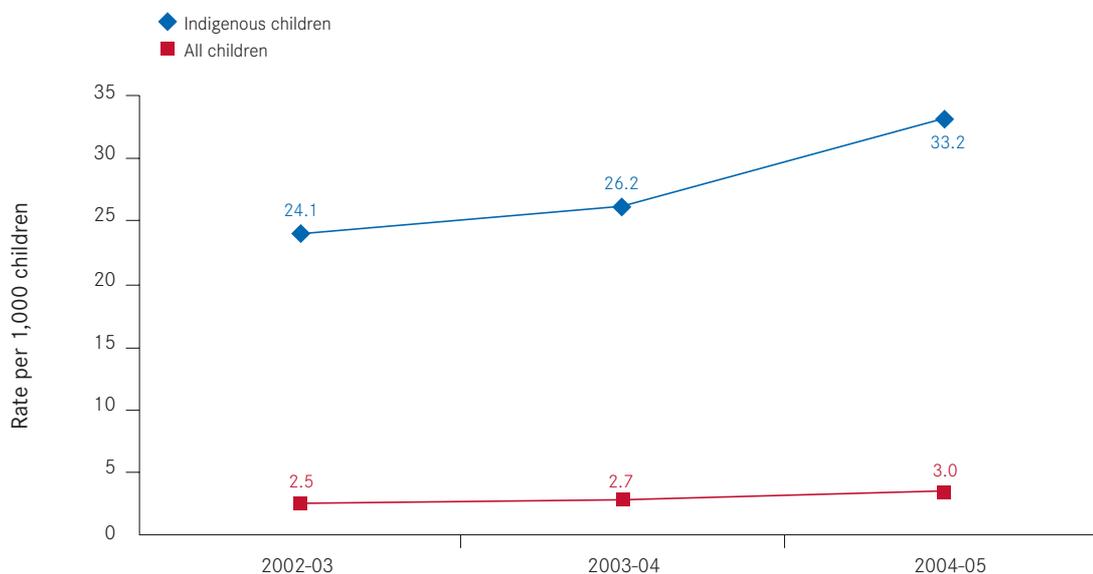
The number of children on care and protection orders has risen by 41 per cent in Australia from 15,718 in 1997 to 25,065 in 2005. The rate of children on orders has varied across the jurisdictions, and this is probably due to the range of orders available and to variations in policy and practice. These too have shown increases across Australia from 3.3 per 1,000 in 1997 to 5.2 per 1,000 in 2005, with Victoria showing a similar pattern to the national trend, increasing from 3.4 per 1,000 to 4.9 per 1,000 over the same period (Australian Institute of Health and Welfare 2006).

The rate of Indigenous children on orders is higher across Australia.

In Victoria the rate of Indigenous children admitted to care and protection orders was 33.2 in 2004–05, 11 times higher than the rate of 3.0 for all children. Figure 2.3.8 shows the rates of Indigenous children and of all children (aged zero to 14 years) admitted to care and protection orders in Victoria over a three-year period (2002–03 to 2004–05).

The rate of admissions to orders for Indigenous children is much higher than that for all children; however, while the rate for all children remains broadly consistent (with a very small rise), the rate for Indigenous children shows an increase over the three-year period.

Figure 2.3.6: Rate of children aged zero to 14 years admitted to care and protection orders in Victoria¹⁰⁴



Source: Department of Human Services calculations based on data from Client and Service Information System and Australian Bureau of Statistics, 2003, 2004a, 2004b, 2005

¹⁰⁴ The calculations used in Figure 2.3.6 use population estimates for the first year in the financial year period, for example, 2004 estimates are used for the year 2004–05, because population estimates for the total population are published one year in arrears.

Children needing out-of-home care

Children and young people may need to be accommodated in out-of-home care when they are not able to live with their parents. Most but not all of these children will be on care and protection orders, and they will be placed in foster care, with relatives and kin, or in residential care. The majority will eventually return to live with their own family.

The number of children in out-of-home care increased nationally between 1996 and 2005 by 70 per cent (from 13,979 to 23,695). Victoria has also witnessed an increase in numbers over this period, although the extent of the increase (approximately 30 per cent) has been less than in some of the other jurisdictions (Australian Institute of Health and Welfare 2006).

Indigenous children are much more likely to be in out-of-home care than other children; their national rate is more than six times the rate for other children. As Table 2.3.4 shows, the rate of Indigenous children in out-of-home care is higher in Victoria than in any other jurisdiction at 40.7 per 1,000 children. Indeed, in 2005, Indigenous children in Victoria were nearly 12 times more likely than other children to be in out-of-home care.

Table 2.3.3: Children, aged ten to 17 years, in out-of-home care: number and rate, by Indigenous status and state and territory, at 30 June 2005

	Indigenous number	Other number	Total number	Indigenous rate	Other rate	Total rate
New South Wales	2,543	6,687	9,230	39.7	4.4	5.8
Victoria	526	3,882	4,408	40.7	3.4	3.8
Queensland	1,275	4,382	5,657	20.8	4.8	5.8
Western Australia	692	1,137	1,829	22.6	2.5	3.8
South Australia	286	1,043	1,329	24.3	3.1	3.9
Tasmania	78	498	576	9.5	4.6	4.9
Australian Capital Territory	60	282	342	32.0	3.8	4.5
Northern Territory	218	106	324	8.9	3.1	5.5
Australia	5,678	18,017	23,695	26.4	3.9	4.9

Source: Australian Institute of Health and Welfare 2006

Outcome area: free from exposure to conflict or domestic violence

Associated indicator reported: domestic violence

Domestic violence

Domestic violence¹⁰⁵ is known to be a risk factor for child abuse. Research published in 1996 by the Department of Human Services indicated that in 40 per cent of the cases reported to Child Protection, domestic violence was a characteristic of the family (Department of Human Services 2002), and an earlier review of 35 research studies found that child maltreatment overlapped with family violence in 30–60 per cent of cases (Edelson 1996). Considerable numbers of children may also be witness to violence between adults; however, the precise numbers affected are unknown and many domestic violence incidents are not reported to the police.

Nationally, the 1996 Women's Safety Survey (Australian Bureau of Statistics 1996) found 23 per cent of women who had ever been married or in a de facto relationship reported experiencing violence by a partner at some point in the relationship. Of women who experienced violence by a current partner, 61 per cent had children in their care at some time during the relationship, 38 per cent said their children had witnessed the violence, and 46 per cent of women who reported violence by a previous partner said their children had witnessed the violence (Australian Bureau of Statistics 1996).

In Victoria, there were 29,161 reports of domestic violence to the police in 2005, and because many incidents of domestic violence may go unreported, this is likely to underestimate the actual level of incidents.¹⁰⁶ Nine out of the top ten areas reporting domestic violence were in rural Victoria (Farouque 2006).

Children who witness family violence have been described as its 'invisible' victims (Osofsky 1995). Perry's research (1997) suggests that in infancy, exposure to stress and trauma results in elevated cortisol levels and affects the stress regulating system in the brain. Infants exposed to domestic violence exhibit greater irritability, sleep disturbances, more 'startle' responses and minor illnesses (Osofsky 1999). Many of the harmful consequences of exposure to family violence overlap with those reported earlier for child abuse and include high rates of:

- conduct disorder, especially for girls (Tonge 1998; Ritter et al. 2002)
- attachment disorders (Zeanah et al. 1999)
- low self-esteem (Ritter et al. 2002)
- proactive aggression (deliberate coercive behaviour used to manipulate others (Connor et al. 2004)
- poor academic performance, school phobia and poor concentration (Cummings & Davies 1994)
- depression, anxiety, and somatic complaints (Spaccarelli et al. 1994)
- high risk health behaviours, including smoking, drinking, and drug use (Dube et al. 2002)
- homelessness (53,800 children under 18 years accompanied their guardian to a homeless service in 2002–03, with domestic and family violence being the most common reason for homelessness) (Australian Institute of Health and Welfare 2004).

¹⁰⁵ Domestic violence is defined in Australia as, 'violence occurring between people who are or have been in an intimate relationship'.

¹⁰⁶ This is a total of all incidents reported (so children may or may not have been living in the households concerned).

Safe from injuries, harm and violence: summary of key findings

- Older young people, and particularly males, have higher rates of injury.
- Children aged zero to four years account for the largest proportion of injury hospital emergency presentations in Victoria, whereas older young people (aged ten to 18 years) account for the largest proportion of injury hospitalisations and injury deaths.
- There appears to be a downward trend in the number of unintentional injury child deaths in Victoria (based on data for 1991–2004). Motor vehicle accidents are the major cause of death across all years.
- Victoria does not show the same pattern of marked increases in child protection notifications and substantiations as do many of the other states and territories.
- The rate of substantiations among Indigenous children is much higher than that among all children, and Victoria has the highest rate of Indigenous children who are the subject of a substantiation of all the states and territories. The rate of substantiations among Indigenous children in Victoria has shown increases (based on data for 2001–02 to 2004–05).
- The rate of Indigenous children admitted to care and protection orders was 11 times higher for Indigenous children than for all children (in 2004–05), and the rate among Indigenous children has shown increases (based on data for 2002–03 to 2004–05).
- Children with a disability are known to be at greater risk of child abuse; however, there is a gap in Australian and Victorian data on this issue.
- Domestic violence is known to be a risk factor for child abuse; however, the number of children who are affected is unknown.

Safe from environmental toxins and from fear of crime

Outcome area: safe from environmental toxins

Associated indicators reported: outdoor air quality, indoor air quality, water quality

Children are known to be uniquely vulnerable to environmental chemical pollutants for a range of reasons, including their higher respiration and metabolic rate, their greater consumption of food and drink (per bodyweight), the use of hand to mouth activity (in young children) and their different detoxification systems.

In 2002, the World Health Organisation, the United Nation's Children Fund (UNICEF) and the United Nations Environment Programme reviewed the impact of the environment on the health and development of children. Their review concluded that

approximately three million children under the age of five die every year, due to environmental hazards (United Nations Environment Programme, United Nations Children's Fund & World Health Organization 2002).

However, despite the growing international evidence of the harmful effects of children's exposure to hazardous environmental chemicals, there is little ongoing monitoring of these effects on children.

Australia has no mechanisms for identifying environmental threats to children or for developing policies to ensure their protection from environmental hazards. In this section most of the information presented is not specific to children.

Environmental safety in Victoria

Outdoor air quality

Exposure to high levels of ozone can result in increases in asthma attacks and in hospitalisations for lung and heart conditions. The Environment Protection Authority monitors the levels of ozone in the Melbourne–Geelong region by recording the levels of ozone present in the environment over one-hour and four-hour averages (on a daily basis) (Department of Human Services 2005). The national goal is to have no more than one day a year when objectives (of 0.10 parts per million for a one-hour average, and 0.08 parts per million for a four-hour average) are not met.

In 2004 there was just one day when these two targets were not met in the Melbourne–Geelong area. Since the early 1980s there has also been an improving trend, principally resulting from improvements over time in vehicle emission standards.

Particles smaller than 10 micrometres can exacerbate existing respiratory and cardiovascular disease, leading to increases in hospitalisations and premature mortality.¹⁰⁷ The national objective for this is a one-day average of 50mg/m³ and the goal is to have no more than five days a year by 2008 where the objective is not met. Melbourne has met this objective every year, with the exception of 2003 (Department of Human Services 2005).¹⁰⁸

Water quality

Monitoring of water quality in Victoria includes the testing of cooling tower water samples for Legionella¹⁰⁹ and for heterotrophic colony counts (Department of Human Services 2005).¹¹⁰ Since March 2001, the trend in water samples testing positive for Legionella has been downward, with a slight increase in 2004.¹¹¹ The percentage of cooling tower water samples that were shown to surpass or fail to comply with prescribed standards for heterotrophic colony counts on testing has also shown a positive trend over the same period.

Indoor air quality

Second-hand smoke is one of the key indoor air pollutants, and passive smoking is known to have a range of adverse effects on the health of children. We discuss what is known about children's exposure to cigarette smoking in Victoria in section 3.1 (the family).

Community safety

Outcome area: low levels of crime in community

Associated indicators reported: households with children where neighbourhood is perceived as unsafe, feeling safe walking alone down the street after dark

¹⁰⁷ The major sources of particles in urban areas are motor vehicles, industry and wood combustion for heating.

¹⁰⁸ Drought-related dust storms and bushfires contributed to this.

¹⁰⁹ Legionella bacteria can cause Legionellosis, an acute bacterial disease, with a usual clinical manifestation of pneumonia.

¹¹⁰ Heterotrophic colony counts is an indicator of the efficacy of biocidal treatment of cooling tower water and the general cleanliness of cooling tower systems.

¹¹¹ Some fluctuations are expected.

The Victorian Child Health and Wellbeing Survey asked parents (of children aged zero to 12 years) a series of questions to elicit their views about the area in which they live. Some of these questions were concerned with aspects of the physical and social environment (such as whether the neighbourhood had good street lighting and was 'clean' or 'safe') and others were concerned with access to local facilities and services. We focus here on perceptions of the physical and social environment and we look at perceived access to local facilities and services in section 3.2 (the community).

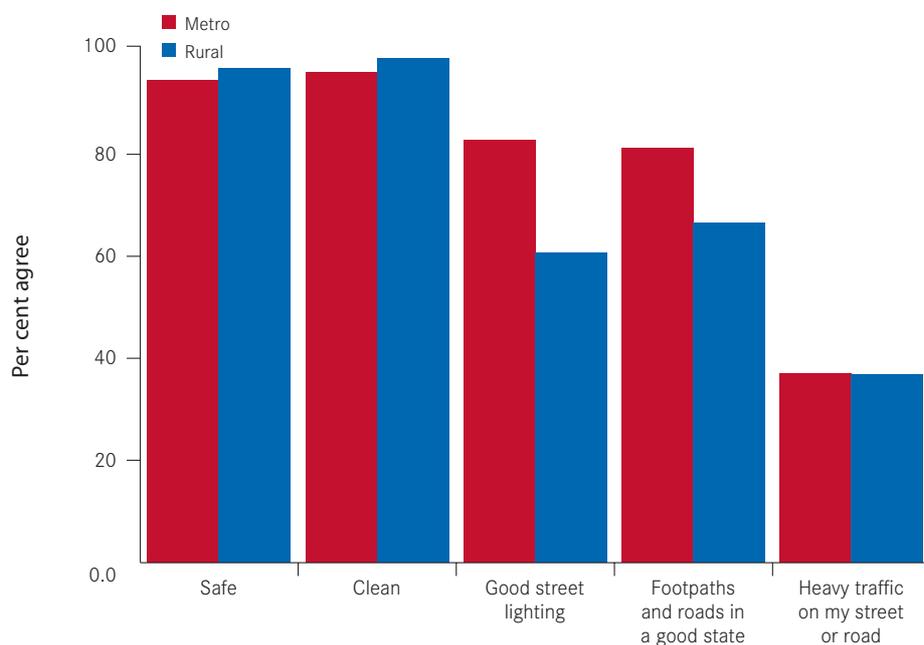
Respondents were asked to rate how strongly they agreed or disagreed with the following statements:

- This is a safe neighbourhood.
- This is a clean neighbourhood.
- There is good street lighting in my neighbourhood.
- The state of the footpaths and roads is good in this neighbourhood.
- There is heavy traffic on my street or road.

Overall, parents rated the liveability of their neighbourhoods very highly. A very high proportion of children live in neighbourhoods which their parents agree or strongly agree are clean (95.9 per cent), safe (94.4 per cent), have good street lighting and where the state of the roads and footpaths was perceived to be good (75.8 per cent and 76.6 per cent respectively). A smaller proportion of children have parents who agreed or strongly agreed that there was heavy traffic on their street or road (36.6 per cent).

As Figure 2.3.11 shows, there were some differences between the responses of parents living in metropolitan areas and those in rural areas. While children in rural areas were more likely to have parents who agreed or strongly agreed that their neighbourhoods were safe and clean, children in metropolitan areas were more likely to have parents who agreed or strongly agreed that there was good street lighting and that the state of the roads and footpaths in their neighbourhoods was good. It is of interest that the proportion of children with parents who agreed or strongly agreed that there was heavy traffic on their street or road is almost identical in rural and metropolitan areas.

Figure 2.3.7 Victorian parents' rating of neighbourhood liveability



Source: Victorian Child Health and Wellbeing Survey 2006

There were also some differences between the responses of parents whose child was on a health care card and the responses of parents whose child was not. As Table 2.3.5 shows, parents of children on healthcare cards were less likely to rate their neighbourhood liveability favourably.¹¹²

Table 2.3.4: Perceived liveability and health care cards

	Child is on a health care card (% agreeing or strongly agreeing)	Child is not on a health care card (% agreeing or strongly agreeing)	Percentage difference
This is a safe neighbourhood.	89.0	96.4	7.4
This is a clean neighbourhood.	93.5	96.8	3.3
There is good street lighting in my neighbourhood.	71.7	77.5	6.2
The state of the footpaths and roads is good.	75.8	76.9	1.1
There is heavy traffic on my street or road.	41.5	34.8	6.7

Source: Victorian Child Health and Wellbeing Survey 2006

The Department of Human Services Victorian Population Health Survey (2005) also collected information from parents about their perceptions of community safety. Parents of children under 18 years were asked, 'Do you feel safe walking alone down your street after dark?'

Just over six in ten (60.4 per cent) of parents said they definitely felt safe walking alone down their street after dark. Around one in seven (14.5 per cent) said they sometimes felt safe, and 22.3 per cent reported they felt safe not often or not at all (5.7 per cent and 16.6 per cent respectively).

Environmental and community safety: summary of key findings

- There is little ongoing monitoring of the effects on children of exposure to a range of hazardous environmental chemicals.
- Overall, parents rated the liveability of their neighbourhoods very highly. There were some differences in the responses of rural and metropolitan parents, and parents with children on healthcare cards gave less favourable ratings (Victorian Child Health and Wellbeing Survey).

¹¹² There was no statistically significant difference between the two groups in the percentages agreeing or strongly agreeing that the state of the footpaths and roads is good.

3: The environment

3.1 The family

Poverty and economic wellbeing

Outcome area: ability to pay for family essentials

Associated indicators reported: percentage of children living in poverty, parental employment, secure parental employment

Child poverty is known to have serious and adverse effects on children's lives. A large body of national and international evidence points to the immediate and longer-term effects of poverty on children and young people. For example, child poverty is known to affect a range of areas that are considered elsewhere in this report: children's nutrition, their access to medical care, the safety of their environment, stress levels in the home and the quality and stability of care. Also, children and young people's socio-emotional functioning, mental and physical health, educational attainment and later employment prospects are all known to be affected by an experience of poverty (Australian Institute of Health and Welfare 2005).

Although many of the effects of child poverty are well recognised and documented, much of the academic and policy literature in Australia is characterised by debate about how poverty should be defined and measured. At the time of writing, there is no clear consensus about how poverty should be measured and monitored and Australia has no national program (such as those that exist in the United Kingdom and Ireland) to address and tackle child poverty (Australian Council of Social Service 2004).

The literature on poverty has commonly used two types of poverty threshold—absolute poverty and relative poverty—to conceptualise and define poverty (see following definitions).

Absolute poverty or 'fixed real poverty lines' are thresholds that permit people living in specified family types to buy the same goods or services in different countries or times (Bradbury 1999).

Poverty in Australia has been more frequently defined in relative terms, meaning that people are considered to be poor if their living standards fall below an overall community standard and they are unable to actively participate in societal activities.

Poverty in Australia has been measured using the Henderson Poverty Line¹¹³ and more recently by comparing family income with the half-average income line or the half-median (or midpoint) income line. More recently, research in Australia has sought to draw on the concepts of deprivation and social exclusion as the basis of a new approach to the conceptualisation, identification and measurement of child poverty.

An Australian Research Council-funded project has conducted focus groups with users of welfare services in New South Wales and Victoria about their living conditions and expectations. These findings are being used to develop new indicators of disadvantage and to inform a second stage of the project which aims to further develop the measures and to give a preliminary indication of the extent of deprivation and exclusion in Australia (Saunders et al. 2006).

¹¹³ The Henderson Poverty Line is based on an estimate of the amount of money that families of different sizes need to cover their essential needs.

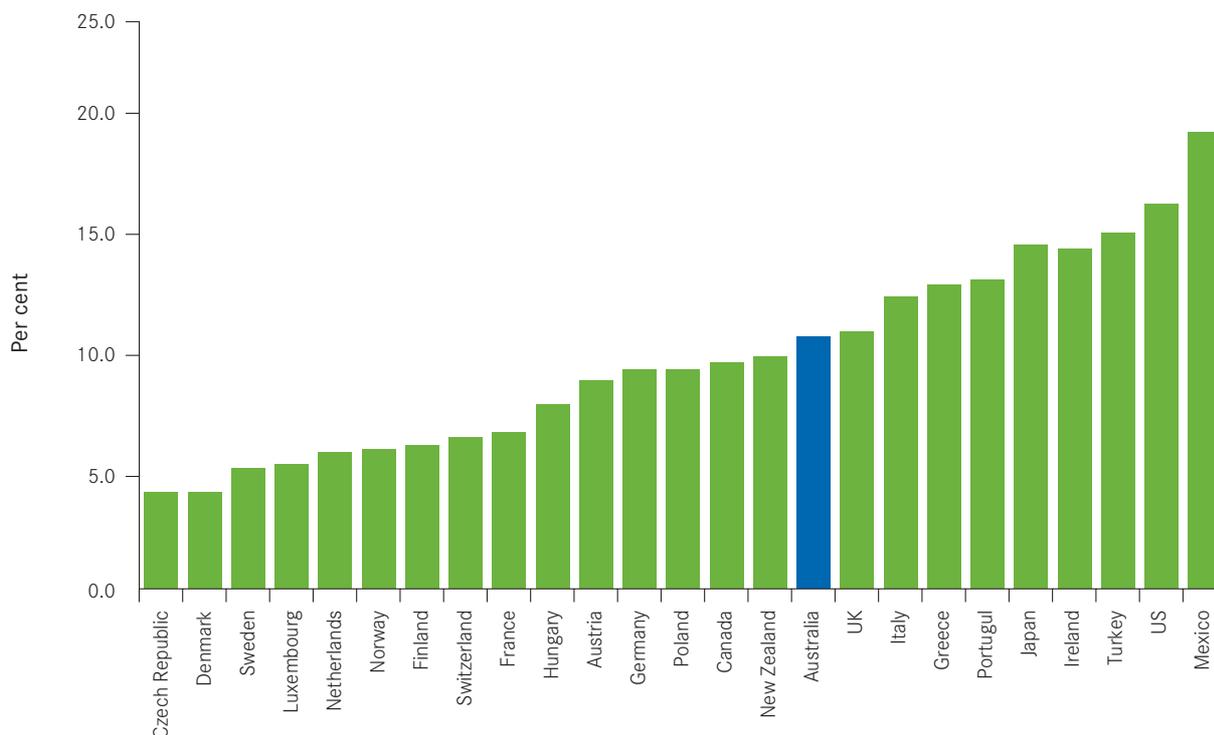
Participatory work to improve the understanding and measurement of poverty is also evident in the United Kingdom where children and young people living in poverty have taken part in in-depth interviews about their experiences (Ridge 2002). This research has shown how young people experience exclusion from school-based activities and from the consumer culture of their more affluent peers. They are prevented, for example, from making and sustaining friendships because of the financial barriers posed by transport and because of their fear of stigma associated with financial hardship.

The extent of child poverty in Australia

Estimates of the extent of poverty in Australia have varied widely and this variation is often linked to the measurement used; however, despite its relative wealth¹¹⁴ Australia has moderately high levels of child poverty in comparison with other OECD countries (Australian Council of Social Service 2004).

The most recent OECD figures indicate that 11.2 per cent of Australian children were living in relative poverty in 2000 (using a poverty line based on 50 per cent of median equivalised household income in each country) (OECD 2005). As Figure 3.1.1 shows, Australia ranked tenth highest of 25 countries in the proportion of children living in relative poverty in 2000.¹¹⁵

Figure 3.1.1: Percentage of children living below the poverty line



Source: Figure derived from data in Organisation for Economic Co-operation and Development 2005

¹¹⁴ Wealth as measured by Gross National Product per capita.

¹¹⁵ Data for Belgium and Spain were not available.

Child poverty trends

The evidence on trends in child poverty is inconsistent. A study that examined a range of poverty lines showed that poverty among adults increased steadily between 1990 and 2000, but that child poverty fell during the first half of the 1990s and increased in the latter half of the decade (Harding et al. 2001). There appear to be no Australia-wide studies that have tracked child poverty since the new millennium.

Groups most at risk of poverty

Recent evidence suggests those most at risk of poverty include Indigenous Australians, the unemployed, sole parent families, people on low wages and young people (Senate Community Affairs Reference Committee 2004).

Groups at high risk of poverty in Australia

- Indigenous Australians
- people who are unemployed
- people dependent on government cash benefits
- sole parent families and their children
- families that have three or more children
- people earning low wages
- people with a disability or those experiencing a long-term illness
- aged people, especially those renting privately
- young people, especially in low income households
- single people on low incomes
- people who are homeless
- migrants and refugees.

Source: Senate Community Affairs Reference Committee 2004

Research by Lloyd, Harding and Payne has identified that poverty rates are clearly linked to income unit type, with more single people experiencing financial disadvantage than people in couples. Poverty rates also increase with the number of dependent children for both single and partnered parents. While poverty is linked to unemployment, a degree of poverty also persists for those in employment, particularly in part time employment (Lloyd et al. 2004).¹¹⁶

Persistence and depth of poverty

Income-based measures of poverty, such as those discussed earlier, give little indication of the persistence of poverty in the same households over time or of the depth or severity of poverty as measured by the extent to which a household's income falls below the poverty line.

The Household Income and Labour Dynamics in Australia (HILDA) Longitudinal Survey has provided information since 2001 from a nationally representative sample of Australian households, allowing for analysis, over time, of the percentage of children who are living in poverty and in jobless households.

¹¹⁶ This research uses data from the 2000–01 Survey of Income and Housing Costs, conducted by the Australian Bureau of Statistics. The study uses the OECD Half Median Poverty Line.

Early analysis (after the first three years of the survey) reported by the Brotherhood of St Laurence suggests that almost 28 per cent of children experienced at least one episode of poverty, with 14 per cent estimated to be living in poverty in at least two of the three years and just over 5 per cent living in poverty in all three years (Scutella & Smyth 2005).¹¹⁷

Lloyd, Harding and Payne (2004) have studied the proportion of Australians living in poverty by the amount by which their income falls below the poverty line¹¹⁸ in order to give an indication of the severity of poverty experienced. Table 3.1.1 shows their findings for the year 2001. While 42 per cent of people in poverty had weekly incomes that fell below the poverty line by less than \$49, 14 per cent had incomes that were \$200 or more below the poverty line.

Table 3.1.1: Proportion of people in poverty by size of income unit poverty gap, 2001

Weekly income	Percentage of people
\$0-49	42.0
\$50-99	15.4
\$100-149	10.3
\$150-199	18.3
\$200 and over	14.0

Source: Derived from Lloyd, Harding & Payne 2004

Based on Australian Bureau of Statistics 2000-01 Survey of Income and Housing Costs

Poverty in Victoria

Estimates of poverty levels in the Australian states and territories also show inconsistencies; however, research published in 2004 by Lloyd, Harding and Payne suggests that Victoria, together with New South Wales, had the highest rate of poverty in 2001 (Lloyd et al. 2004).

Table 3.1.2 shows that Victoria and New South Wales each have a poverty rate of 11.5 per cent. This rate is higher than the Australian average of 11 per cent.

Table 3.1.2 Estimated poverty rate, by state and territory, 2001

	NSW	VIC	QLD	SA	WA	Tas	NT and ACT ¹¹⁹	Aus
%	11.5	11.5	10.5	9.9	10.2	9.6	7.9	11

Source: Derived from Lloyd, Harding & Payne 2004

Based on Australian Bureau of Statistics, 2000-01 Survey of Income and Housing Costs

¹¹⁷ The HILDA survey also shows that nearly a quarter (24.6 per cent) of children were in a household with no adult in paid employment at some stage during the three years, with 15.3 per cent in this situation for at least two years and 8.9 per cent for three years.

¹¹⁸ Using the before housing costs OECD Half-Median Poverty Line

¹¹⁹ The Australian Bureau of Statistics combines the Australian Capital Territory and the Northern Territory in the publicly available unit record file, so the research was unable to provide separate figures.

Rural/metropolitan differences

The same research shows that the poverty rate for people living in capital cities was lower than that of people living in other parts of the states and territories (10.5 per cent in capitals, compared with 12 per cent elsewhere); however, because the majority of Australians live in cities, a greater proportion of people in poverty are also city dwellers.

The Victorian Council of Social Service has also highlighted that in Victoria there is a growing disparity in income levels between regional and rural areas and metropolitan areas and between specific areas within metropolitan centres.¹²⁰

Disadvantage in Victoria and the government Action Plan for A Fairer Victoria

Although progress has been made in reducing disadvantage, some groups of people and some places in Victoria continue to experience disadvantage, hardship and barriers to opportunity.

Some communities in Victoria experience a concentration of several of the factors associated with disadvantage. People living in these communities often experience greater levels of unemployment, economic hardship, poor health, poor educational outcomes, crime and family violence.

The government Action Plan for a Fairer Victoria sets out 85 actions that the government will take to tackle disadvantage within an approach that emphasises the following elements:

- Ensuring that universal services provide equal opportunity for all
- Reducing barriers to opportunity
- Strengthening assistance to disadvantaged groups
- Providing targeted support to the highest risk areas
- Involving communities in decisions affecting their lives and making it easier to work with government

Source: State Government of Victoria 2005a, 2005b

Experiences of poverty in Victoria

A research study by the Brotherhood of St Laurence is continuing to track the circumstances of 167 children born in 1990 whose families were living in two adjoining suburbs of Melbourne at the time.¹²¹ Although this is a small study with a sample that does not necessarily reflect the broader population, it provides some useful insights into the experiences of families and children. The researchers found that three-quarters of the 41 families who had been on low incomes in 1990 were still on low income 12 years later in 2002. Many of the families had difficulty in making ends meet and their children often missed out on school excursions, camps and sporting and cultural activities outside school (Taylor & Fraser 2003).

In the Victorian Child Health and Wellbeing Survey, 5.8 per cent of children were from households where a parent reported that there had been times in the last 12 months when they had run out of food and could not afford to buy more.

¹²⁰ Submission by the Victorian Council of Social Service to the Senate Community Affairs Reference Committee (2004).

¹²¹ The Life Chances Study

Parents who had run out of food reported using the following strategies to cope with the lack of food:

- seeking help from relatives (39.4 per cent)
- seeking help from welfare agencies (30.4 per cent)
- parent skipping a meal (24.9 per cent)
- seeking help from friends (18.3 per cent)
- decreasing variety of food (14.8 per cent)
- seeking help from government or social security (7.4 per cent)
- stretching remaining food (5.9 per cent)
- child eating less food (2.7 per cent)
- growing own food (2.2 per cent).

Sole parents were much more likely than parents in couple households to report that there had been times when they had run out of food and could not afford to buy more (19.7 per cent of sole parents reported this, compared with 3.5 per cent of parents in couple households).

It is also interesting to note that additional evidence highlights the financial pressures sole parents in Victoria experience. Sole parents were less likely to report being able to raise \$2,000 in an emergency than parents in couple households (Victorian Child Health and Wellbeing Survey data reported in section 3.2 (communities) and more likely to be in rental arrears (Department of Human Services data reported in section on housing to follow). These findings may be a reflection of the poorer employment conditions of sole parents in comparison with those in couple parent households (see later).

Parental employment

Data on employment in Victoria are available from the Australian Bureau of Statistics' Family Characteristics Survey.¹²²

According to data collected by the Family Characteristics Survey, 85.4 per cent of Victorian children (aged zero to 14 years) were living in couple families and 17.5 per cent of children were living in sole parent families as at June 2003.

The survey shows that children in couple households were much more likely than children in sole parent households to be living in a household where the adults were employed.¹²³ Of the children living in couple households, the vast majority (93.5 per cent) were in a household where at least one parent was employed, more than half (52.6 per cent) of the children were in a household where both parents were employed, and a minority (6.5 per cent) were in a household where neither parent was employed.

In contrast, of the children living in sole parent households, 48.4 per cent were living with a parent who was not in employment and 51.6 per cent lived with a parent who was employed.¹²⁴

¹²² Commonwealth of Australia, 2004

¹²³ Employed persons are defined by the Australian Bureau of Statistics as comprising all those aged 15 years and over who, during the reference week, worked for an hour or more for pay, profit, commission or payment in kind, in a job or business or on a farm, or who worked for one hour or more without pay on a family business or farm; were employees who had a job but were not at work during the reference week (for a range of reasons specified); or who were employers or own account workers who had a job, business or farm but were not at work.

¹²⁴ Children in sole father households were more likely than children in sole mother households to have an employed parent (72.6 per cent of children from sole father households had an employed father, and 48.2 per cent of children from sole mother households had an employed mother); however, only 14.1 per cent of children in sole parent households live with their father.

Security of employment

The Victorian Child Health and Wellbeing Survey collected data from parents in Victoria about their current employment status¹²⁵ and found that children living in couple households were more likely to have a parent in employment than children with sole parents.

Children from couple households were also more likely to have a parent who was in permanent employment. Of the children living in couple households, 45.9 per cent lived with a main caregiver who was in permanent employment and 80.9 per cent lived in a household where the partner parent was in permanent employment, compared with 28.1 per cent of children from sole parent households who lived with a parent in permanent employment.

Nearly 17 per cent (16.8 per cent) of children from sole parent families lived with a parent who was in casual work. However, 12.3 per cent of children in couple families had a main carer in casual work, and just 6 per cent of the children had partner parents who were in casual work.

Poverty and economic wellbeing: summary of key findings

- There are many inconsistencies in estimates of poverty levels. This variation is linked to the measures used.
- Research published in 2004 suggests that Victoria, together with New South Wales, had the highest rate of poverty of the states and territories in 2001.
- Poverty rates are generally higher in rural and regional areas than in metropolitan areas.
- Of the children whose parents responded to the Victorian Child Health and Wellbeing Survey, 5.8 per cent were from households where a parent reported that there had been times in the last 12 months when they ran out of food and could not afford to buy more. Sole parents were more likely than parents in couple households to have run out of food.
- Children who are living in a couple household are much more likely than children living with a sole parent to have a parent in employment (Victorian Child Health and Wellbeing Survey).
- Children in couple households are more likely to have a parent in permanent employment and less likely to have a parent in casual employment than children from sole parent families (Victorian Child Health and Wellbeing Survey).

Housing and homelessness

Outcome area: adequate family housing

Associated indicators reported: rate of children aged zero to eight years accompanying a parent or guardian seeking assistance from the Supported Accommodation Assistance Program; housing problems and homelessness

Housing is a basic necessity for children and young people and homelessness and insecure housing are known to be significant risk factors for children. There is also a widespread community view that it is not acceptable that there should be homeless children in a rich country such as Australia and that governments have a responsibility to intervene when homelessness occurs (Human Rights and Equal Opportunities Commission 1989; Nicholson 2006).

¹²⁵ The Victorian Child Health and Wellbeing Survey used a similar definition of employment to the Australian Bureau of Statistics (although it did not specify working for one hour or more); however, any direct comparisons between these data and the Australian Bureau of Statistics data should be made with caution.

Homelessness

There has been a continuing debate about the definition of homelessness in Western countries (Chamberlain & MacKenzie 1992; Neill & Fopp 1992; House of Representatives 1995; Avramov 1995; Hopper 1997; Chamberlain & Johnson 2001); however, in Australia two definitions are widely used. One is the cultural definition of homelessness, which is used by the Australian Bureau of Statistics to enumerate the homeless population, and the other is the Supported Accommodation Assistance Program (SAAP) definition (essentially a service delivery definition, which includes people who are at risk of homelessness as well as people who are actually homeless) (the full definitions are in Appendix 4).

The information that is presented here is based on data from the Australian Bureau of Statistics 2001 Census of Population and Housing (reported in Chamberlain and Mackenzie 2003; 2004),¹²⁶ and the national SAAP data collection, which provides information on the number of individuals who access SAAP services and their number of support periods.¹²⁷

Also included is some previously unpublished data based on calculations carried out for the Department of Human Services by Associate Professor Chris Chamberlain (from RMIT University) using 2001 census data.

Age structure of the homeless population

In the 1950s and 1960s, it was thought that the homeless population was disproportionately made up of middle aged and older men (De Hoog 1972; Jordan 1973; Jordan 1994); however, as Table 3.1.3 shows, the homeless population is much more diverse than in the past.

Just over one-third (36 per cent) of the homeless population in Victoria was aged 18 years or under on Census night, identical to the national figure of 36 per cent. In Victoria there were 2,618 homeless children under 12 years and 4,663 homeless young people aged 12–18 years ('teenagers'). In addition, there were 2,401 young adults aged 19–24 years, some of whom probably became homeless when they were 18 years or younger.

Table 3.1.3: Age distribution of homeless population, Australia and Victoria, 2001

	Australia		Victoria	
	No.	%	No.	%
Under 12 years	9,941	10	2,618	13
12–18 years	26,060	26	4,663	23
19–24 years	10,113	10	2,401	12
25–34 years	16,567	17	3,665	18
35–44 years	12,992	13	2,775	14
45–54 years	10,349	10	1,885	9
55–64 years	7,883	8	1,184	6
65 years or older	5,995	6	1,114	5
Total	99,900	100	20,305	100

Source: Chamberlain and Mackenzie 2004

¹²⁶ The 2001 Census analysis of homelessness combined information from the Census with information from the national SAAP data collection and information from the second national census of homeless school students. The Census is a 'point in time' count. It estimates the number of homeless people on a given night. This is an important figure for policy-makers because it provides an indication of the possible demand for services on a 'typical' night.

¹²⁷ This records information on all persons using SAAP services on an ongoing basis. The National Data Collection Agency at the Australian Institute of Health and Welfare is responsible for this data collection.

Homeless children and young people

Homeless children and young people aged 18 years or younger comprise two groups. First, there are children who are accompanying homeless parents. Second, there are 'independent' homeless teenagers who are not part of a family unit. These teenagers have either been ejected from home or run away from home. Most accompanying children are under 12 years, but most homeless teenagers are 'independent'.

Table 3.1.4 shows that nationally on Census night 63 per cent of homeless children and young people were independent teenagers who were not part of a family unit and 37 per cent were accompanying children. The pattern was somewhat different in Victoria where just over half (56 per cent) were independent teenagers and just under half (44 per cent) were accompanying children. There were about 1,630 homeless families in Victoria on Census night and they had 3,237 children with them.

Table 3.1.4: Number of accompanying children and homeless teenagers, Australia and Victoria¹²⁸

	Australia		Victoria	
	No.	%	No.	%
Accompanying children	13,401	37	3,237	44
Independent homeless teenagers	22,600	63	4,044	56
Total	36,001	100	7,281	100

Source: Calculations carried out for the Department of Human Services based on 2001 Census data.

Tables 3.1.5 and 3.1.6 show Victoria had a higher proportion of homeless children under 12 years and of young people (aged 12–18 years) in SAAP than other states.¹²⁹

Table 3.1.5: Proportion of homeless children aged zero to 11 years in SAAP, by state and territory

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Total
Percentage in SAAP	43	66	35	49	28	46	4	53	45

Source: Calculations carried out for the Department of Human Services based on 2001 Census data.

Table 3.1.6: Proportion of young people aged 12–18 years in SAAP, by state and territory

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Total
Percentage in SAAP	9	17	5	7	5	5	1	16	8

Source: Calculations carried out for the Department of Human Services based on 2001 Census data.

Table 3.1.7 shows the accommodation of homeless children by age group on Census night in Victoria. Two-thirds (66 per cent) of accompanying children under 12 years were with one or both parents in SAAP or the Transitional Housing Management program¹³⁰ accommodation on census night and one-fifth (19 per cent) were with other households.

¹²⁸ The Australian Bureau of Statistics' national report identified the total number of homeless young people aged 18 years or younger, and it identified the number of accompanying children, defined as aged 17 years or younger, following SAAP conventions. The Census did not provide information on the number of accompanying children in the states and territories, but these figures have been estimated.

¹²⁹ In Victoria 66 per cent of homeless children under 12 years were in the SAAP, compared with 43 per cent in New South Wales, 35 per cent in Queensland and 4 per cent in the Northern Territory. In Victoria 17 per cent of homeless teenagers (aged 12–18 years) were in the SAAP compared with 9 per cent in New South Wales, 5 per cent in Queensland and 1 per cent in the Northern Territory.

¹³⁰ The Transitional Housing Management Program was introduced in June 1997 when 15 community-based agencies were appointed to provide housing and housing assistance to households in crisis owing to homelessness or impending homelessness.

In contrast, 69 per cent of the young people aged 12–18 years were staying temporarily with other households. About 85 per cent of those aged 12–18 years were independent teenagers, and 15 per cent were teenagers who were accompanying parents.

Table 3.1.7: Accommodation on Census night, by age group

	Under 12 years (n=2,618) %	12–18 years (n=4,663) %	Total (n=7,281) %
Improvised dwelling	10	4	6
Friends and relatives	19	69	51
Boarding house	5	10	8
SAAP/THM	66	17	35
Total	100	100	100

Source: Calculations carried out for the Department of Human Services based on 2001 Census data.

Children accompanying adults receiving assistance from SAAP (2004–05)

Table 3.1.8 provides information about the numbers of children who were accompanying adults receiving assistance from SAAP in 2004–05. The table shows there were 36,100 adults who received SAAP assistance and they had 20,450 accompanying children with them.

It is not possible to know how many of those children were in households that were at risk of homelessness or eviction and how many were in households that were homeless (because the definition used by SAAP includes both these groups).¹³¹

Table 3.1.8: SAAP/Transitional Housing Management Program clients and accompanying children, Victoria, 2004–05

	Support periods ¹³² (no.)	Individuals (no.)
Adults	62,000	36,100
Accompanying children	29,700	20,450
Total	91,700	56,550

Source: Australian Institute of Health and Welfare 2006

¹³¹ One interpretation of the SAAP data is to assume that all SAAP clients were homeless, at least according to the SAAP definition. Unfortunately, this does not tell us how many Victorians experienced homelessness in 2004–05, because it is not known what proportion of homeless people access the SAAP.

¹³² A support period denotes a period of time a client receives support from a SAAP agency. A support period can be long or short, and some SAAP clients have multiple support periods.

Gaps in information about homeless children and young people

There is no detailed information about the geographical distribution of homeless children and young people in Victoria; however, at the time of the Census the total homeless population in Victoria was spread fairly evenly, with a slightly higher rate of homelessness in the north of the state. There were 56 homeless people per 10,000 of the population in northern Victoria on Census night, compared with 42 homeless people per 10,000 in the rest of the state (Chamberlain & MacKenzie 2004).

There is also no detailed information on the number of Indigenous homeless children and young people in Victoria; however, we know that Indigenous people are over-represented in the total homeless population in all states and territories. There were 564 homeless Indigenous people in Victoria on Census night. The rate was 217 per 10,000 of the population (Chamberlain & MacKenzie 2004). In contrast, there were 19,634 non-Indigenous homeless people in Victoria, but the rate was 42 per 10,000.

The Census also provides no information on the length of time people have been homeless. This is an important gap in our knowledge, but it is not possible to obtain reliable information on this issue using Census data. Information on the 'duration of homelessness' is better obtained by trained interviewers who can probe people's housing histories.¹³³

Insecure housing and financial stress

Children and young people may also be at increased risk of living in insecure housing, with financial stress playing a key role. Data relating to this are available from the Public Housing and Community Building Branch of the Department of Human Services. The branch provides approximately 64,000 direct tenure public housing tenancies. As at May 2005, approximately 22 per cent (13,772) of these public tenant households were in rental arrears.

Households with children, and particularly lone parent households, were over-represented among these households. Couples with children accounted for 8 per cent of tenancies, 14 per cent of arrears cases and 6 per cent of arrears evictions. Lone parent households accounted for 25 per cent of all tenancies, 38 per cent of arrears cases and 54 per cent of all arrears evictions.

Housing: summary of key findings

- Just over one-third (36 per cent) of the homeless population in Victoria was aged 18 years or under on Census night, which is identical to the national figure of 36 per cent.
- Just over half of the homeless aged under 18 years were independent teenagers and just under half were accompanying children.
- On 2001 Census night Victoria had a higher proportion of homeless children and young people under 12 years and of homeless teenagers aged 12–18 years in SAAP than other states and territories.
- There is no information on the number of homeless Indigenous children and young people in Victoria; however, Indigenous people are known to be over-represented in the homeless population.

Parental and family lifestyles and health-promoting behaviour

Outcome area: healthy parent lifestyle

Associated indicators reported: alcohol use in pregnancy, smoking in pregnancy, regular cigarette smoking (exposure to cigarette smoke), periconceptional folate supplementation

¹³³ Interviewing also provides an important means of gathering information about the life paths and experiences of homeless people. For example, a five-year longitudinal study in Melbourne (Project i) has used interviews with 225 homeless young people to explore their pathways in and out of homelessness, their family relationships, support networks, service experiences, drug and alcohol use, and risks to health and wellbeing.

The lifestyles and health behaviours of parents are linked to health outcomes for children in many ways. For example, parents who smoke are less likely to be healthy, and they can adversely affect their child's health through environmental tobacco exposure. Children who have a parent or parents who smoke are also more likely to be smokers themselves in the future. Similarly, it would be difficult to address the issue of childhood obesity without considering the lifestyle and diet of parents.

Alcohol use in pregnancy

Both alcohol use and smoking in pregnancy are known to be risk factors for low birthweight and there is evidence to show that smoking cessation programs can have an impact on the incidence of low birthweight (Lumley et al. 2004). (For data on low birthweight, see section 2.1 (health and wellbeing).

Alcohol use during pregnancy is linked to fetal alcohol syndrome¹³⁴ and to a range of other effects, known as fetal alcohol effects.

The Victorian Child Health and Wellbeing Survey collected information from women about their use of alcohol and smoking behaviours during pregnancy. The responses relating to use of alcohol are presented in Table 3.1.9.

Table 3.1.9: Reported alcohol use in pregnancy: women with children under two years of age

	Ever drank alcohol (%)	Binge drank at least once (%)	Binge drank at least once a week (%)
Unaware of pregnancy	60.8	21	8
Aware of pregnancy (early pregnancy)	33.7	3.5	1.0
Aware of pregnancy (late pregnancy)	30.7	3.9	1.3

Source: Victorian Health and Wellbeing Survey 2006

This table shows that six out of ten (60.8 per cent) children under two years of age have mothers who said they had drunk alcohol early in their pregnancy before they knew they were pregnant. The majority (65.3 per cent) of children have mothers who never drank more than four standard drinks in one day ('binge drinking'), 21 per cent of children have mothers who reported they had binge drank at least once during pregnancy, and 8 per cent of children have mothers who said they had binge drank at least once a week.

When women knew they were pregnant they were less likely to drink alcohol and very unlikely to binge drink. One-third (33.7 per cent) of children have mothers who drank alcohol at some point once they knew they were pregnant. Most of these women continued to drink for the rest of their pregnancy, and 30.7 per cent of children have mothers reporting they drank alcohol towards the end of the pregnancy.

Smoking in pregnancy

Over one in five (21.9 per cent) children under two years of age have mothers who reported they had smoked in the early stages of their pregnancy before they knew they were pregnant. Just over one in eight (12.1 per cent) children have mothers who smoked when they knew they were pregnant, and 9.3 per cent of children have mothers who continued to smoke into the late stages of their pregnancy. The number of cigarettes smoked daily during pregnancy reduced once women realised they were pregnant, from a median of ten a day to a median of five a day (Table 3.1.10).

¹³⁴ Fetal alcohol syndrome is characterised by various combinations of growth restriction of the fetus, facial anomalies, microcephaly and central nervous system impairment, including intellectual disability and behaviour problems. It is recognised as the most important preventable cause of intellectual impairment (Allen et al. unpublished).

Table 3.1.10: Reported smoking in pregnancy: women with children under two years of age

	Ever smoked (%)	Median number of cigarettes smoked
Unaware of pregnancy	21.9	10
Aware of pregnancy (early pregnancy)	12.1	5
Aware of pregnancy (late pregnancy)	9.3	5

Source: Victorian Health and Wellbeing Survey 2006

Regular cigarette smoking (exposure to cigarette smoke)

Passive smoking (or the inhalation of second-hand smoke) is known to have a range of adverse effects on the health of children. For example, passive smoking is linked to respiratory infections, middle ear infections and more frequent colds, onset and severity of asthma, decreased lung function, eye and nose irritation, and sudden infant death syndrome (for data on SIDS see section 2.1 (health and wellbeing)).

Information on children's exposure to cigarette smoking is available from the Victorian Child Health and Wellbeing Survey and from the 2005 Victorian Population Health Survey.

The Victorian Child Health and Wellbeing Survey shows that the majority (68.1 per cent) of Victorian children do not live with a regular smoker.

Almost all respondents reported that visitors would be discouraged from smoking in the home. (Just 3.8 per cent of all children came from a household in which the respondent reported they would not discourage a visitor from smoking in the house).

Predictably perhaps, respondents from households with regular smokers were less likely to report that visitors would be discouraged from smoking in the household.

Where children do live with a regular smoker the adults are likely to report they always smoke outdoors (86.9 per cent of children who lived with a regular smoker also lived in a household where the respondent reported the smokers always or usually smoke outside the house; 78.8 per cent of children lived in smoking households where the respondent reported the smokers always smoke outside).

The 2005 Victorian Population Health Survey found that respondents with children had broadly similar proportions of smokers to respondents with no children. There were more ex-smokers among respondents with children and more non-smokers among respondents with no children (Table 3.1.11).

Table 3.1.11: Smoking and parental status

	Respondents with children (%)	Respondents with no children (%)
Current smokers	23.8	24.6
Ex-smokers	24.4	17.6
Non-smokers	51.6	57.7

Source: Victorian Population Health Survey 2005

Respondents with children were slightly more likely than those without children to have a smoke-free home (Table 3.1.12).

Table 3.1.12: Smoking in the home and parental status

	Respondents with children (%)	Respondents with no children (%)
Smoke-free home	90.8	84.6
Occasional smoking in house	4.9	6.7
Frequent smoking in house	4.1	8.6

Source: Victorian Population Health Survey 2005

Spina bifida and periconceptional folate supplementation

Spina bifida is one of a class of serious birth defects called neural tube defects that involve damage to the bony spine and the nervous tissue of the spinal cord.¹³⁵

Intake of folate before and during pregnancy is shown to significantly decrease the risk of spina bifida. It is also believed that the full potential impact of folate is yet to be realised and there is still opportunity to ensure more women are aware of the benefits of folate supplementation (Victorian Perinatal Data Collection Unit 2003).

The 2005 Victorian Population Health Survey asked women aged 18–50 years,

‘Are you currently taking a folate supplement or a multivitamin containing folate?’ A small proportion (20.4 per cent) of the women surveyed were taking folate. Of these, 17.7 per cent were taking folate daily, 1.7 per cent were taking it one to three times a week, 0.7 per cent were taking it four to six times a week, and 0.3 per cent were taking it less often.

Among all the women who were taking folate, 3.4 per cent said their main reason for taking folate was ‘because I could become pregnant’. A further 8 per cent said ‘because I am trying to become pregnant’, and 13.1 per cent said they were taking it ‘because they were pregnant’.

We present data on Victorian spina bifida rates in section 3.3 (services and supports).

Outcome area: parent promotion of child health and development

Associated indicators reported: breastfeeding at three and six months, balanced diet, parents reading to their children, percentage of infants put on back to sleep, use of appropriate sun protection

There are many ways in which parents can actively promote the health and development of their children, including breastfeeding, providing a balanced diet, reading to their children, putting their infants on their back to sleep, and using appropriate sun protection.

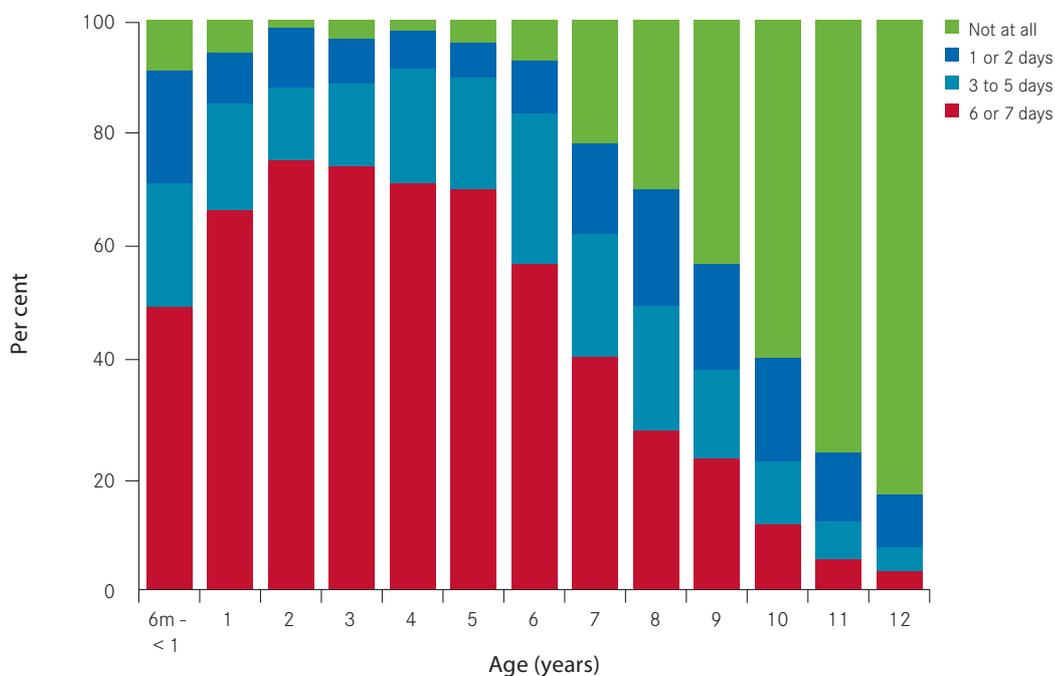
Data relating to breastfeeding and a balanced diet are presented in section 2.1 (health and wellbeing). We look at the other indicators here.

Parents reading to their children

Forty-three per cent of children aged under 13 years whose parents participated in the Victorian Child Health and Wellbeing Survey had parents who reported reading to their child almost every day (six to seven days). As Figure 3.1.2 shows, younger children were read to more frequently than older children.

¹³⁵ In spina bifida, some vertebrae do not close properly during development and the spinal cord's nerves are exposed and damaged. At birth, they protrude through the gap instead of growing normally down the bony spinal column. Nerve signals to most parts of the body located below the level of the ‘split spine’ are damaged and a wide range of muscles, organs and bodily functions are affected.

Figure 3.1.2 Parents reading to child from book (days per week)



Source: Victorian Child Health and Wellbeing Survey 2006

Percentage of infants who are put on their back to sleep

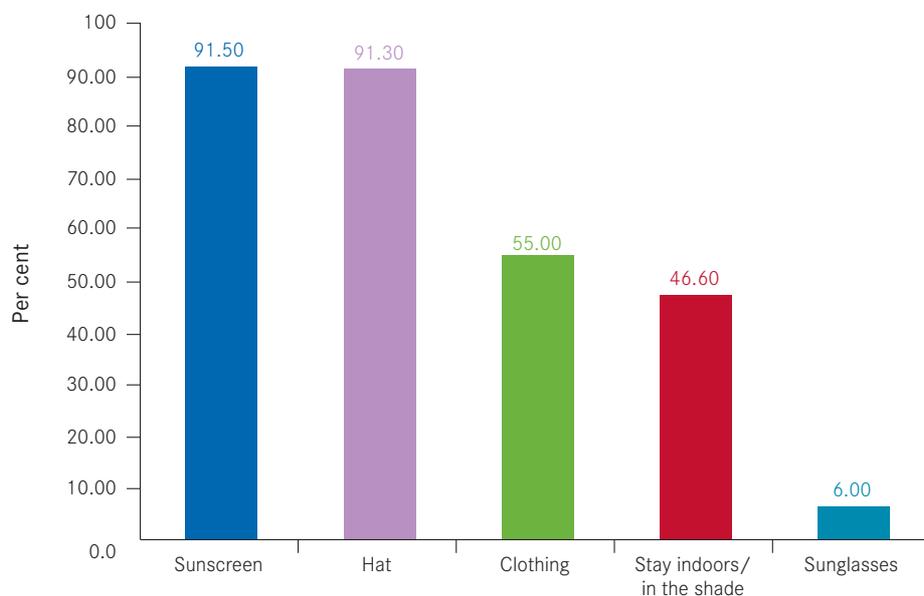
Research has identified that placing an infant in a face-down sleeping position is a risk factor for SIDS. Respondents to the Victorian Child Health and Wellbeing Survey were asked in what position they put their child (aged under one year) to sleep from birth. A very high proportion (89.3 per cent) of children had been put on their back to sleep since birth; 7.5 per cent of children were placed on their side and 2.5 per cent on their tummy.

Use of appropriate sun protection

Parents were asked in the Victorian Child Health and Wellbeing Survey how often they try to protect their child from the sun on summer days when the child is outside. The majority (82.5 per cent) of children were reported to have been protected from the sun every day. Less than 1 per cent of children had parents who reported they never tried to protect their child from the sun.

Using sunscreen and using a hat were the most common ways parents attempted to limit sun exposure. Parents were unlikely to mention sunglasses when reporting how they limit sun exposure (Figure 3.1.3).

Figure 3.1.3 Percentage of children whose parents protect them from sun exposure using the following methods



Source: Victorian Child Health and Wellbeing Survey 2006

Outcome area: good parental mental health

Associated indicators reported: postnatal depression, psychological distress

The health and wellbeing of children and young people is clearly affected by the mental health of their parents. We look here at two indicators: the prevalence of postnatal depression and the prevalence of psychological distress.

The prevalence of postnatal depression

The prevalence of postnatal depression among women in the three to nine months after birth has been measured as around 15 per cent, based on three statewide surveys of mothers at five to nine months after birth in Victoria (Brown et al. 2004), on data from a large randomised trial six months after birth in eight rural and metropolitan communities in Victoria (local government areas) (Lumley et al. 2006), and most recently on the preliminary reports from beyondblue, the national depression initiative.¹³⁶

This prevalence is also typical in English-speaking countries elsewhere (Cox 1989). The prevalence of depression in early pregnancy is lower than after birth—a consistent finding since the earliest use of the Edinburgh Postnatal Depression Scale in 1987 longitudinal studies and reported most recently by beyondblue.

The prevalence of depression in adult women is lower still: around 3–4 per cent at a population level (O'Hara 1996).

The consistency of these findings, and the potential for adverse effects of maternal depression on the child and family, explain why postnatal depression has been widely discussed and researched in the past 15 years.

¹³⁶ Beyondblue is a bipartisan initiative of the Australian, state and territory governments. The initiative aims to raise community awareness about depression and reduce the stigma associated with the illness.

Trials of individual counselling have also been shown to have a positive effect. Six postnatal trials of individual counselling had a strong and consistent positive effect on reducing maternal depression (Lumley et al. 2004)¹³⁷ and the recent Cochrane Review, with stricter criteria for inclusion of studies, came to a similar conclusion (Dennis & Creedy 2004); however, the individual trials with a substantial effect would be difficult to implement in Australia.¹³⁸

The prevalence of psychological distress

The Victorian Child Health and Wellbeing Survey used questions from the Kessler 6 scale¹³⁹ to ascertain those parents who were at high risk of psychological distress. Overall, a very small minority (3 per cent) of children have a main carer who was found to be at high risk of psychological distress. Children were more likely to have a main carer who was at high risk of psychological distress if they belonged to a sole parent family (7.1 per cent of children with sole parents, compared with 2.2 per cent of children with couple parents).

Results from the Victorian Population Health Survey support these findings. The survey found that approximately 3 per cent of parents were at high risk of suffering from psychological distress. The Victorian Population Health Survey also suggests that parents are no more likely to be at high risk of psychological distress than other adults.

Outcome area: positive family functioning

Associated indicators reported: family functioning scale

The McMaster Family Assessment Device is used to measure family functioning.

Overall, 15.5 per cent of children whose parents responded to the Victorian Child Health and Wellbeing Survey were part of a family that scored two or above on the McMaster Family Assessment Device, reflecting 'unhealthy' family functioning. Unhealthy family functioning was more common if a child was from a sole parent household (24.3 per cent)¹⁴⁰ or if the child was reported to have a special health care need (21.2 per cent).

¹³⁷ These trials showed a reduction of close to 50 per cent in the proportion of women depressed, with little heterogeneity across the trials.

¹³⁸ The trial of redesigned postnatal care developed by MacArthur and colleagues (2002) was effective in reducing depression, but it depends on the infrastructure and organisation of maternity services in the United Kingdom. The two interventions developed by Chabrol and colleagues (2002) were also effective, both in prevention and treatment; however, these interventions depend on trained psychologists and psychiatrists to an extent not available in Australia.

¹³⁹ The Kessler 6 scale is used to measure non-specific psychological distress.

¹⁴⁰ This may be directly linked to socioeconomic disadvantage. Families that were rated as having 'unhealthy' family functioning were also less likely to be able to raise \$2,000 in an emergency, and more likely to live in an area with a low SEIFA score (see 2.1: health and wellbeing).

Healthy parent lifestyle: summary of key findings

- According to the Victorian Child Health and Wellbeing Survey 60.8 per cent of children have mothers who reported drinking alcohol when pregnant (before they knew they were pregnant) and 21 per cent of children's mothers reported they had binge drunk at least once. When women knew they were pregnant they were very unlikely to drink alcohol and very unlikely to binge drink.
- Just over one-fifth of children under two years of age have mothers who reported they had smoked in the early stages of their pregnancy (before they knew they were pregnant). Just over one in eight children have mothers who smoked when they knew they were pregnant (Victorian Child Health and Wellbeing Survey).
- The majority (68.1 per cent) of Victorian children do not live with a regular smoker (Victorian Child Health and Wellbeing Survey).
- In the majority of households where there is a smoker, the adults report they always smoke outdoors (Victorian Child Health and Wellbeing Survey).
- Just over one-fifth (20.4 per cent) of the women surveyed in the Victorian Population Health Survey were taking folate and 17.7 per cent were taking folate daily.
- Forty-three per cent of Victorian children aged under 13 years were read to almost everyday (Victorian Child Health and Wellbeing Survey).
- According to the Victorian Child Health and Wellbeing Survey, 89.3 per cent of children aged under one year of age were put on their back to sleep.
- The majority (82.5 per cent) of children have parents who reported protecting the child from the sun on every summer day (Victorian Child Health and Wellbeing Survey).
- The prevalence of postnatal depression among women in Victoria is estimated to be around 15 per cent.
- The Victorian Child Health and Wellbeing Survey found that 3 per cent of children have a main carer with high risk of psychological distress. Children in sole parent families were more likely to have a main carer who was at high risk of psychological distress.
- The Victorian Child Health and Wellbeing Survey showed that 15.5 per cent of children are from a family that scored two or above on the McMaster Family Assessment Device, reflecting 'unhealthy' family functioning. Unhealthy family functioning was more common if a child was from a sole parent household or was reported to have a special health care need.

3.2 The community

Community networks and support

Outcome area: communities that enable parents, children and young people to build connections and draw on informal assistance

Associated indicators reported: households with children where respondent was able to get support in time of crisis from persons living outside the household, children whose parents report high levels of support, ability to raise \$2,000 within two days in an emergency

Research has shown that children's health, development and wellbeing are affected by the level of social cohesion in their families and communities and that children do better when they are living in families and communities where social cohesion is strong (Australian Institute of Health and Welfare 2005). This implies the existence of shared values, trust and a sense of belonging – communities where parents, children and young people are able to build connections and draw on informal assistance.

Our data on social support come from the 2006 Victorian Child Health and Wellbeing Survey and the 2005 Victorian Population Health Survey.

Parents of children aged five to 12 years were asked three questions in the Victorian Child Health and Wellbeing Survey to ascertain their perceived level of social support:

- Could one of your relatives or friends care for you or your children in an emergency?
- Is there someone who you trust who you would turn to for advice if you were having problems?
- Could you raise \$2,000 within two days in an emergency?

Overall, parents reported very high levels of support. For example, 94.4 per cent of children have parents who said that one of their relatives or friends could care for them or their children in an emergency, and 84.9 per cent of children have parents who said they could raise \$2,000 within two days.¹⁴¹ Nearly all the children (96.8 per cent) have parents who agreed or strongly agreed there was someone they could turn to for advice if they were having problems.

There was no apparent difference between the responses of parents living in metropolitan areas and those in rural areas; however, sole parents consistently reported lower levels of social support than parents in couple households (Tables 3.2.1 to 3.2.3). The percentage of sole parents who are able to raise financial resources in an emergency (Table 3.2.3) is markedly lower (62.9 per cent of lone parents compared with 88.6 per cent of parents in couple households).

Table 3.2.1: Parents saying 'yes' when asked whether one of their relatives or friends could care for them or their children in an emergency

	Percentage
Couple with dependent children	95.1
Sole parent	90.5

Source: Victorian Child Health and Wellbeing Survey 2006

¹⁴¹ The proportion of parents with children under 18 years who said in the Victorian Population Health Survey that they could raise \$2,000 in an emergency was very similar (83.7 per cent).

Table 3.2.2: Parents agreeing or strongly agreeing there is someone they trust who they could turn to for advice in an emergency

	Percentage
Couple with dependent children	97.5
Sole parent	93.2

Source: Victorian Child Health and Wellbeing Survey 2006

Table 3.2.3: Parents saying 'yes' when asked whether they could raise \$2,000 within two days in an emergency

	Percentage
Couple with dependent children	88.6
Sole parent	62.9

Source: Victorian Child Health and Wellbeing Survey 2006

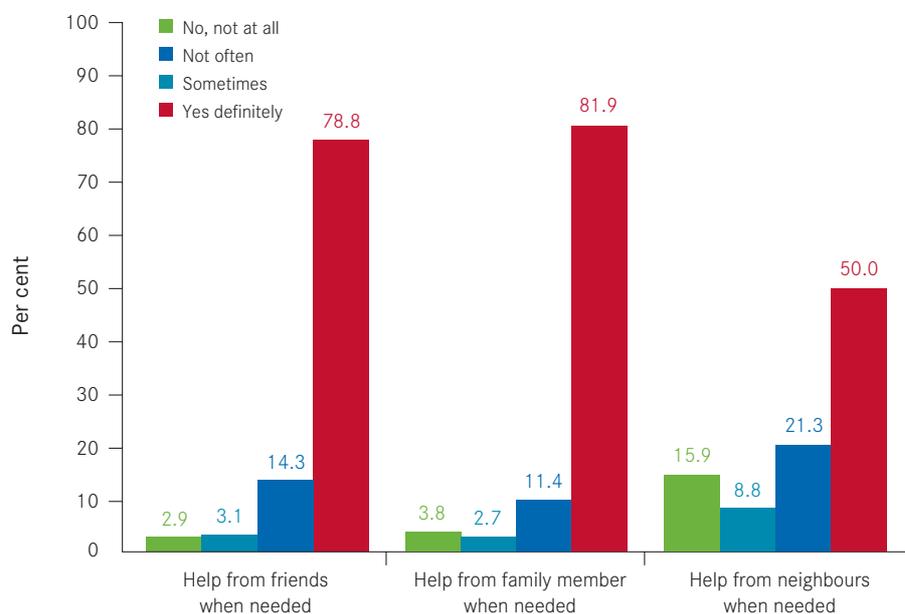
In the Victorian Population Health Survey parents of children under 18 years were asked:

- Can you get help from friends when you need it?
- Can you get help from family members when you need it?
- Can you get help from neighbours when you need it?

The findings from this survey also suggest that parents have high levels of perceived support (Figure 3.2.1). More than eight in ten (81.9 per cent) parents said they could definitely get help from family members when needed, and nearly eight in ten (78.8 per cent) could get help from friends.

The survey also shows that perceived levels of support from family and friends are higher than from neighbours. (Only half (50 per cent) of parents said they could definitely get help from neighbours and 15.9 per cent said they could never receive this kind of support).

Figure 3.2.1: Perceived levels of social support among Victorian parents



Source: Victorian Population and Health Survey 2005

Community networks and support: summary of key findings

- Parents responding to the Victorian Child Health and Wellbeing Survey reported very high levels of social support.
- Sole parents reported lower levels of social support than parents in couple households and sole parents were much less likely than parents in couple households to be able to raise \$2,000 in an emergency.
- The Victorian Population Health Survey suggests that perceived levels of support from family and friends are higher than from neighbours.

Accessible local recreation spaces, activities and community facilities

Outcome area: accessible local recreation spaces, activities and community facilities

Associated indicators reported: access to transport, good facilities and services, ease of access to parks and recreational spaces

The Victorian Child Health and Wellbeing Survey asked parents a series of questions to elicit their views about the area in which they lived – (see also section 2.3 (safety) for survey data on cleanliness, safety and other aspects of the physical and social environment).

Respondents were asked to rate how strongly they agreed or disagreed with the following statements:

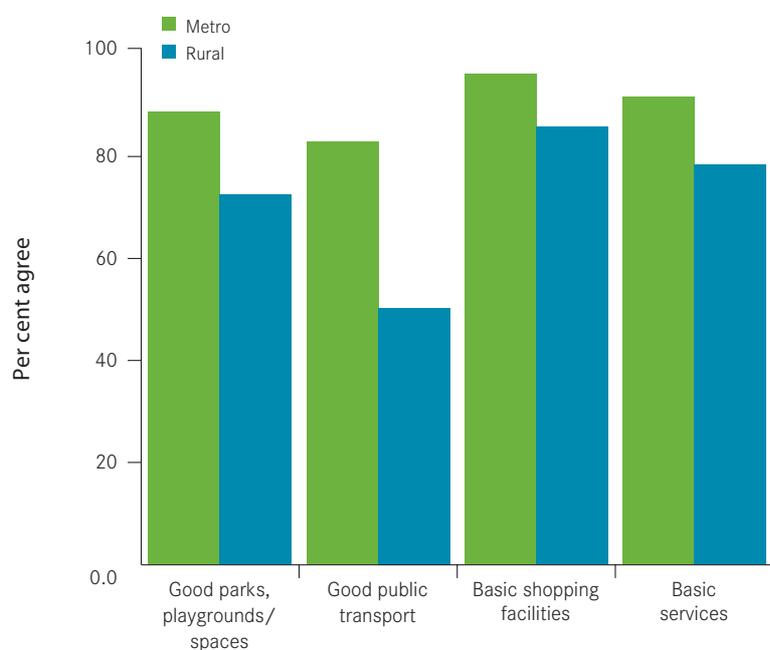
- There are good parks, playgrounds and play spaces in this neighbourhood.
- There is access to close, affordable, regular public transport in this neighbourhood.
- There is access to basic shopping facilities in this neighbourhood.
- There is access to basic services, such as banks and medical clinics, in this neighbourhood.

Overall, a very high proportion of parents rated their neighbourhood positively;¹⁴² however, there were some differences between the responses of parents in metropolitan areas and those in rural areas. Parents in rural areas were less likely to agree or strongly agree with all four statements than parents in metropolitan areas,¹⁴³ and the largest difference in perception related to transport. While 82.5 per cent of metropolitan parents agreed or strongly agreed their neighbourhood had access to close, affordable, regular public transport, only half (50.5 per cent) of rural parents agreed with this statement (Figure 3.2.2).

¹⁴² A very high proportion agreed or strongly agreed that there was access to basic shopping facilities in their neighbourhood (93.1 per cent), and a high proportion of parents agreed or strongly agreed that their neighbourhoods had good parks, playgrounds and play spaces and that there was access to basic services such as banks and medical clinics (83.1 per cent and 87.7 per cent respectively). A lower proportion (73.7 per cent) agreed or strongly agreed that there was access to close, affordable and regular public transport.

¹⁴³ It is of interest too that parents in rural areas were more likely than parents in metropolitan areas to say the statement was not applicable or relevant to them because they live in a remote or rural location.

Figure 3.2.2 Victorian parents' ratings of their neighbourhood



Source: Victorian Child Health and Wellbeing Survey 2006

In general, parents whose child was on a health care card were less likely to give positive ratings than parents whose child was not. (For example, 75 per cent of parents with a child on a health care card agreed or strongly agreed there are good parks, playgrounds and play spaces in their neighbourhood, compared with 86.2 per cent of parents whose child was not on a health care card).¹⁴⁴

Accessible local recreation spaces, activities and community facilities: summary of key findings

- A high proportion of parents responding to the Victorian Child Health and Wellbeing Survey rated their neighbourhood positively.
- Parents in rural areas were less positive about their neighbourhoods than parents in metropolitan areas.
- Parents whose child was on a health care card were less positive about their neighbourhoods than parents whose child was not.

¹⁴⁴ There was no statistical difference in the percentage of those agreeing or strongly agreeing that there was access to good transport.

3.3 Services and supports

Quality antenatal care

Outcome area: **quality antenatal care**

Associated indicators reported: spina bifida rate, smoking cessation advice during pregnancy

Spina bifida rate

Because intake of folate before and during pregnancy is shown to significantly decrease the risk of spina bifida, it is expected that targeted strategies should be able to impact on the incidence of this condition.

The rate of occurrence of spinal bifida is expressed as a rate per 10,000 births.

In 2001–02 there was a total of 33 recorded cases of spina bifida in Victoria, – (representing a prevalence rate of 5.2) (Victorian Perinatal Data Collection Unit 2004). As Figure 3.3.1 shows, the prevalence rate showed a declining trend from 1989 to 2002.

Figure 3.3.1 Spina bifida: trends in prevalence rates, 1989–2002



Source: Victorian Perinatal Data Collection Unit 2004

Smoking cessation advice during pregnancy

The Victorian Maternity Services Indicators (2005–06) include a measure of ‘the rate of women who are offered appropriate antenatal intervention in relation to smoking’. In 2004–05 the proportion of women who were assessed for smoking behaviour and given advice and assistance at the first antenatal appointment prior to 20 weeks gestation was 98.1 per cent.¹⁴⁵ The proportion of further appropriate interventions in relation to smoking prior to 20 weeks gestation, in those hospitals that identified smokers or recent quitters, was 63.3 per cent (Department of Human Services 2006).^{146,147}

¹⁴⁵ This represents an increase from the proportion in 2003–04. (In 2003–04 this was 90.1 per cent).

¹⁴⁶ This represents an increase from the proportion in 2003–04. (In 2003–04 this was 56.8 per cent).

¹⁴⁷ A total of 27 hospitals reported against this indicator in 2004–05, and 20 hospitals reported against it in 2003–04.

Quality antenatal care: summary of key findings

- Spina bifida rates have shown a declining trend (1989–2002).
- The Victorian Maternity Services Indicators (2004–05) show that the proportion of women who were assessed for smoking behaviour and given advice and assistance at the first antenatal appointment prior to 20 weeks gestation was 98.1 per cent.

Early identification of and attention to child health needs

Outcome area: early identification of and attention to child health needs

Associated indicators reported: attendance at the Maternal and Child Health Service three and a half year ages and stages visit, asthma hospitalisations

The primary health care system (particularly maternal and child health, school health nurses, and general practitioners) is ideally placed to identify and address the needs of children and to support parents in health promotion. To deliver on this, primary care services, such as maternal and child health, need to be engaged with and familiar to all families and able to sustain contact with families where needs or risks are very high. Primary care services, such as school nurses and community health services, need to be known and available to adolescents.

The indicators we report on under this outcome area are attendance at the three and a half year ages and stages visit and asthma hospitalisations.

Attendance at the three and a half year ages and stages visit

The Victorian Maternal and Child Health Service aims to 'provide a comprehensive and focused approach for the promotion, prevention, early detection and intervention of physical, emotional or social factors affecting young children and their families' (Department of Human Services 2004). Ages and stages consultations from birth to three and a half years are a key component of the Maternal and Child Health Service. These consultations provide information, advice and support relevant to individual child development and family support.

Table 3.3.1 shows the rates of attendance at the three and a half years ages and stages visits by rural and metropolitan areas from 2000–01 to 2004–05. Rates of attendance are marginally higher in rural areas than in metropolitan areas. The data also highlight an increasing trend in attendance across the five-year period.

Table 3.3.1: Attendance at the three and a half year visit, 2000–01 to 2004–05

	2000–01 (%)	2001–02 (%)	2002–03 (%)	2003–04 (%)	2004–05 (%)
Metropolitan	48.2	48.4	46.3	49.7	54.5
Rural	53.0	50.6	50.3	52.1	59.1
Victoria	49.5	49.0	47.4	50.3	55.7

Source: Department of Human Services Maternal and Child Health Service data

Asthma hospitalisations

Table 3.3.2 shows the hospital admission rate for asthma (per 1,000 population) for zero to 18 year-olds by age and gender in 2004–05.

Table 3.3.2: Rates of hospital admission for asthma, by gender and age, 2004–05

Age	Girls	Boys	Total (by age)
0–4 years	7.0	12.2	9.7
5–9 years	3.1	4.9	4.0
10–14 years	1.5	1.7	1.6
15–18 years	1.1	0.7	0.9
Total (by gender)	3.2	4.9	4.0

Source: Victorian Admitted Episodes Dataset

The table shows that rates of admissions are higher overall among boys. They are also higher among younger children than older children.

This age and gender pattern of hospitalisations for asthma is different from the pattern for all causes of hospitalisation. For all causes of hospitalisation, rates are highest in the oldest age groups and lowest in children aged ten to 14 years (Australian Institute of Health and Welfare Australian Centre for Asthma Monitoring 2005). A high proportion of asthma admissions are for ‘ambulatory care sensitive conditions’. Ambulatory care sensitive conditions are those for which hospitalisation is thought to be avoidable if preventive care and early disease management are applied, usually in the ambulatory setting (Department of Human Services 2002).

Indigenous children

Table 3.3.3 presents the rates (per 1,000 population) of hospital admission for asthma in Indigenous children and in all children aged zero to 18 years from 2002–03 to 2004–05.

The table shows a very slight overall increase in the rates of admission over this entire period in both groups of children.¹⁴⁸ It also shows that rates of admission were higher among Indigenous children in 2002–03 and 2004–05.

Table 3.3.3: Rates of hospital admissions for asthma, Indigenous children and all children, 2002–03 to 2004–05

	2002–03	2003–04	2004–05
Indigenous children	4.4	3.8	4.6
All children	3.5	3.8	4.0

Source: Victorian Admitted Episodes Dataset

¹⁴⁸ Because these data cover just a three-year period this should not be interpreted as a trend.

Early identification of and attention to child health needs: summary of key findings

- Rates of attendance at the three and a half year ages and stages visit show an increasing trend. Attendance rates are marginally higher in rural areas than in metropolitan areas over the five years from 2000–01 to 2004–05.
- Rates of asthma hospital admissions are higher among boys than girls and among younger children than older children. Rates also appear to be higher among Indigenous children.

High quality early education and care experiences available

Outcome area: high quality early education and care experiences available

Associated indicators reported: four year-old kindergarten enrolments in a long day care or integrated children's services setting, child care waiting periods

Very young children, particularly infants, spend most time directly with their parents and siblings, often in the home. Outside the immediate family, significant amounts of time are spent in informal care or play contexts, some of these are spontaneous arrangements and others ongoing, sponsored by local services or professionals.

The use of formal care arrangements (various forms of child care, preschool and school) becomes increasingly common, as children get older. Around a fifth of one year-olds spend an average of two days a week in long day care, and by six years of age virtually all children spend half their waking hours at school.

Childcare provision

Kindergarten education is provided to some three year-olds and to the majority of four year-olds either in sessional kindergartens that are often organised through local parent-managed associations or in long day care settings.

As of 2005, there are 1,583 funded kindergarten services in Victoria. Just under a quarter of these—362 or 23 per cent—are long day care centres with an integrated kinder program.¹⁴⁹ Care is also provided to children in 3,800 family day care homes and (for school-aged children) in out-of-school hours care programs. There are currently 1,590 out-of-school hours care programs based in school communities.

The data we present here on the usage of early education and care services are derived from two sources: the Department of Human Services Children's Services Online (CHISOL) database and the Victorian Child Health and Wellbeing Survey.

¹⁴⁹ Source: Department of Human Services, Children's Services Online (CHISOL) database

Four-year-old kindergarten enrolments in a long day care or integrated children's services setting

Table 3.3.4 illustrates the percentage of the Victorian four year-old population enrolled at kindergarten in 2005 in metropolitan, rural and regional local government areas.

Table 3.3.4 Four year-olds enrolled at kindergarten as a percentage of total population, 2005¹⁵⁰

	First year enrolment (no.)	Estimated resident population aged four years(no.)	Kindergarten participation rate (%)
Metropolitan local government areas	41,124	43,283	95.0
Rural and regional local government areas	16,178	17,425	92.8
Victoria	57,302	60,708	94.4

Source: Department of Human Services, Children's Services Online

The table shows that the overall participation rate is very high (94.4 per cent) across Victoria. Rates of enrolment are slightly higher in metropolitan local government areas (95 per cent) than in rural and regional local government areas (92.8 per cent).

Use of child care

Hours in child care

The Victorian Child Health and Wellbeing Survey shows that older children are spending more time in care than younger children. Where a child had attended preschool, long day care or occasional care in the previous month:

- The majority (95.6 per cent) of five year-olds, 68.0 per cent of four year-olds and 48.4 per cent of three year-olds were reported to have spent ten hours or more in formal care.
- On average, children in the metropolitan areas spent more hours in child care than those in rural and regional areas (median of 12 hours in metropolitan areas, compared with median of ten hours in rural areas).

Use of child care and health care card status

Children listed on healthcare cards appeared to be no less likely to attend long day care than other children; however, they were less likely to be attending playgroups than other children.

School-aged children were less likely to be attending out-of-school hours care if listed as a dependent on a health care card.

Area of residence

Children living in rural areas appeared less likely than children in metropolitan areas to attend three year-old kinder. School-aged children were less likely to be attending out-of-school hours care if they lived in rural areas.

¹⁵⁰ The population base used to calculate the enrolment rates changed in 2005. We have not included data for previous years because these are not comparable.

Waiting times for long day care (Victorian Child Health and Wellbeing Survey data)¹⁵¹

- Six out of ten (60.3 per cent) children in long day care immediately entered a place when they were ready.
- For the remaining children, waiting times for long day care ranged from one day to three years.
- Of these children, those living in metropolitan areas had longer waiting times on average. (There was a median of 152 days wait in metropolitan areas and a median of 91.2 days wait in rural areas).

High quality early education and care experiences available: summary of key findings

- The overall enrolment rate in four-year-old kindergarten is very high (94.4 per cent) across Victoria. Rates of participation are slightly higher in metropolitan (95 per cent) than in rural and regional local government areas (92.8 per cent).
- Victorian Child Health and Wellbeing Survey children listed on health care cards were no less likely to attend long day care than other children; however, they were less likely to be attending play groups, than other children.
- School-aged children were less likely to be attending out-of-school hours care if listed as a dependent on a healthcare card (Victorian Child Health and Wellbeing Survey).
- Children living in rural areas were less likely than children in metropolitan areas to attend three-year-old kinder. School-aged children were less likely to be attending out-of-school hours care if they lived in rural areas (Victorian Child Health and Wellbeing Survey).
- According to the Victorian Child Health and Wellbeing Survey, 60.3 per cent of children in long day care immediately entered a place when they were ready.
- For the remaining children, waiting times for long day care ranged from one day to three years. Children in metropolitan areas had longer average waiting times (Victorian Child Health and Wellbeing Survey).

¹⁵¹ These figures relate to children who are already in long day care, so any child who has not yet found a long day care place will not be represented in the figures.

4: Principal findings

4.1 Overview

This report on the state of Victoria's children provides an overview of the wellbeing of Victoria's children and young people aged zero to 18 years within an outcomes framework that was developed by the Office for Children, in the Department of Human Services, in collaboration with other government departments. For the first time, a wide range of outcomes data relating to the *health and wellbeing*, the *development and learning* and the *safety* of children and young people has been brought together in one document, allowing for comparison both within and across population groups of children.

The contextual factors that impact on the wellbeing of children and young people—family, community, services and supports—form a key element of the comprehensive outcomes framework.

In relation to each of the outcome framework areas, the report asks:

- What do we know about the circumstances for *all* children in Victoria?
- What issues are identified for children from the four identified priority groups (Indigenous children, children with a disability, children from culturally and linguistically diverse backgrounds, including refugees, and children affected by chronic disadvantage, including children in out-of-home care)?
- Are outcomes for children living in rural areas different from outcomes for children living in metropolitan areas?
- What do we know about how Victoria's children are faring in comparison with other children nationally and internationally?

The key report findings are summarised in text boxes throughout the six data reporting sections (*health and wellbeing*, *development and learning*, *safety*, *the family*, *the community*, *services and supports*).

In this final section we describe and discuss the overall themes and findings of the report, drawing on material from across all the sections. We look first at what the evidence tells us about how Victorian children and young people *as a whole* are faring. We move on to focus on what we know about any differences in outcomes for children and young people in the four priority groups, and we compare the outcomes for children and young people living in rural and metropolitan areas.

The section concludes with some comments about the value of the outcomes framework and the implications of the report and its findings for future policy making.

4.2 How are Victorian children and young people faring?

Areas in which children and young people are faring well

The evidence suggests that Victorian children and young people are faring very well in a wide range of outcome areas. Indeed, the report paints a broadly positive picture of the overall position and circumstances of Victorian children and young people.

In relation to health and wellbeing for example, infant mortality rates are lower in Victoria than in the rest of Australia. SIDS deaths have shown a declining trend, and Victorian children are reaching the minimum expected level (90 per cent) of vaccination coverage at 24–27 months of age. Victorian parents also rate their child's general health very highly, and the percentage of parents who report that their child is picked on or bullied is very small (just 4.7 per cent).

From the Victorian Child Health and Wellbeing Survey we also know that the majority of Victorian children do not live in a household with a smoker and that the vast majority of parents are taking action to promote their children's health and development. For example, nearly 90 per cent of parents report putting their infants on their back to sleep and 82.5 per cent take action to protect their child's skin during the summer. In the majority of households where there is a smoker (86.9 per cent) the adults smoke outdoors, and women generally cut back on smoking and alcohol consumption when they know they are pregnant.

The report also highlights a number of positive outcomes in development and learning and safety. In 2004, the proportion of Victorian students achieving the national literacy benchmarks for years three, five and seven was at or above the national average. Children and young people in Victorian schools score highly on measures of connectedness to school, and Year 12 completion rates are showing an improving trend. Victoria does not show the same pattern of marked increases in child protection notifications and substantiations as do many of the other Australian states and territories, and there appears to be a downward trend in the number of unintentional child injury deaths.

Finally, Victorian parents generally give very positive ratings to the 'liveability' of their local neighbourhoods in terms of the physical and the social environment and access to important facilities and services. A very high proportion of children live in neighbourhoods that are viewed by their parents to be clean (95.9 per cent), safe (94.4 per cent) and with good street lighting (75.8 per cent), and where the state of the roads and footpaths is perceived to be good (76.6 per cent). The majority of parents agree they have access to good local parks, playgrounds, transport and shopping facilities and services.

Areas where children and young people are faring less well

While the report paints a broadly positive picture of the wellbeing of Victoria's children and young people, it also suggests young Victorians may not be faring so well against some outcome measures. For example, around 60 per cent of Victorian mothers responding to the Victorian Child Health and Wellbeing Survey report drinking alcohol in pregnancy (before they knew they were pregnant) and a fifth report binge drinking at least once during their pregnancy. More than one in five children under two years of age has a mother who reported they had smoked in the early stages of their pregnancy.

In addition, the evidence shows Victorian children are not reaching minimum levels of vaccination coverage at 72–75 months of age, that more than one in ten children have asthma, and that parents give lower ratings to their children's oral health than to their general health. Injury hospitalisation rates appear to be increasing among 15–18 year-olds, and the prevalence of childhood obesity is increasing with some key areas of concern relating to children's nutrition.

Finally, there are also some areas of concern relating to the emotional and mental wellbeing of Victoria's children and young people. Overall, 15.5 per cent of children whose parents responded to the Victorian Child Health and Wellbeing Survey were part of families that scored two or above on the McMaster Family Assessment Device, reflecting 'unhealthy' family functioning.

The intentional self-harm injury death rate, among 15–18 year-olds, has decreased over the decade 1994/5 – 2003/04. However, self-harm was the second highest cause of injury deaths in this age group, in 2003, and more than 500 young people aged 15–18 years were admitted to hospital as a result of self-harm injuries (representing a rate of 1.9 per 1,000 young people aged 15–18 years).

4.3 Outcomes for children in the four priority groups

Indigenous children and young people

The report highlights that we have access to a considerable amount of outcomes data on Indigenous children and young people¹⁵² and that there are clear and marked differences in outcome between Indigenous children and other children on a wide range of measures. These inequalities in outcomes are evident in the areas of health and wellbeing, education, child protection and youth justice.

The differences in outcome for Indigenous children are apparent from the start of life. Indigenous women in Victoria are more than twice as likely than non-Indigenous women to have low birthweight babies. Perinatal and neonatal mortality rates for babies born to Indigenous mothers are also twice as high as those for babies born to non-Indigenous mothers.

The differences continue on into the primary school entry period, and are clearly identified in the Victorian School Entrant Health Questionnaire. This shows that Indigenous parents are more likely than non-Indigenous parents to have concerns about their young children's health. Indigenous parents are also more likely to have concerns about their children's teeth, but less likely to have visited a dentist in the last one to two years. They are also more likely to report that their child has asthma, less likely to report that their child is 'generally healthy', and more likely to report concerns with their children's behaviour and emotional wellbeing.

At school, there are marked differences between the achievement of Indigenous children and that of non-Indigenous children, as measured by the national benchmarks. While the performance of Indigenous students has increased in years three and five since 2001, the proportion of students achieving the reading, writing and numeracy benchmarks is much lower than it is for non-Indigenous students. Indigenous children are known nationally to have higher rates of absenteeism than non-Indigenous children, and disengagement from school is known to link with poorer educational outcomes, which in turn link to poorer employment outcomes.

Finally, there is a marked over-representation of Indigenous children and young people in the Victorian child protection and the youth justice systems. Although the total number of Indigenous children who are affected is small (in comparison with the total numbers of non-Indigenous children), Indigenous children are far more likely to be involved with these systems.

The rate of child protection substantiations is much higher among Indigenous children than among all children. Victoria has the highest rate of Indigenous children who are the subject of a substantiation of all the states and territories, and the rate of substantiations among Indigenous children in Victoria has shown recent increases (2001–02 to 2004–05). Indigenous children are also over-represented among children admitted to care and protection orders.

This over-representation can be attributed to a number of factors. These include structural risk factors that are shared with other children, such as poverty, unemployment, substandard or inadequate and limited access to societal resources (Richardson 2005). These factors are also compounded by having to deal with a lack of culturally sensitive professional practice which may fail to recognise a child's Aboriginality, cultural differences in child-rearing practices, patterns of trauma, loss and unresolved grief. All these can impact on the quality of parenting and are linked to the legacy of past policies of forced removal of Aboriginal children from their families (Victorian Child Death Review Committee 2005; Australian Institute of Health and Welfare 2006a).

¹⁵² There is a lack of research, however, that highlights the protective factors (that may mitigate against poorer outcomes) for Indigenous children and young people.

Within the youth justice system, the rates of detention of young people aged ten to 17 years in Victoria are lower than national rates. Nevertheless, Indigenous young people in Victoria are 20 times more likely than other children to be in detention. Rates of custody and community orders are also much higher among Indigenous young people.

Given that disadvantage and impoverishment is clearly related to abuse and neglect, there is a great need to work out strategies which restore capacity to Indigenous communities and parents to look after their own.

International evidence, particularly as discerned from the *Harvard Project (USA)* and the *First Nations Governance Handbook (Canada)*, demonstrates that capacity building which provides adequate infrastructure, governance and skill development leads to more effective outcomes for Indigenous children, families and communities.¹⁵³

Significant consultations with the Indigenous community have identified a framework through which Indigenous children's disadvantage can be addressed. This framework is premised on the twin needs of recognising culture as a protective factor for Indigenous children and enhancing Indigenous self-determination as a means of addressing general Indigenous disadvantage.

The International Resiliency Project has outlined some of the key aspects of attributes, traits and circumstances that lead to resilience. They range from individual traits such as self-awareness, a positive outlook, empathy, showing a balance between independence and dependence on others and a sense of humour; to contextual factors such as positive relationships; meaningful sense of community and a strong sense of culture.¹⁵⁴

Programs that are culturally embedded are most likely to build on the resilience that a strong sense of cultural identity provides and enable better outcomes. Capacity building in the Indigenous sector is most likely to empower Indigenous communities and enable them to provide high quality care for their children.

Children with a disability and children from culturally and linguistically diverse backgrounds

There is a broad body of research evidence relating to the experiences of children with a disability in Australia and a wide range of this information has been brought together in the recent Australian Institute of Health and Welfare report, *Children with disabilities in Australia* (Australian Institute of Health and Welfare 2004). This report has highlighted, however, that at this point in time there is an overall lack of good outcomes data relating to children and young people with a disability in Victoria. We also have a lack of good outcomes data relating specifically to children from culturally and linguistically diverse backgrounds (including refugees).

Although there may be very valuable research relating to the experiences of children (and their families) from these priority groups, it is also the case that outcomes data relating to children from these groups have not been routinely collected. This data gap requires attention and will be addressed in future work (see conclusions later).

¹⁵³ Terri Libesman, "Child Welfare approaches for Indigenous communities: International perspectives," *Child Abuse Prevention Issues*, No. 20, Autumn 2004

¹⁵⁴ From the International Resilience Project - www.theresilienceproject

Children in out-of-home care

Our outcomes data on children in out-of-home care are principally in the area of education where we have access to comparable data for cohorts of children and young people in out-of-home care and in the general population. The findings suggest that children and young people in out-of-home care are achieving less well than the general student population, and that absence rates are higher and employment rates (on leaving school) are lower for children in out-of-home care. Nevertheless, it is encouraging to note that comparative data for 2003 show a higher percentage of out-of-home care students (than the general population) moving on to university.

Children suffering chronic disadvantage

Child poverty is known to have serious and adverse effects on the lives of children and young people; however, while many of the adverse effects of child poverty are well recognised and documented, the absence of an official Australian (or Victorian) poverty benchmark has meant it is difficult to comment conclusively on the prevalence of poverty in Victoria. In section 3.1 of this report (the family) we discuss this issue in depth and use a range of data to provide some indication of poverty levels in Victoria and Australia.

These data suggest that considerable numbers of children in Victoria are affected. We also know that key groups of children, including Indigenous children, children from culturally and linguistically diverse backgrounds, and children with a disability, are more likely to be at high risk of experiencing poverty in Victoria and Australia.

The report also draws on new data to highlight a number of associations between measures of low income and socioeconomic disadvantage and poorer outcomes for children and young people. For example, while the link between socioeconomic disadvantage and obesity in adults has been well documented, recent research suggests a link between socioeconomic disadvantage and overweight and obesity in children. The Victorian Child Health and Wellbeing Survey also finds that parents living in more socioeconomically disadvantaged areas are less likely to give positive ratings to their children's health or to the 'liveability' of their local neighbourhoods.

Finally, and importantly, the report highlights the particular range of issues that sole parents in Victoria may face. For example, we have noted how sole parents are less likely than parents in couples to be in secure employment and how they are less likely to be able to raise funds in an emergency. Sole parents in Victoria also have lower perceived levels of social support and higher levels of 'unhealthy' family functioning and of psychological distress. These sole parents include those who are unmarried and those who are either separated from partners or divorced.

4.4 Outcomes for children in rural and metropolitan areas

The health of people who are living in rural areas of Australia is often poorer than that of people living in major cities and other urban locations. This poorer health status of people in rural areas is commonly attributed to limited availability and access to health services and exposure to different health and environmental risks (Australian Institute of Health and Welfare 2006b). It is of note, therefore, that our report found very few differences overall in outcomes between children living in rural areas and those living in metropolitan Victoria.

The Victorian Child Health and Wellbeing Survey identified that children living in rural areas were more likely to have poorer oral health, with more toothache and fillings and more tooth extraction and dental treatment in hospital, than their metropolitan peers. The survey also found a higher incidence of behaviour problems that were 'of concern' in rural children. The Victorian Child Health and Wellbeing Survey, however, showed no statistically significant difference between the ratings parents in rural and metropolitan areas gave to their child's general health; and attendance rates at the three and a half year ages and stages visit are marginally higher in rural areas (Department of Human Services data).

There were some differences between rural and metropolitan parents in their perceptions of their local neighbourhoods, with parents in rural areas tending to give less favourable ratings. Although rural parents were more likely than metropolitan parents to report that their neighbourhoods were safe and clean, they were less likely to agree or strongly agree that they had good access to local services and facilities, such as playgrounds, banks and shopping. The difference in rating between rural and metropolitan parents was marked in relation to transport, with rural parents being much less likely than metropolitan parents to agree that they had good transport access.

4.5 Discussion and conclusions

This report on the state of Victoria's children offers a broad-ranging perspective on key outcomes for Victoria's children from a sound evidence base.

The report clearly demonstrates the value of the newly developed outcomes framework in indicating the areas in which Victorian children and young people are faring well and those in which they are faring less well, and we have been able to comment extensively on the wellbeing of Victorian children as a whole group. Further work to refine the framework will allow for reporting across an even wider range of areas as data relating to all the outcome areas and their indicators becomes available.

The report also shows the potential of the outcomes framework as a mechanism for monitoring the wellbeing of specific population groups in some depth where good and reliable data are available (for example, the Indigenous child population). Further work to address data gaps for children with a disability, children from culturally and linguistically diverse backgrounds, and children in out-of-home care will be undertaken so that we are able to comment more fully on outcomes for these children in future reports.

In conclusion, the report demonstrates that while children and young people in Victoria are faring well against a broad range of outcomes, there are some persistent and newly emerging areas of concern.

The comprehensive data that are presented will allow the government to adapt and to sharpen its focus on these problem areas and on those children and families who are faring less well.

The report will also offer an accessible and comprehensive source of information for those working in other organisations and agencies: local government, community agencies and professionals across health, education and community services. With its focus on the outcomes that matter, it will provide an important resource for all who are engaged in work to improve the life outcomes of children and young people.



Appendices

Appendix 1: School Entrant Health Questionnaire

The School Entrant Health Questionnaire is a parent report instrument that records parents' concerns and observations about their children's health and wellbeing. The School Entrant Health Questionnaire was developed and piloted in 1996–97 as part of the Victorian School Nursing Redevelopment Program and has been distributed to parents and guardians of preparatory grade children in Victorian primary schools since mid-1997. The major aims of the Victorian School Nursing Program are to increase health promotion and to assist early identification of health and wellbeing issues in school children.

The data gathered by the School Entrant Health Questionnaire depends on parents' perceptions and recollections, and does not claim to report medical diagnoses or opinions of health professionals. The questionnaire was designed to assist parents and school nurses in identifying health concerns, to encourage parents and school nurses to work together, and to aid school nurses in assessing the health and wellbeing of each preparatory grade child. The questionnaire is also a rich source of information on parental concerns about child health, providing a population view of parental concerns about health issues of school-entry children. The questions cover the areas of:

- general health
- medication
- immunisation
- dental health
- speech/language
- hearing
- vision
- disabilities
- general development
- behaviour and emotional wellbeing
- family stress.

For eight consecutive years (1997 to 2004), the School Entrant Health Questionnaire responses have been collected and archived. The resulting database of over 400,000 responses is one of the largest databases on parent information about the health and wellbeing of children in the five to seven year age cohort available in Australia.

In 2005 the Department of Human Services commissioned a team from the University of Melbourne and RMIT University to conduct an evaluation of the School Entrant Health Questionnaire and to analyse questionnaire responses from 1998 to 2004. This report, including further technical information about the School Entrant Health Questionnaire, is available on the Office for Children website:

www.office-for-children.vic.gov.au.

Demographics of the sample

As an example, a detailed breakdown of the demographic composition of the sample for 2004 is provided in Table 1 (there is little variability over the seven years of data).

Table 1. Demographic background of parents from 2004

Number of parents who responded	50,508
Gender	
Boys (%)	51.2
Girls (%)	48.8
Family structure	
Both parents (%)	81.9
Mother only (%)	13.1
Father only (%)	0.7
Parent and partner (%)	3.1
Guardian/other (%)	1.2
Cultural background*	
Born in Australia (%)	94.9
Not born in Australia (%)	5.1
English language background	
Child speaks English (%)	98.9
Child does not speak English (%)	1.1
English is spoken at home (%)	98.4
English is not spoken at home (%)	1.6
Aboriginality	
Aboriginal and/or Torres Strait Islander (%)	1.6
Not Aboriginal (%)	98.4

Appendix 2: The 2006 Victorian Child Health and Wellbeing Survey

The Office for Children is currently involved in the development of the Victorian Child and Adolescent Monitoring System, a statewide system for monitoring child outcomes. The Victorian Child Health and Wellbeing Survey was designed to address data gaps in the areas of child health, growth, asthma, nutrition (including breastfeeding), oral health, child activities, reading, injury, child behaviour, family functioning, parental health, parental mental health and health in pregnancy.

The aims of the Victorian Child Health and Wellbeing Survey are to:

- provide baseline and ongoing data which will be used to support and inform planning, implementation and evaluation of child health, wellbeing, development and learning services and programs throughout Victoria
- allow comparisons of how children are faring over time in metropolitan and rural areas and in major demographic groups throughout Victoria.

The Victorian Child Health and Wellbeing Survey is a computerised assisted telephone interview survey of the primary caregivers of randomly selected children aged 12 years and under. Interviews were carried out by a social research company with a call centre facility on behalf of the Department of Human Services. Only one interview concentrating on one randomly selected child was carried out per household.

The Victorian Child Health and Wellbeing Survey questionnaire was developed based on preliminary work by the Centre for Community Child Health and with input from departmental staff and outside experts in child health and wellbeing.

Where available, existing scales with proven reliability and validity were used, including the Special Health Care Needs Screener (Bethel et al. 2002), the Strengths and Difficulties Questionnaire (Goodman et al. 2001) and the Kessler 6 (Kessler et al. 2002). Where it was not possible to identify an appropriate established scale, the recommended short questions for computerised assisted telephone interview surveys were adopted. Recommended questions were used to monitor asthma (Australian Institute of Health and Welfare Australian Centre for Asthma Monitoring 2005), nutrition and breastfeeding (Flood, Webb & Rangan 2005).

To maximise opportunities for the comparison of results, attempts were made to align questions with those used in existing surveys, including the computerised assisted telephone interview surveys used for monitoring the health of child populations in other states (including the South Australian Monitoring and Surveillance System, the New South Wales 2001 Child Health Survey, and the Western Australian Child Health Survey) and the national Longitudinal Study of Australian Children. Where possible, demographic questions were selected to allow comparisons to be made with data collected for the Department of

Human Services' Victorian Population Health Survey, which is an annual survey of adults.

New questions have been included to cover health behaviours in pregnancy (smoking and alcohol intake). The new questions were based on questions included in a preliminary study carried out by the Centre for Child and Community Health (Waters et al. 2004).

In total, 5,000 interviews were completed, of which 2,521 (50.4 per cent) interviews were in metropolitan households and 2,479 (49.6 per cent) interviews were in rural households.

The survey data were weighted to reflect the probability of selection of (1) the household (2) the child within the household and (3) the age, sex and geographic distribution of Victoria's child population (zero to 12 years).

A profile of the survey respondents and information about the children's characteristics are included in Table 1 below.

A full technical report on the Victorian Child Health and Wellbeing Survey can be found on the Office for Children web site, www.office-for-children.vic.gov.au.

Table 1: Profile of respondents*

* Respondents were selected for being 'the parent or carer who knows most about the child's health and daily routine'.

	Survey outcome (%)
Area of residence	
Metropolitan	50.4
Rural	49.6
Sex	
Female	84.0
Male	16.0
Relationship to child	
Biological parent	97.2
Stepparent	0.7
Grandparent	0.9
Legal guardian	1.0
Other	0.1
Family type	
Couple parent	83.9
Single parent	16.0
Unknown	0.1
Education	
Did not complete year 12	24.4
Year 12 or above	72.6
Employment	
Works full time	21.3
Works part time	33.9
Works irregular/unknown hours	8.5
Does not work	36.3
Children's characteristics	
Age group	
< 1 year	7.5
1-4 years	29.6
5-8 years	30.7
9-12 years	32.2
ATSI status	
Aboriginal or Torres Strait Islander	1.3
Mean number of children under 13 years in the household	2.2

Appendix 3: Detailed tables

Causes of injury deaths, emergency department presentations and hospital admissions

Table 1: Major causes of injury deaths among children and young adults, Victoria, 2003 (n=117)

Rank	0-4 years Cause	5-9 years % Cause	10-14 years % Cause	15-18 years % Cause	Total Cause	%
1	Transport	31 Transport	89 Transport	44 Transport	48 Transport	46
	Car occupant	19 Pedestrian	33 Pedestrian	22 Car occupant	36 Car occupant	28
	Pedestrian	13 Car occupant	22 Car occupant	22 Pedestrian	7 Pedestrian	12
				Motorcycle rider	3	
2	Choking/suffocation In bed	22 9	Self-inflicted Hanging/ strangulation	33 22	31 18	21
				Self-harm Hanging/ strangulation	9	12
				Jumping or lying before moving object	9	
				Jumping or lying before moving object	5	5
3	Drowning	16	Drowning	5	5	8
	Bath	6		Choking/ suffocation In bed	3	3
4	Interpersonal violence	9	Interpersonal violence	5	5	7
				Interpersonal violence	7	3
				Natural body of water	3	3
				Poisoning	5	6
Other	22	11	22	7		13
Total	100	100	100	100		100

Source: Australian Bureau of Statistics Death Unit Record File

Table 2: Major causes of injury emergency department presentations (non-admissions) among children and young adults, Victoria, 2003

Rank	0-4 years			5-9 years			10-14 years			15-18 years			Total		
	Cause	No.	%	Cause	No.	%	Cause	No.	%	Cause	No.	%	Cause	No.	%
1	Fall	7,228	37	Fall	6,646	44	Fall	6,898	38	Hit, struck, crush	3,711	23	Fall	24,316	35
	- up to 1m	6,349	33	- up to 1m	5,661	37	- up to 1m	6,304	35	- object	1,987	12	- up to 1m	21,701	31
	- over 1m	789	4	- over 1m	985	6	- over 1m	594	3	- person	1,724	11	- over 1m	2,615	4
2	Hit, struck, crush	3,088	16	Hit, struck, crush	2,910	19	Hit, struck, crush	4,231	23	Fall	3,544	22	Hit, struck, crush	13,940	20
	- object	2,556	13	- object	2,255	15	- object	2,684	15	- up to 1m	3,297	20	- object	9,482	14
	-person	532	3	- person	655	4	- person	1,547	9	- over 1m	247	2	- person	4,458	7
3	Cutting, piercing	1,369	7	Cutting, piercing	1,248	8	Cutting, piercing	1,209	7	Transport	1,527	10	Cutting, piercing	5,313	8
										- car passenger	452	3			
										- car driver	390	2			
										- pedal cyclist	289	2			
										- motorcycle rider	282	2			
4	Poisoning	1,041	5	Transport	660	4	Transport	1,150	6	Cutting, piercing	1,487	9	Transport	3,629	5
	- chemicals	570	3	- pedal cyclist	344	2	- pedal cyclist	591	3				- pedal cyclist	1,315	2
	- drugs and medication	471	2	- car passenger	182	1	- car passenger	253	1				- car passenger	1,044	2
				- motorcycle rider	63	< 1	- motorcycle rider	203	1				- motorcycle rider	552	1
				- pedestrian	44	< 1	- pedestrian	56	< 1				- car driver	437	1
5	Fire, burn scald	705	4	Natural/environment	383	3	Natural/environment	286	2	Interpersonal violence	915	6	Fire, burn scald	1,387	2
				- other animal	232	2	- other animal	179	1						
				- dog related	151	1	- dog related	107	1						
Other		5,927	31		3,427	22		4,355	24		4,957	31		20,317	29
Total		19,358	100		15,274	100		18,129	100		16,141	100		68,902	100

Source: Victorian Emergency Minimum Dataset

Table 3: Major causes of injury hospital admissions among children and young adults, Victoria, 2003 (n=18,618)

Rank	0-4 years			5-9 years			10-14 years			15-18 years			Total		
	Cause	No.	%	Cause	No.	%	Cause	No.	%	Cause	No.	%	Cause	No.	%
1	Fall - playground equipment - slip, trip, stumble - one level to another - bed - chair	1,544	35	Fall - playground equipment - slip, trip, stumble - one level to another - skates, skis, skateboards - tree - out or from building or structure	2,534	59	Fall - playground equipment - skates, skis, skateboards - slip, trip, stumble - push, collide - with another person	2,122	46	Fall - push, collide with another person - skates, skis, skateboards - slip, trip, stumble - out or from building or structure	1,246	24	Fall - playground equipment - slip, trip, stumble - skates, skis, skateboards - push, collide with another person	7,446	40
2	Hit, struck, crush - caught, out, jammed or pinched - struck by or against object	656	15	Transport - pedal cyclist - car occupant - motorcycle rider - pedestrian	524	12	Transport - pedal cyclist - motorcycle rider - car occupant - pedestrian	975	21	Transport - motorcycle rider - pedal cyclist - pedestrian	1,148	22	Transport - pedal cyclist - car occupant - motorcycle rider - pedestrian	2,834	15
3	Poisoning - drugs and medication - chemicals	630	14	Hit, struck, crush - caught, cut, jammed or pinched - stuck by or against object	397	9	Hit, struck, crush - struck by or against object - sporting equipment - other person	578	13	Hit, struck, crush - other person - struck by or against object - sporting equipment	584	11	Hit, struck, crush - caught, cut, jammed or pinched - struck by or against object - other person	2,215	12
4	Fire, burn, scald - hot drink, food, fat, oil - hot tap water	268	6	Cutting, piercing - foreign body through skin - sharp glass	206	5	Cutting, piercing - sharp glass - foreign body through skin	188	4	Self harm - poisoning	508	10	Cutting, piercing - sharp glass - foreign body through skin	915	5

Rank	Cause	0-4 years		5-9 years		10-14 years		15-18 years		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%
5	Cutting, piercing - foreign body through skin	218	5	136	3	113	2	397	8	897	5
		83	2	57	1	24	< 1	244	5	644	3
						18	< 1	60	1	219	1
								34	1	34	< 1
Other		1,153	26	498	12	645	14	1,350	26	4,311	23
Other		4,469	100	4,295	100	4,621	100	5,233	100	18,618	100

Source: Victorian Admitted Episodes Dataset

Appendix 4: Definitions of homelessness

Supported Accommodation Assistance Program (SAAP) definition

The *Supported Accommodation Assistance Program Act 1994* states that:

A person is homeless ... if the only housing to which the person has access:

- (a) damages, or is likely to damage, the person's health; or
- (b) threatens the person's safety; or
- (c) marginalises the person through failing to provide access to:
 - (i) adequate personal amenities; or
 - (ii) the economic and social support that a home normally affords; or
- (d) places the person in circumstances which threaten or adversely affect the adequacy, safety, security and affordability of that housing.

It is implicit in the SAAP definition that we should take into account how people evaluate their housing situation. The SAAP definition includes people who are living in conventional houses as part of the homeless population if they are unhappy with their flat because it might damage their health (clause A), or they are at risk of homelessness because of domestic violence (clause B), or they are at risk of eviction because their flat is too expensive (clause D). The SAAP definition is a 'service delivery' – definition of homelessness, which allows welfare agencies to assist people who are experiencing various types of housing crisis. The SAAP definition includes people who are at risk of homelessness as well as people who are actually homeless. The SAAP definition is a useful service delivery definition, but it is not suitable for enumerating the homeless population.

Cultural definition

The Australian Bureau of Statistics uses the cultural definition of homelessness, which excludes the at-risk population. The cultural definition contends that 'homelessness' has to be defined in relation to shared community standards about the minimum housing that people have the right to expect in order to live according to the conventions and expectations of a particular culture (Chamberlain & MacKenzie 1992). In Australia, the minimum community standard is a small rental flat with a bedroom, living room, kitchen, bathroom and an element of security of tenure because that is the minimum that most people achieve in the private rental market and it is significantly below the culturally desired option of an owner occupied house. While it is true that 'housed' and 'homeless' constitute a continuum of circumstances, this leads to the identification of 'primary', 'secondary' and 'tertiary' homelessness.

Primary homelessness accords with the common sense assumption that homelessness is the same as 'rooflessness'. It includes all people without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, or using cars or railway carriages for temporary shelter. Primary homelessness is operationalised using the Census category 'improvised homes, tents and sleepers out'.

Secondary homelessness includes people who move frequently from one form of temporary shelter to another. On Census night, it includes all people staying in emergency or transitional accommodation provided under SAAP. Secondary homelessness also includes people residing temporarily with other households because they have no accommodation of their own. They report 'no usual address' on their Census form. Secondary homelessness also includes people staying in boarding houses on a short-term basis, operationally defined as 12 weeks or less.

Tertiary homelessness refers to people who live in boarding houses on a medium to long-term basis, operationally defined as 13 weeks or longer. Residents of private boarding houses do not have a separate bedroom and living room, they do not have kitchen and bathroom facilities of their own, their accommodation is not self-contained, and they do not have security of tenure provided by a lease. They are homeless because their accommodation does not have the characteristics identified in the minimum community standard.

Welfare agencies often provide homeless people with vouchers for short-term stays in boarding houses when no SAAP accommodation is available. Boarding houses are an integral part of the service delivery system, particularly in the inner suburbs of major capital cities.

References

Introduction

Australian Institute of Health and Welfare 2005, *A picture of Australia's children*, AIHW, cat. no. PHE 58, AIHW, Canberra.

Ben-Arieh, A 2005, 'Where are the children? Children's role in measuring and monitoring their wellbeing', *Journal of Social Indicators Research*, vol. 74, no. 3, pp. 573–96.

— & Goerge, R 2001, 'Beyond the numbers: How do we monitor the state of our children?', *Children and Youth Services Review*, vol. 23, no. 2, pp. 709–27.

Stanley, F, Richardson, S & Prior, M 2005, *Children of the lucky country? How Australian society has turned its back on children and why children matter*, Pan Macmillan, Australia.

State Government of Victoria 2005, *A fairer Victoria – creating opportunity and addressing disadvantage*, State Government of Victoria, Melbourne.

State Government of Victoria 2005, *Growing Victoria Together – a vision for Victoria to 2010 and beyond*, State Government of Victoria, Melbourne.

United Nations 1989, *Convention on the rights of the child*, United Nations, Geneva.

1. Victoria's children

Australian Bureau of Statistics 2003, *Experimental estimates of Indigenous Australians*, data cube: SuperTABLE, cat. no. 3238.0.55.001 viewed 10 January 2006
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3238.0.55.001Jun%202001?OpenDocument>

— 2004a, *Disability, ageing and carers, Australia: summary of findings, 2003*, cat. no. 4430.0, ABS, Canberra.

— 2004b, *Family characteristics 2003*, 'Table 13: Families with children aged 0-17, family structure for families, persons and children – Victoria – June 2003', data cube: Excel spreadsheet, cat. no. 4442.0, viewed 20 January 2006
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4442.0Jun%202003?OpenDocument>

— 2004c, *Family characteristics Australia, June 2003*, cat. no. 4442.0, viewed 20 January 2006
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4442.0Jun%202003?OpenDocument>

— 2005a, *Population by age and sex, Australia, June 2004*, data cube: SuperTABLE, cat. no. 3235.0.55.001, viewed 16 January 2006,
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.0.55.001Jun%202004?OpenDocument>.

— 2005b, *Demography, New South Wales, 2003*, cat. no. 3311.1.55.001, viewed 17 January 2006,
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/90A32DAEDD39B527CA257115007134F2?opendocument>

- 2005c, *Demography, Victoria, 2003*, cat. no. 3311.2.55.001, viewed 17 January 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/C8419FFBFF418A16CA25711500713429?opendocument>
- 2005d, *Demography, Queensland, 2003*, cat. no. 3311.3.55.001, viewed 17 January 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/FDB366555ADD3261CA25711500713043?opendocument>
- 2005e, *Demography, South Australia, 2003*, cat. no. 3311.4.55.001, viewed 17 January 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/4AAD2C71EBBAEBA2CA2571150071310A?opendocument>
- 2005f, *Demography, Western Australia, 2003*, cat. no. 3311.5.55.001, viewed 17 January 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/93290754705E27F4CA257115007131D0?opendocument>
- 2005g, *Demography, Tasmania, 2003*, cat. no. 3311.6.55.001, viewed 17 January 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/4C7D76C07A5BECB9CA25711500712E7E?opendocument>
- 2005h, *Demography, Northern Territory, 2003*, cat. no. 3311.7.55.001, viewed 17 January 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/0AD29C798228C6DFCA25711500712F7C?opendocument>
- 2005i, *Demography, Australian Capital Territory, 2003*, cat. no. 3311.8.55.001, viewed 17 January 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/ACBF1DF57C1D8812CA25711500713296?opendocument>
- 2005j, *Population projections by capital city/balance of state 2004 - 2051*, data cube: SuperTABLE, cat. no. 3222.0, viewed 16 January 2006, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3222.02004%20to%202101?OpenDocument>
- 2006, *Population projections, Australia*, cat. no. 3222.0, ABS, Canberra.
- Australian Institute of Health and Welfare 2004, *Children with disabilities in Australia*, AIHW cat. no. DIS 38, AIHW, Canberra.
- Department of Sustainability and Environment 2004, *Victoria in future 2004 - detailed data files*, 'Population by sex by 5 yr age grp SLA 5 yr intervals 2001 to 2031', Excel spreadsheet, viewed 18 January 2006 <http://www.dse.vic.gov.au/DSE/dsenres.nsf/LinkView/B9023E3BAACA5A6ACA256EF60019E55806C7DF80826B65674A256DEA002C0DCA>
- The Centre for Multicultural Youth Issues 2005, 'Refugee and CLD young people: definitions', Information Sheet, No.11, Centre for Multicultural Youth Issues, Melbourne.
- The Centre for Multicultural Youth Issues 2006, 'Humanitarian youth arrivals to Victoria', Information Sheet, No.13, Centre for Multicultural Youth Issues, Melbourne.
- United Nations 1951, *Convention relating to the status of refugees*, United Nations, Geneva.

2.1 Health and wellbeing

Australian Bureau of Statistics 2004, *Deaths in Australia*, cat. no. 3302, ABS, Canberra.

Australian Institute of Health and Welfare 2004, *Key national indicators of children's health, development and wellbeing*, Bulletin no. 20, AIHW cat. no. AUS 53, AIHW, Canberra.

— 2005, *A picture of Australia's children*, AIHW cat. no. PHE 58, AIHW, Canberra.

— 2006, *Australia's health*, AIHW cat. no. Aus 73, AIHW, Canberra.

Australian Institute of Health and Welfare Australian Centre for Asthma Monitoring 2005, *Asthma in Australia 2005*, Asthma Series 2, AIHW, Canberra (cited in R Scutella & P Smyth, *The Brotherhood's social barometer: monitoring children's chances*, The Brotherhood of St Laurence, Melbourne).

Beautrais, AL, Joyce, PR & Mulder, RT 1996, 'Risk factors for serious suicide attempts among youths aged 13 through 24 years', *Journal of American Academy of Child and Adolescent Psychiatry*, vol. 35, no. 9, pp. 1,174–82.

Bond, I, Thomas, L, Toumbourou J, Patton, G & Catalano, R 2000, *Improving the lives of young Victorians in our community: a survey of risk and protective factors*, Centre for Adolescent Health, Melbourne.

Booth, M, Oakley, AD, Denny-Wilson, E, Hardy, L, Yang, D & Dobbins, T 2006, *NSW Schools Physical Activity and Nutrition Survey (SPANS) 2004*, NSW Department of Health, Sydney.

— Wake, M, Armstrong, T, Chey, T, Hesketh, K & Mathur, S 2001, 'The epidemiology of overweight and obesity among Australian children and adolescents, 1995–1997', *Australian and New Zealand Journal of Public Health*, vol. 25, pp. 162–9.

— Chey, T, Wake, M, Norton, K, Hesketh, K, Dollman, J & Robertson, I 2003, 'Change in the prevalence of overweight and obesity among young Australians, 1969–1997', *American Journal of Clinical Nutrition*, vol. 77, pp. 29–36.

Burke, V, Beilin, LJ, Simmer K, Oddy, WH, Blake, KV, Doherty, D, Kendall, GE, Newnham, JP, Landau, LI & Stanley, FJ 2005, 'Predictors of body mass index and associations with cardiovascular risk factors in Australian children: a prospective cohort study', *International Journal of Obesity and Related Metabolic Disorders* vol.29(1), pp.15-23

Bywaters, P & Rolfe, A 2002, *Look beyond the scars: understanding and responding to self-harm*, National Children's Home, London.

Clapperton, A & Cassell E 2006 *Victorian child (0-18 years) injury and poisoning indicators*, the Victorian Injury Surveillance Unit at Monash University Accident Research Centre.

Coffey, C, Veit, F, Wolfe, R, Cini, E & Patton, GC 2003, 'Mortality in young offenders: a retrospective cohort study', *British Medical Journal*, vol. 326, no. 7,398, p. 1,064.

— Wolfe, R, Lovett, AW, Moran, P, Cini, E & Patton, GC 2004, 'Predicting death in young offenders: a retrospective cohort study', *Medical Journal of Australia*, vol. 181, no. 9, pp. 473–7.

Cook, P, Rutishauser, IHE & Seelig, M 2001, *Comparable data on food and nutrient intake and physical measurements from the 1983, 1985 and 1995 National Nutrition Surveys*, Australian Food and Nutrition Monitoring Unit, Brisbane.

- Department of Human Services 2003, *Births in Victoria 2001-2002*, Victorian Perinatal Data Collection Unit, Public Health, the Department of Human Services, Melbourne.
- 2005, *Births in Victoria 2003-2004*, Victorian Perinatal Data Collection Unit, Public Health. The Department of Human Services, Melbourne.
- 2005a, *Victorian Burden of Disease Study – mortality and morbidity in 2001*, the Department of Human Services, Melbourne.
- with VicHealth and beyondblue 2006, *Promoting the mental health and wellbeing of children and young people from families with a parental mental illness* (summary publication), the Department of Human Services, Melbourne, with VicHealth and beyondblue.
- Eagar, K, Brewer, C, Collins, J, Fildes, D, Findlay, C, Green, J, Harrison, L, Harwood, N, Marosszeky, N, Masso, M, Matete, S, Morris, D, Peat, J, Rix, M, Shorten, B, Siminski, P, Williams, K & Yeatman, H 2005, *Strategies for gain – the evidence on strategies to improve the health and wellbeing of Victorian children*, Centre for Health Service Development, University of Wollongong.
- Evans, A 2003, 'The outcomes of teenage pregnancy: temporal and spatial trends', *People and Place*, vol. 11, no. 2, pp. 39–48.
- Goodman, R 2001, 'Psychometric properties of the Strengths and Difficulties Questionnaire', *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 40, pp. 1,337–45.
- Haysom, L, Hodson, EM, Williams, R, Roy, LP & Craig, JC, 'Cardiovascular risk factors in Aboriginal and non-Aboriginal children', Paper and abstract presented at the 2006 Royal Australasian College of Physicians Congress, May 2006, Cairns.
- Healey, K 2002, *A good place to learn? What young people think makes schools healthy*, Kings Fund, London.
- Hood, S 2004, *The state of London's children report*, Greater London Authority, London.
- Kessler, RC 2003, 'Epidemiology of women and depression', *Journal of Affective Disorders*, vol. 74, pp. 5–13.
- Laws, PJ, Sullivan, EA 2005, *Australia's mothers and babies 2003*, AIHW cat. no. PER 29, National Perinatal Statistics Unit, Australian Institute of Health and Welfare, Canberra.
- Lobstein, T, Baur, L, Uauy, R 2004, 'Obesity in children and young people: a crisis in public health', *Obesity Review*, vol. 5, suppl. 1, pp. 4–85.
- Magarey, AM, Daniels, LA, Boulton, TJ & Cockington, RA 2003, 'Predicting obesity in early adulthood from childhood and parental obesity', *International Journal of Obesity and Related Metabolic Disorders*, vol. 27, no. 4, pp. 505–13.
- Mathers, C, Vost, T & Stevenson, C 1999, *The burden of disease and injury in Australia*, AIHW cat. no. PHE17 ed, Australian Institute of Health and Welfare, Canberra.
- National Health and Medical Research Council 2003, *Dietary guidelines for children and adolescents in Australia*, NHMRC, Canberra.
- O'Dea, J 2003, 'Differences in overweight and obesity among Australian schoolchildren of low and middle/high socioeconomic status', *Medical Journal of Australia*, vol. 179, no. 1, p. 63 (Letter).

- Office for Standards in Education 2003, *Bullying: effective action in secondary schools*, Ofsted, London.
- Quinlivan, J 2004, 'Impact of demographic factors, early family relationships and depressive symptomatology in teenage pregnancy', *Australian and New Zealand Journal of Psychiatry*, vol. 38, no. 4, pp. 197–203.
- Rigby, M, Kohler, LI, Blair, ME & Metchler, R 2003, 'Child health indicators for Europe: a priority for a caring society', *European Journal of Public Health*, vol. 13, no. 3, pp. 38–46.
- Sawyer, MG, Arney, FM, Baghurst, PA, Clark, JJ, Graetz, BW, Kosky, RJ, Nurcombe, B, Patton, GC, Prior, MR, Raphael, B, Rey, J, Whaites, LC, Zubrick, SR 2000, *The mental health of young people in Australia*, Commonwealth Department of Health and Aged Care, Canberra.
- Smith, P, Morita, Y, Junger-Tas, J, Olweus, D, Catalano, R & Slee, P (eds) 1999, *The nature of school bullying: a cross-national perspective*, Routledge, Oxford, England.
- Stanley, F, Richardson, S & Prior, M 2005, *Children of the lucky country? How Australian society has turned its back on children and why children matter*, Pan Macmillan, Australia.
- Steering Committee for the Review of Government Service Provision 2005, *Overcoming Indigenous disadvantage: key indicators 2005*, Productivity Commission, Canberra.
- The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2005, *Annual report for the year 2004*, incorporating the 43rd survey of perinatal deaths in Victoria, CCOPMM, Melbourne.
- The United Nations Children's Fund 2001, *A league table of teenage births in rich nations*, Innocenti Report Card 5, Innocenti Research Centre, Florence.
- United Nations 1989, *Convention on the rights of the child*, United Nations, Geneva.
- Vaska, VL, Volkmer, R 2004, 'Increasing prevalence of obesity in South Australian four-year-olds: 1995–2002', *Journal of Paediatric Child Health*, vol. 40, pp. 353–5.
- Wilkinson, R & Marmot, M (eds) 2003, *Social determinants of health: the solid facts*, 2nd edn, World Health Organisation, Copenhagen, Denmark.
- Williams, J, Wake, M, Hesketh, K, Maher, E & Waters, E 2005, 'Health-related quality of life of overweight and obese children', *Journal of the American Medical Association*, vol. 293, no. 1, pp. 70–6.
- World Health Organization 2000, *Obesity: preventing and managing the global epidemic*, report of a WHO consultation, WHO, Geneva.
- 2002, *Adolescent friendly services: an agenda for change*, WHO, Geneva.

2.2 Development and learning

- Australian Bureau of Statistics 2002, *Population by age and sex, Victoria, June 2001*, data cube: SuperTABLE, cat. no. 3235.2.55.001, viewed 16 January 2006
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.2.55.001Jun%202001?OpenDocument>
- 2003, *Population by age and sex, Victoria, June 2002*, data cube: SuperTABLE, cat. no. 3235.2.55.001, viewed 16 January 2006
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.2.55.001Jun%202002?OpenDocument>

— 2004a, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, cat. no. 3238.0, ABS, Canberra.

— 2004b, *Population by age and sex, Victoria, June 2003*, data cube: SuperTABLE, Cat. no. 3235.2.55.001, viewed 16 January 2006
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.2.55.001Jun%202003?OpenDocument>

— 2005, *Population by age and sex, Victoria, June 2004*, data cube: SuperTABLE, cat. no. 3235.2.55.001, viewed 16 January 2006,
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.0.55.001Jun%202004?OpenDocument>

Australian Institute of Health and Welfare 2005, *A picture of Australia's children*, AIHW cat. no. PHE 58, Australian Institute of Health and Welfare, Canberra.

— 2006, *Juvenile justice in Australia 2000–01 to 2003–04*, Australian Institute of Health and Welfare cat. no. JUV 1, AIHW, Canberra.

Centre for Community Child Health & Telethon Institute for Child Health Research 2005, *Australian Early Development Index: building better communities for children – community results 2004–2005*, Centre for Community Child Health, Murdoch Children's Research Institute, Royal Children's Hospital, Melbourne and Telethon Institute for Child Health Research, West Perth.

Centre for Excellence in Child and Family Welfare 2005, *Investing for success – the economics of supporting young people leaving care*, Monograph Number 5, Centre for Excellence in Child and Family Welfare, Melbourne.

Department of Education and Training 2006, *Summary Statistics for Victorian Schools*, Issue 1, March 2006, Victorian Government Department of Education and Training, Melbourne.

Department for Victorian Communities 2002, *Respect: the government's vision for young people – a framework for policy and program development*, DVC, Melbourne.

Department of Human Services 2006, *Aboriginal Services Plan key indicators 2004–05*, the Department of Human Services, Melbourne.

Howells, K, Day, A & Rickwood, D 2003, *The Victorian Juvenile Justice Rehabilitation Review*, Department of Human Services, Melbourne.

Mellor, S & Corrigan, M 2004, *The case for change: a review of contemporary research in Indigenous education outcomes*, Australian Council of Educational Research Publication, Melbourne.

Ministerial Council on Education, Employment, Training and Youth Affairs, 2001 *National report on schooling in Australia*, Australian Government Department of Education, Science and Training, Canberra.

— 2002, *National report on schooling in Australia*, Australian Government Department of Education, Science and Training, Canberra.

— 2003, *National report on schooling in Australia*, Australian Government Department of Education, Science and Training, Canberra.

— 2004, *National report on schooling in Australia*, preliminary paper, Australian Government Department of Education, Science and Training, Canberra.

Teese, R, Polesel, J & Mason, K 2005, *The destinations of school leavers in Victoria, report of the 2004 On Track project*, Department of Education and Training, Melbourne.

— Robinson, L, Lamb, S & Mason, K 2006, *The 2005 On Track Longitudinal Survey: the destinations of 2003 school leavers in Victoria two years on*, Department of Education and Training, Melbourne.

The AEDI National Support Centre 2006, *Victorian AEDI implementation: progress to date*, report prepared by the AEDI National Support Centre, Centre for Community Health, Royal Children's Hospital, Melbourne.

Victoria Police, 2005, *Crime Statistics 2005*, Victorian Police, Melbourne.

2.3 Safety

Australian Bureau of Statistics 1996, *The Women's Safety Survey*, ABS, Canberra.

— 2002, *Population by age and sex, Victoria, June 2001*, data cube: SuperTABLE, cat. no. 3235.2.55.001, viewed 16 January 2006

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.2.55.001Jun%202001?OpenDocument>

— 2003, *Population by age and sex, Victoria, June 2002*, data cube: SuperTABLE, cat. no. 3235.2.55.001, viewed 16 January 2006

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.2.55.001Jun%202002?OpenDocument>

— 2004a, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, cat. no. 3238.0, ABS, Canberra.

— 2004b, *Population by age and sex, Victoria, June 2003*, data cube: SuperTABLE, cat. no. 3235.2.55.001, viewed 16 January 2006

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.2.55.001Jun%202003?OpenDocument>

— 2005, *Population by age and sex, Victoria, June 2004*, data cube: SuperTABLE, cat. no. 3235.2.55.001, viewed 16 January 2006,

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.0.55.001Jun%202004?OpenDocument>

Australian Institute of Health and Welfare 2001, *Child protection Australia 1999–00*, AIHW cat. no. CWS 13, Child Welfare Series no. 27, AIHW, Canberra.

— 2003, *Australia's young people: their health and wellbeing*, cat. no. PHE 50, AIHW, Canberra

— 2004, *Children accompanying homeless clients 2002–2003*: SAAP National Data Collection Agency (NDCA), AIHW cat. no. HOU 106, AIHW, Canberra.

— 2005, *A picture of Australia's children*, AIHW cat. no. PHE 58, AIHW, Canberra.

— 2006, *Child protection Australia 2004–05*, AIHW cat. no. CWS 24, Child Welfare Series no. 38, AIHW, Canberra.

- Connor, DF, Steingard, RJ, Cunningham, JA, Anderson, JJ & Melloni, RH Jr 2004, 'Proactive and reactive aggression in referred children and adolescents', *American Journal of Orthopsychiatry*, vol. 74, pp. 129–36.
- Crosse, SB, Kaye, E & Ratnofsky, ACA 1995, *A report on the maltreatment of children with disabilities*, National Center on Child Abuse and Neglect, Washington, DC.
- Cummings, EM & Davies, PD 1994, *Children and marital conflict: the impact of family dispute and resolution*, Guilford Press, New York.
- Department of Human Services 2002, *An integrated strategy for child protection and placement services*, the Department of Human Services, Melbourne.
- 2005, *Your health: a report on the health of Victorians*, the Department of Human Services, Melbourne.
- Dube, SR, Anda, RF, Felitti, VJ, Edwards, VJ & Williamson, DF 2002, 'Exposure to abuse, neglect, and household dysfunction among adults who witnessed intimate partner violence as children: implications for health and social services', *Violence and Victims*, vol. 17, pp. 3–17.
- Edelson, JL 1996, 'The overlap between child maltreatment and women battering', *Violence against Women*, vol. 5, pp. 134–54.
- Eagar, K, Brewer, C, Collins, J, Fildes, D, Findlay, C, Green, J, Harrison, L, Harwood, N, Marosszeky, N, Masso, M, Matete, S, Morris, D, Peat, J, Rix, M, Shorten, B, Siminski, P, Williams, K & Yeatman, H 2005, *Strategies for gain – the evidence on strategies to improve the health and wellbeing of Victorian children*, Centre for Health Service Development, University of Wollongong.
- Edwards, VJ, Holden, GW, Felitti, VJ & Anda, RFI 2003, 'Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the adverse childhood experiences study', *American Journal of Psychiatry*, vol. 160, pp. 1,453–60.
- Farouque, F 2006, 'Rural families at greater risk of domestic violence', *The Age*, 22 May 2006.
- Felitti, VJ, Anda, RF, Nordenberg, D, Williamson, DF, Spitz, AM, Edwards, V, Koss, MP & Marks, JS 1998, 'Relationship of childhood abuse and household dysfunction to many of the leading causes of deaths in adults (The Adverse Childhood Experiences (ACE) Study)', *American Journal of Preventive Medicine*, vol. 14, pp. 245–58.
- Kendall-Tackett, K 2002, 'The health effects of childhood abuse: four pathways by which abuse can influence health', *Child Abuse and Neglect*, vol. 26, pp. 715–29.
- Langsford, JE, Dodge, KA, Pettit, GS, Bates, JE, Crozier, J & Kaplow, J 2002, 'A 12 year prospective study of the long term effects of early child physical maltreatment on psychological, behavioural and academic problems in adolescence', *Archives of Paediatric and Adolescent Medicine*, vol. 156, pp. 824–30.
- Mouzos, J & Rushforth, C 2003, *Family homicide in Australia*, Paper presented at the Eighth Australian Institute of Family Studies Conference, Melbourne Exhibition Centre, 12–14 February, Melbourne.
- Osofsky, JD 1995, 'Children who witness domestic violence: the invisible victims', *Social Policy Report*, vol. 9, pp. 1–16.

- 1999, 'The impact of violence on children', *The Future of Children*, vol. 9, pp. 33–49.
- Perry, BD 1997, 'Incubated in terror: neurodevelopment factors in the 'cycle of violence'', in J Osofsky (ed.), *Children in a violent society*, Guildford Press, New York.
- Ritter, J, Stewart, M, Bernet, C, Coe, M & Brown, SA 2002, 'Effects of childhood exposure to familial alcoholism and family violence on adolescent substance use, conduct problems and self-esteem', *Journal of Traumatic Stress*, vol. 15, pp. 113–22.
- Spaccarelli, S, Sandler, I & Roosa, M 1994, 'History of spouse violence against mother: correlated risks and unique effects in child mental health', *Journal of Family Violence*, vol. 9, pp. 79–98.
- Sullivan, PM & Knutson, JF 2000a, 'Maltreatment and disabilities: a population based epidemiological study', *Child Abuse and Neglect*, vol. 24, pp. 1,257–73.
- 2000b, 'The prevalence of disabilities and maltreatment among runaway children', *Child Abuse and Neglect*, vol. 24, pp. 1,275–88.
- The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2005, *Annual Report for the year 2004*, incorporating the 43rd survey of perinatal deaths in Victoria, CCOPMM, Melbourne.
- Tonge, BJ 1998, 'Common child and adolescent psychiatric problems and their management in the community', *Medical Journal of Australia*, vol. 168, pp. 8–16.
- United Nations Environment Programme, United Nations Children's Fund & World Health Organization 2002, *Children in the new millennium: environmental impact on health*, UNEP, UNICEF & WHO.
- Victoria Police 2005, *Victoria police crime statistics 2004/05*, Corporate Statistics, Victoria Police, Melbourne.
- Zeanah, C, Danis, B, Hirshberg, L, Benoit, D, Miller, D & Heller, S 1999, 'Disorganised attachment associated with partner violence: a research note', *Infant Mental Health Journal*, vol. 20, pp. 77–86.

3.1 The family

- Australian Institute of Health and Welfare 2005, *A picture of Australia's children*, AIHW cat. no. PHE 58, AIHW, Canberra.
- Australian Institute of Health and Welfare 2006, *Homeless people in SAAP: SAAP national data collection annual report 2004-05*, Victoria: *Supplementary Tables*, AIHW, Canberra.
- Australian Council of Social Service 2004, *International comparisons of anti-poverty plans – lessons for Australia*, ACOSS Info 366, October.
- Avramov, D 1995, *Homelessness in the European Union*, European Federation of National Organisations Working with the Homeless (FEANTSA), Brussels.
- Brown, S, Bruinsma, F, Darcy, M, Small, R & Lumley, J 2004, 'Early discharge: no evidence of adverse outcomes in three consecutive population-based Australian surveys of recent mothers, conducted in 1989, 1994 and 2000', *Paediatric Perinatal Epidemiology*, vol. 18, pp. 202–13.
- Chabrol, H, Teissedre, F, Saint-Jean, M et al. 2002, 'Dépistage, prévention et traitement des depression du post-partum: une etude contrôlée chez 857 sujets', *L'Encéphale*, XXVIII, pp. 65–70.

- Chamberlain, C & MacKenzie, D 1992, 'Understanding contemporary homelessness: issues of definition and meaning', *Australian Journal of Social Issues*, vol. 27, no. 4, pp. 274–97.
- & — 2003, *Counting the homeless 2001*, Australian Bureau of Statistics cat. no. 2050.0, Australian Bureau of Statistics, Canberra.
- & — 2004, *Counting the homeless 2001: Victoria*, Swinburne University and RMIT University, Melbourne.
- & Johnson, G 2001, 'The debate about homelessness', *Australian Journal of Social Issues*, vol. 36, no. 1, pp. 35–50.
- Cox, JL 1989, 'Postnatal depression: a serious and neglected postpartum complication', *Baillieres Clinical Obstetrics and Gynaecology*, vol. 3, pp. 839–55.
- De Hoog, J 1972, *Skid row dossier*, Sun Books, Melbourne.
- Dennis, CL & Creedy, D 2004, *Psychosocial and psychological interventions for preventing postpartum depression*, Cochrane Database of Systematic Reviews, 4, CD001134, John Wiley and Sons, Chichester, England.
- Harding, A, Lloyd, R & Greenwell, H 2001, *Financial disadvantage in Australia: 1999–2000. The persistence of poverty in a decade of growth*, The Smith Family, Camperdown, New South Wales.
- Hopper, K 1997, 'Homelessness old and new: the matter of definition', in D Culhane & S Hornburg (eds), *Understanding homelessness: new policy and research perspectives*, Fannie Mae Foundation, Washington DC.
- House of Representatives 1995, *A report on aspects of youth homelessness*, (The Morris Report), Australian Government Publishing Service, Canberra.
- Human Rights and Equal Opportunities Commission 1989, *Our homeless children*, (The Burdekin Report), Australian Government Publishing Service, Canberra.
- Jordan, A 1973, 'Inner city homeless men in Melbourne', unpublished MA thesis, La Trobe University.
- 1994, *Going bad: homeless men in an Australian city*, Council to Homeless Persons, Melbourne.
- Lloyd, R, Harding, A & Payne, A 2004, 'Australians in poverty in the 21st century', Paper prepared for 33rd Conference of Economists, 27–30 September 2004, (online conference paper: CP2004-07).
- Lumley, J, Austin, MP, Mitchell, C 2004, 'Intervening to reduce depression after birth: a systematic review of the randomized trials', *International Journal of Technology Assessment in Health Care*, vol. 20, pp. 128–44.
- , Watson, L, Small, R, Brown, S, Mitchell, C & Gunn, J 2006, 'PRISM (Program of Resources Information and Support for Mothers): a community randomised trial to reduce depression and improve women's physical health six months after birth', [ISRCTN03460211], *BMC Public Health*, vol. 6, no. 1, p. 37.
- MacArthur, C, Winter, H, Bick, DE, Knowles, H, Lilford, R, Henderson, C, Lancashire, RJ, Braunlotz, DA, Gee, H 2002, 'The effects of redesigned postnatal care on women's health four months after birth: a cluster randomised trial', *Lancet*, vol. 359, pp. 378–85.

- Neil, C & Fopp, R 1992, *Homelessness in Australia: causes and consequences*, CSIRO Division of Building, Construction and Engineering, Victoria.
- Nicholson, A 2006, 'Children and homelessness in Australia – a nation's shame', invited address to the Fourth National Conference on Homelessness, Sydney Convention Centre, 2 March 2006, Sydney.
- Organisation for Economic Co-operation and Development 2005, *Society at a glance: OECD social indicators*, 2005 edn., OECD, Paris.
- O'Hara, MW & Swain, AM 1996, 'Rates and risk of postpartum depression – a meta-analysis', *International Review of Psychiatry*, vol. 8, pp. 37–54.
- Ridge, T 2002, *Childhood poverty and social exclusion: from a child's perspective*, Policy Press, Bristol, United Kingdom.
- Saunders, P & Sutherland, K (with Davidson, P, Hampshire, A, King, S & Taylor, T) 2006, *Experiencing poverty: the voices of low-income Australians. Towards new indicators of disadvantage project, stage 1: focus group outcomes*, Social Policy Research Centre, Sydney, with the Australian Council of Social Service, Mission Australia, Brotherhood of St Laurence, Anglicare, Sydney.
- Scutella, R & Smyth, P 2005, *The Brotherhood's social barometer: monitoring children's chances*, Brotherhood of St Laurence, Melbourne.
- Senate Community Affairs Reference Committee 2004, *A hand-up not a hand-out: renewing the fight against poverty*, Commonwealth of Australia, Canberra.
- State Government of Victoria 2005a, *A fairer Victoria – creating opportunity and addressing disadvantage*, State Government of Victoria, Melbourne.
- State Government of Victoria 2005b, *Challenges in addressing disadvantage in Victoria – reporting on progress, identifying future directions*, State Government of Victoria, Melbourne.
- Taylor, J & Fraser, A 2003, *Eleven plus: life chances and family income*, Brotherhood of St Laurence, Melbourne.
- Victorian Perinatal Data Collection Unit 2003, *Birth defects in Victoria 2001–2002*, Department of Human Services, Melbourne.

3.2 The community

- Australian Institute of Health and Welfare 2005, *A picture of Australia's children*, AIHW cat. no. PHE 58, AIHW, Canberra.

3.3 Services and supports

- Australian Institute of Health and Welfare Australian Centre for Asthma Monitoring 2005, *Asthma in Australia 2005*, Asthma Series 2, Australian Institute of Health and Welfare, Canberra.
- Department of Human Services 2002, *The Victorian Ambulatory Care Sensitive Conditions Study: opportunities for targeting public health and health services interventions*, the Department of Human Services, Melbourne.

— 2004, Future direction for the *Victorian Maternal and Child Health Service*, the Department of Human Services, Melbourne.

— 2006, *Victorian Maternity Services Performance Indicators* – complete set for 2004–05, the Department of Human Services, Melbourne.

Victorian Perinatal Data Collection Unit 2004, *Birth defects in Victoria 2001–2002*, Department of Human Services, Melbourne.

4. Principal Findings

Australian Institute of Health and Welfare 2004, *Children with disabilities in Australia*, AIHW cat. no. DIS 38, AIHW, Canberra.

— 2006a, *Child protection Australia 2004–05*, AIHW cat. no. CWS 26, (Child Welfare Series no. 38), AIHW, Canberra.

— 2006b, *Australia's health*, AIHW cat. no. Aus 73, AIHW, Canberra.

Richardson, N 2005, *Child abuse and neglect in Indigenous Australian communities*, National Child Protection Clearing House, Australian Institute of Family Studies, Melbourne.

Victorian Child Death Review Committee 2005, *Annual report of inquiries into child death: Child Protection, 2005*, Victorian Government Publishing Service, Melbourne.

Appendices

Appendix 2

Australian Institute of Health and Welfare Australian Centre for Asthma Monitoring 2005, *Enhancing asthma-related information for population monitoring*, AIHW cat. no. ACM 4, AIHW, Canberra.

Bethell, CD, Read, D, Stein REK, Blumberg, SJ, Wells, N & Newacheck, PW 2002, 'Identifying children with special health care needs: development and evaluation of a screening instrument', *Ambulatory Paediatrics*, vol. 2, pp. 38–48.

Flood, V, Webb, K & Rangan, A 2005, *Recommendations for short questions to assess food consumption in children for the New South Wales health surveys*, New South Wales Centre for Public Health Nutrition, Sydney.

Goodman, R 2001, 'Psychometric properties of the Strengths and Difficulties Questionnaire: a research note', *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 40, pp. 1,337–45.

Kessler, RC, Andrews, G, Colpe, LJ, Hiripi, E, Mroczek, DK, Normand, SL, Walters, EE, Zaslavsky, AM 2002, 'Short screening scales to monitor population prevalences and trends in non-specific psychological distress', *Psychological Medicine*, vol. 32, pp. 959–976.

Waters, E, Maher, E, Williams, J, Goldfeld, S, Wake, M, Mehmet-Radji, O & Oberklaid, F 2004, *Victorian survey of child health and wellbeing, rationale for domains and scales*, unpublished report, Centre for Community Child Health, Royal Children's Hospital, Melbourne.

Appendix 4

Chamberlain, C & MacKenzie, D 1992, 'Understanding contemporary homelessness: issues of definition and meaning', *Australian Journal of Social Issues*, vol. 27, no. 4, pp. 274–97.

