

The state of Victoria's children 2008

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



Published by the Communications Division
for Data, Outcomes and Evaluation Division
Department of Education and Early Childhood Development

Melbourne
June 2009

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Authorised by the Department of Education
and Early Childhood Development,
2 Treasury Place, East Melbourne, Victoria, 3002.
ISBN No. 978-0-7594-0543-1

Accessibility

If you would like to receive this publication in an accessible format, such as large print or audio, please telephone 1800 809 834 or email edline@vic.gov.au

This document is also available in PDF format on the internet at www.education.vic.gov.au/about/directions/children/annualreports.htm

Ministerial foreword

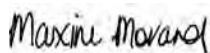
The state of Victoria's children report for 2008 is an important resource that provides a comprehensive overview of the health, learning, development, safety and wellbeing of children and young people up to 18 years. It builds on previous reports to provide a growing evidence base to assist the Government to shape its policy and programs so that every Victorian child is afforded the opportunity to reach their full potential.

This report confirms that Victorian children are well placed to meet the challenges of the future. Children in Victoria are among the highest average achievers in literacy and numeracy, and Victoria's rates of Year 12 (or equivalent) completion and of participation in education and employment continue to be higher than the national average. Improving trends are evident in rising immunisation rates at 24–27 months, in improved reading ability in Prep children, and in declining rates of smoking, teenage fertility and child injury.

There are however, areas of concern where improvements must be made. Asthma, obesity, mental health problems and high levels of alcohol consumption are issues of serious concern that must be addressed. The continued increase in chlamydia notifications, while still a small overall number, is also of specific concern. Indigenous children continue to fare less well than non-Indigenous children across a wide range of outcomes.

This report builds on recent initiatives such as 'Go for Your Life', Victoria's Alcohol Action Plan, Because Mental Health Matters – Victorian mental health reform strategy 2009-19, and the new Victorian Charter of Safety and Wellbeing for Aboriginal Children and Young People.

The Victorian Government is working hard to ensure all Victorians receive the very best foundations in health, wellbeing, learning and development. This report builds on the work we are already doing to ensure that every young Victorian has the opportunity to lead a healthy, fulfilling and productive life so that they can thrive, learn and grow.



Hon Maxine Morand MP
Minister for Children
and Early Childhood Development



Hon Lisa Neville MP
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Acknowledgements

This report on the state of Victoria's children has been produced by the Department of Education and Early Childhood Development in collaboration with the Department of Human Services, the Department of Planning and Community Development, the Department of Transport and the Department of Justice (including Victoria Police).

The Australian Bureau of Statistics was a key source of data for the report.

We are grateful to Angela Clapperton and Erin Cassell from Monash University Accident Research Centre (MUARC) for their analysis of data relating to Victorian child injury and poisoning indicators.

The report draws additionally on analysis provided in expert papers that were commissioned for the *The state of Victoria's children report 2006* and *The state of Victoria's young people 2007* report, including an analysis of the Victorian data from the 2006 Healthy Neighbourhoods School Survey by Joanne Williams at the Centre for Adolescent Health, Murdoch Children's Research Institute, and data provided by the Cancer Council Victoria and Community Indicators Victoria.

It also draws extensively on the 'Victorian Child and Adolescent Monitoring System Evidence Manual' (February 2008, unpublished report) to outline the underpinning evidence for the reported indicators.

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This report represents a large statistical compilation. While the content is correct at the time of preparation, this may be subject to some subsequent minor revision. The online version of the report will include any such revisions. The online version can be viewed or downloaded at www.education.vic.gov.au/about/directions/children/annualreports.htm

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Glossary

ABS	Australian Bureau of Statistics
ACIR	Australian Childhood Immunisation Register
ACPP	Aboriginal Child Placement Principle
AEDI	Australian Early Development Index
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AIM	Achievement Improvement Monitor
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and linguistically diverse
COAG	Council of Australian Governments
CYFA	Children, Youth and Families Act 2005
DEECD	Department of Education and Early Childhood Development
DHS	Department of Human Services
ECIS	Early Childhood Intervention Services
HNSS	Healthy Neighbourhoods School Survey
LBOTE	Language Background other than English
LSAC	Longitudinal Study of Australian Children
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MCH	Maternal and Child Health
NAPLAN	National Assessment Program – Literacy and Numeracy
NHMRC	National Health and Medical Research Council
SAAP	Supported Accommodation Assistance Program
SEHQ	School Entrant Health Questionnaire
SES	Socioeconomic status
STI	Sexually transmissible infection
UNCRC	United Nations Convention on the Rights of the Child
VAED	Victorian Admitted Episodes Dataset
VCAMS	Victorian Child and Adolescent Monitoring System
VCHWS	Victorian Child Health and Wellbeing Survey
VEMD	Victorian Emergency Minimum Dataset
VPHS	Victorian Population Health Survey
WHO	World Health Organization



Executive summary

The Victorian Government has made a strong and continuing commitment to improving the wellbeing of children and young people.

In order to monitor whether children in Victoria are achieving the best possible outcomes – and to identify areas where more attention and investment is needed – the Government has developed the Victorian Child and Adolescent Outcomes Framework.

This framework comprises 35 outcomes of children’s health, learning, development, wellbeing and safety, and 150 indicators to measure progress towards the outcomes. Some of the outcomes relate to the child directly, and others relate to key factors that influence child wellbeing: the family, the community and services and supports.

This report provides an overview of how children (aged 0–17 years) are faring against the majority of indicators from the outcomes framework. It updates the data from *The state of Victoria’s children report 2006*, draws on data from *The state of Victoria’s young people 2007* report and will be regularly updated to show changing trends in children’s wellbeing in Victoria.

Report preview and structure

The report describes the outcomes for all children and – where data is available – for children in four population groups who commonly experience greater disadvantage: Indigenous children, children with a disability, children from culturally and linguistically diverse (CALD) backgrounds and children affected by chronic disadvantage, including children in out-of-home care. Differences in outcomes by sex, by rural and metropolitan locations, and between Victoria and Australia are also considered.

The report refers to children aged 0–17 years inclusive unless otherwise stated. Similarly, parents, carers or families relate to those with children aged 0–17 years inclusive unless stated otherwise.





There are four report sections:

Section 1: Victoria's children and families – *provides information about the Victorian child population and the characteristics of Victorian families*

Section 2: How are Victoria's children faring? – *describes the outcomes for children under five headings: physical health, healthy lifestyles, safety, development and learning, and happiness and engagement with families and communities*

Section 3: How are Victorian families influencing outcomes for their children? – *focuses on the contribution of families to child wellbeing*

Section 4: How well are Victorian families supported? – *focuses on the broader contribution of communities and society to the wellbeing of Victorian families and children*

Overall findings

Overall, the findings suggest that Victorian children are faring very well. We can see evidence of continued improving trends against many of the indicators that were reported in *The state of Victoria's children report 2006*. Nevertheless, the report also highlights some areas of continued and new concern, and some gaps in the data.

The following summary focuses first on outcomes for all children, and secondly on outcomes for children in priority population groups.

How are Victoria's children faring?

Physical health and healthy lifestyles

The evidence relating to health is generally positive:

- Infant, perinatal mortality and low birth weight rates are stable, and the proportion of infants who are fully immunised at age 24–27 months has increased.
- Rates of new cancer diagnoses are stable and may be declining.
- The majority (71.2 per cent) of children meet recommended guidelines for physical activity.
- Rates of illicit drug use are low and the proportion of young people who smoke cigarettes is declining.
- The teenage fertility rate is declining and is lower in Victoria than nationally.
- Most Victorian parents give positive ratings to their children's health.

However, anaphylaxis hospital admission rates are increasing, there are marked increases in chlamydia notification rates in 15–17-year-old females, asthma is the top cause of hospitalisation, and the incidence of type 1 diabetes in children (0–19 years) is increasing in Victoria, as nationally.

We know that considerable numbers of Victorian children are overweight or obese (23 per cent of preschoolers and close to one-third of children aged over 12 years). Survey data suggest that there have been increases (since 1990) in the proportion of 16–17-year-olds who are drinking alcohol at levels that risk short-term harm.

The evidence relating to mental health is mixed. We have limited recent data on the prevalence of mental health problems in children and are principally reliant on hospital admissions data to provide information about child mental health. This shows that rates of hospital admissions for psychiatric problems have declined (2002–03 to 2006–07). There have been increases in self-harm hospital admissions (1996–97 to 2005–06) and decreases in self-harm deaths (1994–95 to 2004–05), although neither of these trends are statistically significant.



Safety

Children and young people in Victoria generally report that they feel safe. However, data from the Healthy Neighbourhoods School Survey (HNSS) shows that while the majority (91.8 per cent) of students report feeling safe at school, a lower proportion (53.9 per cent) feel safe in their neighbourhoods. Nearly two in five (37.5 per cent) students report having experienced bullying recently.

It is very good news that the child injury and poisoning death rate has decreased significantly in Victoria (1994–95 to 2004–05), although injury and poisoning continues to be a leading cause of death for children.

Child protection substantiations do not provide a measure of the prevalence of child abuse as these data relate only to children who have come to the attention of the child protection authorities. However, there appears to be a small declining trend in the rate of child protection substantiations in Victoria.

In 2007–08, there were 11,566 victims of crime aged 0–17 years and 33,865 alleged offenders aged 10–17 years processed by police. The number of child crime victims has decreased from 12,780 in 2002–03 to 11,566 in 2007–08 (a decrease of 9.5 per cent).

Victoria has the lowest rate of young people under youth justice supervision in Australia, at 2.8 per 1000 young people.

Development and learning

The majority (69.4 per cent) of Victorian children who participated in the Australian Early Development Index (AEDI) in the first year of school were assessed as performing well on one or more of the five developmental domains and 24.4 per cent were ‘developmentally vulnerable’ on one or more domains of the AEDI. These proportions are similar to national proportions.

The assessed reading ability of Prep students has improved (1999 to 2007). National Assessment Program – Literacy and Numeracy (NAPLAN) results show that students in Victoria are among the highest achievers, together with students in New South Wales and the Australian Capital Territory.

A greater percentage of Victorian students achieve at or above the national minimum standard than in Australia as a whole in all subject areas and year groups.

Attendance rates are generally higher in the primary than secondary years, with rates for Years 10–12 showing a small overall increase from 2002 to 2007.

In 2007, the proportion of 20–24-year-olds in Victoria who had completed Year 12 or an equivalent (86.1 per cent) was higher than nationally (83.5 per cent) and a greater proportion of young people aged 15–17 years were in education or work (96.5 per cent in Victoria; 92.7 per cent in Australia).

On Track Survey data suggest that there has been an overall increase in the percentage of early school leavers who are taking up employment (2002 to 2007).



Happiness and engagement with families and communities

The majority of children responding to the HNSS had high levels of family attachment. Most children report enjoying school (HNSS) and feeling connected to school (Attitudes to School Survey), although older students are less likely to feel connected, and girls and students from higher socioeconomic status (SES) groups are more likely to report enjoying school (HNSS).

A high proportion (62.9 per cent) of Victorian children aged 5–14 years have participated in an organised sporting activity in the past 12 months. However, while boys are increasingly likely to participate with age, participation among girls declines after the age of 11 years (ABS data).

Two-thirds of Victorian children in the HNSS had volunteered in the past 12 months. 74.4 per cent of children thought they had lots of chances to help decide class activities or rules. CALD children were less likely to say that there were opportunities to have a say in their neighbourhoods.

How are Victorian families influencing outcomes for their children?

The majority of Victorian children (89.5 per cent) live in families with healthy family functioning (Victorian Child Health and Wellbeing Survey (VCHWS)) and most Victorian parents are taking actions to promote the healthy development of their children. The Victorian Population Health Survey (VPHS) shows an increase in the proportion of women who take folate while pregnant (2005 to 2007) and VCHWS data confirm that most parents report putting their infant on their back to sleep and protecting their child from the sun. Breastfeeding rates are stable, although not high, with just under 40 per cent of infants fully breastfed at 6 months.

Nevertheless, there are some areas of concern. Nearly a third (30.7 per cent) of women with children aged under 2 years report that they continued to drink alcohol into the later stages of their pregnancy (VCHWS) and 21.6 per cent of parents in the 2007 VPHS report drinking alcohol at least monthly at levels that risk short-term harm, with nearly half of these (9.7 per cent) drinking at least weekly at levels that risk short-term harm (2007 VPHS).

It is estimated that around one in five Victorian children live with a parent who is affected by mental illness (Maybery 2005, in DEECD 2008).

Trend data from the Victorian Family Violence Database show marked increases in the number of family violence incidents recorded by police (1999–2000 to 2002–03) and in the number of aggrieved family members seeking intervention orders from the courts (between 2003–04 and 2005–06). However, these increases are likely to be linked to greater public reporting of family violence and to enhanced police training, and data collection and recording practice, following on from a Victorian Police review of practice in relation to family violence in 2001 and the introduction of *The Code of Practice for the Investigation of Family Violence* in 2004.



How well are Victorian families supported?

Support from communities

VCHWS data show that Victorian parents report very high levels of social support (94.4 per cent can access care in an emergency and 96.8 per cent have someone to turn to if they are having problems). Parents also rate the physical and social environments of their neighbourhoods very highly (95.9 per cent agree or strongly agree that their neighbourhoods are clean and 94.4 per cent agree that they are safe).

The majority (78.7 per cent) of parents agree that multiculturalism makes life in their area better, and parents are more likely than other adults to have attended a community event in the past six months (61.3 per cent of parents, compared with 43.9 per cent of other adults) (2007 VPHS).

However, single parents report lower levels of social support and rural parents are less likely to report that their neighbourhood has access to close, affordable and regular public transport (50.5 per cent of rural parents report this, compared with 82.5 per cent of metropolitan parents).

Economic wellbeing, housing and homelessness

While the majority of Victorian families live in comfortable financial circumstances, this report confirms the picture that was presented in 2006 of relative disadvantage for one-parent families (DHS 2006). The median weekly income for one-parent families (\$587) is less than half that of two-parent families (\$1434). One in five one-parent households reported running out of food in the past 12 months and being unable to buy more, compared with just 3.5 per cent of two-parent households (VCHWS).

It is encouraging that the rate of youth homelessness in Victoria has decreased (2001 to 2006). Supported Accommodation Assistance Program (SAAP) homelessness data are not comparable with previous years so we cannot comment on trends in relation to families with children receiving assistance from SAAP.

Support from services

Prenatal and infant health service data show that there have been increases in the percentage of women who are given appropriate interventions for smoking in pregnancy (from 2003–04 to 2006–07). There have also been increases in the proportion of children attending Maternal and Child Health Services visits at age 3.5 years (from 49.5 per cent in 2000–01 to 57.8 per cent in 2006–07).

Rates of kindergarten participation for 4-year-olds are high (92.4 per cent in 2008) and around 90 per cent of Prep children in participating schools receive a Primary Health Assessment each year (2002 to 2007).

The findings on child protection performance indicators are also generally positive, with small decreases in recent years in child protection re-reporting and re-substantiation rates, and the percentage of substantiations within three months of a decision not to substantiate.

There is an increasing trend in the rate of children in out-of-home care and an increase in placement instability, with greater numbers of children exiting care who have had three or more placements while in care. However, greater proportions of children in out-of-home care are being placed with relatives or kin (40.9 per cent were placed with relatives or kin at 30 June 2007, compared with 31.7 per cent at 30 June 2002).



Outcomes for Indigenous children

The report draws on a wide range of data to show that Indigenous children continue to fare less well than other children, although there is some recent evidence of improvements.

As we noted in 2006, babies born to Indigenous women in Victoria are more than twice as likely to have a low birth weight as babies born to non-Indigenous women and the perinatal mortality rate for infants born to Indigenous mothers is much higher. Indigenous children are also more likely to be admitted to hospital for asthma and to have higher levels of dental decay.

Data from the School Entrant Health Questionnaire (SEHQ) showed that Aboriginal and Torres Strait Islander (ATSI) parents expressed higher than average concerns on overall health, behaviour, family stress, speech and hearing of their children than non-ATSI parents.

Children of ATSI origin were also more likely to:

- not have attended kindergarten (10.1 per cent of children from ATSI backgrounds did not attend kindergarten, compared to 6.7 per cent of the total sample)
- have a chronic health problem (9.8 per cent of children from ATSI backgrounds were reported as having a chronic health problem, compared to 6.3 per cent of the total sample)
- have a disability (3.1 per cent of children from ATSI backgrounds were reported as having a disability, compared to 2.0 per cent of the total sample).

The school results of Indigenous students remain lower than those of non-Indigenous students. However, there have been some marginal improvements in the results of Indigenous students from 2001.

Indigenous young people continue to be markedly overrepresented in the youth justice system, with a rate of 26.2 per 1000 in the Indigenous population under juvenile justice supervision, compared with a rate of 2.1 per 1000 in the non-Indigenous population. This remains a serious concern, although this overrepresentation is less marked in Victoria than in other states and territories.

The evidence in relation to child protection is mixed. There has been a recent decline in the rate of child protection substantiations and care and protection orders for Indigenous children. However, Indigenous children continue to be markedly over-represented in the Victorian child protection system and they fare less well against child protection performance indicators (re-notification, re-substantiation and substantiations within three months of a decision not to substantiate).

Indigenous children are also overrepresented in out-of-home care. Nevertheless, they are more likely than all children to have had placement stability in care (as measured by the proportion of children exiting care who have had three or more care placements in care) and the proportion of Aboriginal children who are placed with the family of Aboriginal carers (in accordance with the Aboriginal Child Placement Principle (ACCP) has increased.



Outcomes for children in other priority population groups

Outcomes data in relation to children with a disability, CALD children and children in out-of-home care continue to be limited, and this is particularly so in respect of Victorian data.

Available data suggest that outcomes for children in these groups are generally poorer than for the general child population. However, as shown below, this is not the case for all indicators:

- Australian research shows that a considerable proportion (around 63 per cent) of children with a disability experience difficulties at school. In Victoria, around 20 per cent of people aged over 15 years with a disability have not attended school or have only progressed to Year 8, compared to 5 per cent of the general population, and only 55 per cent of people with a disability are employed, while over 81 per cent of the total Victorian population is in paid work.
- Studies in the United States have highlighted that children with disabilities are more likely to be abused. There are no population-based Australian data on this issue.
- The Achievement Improvement Monitor (AIM) program results of Language Background other than English (LBOTE) students have shown improvements and are broadly comparable with results of other students.
- Children from CALD backgrounds (in the HNSS) were more likely to report that they had experience of volunteering, but less likely to report having opportunities to have a say.
- Longitudinal Study of Australian Children (LSAC) and HNSS data suggest that CALD children may be more likely to be overweight or obese than other children.
- Comparative Victorian data for out-of-home care students and the general student population show higher levels of absenteeism for out-of-home care students and lower levels of achievement. Children in out-of-home care are also more likely to be at risk of having behavioural and mental health problems than children in the general population.

The gaps in our knowledge about outcomes for children with a disability, CALD children and children in out-of-home care will be addressed by future data collections.





Introduction

A series of reports on how Victorian children are faring

This is the third Victorian Government report on how Victorian children are faring. The report updates data from the 2006 *state of Victoria's children report* (the 2006 children's report), draws on relevant data from *The state of Victoria's young people 2007* (the 2007 young people report),¹ and will be further updated in 2011 and 2014. This third report includes 134 indicators of child wellbeing, and adds to the evidence from 90 indicators reported in 2006.

By systematically identifying how Victoria's children and young people are faring against the most recent evidence, this series of reports will build a picture, over time, of changing trends in the wellbeing of children and young people in Victoria. This picture will allow the Government to shape its policy and programs in response to the evidence and to identify where additional action may be required to improve child wellbeing.

The Government has made a strong and continuing commitment to improving the wellbeing of children and young people (*Growing Victoria Together: a vision for Victoria to 2010*) and is prioritising giving children the best start in life, improving education and helping people into work, improving health and wellbeing and developing liveable communities (*A Fairer Victoria: Strong People, Strong Communities*).

A Fairer Victoria 2008 : key priorities

Priority area 1 – Getting the Best Start

- Early years support for children and families most at risk

Priority area 2 – Improving education and helping people into work

- Reducing educational inequality, supporting young people at risk and reducing barriers to workforce participation

Priority area 3 – Improving Health and Wellbeing

- Reducing health inequalities and promoting wellbeing

Priority area 4 – Developing liveable communities

- Strengthening neighbourhoods and local communities

(Source: *A Fairer Victoria: Strong People, Strong Communities*)

¹ The 2007 young people report sets out how young people (aged 12–24) are faring, focusing on their health, economic wellbeing, learning, safety and community engagement.





Alongside the commitment to improving the wellbeing of all young Victorians, the Government is focusing attention on four identified priority groups: Indigenous children; children with a disability; children from CALD backgrounds and children affected by chronic disadvantage, including children in out-of-home care. Evidence suggests that these groups of children are not faring as well as others, that they face different or a particular set of problems, or that they are likely to require different approaches.

A Victorian Charter and Plan for Aboriginal Children and Young People

A Victorian Charter of Safety and Wellbeing for Aboriginal Children and Young People has been developed in 2008 in recognition that, despite the strength of Aboriginal families and culture, Aboriginal children and young people continue to experience significantly worse outcomes in life than non-Aboriginal children and young people. This is in accord with *The Child Wellbeing and Safety Act 2005*, which places a responsibility on the Victorian Government to develop and promote a charter of wellbeing and safety for Aboriginal children and young people. The commitment is to outline key actions and measures of progress in improving their safety, health, learning, development and wellbeing, and to describe the roles and responsibilities of families, communities, community-controlled organisations and mainstream services in making a positive difference in the lives of Aboriginal children and young people.

An important context for the development of the charter is the recognition of the impact of past removal policies, particularly the Stolen Generation of Aboriginal and Torres Strait Islander children who were forcibly removed from their families and communities by state and territory governments. Importantly, the charter recognises the strength and resilience of Aboriginal families and cultures and the need to promote protective factors for children.

The charter includes a preamble, principles and outcome measures consistent with a vision for the future for Aboriginal children and families, which focuses on improved outcomes within a framework of cultural safety and respect. Outcomes are consistent with the Victorian Indigenous Affairs Framework and outcomes identified by the Council of Australian Governments.

The Aboriginal Children's Charter is a whole-of-government initiative led by the Aboriginal Children and Families Advisory Committee and the Ministerial Taskforce on Aboriginal Affairs.

The charter will be complemented in 2010 by a 10-year plan outlining key directions, strategies and evidence-based interventions to improve safety, health, development and learning outcomes for Aboriginal children and young people.

Monitoring and measuring how children are faring using an outcomes framework

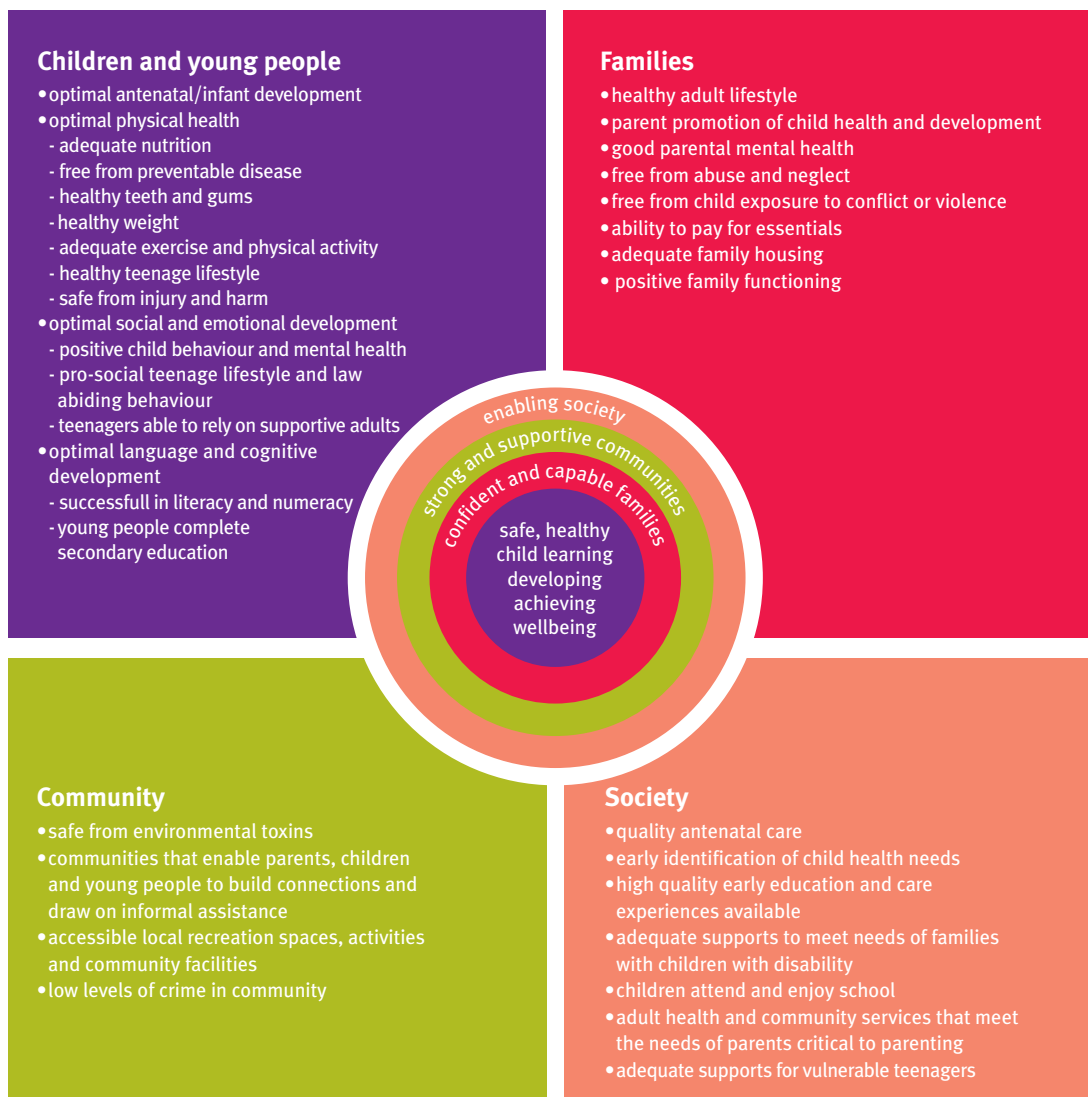
In order to monitor whether children and young people in Victoria are achieving the best possible outcomes, and to identify areas where more attention and investment are needed, the Government has carried out a rigorous review of the evidence on factors that are known to make a difference to children and young people.

This process has led to the identification of 35 measurable aspects, known as outcomes, of children's health, learning, development, wellbeing and safety that are known to be of importance to children, relevant to all or most children, likely to respond to programs of intervention, and appropriate for government intervention and support. This forms the Victorian Child and Adolescent Outcomes Framework and reflects an ecological approach incorporating the impact of parent and family factors and the community and supporting services (figure A).



The framework provides the basis against which child wellbeing is measured in *The state of Victoria's children* report series.

Figure A: The Victorian Child and Adolescent Outcomes Framework



Key elements of the outcomes framework

Underpinning the outcomes framework are the aspirations that the Government and the wider community have for Victoria's children. The shared vision is of a Victoria in which all children are safe, healthy, learning, developing and achieving wellbeing.



Defining child health, development, learning, safety and wellbeing

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 interaction with others.

Child learning implies opportunities for interactions with others and discovery of the world, and 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 and exclusion.

These five broad overlapping areas of health, development, learning, safety and wellbeing are of central and critical importance to children's current and future wellbeing.

However, children do not achieve these outcomes without the support of confident, capable families, a strong community and a society which provides the opportunities and services they need. For this reason, the framework includes outcomes that relate to the child and young person directly, together with others that relate to the family, the community and the wider society.

The child is at the centre of the framework surrounded by their family, the community that supports families, and the societal services and supports that enable communities and families to support children.

All these factors are known to interact as drivers or determinants of child outcomes. It is also important to recognise that children interact with their environments in ways that can make a difference to their lives. This observation is true of young children, and becomes more relevant as they grow older.

The Government's approach to community strengthening

The importance of social connectedness and support to health and wellbeing has been well documented. The Victorian Government's approach to community strengthening recognises the personal benefits of social participation to include people feeling safer in their communities, being more likely to enjoy living in their community, having improved physical and mental health and wellbeing, having improved access to formal and informal sources of personal support, having improved family relationships, and improved access to employment opportunities (Pope 2006, in DEECD 2008).

The Victorian Child and Adolescent Monitoring System

The Victorian Child and Adolescent Monitoring System (VCAMS) is a comprehensive, across government, monitoring system that facilitates reporting against the agreed 35 outcomes for children. Each outcome has a set of associated indicators that can be used to measure progress towards the outcome. These outcomes, and the associated 150 evidence-based indicators, form the basis of VCAMS. In line with the Outcomes Framework, the VCAMS indicators relate to the health, safety, learning, development and wellbeing of children from the antenatal period up to 18 years of age.

This monitoring system is intended to facilitate more informed decision making across government through better access to validated outcome measures for children and families. The data reported through VCAMS can assist the government to consider more effective setting of priorities, more efficient allocation of resources and whether programs and policies are making a difference for Victorian children and families.



How Victorian children are faring: evidence from the previous report

The 2006 children's report reported on 90 indicators of child wellbeing and found that young Victorians were faring very well across a wide range of outcome areas.

For example:

- Infant mortality rates were lower in Victoria than in the rest of Australia.
- Victorian parents rated their child's general health very highly.
- Attendance at Maternal and Child Health (MCH) 3.5-year ages and stages visits were showing an improving trend.
- The majority of Victorian parents were taking action to promote their children's health and development.
- Victorian children scored highly on measures of connectedness to school.
- Year 12 completion rates were improving.
- The proportion of Victorian students achieving the national literacy and numeracy benchmarks (at Years 3, 5 and 7) was at or above the national average.
- Victoria did not show the same pattern of marked increases in child substantiations (and notifications) as many of the other states and territories.
- There was a small downward trend in the number of unintentional child injury deaths.
- Victorian parents interviewed in the 2006 VCHWS were positive about the liveability of their local communities and the majority experienced high levels of social support.

However, the report highlighted five areas in which children and young people were faring less well:²

- The increasing prevalence of childhood overweight and obesity
- The mental health of children and young people
- The poorer oral health of children in rural areas compared with children in metropolitan areas
- The financial hardship and related stresses experienced by sole parents
- The marked differences in outcomes between Indigenous and non-Indigenous children.

The 2006 report also identified an inadequate research base on protective factors for Indigenous children and a lack of good outcomes data relating to children with a disability, children from CALD backgrounds and children in out-of-home care.

² Some of these areas are also identified as being of concern in the 2007 young people's report. For example, this report highlights the mental health of young people, issues relating to healthy body weight, body image and diet, and physical activity as issues of concern. The 2007 report also identifies a gap in outcomes data relating to young people with a disability and young CALD people; and notes that, while there are some areas of improvement, Indigenous young people fare less well than non-Indigenous young people across a range of outcome areas.



This report on Victoria's children

This report aims to:

- Describe the current status of Victoria's children by drawing on the most up-to-date outcomes data available
- Identify any patterns of improvement or deterioration in the wellbeing of Victoria's children and young people by updating outcomes data, from the 2006 children's report.

Focus

The focus is on reporting on outcomes for all Victorian children and on outcomes for children from the four identified priority groups:

- Indigenous children
- children with a disability
- children from CALD backgrounds (including refugees)
- children who are affected by chronic disadvantage, including children in out-of-home care.

Where data are available, the report also considers differences in outcome by:

- sex
- rural and metropolitan locations
- Victorian and national trends.

The report is concerned with children aged under 18 years, in line with the definition of 'child' that is adopted in the *Child Wellbeing and Safety Act 2005* and the *UN Convention on the Rights of the Child (UNCRC)*. However, there are instances where outcomes for people over 18 years and over are reported (for example, in relation to post-school pathways).

Report structure

There are four sections as follows:

Section 1: Victoria's children and families – provides demographic information about the Victorian child population and the characteristics of Victorian families.

Section 2: How are Victoria's children faring? – reports on key health, learning, development and wellbeing outcomes for Victoria's children, under the following headings: Physical health (2.1); Staying healthy and healthy lifestyles (2.2); Safety (2.3); Development and learning (2.4); Happiness and engagement with families and communities (2.5).

Section 3: How are Victorian families influencing outcomes for their children? – includes information about family factors that can promote child wellbeing (such as breastfeeding) (3.1); and factors that can have adverse impacts (such as parental drinking) (3.2).

Section 4: How well are Victorian families supported? – focuses on the extent to which parents feel supported in their communities (4.1); the financial wellbeing and housing of Victorian families (including homelessness) (4.2); and the level and nature of service support that is available to Victorian children and families (4.3).

The report also includes some information in text boxes about:

- research studies and findings that are relevant to the outcomes data
- relevant government policy initiatives and programs.



Data sources

Administrative and survey data

This report draws on a wide range of administrative and survey data from a variety of sources, including data held by the Department of Education and Early Childhood Development, the Department of Human Services, the Department of Planning and Community Development, the Department of Transport and, the Department of Justice (including Victoria Police). The ABS is a key data source and 2006 Census of Population and Housing findings are included throughout the report.

Key Victorian survey sources include:

- The 2006 Victorian Child Health and Wellbeing Survey
- The 2006 Healthy Neighbourhoods School Survey
- The 2007 Victorian Population Health Survey
- The School Entrant Health Questionnaire (1998 to 2004)
- The annual *On Track* Survey (2002 to 2007).

Further details of survey sources are provided in Appendix 1.

Commissioned analyses

An analysis of data relating to Victorian child injury and poisoning indicators was carried out, for inclusion in this report, by the Victorian Injury Surveillance Unit at Monash University Accident Research Centre.

The report draws additionally on analyses provided in a range of expert papers that were commissioned from academics for the 2006 children's report and the 2007 young people report, including an analysis of the Victorian data from the 2006 HNSS (Williams 2007) and data provided by Community Indicators Victoria and The Cancer Council Victoria.

It also draws extensively on the Victorian Child and Adolescent Monitoring System Evidence Manual (February 2008, unpublished report) to outline the underpinning evidence for the reported indicators.

A technical note on the choice of indicator data and data limitations

The development of the VCAMS has adopted a whole-of-government approach, involving collaboration between government departments. This work has been developing over a period of years and has involved several complex elements, including the specification of indicators in line with key selection criteria and work to ensure appropriate data are available to support each of the indicators.

When the 2006 children's report (the first report in the series) was written, this indicator development work was at a mid-way stage and the report focused on reporting on those indicators – around 90 – for which reliable data was available.

This work is further advanced at the time of writing this report and we are now able to report on most of the 150 indicators.

We have aimed, wherever possible, to report on indicators using the specified VCAMS data source, and have been able to do so in the majority of cases. In some instances, however, owing to the timing of data collections, data from the VCAMS data source has not been available. For example, the Victorian Adolescent Health and Wellbeing Survey – a specified data source for a range of the indicators – is scheduled to take place in 2009.

Where data from the specified VCAMS source is not available, we have opted to use alternative reliable data sources wherever possible, to give a full and comprehensive picture of child wellbeing.

Section 1: Victoria's children and families

1.1 An introduction to Victoria's children

Victoria is the second most populated state or territory in Australia. It has a total population of 5,126,540, representing almost a quarter (24.8 per cent) of the national population.

Victoria is home to 1,181,483 children, representing almost 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 third-lowest proportion of children (23.0 per cent) (see table 1.1).

Table 1.1: Number and percentage of children aged 0–17 years, states and territories, 2006

State or territory	Number of 0–17-year-olds	Percentage of state population (0–17 years)	Percentage of Australia's children
Victoria	1,181,483	23.0	24.1
New South Wales	1,610,112	23.6	32.8
Queensland	1,007,003	24.6	20.5
South Australia	349,923	22.3	7.1
Western Australia	498,037	24.2	10.2
Tasmania	117,353	24.0	2.4
Northern Territory	61,152	29.0	1.2
Australian Capital Territory	76,515	22.9	1.6
Australia *	4,902,206	23.7	100.0

Population at 30 June 2006

Source: ABS 2008a–i *Total for Australia includes *other territories*



Geographical distribution of Victoria's children

Although the majority of Victoria's children live in metropolitan Victoria (71.0 per cent), children represent a greater proportion of the population in rural Victoria (table 1.2).

Table 1.2: Number, percentage and distribution of children aged 0–17 years, Victoria, 2006

Region	Number of 0–17 year-olds	Percentage (0–17 years)	Distribution across regions
Eastern Metro	222,582	22.3	18.8
Northern Metro	181,874	22.3	15.4
Southern Metro	274,709	22.5	23.3
Western Metro	159,545	22.4	13.5
Metropolitan Victoria	838,710	22.4	71.0
Barwon-South Western	85,745	24.1	7.3
Gippsland	60,167	24.3	5.1
Grampians	52,985	24.7	4.5
Hume	66,263	25.4	5.6
Loddon Mallee	77,360	25.4	6.5
Rural Victoria	342,520	24.8	29.0
Unincorporated Vic	108	14.1	0.0
Victoria	1,181,338	23.0	100.0

Population at 30 June 2006

Source: DEECD calculations based on ABS 2008 (data available on request)

Note: Regional data differ from the statewide data presented in table 1.1, as the final 2006 estimated resident population below state level had not been released at the time of preparation

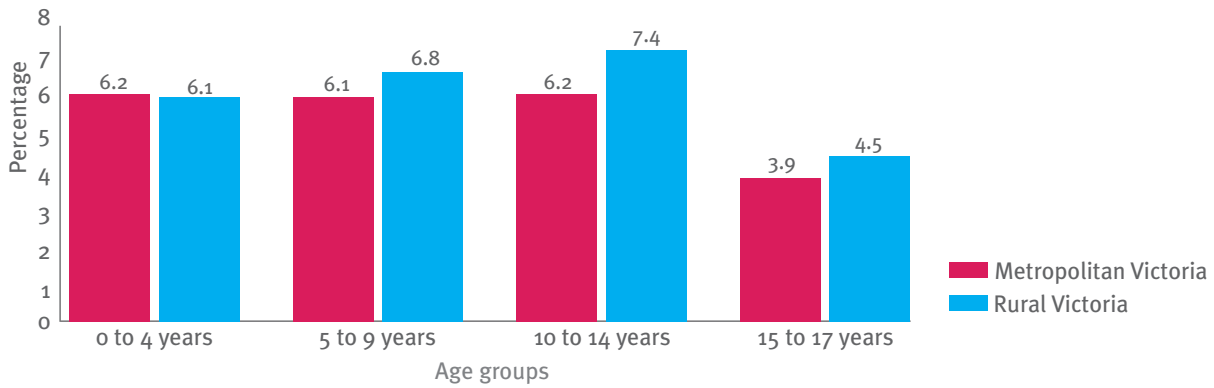
Sex distribution

The sex distribution of Victoria's child population (48.7 per cent female and 51.3 per cent male) is consistent with that of most states and territories and the national distribution at 30 June 2006.

Age structure and distribution

Figure 1.1 illustrates the percentage of children in four age groups within the total population of rural and metropolitan Victoria. This shows that rural and metropolitan Victoria have a comparable percentage of 0–4-year-olds but that rural Victoria has a larger percentage of children in other age groups.

Figure 1.1: Percentage of children aged 0–17 years in each age group by area, Victoria, 2006



Population at 30 June 2006

Source: DEECD calculations based on ABS 2008 (ABS data available on request)

Note: Regional data differ from the statewide data presented in table 1.1, as the final 2006 estimated resident population below state level had not been released at the time of preparation

The pattern of population growth

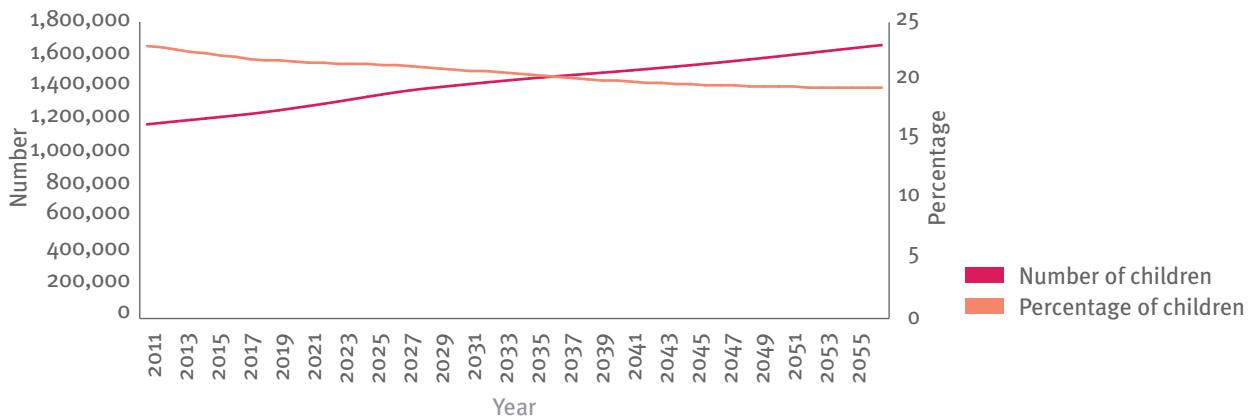
The 2006 children’s report notes that Victoria has experienced a falling birth rate in recent decades (DHS 2006). However, more recently, Victoria has seen a slight upturn in the total fertility rate and a substantial increase in the number of births. From 2001 to 2006 the total fertility rate increased from 1.61 to 1.75, with an increase also observed nationally, from 1.73 to 1.81 over the same period (ABS 2007).

In 2006–07, Victoria’s Maternal and Child Health Service recorded 70,158 births to women resident in Victoria. This represented a net increase of 15 per cent in the number of births since 2000–01, with the most significant growth from 2004–05 to 2006–07 (an increase of 10 per cent). This was the first time since the early 1970s that the number of births in Victoria reached 70,000, suggesting an unexpected ‘baby boom’ (DEECD 2007).

According to the latest population projection estimates from the ABS, the total population of Victoria is projected to increase by 59 per cent from 2009 to 2056. The number of children in the population is projected to increase by 38 per cent over the next 47 years (DEECD calculations based on ABS 2008j).

The percentage of children in the population is projected to decrease as shown in figure 1.2, in line with increases in life expectancy and an ageing population.

Figure 1.2: Projected number and percentage of children aged 0–17 years, Victoria, 2011 to 2056



Source: ABS 2008

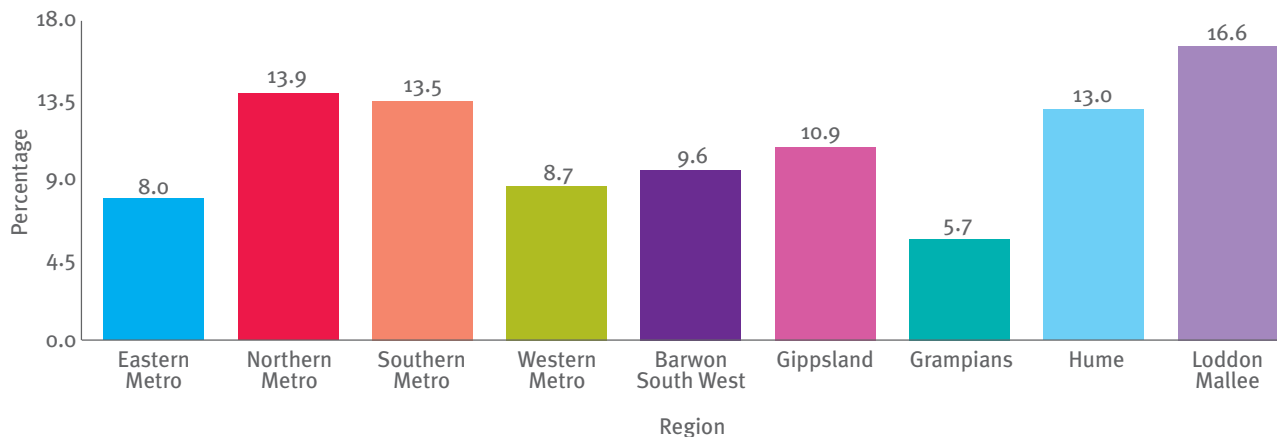
1.2 Diversity in Victoria's population

Indigenous Victorians

Based on the 2006 Census of Population and Housing, 0.6 per cent of Victoria's population identify as Indigenous, that is approximately 30,000 people.³ There are marked age differences between the age structure of the Indigenous population and the total population. Children make up 43.9 per cent of the Indigenous population, almost double the proportion of children in the total population (23.4 per cent as recorded by the 2006 Census).

Of all children in Victoria, 1.1 per cent are Indigenous, that is, approximately 13,000 children. As noted earlier, approximately 70 per cent of all children live in metropolitan Victoria. However, the population of Indigenous children is more evenly distributed across metropolitan and rural Victoria (44 per cent and 56 per cent respectively). Figure 1.3 presents the distribution of Indigenous children across regions in Victoria.

Figure 1.3: Distribution of Indigenous children aged 0–17 years across regions, Victoria, 2006



Source: DEECD calculations based on the 2006 Census of Population and Housing

Place of birth

Based on the 2006 Census of Population and Housing, 23.8 per cent⁴ of all Victorians were born overseas (compared to 22.2 per cent of all Australians). The top stated countries of birth for all Victorians (after Australia) were the United Kingdom (4.2 per cent), 'born elsewhere' (3.9 per cent),⁵ Italy (1.7 per cent), New Zealand (1.3 per cent) and Vietnam (1.2 per cent).

Children born overseas represent 6.6 per cent of all children in Victoria (compared to 6.9 per cent of all children in Australia). The top stated countries of birth for children in Victoria (after Australia) were 'born elsewhere' (1.9 per cent),⁶ New Zealand (0.9 per cent), United Kingdom (0.7 per cent), India (0.4 per cent) and the Philippines (0.3 per cent).

³ Note that this data is based only on the information collected in the 2006 Census. This does not include approximately 5 per cent of the population who did not provide information on their Indigenous status. At the time of preparation, the ABS Experimental Estimates of Indigenous Australians based on the 2006 Census of Population and Housing had not been released.

⁴ This does not include approximately 6 per cent for whom birth place was not stated.

⁵ Includes countries not identified individually, 'Australian External Territories', 'Inadequately described', 'At sea' and 'Not elsewhere classified'.

⁶ Includes countries not identified individually, 'Australian External Territories', 'Inadequately described', 'At sea' and 'Not elsewhere classified'.

Language spoken at home

Based on the 2006 Census of Population and Housing, 20.4 per cent⁷ of all Victorians speak a language other than English at home (compared to 15.8 per cent of all Australians). The top stated languages spoken at home for all Victorians (after English) are the Chinese languages (2.9 per cent),⁸ 'other' (2.7 per cent),⁹ Italian (2.7 per cent), Greek (2.4 per cent) and Vietnamese (1.5 per cent).

Children who speak a language other than English at home represent 16.8 per cent of all children in Victoria (compared to 13.6 per cent of all children in Australia). The top stated languages spoken at home for children in Victoria (after English) were 'other' (3.2 per cent),¹⁰ Chinese languages (2.4 per cent),¹¹ Vietnamese (1.9 per cent), Arabic (1.6 per cent) and Greek (1.6 per cent).

Religion

In the 2006 Census of Population and Housing, 20.4 per cent of all Victorians reported having 'no religion',¹² (compared to 18.7 per cent of all Australians) and a further 11.2 per cent provided no information about their religious affiliation. Of those Victorians who stated a religious affiliation, the majority described themselves as Christian (60.5 per cent), followed by Buddhism (2.7 per cent), Islam (2.2 per cent) Hinduism (0.9 per cent) and Judaism (0.8 per cent).

The 2006 Census also finds that 25.4 per cent of children in Victoria reportedly have 'no religion',¹³ (compared to 23.5 per cent of all children in Australia) and no information was reported about the religious affiliation of a further 9.1 per cent of children in Victoria. Of those children in Victoria for whom a religious affiliation was stated, the majority were described as Christian (56.9 per cent), followed by Islam (3.5 per cent), Buddhism (2.6 per cent), Hinduism (0.8 per cent) and Judaism (0.8 per cent).

Refugee children

In 2006–07, there were 3477 humanitarian entrants to Victoria, with 1713 of these (43.9 per cent) being children. A further age breakdown is presented in table 1.3.

Table 1.3: Age on arrival of humanitarian entrants, Victoria, 2002–03 to 2006–07

Age (years)	2002–03	2003–04	2004–05	2005–06	2006–07	Total
0–5	379	527	689	572	475	2,642
6–11	476	506	663	580	660	2,885
12–15	335	327	367	338	374	1,741
16–17	176	173	184	164	204	901
18–24	403	435	606	508	541	2,493
25+	1,289	1,270	1,392	1,228	1,223	6,402
Total	3,058	3,238	3,901	3,390	3,477	17,064

Source: Department of Immigration and Citizenship 2007

Most humanitarian entrants in Victoria in 2006–07 were from Sudan (21.9 per cent), Burma (21.2 per cent), Afghanistan (15.3 per cent) and Iraq (13.6 per cent).

⁷ This does not include approximately 5 per cent for whom language spoken at home was not stated.

⁸ Includes Cantonese and Mandarin.

⁹ Comprises languages not identified individually, 'Inadequately described' and 'Non-verbal, so described'.

¹⁰ Comprises languages not identified individually, 'Inadequately described' and 'Non-verbal, so described'.

¹¹ Includes Cantonese and Mandarin.

¹² Comprises 'No Religion, Not further defined', 'Agnosticism', 'Atheism', 'Humanism' and 'Rationalism'.

¹³ Comprises 'No Religion, Not further defined', 'Agnosticism', 'Atheism', 'Humanism' and 'Rationalism'.

Children with a disability

It can be difficult to provide accurate estimates of the number of children with a disability because of debate surrounding the definition of a disability and because of identification problems even where a definition is agreed.

Each person's experience of disability is different, being influenced by a range of factors, including a person's own life experiences, the attitudes of community members towards disability, and the ease with which a person can access information, services and the physical environment (DHS 2002, in DEECD 2008).

Disabilities can be caused by a genetic condition, illness or an accident.

Our data on the prevalence of childhood disability is derived from the 2003 Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (ABS 2004, in DHS 2006; AIHW 2006). The ABS 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 (ABS 2004, in DHS 2006).¹⁴

The ABS 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) (ABS 2004, in DHS 2006).

In Australia, around half of children with a disability have a severe or profound core activity limitation (4.3 per cent). Boys are more likely than girls to have a disability (10 per cent compared with 6.5 per cent) and to have a severe or profound core activity limitation (AIHW 2006).

Indigenous children

Analysis of SEHQ data showed that parents of children of ATSI background were more likely to report that their child had a disability compared with parents in the total sample (3.1 per cent of ATSI parents reported this, compared to 2.0 per cent of the total sample) (Griffin et al. 2006).

Children with special health care needs

The 2006 VCHWS asked parents a series of questions to ascertain whether their child has special health care needs.¹⁵

Overall, 15.7 per cent of children were reported to have special health care needs. Nearly one in 10 children were reported to be dependent on medication (9.3 per cent) and to require or use more services (9.5 per cent). One in 25 (4.1 per cent) children were regarded as having functional limitations.

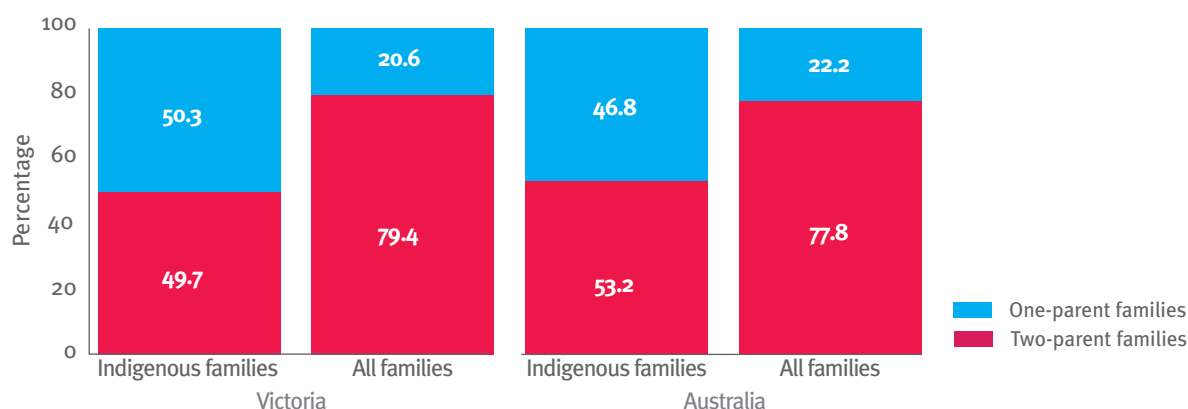
¹⁴ There are four levels of core activity restriction: profound, severe, moderate and mild. Children with a disability can also have a core activity restriction if the disability limits their ability to some degree to perform tasks, such as self-care, mobility, communication and schooling.

¹⁵ 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.

1.3 Family characteristics

According to the 2006 Census of Population and Housing, there are approximately 576,700 families in Victoria with one or more children. Approximately 1.2 per cent of these families are Indigenous.¹⁶ Approximately one-fifth of these families in Victoria are one-parent families, compared to half of all Indigenous families (see figure 1.4).

Figure 1.4: Families with children aged 0–17 years, Victoria and Australia, 2006



Source: ABS 2006 Census of Population and Housing

The 2006 Census also provides more detailed information about family blending, recording information about intact, step and blended families.

The composition of Victorian families is broadly similar to that of families in Australia. However, Victoria has a slightly lower proportion of one-parent families, and a slightly higher proportion of intact families, than Australia as a whole (see table 1.4).

Table 1.4: Family composition, Victoria and Australia, 2006

Family composition	Victoria		Australia	
	Number	Per cent	Number	Per cent
Intact	414,491	71.9	1,621,483	69.1
Step	22,228	3.9	103,424	4.4
Blended	19,484	3.4	91,454	3.9
Total two-parent families*	457,820	79.4	1,825,952	77.8
Lone mother	104,074	18.0	450,679	19.2
Lone father	14,828	2.6	69,495	3.0
Total one-parent families	118,902	20.6	520,174	22.2
Total	576,722	100.0	2,346,126	100.0

Source: ABS 2006 Census of Population and Housing

*Includes 'other' couple families that are not classified as intact, step or blended.

Note: A small proportion of intact, step and blended families may also have 'other' children present, who are otherwise related; unrelated, such as foster children; or grandchildren being raised by their grandparents

¹⁶ An Indigenous family is defined as a family where one or more members has identified as Indigenous.





Section 2: How are Victoria's children faring?

Underpinning the outcomes framework are the aspirations that the Government and the wider community have for Victoria's children. The shared vision is of a Victoria in which all children are safe, healthy, learning, developing and achieving wellbeing.

Section 2 reports on key health, learning, development and wellbeing outcomes for children, under the headings of: Physical health (2.1), Staying healthy and healthy lifestyles (2.2), Safety (2.3), Development and learning (2.4), and Happiness and engagement with families and communities (2.5).





2.1 Physical health

Summary

- Infant mortality rates in Victoria are lower than national rates and low by comparison with rates in New Zealand, Canada and the UK.
- Babies born to Indigenous women are more than twice as likely to have a low birth weight as babies born to non-Indigenous women.
- The perinatal mortality rate for infants born to Indigenous mothers is much higher than that for infants born to non-Indigenous mothers.
- There is a continuing declining trend in SIDS in Victoria (1985 to 2005).
- There have been increases (2000 to 2007) in the rate of notifications for influenza and decreases in the rate of notifications for pertussis (whooping cough).
- The proportion of infants who are fully immunised at age 24–27 months has increased steadily since 2000–01.
- Rates of new cancer diagnoses in Victoria among children are stable (1996 to 2005) and may be declining. Further data will be needed to confirm whether this represents a trend.
- The incidence rate of type 1 diabetes is increasing in Victoria among children and young people aged 0–14 years (2001 to 2006), in line with the national rate. Rates are highest in Victorian children aged 10–14 years.
- Of Victorian children aged 1–12 years, 13.2 per cent are reported to have asthma (2006 VCHWS). Parents of Indigenous children are more likely to report that their child has asthma (School Entrant Health Questionnaire (SEHQ)).
- Asthma (unspecified) is the top cause of hospitalisation among Victorian children, affecting more males than females.
- Anaphylaxis hospital admission rates appear to be increasing (2002–03 to 2006–07).
- Among children attending Victorian public dental services, Indigenous children have a higher incidence of dental caries than non-Indigenous children.
- Available data suggest that 23 per cent of Victorian preschoolers may be overweight or obese, and close to one-third of young people (aged over 12 years) are overweight. Children and young people from socioeconomically disadvantaged backgrounds are more likely to be overweight.

Children and young people's health is affected by a range of individual, familial, social, economic, neighbourhood, environmental and political factors, and low socioeconomic status is a key risk factor for poorer health outcomes (AIHW 2005).

The health of Australia's and Victoria's children has shown some marked improvements over the past 40–50 years on some of the commonly used measures of child health. For example, death rates for almost all causes have continued to fall, 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 children the recent advances in child health outcomes are less marked. Child poverty remains a significant impediment to child health and Indigenous children and children from less advantaged socioeconomic backgrounds continue to experience poorer health outcomes.

This section focuses principally on children and young people’s physical health. For the purposes of this report, we adopt a broad understanding of child health as ‘a state of complete physical, mental and social wellbeing’. In line with this understanding, we focus on children and young people’s social and emotional health and development in subsequent sections of the report.

Prenatal and infant health

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.

Indicator: The number of infants born with low birth weight

Low birth weight is associated with an increased risk of death in the first year of life, long-term disability and diseases, and the development of chronic disease in later life (Barker 1994).

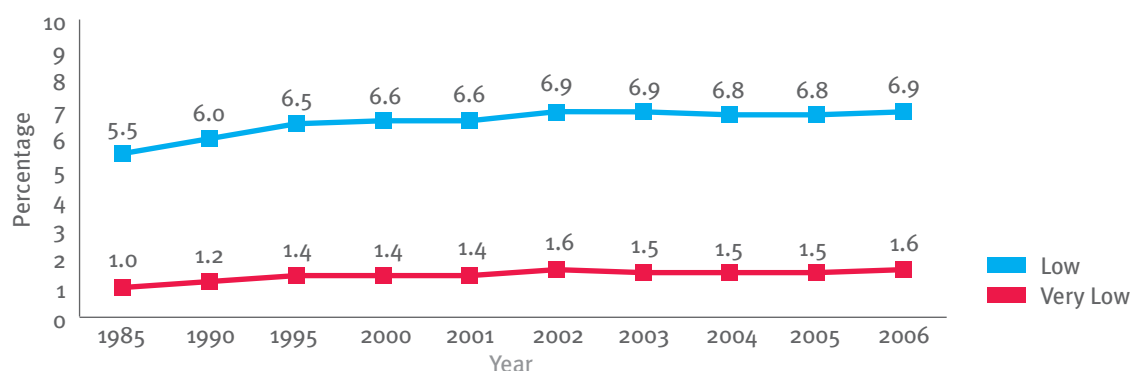
Risk factors associated with low birth weight include maternal age and education, multiple pregnancies, low socioeconomic status, smoking and antenatal care (McCormick 1985). Other contributory factors to low birth weight include parental size, mother’s nutritional status, alcohol intake and illness during pregnancy (Horta et al. 1997; Kramer & Kakuma 2004).

Low birth weight is defined as a birth weight of less than 2500 grams and very low birth weight as a birth weight of less than 1500 grams.¹⁷

In 2005, 6.4 per cent of all live-born babies in Australia had a low birth weight and 1.1 per cent had very low birth weight. Of Australian babies live-born to Aboriginal mothers, 13.2 per cent had a low birth weight and 2.4 per cent had a very low birth weight (Laws et al. 2007).

Figure 2.1 shows the proportions of low and very low birth weight babies born in Victoria from 1985 to 2006.¹⁸ The proportion (of low and very low birth weight babies) increased from 1985 to 2002, but has remained stable since then.

Figure 2.1: Trends in low birth weight and very low birth weight as a proportion of all births, Victoria, 1985 to 2006



Source: Births in Victoria 2003–04 Victorian Perinatal data Collection Unit (VPDCU) (1985 to 2004 data) (DHS 2005a); unpublished VPDCU data (2005–06)

¹⁷ These definitions include both premature and full-term babies.

¹⁸ Adjusted to exclude terminations for psychosocial indications.



As table 2.1 shows, babies born to Indigenous women in Victoria are more than twice as likely to have a low birth weight as babies born to non-Indigenous women.¹⁹

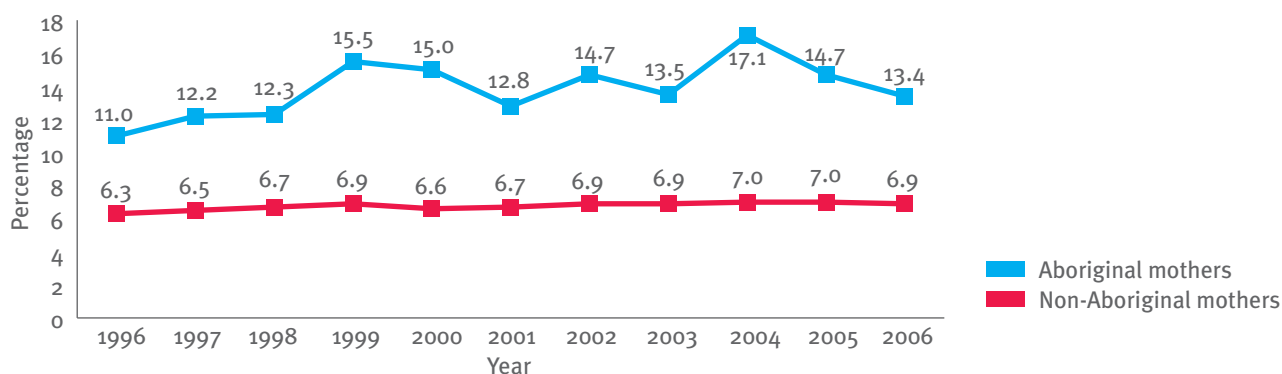
Table 2.1: Birth weight of Indigenous and non-Indigenous infants, Victoria, pooled data, 2005 to 2006

Birth weight (grams)	Indigenous (%)	Non-Indigenous (%)
<1500	2.4	1.5
1500–2499	11.4	5.3
2500–4499	84.9	91.3
4500+	1.3	1.8

Source: Victorian Perinatal Data Collection Unit, unpublished data

However, as figure 2.2 shows, there are some preliminary indications that the Koori Maternity Services Strategy may be succeeding in reducing the rate of low birth weight babies through improved antenatal care (DHS 2008).

Figure 2.2: Percentage of babies with low birth weight, born to Aboriginal and non-Aboriginal mothers, Victoria, 1996 to 2006



Source: DHS 2008a

The Koori Maternity Services Strategy

The Koori Maternity Services Strategy provides culturally appropriate support to Aboriginal women throughout pregnancy and in the postnatal period through the employment of Aboriginal health workers and midwives and providing outreach services from 11 Aboriginal community controlled health organisations (DHS 2008a).

Indicator: Infant mortality rate

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 2004a, in DHS 2006).

Infant mortality rates have shown a marked decline in Australia since 1900. However, recent analysis has shown that infants from more socioeconomically disadvantaged areas are twice as likely to die as those from the least disadvantaged areas (Australian Institute of Health and Welfare 2006, in DHS 2006). Also, the infant mortality rate for the Indigenous population is almost 3 times that of the general population (ABS 2007b).

¹⁹ Adjusted to exclude terminations for psychosocial indications.



In Victoria, in 2006, the infant mortality rate was 3.9 per 1000 live births (provisional data).

Infant mortality rates in Victoria are consistently lower (2000 to 2005) than nationally and they are also lower than in New Zealand, Canada and the United Kingdom (table 2.2).

Table 2.2: Comparison of Victorian infant mortality rates (per 1000 population) with selected OECD countries, 2000 to 2006²⁰

	2000	2001	2002	2003	2004	2005	2006 ²¹
Victoria	3.8	4.2	4.4	4.1	3.9	4.4	3.9
Australia	5.2	5.0	4.8	4.8	4.7	5.0	–
New Zealand	6.1	5.3	5.6	4.9	5.6	5.1	–
Canada	5.3	5.2	5.4	5.3	5.3	–	–
United Kingdom	5.6	5.5	5.2	5.3	5.0	5.1	–

Source: The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2008

Indicator: Perinatal mortality rate

Perinatal mortality measures the rate of stillbirths (foetal deaths of more than 20 weeks gestation or 400 grams) and neonatal deaths (deaths of live born infants within 28 days of birth). These rates are a key measure of maternal and infant health and of wellbeing in the community. They are also indicators of antenatal care quality, the effectiveness of obstetric services, and the quality of infant care in the hospital and the community (DHS 2005a).

In 2006, the perinatal mortality rate in Victoria was 9.8 per 1000 live births. Between 2000 and 2006 perinatal mortality rates have ranged from a low of 9.2 per 1000 live births in 2000 to a high of 10.3 per 1000 live births in 2003 (table 2.3).

Table 2.3: Adjusted perinatal mortality rates (per 1000 population),²² Victoria, 2000 to 2006

	2000	2001	2002	2003	2004	2005	2006
Number of stillbirths	394	399	385	418	413	421	457
Rate per 1000	6.3	6.4	6.1	6.6	6.5	6.3	6.6
Number of neonatal deaths	182	204	227	237	207	245	227
Rate per 1000	2.9	3.3	3.6	3.8	3.3	3.7	3.3
Number of perinatal deaths	576	603	612	655	620	666	684
Rate per 1000	9.2	9.7	9.8	10.3	9.8	10.0	9.8

Source: The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2008

Table 2.4 shows perinatal mortality rates for Victoria, by Indigenous status, using pooled data for the years 2000 to 2006. The perinatal mortality rate in infants born to Indigenous mothers (20.4 per 1000) is much higher than that for infants born to non-Indigenous mothers (9.7 per 1000).

²⁰ For Victorian data, neonatal deaths that were the result of termination of pregnancy have been excluded from the calculations.

²¹ Provisional data.

²² Adjusted to exclude terminations for psychosocial indications.



Table 2.4: Adjusted perinatal mortality rate (per 1000 population),²³ by Indigenous status, Victoria, pooled data, 2000 to 2006

	Indigenous	Non-Indigenous
Number of stillbirths	33	2844
Rate per 1000	10.5	6.4
Number of neonatal deaths	31	1493
Rate per 1000	10.0	3.4
Number of perinatal deaths	61	4337
Rate per 1000	20.4	9.7

Source: The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2008

Indicator: Rate of birth defects

A birth defect is any abnormality of prenatal origin, and includes structural, functional, genetic, chromosomal and biochemical abnormalities (Riley & Halliday 2006). Congenital anomalies are a major reason for hospitalisation in infancy and childhood and are a major public health concern. They often result in serious disability and can cause death in some cases (Abeywardana et al. 2007).

In the two years 2003 to 2004 there was a birth defect in 4.3 per cent of all births. This represents approximately 2700 babies for each year in Victoria (Riley & Halliday 2006).

The four most common birth defects include hypospadias,²⁴ obstructive defects of the renal pelvis, ventricular septal defects and congenital dislocated hip. The next most common defect, trisomy 21 (Down syndrome) is increasing in prevalence due to increased maternal age. Cardiac defects comprise 24 per cent of birth defects (Riley & Halliday 2006).

Indicator: Sudden Infant Death Syndrome rate

Sudden Infant Death Syndrome (SIDS) refers to the sudden and unexpected death of an infant for no known cause.²⁵ Identified risk factors for SIDS include exposure to cigarette smoking during pregnancy and after birth, over-wrapping and overheating and a prone sleeping position (Eagar et al. 2005, in DHS 2006).

SIDS rates among Indigenous infants were five times higher than the national average between 1998 and 2000 (Al-Yaman et al. 2002; Beal 2000).

Between 1985 and 2005, deaths from SIDS declined by 83 per cent (ABS 2007a). This decline is strongly associated with a public health campaign launched by SIDS and Kids that highlighted the link between face-down sleeping and SIDS (SIDS and Kids Online).

There were 21 deaths of infants (aged from 9 days) from SIDS in Victoria in 2006, compared with 16 in 2005. The declining trend in SIDS deaths in Victoria from 1985 to 2006 is illustrated in figure 2.3.

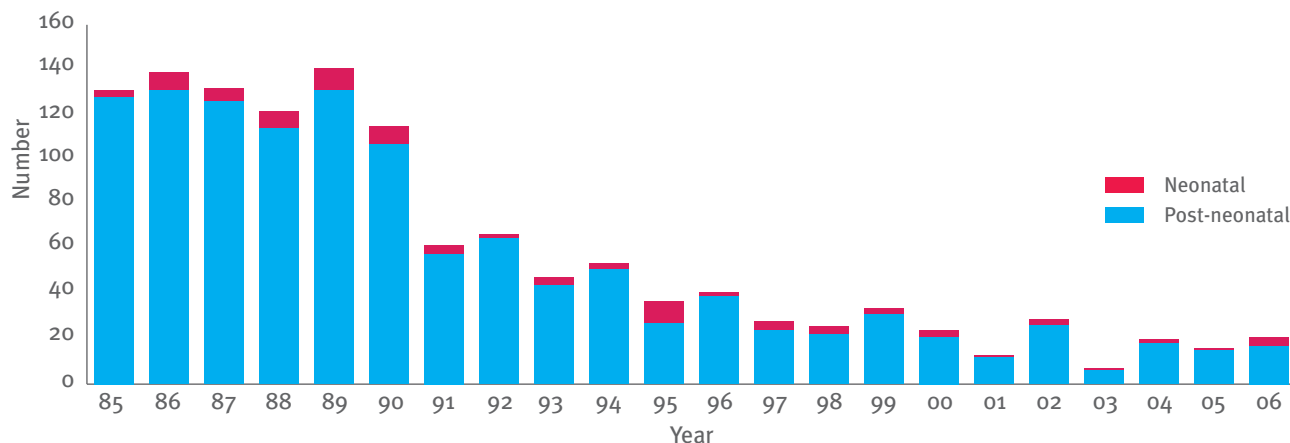
²³ Adjusted to exclude terminations for psychosocial indications.

²⁴ Abnormal development of the urethra in males.

²⁵ SIDS is more specifically defined as 'the sudden unexpected death of an infant less than 1 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. 2004, in The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2007).



Figure 2.3: Number of deaths from SIDS, neonatal and post-neonatal infants, Victoria, 1985 to 2006



Source: The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2008

Child deaths

Indicator: Child mortality rate

In Victoria in 2006, there were 222 deaths of children aged between 29 days and 17 years. Table 2.5 shows the number and rate of child deaths by age group.

Table 2.5: Number and rate (per 100,000) of child deaths, by age group, Victoria, 2006

Age group	Number	Rate
29 days – 364 days	84	132.9
1–4 years	35	14.4
5–9 years	27	8.6
10–14 years	28	8.5
15–17 years	48	23.8

Source: The Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2008

The majority of child deaths (n = 95) were due to conditions that were determined at birth.²⁶ A further 43 deaths were the result of acquired disease and 48 were caused by unintentional injuries. 17 deaths were from SIDS,²⁷ 16 were from intentional injury and three were from an undetermined cause.

²⁶ These conditions included birth defects and genetic conditions and other conditions determined at birth (e.g. prematurity, birth asphyxia).

²⁷ It should be noted that this number of SIDS deaths (17) differs from the figure of 21 given with the Sudden Infant Death Syndrome rate indicator above. This is because four of the 21 SIDS deaths were in infants aged less than 29 days.



Immunisations and vaccine preventable illnesses

Indicator: Proportion of children who are fully vaccinated

Immunisation against communicable diseases reduces morbidity and mortality from a range of childhood diseases (AIHW 2004a). Immunisation offers protection for individual children and also markedly reduces the rate at which disease circulates within the broader community.

Evidence suggests that a minimum of 90 per cent vaccination coverage is required to interrupt the transmission of disease (Lister et al. 1999).

Immunisation in the early years

The Australian Childhood Immunisation Register (ACIR) provides information about vaccine coverage at the three key milestones of 12 months, 24 months and 6 years of age.^{28, 29} Coverage is measured three months after the last cut-off date for the cohort for completion of each milestone, to allow for delayed notification to the ACIR.

Fully immunised children are those who have received all the standard immunisations appropriate to their age. Children are routinely immunised free of charge, as part of the National Immunisation Program, against hepatitis B, rotavirus, diphtheria, tetanus, pertussis (whooping cough), polio, pneumococcal, haemophilus influenza type B (Hib), measles, mumps, rubella, meningococcal C and varicella.

Figure 2.4 shows immunisation rates and trends for all children in Victoria for the financial years 2000–01 to 2006–07 for children at 12–15 months, 24–27 months and 72–75 months.

Percentages for the 12–15-month cohort have remained consistent since 2000–01.

Percentages for the 24–27-month cohort have steadily increased by almost 8 percentage points since 2000–01.

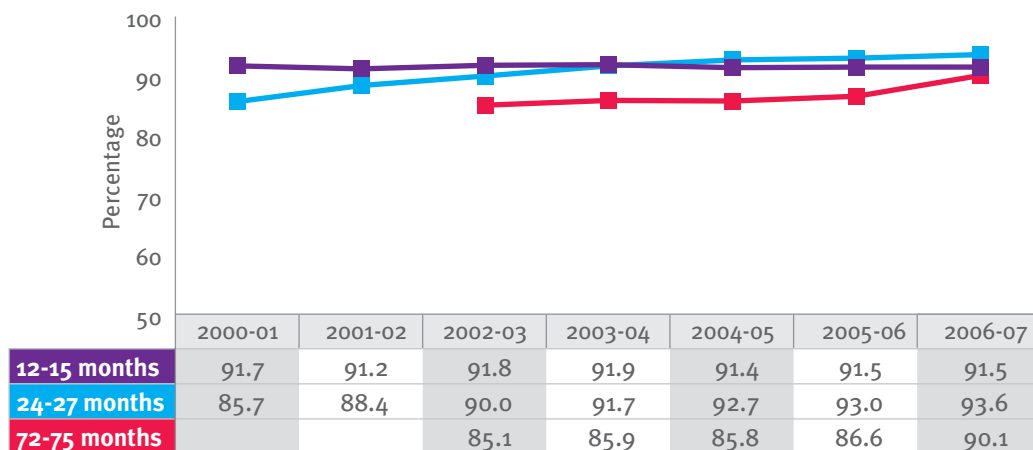
Percentages for the 72–75-month cohort have increased by 5 percentage points since 2002–03 and by 3.5 percentage points since 2005–06.

²⁸ The 12-month milestone measures vaccinations due at six months of age, and includes only vaccinations administered before the child turns 12 months old. The 24-month milestone includes vaccinations due at 12 months of age and administered before the second birthday. The six-year milestone includes vaccinations due at 4 years of age and administered before the sixth birthday.

²⁹ Limitations to the ACIR data, as an estimate for vaccination coverage, include under-reporting, and the fact that records are only held for children up to 7 years of age and that coverage is calculated only for children registered with Medicare (Hull et al. 1999; Yohannes et al. 2004).



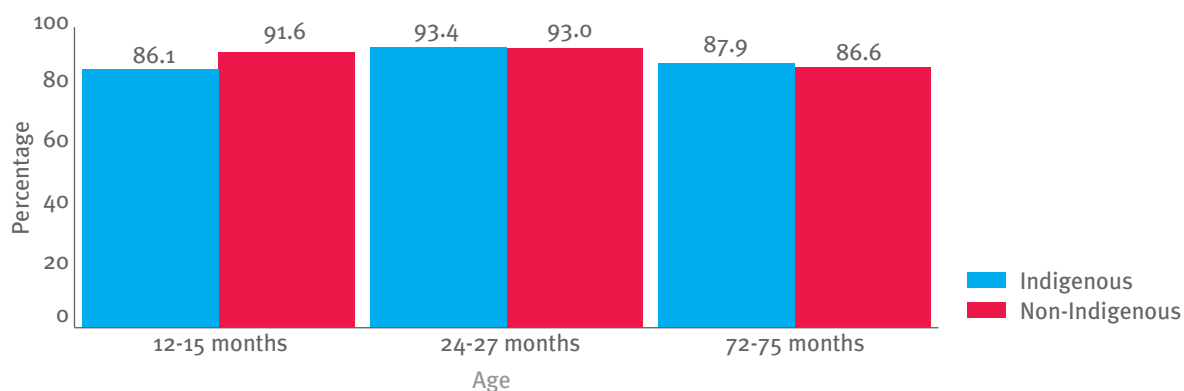
Figure 2.4: Percentage of children immunised at ages 12–15 months, 24–27 months and 72–75 months, Victoria, 2000–01 to 2006–07



Source: Australian Childhood Immunisation Register

Figure 2.5 shows that Indigenous children in Victoria are slightly less likely than non-Indigenous children to be immunised at 12–15 months.

Figure 2.5: Percentage of children immunised by Indigenous status at ages 12–15 months, 24–27 months and 72–75 months, Victoria, 2005–06



Source: Australian Childhood Immunisation Register

Meningococcal C vaccine

All children who are born since 1 January 2002 and who are 12 months old or over are eligible for free meningococcal C vaccine under the National Immunisation Program. Between 2003 and mid-2006, a meningococcal C vaccine catch-up program was undertaken nationally and every child from 12 months of age to 19 years of age was eligible for a free dose of meningococcal C vaccine.

From a peak of 88 cases in 2002, the number of notified cases of serogroup C invasive meningococcal disease in Victoria has fallen every year since the introduction of funded meningococcal C vaccine in 2003 to just two cases in 2007. There have been no deaths in Victoria due to serogroup C invasive meningococcal disease since 2004 and there have been no cases in age groups eligible for funded vaccine since 2005. There have been no notified cases in persons reported to be vaccinated for serogroup C invasive meningococcal disease.



Secondary school immunisation

Table 2.6 provides information about immunisation coverage in secondary schools in Victoria.

Long-term trend data relating to immunisation coverage for this age group are only available for Year 7 hepatitis B. In 2007, 74 per cent of children had completed the course of immunisation against hepatitis B. Between 2001 and 2007 the percentage of children who are immunised against hepatitis B has ranged from a low of 70 per cent in 2001 to a high of 76 per cent in 2003.

The dTPa (diphtheria, tetanus and acellular pertussis³⁰) vaccine was introduced to Year 10 secondary school children in 2004. The proportion of children receiving this vaccine at school has increased from 67 per cent in 2004 to 74 per cent in 2007. A higher proportion (78 per cent) has completed dTPa immunisation.³¹

Table 2.6: Secondary school immunisation coverage, Victoria, 2001 to 2007

Immunisation	2001 (%)	2002 (%)	2003 (%)	2004 (%)	2005 (%)	2006 (%)	2007 (%)
Year 7 hepatitis B course complete	70	78	76	71	71	75	74
Year 7 varicella at school ³²						27	26
Year 7 varicella total immunised/natural immunity						72	73
Year 10 Boostrix dTpa at school				67	70	71	74
Year 10 Boostrix dTpa complete				78	78	78	78
Year 7 HPV complete ³³							75
Year 10 HPV complete							69
Year 11 HPV complete							70
Year 12 HPV complete							71

Source: DHS Public Health Branch

Indicator: Notification rate of vaccine-preventable illnesses

There were 782 notified cases of vaccine-preventable illnesses among children aged 0–17 years in Victoria in 2007, representing a rate of 65.7 cases per 100,000 children. The rate of notifications was higher among males (68.6) than among females (61.6).

The majority of these notifications were for influenza (n = 454), followed by pertussis (n = 205), hepatitis B (n = 72) and invasive pneumococcal disease (n = 47).

Figure 2.6 shows the rate (per 100,000 children) of notified cases of pertussis, influenza, hepatitis B and invasive pneumococcal disease among children aged 0–17 years in Victoria from 2000 to 2007.

The rate of notified cases for pertussis has decreased overall since 2000, dropping from 30.5 per 100,000 children in 2000 to 7.2 per 100,000 children in 2006. However, the rate of notified cases of influenza increased rapidly from 0.1 in 2000 to 28.7 in 2003, and went through a period of flux between 2004 and 2006 before increasing again to 38.1 in 2007. The rate of notified cases for invasive pneumococcal disease increased from 0.5 per 100,000 children aged 0–17 years in 2000 to 14.8 in 2002, before dropping down to 4.0 by 2007. The rate of notified cases of hepatitis B remained largely unchanged over the period 2000 to 2007.

³⁰ Whooping cough.

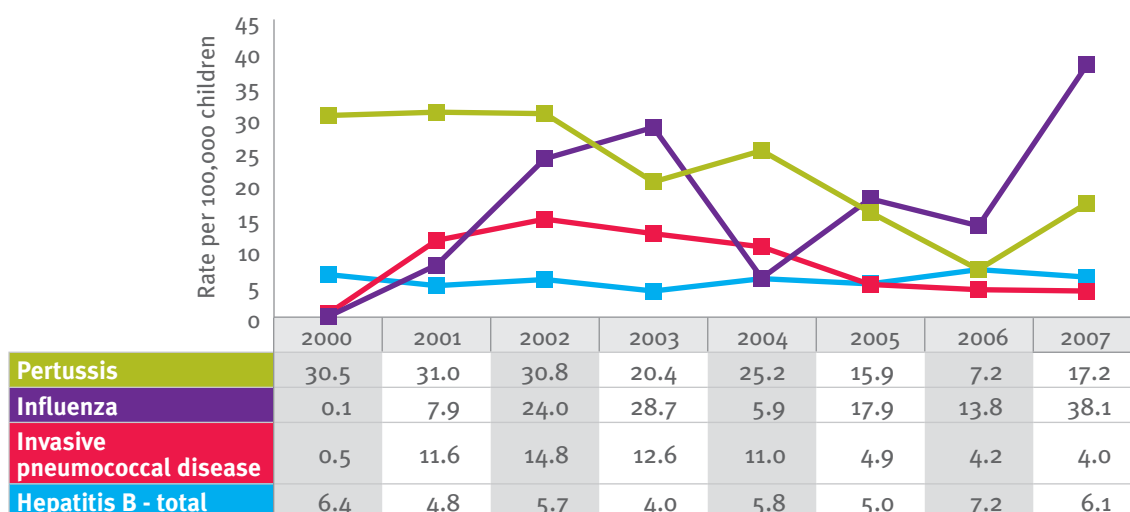
³¹ This proportion is higher, as it includes students who have been immunised outside school as well as those immunised in school.

³² Varicella (chicken pox) vaccine was introduced to Year 7 secondary school children in 2006.

³³ Human papilloma virus (HPV) vaccine was introduced to secondary school girls from Year 7 in 2007.



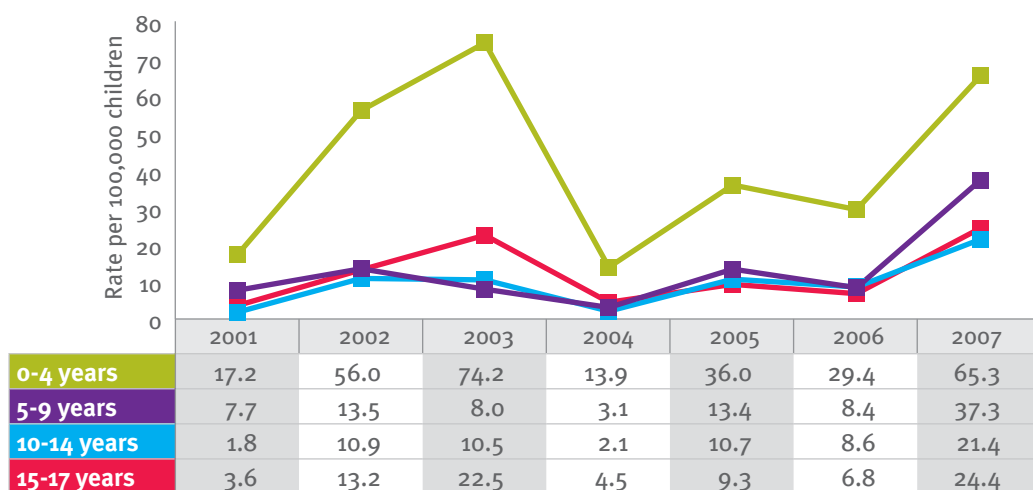
Figure 2.6: Rate of notifications for pertussis, influenza, invasive pneumococcal disease and hepatitis B per 100,000 children aged 0–17 years, Victoria, 2000 to 2007



Source: DHS Public Health Branch and ABS 2008a

Notification rates for influenza were highest in the 0–4-year-old age group, followed by 5–9-year-olds, then 15–17-year-olds and 10–14-year-olds (figure 2.7).

Figure 2.7: Rate of notifications for influenza per 100,000 children aged 0–17 years, by age group, Victoria, 2001 to 2007

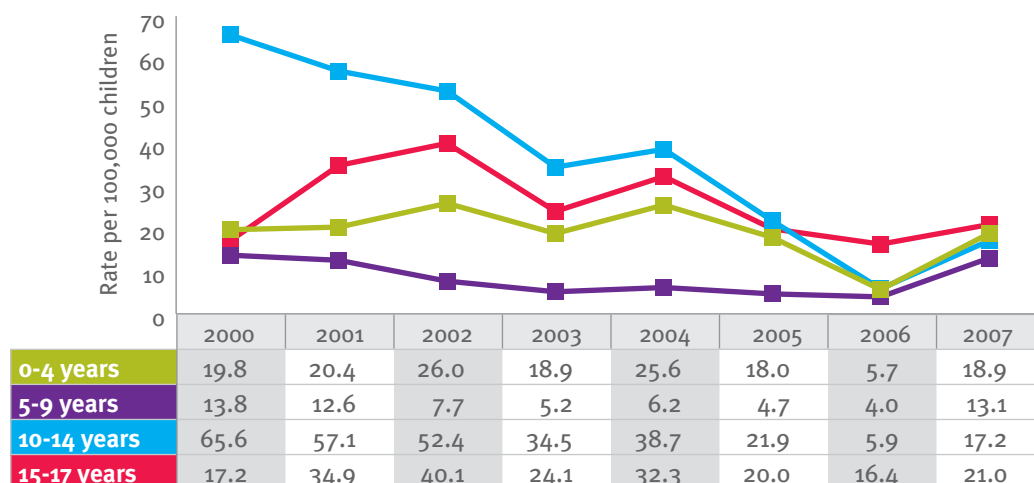


Source: DHS Public Health Branch and ABS 2008a



Notification rates for pertussis were highest in the 10–14-year age group, followed by the 15–17-year-olds, then 0–4-year-olds and 5–9-year-olds (figure 2.8).

Figure 2.8: Rate of notifications for pertussis per 100,000 children aged 0–17 years, by age group, Victoria, 2000 to 2007



DHS Public Health Branch and ABS 2008a

Cancer, diabetes and asthma

Indicator: Cancer incidence

Although cancer in children is relatively uncommon, it is a leading cause of death among Australian children aged 1–14 years. Cancer incidence increases with age. In Australia, in 2002, the incidence was 1.8 times higher for those aged 15–19 years than for the 12–14-year age group.

In Victoria, there were 989 new diagnoses of cancers in males in the 10 years 1996 to 2005, and 837 new diagnoses in females. Three-quarters (74.5 per cent) of these diagnoses were in metropolitan areas³⁴ and 25.5 per cent in the rest of Victoria.

Leukaemia, brain and central nervous system (CNS), and lymphoma were the most common types of cancers diagnosed accounting for 60.6 per cent of all diagnoses (data from the Victorian Cancer Registry, provided by The Cancer Council Victoria).³⁵

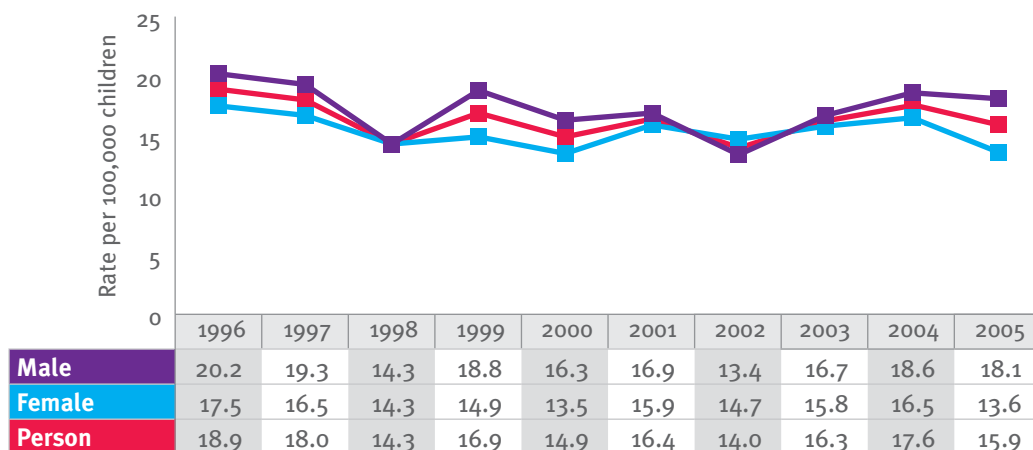
Figure 2.9 shows age-standardised rates of new cancer diagnoses, by sex, among young Victorians, from 1996 to 2005. There is some fluctuation in the rates of new diagnoses from year to year. However, the overall trend appears to be largely stable, for both females and males, with some suggestion of a decline, although further data will be needed to confirm this.

³⁴ Metropolitan includes Melbourne and Greater Geelong.

³⁵ 32.3 per cent of all diagnoses were for leukaemia, 14.6 per cent for brain and central nervous system, and 13.7 per cent were for lymphoma.



Figure 2.9: Age-standardised rates of new cancer diagnoses, children aged 0–17 years, Victoria, 1996 to 2005



Source: data from the Victorian Cancer Registry, The Cancer Council Victoria

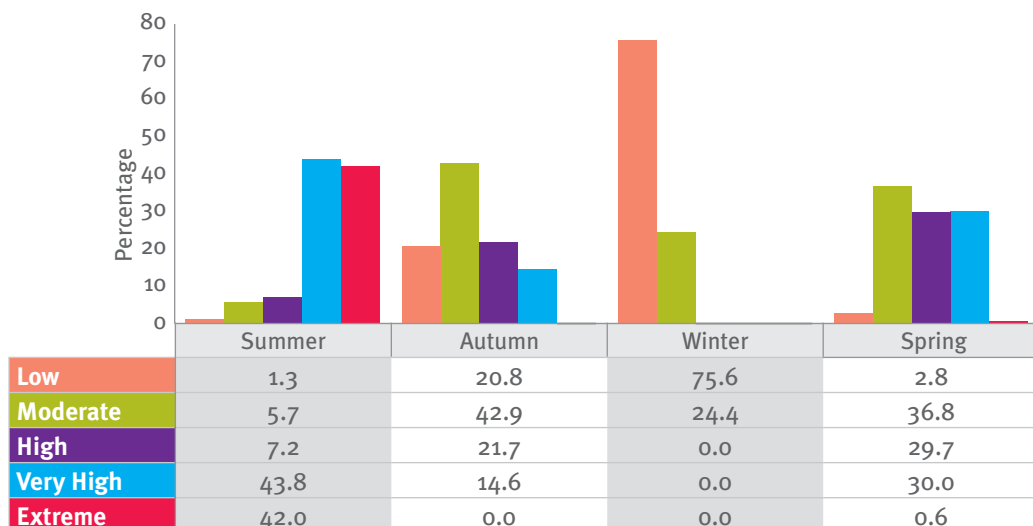
Indicator: Proportion of days rated high on the Ultraviolet Radiation Index

Australia has the highest incidence of skin cancer in the world. While skin cancers are very rare among children, excessive sun exposure before the age of 15 years significantly increases an individual’s lifetime risk of developing skin cancer, with melanoma being the most common cancer diagnosed among young people aged 12–24 years (DEECD 2008).

The WHO Global Solar UV (ultraviolet) index is a number relating to how much solar UVR (ultraviolet radiation) reaches the ground, based on the potential for skin injury. The Bureau of Meteorology issues SunSmart UV alerts when the UV index is forecast to reach or exceed exposure category 3 (moderate), a level that can damage skin and lead to skin cancer later in life.

Figure 2.10 shows the average number of UV index days for each exposure category in Melbourne, by season, from 2000–01 to 2006–07.

Figure 2.10: The average percentage of UV index days for each exposure category grouped by season, Melbourne, 2000–01 to 2006–07



Source: Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) Solar UV radiation level data for Melbourne, 1 December 2000 to 30 November 2007



Awareness of sun protection in young people

Evidence suggests that while adolescents show a high level of awareness of the dangers of sun exposure, they tend to adopt sun protection behaviours less frequently than adults (The Cancer Council Australia 2004). Some information about young people’s sun protection awareness and behaviours is provided in the 2007 young people report. Further information about young people’s awareness of sun protection will be collected through the Victorian Adolescent Health and Wellbeing Survey. Information about parental awareness of sun protection is included in Section 3.1 of this report.

Indicator: Proportion of children and young people with diabetes

Diabetes is a serious chronic disease, which can lead to a variety of major complications, resulting in loss of working ability, shortened life expectancy and reduced quality of life.

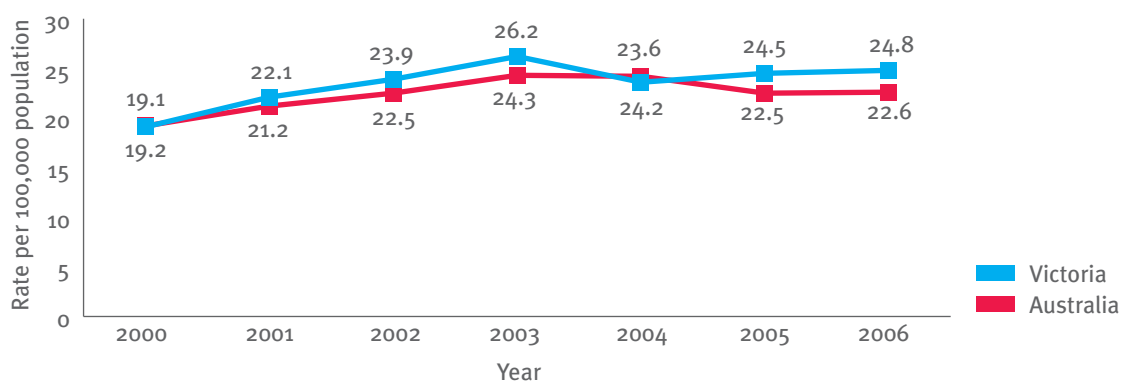
Type 1 diabetes usually arises in childhood, lasts throughout life and is caused by an autoimmune disorder, resulting in destruction of the pancreatic cells that produce insulin. Treatment requires a daily insulin injection (AIHW 2005). Exposure to environmental factors, toxins or viruses may contribute to the onset of this disease.³⁶

Type 2 diabetes results from a combination of genetic, environmental and behavioural risk factors and is caused by reduced insulin production or the inability of the body to use insulin properly.³⁷

Data on the incidence of type 2 diabetes in children in Victoria is not available.

Between 2000 and 2006, the age-adjusted incidence rate of type 1 diabetes in children aged 0–14 years increased significantly in Australia from 19.2 to 22.6 per 100,000 children.³⁸ Over the same period, the rate increased in Victoria from 19.1 to 24.8 per 100,000 children (figure 2.11).

Figure 2.11: Incidence rate per 100,000 children of type 1 diabetes among 0–14-year-olds, Victoria and Australia, 2000 to 2006



Source: AIHW 2008

³⁶ An inherited component is also suspected, although a large number of cases occur with no family history. Race and ethnicity are important contributory factors (AIHW 2002).

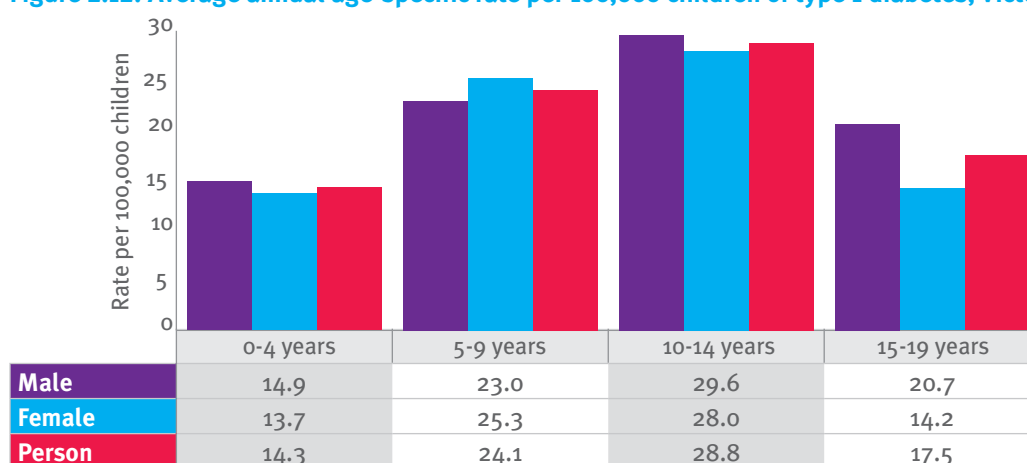
³⁷ This disease demonstrates a strong relationship with family history, and with race, ethnicity and age. Other risk factors include overweight, obesity, physical inactivity, impaired glucose tolerance and poor nutrition. Risk factors for type 2 diabetes are largely modifiable with a change in lifestyle, including increased physical activity and modification of diet (AIHW 2002).

³⁸ This increasing trend in the rate of new cases of type 1 diabetes in children is not unique to Australia and has also been observed in Asia, Europe and North America (DIAMOND Project Group 2006, in AIHW 2008).



Figure 2.12 provides information about the rate of type 1 diabetes in Victoria and nationally by age for 0–19-year-olds. Rates are highest among 10–14-year-olds, followed by 5–9-year-olds. There are no marked gender differences in age-specific rates for children aged under 15 years. However, among 15–19-year-olds rates of type 1 diabetes are higher in males than females.

Figure 2.12: Average annual age-specific rate per 100,000 children of type 1 diabetes, Victoria, 1999 to 2005



Source: AIHW 2007a

Indicator: Proportion of children and young people with asthma

Indicator: Proportion of children and young people with current asthma who have a written asthma plan

Asthma is a chronic inflammatory disease caused by narrowing of the small air passages (bronchi) of the lungs due to the air passages becoming swollen and inflamed. Asthma is the primary cause of disease burden for Victorian children and accounts for approximately one-fifth of the total disease burden (Department of Human Services 2005b). The underlying causes of asthma are not well understood.³⁹

Parent-report data from the 2006 Victorian Child Health and Wellbeing Survey show that 13.2 per cent of Victorian children aged 1–2 years have current asthma⁴⁰ and 23.3 per cent of children have experienced wheezing or whistling in the chest in the last 12 months. Boys and children living in rural areas are slightly more likely to have asthma, although the differences are not statistically significant.⁴¹

Just over six in 10 (62.6 per cent) children with current asthma were reported to have an asthma action plan⁴² (data reported in DHS 2006).

³⁹ Factors such as genetic traits, obesity and sex may influence the development of asthma. Environmental factors, including diet, allergens, tobacco smoke, infections and pollution may also increase the risk of developing this disease (GINA (Global Initiative for Asthma) 2005).

⁴⁰ 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.

⁴¹ 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.

⁴² An asthma action plan includes written instructions for what to do if the asthma becomes worse or out of control.



Indigenous children and asthma

The estimated national prevalence for asthma among young Indigenous people in 2004–05 was 16 per cent compared with 9 per cent for all young Australians (AIHW 2007b).

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) (data reported in DHS 2006).

Hospitalisations

Indicator: Hospitalisation rate for asthma

Indicator: Leading causes of hospitalisation

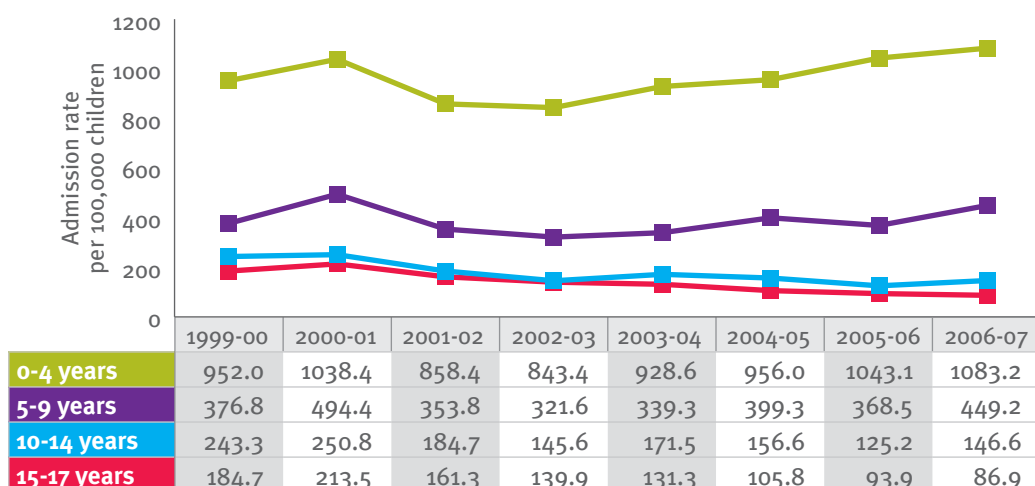
Hospitalisation rates can be used to help signify the level of serious illness in the Australian community (AIHW 2005). Asthma hospitalisation rates may reflect changes in the prevalence or severity of asthma, or in asthma management practices and hospital admission criteria (AIHW 2007b, in DEECD 2008).

In Victoria, in 2006–07, there were 5546 hospital admissions for asthma in children, representing a rate of 469.4 per 100,000 children.

Analysis of trend data from 1999–2000 to 2006–07 shows that the rate of hospital admissions for asthma is consistently higher among males than females (DEECD analysis of Victorian Admitted Episode Dataset and ABS 2008a).

Rates of asthma hospital admissions are also higher in children aged under 10 years, with the highest rates in the youngest age group (aged 0–4 years), and an apparently increasing trend in hospitalisations among this youngest group of children (figure 2.13).

Figure 2.13: Asthma hospital admission rate per 100,000 children, by age group, Victoria, 1999–2000 to 2006–07



Source: DEECD analysis of Victorian Admitted Episode Dataset and ABS 2008a

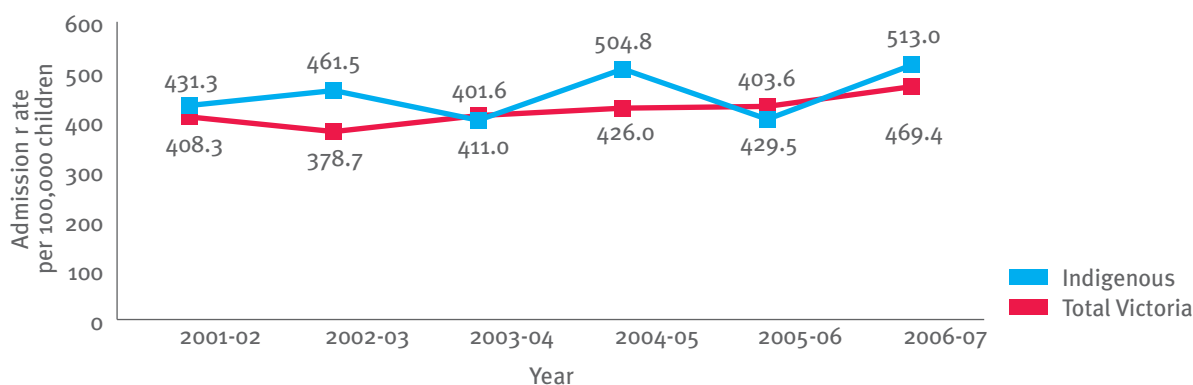


Indigenous children and asthma hospitalisations

Indigenous children accounted for 76 of the 5546 asthma hospital admissions in Victoria in 2006–07, representing a rate of 513.0 per 100,000 children.

Figure 2.14 shows that the asthma hospitalisation rate is higher among Indigenous children in four of the six years 2001–02 to 2006–07.⁴³ The rate for Indigenous children has fluctuated and appears to be rising overall. However, it is important to note that these rates relate to small numbers of Indigenous children.

Figure 2.14: Asthma hospital admission rate per 100,000 children aged 0–17 years, by Indigenous status, Victoria, 2001–02 to 2006–07



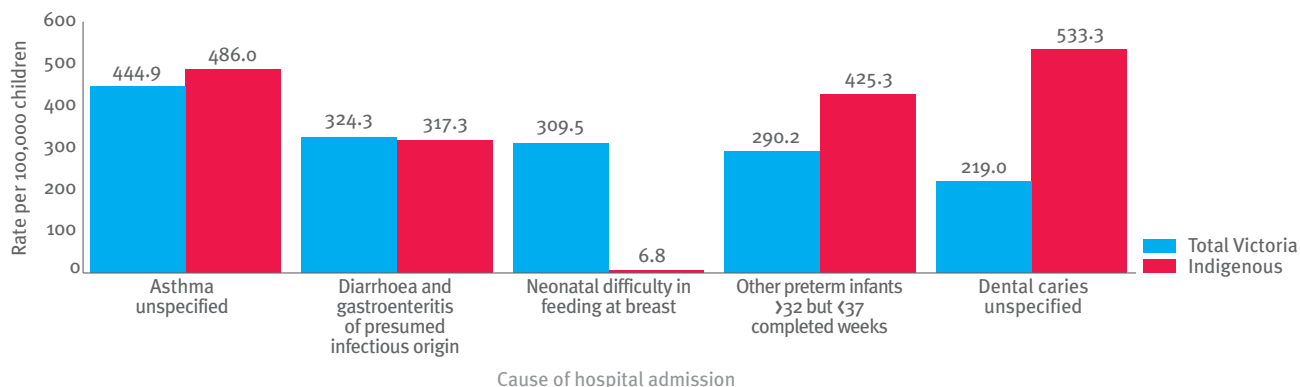
Source: DEECD analysis of Victorian Admitted Episode Dataset and ABS 2008a and 2008b

The top five causes of hospitalisation: Indigenous and all children

In 2006–07 the top cause for hospitalisation among children and young people in Victoria was ‘asthma unspecified’ (DEECD analysis of Victorian Admitted Episode Dataset and ABS 2008a).

Comparison of hospitalisation rates of Indigenous and all children, for the top five causes of hospitalisation, shows that rates are higher for dental caries and for ‘other pre-term infants’ in Indigenous children. However, rates of ‘neonatal difficulty in feeding at the breast’ are almost negligible among Indigenous children and considerably higher in the general child population (figure 2.15).

Figure 2.15: Top five causes of hospitalisation among children aged 0–17 years, rate (per 100,000), Indigenous and all children, Victoria, 2006–07



Source: DEECD analysis of Victorian Admitted Episode Dataset and ABS 2008a and 2008b

⁴³ Indigenous population estimates data are not available prior to 2001–02.



Indicator: Hospitalisation rate for anaphylaxis

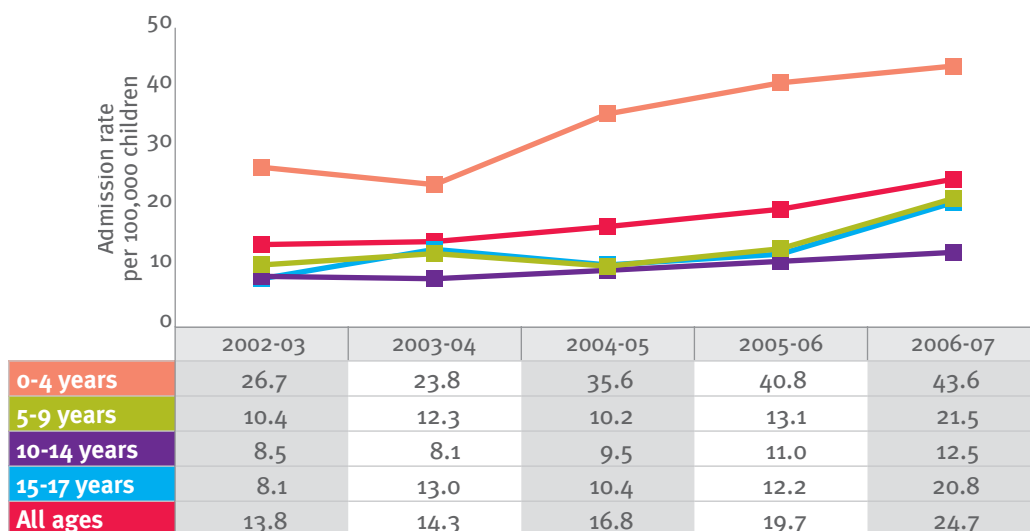
Anaphylaxis is the most sudden and severe form of immediate allergic reaction. It can be fatal if left untreated (American Academy of Allergy and Immunology 1994).

There were 292 anaphylaxis hospitalisations in Victorian children in 2006–07, representing a rate of 24.7 per 100,000 children.

Figure 2.16 shows the rate (per 100,000 children) of anaphylaxis hospitalisations in Victorian children from 2002–03 to 2006–07.

Anaphylaxis hospitalisation rates are consistently higher in males than in females⁴⁴ and are highest in children aged 0–4 years. Anaphylaxis hospitalisation rates also appear to be showing an increasing trend, rising from 13.8 (per 100,000 children) in 2002–03 to 24.7 (per 100,000 children) in 2006–07 (figure 2.16).⁴⁵

Figure 2.16: Anaphylaxis hospital admission rate per 100,000 children, by age group, Victoria, 2002–03 to 2006–07



Source: DEECD analysis of Victorian Admitted Episode Dataset and ABS 2008a

Dental health

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 (AIHW 2005).

There are some clear inequalities in oral health, with higher rates of dental caries in Indigenous and overseas-born children and children living in socioeconomically disadvantaged areas, and rural and remote areas (AHMAC 2001; AIHW Dental Statistics and Research Unit 2007).

⁴⁴ Of the 292 anaphylaxis hospitalisations in Victorian children in 2006–07, 179 were for males (a rate of 29.52 per 100,000) and 113 were for females (a rate of 19.65 per 100,000).

⁴⁵ An increasing trend has also been shown in other studies. A recent study in the Australian Capital Territory examined the records of 1489 children aged between 0–5 years and showed that there was an increase of food anaphylaxis in this cohort from 5 to 37 children between 1995 and 2006. There were similar trends in age-adjusted Australian hospitalisation rates for anaphylaxis in children aged 0–4 years (Mullins 2007).



Indicator: Proportion of children whose teeth are decay-free

Indicator: Mean number of decayed, missing or filled teeth among children

Tables 2.7 to 2.9 present information on the caries experience of children attending Victorian public dental services. It is important to note that this sample of children is skewed towards lower socioeconomic groups and is not representative of the general child population.

The tables show the average number of decayed, missing and filled teeth among children in the sample and the percentage of children who have no decayed, missing and filled teeth, for primary dentition (dmft) and secondary dentition (DMFT).

Table 2.7 shows that 37.8 per cent of the sample of 6-year-olds have no decayed, missing and filled teeth, and there is a higher incidence of dmft in children living in rural areas. For 12-year-olds, 49.0 per cent have no decayed, missing and filled teeth, and there is a lower incidence of DMFT in children living in rural areas.

Table 2.7: Caries in children aged 6 and 12 years attending Victorian public dental services, Victoria, 2007

	6-year-old dmft	% dmft=0	12-year-old DMFT	% DFMT =0
Victoria	3.02	37.8	1.43	49.0
Rural	3.43	33.2	1.36	52.4
Metro	2.72	41.1	1.50	45.6

Source: DHS Primary Health Branch

Table 2.8 shows that Indigenous children have a much higher incidence of decayed, missing and filled teeth than non-Indigenous children.

Table 2.8: Caries in children aged 6–8 years and aged 12–17 years attending Victorian public dental services, by Indigenous status, Victoria, 2007

	6–8-year-old dfmt	% dmft = 0	12–17-year-old DMFT	% DFMT=0
ATSI	5.05	17.2	2.73	36.4
Non-ATSI	2.82	38.0	1.77	48.5

Source: DHS Primary Health Branch

Finally, table 2.9 shows that within the sample, children who are concession card dependents, are more likely to have experience of dental caries.

Table 2.9: Caries in children aged 6 and 12 years attending Victorian public dental services, by concession card status, Victoria, 2007

	6-year-old dmft	% dmft = 0	12-year-old DFMT	% DFMT = 0
Non-concession card dependents	2.37	45.3	1.04	60.0
Concession card dependents	3.34	33.9	1.37	52.6

Source: DHS Primary Health Branch



The *Oral Health Guidelines for Victorians 2003* recommend that teeth should be cleaned at least twice a day and that for children aged 2–6 low-fluoride toothpaste is used unless otherwise recommended by a dental professional. The guidelines also state that an adult should assist a child aged under 7 years to brush their teeth.

The 2006 VCHWS found that seven in 10 (70.4 per cent) children aged 2–12 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 2–4-year-olds and 75.3 per cent of 5–12-year-olds used toothpaste twice a day or more).

Just under three-quarters (73.9 per cent) of children aged 2–7 years were reported to use low fluoride toothpaste. While the majority of parents said they actively assisted their children (under 7 years of age) with toothbrushing, just under one-fifth of parents (18.2 per cent) reported they never did so (data reported in DHS 2006).

Overweight and obesity

Overweight and obesity account for a large proportion of the total global burden of disease. Childhood and adolescence are critical periods for the development of this condition, and obesity early in life is of particular concern because of the associated short and long-term health consequences and its influence on young people's psychosocial development.

High levels of overweight and obesity are linked to increasingly sedentary lifestyles and to changing dietary habits, particularly the increased consumption of energy-dense food and drinks (processed foods and snacks that are high in fat and sugar) (DEECD 2008).

While the significance of overweight and obesity for young people's lives cannot be contested, it may be less potentially stigmatising to place policy emphasis on the wider, more positive goal of attaining a healthy body weight. It is important to recognise that there are social pressures on young people to fit in with desired body images and that these body images may bear little relationship to healthy body weight and may even contribute to the development of eating disorders (DEECD 2008).

Indicator: Proportion of young people with an eating disorder

The two most common eating disorders in young people are anorexia nervosa and bulimia nervosa. Bulimia is the more common of these, although both occur only rarely.

Information on the prevalence of eating disorders in Victoria is limited. A recent longitudinal study of young Victorian women suggests that around 10 per cent of young women (who did not have a diagnosed eating disorder) reported that they experienced at least two symptoms associated with anorexia or bulimia at some point between adolescence and young adulthood (Patton et al. 2007, in DEECD 2008).⁴⁶

⁴⁶ Surveys in developed Western countries have generally found prevalence rates of around 0.5 per cent for anorexia nervosa and 1 per cent for bulimia nervosa in females aged 15–24. In contrast rates for 'partial syndromes' have been around 3 to 5 per cent (Johnson-Sabine et al. 1988, Rastam, Gillberg & Garton 1989, in DEECD 2008).



Indicator: Proportion of children and young people who are overweight and obese

Body mass index (or BMI)⁴⁷ provides the most useful population-level measure of obesity as it is commonly collected in population health surveys and has good reliability and validity. However, there is a lack of data that uses measured BMI and a lack of information about trends in overweight among children and young people (DHS 2008b).^{48,49}

Go For Your Life!

The Victorian Government is committed to promoting the health and wellbeing of young people. By improving eating and physical activity habits, the development of chronic diseases such as diabetes and cardiovascular disease can be prevented. More support is being provided through physical activity grants to reduce ill health linked to lifestyle.

It is recognised that emphasis on children provides the greatest capacity for prevention of health-related issues and also provides the opportunity to engage and involve parents. Specific activities will be developed for implementation in childhood settings, including schools, child care services and maternal and child health programs.

One such program is the Healthy Start in Schools program. Government primary schools receive grants of up to \$6000 to install bicycle sheds, create cafe-style school canteens, establish kitchen gardens, and upgrade their playgrounds. This is in addition to providing free fruit once per week for all students in Prep to Year 2.

The Positive Body Image Program also promotes a healthy body image among young people through new community education and training partnerships, community-based programs and partnerships with media and fashion industries.

Obesity and overweight in preschool children

Analysis of data from the first wave of the Longitudinal Study of Australian Children (LSAC)⁵⁰ found that just over one in six (17.3 per cent) of the Victorian 4–5-year-olds were overweight and around one in 17 (5.7 per cent) were obese. Victorian preschoolers were 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) (data reported in DHS 2006).⁵¹

Analysis of LSAC data also shows that Indigenous children, children from CALD backgrounds and socioeconomically disadvantaged children, are more likely to have heavier BMI status (particularly boys). Preschoolers in the lowest fifth of the population for social disadvantage have ‘nearly 50 per cent higher odds’ of being in a heavier category of BMI, compared with preschoolers in the top fifth of the population (Wake et al. 2006, reported in Royal Children’s Hospital, Policy Brief no. 7, 2007).

⁴⁷ BMI is calculated as a person’s weight in kilograms divided by the square of their height in metres.

⁴⁸ The most recent Australian surveys to use measured weight in children – the National Nutrition Survey – were conducted in 1985 and 1995. Results from the current (2007) National Nutrition Survey should provide a better indication of the trends.

⁴⁹ Recent analysis of data from national and state population surveys with measured weight and height confirms that, based on past trends and no effective interventions, BMI is predicted to increase for both males and females, resulting in around one-third of 5–19-year-olds being overweight and/or obese by 2025 (DHS 2008).

⁵⁰ These data are based on a nationally representative sample of 4–5-year-olds, including 1200 from Victoria.

⁵¹ 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).



Recent research has analysed routine health check data to investigate the influence of SES and secular trends on changes in weight status between young preschoolers at aged 2 and 3.5 years in Victoria.⁵² This research found that there was no upward trend in the proportion of children becoming overweight or obese. However, a higher proportion of the most disadvantaged children became overweight or obese, compared to the least disadvantaged.

Obesity and overweight in middle childhood

Recent Victorian data from the HNSS show that nearly a quarter (23.7 per cent) of young people in Years 6 and 8 were measured as being overweight and 7.4 per cent were measured as being obese.⁵³ The prevalence of overweight and obesity was not significantly different between boys and girls (Williams 2007, reported in DEECD 2008).

Indigenous students were more likely to be overweight, but not as likely to be obese as non-Indigenous students.⁵⁴ Indigenous students were also more likely to have been physically active for at least 60 minutes on seven days in the past week⁵⁵ (Williams 2007).

Students who spoke a language other than English at home were significantly more likely to be overweight or obese than those who spoke only English at home.⁵⁶ They were less likely (than students who spoke English at home) to have been physically active for at least 60 minutes on seven days in the past week.⁵⁷ Students in the lowest socioeconomic quintiles had significantly higher rates of overweight and obesity (table 2.10).

Table 2.10: Socioeconomic quintile by weight category, young people in Years 6 and 8, Victoria, 2006

	Normal weight Number (%)	Overweight Number (%)	Obese Number (%)	Total Number (%)
Lowest	406 (61.3)	165 (24.9)	91 (13.7)	662 (19.3)
2	463 (67.0)	180 (26.0)	48 (7.0)	691 (20.1)
3	486 (69.3)	170 (24.2)	46 (6.5)	701 (20.4)
4	516 (73.7)	152 (21.7)	32 (4.6)	700 (20.4)
Highest	494 (72.8)	148 (21.8)	37 (5.4)	678 (19.7)
Total	2366 (68.9)	814 (23.7)	254 (7.4)	3433 (100)

Source: Williams 2007, in DEECD 2008 (Table 2.9)

⁵² A total of 34,810 cases were analysed. Weight status was determined using International Obesity Taskforce definitions. The prevalence of overweight and obesity was found to be 12.6 per cent at 2 years and 15.1 per cent at 3.5 years. Overall 8 per cent of boys and 9.4 per cent of girls moved to a higher weight category and 5.9 per cent of boys and 5.7 per cent of girls moved to a lower weight category between measurements.

⁵³ In the HNSS, the weight of students was measured (along with their height, blood pressure and pulse rate) for students who consented to this part of the survey (n = 3433).

⁵⁴ 38.2 per cent of Indigenous students were overweight and 2.5 per cent were obese, compared with 23.4 per cent of non-Indigenous who were overweight and 7.5 per cent who were obese.

⁵⁵ 37.4 per cent of Indigenous students were more physically active for at least 60 minutes on seven days in the past week, compared with 22.8 per cent of non-Indigenous.

⁵⁶ 27.3 per cent of students who spoke a language other than English at home were overweight and 12.7 per cent were obese, compared with figures for students who spoke only English at home of 23 per cent overweight and 6.3 per cent obese.

⁵⁷ 17.9 per cent of those speaking another language at home were physically active for at least 60 minutes on seven days in the past week, compared with 24.1 per cent of those speaking English.



Obesity and overweight in young people aged 12–24 years

The 2007 young people report finds that close to one-third of all young people are overweight or obese – drawing on data for 12–18-year-olds from the 1995 National Nutrition Survey, 2005 data for 12–18-year-olds from one region in Victoria, and data for 15–17-year-olds and 18–24-year-olds from state and national surveys (2004 and 2004–05). However, this finding should be treated with caution as the 2005 data are from one region only in Victoria and the state and national surveys (2004 and 2004–05) use self-reporting of height and weight.

Self-reports on health

Most of the data included in this section are not based on self-report data. However, self-reported health ratings provide an important global measure of health status, and these assessments are also powerful predictors of future health care use and mortality.

The 2006 VCHWS asked parents of children (aged 0–12 years) to rate their children’s general health,⁵⁸ as either ‘excellent’, ‘very good’, ‘good’, ‘fair’ or ‘poor’. The vast majority of children (88.7 per cent) were described as being either in excellent or very good health. 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.

Results from the ABS National Health Survey 2004–05, reported in the 2007 young people report, show that in Victoria, 68.8 per cent of young males (aged 15–24 years) and 71.6 per cent of young females rate their health as either ‘excellent’ or ‘very good’.

The SEHQ elicits a comprehensive and informed picture of a parent’s perception of their child’s health upon school entry. Parents of children of ATSI background expressed higher than average concerns on the overall health of their children. Furthermore, parents of children of ATSI background reported a higher rate of chronic health problems in children than non-ATSI parents (9.8 per cent compared to 6.3 per cent in the total sample (Griffin et al. 2006).

⁵⁸ The Global Health Status scale was used. This scale has been used in child health surveys in New South Wales, Western Australia and South Australia, but there are no comparable Australia-wide data relating to parent report of child health.



2.2 Staying healthy and healthy lifestyles

Summary

- A greater proportion of children aged 4–12 years (87.5 per cent) meet recommended guidelines for fruit consumption than for vegetable consumption (38.6 per cent). In young people aged 12–18 the pattern is reversed (57.3 per cent meet vegetable recommendations and 27.1 per cent meet fruit recommendations).
- 71.2 per cent of Victorian children aged 5–12 years meet the recommended guidelines for physical activity, although the proportion is lower for girls and older children (VCHWS). The HNSS found that Indigenous students were more likely than non-Indigenous students to have been physically active in line with the recommended guidelines.
- The proportion of trips to school by car has increased markedly. The VCHWS shows that 43.4 per cent of children living within 2 kilometres of their school make no trips to school on foot.
- A 2002 survey found that 26.4 per cent of Year 10 students and 44.2 per cent of Year 12 students reported having had sexual intercourse.
- The majority of notifications of STIs are for chlamydia in young females (15–17 years). The rate of chlamydia notifications has increased markedly in this age group (2000 to 2007).
- There were 1652 births to teenage mothers in Victoria in 2006. The age-specific fertility rate for 15–19-year-olds in Victoria is falling (1996 to 2006) and is lower in Victoria than in Australia.
- The percentage of Aboriginal women under 20 years giving birth is higher than the percentage of non-Aboriginal women. There have been increases in the percentage of Aboriginal women aged under 20 years giving birth over the last 10 years, but this percentage has decreased in recent years.
- A Victorian school-based survey shows that the proportion of young people (aged 12–17 years) who smoke cigarettes is declining.
- While most young people drink alcohol at responsible levels, trend data suggest there have been recent increases in the proportions of 16–17-year-olds who drink at levels that risk short-term harm.
- Rates of illicit drug use among young people are very low. Cannabis is the drug most commonly used and the use of cannabis is declining (1996 to 2005).
- One in nine children in Victoria (aged 4–12 years) were shown by the VCHWS to have behaviour problems that were either ‘borderline’ or ‘of concern.’
- Rates of hospital admissions for psychiatric problems have declined (2002–03 to 2006–07) and are highest in young people aged 15–17 years.
- In Victoria in 2005–06, 396 young people aged 15–18 years were admitted to hospital due to intentional self-harm injury. Females accounted for 81 per cent of admissions. Seventeen young people aged 15–18 died as a result of intentional self-harm injury in 2004–05.



Nutrition and Physical Activity

Fruit and vegetable consumption

Adequate consumption of fruit and vegetables helps young people to maintain good health and reduces the risk of chronic diseases. The Australian National Health and Medical Research Council (NHMRC) minimum guidelines for the recommended intake of serves of fruit and vegetables are given by age as follows: 4–7-year-olds (one fruit, two vegetables), 8–11-year-olds (one fruit, three vegetables), and 12–18-year-olds (three fruit, three vegetables) (NHMRC 2003).

Indicator: Proportion of children and young people who eat the minimum recommended serves of fruit and vegetable every day

The 2006 Victorian Child Health and Wellbeing Survey found that while 87.5 per cent of children aged 4–12 years were meeting the minimum NHMRC daily recommended intake for fruit,⁵⁹ only 38.6 per cent met the minimum daily recommended intake for vegetables.

A minority of children (35.7 per cent) met minimum daily recommendations for both fruit and vegetable intake and 9.3 per cent of children met neither the minimum daily recommendations for fruit or vegetables.

Just over a quarter (27.1 per cent) of Victorian 12–18-year-olds meet the NHMRC recommendations for fruit consumption, with females more likely to meet these. A much greater proportion (57.3 per cent) meets the recommendations for vegetable consumption, with little difference between females and males (ABS, NHS 2004–05, ABS data available on request).

Physical activity

Australia's physical activity guidelines state that children and young people (aged 5–18 years) should participate in at least 60 minutes (and up to several hours) of moderate- to vigorous-intensity physical activity every day (Australian Government Department of Health and Ageing 2004a and 2004b).

Indicator: Proportion of children and young people who do the recommended amount of physical activity every day

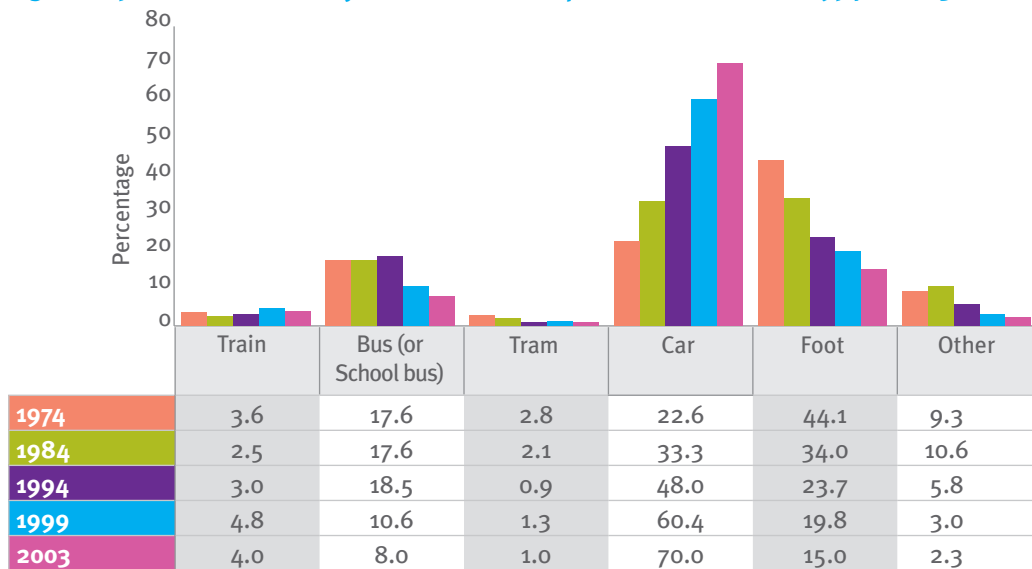
The 2006 VCHWS showed that a high proportion of children aged 5–12 years were meeting the daily physical activity guidelines (71.2 per cent) although the proportion was lower in girls and in older children (67.7 per cent of girls met physical activity guidelines, compared with 74.4 per cent of boys). 67.4 per cent of children aged 9–12 years met physical activity guidelines, compared with 75.1 per cent of children aged 5–8 years.

⁵⁹ Of the children not meeting the minimum guidelines for daily intake of fruit, most children were aged 12 years – the age at which the recommended minimum daily serves of fruit increases from one to three serves per day. Almost all children aged under 12 years ate the recommended one serve of fruit per day. Only 28 per cent of children aged 12 years old met the fruit targets compared to more than 93 per cent of children in the other age groups.



One way in which children can get regular physical activity is through walking or cycling to and from school. However, the proportion of trips to school by car has increased dramatically, from 22.6 per cent in 1974 to 70 per cent in 2003 (see figure 2.17).

Figure 2.17: Travel to school by students from Prep to Year 12, Victoria, 1974 to 2003



Source: *1974 *Journey to Work and Journey to School*, August 1974, ABS, Canberra (April 1976), *1984 *Travel to Work, School and Shops*, Victoria, October 1984, ABS, Victoria (Released June 1985) 1994 *Travel to Work, School and Shops*, Victoria, October *1994, ABS (released August 1995), figure in DEECD 2008, *1999 *Victoria Activity and Travel Survey*, RMIT, 1999, and *2003 *TravelSmart Survey*, Victorian Department of Infrastructure. Please note that data from all these surveys may not be statistically comparable.

Analysis of the 2006 VCHWS data shows that nearly half (49.7 per cent) the children (aged 5–12 years) made all of their trips to school by car, compared with 11.7 per cent who made all of their trips on foot, and 6.3 per cent who made some or all of their trips by bicycle.

Although children living within 2 kilometres of their school were less likely to make all their trips to school by car (37 per cent of children living within 2 kilometres of school made all their trips by car), only 20.1 per cent of children who lived less than 2 kilometres from school always walked to school. More than four in 10 children (43.4 per cent) living within 2 kilometres of their school made no trips to school on foot (VCHWS 2006).



Initiatives aimed at improving health and wellbeing in Neighbourhood Renewal

Increasing physical activity and improving nutrition through the development of recreation opportunities, redevelopment of parks, and establishment of community kitchens, food cooperatives and partnerships with schools to implement programs such as breakfast clubs. Physical activity projects include Sustainable Physical Activity in Neighbourhoods (SPAN) projects, Active Places Projects, partnerships with RecLink, after school activity programs and Midnight Basketball.

Improving mental health and social connectedness through peer support and mentoring programs for young people, arts and culture programs and other recreation opportunities as well as the development of available community space such as community gardens.

Improving access and responsiveness of health and wellbeing programs and services through partnerships with local agencies and organisations. Partnerships with community health services, schools, non-government organisations (NGOs) and sport and recreation clubs have been particularly important in reorientating services and programs to Neighbourhood Renewal areas

Australia's physical activity guidelines state that children and young people should not spend more than two hours a day using electronic media for entertainment (e.g. computer games, internet, TV), particularly during daylight hours (Australian Government Department of Health and Ageing 2004a, 2004b).

Indicator: Proportion of children and young people who use electronic media for more than two hours per day

The internet and electronic media play a central role in the lives of many young people (DEECD 2008). However, recent evidence suggests that sedentary behaviours such as watching television, sitting or driving a car, are directly related to risk of chronic disease, independent of physical activity levels.

Parent-report data from the 2006 VCHWS show that nearly one in four (23.3 per cent) children aged 9–12 years exceeded the recommended guidelines for use of electronic media, compared with 14.3 per cent of children aged 5–8 years.

Sexual health and health-related behaviour

Indicator: Proportion of young people who have had sexual intercourse

Indicator: Age of initiation of sexual intercourse in young people

The timing of first sexual intercourse and the context in which it occurs have important implications for health. Consistent with international trends, there has been a downward shift in the age of onset first sexual activity in Australian youth (Rissel et al., 2003), and due to this young people may be at higher risk of unplanned pregnancy and sexually transmissible infections (STIs), as well as a range of other poorer health and life outcomes (Bearinger et al. 2007; Quinlivan & Evans 2002; Quinlivan et al. 1999; Wellings et al. 2006).

The 2002 National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health found that 26.4 per cent of Year 10 students and 44.2 per cent of Year 12 students reported having had sexual intercourse, giving an average figure of 34.4 per cent (Smith et al. 2002, in DEECD 2008). Two-thirds of students surveyed (66.4 per cent) had not had sexual intercourse.



Two representative samples of young people aged 16–25 found that 76 per cent of respondents had experienced sexual intercourse (Rissel et al. 2003, Smith et al. 2007a&b, in DEECD 2008). The median age of initiation of sexual intercourse was 17 years of age.

Among respondents to a national survey of same-sex-attracted young people aged 14–21, 67.6 per cent reported having experienced penetrative sex, while 27 per cent of 12–17-year-olds from rural towns in Victoria, Tasmania and Queensland reported having had sexual intercourse (Hillier et al. 1996; 2005, in DEECD 2008).⁶⁰ Eleven per cent reported first having sex aged 15, 13 per cent aged 16, 12 per cent aged 17 and 18 per cent were aged 18 and over (Hillier et al. 2005, in DEECD 2008).

Indicator: Proportion of young people practising safe sex by using a condom

Indicator: Proportion of young women who have used contraception to avoid pregnancy

Surveys have found that condoms are the most common form of contraception used, with between 56 per cent and 71 per cent of young people reporting condom use at their most recent sexual encounter (Hillier et al. 1996 2005, Smith et al. 2002, de Visser et al. 2003, in DEECD 2008).⁶¹

Data on other contraceptive methods used by young people show that 37.4 per cent of school students report using the oral contraceptive pill (at the most recent sexual encounter), 5 per cent the morning-after pill, 2.1 per cent the rhythm method, 1.3 per cent an intra-uterine device and 1.3 per cent a diaphragm. 11.1 per cent reported not using any method of contraception (Smith et al. 2002, in DEECD 2008).

Sexually transmissible infections

Sexually transmissible infections can have significant impacts on health and fertility. Since the 1990s, the prevalence of STIs has continued to rise in most countries (Weinstock et al. 2004).

Indicator: Rate of sexually transmissible infections in young people

In 2007 there were 747 notified cases of STIs in children in Victoria, representing a rate of 62.8 per 100,000 children (DHS Public Health Branch and ABS 2008a).

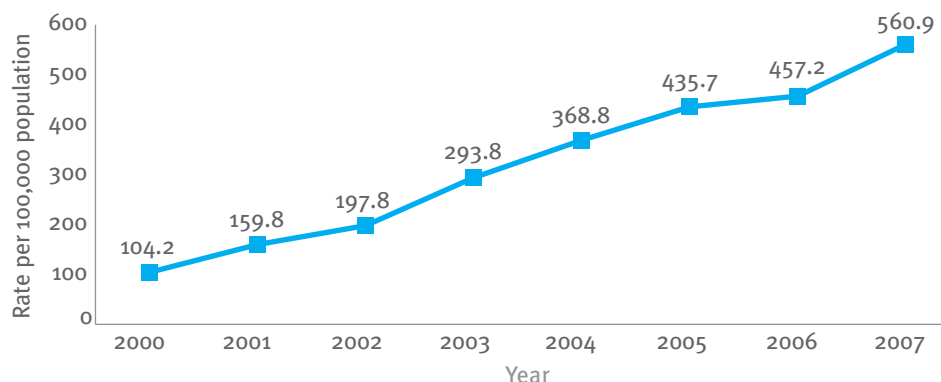
⁶⁰ It is important to note that young people reported having experienced a range of sexual practices, including oral sex. The 2002 National Survey of Australian Secondary Students found that 44.7 per cent of students reported having either given or received oral sex (Smith et al. 2002, in DEECD 2008). Further, a high proportion of young people agreed that two people who had oral sex but not intercourse could be considered to have had sex (Smith 2007, in DEECD 2008). This indicates that sexual practices other than intercourse are also important to young people.

⁶¹ Surveys have addressed contraception use by asking respondents whether they used a condom at the most recent sexual encounter, use of contraception at the most recent sexual encounter and the frequency of condom use over the previous year.



The majority of the 747 STI notifications were for chlamydia in young females aged 15–17 years (n = 571). Figure 2.18 shows that the rate of notifications for chlamydia has increased markedly in young females (aged 15–17) from 2000 to 2007.

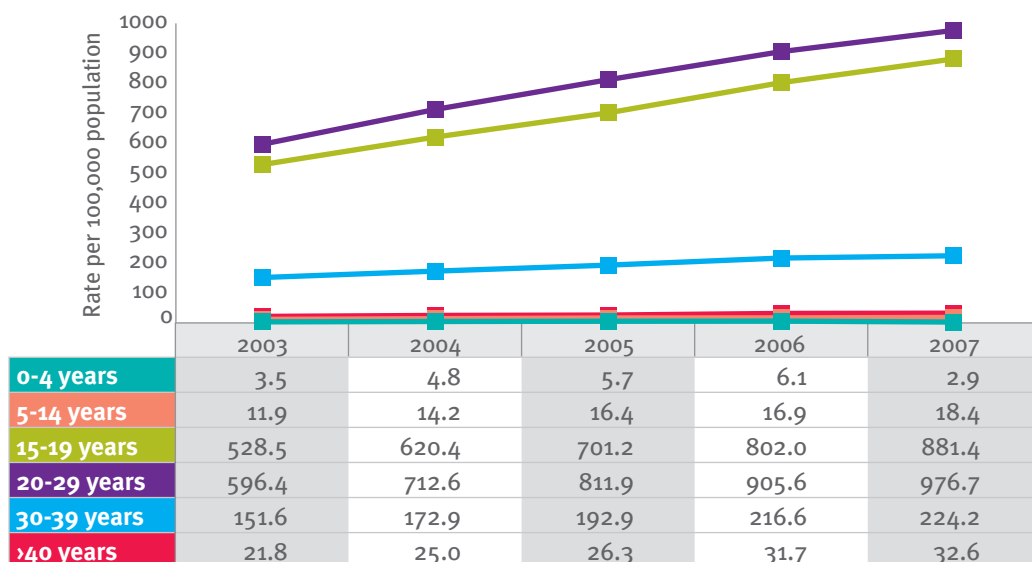
Figure 2.18: Rate of notifications for chlamydia per 100,000 young females aged 15–17 years, Victoria, 2000 to 2007



Source: DHS Public Health Branch and ABS 2008a

There has been an observed increase nationally in chlamydia notification rates among young people, as shown in figure 2.19.

Figure 2.19: Chlamydia by year and age group, Australia, 2003 to 2007



Source: National Centre in HIV Epidemiology and Clinical Research 2008

This increase in chlamydia notification rates is likely to be due, in part at least, to increased testing (National Centre in HIV Epidemiology and Clinical Research 2008). In Victoria DHS initiatives to increase chlamydia testing rates include GP education as well as public education campaigns encouraging younger people to be tested for STIs. However, it is difficult to quantify the relative contributions that increases in testing and increases in transmission/incidence are making to this.



Sexuality education in Victorian schools

The Department of Education and Early Childhood Development and the Department of Human Services have produced a resource guide to assist schools in the development and maintenance of comprehensive sexuality education programs for Victorian schools.

The resource has a strong evidence base and has been developed from the key learnings of the Whole-school Sexuality Education Project involving 50 schools across all sectors.

The resource is in two parts:

- **Program planning: concepts and policy**, which provides a background to the project, a literature review and an outline of the sexuality education policy environment.
- **School practice in sexuality education**, which provides the Model for Whole-school Learning in Sexuality Education, five school case studies, a three-year plan for program development and a sexuality education curriculum audit tool.

The Department has also developed a comprehensive sexuality education website, *Catching On* to support principals and teachers.

(<http://www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality/default.htm>)

Births to young mothers

Indicator: Teenage fertility rate

Motherhood in the teenage years is associated with an increased risk of poor social, economic and health outcomes, although it is important to note that not all teenage conceptions are unplanned or unwanted (DEECD 2008).

There were 1652 births to teenagers aged 15–19 years⁶² in Victoria in 2006 (ABS 2007).

Age-specific fertility rates (ASFR) give the number of births per 1000 females in each age group. The ASFR⁶³ for teenagers aged 15–19 years in Victoria has fallen gradually over the past 10 years, from 12.8 in 1996 to 9.7 in 2006.⁶⁴

As figure 2.20 shows, the ASFR for 15–19-year-olds in Victoria is consistently lower than for the whole of Australia.

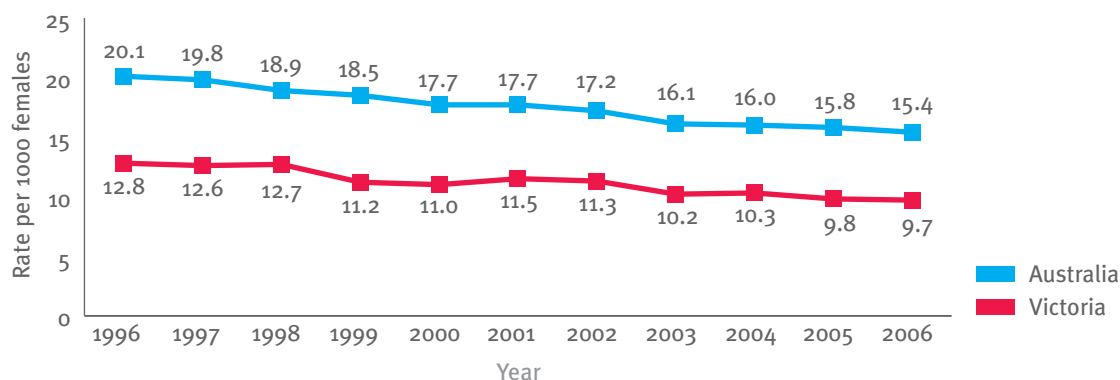
⁶² It should be noted that this can also include births to mothers who are aged less than 15 years. These births are not reported separately.

⁶³ In Victoria, the highest ASFRs are among women aged 30–34 (126.9), followed by women aged 25–29 (91.0) and women aged 35–39 (69.7).

⁶⁴ Since 2003, the 15–19-year ASFR in Victoria has been lower than for women aged 40–44. (The ASFR has been gradually increasing for this age group over the past 10 years).



Figure 2.20: Age-specific fertility rate per 1000 females aged 15–19 years, Victoria and Australia, 1996 to 2006

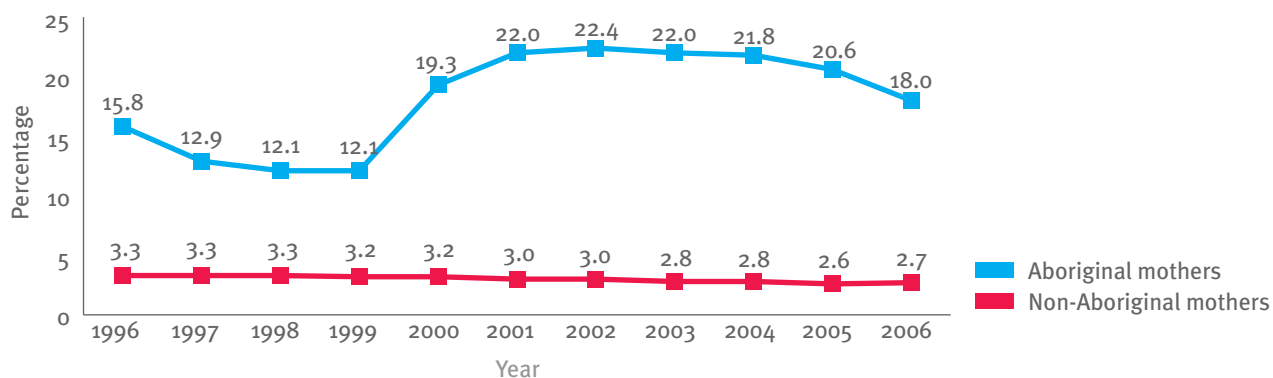


Source: ABS 2007

Aboriginal women give birth at younger ages than non-Aboriginal women.

In 2006 18 per cent of Aboriginal women giving birth in Victoria were aged under 20 years. Only 3 per cent of non-Aboriginal women giving birth were aged under 20 years (figure 2.21). Figure 2.21 also shows that the percentage of Aboriginal women under 20 years giving birth has increased in the last 10 years, but has decreased in recent years. Some of the increase is the result of better identification of women as Aboriginal (DHS 2008).

Figure 2.21: Percentage of women giving birth aged less than 20 years, Victoria, 1996 to 2006



Source: Department of Human Services 2008



Alcohol and tobacco use

Indicator: Proportion of young people who use drugs (alcohol, nicotine, illicit drugs)

Indicator: Age of initiation in young people of drug use

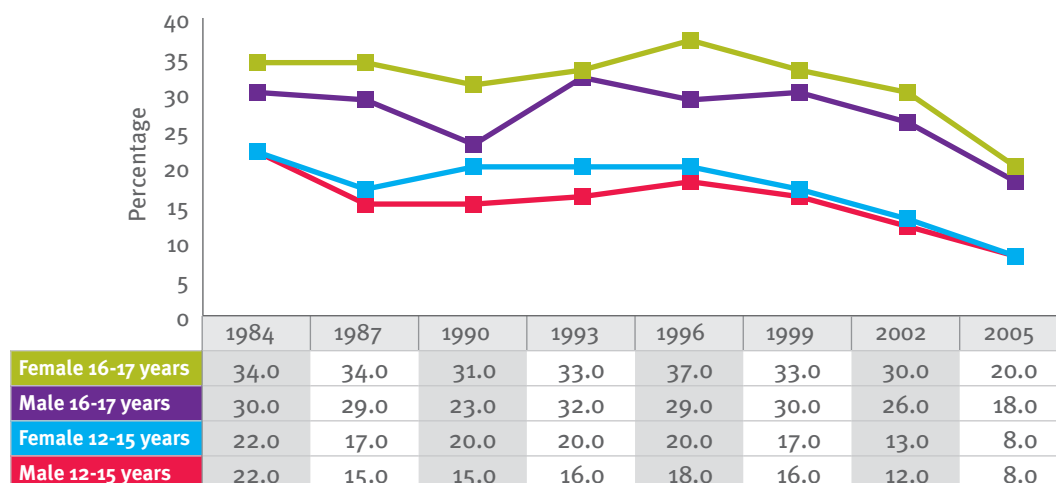
In adolescence, many young people begin experimenting with substances that can cause health problems if misused. For the majority of young people, this does not develop into an ongoing pattern of addiction and risk-taking behaviour. However, for a minority, particularly those who engage in chronic or multiple substance abuse, there may be serious present and long-term health consequences (AIHW 2007, Pitman et al. 2003, in DEECD 2008).

Tobacco smoking

Tobacco smoking is responsible for 19,000 deaths in Australia per year and is the single most preventable cause of chronic disease and premature death (AIHW 2007, in DEECD 2008). The majority of smokers commence smoking as teenagers and the earlier the age of smoking initiation, the greater the likelihood of continued smoking into adulthood. The smoking behaviour of friends and family are key influences on whether young people smoke (DEECD 2008).⁶⁵

The Victorian Secondary School Students' Use of Licit and Illicit Substances 2005 report (DHS 2006b, in DEECD 2008) draws on results from the 2005 Australian Secondary Students' Alcohol and Drug Survey⁶⁶ to highlight a declining trend in current smoking, between 1984 and 2005, among young people aged 12–17 years. While females have been more likely to smoke than males, this pattern is also changing so that by 2005, there is little gender difference in smoking at ages 16–17 years and no difference at ages 12–15 years (figure 2.22).

Figure 2.22: Trends in current cigarette smokers aged 12–17 years, Victoria, 1984 to 2005



Source: DHS 2006b, in DEECD 2008

⁶⁵ Among young people surveyed for the 2005 Secondary School Students' use of Licit and Illicit Substances, students were more likely to have never smoked a cigarette if neither of their parents were smokers, and for 12–15-year-olds, when a parents smokes, bans on smoking in the home reduce the likelihood that the young person will smoke.

⁶⁶ The Australian Secondary Students Alcohol and Drug (ASSAD) survey is a triennial secondary school-based survey that monitors the use of tobacco, alcohol and other substances among adolescents in Australia. The Victorian Secondary School Students' Use of Licit and Illicit Substances 2005 report relates to the Victorian data collected by this survey as part of a collaboration between the Department of Human Services, The Cancer Council Victoria and the Australian Government Department of Health and Ageing. Up to 80 students were surveyed from each school in a representative sample of 69 secondary schools (including government, Catholic and independent). The results represent the responses of a total of 4552 male and female students aged 12–17.

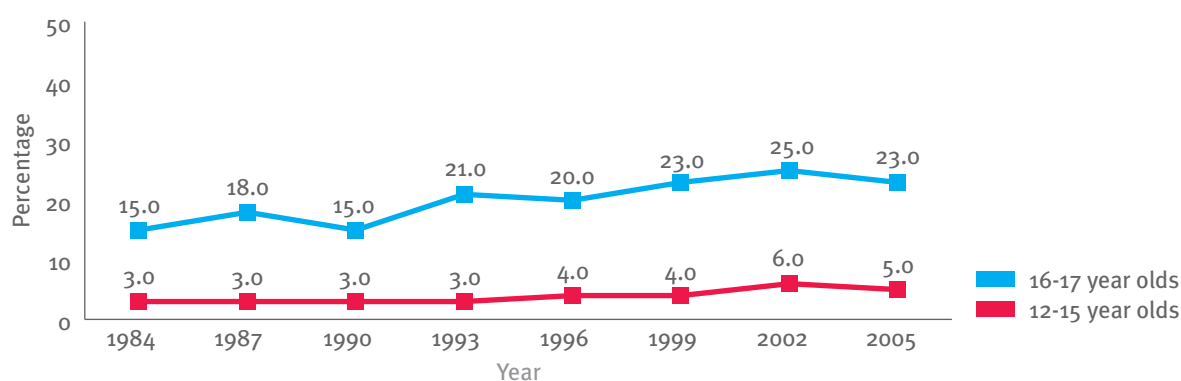


Alcohol

Excessive consumption of alcohol is a major risk factor for morbidity and mortality – and is associated with transport accidents, physical and sexual assault, drowning and suicide, together with a range of long-term health problems (AIHW 2007, in DEECD 2008). As with smoking, young people are more likely to consume alcohol as they get older.⁶⁷ However, evidence also suggests that the age of initiation of alcohol consumption is decreasing.⁶⁸

The Victorian Secondary School Students' Use of Licit and Illicit Substances 2005 report (DHS 2006b, in DEECD 2008) reported that 5 per cent of 12–15-year-olds and 23 per cent of 16–17-year-olds were drinking at levels that risked short-term harm in 2005.⁶⁹ The percentage of 16–17-year-olds who are drinking at levels that risk short-term harm has increased (from 15 per cent) since 1984 (figure 2.23).⁷⁰

Figure 2.23: Trends in the percentage of all students drinking at risk of short-term harm, among 12–15-year-olds and 16–17-year-olds, Victoria, 1984 to 2005



Source: DHS 2006b, in DEECD 2008

⁶⁷ In the Secondary School Students' use of Licit and Illicit Substances survey, 82 per cent of 12-year-olds, 51 per cent of 14-year-olds and 14 per cent of 17-year-olds considered themselves to be non-drinkers (data cited in DEECD 2008).

⁶⁸ The 2004 National Drug Strategy Household Survey data demonstrates that for each successive 10-year generation over the last 50 years, initiation into drinking has occurred at earlier and earlier ages.

⁶⁹ Drinking at risk of short-term harm is defined for males as consuming more than six alcoholic drinks on any day in the past week, and for females as consuming more than four alcoholic drinks on any day in the past week. Students who reported consuming more than 20 alcoholic drinks on any day in the past week were excluded from the analysis.

⁷⁰ Data from the Victorian Population Health Survey (cited in DEECD 2008) show that among young people aged 18–24 there has been an increase from 2002 to 2005 in the proportion of females and a decrease in the proportion of males who are drinking at least weekly at risky and high-risk levels.



Restoring the balance - Victoria's alcohol action plan 2008 – 2013

Restoring the balance - Victoria's alcohol action plan 2008–13 articulates the Victorian Government's commitment to preventing and reducing harm associated with alcohol misuse. It identifies specific immediate actions to be undertaken and establishes a long-term framework for change that will focus action across government, stakeholders and the wider community.

In November 2007, the Premier established the Ministerial Taskforce on Alcohol and Public Safety to lead the development of this action plan and respond to public safety issues.

This work also reflects the National Reform Agenda's focus on human capital and productivity, which has become a priority for the Council of Australian Governments (COAG). Alcohol has also been identified as a key risk factor in the National Chronic Disease Strategy and by the National Preventative Health Taskforce.

The National Alcohol Strategy 2006–2009 provides the national framework for 'partnership' actions to support a reduction in alcohol-related harm. The action areas within Victoria's alcohol action plan are consistent with the National Alcohol Strategy's goal to prevent and minimise alcohol-related harm to individuals, families and communities, in the context of developing a safer and healthier drinking culture in Australia.

One of the action plan aims is to reduce risky drinking and its impact on families and young people. The plan builds on existing programs and initiatives that have been established by the Government to minimise alcohol-related harm in the community. Examples of existing initiatives include:

Education and information

All government and most non-government primary and secondary schools provide alcohol and other drug education and primary prevention programs.

A number of quality resources have been developed for primary and secondary schools, including:

- Get Wise (a guide and strategies for educating about illicit drugs and responding to incidents of illicit drug use),
- Creating Conversations (a program that involves students in facilitating discussions with parents on parenting, drug-related issues and young people) and Talking Tactics Together (an interactive family drug education program for parents and their primary-school children)
- A four-year strategic drug education plan, including initiatives to enhance alcohol prevention and drug education in schools
- Teenagers and alcohol: supporting parents in the prevention of harm, a series of fact sheets for parents to help them deal with the issue of alcohol and their children.

FReeZA

The Government promotes alcohol-free events in public places for young people through FReeZA, a youth development program targeting young people aged 14–18 years.

Partysafe

Partysafe provides information and advice for parents and young people on how to minimise the chances of alcohol-related harm when hosting parties, including how to deal with gatecrashers and intoxicated guests. Party hosts also have the option of registering their party with their local police station, which will assist with a police response if required.

Schoolies week

Safer schoolies week celebrations are promoted through responsible serving of alcohol initiatives by liquor licensing accords, and the provision of support to councils during schoolies week periods.

Safe partying and other harm minimisation messages are also provided to school leavers to help young people enjoy themselves in a safe and responsible manner.



Illicit drugs

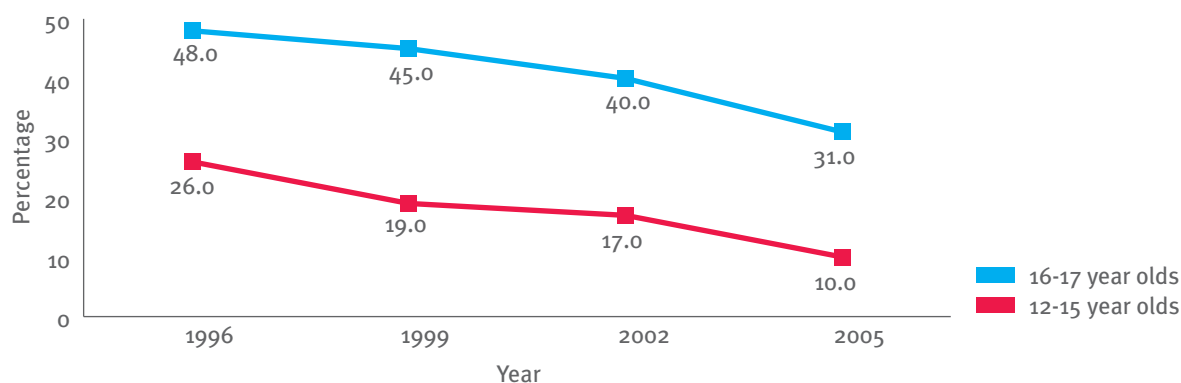
Illicit drug use adversely impacts on individual physical health, mental health and personal and social adjustment⁷¹ while also undermining the security and wellbeing of families and the broader community. Adolescence is a critical age for monitoring the initiation of illicit drug use. However, harmful patterns of illicit drug use can be predicted by problems in adjustment pathways that are evident in childhood (Loxley et al. 2004).

The Victorian Secondary School Students' Use of Licit and Illicit Substances 2005 (DHS 2006b, in DEECD 2008) shows that cannabis is the most commonly used illicit drug among students aged 12–17 years and use is higher among males.

While the percentage of young people who have ever used cannabis ranges from 3 per cent (of 12-year-olds) to 33 per cent (of 17-year-olds), rates of regular usage⁷² are very low (between 1 and 6 per cent).

There has also been a significant decrease in cannabis use among young students between 1996 and 2005 (see figure 2.24).⁷³

Figure 2.24: Percentage of students aged 12–17 years who have ever tried cannabis, Victoria, 1996 to 2005



Source: DHS 2006b, in DEECD 2008

Mental and emotional health

Mental health is defined by the World Health Organization (WHO) as ‘a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community’ (WHO 2001, in DEECD 2008).

The majority of children have good mental health with positive psychosocial development, the capacity for learning, and good social and family relationships. For most children who experience mental health problems, the disorders are short-lived. However, there are some children that experience more complex and severe problems, which can have long-term effects.

⁷¹ The World Health Organization (WHO) burden of disease study estimated that in 2000 illicit drug use in developed nations was responsible for 4 per cent of deaths and 5 per cent of disability-adjusted years lost for young people aged 15–29 (Toumbourou et al., 2007).

⁷² This is defined as having used cannabis 10 or more times in the past year.

⁷³ The Victorian Youth Alcohol and Drug Survey found that cannabis is also the most widely used illicit drug among young people aged 16–24, with 48 per cent of young people reporting having ever used cannabis. The survey also identifies a decline in the use of any illicit drugs, with the proportion of those who had ever used (defined as lifetime use) illicit drugs falling from 54 to 50 per cent between 2003 and 2004. The reported use of cannabis shows the most significant fall. Use of other illicit drugs ranged from 18 per cent who had ever used ecstasy, to 15 per cent (ever using) amphetamines and 6 per cent cocaine.



This section looks principally at what is known about emotional, behavioural and mental health problems among Victoria's children and young people.

There are a number of definitional and methodological difficulties associated with measuring these problems as these are clearly subjective states that vary across time and across cultures and subgroups of children and families. There are also difficulties in employing service-based data to estimate prevalence as many young people who are experiencing psychological difficulties may not come to the attention of mental health services (DEECD 2008).

A distinction is commonly made 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 challenges of everyday life. The term mental health problem is commonly used to define a level of mental disorder of concern to health practitioners but one that does not necessarily meet all of the diagnostic criteria for a mental disorder (DEECD 2008).

Adult mental disorders most commonly manifest themselves in adolescence, and can have a serious impact on the current and long-term wellbeing of young people – affecting their participation in education and the workforce, and relationships with families and friends. In some instances they can affect personality development and even lead to death as a result of suicide or drug overdose (DEECD 2008).

Until recently, little information has been available on the mental health of Australia's children. The Child and Adolescent Component of the National Survey of Mental Health was the first national survey of its kind (Sawyer et al. 2000). This survey showed that there was a high prevalence (14 per cent) of mental health problems in Australian children, who were experiencing a broad range of emotional and behavioural difficulties that may cause concern or distress.

Indicator: Proportion of children with emotional or behavioural difficulties

The 2006 VCHWS collected information from parents about their children's mental health and behaviour using the Strengths and Difficulties Questionnaire (SDQ).⁷⁴

Data were obtained about the proportion of children aged 4–12 years scoring 'normal', 'borderline' or 'of concern' on each of five domains⁷⁵ (emotional symptoms, conduct problems, hyperactive behaviour, peer relationships and pro-social behaviour).

Results, reported in the 2006 children's report (DHS 2006), 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'.⁷⁶

⁷⁴ The SDQ is a brief behavioural screening questionnaire for emotional and behavioural disorders in children and adolescents aged 4–16 years (Goodman, 2001). The SDQ has moderate to strong internal reliability, and sound internal and external validity. It is very widely used, so it offers excellent comparability with data collections elsewhere.

⁷⁵ 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').

⁷⁶ 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'.



Improving mental health services

Strengthening the mental health system has been a major focus of A Fairer Victoria with investments in forensic, emergency and intensive care, outreach and prevention, and recovery services across the state. The 2008 renewal of the Victorian Government's commitment to A Fairer Victoria will refocus emphasis and investment on early intervention, recovery and ongoing social support, including help for the children of parents with a mental illness. There will also be early work on the redevelopment of specialist mental health services for children and young people.

The mental health and wellbeing of young people in out-of-home care

Looking After Children Assessment and Action Records (A&ARs) are used in Victoria, as in most other jurisdictions, to assess individual child needs and outcomes in order to develop and review annual plans for care. Recent Australian Institute of Family Studies (AIFS) research commissioned by the DHS provides information from a sample of A&ARs about outcomes for 614 children in out-of-home care⁷⁷ (AIFS 2008). This research found that a very low proportion of the children (22.8 per cent) were 'free from serious emotional and behavioural problems'.

DHS analysis of 2006 data also suggests that children and young people in residential out-of-home care are more likely to have or be at risk of having behavioural and mental health problems than young people in the general population (DEECD 2008).

During April 2006, 342 young people in residential care in Victoria were assessed using the SDQ. The DHS analysis found that the mean (average) total difficulties score for the residential care group was 19.25. Sixty-five per cent had total difficulty scores of 17 or more. UK research identifies children with scores of 14 to 16 as 'borderline' and with scores of 17 or above as at 'abnormal' risk of having a diagnosable mental health disorder (Meltzer et al. 2000).

These findings illustrate the impact that experiences of abuse and trauma have had on the mental health status and wellbeing of young people in state care, and the significant challenges that are faced in providing them with appropriate care. There is a clear need to further strengthen service responses to better meet the needs of these children, and this requires joint effort across numerous areas of government. In Victoria, significant investment is occurring through services such as Take Two, which provides intensive support to children and young people displaying significant emotional and behavioural difficulties as a result of abuse, and the Therapeutic Foster Care program which seeks to provide care better able to meet the therapeutic needs of children. The Hurstbridge Farm Therapeutic Care service is another example of our focus on meeting therapeutic and mental health needs. The out-of-home care service system continues to strive to improve the quality of services, so that the care young people receive provides a therapeutic response that is able to address immediate needs and improve long-term outcomes.

These issues will also be addressed in the Mental Health Reform Strategy. A key thrust of this Strategy is to resource better responses to mental health problems experienced by clients of other state-funded service systems, with priority being given to vulnerable young people. This will involve stronger partnerships between specialist Child and Adolescent Mental Health Services and out-of-home care providers, training of workers in the residential care system in mental health issues, and new funding models that support more flexible, tailored mental health interventions.

Indicator: Rate of admission to hospital for psychiatric problems

If mental health problems are poorly managed or a young person is self-harming or threatening to self-harm, or is experiencing an acute phase of a psychiatric illness, hospitalisation may be required.

⁷⁷ This sample was reasonably representative of children in the out-of-home care population in relation to special health and education needs, although it may not be representative of children from ATSI and CALD backgrounds.



In 2006–07 there were 5881 hospital admissions due to psychiatric problems of children in Victoria (representing a rate of 497.8 per 100,000 children). The number of admissions has declined from 6818 in 2002–03 (a rate of 587.40 per 100,000 children). Of the 5881 admissions in 2006–07, 3478 were for 15–17-year-olds, 926 for 10–14-year-olds, 282 for 5–9-year-olds and 1195 for 0–4-year-olds. Table 2.11 presents the top causes for admission, by sex and age group.

Table 2.11: Main psychiatric causes for hospital admissions in children, Victoria, 2006–07

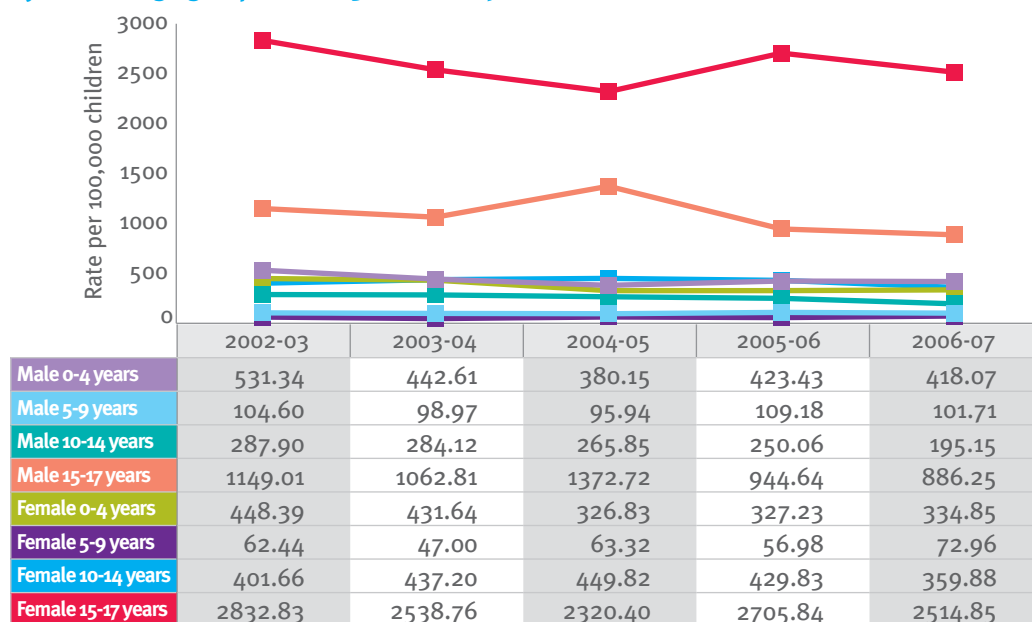
Sex and age (years)	Cause	Number	Rate per 100,000
Male			
0–4	Feeding disorders of infancy and childhood	208	128.3
5–9	Childhood autism	80	48.4
10–14	Childhood autism	53	30.7
15–17	Mental and behavioural disorder due to use of alcohol acute intoxication	213	200.4
Female			
0–4	Feeding disorders of infancy and childhood	166	107.5
5–9	Anorexia nervosa	24	15.4
10–14	Anorexia nervosa	95	58.1
15–17	Depression episode not in the postnatal period	362	359.0

Source: DEECD analysis of Victorian Admitted Episode Dataset (Public and Private 2002–03 to 2006–07) and ABS 2008a

Analysis of trend data (2002–03 to 2006–07) shows that the rate of hospital admissions for psychiatric problems is consistently higher for 15–17-year-olds, although there also appears to be a declining trend in admissions in this age group over the five-year period.⁷⁸

Rates of admission for psychiatric problems are higher overall in females. This is largely accounted for by a much higher rate among females in the 15–17-year age group, as shown in figure 2.25.

Figure 2.25: Hospital admissions due to psychiatric problems, rate per 100,000 children in Victoria, by sex and age group, 2002–03 to 2006–07



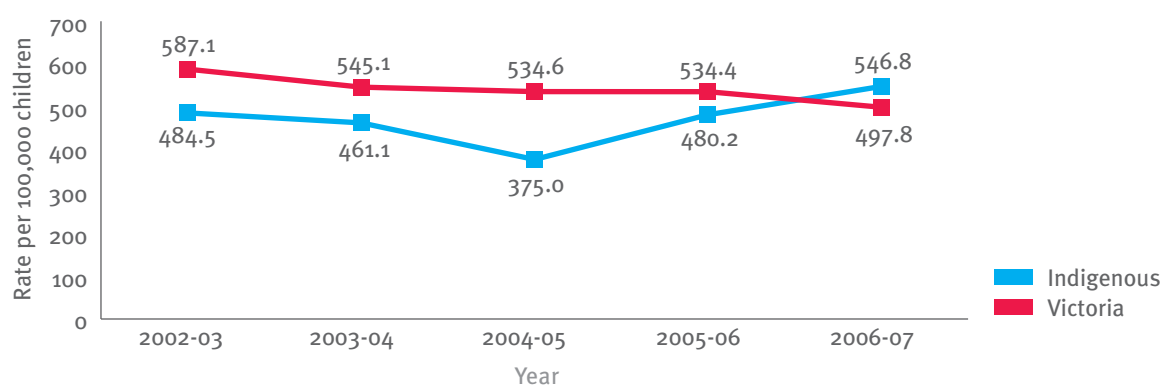
Source: DEECD analysis of Victorian Admitted Episode Dataset (Public and Private 2002–03 to 2006–07) and ABS 2008a and 2008b

⁷⁸ The rate of hospital admissions due to psychiatric problems in young people aged 15–17 years was 1977.7 (per 100,000) in 2002–03 and 1679.1 (per 100,000) in 2006–07.



Indigenous children accounted for 81 of the 5881 children admitted to hospital for psychiatric problems in Victoria in 2006–07. The rate of hospital admissions owing to psychiatric problems is lower in Indigenous children than in children in Victoria as a whole from 2002–03 to 2005–06. However, the rate of admissions for Indigenous children has increased and was higher in 2006–07 than the rate for all children (figure 2.26).⁷⁹

Figure 2.26: Hospital admissions due to psychiatric problems, rate per 100,000 children in Victoria, by Indigenous status, 2002–03 to 2006–07



Source: DEECD analysis of Victorian Admitted Episode Dataset (Public and Private 2002–03 to 2006–07) and ABS 2008a and 2008b

Suicide and self-harm

Suicide is uncommon in children prior to puberty but rates rise progressively through to young adulthood. In recent decades, suicide has been second only to motor vehicle injury as a cause of death in adolescents and young adults (AIHW 2007). Rates of suicide are higher among young males than females.

A range of factors contributes to suicide in young people. Most important is a history of mental illness, with depression being the clearest predictor (National Suicide Prevention Strategy 1999). Alcohol and drug use is frequently part of the constellation of factors leading to suicide and a history of self-harm⁸⁰ is a further important risk factor.^{81,82}

⁷⁹ It is important to remember that small changes in numbers of Indigenous children admitted to hospital can be reflected in large changes in rate of admissions. 52 Indigenous children were admitted to hospital for psychiatric problems in 2004–05 and 69 were admitted in 2005–06.

⁸⁰ Intentional self-harm refers to the deliberate infliction of injury by an individual on him/herself. Self-harm is uncommon in childhood but rises steeply in prevalence in late puberty, particularly in girls (Patton et al. 2007).

⁸¹ In those young people presenting clinically with self-harm, rates of later suicide have been estimated to be 30-fold higher (Hawton & James 2005).

⁸² Further predictive factors of suicide include experience of abuse in childhood, access to lethal means (including firearms), unemployment and a low level of academic achievement. Some groups such as those in youth justice systems and Indigenous youth have very high levels of death due to suicide (Coffey et al. 2003).



Indicator: Rate of intentional self-harm in young people

Rates of self-harm hospitalisation among young people aged 12–24 years in Australia have increased by 59 per cent, from 138.2 per 100,000 young people in 1996–97, to 197.2 per 100,000 young people in 2005–06. As table 2.12 shows, the percentage increase has been greater among females than males. The rate of intentional self-harm-hospitalisation in females is at least twice as high as the male rate over the 10-year period.

Table 2.12: Intentional self-harm hospitalisation rates (per 100,000 young people) young people aged 12–24 years, Australia, 1996–97 to 2005–06⁸³

	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	% change
Males	90.9	107.1	116.9	114.3	122.6	111.3	110.0	114.1	117.0	115.4	+ 24.1
Females	187.5	208.1	221.4	224.0	244.8	241.8	253.9	279.0	303.5	283.2	+ 95.7
Persons	138.2	156.6	168.0	168.1	182.5	175.3	180.5	194.7	208.1	197.2	+59.0

Source: AIHW National Hospital Morbidity Database, in AIHW: Eldridge. D 2008

Victorian data on self-harm hospital admissions and self-harm deaths are available from the Victorian Admitted Episodes Dataset (VAED) and the Australian Bureau of Statistics Death Unit Record File (ABS-DURF). Analysis of this data was carried out by the Victorian Injury Surveillance Unit at the Monash University Accident Research Centre (MUARC).

In 2005–06, 396 young people aged 15–18 years were admitted to Victorian hospitals due to intentional self-harm injury, with an age-adjusted admission rate of 146 per 100,000 young people.⁸⁴ Females accounted for 81 per cent (n = 319) of intentional self-harm injury hospital admissions.⁸⁵

The self-harm injury and poisoning age-adjusted admission rate for young people aged 15–18 years (excluding same-day admissions) increased over the 12-year period from 127 per 100,000 young people in 1994–95 to 146 per 100,000 young people in 2005–06 (figure 2.27).⁸⁶ However, this increase was not statistically significant.

⁸³ Age-standardised to the Australian population as at 30 June 2001.

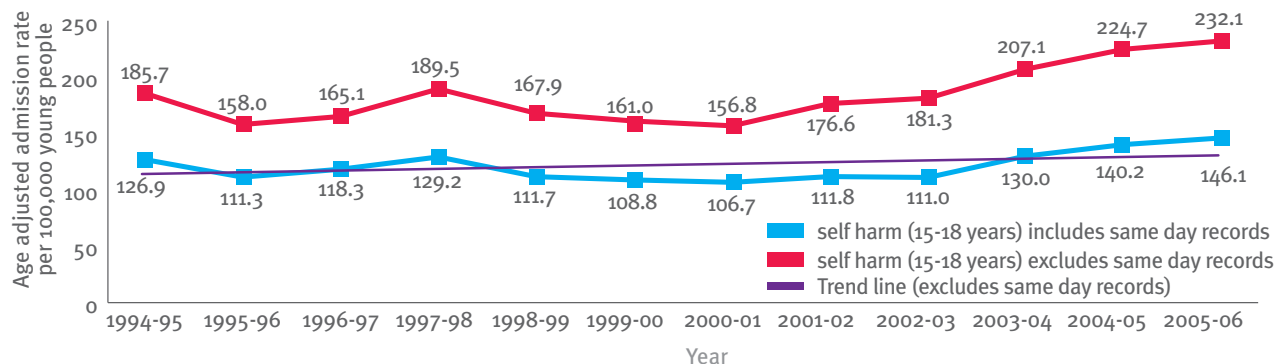
⁸⁴ A young person is recorded as an admission (in hospital records) if the duration of their treatment lasts more than four hours. Where the young person is discharged from hospital in less than 24 hours, they are counted as a 'same-day admission'. These figures exclude 233 same day admissions.

⁸⁵ The leading causes of intentional self-harm injury admissions were poisoning by pharmaceuticals (n = 317, 80 per cent) and sharp objects (n = 49, 12 per cent) (Victorian Admitted Episodes Dataset (VAED)).

⁸⁶ This represents an estimated annual increase of 1.3 per cent (95 % confidence intervals –0.6% to 3.2%) and an overall increase of 17 per cent (–7% to 46%) based on the trend line.



Figure 2.27: Yearly trend in the rate (per 100,000 young people) of intentional self-harm injury hospital admissions in young people aged 15–18 years, Victoria 1994–95 to 2005–06



Selection criteria: (1) An ICD9 injury or poisoning diagnosis code in the range 800–904, 910–999 or an ICD10 diagnosis code in the range S00–T89 if the cause of injury was intentional self-harm. (2) Deaths and transfers within and between hospitals were excluded. (3) Same day records were excluded from the final analysis, but are shown on figures.

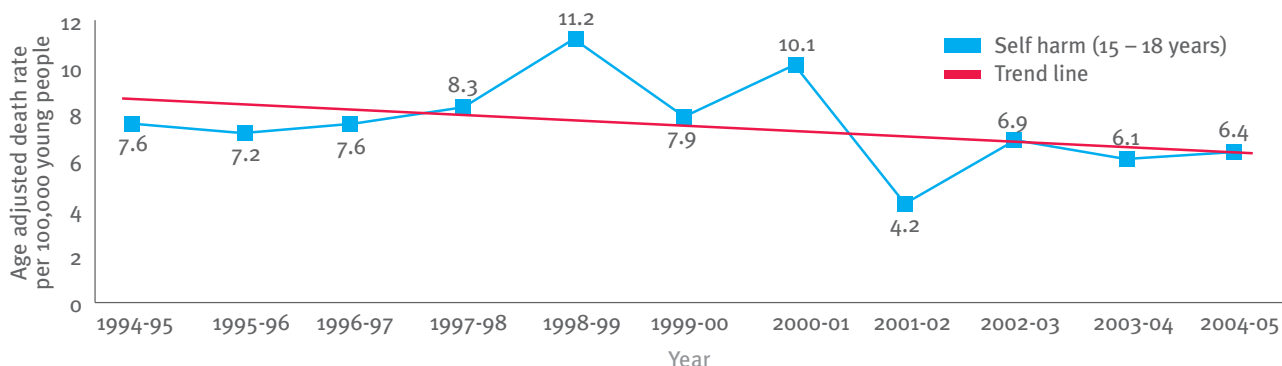
Source: Victorian Admitted Episodes Dataset (VAED) July 1994 to June 2006, data supplied by Monash University Accident Research Centre

Indicator: Age-specific death rate from suicide

In 2004–05, 17 young people aged between 15–18 years died in Victoria due to intentional self-harm injury, an age adjusted death rate of 6.4 per 100,000 young people. Males accounted for 65 per cent ($n = 11$) of these intentional self-harm injury deaths.⁸⁷

The intentional self-harm injury and poisoning age-adjusted death rate for young people aged 15–18 years decreased over the 11-year period from 7.6 per 100,000 in 1994–95 to 6.4 per 100,000 in 2004–05.⁸⁸ However, this decrease was not statistically significant (figure 2.28).

Figure 2.28: Yearly trend in the rate (per 100,000 young people) of intentional self-harm injury deaths in young people aged 15–18 years, Victoria 1994–95 to 2004–05



Selection criteria: An ICD9 cause of death code in the range 950–959 or an ICD10 cause of death code in the range X60–X84

Source: Australian Bureau of Statistics Death Unit Record File (ABS-DURF) July 1994 to June 2005, data supplied by Monash University Accident Research Centre

⁸⁷ The main causes of intentional self-harm injury deaths in this age group were hanging, strangulation and suffocation ($n = 11$, 65 per cent).

⁸⁸ This represents an estimated annual decrease of 2.6 per cent (95% confidence intervals –8% to 2.7%) and an overall reduction of 25 per cent (–60% to 34%) based on the trend line.



2.3 Safety

Summary

- The HNSS found that 53.9 per cent of students in Years 6 and 8 reported feeling safe in their neighbourhoods. Those in urban areas were less likely to report feeling safe than those in regional areas.
- 37.5 per cent of students had experienced some bullying recently and 19.4 per cent had taken part in bullying (HNSS).
- 91.8 per cent of students responding to the HNSS said they felt safe at school. This reduced with older students and was lower for CALD students and students from lower-socioeconomic quintiles.
- In 2007–08 there were 11,566 victims of crime aged 0–17 years. The number of youth crime victims has decreased overall from 12,780 in 2002–03 to 11,566 in 2007–08 (a decrease of 9.5 per cent).
- In 2007–08, 33,865 alleged offenders aged 10–17 years were processed by police. The number of alleged offenders aged 10–17 years increased from 32,518 in 2002–03 to 33,865 in 2007–08 (an increase of 4 per cent).
- Victoria has the lowest rate of young people under youth justice supervision in Australia, with a rate of 2.8 per 1000. Indigenous young people are overrepresented in the youth justice system.
- 9464 children and young people aged 0-18 years were admitted to hospital due to injury and poisoning in 2005–06, and in 2004–05, 74 children and young people died due to injury and poisoning. Males accounted for 63 per cent of admissions and 54 per cent of deaths.
- The leading causes of injury and poisoning hospital admissions were falls (40 per cent), transport (19 per cent), hit/struck/crush incidents (10 per cent) and self-harm (5 per cent). The leading causes of deaths were transport (46 per cent), self-harm (24 per cent) and drowning (12 per cent).
- The injury and poisoning hospital admission rate decreased significantly between 1994–95 and 2005–06. The injury and poisoning death rate also decreased significantly between 1994–95 and 2004–05.
- There appears to be a small declining overall trend in the rate of child protection substantiations for all children in Victoria (2000–01 to 2006–07). While the substantiation rate among Indigenous children declined markedly from 2005–06 to 2006–07, rates are still much higher in Indigenous children than in all children.

A secure and safe physical and social environment is critical to the emotional wellbeing and healthy development of children, and safety can be understood as a necessary precondition of health (DHS 2006).

The safety of children relates to a wide range of spheres – to their physical safety, emotional, social and mental safety, to safety at school and in their homes, to safety in their local neighbourhoods, in public spaces and in public transport and to freedom from racism, crime, bullying and discrimination.

This section begins with an account of how safe young Victorians feel in their local neighbourhoods. It looks at their perceptions of safety as well as the prevalence of factors that affect their safety, including bullying, racism and discrimination and involvement in crime.

Children's safety can also be compromised by risk-taking behaviour (by themselves and by others), which can lead to injuries – and by the experience, for a minority, of child abuse. The section moves on to review the current knowledge about injuries and injury deaths to young people, and substantiated child abuse.

While the focus is on issues that compromise children's safety, it is important to recognise that the majority of children feel safe, are safe and are not involved in any form of criminal activity.



Children and young people’s perceptions of community safety

Indicator: Crime rates

Indicator: Proportion of children and young people who feel safe

Access to public space free from discrimination and violence is a fundamental human right (Youth Affairs Council of Victoria 2005). It is important that young people have the ability to access safe public space for relaxation, socialising, and interaction, free from parental supervision. Multiple studies have found benefits to young people’s wellbeing as a result of ‘hanging out’ in public spaces (Youth Action and Policy Association NSW 2002).

The HNSS asked children in Years 6 and 8 whether the statement: ‘I feel safe in my neighbourhood’ was true for them. They were asked to respond with a strong YES (where the statement was definitely true for them), a weaker yes (where the statement was mostly true), a strong NO (where the statement was definitely not true for them) or a weaker no (where the statement was mostly not true).

Just over half (53.9 per cent) of the respondents said that YES, they definitely felt safe, with a further 38.3 per cent saying that yes they mostly felt safe. Children and young people in urban areas were significantly less likely than those in regional areas to report feeling safe (table 2.13)

Table 2.13: Percentage of students responding to the statement: ‘I feel safe in my neighbourhood’, by urban/regional location, Victoria, 2006

	Urban (%)	Regional (%)	Total (%)
YES	52.6	57.1	53.9
Yes	38.9	36.5	38.3
No	6.2	4.3	5.6
NO	2.3	2.1	2.2

Source: Williams 2007

Further data related to this indicator will be collected in the Victorian Adolescent Health and Wellbeing Survey.

Victorian Police data have also shown that the overall crime rate has decreased by 24.5 per cent from 2000–01 to 2007–08 and total offences decreased by 17.0 per cent during the same period (Victoria Police 2008).

Bullying

Indicator: Proportion of children who are bullied

Bullying is known to negatively impact on children’s mental health status, including increasing risk of depression.⁸⁹ Bullying is also associated with increased absenteeism from school and decreased academic performance, although the direction of causality is unclear (Victorian Child and Adolescent Monitoring System, Evidence Manual for Indicators, unpublished, February 2008).

Estimates of the prevalence of bullying vary widely, and this is partly due to a lack of clarity and consistency in its definition (Tucci, Mitchell & Goddard 2008).

⁸⁹ Bullying can also lead to anxiety, poor self-esteem and withdrawal, although the relationship with depression is stronger (Hawker & Boulton 2000).



Experiences of bullying among children and young people in Victoria

Victorian students from Years 6 and 8 who took part in the 2006 HNSS were asked whether they had been bullied recently (teased or called names, had rumours spread about them, been deliberately left out of things, threatened physically or actually hurt). Analysis of the Victorian data found that 62.5 per cent of students stated that they had not experienced bullying recently, 23.8 experienced bullying less than once a week, 6.6 per cent experienced bullying once a week, 7.1 per cent said they experienced bullying most days (Williams 2007, in DEECD 2008).

The survey also asked students whether they had taken part in bullying recently. The majority of students (80.6 per cent) said that they had not taken part recently, while 15.7 per cent said less than once a week, 2.5 per cent said once a week and 1.3 per cent said most days.

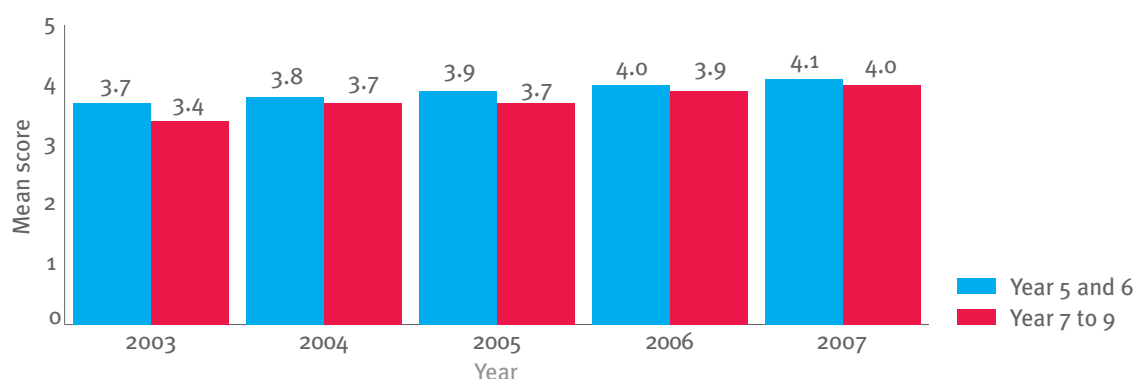
Each year students in Victorian government schools are surveyed about their opinions on aspects of school life, including 'school safety', using the Attitudes to School Survey.

In order to measure 'school safety', students are asked to rate (on a five-point Likert scale) how far they agree with the following statements:

- I have been bullied recently at school.
- I have been teased in an unpleasant way recently at my school.
- Students are mean to me at this school.
- I have been deliberately hit, kicked or threatened by another student recently.
- Other students often spread rumours about me at my school.

Figure 2.29 shows the statewide government school mean scores for 'school safety' for students in Years 5 and 6 and Years 7–9, from 2003 to 2007. The mean scores have increased in both age groupings over the five-year period, suggesting that students feel increasingly safe at school. Younger students (in Years 5 and 6) are slightly more likely to have higher mean scores on the 'school safety' measure than older students (in Years 7 to 9) but the difference is minimal.

Figure 2.29: Mean scores for school safety, students in Years 5 and 6 and Years 7 to 9, Victoria, 2003 to 2007



Source: Department of Education and Early Childhood Development Attitudes to School Survey

Victorian students from Years 6 and 8 who took part in the 2006 HNSS were also asked a number of general questions about their experiences and views of school, including whether they felt safe at school.

Overall, most students stated they felt safe at their school (91.8 per cent). However, this reduced with older students and was also lower (89.3 per cent) for CALD students and students from lower socioeconomic quintiles (Williams 2007, in DEECD 2008).



Children and young people as victims of crime

Indicator: Proportion of young people who report victimisation

Indicator: Proportions of all victims of crime where the victim is a child or young person

Indicator: Proportion of assaults where the victim was a child or young person

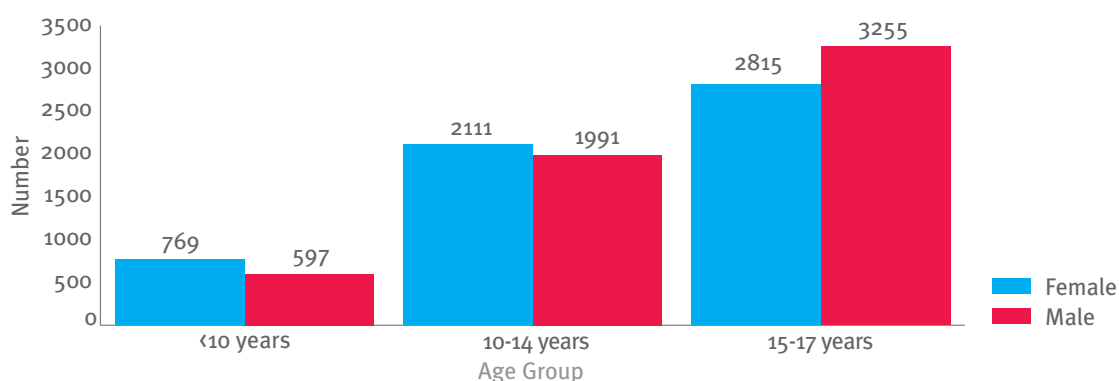
The age and sex of child crime victims 2007–08

Victorian Police data show that in 2007–08 there were 11,566 victims of crime aged under 18 years, representing 5.5 per cent of the total population of victims of crime.

Figure 2.30 shows that the majority of child victims of crime reported in 2007–08 were aged 15–17 years (52.6 per cent), followed by 10–14-year-olds (35.5 per cent) and children aged less than 10 years (11.8 per cent).

Figure 2.30 also shows that victims of crime aged under 10 years are more likely to be female, whereas victims aged 15–17 years are more likely to be male.

Figure 2.30: Victims of crime aged under 18 years,⁹⁰ by age group and sex, Victoria, 2007–08



Source: Victoria Police Crime Statistics 2007–08

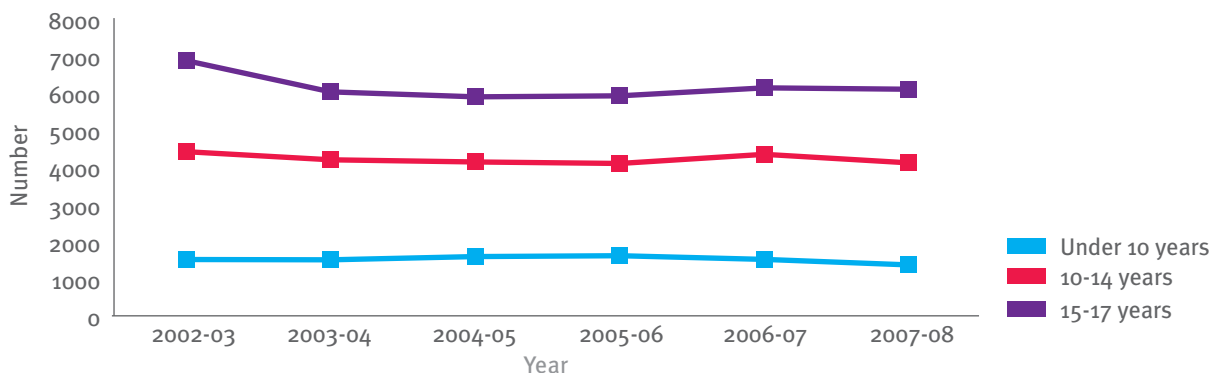
Trends in victimisation of children 2002–03 to 2007–08

The numbers of child crime victims decreased from 12,780 in 2002–03 to 11,566 in 2007–08 (a decrease of 9.5 per cent). Figure 2.31 shows that there were decreases for each age group over the six-year period (under 10 years: –9.6 per cent, 10–14 years: –6.8 per cent, 15–17 years: –11.2 per cent).

⁹⁰ Excludes 28 victims of crime for whom gender was not specified.



Figure 2.31: Victims of crime aged under 18 years, by age group, Victoria, 2002–03 to 2007–08



Source: Victoria Police Crime Statistics 2007–08

Types of crime

The majority of child crime victims (64.3 per cent) in 2007–08 were victims of crime against the person, 33.6 per cent were victims of crime against property and 2.1 per cent were victims of other crimes (table 2.14).⁹¹

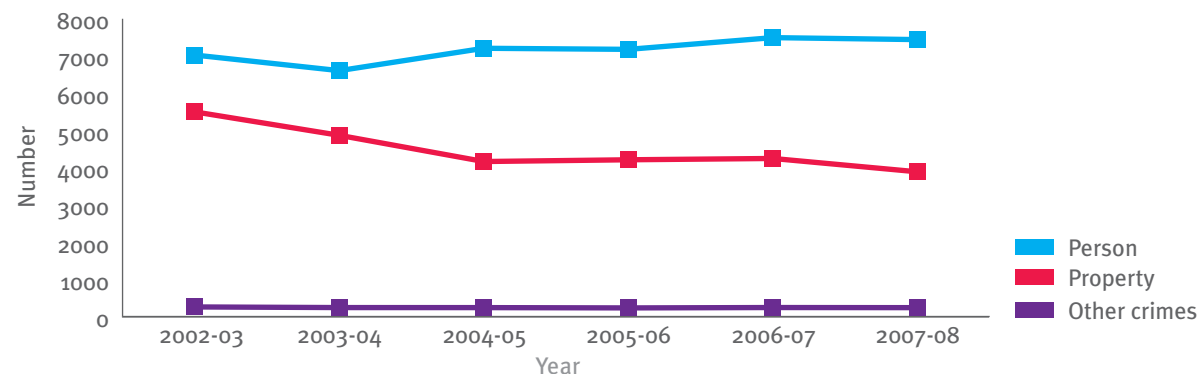
Table 2.14: Victims of crime aged under 18 years, by type of crime, Victoria, 2007–08

	Number	Per cent
Crime against the person	7,440	64.3
Crime against property	3,888	33.6
Other crimes	238	2.1
Total	11,566	100.0

Source: Victoria Police Crime Statistics 2007–08

Figure 2.32 shows that there has been a decrease from 2002–03 to 2007–08 in child victims of crime against property. There has been a marginal increase in child victims of crime against the person over the same time period.

Figure 2.32: Victims of crime aged under 18 years, by offence type, Victoria, 2002–03 to 2007–08



Source: Victoria Police Crime Statistics 2007–08

⁹¹ Crimes against property include arson, property damage, burglary (aggravated/residential and other), deception, handling stolen goods, and theft (from motor vehicle, shops, of motor vehicle, of bicycle, other). Crimes against the person include homicide, rape, sex (non-rape), robbery, assault and abduction/kidnap. Other crimes include going equipped to steal, justice procedures, regulated public order, weapons/explosives, harassment, behaviour in public and other crime.



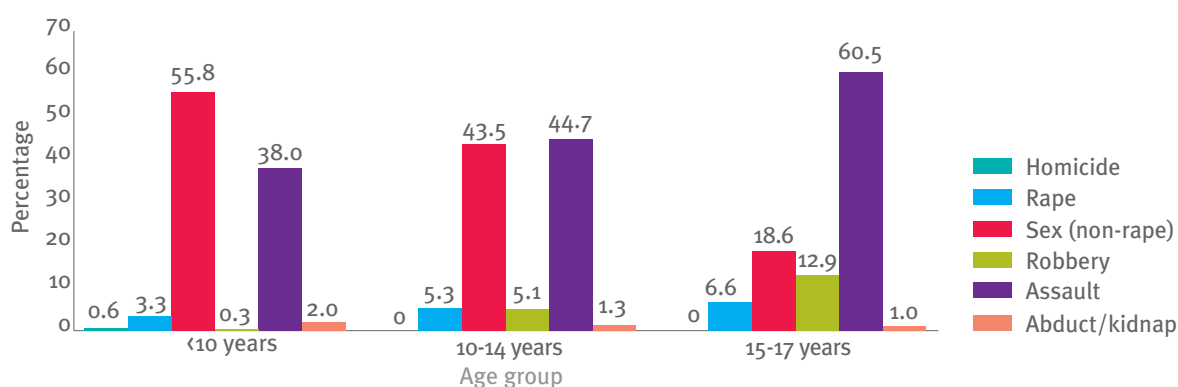
Victims of crime against a person

Figure 2.33 presents an analysis of the 7440 child victims of crime against the person in 2007–08, by age and type of offence. More than half (56 per cent) of crimes against the person aged 10 or under are victims of sexual crimes.

While the proportion of children and young people who are victims of sexual crimes declines with age, the proportion of children and young people who are victims of assault increases with age. Six in 10 (60 per cent) crimes against the person victims aged 15–19 years are victims of assault.

Overall, children and young people (aged 0–17 years) account for 13.5 per cent of all victims of assault.

Figure 2.33: Victims of crime against a person aged under 18 years, by offence and by age group, Victoria, 2007–08



Source: Victoria Police Crime Statistics 2007–08

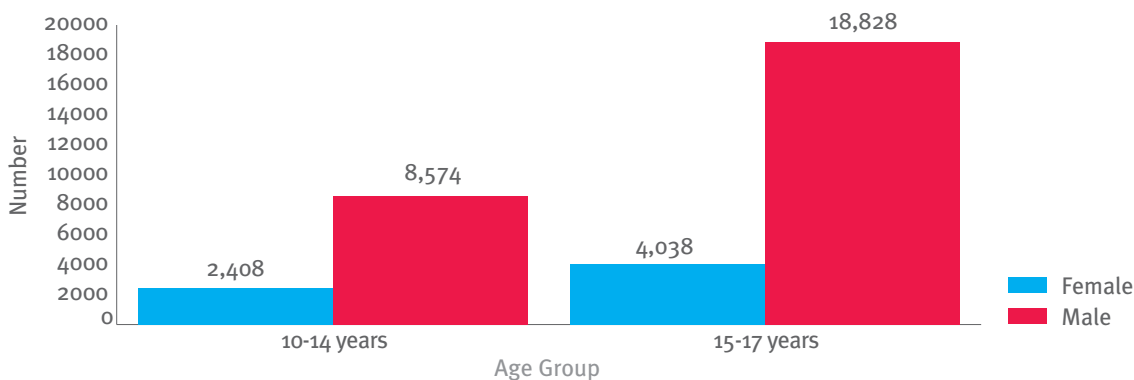
Children and young people as offenders

The age and sex of child alleged offenders 2007–08

Victoria Police data show that a total of 33,865 alleged offenders aged under 18 years were processed by police in 2007–08. This represents 21.5 per cent of all offenders processed.

Young people aged 15–17 years accounted for the majority of offenders (68 per cent) aged under 18 years, with 10–14-year-olds accounting for 32 per cent. The majority (81 per cent) of alleged young offenders in 2007–08 were male (figure 2.34).

Figure 2.34: Young alleged offenders processed by police, by age group and sex, Victoria, 2007–08



Source: Victoria Police Crime Statistics 2007–08

Note: Numbers in the figure do not add up to 33,865 as there were 17 offenders for whom sex was unspecified.

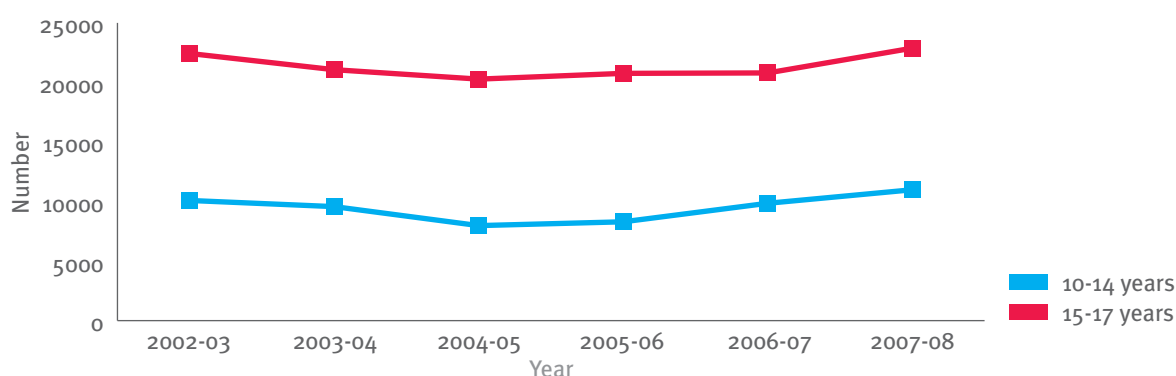


Trends in child offending 2002–03 to 2007–08

The number of alleged offenders aged 10–17 years increased from 32,518 in 2002–03 to 33,865 in 2007–08 (an increase of 4 per cent).

The largest percentage increase in offenders processed from 2002–03 to 2007–08 was for the 10–14-year age group which increased 9 per cent, compared to the 15–17-year-olds (an increase of 2 per cent) (figure 2.35).

Figure 2.35: Young alleged offenders processed by police, by age group, Victoria, 2002–03 to 2007–08



Source: Victoria Police Crime Statistics 2007–08

Types of crime

The majority of young alleged offenders (64.8 per cent) were processed by police for crimes against property followed by crimes against the person (19.7 per cent), other crimes (13.6 per cent) and drug offences (1.9 per cent) (table 2.15).

Table 2.15: Young alleged offenders processed by police, by type of crime, Victoria, 2007–08

	Number	Per cent
Crime against the person	6,656	19.7
Crime against property	21,943	64.8
Drugs	653	1.9
Other crimes	4,613	13.6
Total	33,865	100.0

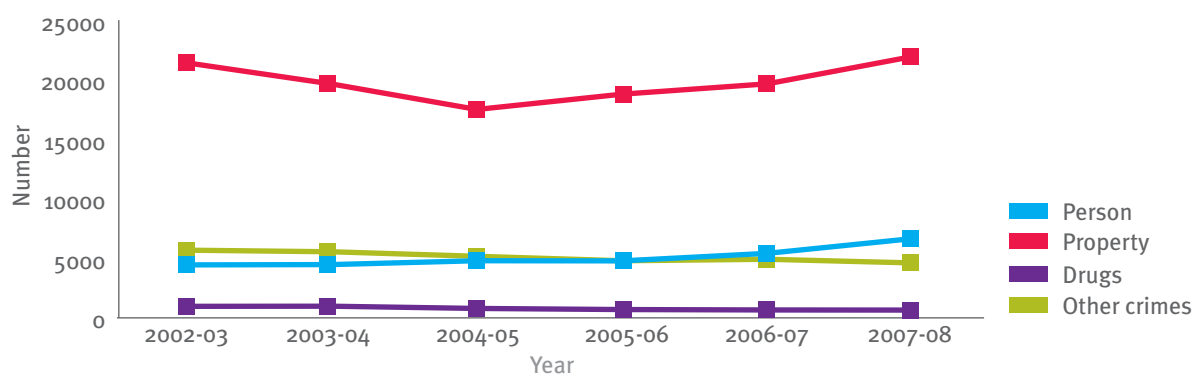
Source: Victoria Police Crime Statistics 2007–08

The proportion of alleged offenders processed for property crime was slightly higher in the 10–14-year age group (72.4 per cent) than in the 15–17-year age group (61.1 per cent). The percentage of alleged offenders processed for crimes against the person, drugs and other offences is higher for young people aged 15–17 years.

Figure 2.36 shows that there has been an overall increase from 2002–03 to 2007–08 in the number of young alleged offenders processed by police for crimes against the person. The number of young alleged offenders processed for property crimes decreased from 2002–03 to 2004–05, and then increased until 2007–08. There have been small decreases, over the same period, in the number of young alleged offenders processed for drug crimes and for other crimes.



Figure 2.36: Young alleged offenders processed by police, by offence type, Victoria, 2002–03 to 2007–08



Source: Victoria Police Crime Statistics 2007–08

Youth justice

The youth justice system in Victoria

The Victorian Youth Justice program is administered by the Department of Human Services. The program provides a statewide service through three metropolitan and five rural community-based regional youth justice units and three custodial centres.

In Victoria, young offenders aged 10–17 years are tried and sentenced by the Children’s Court under the *Children, Youth and Families Act 2005*. The Act sets out the sentencing hierarchy and judicial processes that result in entry to the youth justice program. The Act outlines matters that must be taken into account by a magistrate when passing sentence on a young offender and specifies that the developmental needs of young people must be considered in the court process.

The youth 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.

In addition, in the adult courts, Victoria has a unique ‘dual track’ system, which allows 18–20-year-olds to be sentenced to a youth justice custodial centre (YJC) rather than prison if they are assessed as immature and vulnerable. During 2006–07, almost half of all young people in custody in the youth justice system were aged 18 years or over and sentenced to a youth justice custodial order through the adult court.

The Youth Justice program has undergone significant changes over the past four years. The main legislative change has been the raising of the age jurisdiction in the Children’s Court, from July 2005, to include 17-year-olds, where previously it included up to 17-year olds. Other legislative or program changes have been the program name change from Juvenile Justice to Youth Justice, the enactment of enabling legislation for the Youth Justice Group Conferencing program, the development of the Children’s Koori Court and the implementation of the Victorian Offender Needs Indicator for Youth (VONIY), a tool to assess risk of reoffending of young people within the system.

Key policy directions for the Youth Justice program were outlined in the Government’s reform agenda ‘A balanced approach to Juvenile Justice in Victoria’ (2000). The three-pronged approach outlined in this document focuses on:

- Diverting young people from entering the youth justice system or progressing further into a life of crime
- Providing better rehabilitation of high-risk young offenders
- Expanding pre-release, transition and post-release support programs for young people in custody to reduce the risk of reoffending.



Key programs and practices that meet the policy directions in the Victorian youth justice system are summarised as follows.

1. Diverting young people from entering the youth justice system, or progressing further into a life of crime is supported by:

- The *Children, Youth and Families Act 2005* and the increased age jurisdiction of the Children's Court to include 17-year-olds
- Providing court advice to the children's and adult court systems and advocacy programs such as the Central After Hours Assessment and Bail Placement Service
- The intensive bail support program for Koori young people
- Introducing diversionary programs such as group conferencing.

2. Providing better rehabilitation of high-risk young offenders

The Victorian youth justice system carried out a review of the rehabilitation programs provided to clients in 2003. From this review, improved assessment and intervention practices to reduce offending have been introduced, including:

- A comprehensive client assessment and planning process, which includes the risk assessment tool VONIY
- Introducing a targeted model of intervention matching the level of intervention to the level of risk displayed by the offender
- Providing offender-focused and offence-specific programs such as CHART (Changing Habits And Reaching Targets)
- Reducing violence/anger management programs such as BravE (Being Real About Violence), RavE (Relationships and Violence).

3. Expanding pre-release, transition and post-release support programs for young people in custody to reduce the risk of reoffending through:

- Providing transitional support services to reintegrate young people into the community such as the Transitional Housing Management Youth Justice Housing Pathways Initiative, which assists young people at risk of homelessness on release from custody
- Consolidating the pre-release program where young people may be supported to return to external school or employment while still in custody during the latter part of their sentence
- Introducing the community transition program, which allows young people to test their ability to live in a house in the community while remaining under 24-hour supervision
- Providing a Koori intensive support practitioner (post-release)
- Introducing the Service Delivery Model to provide an integrated approach to post-release support, targeted at a regional and local level, to better meet the needs and deliver outcomes for Youth Justice clients.

Another policy goal of the youth justice system is to introduce programs and policies that address the overrepresentation of Indigenous young people within the system. This is being done through the partnership of the second phase of the Aboriginal Justice Agreement (AJA2) and the continued development of approaches that address systemic issues that draw young Indigenous people into the justice system.

An example of the initiatives under way is the development of the Children's Koori Court, which was created with the objective of ensuring greater participation of the Koori community in the diversion of young Koori people from the youth justice and criminal justice system. Other initiatives include the Koori Youth Justice Program, which provides assistance to young Indigenous offenders by providing dedicated Koori youth justice workers to develop Aboriginal cultural support plans for Indigenous clients, as well as providing assistance to other youth justice workers and practical support to clients and their families.



Young people under youth justice supervision

In 2006–07 there were 1541 young people aged 10–17 years under youth justice supervision in Victoria. Of these, 83.9 per cent (n = 1293) were male and 16.1 per cent (n = 248) were female. As table 2.16 shows, Victoria has the lowest rate of young people under youth justice supervision across Australia, with a rate of 2.8 per 1000 population.

Table 2.16: Rate (per 1000) of young people aged 10–17 years under youth justice supervision, by sex, states and territories, 2006–07

Sex	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus
Number of young people									
Male	2593	1293	1961	1495	762	289	167	239	8799
Female	451	248	477	391	163	73	50	17	1870
Total	3044	1541	2438	1892	925	362	217	256	10,675
Rate per 1000 young people									
Male	7.2	4.9	8.6	13.2	9.5	10.8	9.7	18.7	8.0
Female	1.2	0.9	2.0	3.2	1.9	2.6	2.8	1.2	1.6
Total	4.1	2.8	5.2	8.1	5.6	6.6	6.2	9.6	4.7

Note: Total includes young people of unknown sex.

Age was calculated as at date of entry to first period of supervision during 2006–07.

Source: AIHW 2008b

Young Indigenous people are overrepresented in the youth justice system across Australia.

Of the 1541 young people under youth justice supervision in Victoria, 182 were Indigenous (a rate of 26.2 per 1000 Indigenous population, compared with a rate of 2.1 per 1000 non-Indigenous population). This remains a serious concern, although this overrepresentation is less marked in Victoria than in Australia as a whole (see table 2.17).

Table 2.17: Rate (per 1000) of young people aged 10–17 years under youth justice supervision, by Indigenous status, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus
Number of young people									
Indigenous	1027	182	1162	1165	279	79	41	228	4163
Non-Indigenous	1792	1152	1275	709	596	251	176	27	5978
Unknown	225	207	1	18	50	32	0	1	534
Total	3044	1541	2438	1892	925	362	217	256	10,675
Rate per 1000 young people									
Indigenous	31.8	26.2	38.1	79.8	49.7	20.5	42.1	20.3	39.3
Non-Indigenous	2.6	2.1	2.9	3.2	3.8	4.9	5.2	1.8	2.8
Total	4.1	2.8	5.2	8.1	5.6	6.6	6.2	9.6	4.7

Note: Calculation of rates excludes unknown.

Age was calculated as at date of entry to first period of supervision during 2006–07.

Source: AIHW 2008b



Youth justice supervisory orders

The two main types of supervision orders within the youth justice system are community-based and custodial orders.

- Community-based orders are those where the conditions of the order mean that the young person continues to reside in the community during the order (i.e. probation, youth supervision order, youth attendance order). The level/intensity of supervision by youth justice staff depends on the level of order imposed by the court.
- Custodial orders are those orders where a young person is sentenced to a period of detention in a youth justice or youth residential centre.

Indicator: Number of young people convicted and placed on a community order

Youth justice community-based orders

Table 2.18 shows the total number of young people on community-based orders, including those identifying as Aboriginal or Torres Strait Islander as at 30 June 2006 to 2008.⁹² This number has increased from 601 in 2006 to 698 in 2008.

Indigenous young people account, on average, for around 13 per cent of young people on community-based orders.

Table 2.18: Total number of young people aged 10–17 years on community-based orders, by Indigenous status, Victoria, as at 30 June 2006, 30 June 2007 and 30 June 2008

As at 30 June	Total	Indigenous	Indigenous as percentage of total
2006	601 ⁹³	79	13.1
2007	638	76	11.9
2008	698	102	14.6

Source: Children, Youth & Families Division, Department of Human Services

In Victoria, the rate of young people under youth justice community supervision was 2.7 in 2006–07, compared with a rate of 3.9 in Australia as a whole (table 2.19). Victoria's rate of young people under youth justice community supervision is consistently lower than in the other states and territories (2002–03 to 2006–07).

Table 2.19: Rate (per 1000) of young people aged 10–17 years under youth justice community supervision, states and territories, 2002–03 to 2006–07

Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus
2002–03	3.5	2.8	5.5	6.5	6.6	5.7	n.a.	7.4	4.3
2003–04	3.4	2.7	5.2	6.2	5.8	5.9	7.5	9.6	4.3
2004–05	3.2	2.4	5.1	6.5	5.4	5.7	6.7	10.1	4.1
2005–06	3.3	2.5	5.0	7.0	4.9	6.4	5.6	9.5	4.2
2006–07	2.8	2.7	5.0	6.5	4.8	6.3	5.7	7.5	3.9

Source: AIHW 2007b and AIHW 2008b

⁹² This statistic can be quite volatile as it is based on the number of young people on community-based orders at one point in time.

⁹³ This number (601) is lower than that recorded for 2006 in the 2007 young people's report (916). This is because the 2007 report includes all young people aged between 10–21 years serving a community based order, whereas this report includes young people aged 10–17 years.



Indicator: Proportion of young people in youth justice facilities

Youth justice custodial orders

Table 2.20 shows the total number of young people on custodial orders as at 30 June 2006 to 30 June 2008. This number has increased from 42 in 2006 to 63 in 2008.

Indigenous young people account, on average, for around 18 per cent of young people on custodial orders.

Table 2.20: Total number of young people aged 10–17 years on custodial orders, by Indigenous status, Victoria, as at 30 June 2006, 30 June 2007 and 30 June 2008

As at 30 June	Total	Indigenous	Indigenous as percentage of total
2006	42 ⁹⁴	6	14.3
2007	47	12	25.5
2008	63	9	14.3

Source: Children, Youth & Families Division, Department of Human Services

In Victoria, the rate of young people under youth justice detention was 0.6 per 1000 young people in 2006–07, compared with a rate of 2.2 per 1000 young people in Australia as a whole (table 2.21). Victoria’s rate of young people in sentenced detention is consistently lower than in the other states and territories (2002–03 to 2006–07).

Table 2.21: Rate (per 1000) of young people aged 10–17 years under juvenile justice detention, states and territories, 2002–03 to 2006–07

Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus
2002–03	2.4	0.6	2.0	3.4	3.8	1.5	n.a.	4.7	2.1
2003–04	2.3	0.5	2.1	3.8	3.2	1.4	3.5	4.8	2.1
2004–05	2.4	0.4	1.4	3.7	3.0	1.6	3.2	4.7	1.9
2005–06	2.6	0.5	1.5	3.7	2.7	2.1	3.6	5.3	2.0
2006–07	2.9	0.6	1.6	3.9	2.7	2.0	3.8	4.9	2.2

Age was calculated as at date of entry to first period of supervision during the relevant financial year.

Tasmania has incomplete data resulting in higher reported numbers in detention.

Source: AIHW 2007b and AIHW 2008b

A combination of enabling legislation, early intervention and active diversion by the police, courts and the youth justice program are the main reasons for the low rate of detention and of community supervision in Victoria.

Indicator: Most common offences for young people in custodial detention

The most common offences for young people aged 10–17 years in custodial detention at 30 June 2008 in Victoria were robbery (25.6 per cent of offences), assault (24.4 per cent), unlawful entry with intent/burglary, break and enter (14.1 per cent) (Children, Youth & Families Division, Department of Human Services).

⁹⁴ This number (42) is lower than that recorded for 2006 in The state of Victoria’s young people 2007 (123). This is because the 2007 report includes all young people aged between 10–21 years serving a custodial order, whereas this report includes young people aged 10–17 years.



Indicator: Proportion of children and young people who have a parent involved in the criminal justice system

Very little work has been done in Victoria to assess and address the outcomes for children whose parents are involved in the criminal justice system. However, there is evidence to show that the prison population is both culturally and linguistically diverse and that Indigenous persons are significantly overrepresented. This is likely to have an impact on children from these backgrounds.

In 2003 Corrections Victoria undertook a snapshot analysis of female prisoner files and found that of all women imprisoned (as at 16 June 2003) 62.4 per cent were identified as having at least one child of dependent age at the time they entered prison. Of these women, 18.1 per cent were from CALD backgrounds and 3.6 per cent were Indigenous. In addition, the study findings suggest that sole parents/mothers may be overrepresented among the women's prison population with 50.7 per cent of the women with children identifying as single, never married, separated or divorced. The study also looked at the current living arrangements of the children of these women and found that 11 per cent of the children were in the care of the Department of Human Services (data provided by Corrections Victoria, 2007 and cited in the Victorian Child and Adolescent Monitoring System: Evidence Manual for Indicators, unpublished, February 2008).

Injuries and injury deaths

Injury and poisoning is the leading cause of death and a major cause of morbidity among children in Australia causing the deaths of approximately 300 children every year. Boys are more likely to be killed or seriously injured. Injury and poisoning is also the second most common reason for admission to hospital (AIHW 2005).

Indigenous children and children from low-SES backgrounds show a disproportionately high risk of injury leading to death or hospitalisation compared to other Australian children. Other high-risk groups include children of single parents, children whose mothers are young or poorly educated, children from a large family or where there is parental drug or alcohol use, and children living in poor housing (ABS 2006; AIHW 2005).

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. However, childhood deaths and morbidity as a result of injury are preventable and can be reduced through a range of strategies (AIHW 2005a, in DHS 2006).⁹⁵

Indicator: Age-specific hospitalisation rates from injuries and poisoning

In 2005–06, 9464 children and young people aged 0–18 years were admitted to Victorian hospitals due to injury and poisoning, an age adjusted admission rate of 761 per 100,000 persons. These figures exclude 9335 same-day injury hospitalisations.⁹⁶ Males accounted for 63 per cent (n = 5915) of these hospital admissions.

The four leading causes of injury and poisoning admissions were falls (n = 3801, 40 per cent), transport (n = 1781, 19 per cent), hit/struck/crush incidents (n = 956, 10 per cent) and self-harm (n = 465, 5 per cent) (for detailed self-harm data see Section 2.2).

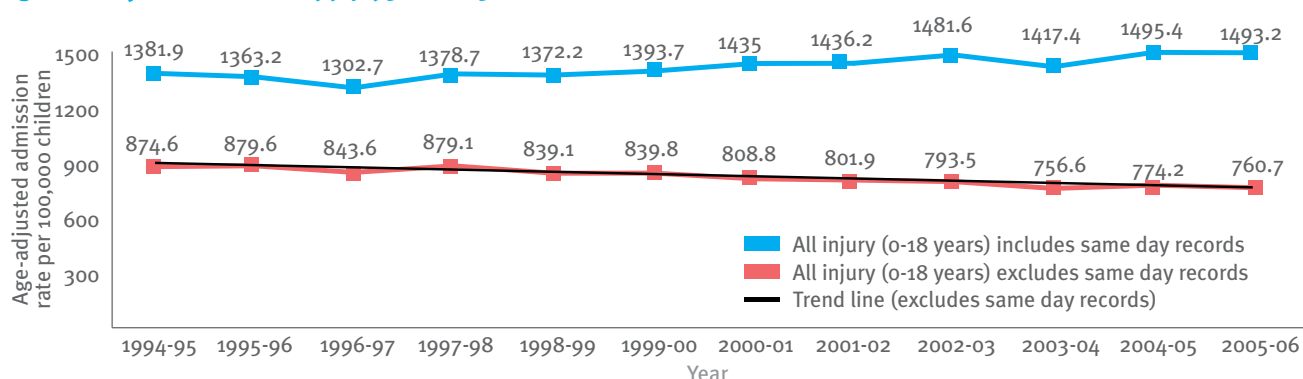
⁹⁵ These strategies include the use of child resistant closures to prevent poisoning, compulsory use of seatbelts in private vehicles, and pool fencing to prevent drowning.

⁹⁶ A young person is recorded as an admission (in hospital records) if the duration of their treatment lasts more than four hours. Where the young person is discharged from hospital in less than 24 hours, they are counted as a 'same-day admission'.



The all injury and poisoning age-adjusted admission rate for children aged 0–18 years (excluding same-day admissions) decreased significantly over the 12-year period from 875 per 100,000 children in 1994–95 to 761 per 100,000 children in 2005–06 (figure 2.37).⁹⁷

Figure 2.37: Yearly trend in the rate (per 100,000) of all child injury and poisoning hospital admissions, children aged 0–18 years, Victoria, 1994–95 to 2005–06



Selection criteria: (1) An ICD9 primary injury or poisoning diagnosis code in the range 800–904, 910–999 or an ICD10 primary injury or poisoning diagnosis code in the range S00–T89. (2) Deaths and transfers within and between hospitals were excluded. (3) Admissions resulting from medical causes (an ICD9 cause code in the range 870–879 or an ICD10 cause code in the range Y40–Y84) and same day records were excluded from final analysis but same day records are shown on figures.

Source: Victorian Admitted Episodes Dataset (VAED) July 1994 to June 2006, data supplied by Monash University Accident Research Centre

Indicator: Rate of unintentional injury-related long bone fractures in young people

The rate of unintentional injury related to long bone fracture is an indicator for serious injury.

In 2005–06, 5257 children aged 0–18 years were admitted to Victorian hospitals with unintentional injury-related long bone fracture, an age-adjusted admission rate of 426.9 per 100,000 persons. Males accounted for 65 per cent (n = 3406) of these admissions.

The leading cause of injury-related long bone fracture was falls, accounting for 74 per cent of all these hospital admissions (n = 3878), followed by transport (19 per cent, n = 984) and hit/struck/crush incidents (6 per cent, n = 287).

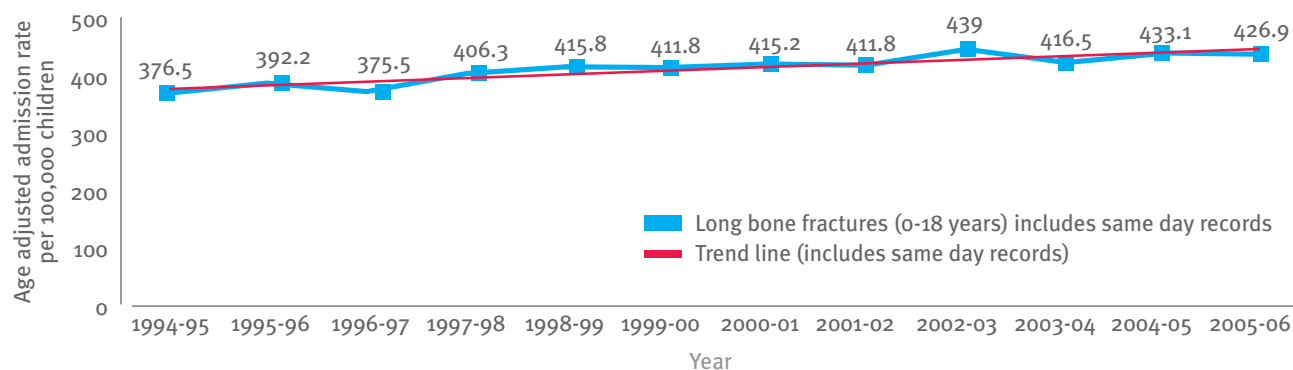
The unintentional long bone fracture age-adjusted admission rate for children aged 0–18 years (including same-day admissions) increased significantly over the 12-year period from 377 per 100,000 children in 1994–95 to 427 per 100,000 children in 2005–06 (figure 2.38).⁹⁸

⁹⁷ This represents an estimated annual decrease of –1.4 per cent (95% confidence intervals –1.8% to –1.1%) and an overall reduction of 16 per cent (–19% to –12%) based on the trend line.

⁹⁸ This represents an estimated annual increase of 1.5 per cent (95% confidence intervals 1% to 2%) and an overall increase of 20 per cent (13% to 27%) based on the trend line.



Figure 2.38: Yearly trend in the unintentional injury-related long bone fracture hospital admission rate (per 100,000), children aged 0–18 years, Victoria, 1994–95 to 2005–06



Selection criteria: (1) An ICD9 injury diagnosis code in the range 812, 812.99, 813, 813.93, 820, 821.39, 823, 823.99 or an ICD10 injury diagnosis code in the range S42, S4249, S52, S5289, S72, S7299, S821, S8249 if the cause of injury was unintentional and the person was aged between 0 and 18 years. These codes include fractures of the radius, ulna, humerus, femur, tibia and fibula (2) Deaths and transfers within and between hospitals were excluded.

Source: Victorian Admitted Episodes Dataset (VAED) July 1994 to June 2006, data supplied by Monash University Accident Research Centre

Falls are a major cause of morbidity in Australia in children between 0–14 years of age and the National Injury Intervention Plan identifies falls as an area of high priority for injury prevention in children (National Public Health Partnership 2005).

Indicator: Age-specific death rates from injuries and poisoning

In 2004–05, 74 children and young people aged 0–18 years died in Victoria due to injury and poisoning, an age-adjusted death rate of 6.0 per 100,000 persons. Males accounted for 54 per cent (n = 40) of these deaths.

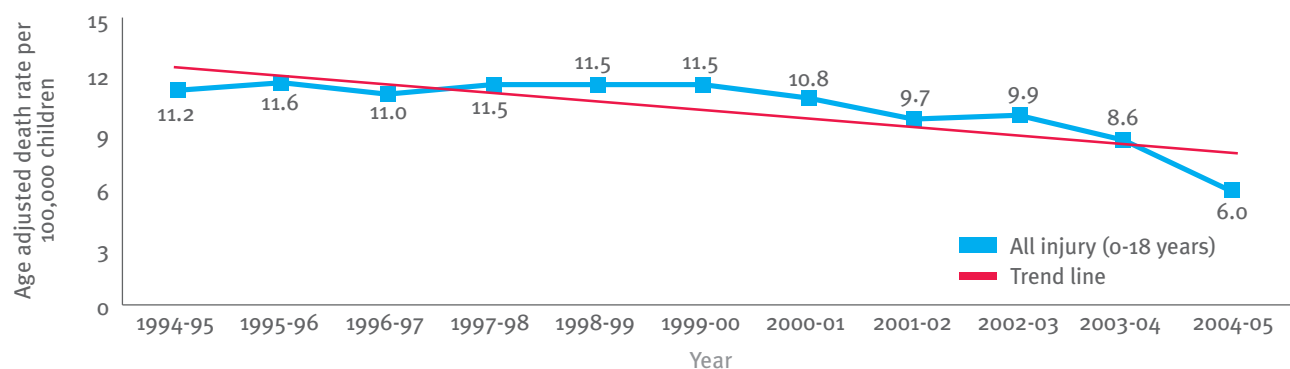
The three leading causes of injury and poisoning deaths were transport (n = 34, 46 per cent), intentional self-harm (n = 18, 24 per cent) and drowning (n = 9, 12 per cent).

The all injury and poisoning age-adjusted death rate in children aged 0–18 years has decreased significantly over the eleven-year period from 11.2 per 100,000 children in 1994–95 to 6.0 per 100,000 children in 2004–05 (figure 2.39).⁹⁹

⁹⁹ This represents an estimated annual decrease of 4 per cent (95% confidence intervals –6.6% to –1.4%) and an overall reduction of 36 per cent (–53% to –15%) based on the trend line.



Figure 2.39: Yearly trend in the rate (per 100,000) of child injury and poisoning deaths, Victoria, 1994–95 to 2004–05



Selection criteria: (1) An ICD9 cause of death code in the range 800–928, 930–958, 960–968, 970–978, 990–998 or an ICD10 cause of death code in the range V00–Y84. (2) Deaths resulting from medical causes (adverse events and medical misadventure) were then excluded for final analysis (an ICD9 external cause code in the range 870–879 or an ICD10 code in the range Y40–Y84).

Source: Australian Bureau of Statistics Death Unit Record File (ABS-DURF) July 1994 to June 2005, data supplied by Monash University Accident Research Centre

Child abuse

Child abuse and neglect are major issues of public concern in Australia. The definition of child abuse and neglect has expanded in the last decade (Cashmore 2001) with the focus of investigation on a broader definition of whether the child has suffered harm.

Child abuse and neglect are generally classified into one of the following four categories: physical abuse, sexual abuse, emotional abuse and neglect. Children are often subject to more than one type of abuse, and there are close links also between child abuse and family violence.

Abuse and neglect have both current and long-term adverse consequences for children (Shonkoff & Phillips 2000), although some factors may help to minimise the effects of abuse.¹⁰⁰ Children who are subject to maltreatment may experience fear and bodily harm, poor school performance, learning disorders, poor peer relations, anti-social behaviour and mental health disorders (Paolucci et al. 2001). In severe cases abuse can lead to injury or serious harm and subsequent hospitalisation.

There is no reliable measure of the overall prevalence of child abuse. The data presented below relate only to situations where children have come to the attention of the child protection authorities. As some children who are experiencing abuse will not come to the attention of these authorities, the statistics represent only a proportion of all abuse and neglect cases that occur (AIHW 2005).

¹⁰⁰ For example, if the child received emotional support from another important adult the effects of abuse have been found to be less harmful (Shonkoff & Phillips, 2000).



Legislative reform and the Victorian child protection system

The Victorian Government has introduced a comprehensive program of reform to child, youth and family services, including the development and implementation of new legislation.

The *Child Wellbeing and Safety Act 2005* guides the operation of new administrative structures, including the establishment of a Child Safety Commissioner, the Victorian Children's Council and the Children's Services Coordination Board to oversee administration of children's services across government.

The *Children, Youth and Families Act 2005* commenced in April 2007. The Act introduced new service pathways and processes in Victorian Child Protection and Family Services to support earlier intervention and prevention for vulnerable children and their families (AIHW 2008).

The new legislation more explicitly places children and young people's best interests at the heart of all decision making and service delivery from earlier intervention through to the Children's Court. The legislation aims to improve children's stability, strengthening service responses to cumulative harm and better maintaining Indigenous children and young people's connection to their community and culture.

Reports and substantiations

Indicator: Rate of substantiated child abuse

In Victoria, key professionals who have contact with children and young people are mandated to report suspected cases of child sexual and physical abuse to Child Protection. In addition, anyone who has concerns that a child or young person is being neglected or physically, emotionally or sexually abused can report their concerns to Child Protection.

Reports made to Child Protection Victoria are assessed and either referred to appropriate support services or if appropriate, sent for child protection investigation or closed. A report is 'substantiated' where it is concluded that the child or young person is in need of protection.

In Victoria, in 2006–07 there were 6588 substantiations for children aged 0–16 years (representing a rate of 5.9 per 1000 children). 697 of these were for Indigenous children (representing a rate of 56.6 per 1000 Indigenous children) (AIHW 2008a).

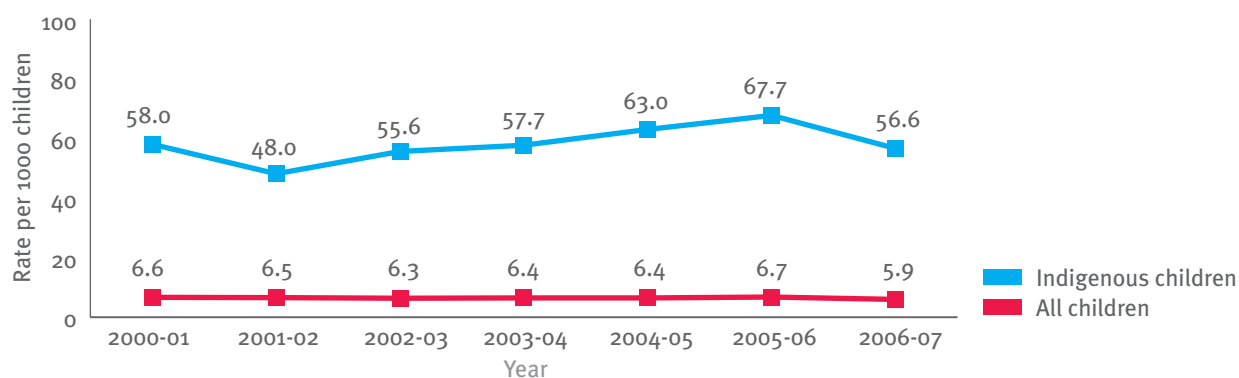
Indigenous children in Victoria were 9.6 times more likely to be the subject of a substantiation than all children. Across Australia, Indigenous children were 4.5 times more likely to be the subject of a substantiation (AIHW 2008a).¹⁰¹

Figure 2.40 suggests that there may be a small declining overall trend in the rate of substantiations for all children in Victoria (2000–01 to 2006–07). While the substantiation rate among Indigenous children declined markedly between 2005–06 and 2006–07, rates are still much higher in Indigenous children than in all children.

¹⁰¹ In 2006–07, the rate (per 1000 children) of substantiations in Australia was 7.0 for all children and 31.8 for Indigenous children.



Figure 2.40: Rate (per 1,000) of children aged 0–16 years who were the subject of substantiations, Indigenous and other children, Victoria, 2000–01 to 2006–07



Source: AIHW 2002, 2003, 2004, 2005, 2006, 2007a and 2008a

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 American national surveys underline the importance of this gap in Australian data. Crosse, Kaye & Ratnofsky 1995, in DEECD 2008 found that children with a disability were 1.7 times more likely to be maltreated and Sullivan & Knutson 2000a and 2000b, in DEECD 2008 reported that these children were 3.4 times more likely to be maltreated than other children.



2.4 Development and learning

Summary

- The majority (69.4 per cent) of Victorian children in the first year of school were assessed as performing well on one or more of the five developmental domains of the Australian Early Development Index, and 24.4 per cent were 'developmentally vulnerable' on one or more domains. These proportions are similar to national proportions.
- The assessed reading ability of Prep students has improved from 1999 to 2007; and has stabilised in students in Years 1 and 2 at high levels.
- Results from the 2008 National Assessment Program Literacy and Numeracy (NAPLAN) tests show that Victorian students are achieving very well. Students in Victoria are among the highest achievers, together with students in New South Wales and the Australian Capital Territory, and a greater percentage of Victorian students achieve at or above the national minimum standard than in Australia as a whole, in all subject areas and year groups.
- AIM test results show that girls generally achieve more highly than boys and Indigenous children achieve less well, although there have been marginal improvements for Indigenous students since 2001. The results of LBOTE students are broadly comparable with students as a whole and show an improving trend.
- Attendance rates are generally higher in the primary than secondary years. Rates have remained broadly stable in Prep to Year 9 but have shown small increases in Years 10, 11 and 12.
- Apparent retention rates are higher in Victoria than in Australia as a whole.
- Comparative analysis of Victorian data shows that absenteeism is higher in out-of-home care students than in the general student population and levels of attainment are lower.
- The proportion of 19-year-olds who have completed Year 12 or its equivalent in Victoria has increased from 73.6 per cent in 1999 to 77.6 per cent in 2007.
- In 2007, 86.1 per cent of 20–24-year-olds had completed Year 12 or an equivalent, compared with an Australian rate of 83.5 per cent.
- As at May 2007, 96.5 per cent of young people aged 15–17 years, in Victoria, were in education or work, compared with 92.7 per cent in Australia as a whole.
- On Track survey data suggest that there has been an overall increase in the percentage of early school leavers who are taking up employment (2002 to 2007).

Children and young people develop and learn through a range of different experiences and in a range of contexts. In this section we focus on outcomes that are principally concerned with children's development at school entry and their cognitive development in school-based learning.

These outcomes include social and emotional development at school entry, achievement in literacy and numeracy, school engagement and attendance, and Year 12 completion. We also provide some information about the training and employment pathways that are taken by young people after they leave school.



Social and emotional development at school entry

Indicator: Proportion of children who are developmentally vulnerable

Research evidence shows that what happens to children in their early years has consequences right through the course of their lives. The quality of a child's earliest environments and the availability of appropriate experiences at the right stages of development are crucial in shaping their developmental outcomes.

The Australian Early Development Index (AEDI) assists communities in understanding early childhood development at the time children start school. This information enables communities and governments to pinpoint the types of services, resources and supports young children and their families need to give children the best possible start in life.

The AEDI is a population measure of young children's development based on a teacher-completed checklist. It consists of over 100 questions measuring the following five developmental domains:

- Physical health and wellbeing
- Social competence
- Emotional maturity
- Language and cognitive skills
- Communication skills and general knowledge.

Between 2004 and 2007, 60 geographic areas across all Australian states and territories (with the exception of the Northern Territory) have been involved in the AEDI. Within these AEDI communities, 2157 teachers from 1012 schools (both government and non-government) completed the AEDI checklist on 37,420 children in the first year of full-time school.

To date, 16 Victorian communities have completed the AEDI on 14,549 children. Overall, 69.4 per cent of children were 'performing well' on one or more domains. There were 24.4 per cent 'developmentally vulnerable' on one or more domains and 12.4 per cent were 'developmentally vulnerable' on two or more domains. (Nationally, 66.6 per cent of children were 'performing well' on one or more of the domains, 25 per cent of children were considered 'developmentally vulnerable' on one or more domains, and 12.6 per cent were considered to be 'developmentally vulnerable' on two or more domains).

The AEDI is conducted by the Centre for Community Child Health¹⁰² at The Royal Children's Hospital Melbourne, in partnership with the Telethon Institute for Child Health Research, Perth.

In recognition of the need for all communities to have data on early childhood development, and the national and international work completed to date, the Federal Government has provided \$15.9 million for the national implementation of the AEDI commencing in 2009. The Council of Australian Governments (COAG) has also endorsed the AEDI as the national progress measure of early childhood development in Australia.

The national implementation of the AEDI is funded by the Australian Government Department of Education, Employment and Workplace Relations. This will provide an opportunity for every community across Australia to obtain a comprehensive picture of the early childhood development outcomes of children in their community.

¹⁰² The Centre for Community Child Health is a department of the Royal Children's Hospital, Melbourne, and a key research centre of the Murdoch Children's Research Institute.



Indicator: Proportion of children entering school with basic skills for life learning

The transition to school represents a major shift for young children involving a move from small-scale to large-scale interactions, from highly personalised to less personalised relationships and from environments with a limited range of ages to an institution with children of many ages (Royal Children's Hospital, Centre for Community Child Health Policy Brief 2008).

Research shows that children are more successful at school when they have developed the emotional capacity to manage their feelings and behaviour and when they have a base of academic and social skills (Klein 2006, in AIHW 2008). It is important, therefore, that children are 'ready' for the transition to school. Readiness is not just a feature of the child and his or her maturation, but is a feature of the child's wider environment and family, service and community factors.

Key factors contributing to a child's readiness for school

Ready families, ready services, ready communities and ready schools all make a contribution to children's school readiness.

Ready families: refers to children's family context and home environment. Families differ in their resources and in their parenting skills and attitudes. Support is needed to promote family wellbeing and to assist families in providing responsive care and appropriate learning experiences for their children.

Ready services: refers to the availability, quality and affordability of programs and services that support child development. These services include education and care in preschools, kindergartens and child care settings.

Ready communities: refers to informal and formal resources and supports that are available to families with young children. Informal resources include opportunities for families with young children to develop social networks, and formal resources include health services and libraries.

Ready schools: refers to key elements of schools that influence child development and success. These elements include links that are established with early years services, transition support programs at the start of school, programs and supports to cater for children with diverse needs and teachers with an understanding of child development.

Source: Royal Children's Hospital, Centre for Community Child Health Policy Brief, 2008

The Victorian Child and Adolescent Monitoring System is using an assessment of speech and language difficulties as a proxy measure for children entering schools with basic skills for life and learning until a more appropriate measure for this indicator is identified. Parents were asked, in the SEHQ, to respond to whether their children had any difficulties with speech or language. The majority of parents (85.6 per cent) did not report any speech or language concerns. Eight per cent of parents reported one speech concern and 3.3 per cent of parents reported two concerns (Griffin et al. 2006).

School Start Bonus

Preparing for primary school, or making the transition to Year 7, is an important time for a child and can involve a big expense for families. The Victorian Government is helping to ease the strain for families by providing a one-off School Start Bonus of \$300 for each student entering Prep or Year 7 in 2009.

The School Start Bonus will help meet the costs of purchasing school and sporting uniforms, school bags and other school items so that children get the best possible start to school.



The Blueprint for Education and Early Childhood Development

The Blueprint for Education and Early Childhood Development articulates a new vision for Victorian education and early childhood development over the next five years.

It encompasses both education and early childhood services and government and non-government schools and is based on the outcomes we want for all children and young people from birth to adulthood. The blueprint provides a basis for strengthened collaboration between families, schools, early childhood services and the broader community, a shared understanding of our goals and basis for intervention where they are not being achieved.

Achievement in literacy and numeracy

Indicator: Percentage of students achieving national benchmark in literacy

Indicator: Percentage of students achieving national benchmark in numeracy

Indicator: Student attainment at the designated text level at the end of the designated year level in reading

The ability to read, write and perform mathematics is essential in day-to-day life and for educational opportunities and employment prospects (Lemos 2002; Bird & Akerman 2005; Doig 2001). In addition, early school experiences can have a lasting impact on a person's attitude to education and training and confidence in their learning abilities (Frigo et al. 2003).

Reading ability of Prep to Year 2 students

Table 2.22 shows the proportion of children assessed by their class teachers to be reading at 90 to 100 per cent accuracy at Level 5 (in Prep) and at Levels 15 (in Year 1) and 20 (in Year 2). The table shows that the assessed reading ability of Prep students has improved from 1999 to 2007 (+14.2 percentage points). The assessed reading ability of students in Years 1 and 2 has stabilised at high levels in 2004 to 2007.

Table 2.22: Government schools' assessment of reading : Percentage¹⁰³ of Prep to Year 2 students reading text with 90–100 per cent accuracy, 1999 to 2007

	Level	1999 (%)	2000 (%)	2001 (%)	2002 (%)	2003 (%)	2004 (%)	2005 (%)	2006 (%)	2007 (%)	% change 1999 to 2007
Prep	5	66.2	70.6	74.1	75.9	77.9	79.0	79.7	80.3	80.4	+ 14.2% points
Year 1	15	76.4	79.9	83.1	84.5	85.7	87.0	86.3	86.9	86.7	+ 10.3% points
Year 2	20	90.3	92.9	93.5	94.6	94.5	94.8	94.8	94.9	94.8	+ 4.5% points

Source: School Performance Data, Data, Outcomes and Evaluation Division, Office for Planning Strategy & Coordination, DEECD

¹⁰³ The percentage is calculated based on all students. This includes students who are not deemed to be capable.



Literacy Improvement Teams

Literacy programs have been significantly boosted to provide a building block for successful learning. Literacy Improvement Teams will provide expert advice and assistance on classroom programs to improve literacy in those schools where the reading and writing skills of students in Years 3 to 8 are falling behind.

The program will include one-on-one mentoring for teachers in the classroom on more effective ways to teach literacy to students.

Literacy Improvement Teams will also:

- Develop tools, including intervention support materials, to target literacy in all Victorian classrooms
- Target specific professional learning programs attended by literacy teaching team leaders in government schools and Koori educators working with teachers and Koori students.

A panel of prominent literacy specialists has also been engaged under this initiative to provide expert advice on programs to further assist literacy outcomes at all schools.

Achievement in literacy and numeracy: Year 3, 5, 7 and 9 students

In 2008, all students in Australia in Years 3, 5, 7 and 9 were tested for the first time using a common assessment test under the National Assessment Program – Literacy and Numeracy (NAPLAN). Prior to the introduction of this national testing, states and territories conducted their own literacy and numeracy tests and national assessments were collated from the range of different tests. In Victoria information on student outcomes was collected through the AIM tests.

The new NAPLAN tests will be administered annually and the results will provide an important measure of how Australian students are performing in numeracy, reading, writing, spelling, grammar and punctuation.

Results of the NAPLAN tests are presented below for students in each year group by state and territory. The information on the achievement of girls and boys and of Indigenous and LBOTE students that follows is derived from AIM tests, as NAPLAN data for these groups is not currently available.

In 2005 the government update to Growing Victoria Together set the following target:

‘The proportion of Victorian primary students achieving the national benchmark levels for reading, writing and numeracy will be at or above the national average’.

Tables 2.23 to 2.27 show the percentage of students who are achieving at or above the national minimum standard for reading (table 2.23), writing (table 2.24), spelling (table 2.25), grammar and punctuation (table 2.26) and numeracy (table 2.27).

The results show that Victorian students are achieving very well in comparison to other states and territories. Students in Victoria, together with those in New South Wales and the Australian Capital Territory, are the highest achievers and a greater percentage of Victorian students achieve at or above the national minimum standard than in Australia as a whole, in all subject areas and year groups.¹⁰⁴

¹⁰⁴ The achievement percentages are subject to 95% confidence intervals, for example, 80 per cent \pm 2.7% means that there is a 95% chance that the true percentage lies between 77.3% and 82.7%.



Table 2.23: Percentage of Year 3, 5, 7 and 9 students achieving at or above the national minimum standard in reading, states and territories, 2008

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Year 3	95.1±0.3	95.2±0.2	87.0±0.7	89.5±0.9	91.5±1.0	92.8±1.0	94.4±1.5	63.1±6.6	92.1±0.3
Year 5	93.5±0.4	93.7±0.3	86.7±0.8	89.2±0.9	89.9±1.1	89.7±1.4	94.8±1.2	62.6±6.6	90.9±0.3
Year 7	95.4±0.4	95.8±0.3	92.7±0.6	92.8±0.7	93.4±0.8	93.9±1.5	96.3±1.4	67.8±9.4	94.2±0.3
Year 9	94.4±0.5	94.7±0.4	90.4±0.9	92.2±1.1	91.7±1.8	93.0±1.7	96.6±1.3	70.8±8.3	92.9±0.3

Source: MCEETYA 2008

Table 2.24: Percentage of Year 3, 5, 7 and 9 students achieving at or above the national minimum standard in writing, states and territories, 2008

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Year 3	97.5±0.2	96.2±0.2	92.5±0.6	94.9±0.6	95.0±0.8	97.1±0.5	96.3±1.2	73.6±6.3	95.4±0.2
Year 5	95.1±0.3	93.9±0.3	89.5±0.6	91.0±0.8	91.7±0.9	92.6±1.1	94.9±1.3	65.5±6.5	92.5±0.2
Year 7	93.5±0.5	93.4±0.5	89.9±0.6	90.2±0.9	92.4±0.8	90.0±2.0	93.4±2.1	64.1±9.4	91.8±0.3
Year 9	88.9±0.7	90.1±0.7	83.6±1.2	85.6±1.6	87.2±2.0	84.1±2.8	88.9±3.2	63.5±8.0	87.2±0.5

Source: MCEETYA 2008

Table 2.25: Percentage of Year 3, 5, 7 and 9 students achieving at or above the national minimum standard in spelling, states and territories, 2008

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Year 3	96.1±0.2	95.4±0.2	87.1±0.7	89.4±0.8	91.1±1.0	92.4±1.0	93.7±1.5	61.1±6.6	92.4±0.3
Year 5	94.5±0.3	94.1±0.3	88.0±0.6	89.6±0.8	90.1±1.0	89.9±1.4	92.8±1.3	62.3±6.3	91.7±0.2
Year 7	94.2±0.4	94.2±0.4	90.1±0.6	90.7±0.8	92.4±0.8	91.3±1.5	94.8±1.6	64.2±8.8	92.4±0.3
Year 9	92.2±0.5	90.9±0.6	87.3±0.9	87.8±1.3	88.2±1.8	87.2±1.9	94.1±1.4	65.3±8.1	89.7±0.4

Source: MCEETYA 2008

Table 2.26: Percentage of Year 3, 5, 7 and 9 students achieving at or above the national minimum standard in grammar and punctuation, states and territories, 2008

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Year 3	95.2±0.3	95.3±0.2	86.3±0.8	87.8±0.9	90.8±1.0	91.7±1.0	93.6±1.4	59.8±6.9	91.7±0.3
Year 5	93.9±0.4	94.7±0.2	88.6±0.7	89.3±0.9	91.1±1.0	91.4±1.2	95.5±1.1	61.1±6.7	91.9±0.3
Year 7	93.4±0.5	93.6±0.5	90.0±0.7	88.3±1.0	91.2±1.0	91.3±1.9	94.0±1.8	60.7±9.6	91.6±0.3
Year 9	91.4±0.6	91.8±0.6	88.1±1.1	87.7±1.5	88.8±2.0	87.7±2.4	94.6±1.7	64.6±8.6	89.9±0.4

Source: MCEETYA 2008

Table 2.27: Percentage of Year 3, 5, 7 and 9 students achieving at or above the national minimum standard in numeracy, states and territories, 2008

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Year 3	96.9±0.2	96.5±0.2	91.9±0.6	94.7±0.6	93.8±0.9	96.7±0.6	96.4±1.2	77.3±5.6	95.0±0.2
Year 5	94.4±0.3	94.6±0.3	90.2±0.7	91.2±0.8	90.5±1.0	92.1±1.2	94.9±1.2	69.3±5.8	92.6±0.2
Year 7	96.0±0.4	96.5±0.3	94.6±0.5	94.8±0.6	94.5±0.8	95.2±1.3	97.1±1.2	76.8±7.1	95.4±0.2
Year 9	94.7±0.4	95.2±0.4	92.1±0.8	92.7±1.0	92.0±1.8	92.3±1.8	96.6±1.2	75.0±7.4	93.6±0.3

Source: MCEETYA 2008



Tables 2.28 to 2.30 are based on 2007 Achievement Improvement Monitor (AIM) test data and show the percentages of children in Victoria achieving the national benchmarks by gender, Indigenous status and LBOTE. The results for children in Year 3 are shown in table 2.28, for children in Year 5 in table 2.29 and for children in Year 7 in table 2.30.

These tables show a clear pattern, which is largely consistent across all subjects and the three age stages. In summary, girls generally achieve more highly than boys in reading and writing, and Indigenous children generally achieve less well than students as a whole. The results of LBOTE students are slightly lower, but broadly comparable with those of students as a whole.

Table 2.28: Percentage of Year 3 students achieving the national benchmarks, by sex, Indigenous status and LBOTE, Victoria, 2007

	All students	Male students	Female students	Indigenous students	LBOTE students
Reading	93.6 ± 1.8	92.0 ± 2.1	95.3 ± 1.4	86.1 ± 4.7	92.0 ± 2.0
Writing	94.1 ± 1.2	91.6 ± 1.6	96.6 ± 0.8	86.1 ± 4.2	93.7 ± 1.0
Numeracy	95.0 ± 1.1	94.5 ± 1.0	95.6 ± 1.2	88.5 ± 4.1	93.1 ± 1.3

Source: National Report on Schooling in Australia, 2007 Preliminary Paper

Table 2.29: Percentage of Year 5 students achieving the national benchmarks, by sex, Indigenous status and LBOTE, Victoria, 2007

	All students	Male students	Female students	Indigenous students	LBOTE students
Reading	91.4 ± 1.4	89.6 ± 1.5	93.2 ± 1.2	79.9 ± 5.1	89.5 ± 1.5
Writing	96.0 ± 0.3	94.4 ± 0.4	97.8 ± 0.2	89.6 ± 2.8	95.7 ± 0.3
Numeracy	91.5 ± 1.3	91.6 ± 1.2	91.4 ± 1.4	75.4 ± 4.6	89.9 ± 1.3

Source: National Report on Schooling in Australia, 2007 Preliminary Paper

Table 2.30: Percentage of Year 7 students achieving the national benchmarks, by sex, Indigenous status and LBOTE, Victoria, 2007

	All students	Male students	Female students	Indigenous students	LBOTE students
Reading	93.0 ± 0.7	91.6 ± 0.8	94.5 ± 0.7	79.9 ± 4.3	90.7 ± 1.0
Writing	94.8 ± 0.5	92.1 ± 0.8	97.7 ± 0.3	82.8 ± 3.3	94.9 ± 0.6
Numeracy	89.0 ± 0.9	89.2 ± 0.9	88.8 ± 1.0	67.6 ± 4.4	87.3 ± 1.1

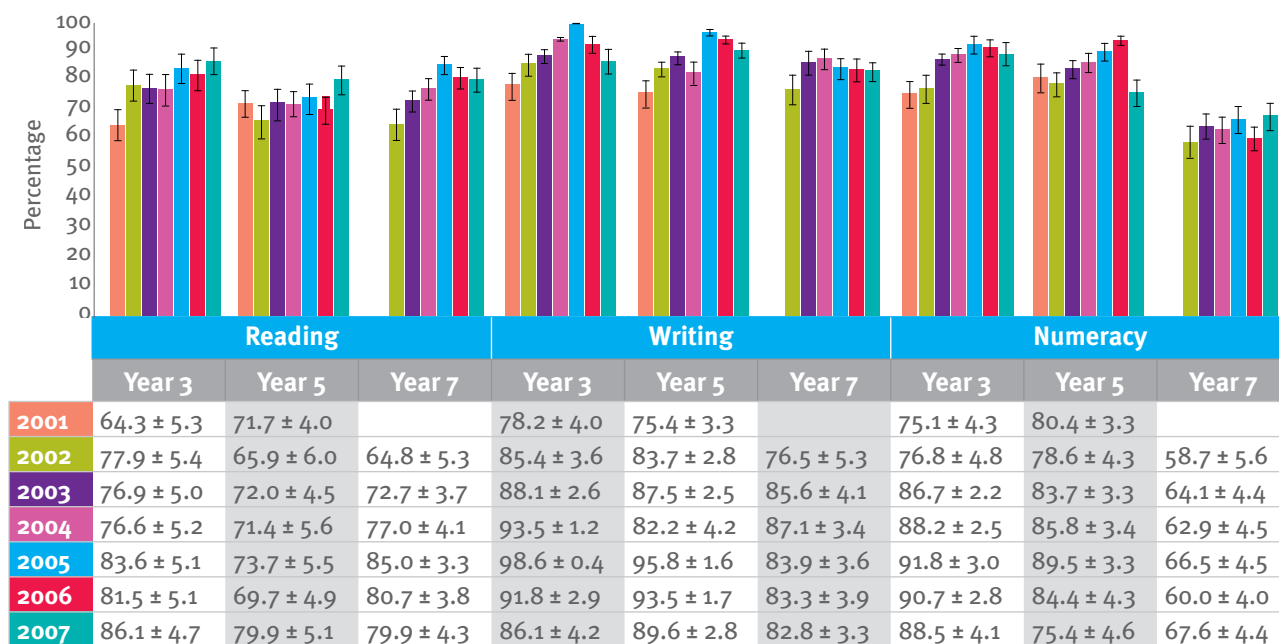
Source: National Report on Schooling in Australia, 2007 Preliminary Paper

Indigenous students

While the results of Indigenous students remain lower than those of non-Indigenous students, their performance has marginally improved since 2001 (figure 2.41).



Figure 2.41: Percentage of Year 3, Year 5 and Year 7 Indigenous students achieving the national benchmarks for reading, writing and numeracy, Victoria, 2001 to 2007



Source: MCEETYA National Report on Schooling in Australia, 2001, 2002, 2003, 2004, 2005, 2006 and 2007

School attendance and achievement in young people with a disability

Data from the 2003 ABS Survey of Disability, Ageing and Carers indicates that 89 per cent of students aged 5–14 years with a disability were attending an ordinary school in either an ordinary school class (62 per cent) or a special class (27 per cent). A further 9 per cent were attending a special school. Around 63 per cent of students with disabilities experienced difficulty at school. Intellectual/learning difficulties, fitting in socially and communication difficulties were the most common difficulties experienced (AIHW 2006).

The ABS 2003 Students with Disabilities Advisory Committee (SDAC) found that an estimated 14,000 (12 per cent) of young people in Australia with a disability reported needing at least one day a week off school or not being able to attend school because of their disability (AIHW 2007). However, 2002 Australian Social Trends suggests that the school participation rates of young people with a disability are not much lower during the compulsory years of schooling (92.6 per cent for children with a disability and 97.9 per cent for those without), although participation decreases in the post-compulsory years of schooling (60.8 per cent compared with 72.5 per cent) (cited in Pitman et al. 2003, and reported in DEECD 2008).

In general, young people with disabilities perform less well in literacy and numeracy in comparison to young people without disabilities. However, a 2002 research study cited examples where young people with a disability were achieving at the same level as, and occasionally better than, their peers. This study suggests that other factors (in addition to disability) may influence achievement, including attendance, early application of assistive devices, communication skills and health and medical problems (research cited in Pitman et al. 2003, and reported in DEECD 2008).



Attendance and retention

Regular attendance at school is crucial for the development of children’s education and social skills. Students who do not attend school are generally at a disadvantage as they reduce their likelihood of academic progress and success and miss out on interactions with their peers. This can compound issues of low self-esteem, social isolation and dissatisfaction (Bond 2004).

Prolonged non-attendance can also have serious effects for children in later life. A recent Auditor-General’s report stated that ‘students who are absent from school are at the greatest risk of dropping out of school early, becoming long-term unemployed, being caught in the poverty trap, depending on welfare and being involved in the justice system’ (Auditor-General Victoria 2004).

Indicator: Average rates of student attendance in primary and secondary school

Table 2.31 shows attendance rates for students in Prep to Year 12, in Victorian government schools, from 2002 to 2007. Attendance rates are higher in general in the primary (Prep to Year 6) years than in the secondary years (Years 7 to 12). However, while rates have remained broadly stable in Prep to Year 9, there has been a small increase from 2002 to 2007 in rates in Years 10, 11 and 12.

Table 2.31: Average student attendance rates (percentages)¹⁰⁵ by year level for primary, primary - secondary and secondary government schools, Victoria, 2002 to 2007

	Prep	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 11	Yr 12
2002	93.2	93.4	93.7	93.9	93.8	93.6	93.4	92.5	90.7	89.6	87.9	90.1	91.4
2003	93.3	93.6	93.8	94.0	93.8	93.7	93.3	92.2	90.6	89.9	88.6	90.3	91.5
2004	93.3	93.6	93.8	94.0	94.0	93.8	93.5	92.6	91.2	90.3	88.8	90.8	91.8
2005	93.0	93.3	93.5	93.6	93.6	93.6	93.3	92.3	90.7	90.0	88.9	90.3	92.0
2006	93.3	93.7	93.9	93.9	93.9	93.8	93.5	92.8	91.2	90.4	90.9	92.8	94.1
2007	92.6	93.0	93.3	93.4	93.4	93.4	93.2	92.4	90.7	89.7	90.2	92.6	93.9

Source: School Management Benchmarks 2006, <http://www.education.vic.gov.au/management/schoolimprovement/performance/data/publications.htm>; 2007 – School Performance Data, Data, Outcomes and Evaluation Division, Office for Planning Strategy & Coordination, DEECD

Indicator: Years 10–12 apparent retention rates

Year 10–12 apparent retention rates refer to Year 12 enrolment of students in full-time school education (FTE) expressed as a proportion of Year 10 FTE enrolments two years earlier.

Because apparent retention rates are derived from school enrolment information they do not include young people undertaking secondary senior studies in non-school locations such as TAFE colleges or the Centre for Adult Education (CAE). Apparent retention rates do not track individual students nor do they take into account changes due to students repeating year levels, interstate and overseas migration, transfer of students between schools and returning students. Nevertheless these rates are a commonly used indicator of underlying progression rates in schools.¹⁰⁶

Tables 2.32 and 2.33 provide information about the apparent retention rate of students from Years 10 to 12 by metropolitan and non-metropolitan Victoria (table 2.32) and for Victoria and Australia (table 2.33).

In Victoria the apparent retention rate for school students from Years 10–12 peaked in 2004. For non-metropolitan regions, the rates have remained stable (table 2.32). It is likely that metropolitan rates are affected by full fee paying students moving into Victoria to complete Year 12 and country students moving to city schools to complete their secondary studies.

¹⁰⁵ Measured using student headcount.

¹⁰⁶ Note that apparent retention rates calculated for February are higher than for August, as a number of Year 12 students leave during the year.



Table 2.33 shows that apparent retention rates in Victoria are higher than in Australia as a whole.

Table 2.32: All schools: Years 10–12 apparent retention rates (full-time students), by metropolitan and non-metropolitan Victoria, 1999 to 2008

	1999 (%)	2000 (%)	2001 (%)	2002 (%)	2003 (%)	2004 (%)	2005 (%)	2006 (%)	2007 (%)	2008 (%)	Change 1999 to 2008
Metropolitan	85.7	86.9	88.6	89.8	90.8	90.9	90.3	89.7	89.4	88.7	+3.0 % points
Non-Metropolitan	76.4	74.7	77.0	78.7	78.1	78.7	77.5	76.9	76.6	76.6	+0.2 % points
Victoria	82.8	83.1	85.0	86.4	86.9	87.2	86.5	85.8	85.5	85.1	+2.3 % points

Source: Statistical Information & Analysis, Data, Outcomes and Evaluation Division, Office for Planning Strategy & Coordination, DEECD

Table 2.33: All schools: Years 10–12 apparent retention rates (full-time students), Victoria and Australia, 1999 to 2007

	1999 (%)	2000 (%)	2001 (%)	2002 (%)	2003 (%)	2004 (%)	2005 (%)	2006 (%)	2007 (%)	Change 1999 to 2007
Victoria	78.7	79.7	81.6	82.9	82.9	83.0	82.2	82.1	81.8	+ 3.1 % points
Australia	74.4	74.4	75.4	77	76.9	77.2	76.5	76.2r	75.6	+1.2 % points

r = revised

Source: Schools Australia, ABS (Cat, 4221.0)

School attendance and achievement of children in state care

For many children in the care of the state, the school is a safe environment (Queensland Government 2003) and can provide social connectedness and friendship (Bonny et al. 2000; Mansour et al. 2003). However, children on care and protection orders often have disrupted school attendance and this may mean that their educational needs are not met (Harvey & Testro 2006; Queensland Government 2003).

A recent pilot study conducted by the AIHW has examined the educational outcomes for children on guardianship or custody orders. These children were considerably less likely to attain the national benchmarks for numeracy and literacy across almost all year levels. Indigenous children on orders had much lower reading and numeracy scores than other children on orders. There was no relationship between sex, living arrangements or length of time on care orders with reading and numeracy scores (AIHW 2007).

Data on the attendance and achievement of young people in out-of-home care in Victoria are available from analysis of data, gathered as part of a 2003 Partnering Agreement between the Department of Education and Training and the Department of Human Services (DHS unpublished paper, in DEECD 2008).

Survey findings based on the 1651 students who were in out-of-home care in November 2005, show that enrolment levels of students in out-of-home care started to decline from age 13 onwards, reaching a low of 57.3 per cent for 17-year-olds.

Comparative data for out-of-home care students and the general student population show that there were higher levels of absenteeism for out-of-home care students; and that the degree of disparity between absenteeism in out-of-home care students and the general population of students was generally greater in secondary school than primary school students (2003 and 2004 data).

Academic achievement in English and in mathematics was lower for out-of-home care students than for the general population at all year levels (2004 data).



Student Support Program

The Student Support Program provides psychologists, guidance officers, speech pathologists and visiting teachers to intervene when a student requires extra assistance. By providing early, targeted intervention and specialised support, this program helps improve educational outcomes for students who require assistance for learning, disability or behaviour-related needs.

School Nursing

The Department of Education and Early Childhood Development facilitates the delivery of the Primary and Secondary School Nursing Programs. The policy and program management for these programs is located in the Office for Children and Early Childhood Development.

The Primary School Nursing Program employs 75.8 effective full-time (EFT) nurses to deliver a universal vision screening and targeted hearing screening service to all Prep students in primary schools across the state. Primary school nurses conduct a health assessment of all students in participating schools in their first year of school, provide follow up contact with parents, respond to referrals from school staff regarding identified health issues for students at any year level and provide referrals to relevant health practitioners.

The Secondary School Nursing Program is funded to place 100 effective full time nurses in 199 Victorian government secondary schools. The program's goal is to reduce risks to young people and promote better health in the school community through health promotion activities and individual health counselling for students.

School Focused Youth Service

The School Focused Youth Service (SFYS) aims to assist schools and agencies develop partnerships and enhance existing relationships which support young people 10–18 years old. This support aims to ensure the continuation of education and the reduction of risk factors associated with self-harm, mental health issues and suicide, through the development of integrated service responses and the provision of brokerage funding.

Completion of Year 12

The completion of Year 12 or an equivalent qualification, such as an apprenticeship or traineeship provides a good foundation for students to engage in further education, training or employment.¹⁰⁷ Year 12 completion or an equivalent has been shown to reduce the probability of unemployment, to increase workforce participation, and to increase wages throughout life.

In 2005, the government update to *Growing Victoria Together* set the following target:

'By 2010, 90 per cent of young people in Victoria will successfully complete Year 12 or its educational equivalent'.

Indicator: Proportion of students successfully completing Year 12 or equivalent

Table 2.34 shows the proportion of 19-year-olds completing Year 12 or an equivalent by Victorian region from 1999 to 2007. The proportions have increased in both metropolitan and non-metropolitan Victoria over the period, although the proportion of 19-year-olds completing is lower in non-metropolitan than metropolitan areas.

¹⁰⁷ Year 12 or equivalent includes the Victorian Certificate of Education (VCE), the Victorian Certificate of Applied Learning (VCAL) at intermediate level or higher, the International Baccalaureate Diploma program or vocational education and training qualifications at Certificate II level or higher.



Table 2.34: Percentage of 19-year-olds who have completed Year 12 or an equivalent, 1999 to 2007

	1999 (%)	2000 (%)	2001 (%)	2002 (%)	2003 (%)	2004 (%)	2005 (%)	2006 (%)	2007 (%)	Change 1999 to 2007
Metropolitan	75.0	76.0	77.5	77.7	79.5	80.5	79.1	80.2	79.3	+ 4.3 % points
Non-Metropolitan	70.3	70.6	71.4	71.5	74.9	74.8	72.6	74.4	73.5	+ 3.2 % points
Victoria	73.6	74.4	75.7	75.8	78.4	78.8	77.2	78.5	77.6	+ 4.0 % points

Source: VCAA administrative data, OTTE (DIIRD) administrative data, ABS 2001 Census data, ABS population estimates

Year 12 or equivalent completions are also 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 measure used in the *Growing Victoria Together* target noted earlier.

In 2007, 86.1 per cent of 20–24-year-olds in Victoria had completed Year 12 or an equivalent qualification, compared with an Australian completion rate of 83.5 per cent. Victoria's completion rate has consistently been the highest of the states (except in 2000 when the NSW rate was slightly higher) and consistently higher than the national rate.

Pathways after leaving school

Indicator: Proportion of young people who are engaged in full-time education or work

Table 2.35 shows that young Victorians aged 15–17 years are more likely to be in full-time education or work than young people across Australia.

Table 2.35: Percentage of people aged 15–17 years who are in education and/or employment, Victoria and Australia, as at May 2007

	Victoria (%)	Australia (%)
Full-time education only	57.0	53.3
Full-time employment only	1.3	3.6
Full-time employment and part-time education	3.1	2.9
Full-time education and part-time employment	34.4	32.4
Full-time education and full-time employment	0.7	0.5
Total participation full-time in education and/or work	96.5	92.7
Part-time education and part-time employment	0.3	0.7
Part-time education only	0.0	0.2
Part-time employment only	0.5	2.2
Not in education or employment	2.8	4.2
Total	100.0	100.0

Source: ABS 2007 Survey of Education and Work, ABS data available on request

Indicator: Proportion of early school leavers who are unemployed six months after leaving school

Information about student pathways and transitions to post-school destinations is available from the Department for Education and Early Childhood Development's *On Track* survey. This survey has been carried out annually since 2003 and has improved understanding of the factors that play a role in navigating young people towards a variety of post-compulsory outcomes, and which facilitate successful transitions into education, training and employment.



When the destinations of Year 12 completers and early school leavers are compared, the *On Track* data highlight how Year 12 completers are more likely to be employed or in further education than young people who left school prior to completing Year 12 (data cited in DHS 2006a; DEECD 2008).

In its update to *Growing Victoria Together*, the Government has set the following target:

‘The number of early school leavers who are unemployed after six months will decline.’

Table 2.36 shows the destinations of early school leavers in 2002 to 2007. These results should be interpreted with care.¹⁰⁸ However, they suggest that there has been an increase in the percentage of early school leavers taking up employment. This can be attributed to the strength of the labour market with more opportunities for employment available for young people.

Table 2.36: Destinations of early school leavers by cohort year, percentages, Victoria 2002 to 2007

	2002	2003	2004	2005	2006	2007	Change 2002 to 2007
In Education and Training	57.1	51.2	57.6	57.2	53.1	55.1	-2.0 % points
VET	23.0	22.4	19.8	14.6	15.8	14.6	-8.4 % points
Apprentice	28.7	23.5	29.8	35.5	30.2	33.2	+4.5 % points
Trainee	5.4	5.3	8.0	7.1	7.1	7.3	+1.9% points
Employed (Full or Part-time)	25.9	29.6	27.0	27.9	31.5	30.9	+5.0 % points
Unemployed	17.1	19.2	15.4	14.8	15.4	14.0	-3.1% points

Source: The destinations of school leavers in Victoria, *On Track* 2007, 2008 *On Track* Early Leaver Survey, DEECD

Data relating to the Victorian adult population show that people with a disability do not have the same access to education or employment opportunities as others within the community. For example, approximately 20 per cent of people with a disability over 15 years in Victoria have not attended school or have only progressed to Year 8, compared to 5 per cent of the general population. Only 55 per cent of people with a disability are employed, while over 81 per cent of the total Victorian population is in paid work (DHS 2006b).

TAFE guarantee

Opportunities for young people in VET continue to grow with initiatives announced in the Victorian Government’s 2006 skills strategy: *Maintaining the Advantage – Skilled Victorians*. Key initiatives targeting young people include a ‘guaranteed place in TAFE or other public provider’ for students aged less than 20 years to complete Year 12 or equivalent training qualification. In addition, the Government has committed to funding an additional 4500 pre-apprenticeship places to encourage more young people to consider a trade as a career option.

New Technical Education Centres (TECs) will give students in Victoria the opportunity to undertake a broad range of applied learning programs, targeted to priority industry needs, as part of their senior secondary education. Programs will include pre-apprenticeships, apprenticeships, the VCAL and vocational components of the VCE.

The TECs are to be based in TAFE institutions, in purpose-built, high-tech, industry-standard facilities that will take advantage of TAFE links with industry.

¹⁰⁸ It should be noted that early leavers are hard to identify. The number of early leavers included in the *On Track* sample varies from year to year. The sample of early school leavers includes only those young people who could be identified, contacted and consented to participate in the study.



2.5 Happiness and engagement with families and communities

Summary

- Victorian children responding to the HNSS have high levels of family attachment and national survey data highlight the importance to children of family and friends as sources of advice.
- Results from the Attitudes to School Survey suggest that levels of school connectedness are higher in Years 5 and 6, than students in Years 7 to 9.
- 71.3 per cent of female students surveyed in the HNSS reported enjoying school almost always or often, compared with 61 per cent of males. Students from higher SES quartiles were more likely to report that they enjoyed being in school.
- ABS survey data show that 62.9 per cent of Victorian children aged 5–14 years participated in an organised sporting activity outside school hours in the previous 12 months (63.5 per cent in Australia).
- Boys were more likely to participate in an organised sporting activity than girls and, while boys were increasingly likely to participate with age, participation among girls peaked at age 9–11 years and then declined.
- Children aged 5–14 participated in cultural and arts activities at a lower level than their participation in sports. Girls participate in cultural and arts activities at a higher level (44 per cent) than boys (21.5 per cent).
- In Victoria, 79.7 of children have access to the internet at home (2006 Census of Population and Housing).
- In the HNSS, two-thirds (66.6 per cent) of Victorian children in Years 6 and 8 reported having volunteered either once or more in the past 12 months. Students speaking a language other than English at home were significantly more likely to report volunteering.
- 74.4 per cent of students surveyed in the HNSS reported that there were lots of chances in their schools to help decide things like class activities or rules. Sixty-five per cent reported that adults paid attention to what students have to say in their neighbourhood and 45.8 per cent said that students could help decide what activities are provided in their neighbourhoods and how they are run.
- Younger students in the HNSS were significantly more likely (than older students) to report that there were opportunities to decide things like class activities and rules and Aboriginal and Torres Strait Islander (ATSI) children were more likely (than non-ATSI children) to say that children can help decide when activities are provided and how they are run in their neighbourhoods. Overall, young students from CALD backgrounds felt that they had fewer opportunities to have a say.

The health and wellbeing of children and young people is known to be strongly associated with a sense of connectedness to family, to school and to the community (AIHW 2003, in DEECD 2008). Close personal networks (such as family, close friends and neighbours) provide children and young people with a foundation for dealing with everyday life, taking on challenges, developing new skills and exploring new roles and experiences (Pope & Warr 2005, in DEECD 2008).

Community networks provide many of the benefits of close personal networks for young people. They also provide a broader source from which these benefits can be drawn. Associational networks are built through participation in public life, such as involvement in community events, arts, organised sport, organised groups and volunteering (Pope 2006, in DEECD 2008).



This section focuses broadly on Victorian children’s connectedness with their families and friends and their engagement with their local communities. More specifically, it looks at their access to social support and participation in sport and recreation, and in arts and culture. In addition, the section reviews what is known about the civic engagement of young Victorians. Finally, the section looks at children’s access to transport and how this impacts on their participation in leisure and education.

There are some clear gaps in our knowledge of key outcome areas. For example, we are unable to report, as yet, on indicators such as ‘children and young people’s overall satisfaction with the quality of their lives’, and ‘the proportion of young people who have a high level of emotional wellbeing’. We know little of children’s own views about the nature and quality of their local neighbourhoods and the extent to which they believe they are valued by society and can contribute to decision-making. These important knowledge gaps will be addressed through the Adolescent Health and Wellbeing Survey.

Social support and family attachment

Social support includes feeling that there are people to share problems with and to feel close to. This kind of support is a particularly important contributory factor to the health and wellbeing of children as well as adults. Studies investigating the link between social support and adolescent health have found a relationship between social support and health risk factors such as physical inactivity, depression and smoking (Beets et al. 2006; Vilhjalmsson 1994).

A continuing relationship with a significant and supportive adult – at home, at school or in the community – has also been shown to be a key protective factor for teenagers who are facing other challenges in their life (DHS 2006).

Indicator: The proportion of young people who have someone to turn to for advice when having problems

Indicator: The proportion of young people who have a trusted adult in their life

While Victorian data is not currently available for these two indicators,¹⁰⁹ Australian survey data highlight the importance to children of both family and friends as sources of advice.

The 2007 YouthSCAN survey found that family, parents and particularly mothers, remain the central and dominant influences in young people’s lives. The majority of those aged 14–17 years who were surveyed by YouthSCAN agreed with the statement that ‘family is the most important thing to me’, and three-quarters (75 per cent) reported having a ‘great deal’ of confidence in parental advice. Friends were rated by young people (aged 10–17) as extremely or very important (YouthSCAN 2007, in DEECD 2008).

¹⁰⁹ Information on these two indicators will be collected in the Victorian Adolescent Health and Wellbeing Survey. It is possible that this may identify that some young people have no one to turn to for advice when having problems. A recent school-administered survey of 4400 11–16-year-olds in the UK suggests that some young people may have no one to talk to about their worries and concerns. More than one-third of the young people reported that they had wanted to talk to someone about a problem in the last 12 months with 3 in 10 of these young people reporting that they had no one to talk to (NSPCC 2005).



Mission Australia’s national survey of young Australians found that friends and parents were the top two sources of advice and support for those aged 11–14 and 15–19 years (Mission Australia 2007) (table 2.37).

Table 2.37: Where young people turn for advice and support, by age, Australia, 2007 ¹¹⁰

	11–14 years (%)	15–19 years (%)
Friend/s	83.6	88.3
Parent/s	78.3	70.9
Relative/family friend	66.0	61.9
Internet	13.9	22.0
Magazines	10.8	12.2
Community agencies, e.g. youth worker	10.4	11.3
School counsellor	11.9	10.1
Teacher	11.4	10.1
Someone else in your community e.g. doctor, church minister	7.8	8.9
Telephone helpline	6.9	4.7

Source: Mission Australia 2007

Family attachment

Data from the HNSS emphasises the importance of parents and families to the survey sample of children in Years 6 and 8 from Victoria. The survey included a series of questions such as ‘do you feel very close to your mother?’ to measure the level of family attachment, and found that children had a high level of family attachment.

The family and social relationships of children in out-of-home care

A recent AIFS study, commissioned by the DHS, provides information about outcomes for a sample of 614 children in out-of-home care in Victoria, including information about their family and social relationships.¹¹¹ Approximately a quarter of the sample of children did not have any contact with any member of their birth family.

The study found that almost three-quarters of the children (72.9 per cent) had a special friend although only one-fifth (22.0 per cent) frequently saw their friends outside school. Nearly seven in 10 children (68.5 per cent) were reported to have a supportive adult other than their carer/parent whom they could turn to in a crisis (AIFS 2008).

¹¹⁰ Data is aggregated and includes items ranked one, two or three by respondents.

¹¹¹ This sample was reasonably representative of children in the out-of-home care population in relation to special health and education needs, although it may not be representative of children from ATSI and CALD backgrounds.



Engagement with school

Indicator: Proportion of students who report feeling connected with their school

Each year students in Victorian government schools are surveyed about their opinions on aspects of school life, including their 'school connectedness', using the Department of Education and Early Childhood Development's Attitudes to School Survey.

In order to measure this students are asked to rate (on a five-point Likert scale)¹¹² how far they agree with the following statements:

- I feel good about being a student at this school.
- I like school this year.
- I am happy to be at this school.
- I feel I belong at this school.
- I look forward to going to school.

Student responses to these statements provide a good indication of their engagement with, and enjoyment of school.

Results for students in Years 5 and 6 and Years 7 to 9, in 2006 and 2007, suggest that average connectedness to school scores are higher among the younger students.

The mean score for Years 5 and 6 students was 4.1 in 2006 and 4.2 in 2007, and the mean score for Years 7 to 9 students was 3.5 in both 2006 and 2007 (Department of Education and Early Childhood Development Attitudes to School Survey).¹¹³

Data from the 2006 Healthy Neighbourhoods School Survey

Victorian students from Years 6 and 8 who responded to the 2006 HNSS were asked a series of questions about their experiences and views of school, including whether they enjoy school.

Students were asked to think back over the past year and indicate how often they had enjoyed being in school and how often they had hated being at school. Students from higher SES quartiles were more likely (than those from lower quartiles) to state that they enjoyed being in school and less likely to say that they hated school (11.7 per cent of students in the highest SES quartiles said that they hated school 'almost always' or 'often' compared with 20.9 per cent in the lowest quartile).

Results by sex are charted in figure 2.42 and show that 71.3 per cent of females stated that they enjoyed school almost always or often compared with 61 per cent of males. In addition, 13.0 per cent of males and 7.9 per cent of females stated that they rarely or never enjoyed school.

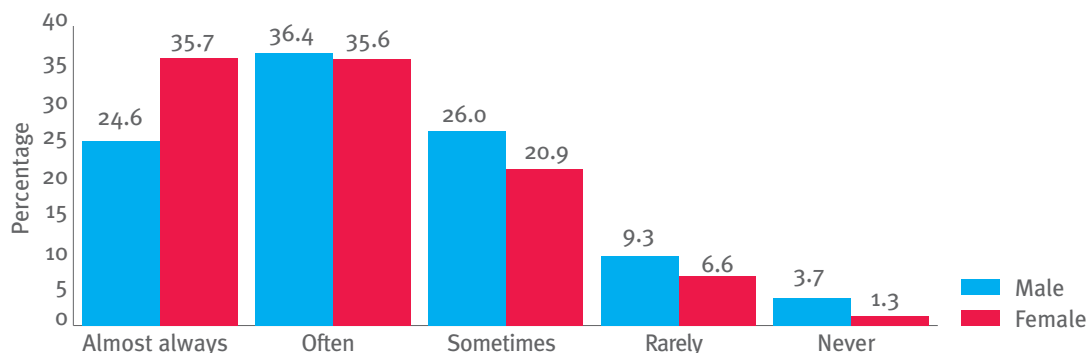
14.2 per cent of Indigenous students reported rarely or never enjoying school compared with 10.4 per cent of other children.

¹¹² This scale ranges from 1 (strongly disagree) to 5 (strongly agree).

¹¹³ From 2003 to 2005 a different measure termed connectedness – school was used derived from student responses to three statements. Results for these years have not been given as they are not directly comparable with results from 2006 and 2007.



Figure 2.42: Percentage of students who had enjoyed school over the past year by sex, 2006



Source: Williams 2007, in DEECD 2008

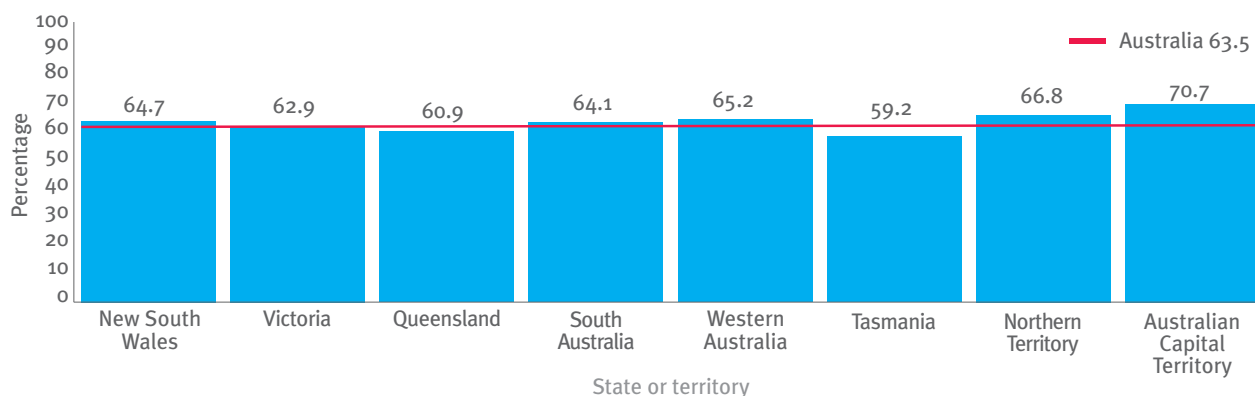
Participation in sport and recreation

Children and young people’s engagement in physical activity, including sport, has clear health benefits. However, sport is also an important social activity. Participation in organised sport helps children and young people to build associational and community networks. Many children and young people also prefer to participate informally, pursuing recreational activities in their friendship networks (DEECD 2008).

Our data on children’s participation in recreation and sport is derived from the 2006 Survey of Children’s Participation in Cultural and Leisure Activities (ABS 2006). This survey was conducted throughout Australia as part of the ABS’s Monthly Population Survey. Information was collected on the participation of children aged 5–14 in selected organised sports in the 12 months prior to interview.

The survey shows that 62.9 per cent of children in Victoria participated in an organised sporting activity outside of school hours at least once in the previous 12 months. This participation rate is similar to the rate for Australia (63.5 per cent). As figure 2.43 shows, the participation rate ranges from 70.7 per cent in the Australian Capital Territory to 59.2 per cent in Tasmania.

Figure 2.43: Percentage of children aged 5–14 years who participated at least once in the previous 12 months in a sporting activity out-of-school hours, states and territories, 2006



Source: ABS 2006

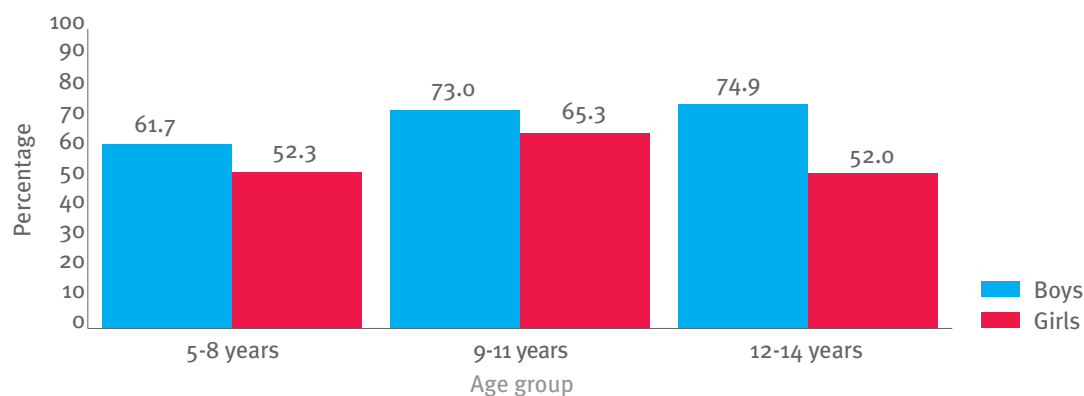


Sex and age

The ABS survey also reports that Victorian boys were more likely to participate in a sporting activity than Victorian girls. The rate for boys was 62.9 per cent, compared with 56.2 per cent for girls.¹¹⁴ This pattern was also reflected in Australia as a whole (ABS 2006).¹¹⁵

The sex difference is most marked in Victoria in the 12–14-year age group, with 52 per cent of girls participating, compared with 74.9 per cent of boys (figure 2.44). Figure 2.44 shows that as boys got older they were increasingly likely to participate in a sporting activity, whereas the participation of girls peaked at age 9–11 years and then declined.

Figure 2.44: Percentage of children who participated at least once in the previous 12 months in a sporting activity out-of-school hours, by sex and age, Victoria, 2006



Source: ABS 2006

Time spent participating in sport

Of those Victorian children who participated in an organised sporting activity, 41 per cent played or trained for two hours or less in the two most recent school weeks, and 17 per cent played or trained for 10 hours or more. Overall, boys spent more time playing or training, with 44 per cent participating for more than five hours compared with 29 per cent of girls (ABS 2006).

Children who did not participate in sport

Nearly four in 10 (37 per cent) Victorian children did not participate in an organised sporting activity outside of schools hours during the 12 months prior to April 2006. For girls, the rate was 43.8 per cent, and for boys, 30.8 per cent (ABS 2006).

¹¹⁴ The activity with the highest participation rate overall was swimming at 20 per cent. For boys, the most popular activity – at 25 per cent – was Australian Rules football followed by swimming at 19.2 per cent. For girls, it was swimming at 21 per cent followed by netball at 16.8 per cent.

¹¹⁵ In Australia the rate for boys was 68.9 per cent and the rate for girls was 57.8 per cent.



Involvement in arts and culture

The ABS Survey of Children’s Participation in Cultural and Leisure Activities (ABS 2006) provides information about children’s involvement in arts and culture, including information about children’s engagement with specific activities (such as playing a musical instrument) and children’s attendance at cultural venues and events. Overall, the findings suggest that children participate in cultural and arts activities at a lower level than their participation in sports.

Specific activities

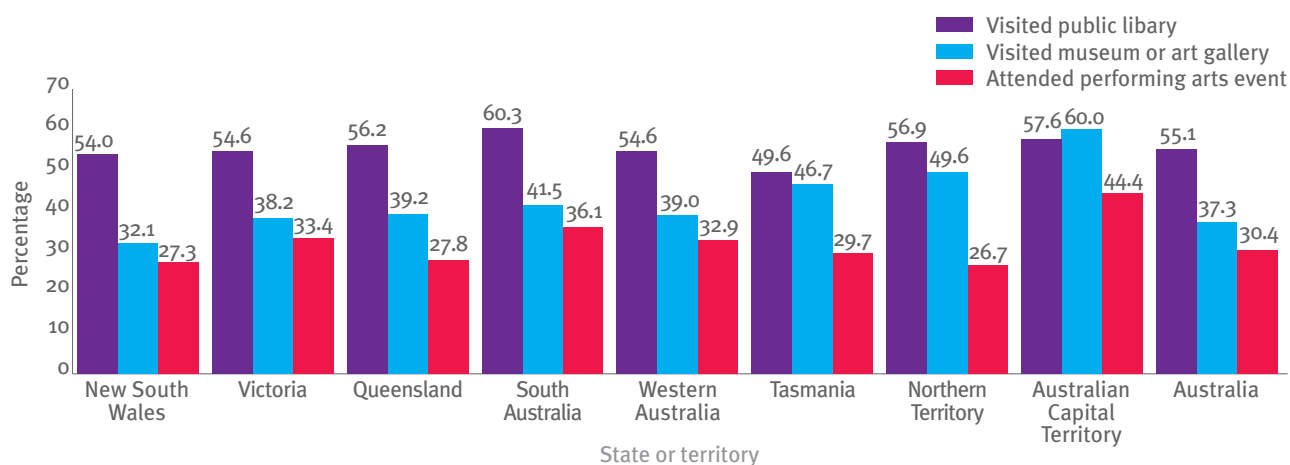
In the 12 months prior to April 2006, 18.5 per cent of 5–14-year-old Victorians played a musical instrument, 10.8 per cent had lessons or gave a dance performance, 5.1 per cent had lessons or gave a singing performance and 4.1 per cent participated in drama.

Victorian girls participated in these activities at twice the rate of Victorian boys (44 per cent compared with 21.5 per cent). The state and territory participation rates for these activities ranged from 38 per cent in the Australian Capital Territory to 25 per cent in the Northern Territory. The overall participation rate for Victoria was 30.5 per cent, compared with 32.6 per cent in Australia as a whole (ABS 2006).

Cultural venues and events

In the 12 months prior to April 2006, 54.6 per cent of 5–14-year-old Victorians visited a public library, 38.2 per cent visited a museum or art gallery and 33.4 per cent attended a performing arts event.¹¹⁶ As figure 2.45 shows, the proportions of Victorian children who attended these specified cultural venues and events were similar to the proportions in Australia as a whole.

Figure 2.45: Percentage of children aged 5–14 years who attended a cultural venue at least once in the previous 12 months, states and territories, 2006



Source: ABS 2006

¹¹⁶ Victorian girls were 5 per cent more likely than boys to attend a library, and 10 per cent more likely to attend a performing arts event. Boys were 2 per cent more likely than girls to visit a museum or art gallery.



Use of electronic media

While the use of electronic media arguably increases isolation and may divert young people from physical activity,¹¹⁷ media such as mobile phones, chat rooms and instant messaging are important to many young people's social connections and networks (DEECD 2008).

Based on the 2006 Census of Population and Housing, 79.7 per cent of children in Victoria have access to the internet at home (compared to 78.8 per cent of all children in Australia). As shown in figure 2.46, most children access the internet through broadband.

Figure 2.46: Type of connection for children aged 0–17 years with internet access at home, Victoria and Australia, 2006

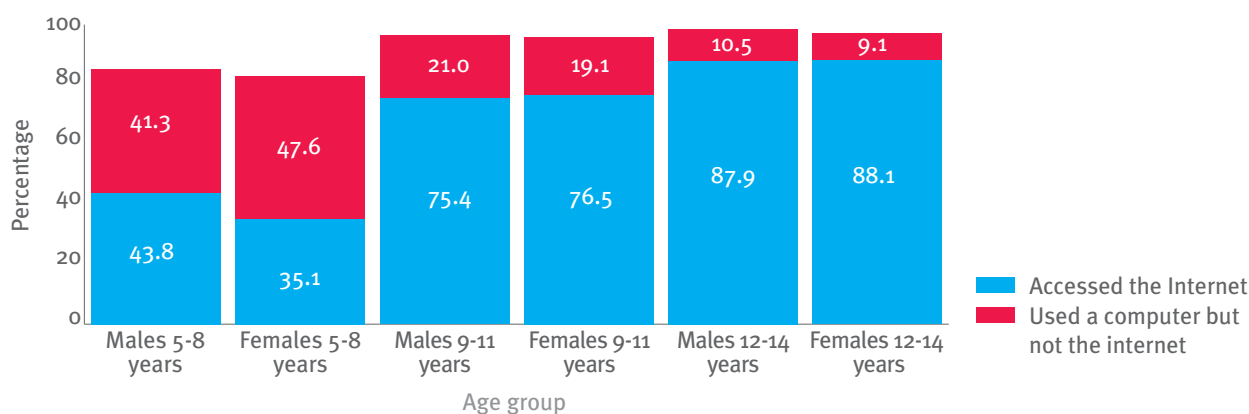


Source: ABS 2006 Census of Population and Housing

The ABS survey of Children's Participation in Cultural and Leisure Activities found that in Victoria an estimated 425,200 children aged 5–14 years accessed the internet during the previous two weeks either during or outside school hours. This represents 71 per cent of the total number of children who used a computer (ABS 2006).

The survey also found that the use of the internet increases markedly with age. Boys and girls have similar internet usage with the exception of 5–8-year-old girls, who are less likely to use the internet than boys of the same age (figure 2.47).

Figure 2.47: Computer and internet use by children aged 5–14 years in the previous two weeks, by age and sex, Victoria, 2006



Source: ABS 2006

¹¹⁷ This is discussed in Section 2.2.



Children and young people’s engagement with their communities

Volunteering

In the Victorian HNSS, children in Year 6 and 8 were asked:

‘During the past 12 months, how often have you done volunteer work to help other people, such as helping out at a hospital or raising money for charity?’

As table 2.38 shows, two-thirds (66.6 per cent) of children reported having volunteered either once or more in the past 12 months, with 12 per cent volunteering three or four times and 9 per cent volunteering five or more times.

Table 2.38: Percentage of children aged 11–13 years who did volunteer work during the past 12 months, Victoria, 2006

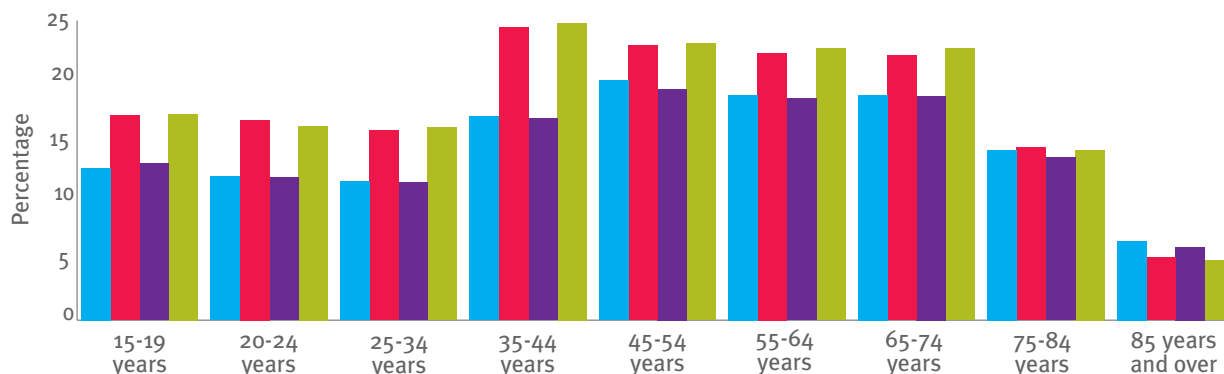
	Age			Total (%)
	11 (%)	12 (%)	13 (%)	
Never	32.6	32.9	35.2	33.4
Once	23.6	27.3	28.0	26.4
Twice	19.4	19.2	19.0	19.2
3 or 4 times	12.9	12.0	11.1	12.0
5 or more times	11.5	8.6	6.8	9.0

Source: Williams 2007 in DEECD 2008

Students speaking a language other than English at home were significantly more likely to report volunteering. Students from the lowest SES quartiles were more likely to report that either they have never volunteered or that they have volunteered regularly over the last 12 months.

Information about volunteering activity among older age groups is provided by the 2006 Census of Population and Housing (figure 2.48). The figure shows that 15–19-year-olds are less likely to volunteer than most older age groups, that females are more likely to volunteer than males, and that Victorian data is consistent with national figures.

Figure 2.48: Percentage of people (aged 15 years and over) volunteering, by age group and sex, Victoria and Australia, 2006



Source: ABS 2006 Census of Population and Housing, in DEECD 2008



Advance program

Advance is a school-based program for young people to volunteer in their community. It is a partnership between the Office for Youth, Victorian government secondary schools and community organisations.

Through Advance, young people, schools and community organisations develop networks of relationships while achieving shared goals. The program also encourages communities to support and recognise young people's participation and positive role in society.

Advance gives young people a chance to do something great in their community based on their choice. Young people are able to plan projects, meet new people, build skills and make a difference in their community.

The Advance framework

Participating schools deliver five program elements:

- Learning modules 1, 2 and 3 (Community, Communication and Project management skill development)
- Recognised training
- A community project or series of volunteering activities delivered in partnership with innovative approaches to program delivery are encouraged
- Recognition and celebration
- Program reporting

Young people's participation in decision-making is expected to be included throughout the delivery of the five program elements.

Youth Participation and Access Program

Local governments and not-for-profit organisations have been invited to work in partnership with the Victorian Government to deliver the Youth Participation and Access (YPA) program 2009–11.

The Youth Participation and Access program is funded by the Office for Youth to deliver a mix of activities for a targeted group of vulnerable young people who face additional barriers to participation in their community. The Office for Youth will provide grants of between \$30,000 and \$50,000 per annum over three years to successful applicants who deliver a range of activities for young people in local communities. The program seeks potential providers with a demonstrated capacity to deliver effective youth participation activities.

Children and young peoples' perceptions of their local communities

Children's perceptions of their local communities are key influences on the quality and nature of their engagement with communities. For example, children who feel safe in and positive about their local neighbourhoods are more likely to actively participate in local activities and more likely to feel able to travel around and make local connections (DEECD 2008).



Information about children’s perceptions of safety is included in Section 2.3. Further information about Childrens’ views on their communities will be available from the Victorian Adolescent Health and Wellbeing Survey.^{118, 119}

Indicators of community strength in Trafalgar

Surveys in the town of Trafalgar in Gippsland demonstrate that differences exist not only between areas, but in the way different population groups experience aspects of community strength. The Trafalgar Community Development Association ran one neighbourhood survey in 2005. In 2006 it also ran a survey of 189 students in Years 7–11 (aged 12–17) at Trafalgar High School. This represents 32 per cent of students in these years. This is the first time young people have been surveyed using these indicators.

Compared with adults¹²⁰ in Trafalgar, this group of young people were more likely to be members of organised groups and to be involved in organised sport, but less likely to be members of decision-making boards or committees (see table 2.39).

Table 2.39: Indicators of community strength in Trafalgar, adults (2005) compared with young people (2006)

	Adults (aged 18 years or more) 2005 (%)	Young people (aged 12–17 years) 2006 (%)
Participation		
Participation in organised sport	41	66
Members of organised groups such as sports, church, community or professional groups	49	58
Members of organised groups that had taken local action on behalf of the community in the last 12 months	23	26
Members of decision-making boards or committees	20	13
Attendance at community events	55	52
Volunteers	42	45
Rating the area on a range of characteristics		
Likes living in the local area	94	54
It is a pleasant environment, nice streets, well planned, open spaces, no pollution	96	65
It is a place where people are friendly, good neighbours, help others	97	57
It has a distinct character, is a special place	90	49
It has good facilities and services like shops, child care, schools, libraries	85	58
It has a wide range of community and support groups	88	42
It is an active community, people do things and get involved in local issues and activities	89	49
There are opportunities to volunteer in local groups	93	50
It has easy access to parks, bike tracks and recreational areas	83	70
Other community attitudes		
Feels multiculturalism makes life in the area better	82	20
Feels there are opportunities to have a say on issues that are important	71	56
Feels valued by society	73	62

Source: DVC 2007, in DEECD 2008

¹¹⁸ Young people will be asked, in the survey, about their perceptions of the physical and social environment (safety, cleanliness, street lighting, etc.) and their access to local facilities and services.

¹¹⁹ Information on the views of young people aged 18–24 about their local areas is included in the 2007 young people report (DEECD 2008).

¹²⁰ Aged 18 or more.



Feeling valued by society and having a say

Indicator: The proportion of young people who believe they have the opportunity to have a say on issues that matter to them

Indicator: The proportion of young people who feel valued by society

The right of children to give their views about matters that affect them and to have their views taken seriously (according to their age and maturity) are set out under Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) (United Nations 1989) and there are several realms of decision-making in which they can ‘have a say’. They can be involved in decisions about themselves as individuals, in decisions about services or facilities and in decisions in a community or civic context (civic participation).

Children and young people’s participation in decision-making in Victoria

In Victoria, the *Child Wellbeing and Safety Act 2005* states that: the providers of services to children and families should: ‘protect the rights of children and families and, to the greatest extent possible, encourage their participation in any decision-making that affects their lives’ (Part 2: Principles for Children Section 5(3)). The Future Directions Youth policy’ includes a policy commitment to ‘hearing the voices of young people.’

More than 800 young people had direct input into the shaping of the Future Directions Youth policy through participation in forums in their schools and communities. Young People Direct, a key action of Future Directions, provides opportunities for young Victorians to have direct access to the Minister for Youth Affairs using the youthcentral website, involvement in existing programs and dedicated forums on particular issues.

The Government also funds the Youth Affairs Council of Victoria (YACVic) and the Centre for Multicultural Youth Issues to support young people to bring their voice to the Government.

The Victorian Indigenous Youth Affairs Council (VIYAC) and the Multifaith Multicultural Youth Network (MMYN) each provide key advice to the Government on issues and initiatives relevant to Indigenous Victorians and people of all faiths and cultures

The Student Voice initiative identifies and promote ways in which students can be involved in school and wider community decision making processes.

The Youth Arts Reference Group meets regularly to develop and provide ongoing policy advice and influence in the arts portfolio to Arts Victoria.

Information on the two related indicators: the proportion of children who believe they have an opportunity to have a say – and the proportion of young people who feel valued by society – is limited for the age group 0–18 years, although VPHS data are available for those aged over 18 years (reported in DEECD 2008).

Some relevant information about the views of 11–13-year-old students in Victoria is available, however, from the HNSS. The HNSS asked students whether they felt they had chances to help decide things like class activities and rules; whether adults pay attention to what children have to say in their neighbourhoods; and whether children can help decide when activities are provided and how they are run in their neighbourhoods.



Overall, 74.4 per cent of students agreed or strongly agreed that there were lots of chances in their schools to help decide things like class activities or rules.

65 per cent of students agreed or strongly agreed that adults paid attention to what children have to say in their neighbourhood.

45.8 per cent agreed or strongly agreed that children could help decide what activities are provided in their neighbourhoods and how they are run.

The survey found some differences in the responses of students.

- Younger students (among the 11–13-year-olds) were significantly more likely to report that there were opportunities to decide things like class activities and rules; and were more likely to report that adults will listen to what children say in their neighbourhoods.
- Students living in urban areas were significantly less likely to report there are opportunities to decide things like class activities and rules.
- Males were more likely than females to report that children can help decide when activities are provided or how they are run in their neighbourhoods.
- Aboriginal and Torres Strait Islanders were more likely (than non-ATSI students) to say children can help decide when activities are provided and how they are run in their neighbourhoods (Williams 2007, in DEECD 2008).

It is of some concern that young students from CALD backgrounds felt they had less opportunities to have a say. For example, CALD young people were less likely to report there are chances for children to decide things like class activities and rules; and least likely to say that children can help decide when activities are provided or how they are run in their neighbourhoods (Williams 2007, in DEECD 2008).

Access to transport

Indicator: Proportion of young people whose lack of access to transport impacts on their capacity to achieve key work and/or life goals

Together with appropriate opportunities for walking and cycling, safe, accessible and affordable public transport is important for ensuring children's access to health services, cultural activities, and their rights under the UN Convention to play, leisure and recreation (United Nations 1989, in DEECD 2008).

While children are dependent for a significant proportion of their travel on adults, as they get older an increasing share of their travel is by independent means. This is important for their participation in community and civic activities, accessing significant life opportunities such as training, education and employment, and to support their growing independence. Walking and cycling can provide suitable options for local travel and can contribute to physical activity. For longer trips, children require access to public transport. Restricted access to any form of transport can impact on their health and wellbeing, engagement with community and socialising with peers.

Data relating to this indicator will be collected in the Victorian Adolescent Health and Wellbeing Survey (2009).





Section 3: How are Victorian families influencing outcomes for their children?

A range of family factors can influence child wellbeing outcomes, including health-promoting behaviours (such as breastfeeding) and parental health behaviours such as parental nutrition and alcohol consumption. Other factors such as family functioning, family violence and parental mental illness can also impact on child wellbeing.

The level and quality of support that is available from the wider community and from child and family services are critical influences on the capacity of families to function well and to help ensure the best outcomes for their children (see Section 4).

Section 3 focuses on factors promoting child wellbeing (3.1) and factors that may have adverse impacts (3.2).





3.1 Factors promoting child wellbeing

Summary

- 26.3 per cent of women aged 18–50 years reported taking folate in the 2007 VPHS, compared with 20.4 per cent in the 2005 VPHS.
- 89.3 per cent of parents in the VCHWS reported that they had put their infant (aged under 1 year) on their back to sleep.
- There is a stable trend in the percentages of infants who are fully breastfed at 3 and 6 months of age (2000–01 to 2006–07) with just over half of infants fully breastfed at 3 months and just under 40 per cent fully breastfed at 6 months.
- 43 per cent of children aged under 13 years have parents who reported reading to their child almost every day (VCHWS).
- The majority (82.5 per cent) of parents report protecting their child from the sun every day on summer days (VCHWS).
- The 2007 VPHS found that 64.4 per cent of parents had undertaken the recommended amount of physical activity during the previous week.
- Just 6.2 per cent of parents and carers had consumed the daily recommended level of vegetables, whereas 44.8 per cent had consumed the daily recommended level of fruit (2007 VPHS).
- The vast majority (89.5 per cent) of Victorian children under 13 years live in families with healthy family functioning (VCHWS).

Best Start

Best Start is a Victorian Government early years initiative. It supports families, caregivers and communities to provide the best possible environment, experiences and care for young children in the important years from pregnancy to school. Best Start aims to improve the health, development, learning and wellbeing of all children (0–8 years). It supports communities, parents and service providers to improve universal early years services so they are responsive to local needs. It has a strong emphasis on prevention and early intervention. These improvements are expected to result in:

- better access to child and family support, health services and early education
- improvements in parents' capacity, confidence and enjoyment of family life
- communities that are more child and family friendly.

There are 30 Best Start project sites across the state. Six of these sites focus specifically on working with Aboriginal communities. Local partnerships are the cornerstone of each project site.



Folate in pregnancy

Intake of folate before and during pregnancy is shown to significantly decrease the risk of spina bifida.¹²¹

Since 1996 there has been a marked decrease (35–45 per cent) in the incidence of neural tube defects in Australia (AIHW 2004). This decrease has been associated with increased peri-conceptual folic acid intake through the fortification of selected foods and through health promotion campaigns (Bower et al. 2004; Chan et al. 2001; Owen et al. 2000).

Indicator: Proportion of women of child-bearing age who take folate supplements

The 2007 Victorian Population Health Survey found that 26.3 per cent of women aged 18–50 years reported that they were currently taking a folate supplement or a multivitamin containing folate. This compares with a figure of 20.4 per cent from the 2005 VPHS. Women aged 25–34 years were more likely than women in other age groups to report that they were consuming folate.

Putting infants on their backs to sleep

Research has identified that placing an infant in a prone (face-down) sleeping position is a risk factor for SIDS. Improved parental education about infant sleep positions has contributed to substantial reduction in SIDS deaths since the 1990s, when SIDS was the leading cause of death in Australian infants (Al-Yaman et al. 2002).

Indicator: The proportion of infants who are put on their back to sleep from birth

When asked in what sleeping position they placed their infant aged under 1 year, respondents to the 2006 VCHWS indicated that 89.3 per cent of the infants had been placed on their back, with 7.5 per cent on their side and 2.5 per cent on their stomach (data reported in DHS 2006).

Breastfeeding

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 (AIHW 2005).

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 below) and those who are predominantly breastfed, receiving breast milk and other fluids (for example, water) but no infant formula or solids.

In Australia the NHMRC, in accordance with WHO guidelines, recommends exclusive breastfeeding from birth up to 6 months of age (NHMRC 2003). Exclusively breastfed infants receive only breast milk (plus medication or vitamins as required).

¹²¹ 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.

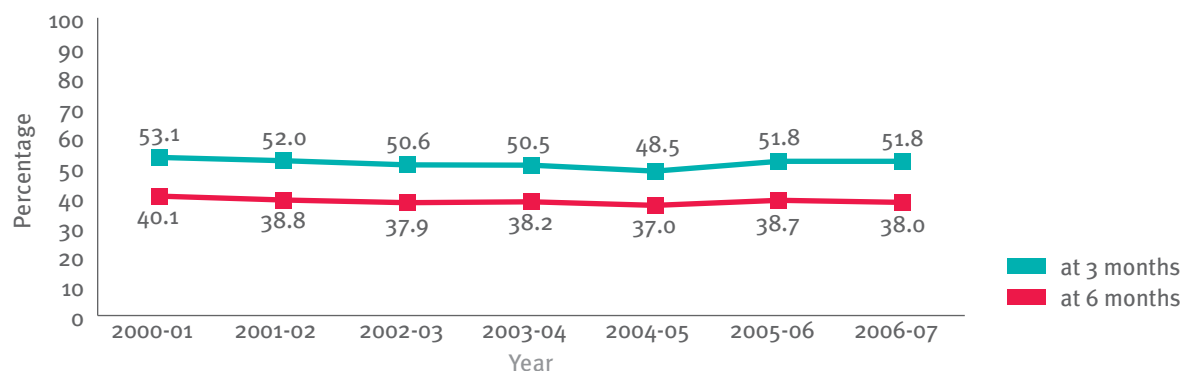


Indicator: Proportion of infants breastfed

Figure 3.1 shows the percentage of infants in Victoria who are fully breastfed at 3 and 6 months of age, by year, over a seven-year period, from 2000–01 to 2006–07.

The figure highlights a stable trend across the seven years in the percentages of infants who are fully breastfed at 3 and 6 months of age, with just over half of infants fully breastfed at 3 months and just under 40 per cent of infants fully breastfed at 6 months.

Figure 3.1: Percentage of infants fully breastfed at 3 and 6 months, Victoria, 2000–01 to 2006–07



Source: DHS Maternal and Child Health Service Database

Reading to children

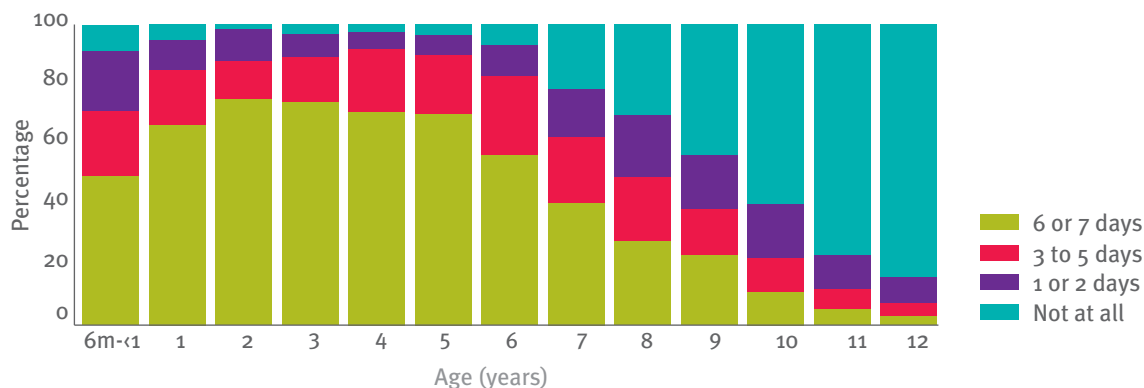
There is undisputed evidence of the benefits to the child if parents read to them (Epstein 1996, in Persampieri et al. 2006). Parents can positively contribute to the academic success of their children by extending their learning environment and enabling one-on-one attention that schooling cannot provide (Christenson et al. 2001, in Persampieri et al. 2006). Positive early exposure to books is important for a child's future literacy, as it provides opportunities for children and their parents to bond, promotes language development and contributes to school readiness. Reading out aloud with children in a highly interactive way has been shown to be very effective (Huebner & Meltzoff 2005). This also develops a child's oral language, in turn promoting phonemic awareness, a strong predictor of a child's future success in learning to read (Adams 1990, in Hill 2006).

Indicator: Proportion of children who are read to by a family member every day

The 2006 VCHWS found that 43 per cent of children aged under 13 years had parents who reported reading to their child almost every day (six to seven days). Unsurprisingly, younger children were read to more frequently than older children (figure 3.2).



Figure 3.2: Percentage of children under 13 years whose parents read to them from a book (days per week), Victoria, 2006



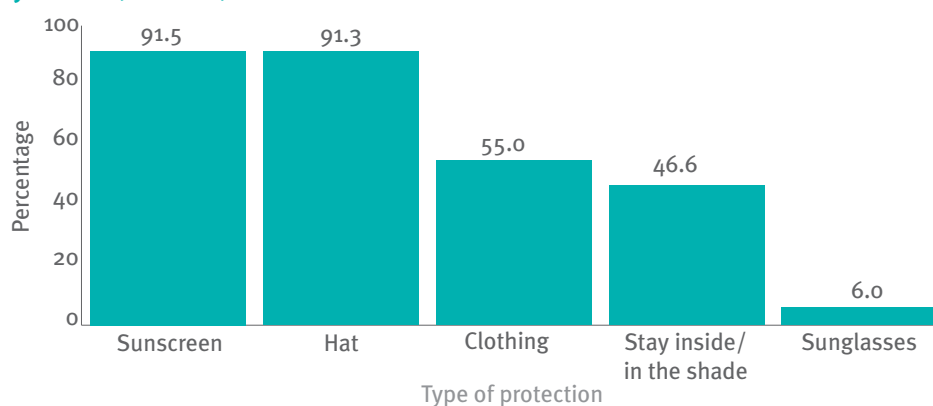
Source: VCHWS 2006, in DHS 2006

Parental awareness of sun protection

Indicator: Proportion of parents aware of sun protection

Parents were asked in the VCHWS about how often they try to protect their child from the sun on summer days. The majority, 82.5 per cent, reported protecting their child every day, with less than 1 per cent reporting they never tried to protect their child. Using sunscreen and using a hat were the most common ways of attempting to limit sun exposure (see figure 3.3).

Figure 3.3: Percentage of children under 13 years whose parents attempt to protect them from sun exposure, by method, Victoria, 2006



Source: Victorian Child Health and Wellbeing Survey 2006

Avoidance of sunlight with the use of clothing and sunscreen, avoidance of exposure to sunlight in the middle of the day, use of a broad-spectrum sunscreen with a minimum sun protective factor 15 and the use of sun protective structures are all strategies that can be employed to reduce the exposure to sunlight (The Cancer Council Australia 2004).



Parental physical activity

The National Physical Activity Guidelines recommend that adults should engage in at least 30 minutes of moderate-intensity activity on at least five days per week.

Indicator: Proportion of parents meeting recommended physical activity levels

The 2007 VPHS found that just under two-thirds (64.4 per cent) of parents and carers with children aged under 18 years had undertaken sufficient physical activity during the previous week. (The proportion of adults who were not parents of children under 18 undertaking sufficient physical activity was similar at 66.2 per cent).

The proportion of parents and carers undertaking sufficient physical activity is marginally lower in 2007 than in 2006 and 2005.¹²² However, the differences are not statistically significant and future data will be needed to determine any trends.

Parental nutrition

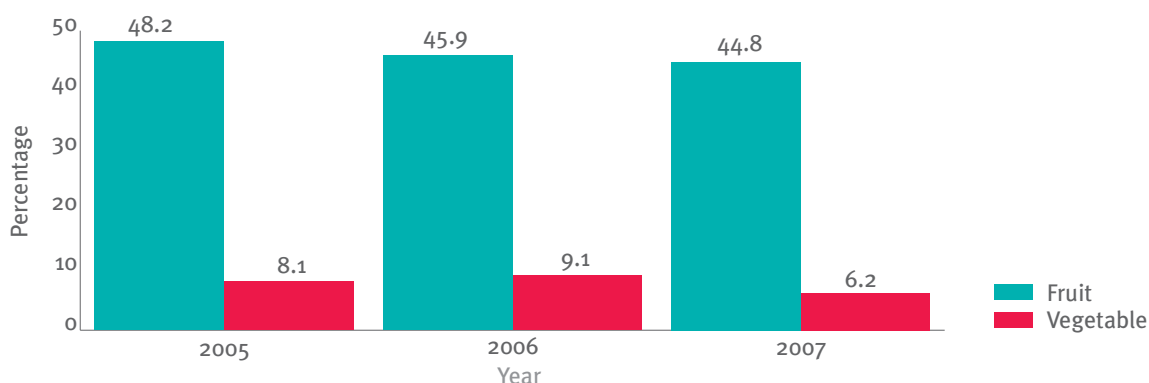
The Dietary Guidelines for Australian Adults recommend five serves of vegetables¹²³ and two serves of fruit¹²⁴ daily in order to ensure a healthy diet (NHMRC 2003).

Indicator: Proportion of parents who eat the minimum recommended serves of fruit and vegetable every day

The VPHS 2007 found that only 6.2 per cent of parents and carers with one or more children under the age of 18 years consumed the daily recommended level of vegetables, whereas 44.8 per cent consumed the daily recommended level of fruit.

As figure 3.4 shows, the percentage of parents and carers consuming the recommended serves of vegetables has declined from 9.1 per cent in 2006.

Figure 3.4: Percentage of parents and carers with one or more children aged 0–17 years, consuming recommended serves of fruit and of vegetables, Victoria, 2005 to 2007



Source: VPHS 2005 to 2007

¹²² The proportion of parents and carers with one or more children under 18 years who met recommended physical activity levels was 66 per cent in 2005 and 66.8 per cent in 2006.

¹²³ A serve is half a cup of cooked vegetables or a cup of salad vegetables.

¹²⁴ A serve is one medium piece or two small pieces of fruit, or one cup of diced pieces.



Healthy family functioning

Family functioning is about how families make decisions, solve daily problems, communicate and maintain relationships (Zubrick et al. 1996). In families where cohesion is high, the benefits include having positive role models for building relationships, an ability to cope with stressful events in life and development of high self-esteem. In contrast, in families where there are high levels of conflict and discord, the effects on the wellbeing of children can be adverse (AIHW 2007). As noted earlier, the wider community context is a key influence on family functioning.

Indicator: Proportion of children and young people living in families with healthy family functioning

The 2006 VCHWS found that the vast majority (89.5 per cent) of Victorian children aged under 13 years were reported to live in households with healthy family functioning (as measured using the McMaster Family Assessment Device, Epstein et al. 1983).



3.2 Factors that may have adverse impacts

Summary

- 33.7 per cent of children aged under 2 years had mothers who drank alcohol after becoming aware of their pregnancy, with 30.7 per cent continuing to drink into the later stages. 12.1 per cent of women reported smoking during the early stages of pregnancy and 9.3 per cent continued to smoke (VCHWS).
- 68.1 per cent of Victorian children aged below 13 years do not live with a regular smoker. Children in rural areas and those who are listed on health care cards are less likely to be from smoke-free households (VCHWS).
- 21.6 per cent of parents and carers are drinking alcohol at least monthly at levels that risk short-term harm. This includes 9.7 per cent of parents and carers who are drinking at least weekly at levels that were risky or high risk to health in the short term. 3.2 per cent of parents and carers are drinking at levels that risk long-term harm (2007 VPHS).
- Between 21.7 per cent and 23.5 per cent of children in Victoria are estimated to live in homes where a parent is affected by mental illness (Maybery 2005, in DEECD 2008).
- The prevalence of postnatal depression among women is estimated at around 15 per cent (based on statewide surveys). The 2007 VPHS reports that 2.9 per cent of parents and carers are at high risk of psychological distress (3.2 per cent in 2005).
- Trend data from the Victorian Family Violence Database show marked increases in the number of family violence incidents recorded by police (1999–2000 to 2002–03) and in the number of aggrieved family members seeking intervention orders from the courts (2003–04 to 2005–06). These increases are likely to be linked to greater public reporting of family violence and to enhanced police, training and data collection and recording practice, following on from a Victoria Police review of practice in relation to family violence in 2001 and the introduction of *The Code of Practice for the Investigation of Family Violence* in 2004.
- In around 65 per cent of family violence incidents recorded by police in each of the five years 1999–2000 to 2005–06, at least one child was recorded as being present during the incident. The number of children aged 16 and under who were recorded by police as present at family violence incidents increased between 1999–2000 and 2003–04, but declined again in 2005–06 (Department of Justice, 2008).



Alcohol use and smoking in pregnancy

Indicator: Proportion of children exposed to alcohol while in utero

Indicator: Proportion of children exposed to tobacco while in utero

Alcohol in pregnancy is related to low birth weight, premature births and increased risk of cognitive defects and congenital abnormality.¹²⁵

Smoking in pregnancy significantly increases the rate of perinatal mortality and doubles the risk of having a low-birth-weight baby (Laws et al. 2006). There is also strong evidence that smoking is associated with intrauterine growth restriction, prematurity, birth defects and Sudden Infant Death Syndrome (AIHW 2005; Chomitz et al. 1995; McCormick 1985; McDermott et al. 2002).¹²⁶

The 2006 VCHWS collected information about the alcohol use and smoking during pregnancy of women with children under 2 years of age.

The survey found that a third of children aged under 2 years had mothers who continued to drink alcohol after becoming aware of their pregnancy, with just over 30 per cent continuing to drink into the later stages (table 3.1). After becoming aware of their pregnancy, just over 3 per cent of the mothers reported ‘binge drinking’ – more than 4 standard drinks in one day – at least once and just over 1 per cent reported binge drinking at least once a week (data reported in DHS 2006).

Table 3.1: Reported percentage of alcohol use in pregnancy, women with children under 2 years of age, Victoria, 2006

Aware of pregnancy?	Drank alcohol (%)	Binge drank once or more (%)	Binge drank at least weekly (%)
No	60.8	21.0	8.0
Yes (early stages)	33.7	3.5	1.0
Yes (later stages)	30.7	3.9	1.3

Source: VCHWS 2006

Just over one in five women reported smoking prior to being aware of their pregnancy, one in eight continued to smoke during the early stages, with one in 11 continuing to smoke in the later stages. The median number of cigarettes smoked daily halved when the women became aware of their pregnancy (table 3.2).

Table 3.2: Reported percentage of cigarette smoking during pregnancy, women with children under 2 years of age, Victoria, 2006

Aware of pregnancy?	Smoked cigarettes (%)	Median number smoked daily (%)
No	21.9	10.0
Yes (early stages)	12.1	5.0
Yes (later stages)	9.3	5.0

Source: VCHWS 2006

¹²⁵ The most severe of these is foetal alcohol syndrome (FAS), which includes characteristic physical anomalies, growth retardation and neurological dysfunction with developmental delay (O’Leary 2002; Single et al. 1999).

¹²⁶ Smoking in pregnancy has also been linked to asthma, attention deficit disorder and obesity (Laws et al. 2006).



Healthier mothers and babies

A key focus under Best Start will be modifying risk behaviours of women during pregnancy, such as smoking and alcohol use. A series of education and support sessions for women will be made available throughout their pregnancy with links to a range of health professionals and other important services.

Exposure to tobacco smoke

Indicator: Proportion of children and young people exposed to tobacco smoke in the home

Passive smoking, or the inhalation of second-hand smoke, may lead to childhood respiratory infections, increased severity of asthma, and inflammation and allergic responses. Children in households with a smoker are also more likely to take up smoking themselves, with a threefold increase in daily smoking among young people with any second-hand smoke exposure (Darling & Reeder 2003).

The 2006 VCHWS found that the majority (68.1 per cent) of Victorian children up to 13 years do not live with a regular smoker (data reported in DHS 2006). More recent analysis of VCHWS data show that children in rural areas of Victoria and children who are listed on health care cards are less likely to be from smoke-free households (55.1 per cent of Victorian children on health care cards live in a smoke-free household, compared with 73.1 per cent of children who are not on a health care card). 64.5 per cent of children in rural areas live in smoke free homes, compared with 69.4 per cent of children in metropolitan areas.

Parental risky drinking

Indicator: The proportion of parents who report risky drinking

While alcohol consumption at low or moderate levels can yield health benefits, regular excessive consumption can have major negative impacts, including reduction in family income and social isolation, ill health and depression.

Younger family members can acquire patterns of alcohol consumption from older family members (Abrams & Niaura 1987; Barnes et al. 1997; Kandel 1983; Sher et al. 1997). Alcohol is involved in many cases of family violence and appears to play a role in child neglect (English et al. 1995).

The *Australian Alcohol Guidelines* (NHMRC 2001) categorise risk according to three levels:

- Low risk – a level of drinking at which the risk of harm is minimal and there are possible benefits for some of the population
- Risky – a level of drinking at which the risk of harm outweighs any possible benefit
- High risk – a level of drinking at which there is substantial risk of serious harm and above which risk increases rapidly

The 2007 VPHS found that 21.6 per cent of parents and carers were drinking at least monthly at levels that were risky or high-risk to health in the short term. This includes 9.7 per cent of parents and carers who were drinking at least weekly at levels that were risky or high-risk to health in the short term. Just over one third (34.9 per cent) of parents and carers were consuming alcohol at low risk levels and 17 per cent were abstainers.

A minority of parents and carers were drinking at levels that risked long-term alcohol-related harm. 3.2 per cent of parents and carers were drinking at this level, compared with 3.7 per cent of adults without children.



Mental health problems and disorders in parents

Indicator: The proportion of children and young people who have parents with mental health difficulties

Indicator: The proportion of mothers with post-natal depression

When a parent is affected by a mental illness, there are serious implications for immediate family members, especially children. These children may experience disconnection from family, friends, school and their communities. Research indicates that children of a parent with a mental illness are at higher risk for the onset of mental illness themselves.¹²⁷

Children with a parent who has a mental illness may take on significant daily responsibilities in the family home, caring not only for the parent but also other family members. There are many negative effects for these children if they are unsupported in this role.¹²⁸ They may also be confronted by fear, misunderstanding and prejudice associated with mental illnesses, which can result in lasting negative psychological effects (Ostman 2002).

According to estimates based on ABS data, between 21.7 per cent and 23.5 per cent of children in Victoria (or approximately 250,000 children) are estimated to live in homes where a parent is affected by a mental illness (DHS 2007, in DEECD 2008).

Postnatal depression

Postnatal depression occurs in the months following childbirth and is the most prevalent mood disorder associated with childbirth. Postnatal depression tends to develop gradually but can persist for months. Research suggests that the mother's depressive symptoms may have both direct and indirect impacts on the infant's emotional, behavioural and social development (Cooper et al. 1996; Murray 1992; Murray & Cooper 1997).¹²⁹ Postnatal depression can also impact on any older children as the depression may impair the mother's ability to be involved in her children's lives (Murray & Cooper 1997).

In Victoria, the prevalence of postnatal depression among women in the three to nine months after birth has been measured as approximately 15 per cent, based on three statewide surveys of mothers at five to nine months after birth in Victoria (Brown et al. 2004, in DHS 2006).

¹²⁷ Adolescents who have a parent with a mental illness are two to four times more likely to develop mental health problems (Lieb 2002, Clarke, 2001, Chang 2000, Beardslee 1998). Greater severity of parental mental illness is associated with increased risk, earlier age of onset (Beardslee et al. 1998), and a more complicated course of illness for the children (Chang 2000, Lieb 2002).

¹²⁸ These include socioeconomic disadvantage, isolation, low levels of health and emotional wellbeing, impaired psychosocial development, limited friendships, difficulties developing intimate relationships, low participation and attainment at school and in employment, difficulties making the transition to independence, and a lack of opportunities and choices (Carers Australia 2001, Handley et al. 2001).

¹²⁹ There is also evidence to suggest that maternal depression in the first year can influence children's cognitive abilities and behaviour later in childhood (Cogill et al. 1986, Hay & Kumar 1995, Sharp et al. 1995, Williams & Carmichael 1985).



The National Perinatal Depression Initiative

The National Perinatal Depression Initiative is a joint federal and state initiative, with funding being provided by each Australian state and territory. The initiative is intended to enhance early identification of mothers and expectant mothers who are experiencing distress, depression, anxiety or other mental health problems. This will be achieved via investment in training a range of front-line practitioners in the effective use of identification tools such as the Edinburgh Postnatal Depression Scale. The initiative will also consider how referral pathways for services can be improved, so that women at risk of developing depression receive a timely response.

The initiative will complement existing services for women at risk of developing prenatal or postnatal depression. Examples of such services are the Postnatal Depression Mental Health Initiative which funds specialist mother/baby services to deliver primary and secondary consultation to maternal and child health nurses, and funding for PaNDa, a statewide association that works with women and their families affected by antenatal and postnatal mood disorders.

Psychological distress

Psychological or emotional distress refers to an individual's overall level of psychological strain or pain, as reflected in states of depression, anxiety and anger. Psychological distress may be fairly transient, but may also be a continuing problem, particularly among those experiencing mental health problems and clinical disorders (AIHW 2007).

The VPHS uses the Kessler 10 scale to assess the proportion of parents who are at high risk of suffering from psychological distress.^{130,131}

The 2007 VPHS found that 2.9 per cent of parents and carers were at high risk of suffering from psychological distress. This proportion is not significantly different from the proportions in 2005 (3.2 per cent) and 2006 (2.6 per cent). Parents were no more or less likely to be at high risk of psychological distress than other adults.

These results are similar to those reported in the 2006 VCHWS.¹³² However, although only a small minority of parents in the VCHWS were reported to be at high risk of psychological distress, single parents and the main carers of children listed on health care cards were significantly more likely to be categorised as being at high risk of psychological distress (in comparison to the carers of children not listed on health care cards or with couple parents).

An evaluation of the Paying Attention to Self (PATS) program for young people who have a parent affected by mental illness

A study of young people attending a peer support program for those living with a parent affected by a mental illness found that these young people were three times more likely to report depressive symptoms and three times more likely to report a high risk of homelessness compared to a Victorian school-based representative sample (Hargreaves et al. 2006).

With respect to caring for their parent and/or family, 30 per cent reported a high level of burden of care in terms of time and responsibility and 72 per cent reported a high level of emotional impact (Hargreaves et al. 2006). About 45 per cent reported experiencing moderate to high levels of stigma. The females were twice as likely and the males five times more likely to have been suspended from school but they were less likely to smoke or drink alcohol.

¹³⁰ Standardised self-report questionnaires are commonly used to measure psychological distress and generally have predefined cut-off points reflecting high levels. Respondents scoring more than 30 on the Kessler 10 scale are considered to be at high risk of psychological distress.

¹³¹ There are no current sources of data to measure this for children and young people aged under 18 years. The Victorian Adolescent Health and Wellbeing Survey will collect data for this indicator.

¹³² The VCHWS found that 2.9 per cent of parents with children under 13 years were at high risk of psychological distress.



The Families where a Parent has a Mental Illness (FaPMI) strategy

The overall aim of the FaPMI strategy is to reduce the impact of parental mental illness on all family members through timely, coordinated, preventative and supportive action.

Three service development objectives underpin the strategy:

- Increase the capacity of specialist mental health services (clinical and psychiatric disability rehabilitation and support services – PDRSS) to provide a family-focused response to the parenting needs of their clients and the needs of their clients’ children.
- Increase the capacity of specialist mental health service network partners to recognise and respond appropriately to parental mental illness.
- Establish and strengthen the capacity of networks and support structures involving mental health services and their network partners, in partnership with consumers and carers, to support the needs of all family members through collaborative approaches to service provision.

Some services will require relatively small modifications to the ways they do their work. For others, more integrated service innovations and partnerships will be required.

The 2008–09 budget investment has enhanced the FaPMI strategy to focus on vulnerable families with parental mental illness and/or substance abuse issues who present to Child FIRST. By early 2009, there will be some FaPMI presence in each of the DHS regions and these enhanced positions will work collaboratively and closely with Child FIRST.

Family violence

Indicator: Proportion of mothers exposed to partner violence

Indicator: Proportion of family violence incidents where children and young people are involved as other parties

Family violence is defined for the purposes of the Victorian Family Violence Database as: ‘Violent, threatening, coercive or controlling behaviour in current or past familial, domestic or intimate relationships’. This encompasses not only physical injury but direct or indirect threats, sexual assault, emotional and psychological torment, economic control, property damage, social isolation and behaviour that causes a person to live in fear.

Family violence is committed primarily, though not exclusively, by men against women. This definition encompasses violence against children and between siblings and is not limited to criminal behaviours as identified in the Victorian *Crimes (Family Violence) Act 1987* (Department of Justice 2008), recently replaced by the *Family Violence Protection Act 2008*.

While the focus of work on family violence has generally in the past been limited to ‘intimate partner’ or ‘domestic’ violence between spouses and de facto partners, there is increasing recognition that family violence can involve other family members, including children, and that child abuse and family violence often co-exist (Bagshaw & Chung 2000a; Laing 2000, in Department of Justice 2008; *Family Violence Protection Act 2008*).¹³³

¹³³ The *Family Violence Protection Act 2008* recognises that ‘children exposed to family violence are vulnerable and their current and future physical, psychological and emotional wellbeing may be affected’ (Australian Government Department of Parliamentary Services 2008). The definition of family violence has been expanded to include behaviour which ‘causes a child to hear or witness, or otherwise be exposed to the effects of family violence’. Examples may include not only overhearing or witnessing abuse but also ‘comforting or providing assistance’ to a victim of physical family violence, ‘cleaning up a site’ after a family member has intentionally damaged another member’s property, or being present when police attend an incident of physical family violence’.



For example, a quarter of Australian children and young people have witnessed acts of violence against their mother or stepmother (Indermaur 2001, in Department of Justice 2008) and estimates suggest that between 30 and 60 per cent of children who witness family violence also experience some forms of abuse (Brown & Endekov 2005, in Department of Justice 2008). Research also identifies pregnancy as a high-risk factor for family violence (ABS 1996; Walsh & Weeks 2004, in Department of Justice 2008).

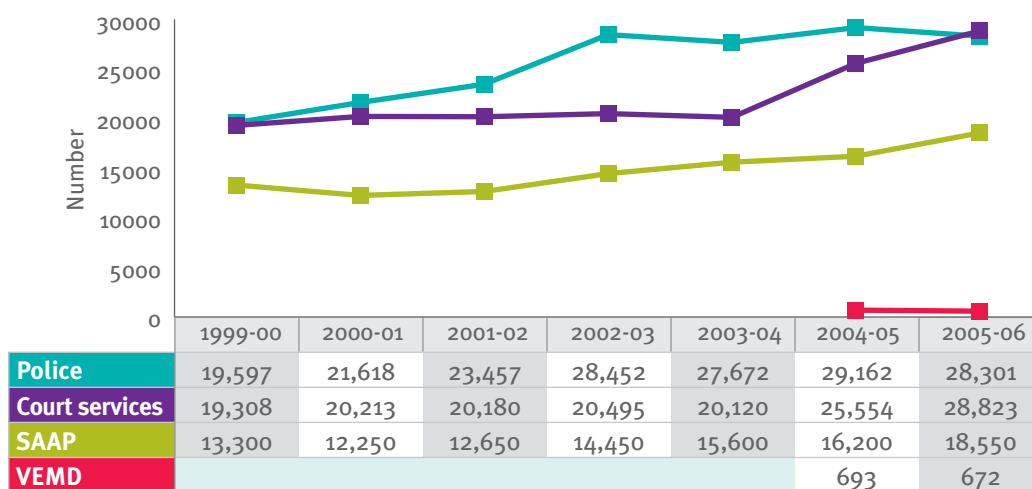
The Victorian Family Violence Database provides information about family violence from a comprehensive database, primarily drawn from the following four sources:

- Incidents that have been recorded by the police (1999–2000 to 2005–06)
- The number of family-violence-related intervention order applications finalised in the Magistrates’ Court and Children’s Court of Victoria (1999–2000 to 2005–06)
- The number of client support periods where Victorian SAAP agencies provided assistance for family-violence-related issues (1999–2000 to 2005–06)
- Incidents of ‘human intent injuries’ identified in hospital emergency departments (from the Victorian Emergency Minimum Dataset, VEMD) (2004–05 and 2005–06).

As people who are experiencing family violence may not come to the attention of these agencies, the database does not provide a picture of overall levels of family violence in Victoria. However, it does contribute to a more comprehensive picture about the services that are being provided to those families who do seek assistance than has been available previously and allows for analysis of trends and patterns across agencies responding to family violence.

Figure 3.5 provides data from the Victorian Family Violence Database on the total number of family violence incidents/support periods recorded in each of the four sources, in the seven years 1999–2000 to 2005–06.

Figure 3.5: Number of family violence incidents recorded by the police, court services, SAAP and VEMD, Victoria, 1999–00 to 2005–06



Department of Justice 2008



Between 1999–2000 and 2002–03, there was a marked 45 per cent increase in the number of family violence incidents recorded by police, with the number of incidents levelling off at around 28,500 over the past four years. Similarly, between 2003–04 and 2005–06, there was a notable 43 per cent increase in the number of aggrieved family members seeking intervention orders from the courts. Rather than an actual increase in the number of incidents of family violence, factors that are likely to have contributed to these notable increases include: greater public awareness and confidence about reporting family violence; and enhanced police training, data collection and recording practices, following on from a Victorian Police review of practice in relation to family violence in 2001 and the introduction of the *Victoria Police Code of Practice for the Investigation of Family Violence* in 2004 (Department of Justice 2008).

There has also been a steady increase in the number of client support periods where Victorian SAAP agencies provided assistance for family-violence-related issues since the Victoria Police conducted the 2001 review of practice in relation to family violence.

Victorian family violence reform milestones

Since 2002, the Government's family violence reform agenda has focused on the development and implementation of culturally appropriate primary prevention responses, including improvements in intensive case management, crisis responses, access to men's behaviour change programs and the introduction of a Statewide Prevention Plan.

Specific 2008 priorities have included a communications campaign to increase awareness of the new Victorian *Family Violence Act 2008*; the release of the *Practice Guidelines for Family Violence Women's and Children's Counselling and Support Programs*; and the commencement of community consultation regarding the Indigenous Family Violence Ten Year Plan.

Indigenous women

Indigenous women are much more likely than non-Indigenous women to reportedly be the victims of family violence. For example, across Australia, 24 per cent of female clients escaping domestic violence with assistance from SAAP services were Indigenous (Department of Justice 2008).

Children and family violence

In around 65 per cent of family violence incidents recorded by police in each of the five years 1999–2000 to 2005–06, at least one child was recorded as being present during the incident. The 0–4-year-old age group was the most highly represented, with approximately 40 per cent of children recorded as 'present' falling into this age group.¹³⁴

Police records also show that the number of children aged 16 years and under who were recorded as present at family violence incidents increased by 38 per cent from 18,541 in 1999–00 to 25,577 in 2003–04, but declined again in 2005–06 to 23,451 (Department of Justice 2008). Increases in the number of children reported as present at family violence incidents may be a reflection of both increased reporting of family violence to police, and increased police reporting about children present.

The number of aggrieved family members in finalised intervention order applications, who were aged 17 years and under, increased by 17 per cent over the five-year period from 4530, in 1999–00, to 5310 in 2003–04. In 2005–06 the number of children nearly doubled to 9718 (Department of Justice 2008). As a result of family violence reform in the justice system, intervention orders more commonly list children separately from their parents, whereas previously children were more frequently included on the application with the mother and were therefore unable to be counted.

¹³⁴ Over the first four years of data collection, the remaining children were almost equally as likely to be aged 5–9 years or 10–16 years. However, over the most recent three years there was a notable increase in the presence of older children aged between 10–16 and a decline in the presence of those aged 5–9 years (Department of Justice 2008).





Section 4: How well are Victorian families supported?

The level and quality of support that is available from the wider community and from child and family services are critical influences on the capacity of families to function well and to help ensure the best outcomes for their children.

Section 4 focuses on: the support that families receive from communities (4.1), the financial resources and housing that are available to Victorian families (4.2) and the support that families receive from services (4.3).





4.1 Support from communities:

Summary

- Victorian parents report high levels of social support, with 94.4 per cent reporting that one of their relatives or friends could care for them or their children in an emergency, and 96.8 per cent reporting that there is someone they could turn to for advice if they were having problems. Single parents report lower levels of support (VCHWS).
- Parents rate their local neighbourhoods very highly, with 95.9 per cent agreeing or strongly agreeing that their neighbourhoods are clean, and 94.4 per cent that they are safe.
- 82.5 per cent of metropolitan parents agree or strongly agree that their neighbourhood has access to close, affordable and regular public transport, compared to 50.5 per cent of rural parents.
- Parents whose child is listed on a health care card give less positive ratings of their local facilities and services than parents whose child is not (VCHWS).
- The 2007 VPHS found that parents with children were more likely than adults without children to have attended a community event in the past six months (61.3 per cent of parents, compared with 43.9 per cent of other adults).
- The majority (80.6 per cent) of Victorian parents agree that multiculturalism makes life in their area better (2007 VPHS) (compared with 78.7 per cent of parents in 2006 and 83.7 per cent of parents in 2005). 36.5 per cent of parents agree that there are opportunities to have a say on issues that are of importance to them.

Help when needed and social support

As noted earlier in this report, social support is a contributory factor to the health and wellbeing of both adults and children. In order for families to build connections and draw on informal assistance, the existence of networks of shared values, trust and belonging are important.

The 2006 VCHWS asked parents of children aged 5–12 years the following:

- 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?

Indicator: The proportion of children and young people from families who are able to get support in time of crisis when needed

Indicator: The proportion of parents who have someone to turn to for advice when having problems

Overall, 94.4 per cent of children had parents who reported very high levels of support stating that one of their relatives or friends could care for them or their children in an emergency. In addition, 96.8 per cent of children had parents who agreed or strongly agreed there was someone they could turn to for advice if they were having problems.

There was no difference between the responses of parents living in metropolitan areas and those in rural areas. However, one-parent families consistently reported lower levels of social support than two-parent families (tables 4.1 and 4.2).



Table 4.1: Percentage of children, aged 5-12 years, who had a parent that answered ‘yes’ when asked whether one of their relatives or friends could care for them or their children in an emergency, Victoria, 2006

All parents	94.4
Two-parent families with dependent children	95.1
One-parent families with dependent children	90.5

Source: VCHWS 2006

Table 4.2: Percentage of children, aged 5-12 years, who had a parent that agreed or strongly agreed there is someone they trust who they could turn to for advice in an emergency, Victoria, 2006

All parents	96.8
Two-parent families with dependent children	97.5
One-parent families with dependent children	93.2

Source: VCHWS 2006

Neighbourhood safety and the physical and social environment

An individual’s perceptions of neighbourhood safety relate closely to their general level of satisfaction with their local community. The physical environment can also inhibit or promote health-related behaviours. For example, while physical activity may be encouraged through the provision of public spaces that are easily accessible and well maintained, people are often unwilling to visit spaces that are considered to be unsafe because they are poorly lit or under-used (Butterworth 2000).

Living in areas of heavy traffic can contribute to parents’ fears of traffic accidents, restricting children’s freedom to walk or cycle (WHO 2002). This in turn may hinder the development of independence, reduce social contact and lead to unhealthy levels of inactivity. As shown earlier, there has been a marked increase in the proportion of trips to school by car over the past 30 years, and fear of traffic may be a contributory factor. Research in the UK suggests that traffic fears and fear of ‘stranger danger’ are key concerns among parents (Greater London Authority 2004).

Exposure to heavy road traffic has been linked to increased prevalence of respiratory symptoms with studies showing that children living next to busy roads have an increased risk, around 50 per cent, of suffering from respiratory disease (WHO 2002). Children living in low-income families are more likely to grow up in neighbourhoods bordering on polluting industries or main roads (Chaudhuri 1998).

Children are known to be more vulnerable than adults when exposed to environmental toxins. There are several reasons for this. As children have a higher metabolic rate they eat more food, drink more water and breathe more air relative to their body size, potentially exposing them to more environmental toxins. Young children’s intake of soil, particulate matter and dust is higher than in adults, as they may play on, and are closer to the ground (Wigle 2003). Children also face a greater risk from environmental hazards because they are growing rapidly and have a different physiology from adults.^{135,136}

¹³⁵ Cells that are growing and dividing most rapidly are more likely to be affected by environmental toxins (Chance and Harmsen 1998). As the blood/brain barrier is more permeable in children they may be more vulnerable to the effects of some toxic chemicals than adults (Wigle 2003).

¹³⁶ Older children are also more susceptible than adults to environmental hazards. Adolescents have higher metabolic rates (Pike-Paris 2004, Yassi et al. 2001) and their normal growth can be affected when exposed to pollutants at a critical time of development (Hansen et al. 2003; Mathieu-Nolf 2002). They are also at higher risk of exposure to certain environmental factors, as they tend to spend more time outdoors (Hansen et al. 2003).



Outdoor air quality

Indicator: Proportion of days each year with very poor to very good air quality index ranges for ozone

Indicator: Number of days not meeting air quality standards

Ozone and particles smaller than 10 micrometres (PM₁₀)

Ozone is a naturally occurring gas that is found in low concentrations in the lower atmosphere (the air we breathe). Ozone is also a pollutant, and is the main component in summer smog. Exposure to high levels of ozone can result in increases in asthma attacks and hospitalisations for heart and lung conditions. Higher concentrations of ozone are formed when chemical reactions between certain pollutants (nitrogen dioxide and hydrocarbons) take place in the presence of sunlight. This happens between late spring and early autumn, when there is enough warmth and sunlight for the chemical reactions to occur.¹³⁷

The air objectives for ozone and PM₁₀ are:

Air quality indicator	Air objectives	Goal (by 2008)*
Ozone	One-hour average of 100 ppb Four-hour average of 80 ppb	No more than one day a year where the objectives are not met
PM₁₀ particles	One-day average of 50 µg/m ³	No more than five days a year where the objective is not met

* as measured at each monitoring site

ppb = parts per billion

In Melbourne in the early 1980s, the ozone objectives were frequently not met. Significant improvement has occurred since then. In recent years we typically only see a day not meeting the objectives approximately once every two years. This is mainly due to progressive improvements in vehicle emission standards.¹³⁸

Particles smaller than 10 micrometres (or less than a tenth the width of human hair) are called PM₁₀. If levels of outdoor PM₁₀ are high, this can exacerbate existing heart and lung conditions. The major sources of particles in an urban environment are motor vehicles (particularly diesel-powered), industry and wood combustion for heating. In recent years, bushfire smoke and windblown dust have contributed significantly to high particle levels. In years not significantly affected by bushfire smoke or dust, Melbourne monitoring stations typically meet the goal.

¹³⁷ Ozone in the air we breathe should be distinguished from ozone in the stratosphere (the ozone layer), which has the beneficial effect of absorbing harmful radiation.

¹³⁸ Exceptional ozone events may occur if bushfire smoke is blown towards the city; several such events occurred in 2003. However, most ozone events are a result of pollution generated in the urban area. A similar bushfire effect will be observed in monitoring data from 2006.



Drinking water

Indicator: Number of accedence of water quality standards for E. Coli

Escherichia coli (*E. coli*) is a bacterium that can occur in water supplies as a result of faecal contamination from humans and animals or from vegetative sources. Detecting *E. coli* in treated drinking water supplies can also indicate that the disinfection process is inadequate or has failed.

The state's water quality standard for *E. coli* states that 98 per cent of samples collected over any 12-month period should contain no *E. coli* per 100mL of drinking water.¹³⁹

For the 2005–06 reporting period, 471 out of 493 water sampling localities (95.5 per cent) met this *E. coli* standard. This compares with 451 out of 473 water sampling localities (95.4 per cent) for 2004–05 (reported in DHS 2006).

Water localities that did not comply with the standard in either reporting period were Clunes, Sea Lake, Corryong (high level), Corryong (low level), Tawonga, Tawonga Ranch Road, Mount Baw Baw and Mount Buller (low level).

What Victorian parents think about the physical and social environment

The 2006 VCHWS asked parents (of children aged 0–12 years) 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.

Indicator: Proportion of children and young people living in clean neighbourhoods

Indicator: Proportion of children and young people living in neighbourhoods with heavy traffic

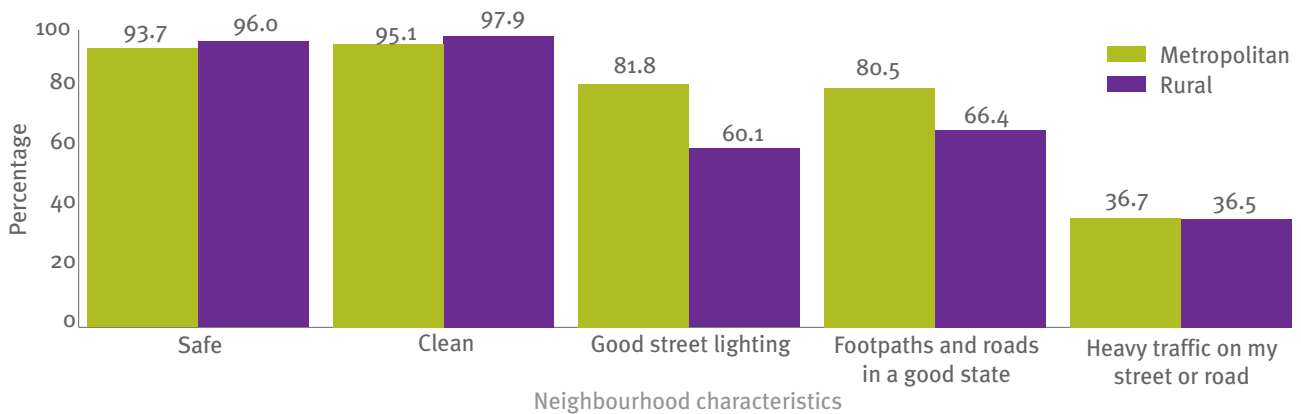
Overall, parents rated the liveability of their neighbourhoods very highly. A very high proportion of children live in neighbourhoods which their parents agreed or strongly agreed were clean (95.9 per cent), safe (94.4 per cent), had good street lighting and where the state of the roads and footpaths 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) (2006 VCHWS, in DHS 2006).

As figure 4.1 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. 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.

¹³⁹ Under the *Safe Drinking Water Act 2003*, water authorities collect and report on this indicator to the Environmental Health Unit of the DHS. All drinking water sampling localities are monitored weekly for the presence of *E. coli*.



Figure 4.1: Rating by parents of children aged 0–12 years of the physical and social environment of their local neighbourhoods, Victoria, 2006



Source: VCHWS 2006, in DHS 2006

Access to local facilities and services

Social opportunities and economic conditions within an area, such as housing, employment opportunities, access to services and amenities and the quality of the environment impact significantly on the health and wellbeing of parents and their children (Butterworth 2000).

The 2006 VCHWS asked parents of children aged 0–12 years 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.

Indicator: Proportion of children and young people living in neighbourhoods with good parks, playgrounds and play-spaces

Indicator: Proportion of children living in neighbourhoods with close, affordable public transport

Indicator: Proportion of children and young people living in neighbourhoods with basic services

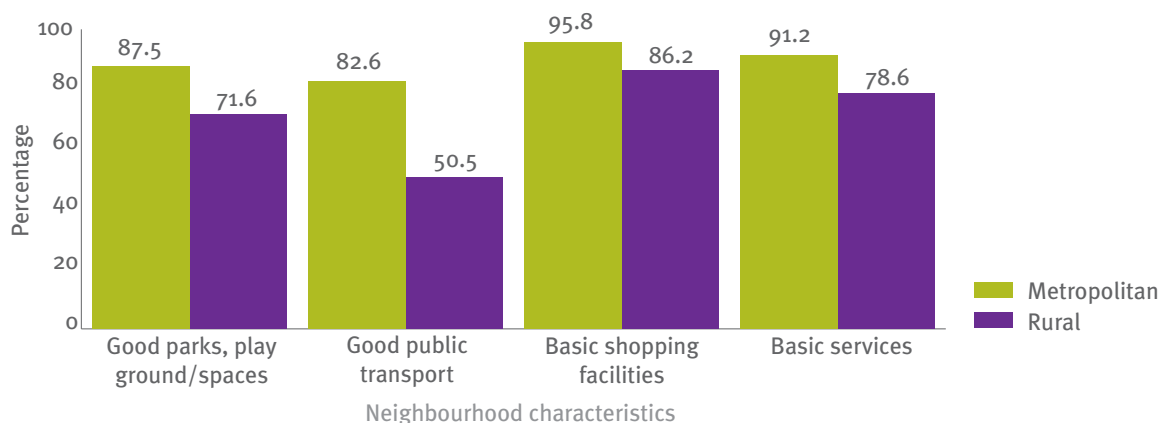
Indicator: Proportion of children and young people living in neighbourhoods with basic shopping facilities



Overall, parents rated their neighbourhoods very positively. 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 (2006 VCHWS, in DHS 2006).

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,¹⁴⁰ and the largest difference in perception related to transport (2006 VCHWS, in DHS 2006). While 82.6 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 4.2).

Figure 4.2: Rating by parents of children aged 0–12 years of access to local facilities and services in their neighbourhoods, Victoria, 2006



Source: VCHWS 2006, in DHS 2006

In general, parents whose child was listed 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 listed 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 (2006 VCHWS, in DHS 2006).¹⁴¹

¹⁴⁰ 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.

¹⁴¹ There was no significant difference in the percentage of those agreeing or strongly agreeing that there was access to good transport.



Acceptance of diversity and multiculturalism, and opportunities to have a say

Indicator: The percentage of parents and young people who believe their community is an accepting place for people from diverse cultures and backgrounds

Indicator: The percentage of parents who believe that they have the opportunity to have a say on issues that matter to them

Multiculturalism is an important characteristic of Victorian communities and attitudes to multiculturalism can impact on people's community participation and feelings of safety (DEECD 2008).

Parents' willingness to become involved in community networks and activities may be influenced by the extent to which they feel they have a say on issues that are of importance to them. Respondents to the 2007 VPHS were asked: 'Do you think that multiculturalism makes life in your area better?' The majority (80.6 per cent) of parents agreed¹⁴² that multiculturalism made life in their area better (compared with 78.7 per cent of parents in 2006 and 83.7 per cent of parents in 2005).

The 2007 VPHS also asked: 'Do you feel there are opportunities to have a say on issues that are important to you?' 36.5 per cent of parents answered, 'Yes, definitely.'¹⁴³

Opportunities to participate in activities

Indicator: Opportunities for families to participate in community, cultural and recreational activities

The 2007 VPHS asked respondents: 'Have you attended a local community event in the past six months (like a church fete, school concert, or craft exhibition)?'

51.5 per cent of the survey population answered 'yes'. Parents were much more likely to answer 'yes' than adults with no children (61.3 per cent and 43.9 per cent respectively). This difference in response was statistically significant and is probably explained, in part at least, by parental involvement in school-based activities.

Children play an active role in the development of their families' social networks and this may be a key contributory factor in explaining the difference.¹⁴⁴

¹⁴² 'Parents' refers here to parents of one or more children under the age of 18 years. The proportion who agreed combines the responses of those who said 'yes, definitely' and those who said 'Sometimes.'

¹⁴³ The proportion of the survey population answering 'Yes, definitely' was 38.8 per cent.

¹⁴⁴ Recent research in the UK has highlighted that children play an active role in the development of neighbourly relationships and connections. A study funded by the Economic and Social Research Council showed that the more social networks the children have in a neighbourhood, the greater the parents' confidence in the safety of the area. This research challenges the idea that social networks are largely determined by parents, and suggests that children are active participants in developing neighbourhood relationships and connections (Weller S and Brugel I, in Greater London Authority 2007).



4.2 Economic wellbeing, housing and homelessness

Summary

- The median weekly income for one-parent families in Victoria is \$587, compared with \$1434 in two-parent families.
- While parents in one-parent households are just as likely as parents in two-parent households to have a non-school qualification of diploma level or higher, single parents are less likely to have completed Year 12 or equivalent.
- 5.8 per cent of children aged under 13 years were from families where a parent reported that there had been times in the past 12 months when they had run out of food and couldn't afford to buy more. In one-parent households, the proportion was 19.7 per cent, compared with 3.5 per cent in two-parent households (VCHWS).
- 88.6 per cent of children from two-parent households had parents who could raise \$2000 within two days in an emergency, compared with 62.9 per cent of parents of children in one-parent households (VCHWS).
- 75.1 per cent of families with children in Victoria either fully own or are purchasing their home. Indigenous families are less likely to be home owners and more likely to be in rented accommodation.
- The majority of families spend less than 30 per cent of their income on housing. However, the lower the household income, the greater the proportion that is spent on housing costs.
- 24,400 children accessed SAAP services in 2006–07. 20,500 of these were accompanying their parents and 3900 accessed SAAP independently. ATSI children accounted for 9.8 per cent of accompanying children.
- Victoria and New South Wales have the lowest rates of homeless young people aged 12–18 years in Australia (8 homeless youth per 1000). The rate of homelessness in Victoria (and New South Wales) has decreased (2001 to 2006), in line with a national decrease.

There is a strong relationship between socioeconomic disadvantage and poor health, and between education, employment and income with people commonly experiencing disadvantage across all three areas (AIHW 2007a).¹⁴⁵

While Australia is a wealthy country by international standards, some Australians remain at high risk of poverty. Children living in socioeconomically disadvantaged households are at greater risk of poor outcomes both in the short and longer term with respect to many of the areas that are covered elsewhere in this report, including health, access to medical care, safety, family stress and the quality and stability of their care (AIHW 2005a). Research confirms that for many health, development and wellbeing outcomes, children in the lowest income groups are at a greater risk of disadvantage than other children (AIHW 2005a).

There are strong links between poverty, poor housing and poor health. Good-quality, well-located and affordable housing has a key role to play in helping move people out of poverty and in ensuring the wellbeing of children (*A Fairer Victoria: Building on our commitment 2007*), and access to stable, adequate housing is a basic human right.

¹⁴⁵ Although a low socioeconomic background is known to increase the chances of poorer outcomes and opportunities, the causal pathways for this are not fully understood.



Groups at high risk of poverty in Australia

- Indigenous Australians
- People who are unemployed
- People dependent on government cash benefits
- One-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, in DHS 2006

Household employment and income

Indicator: Parental employment status

Indicator: Average real equivalised disposable household income for households with children in the second and third income deciles

Indicator: Median household income

Unemployment is a major cause of income poverty in Australia, although the relationship between unemployment and poverty varies with changes in the labour market.

Generally, families without an employed parent have low income, and are often more socially isolated. Living in a family experiencing unemployment can have long-term effects on children's development, educational progress and employment prospects. Lack of employment can also lead to family stress and conflict that can impact on children's emotional and mental health (McClelland 1994).

Tables 4.3 and 4.4 show the employment status of Victorian parents in two- and one-parent families. In 58.8 per cent of couple households, both parents are employed, with 54.2 per cent of single parents employed. 7.5 per cent of parents in one-parent households are unemployed, compared with 5.4 per cent of two-parent households where no parent is employed.



Table 4.3: One-parent families with children aged 0–17 years, by employment status, Victoria, 2006

Employment status	Percentage
Employed	54.2
Not in the labour force	36.4
Unemployed	7.5
Not stated	1.8
Total	100.0

Source: ABS 2006 Census of Population and Housing

Table 4.4: Two-parent families with children aged 0–17 years, by employment status, Victoria, 2006

Employment status	Percentage
Both parents employed	58.8
One parent employed, other not in labour force	28.1
No parent employed	5.4
Other	7.7
Total	100.0

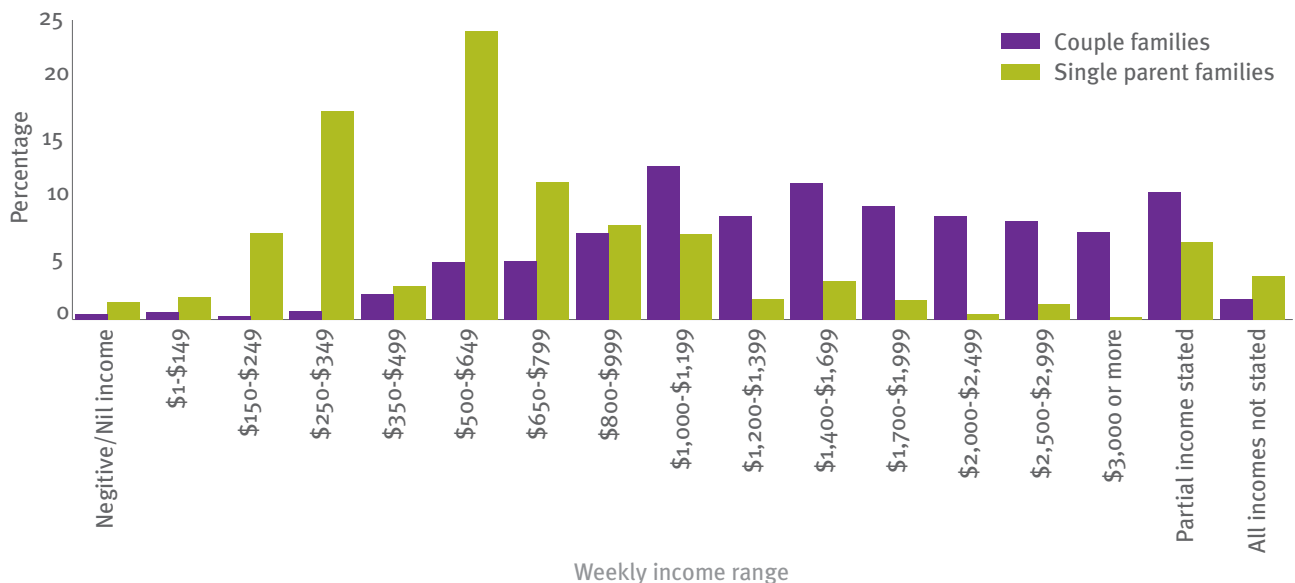
Source: ABS 2006 Census of Population and Housing

While these differences in employment status are not large, the income of one-parent families in Victoria is much lower than that of two-parent families.

Based on the 2006 Census of Population and Housing, the median weekly income for families with children in Victoria was \$1209 (compared to \$1216 for all families with children in Australia). The median weekly income for one-parent families in Victoria is \$587 compared with \$1434 in two-parent families.

Figure 4.3 presents the distribution of weekly income for one- and two-parent families in Victoria based on the 2006 Census.

Figure 4.3: Percentage of one- and two-parent families with children aged 0–17 years in each weekly income range, Victoria, 2006



Source: ABS 2006 Census of Population and Housing



One explanation for this difference in income levels may be the differing working circumstances of parents from one- and two-parent families. The 2006 VCHWS found, for example, that children from two-parent households were less likely to have a parent in casual employment than children from one-parent households.¹⁴⁶

Indicator: Education level of parents

Parental education levels are linked to employment and income (Ewald & Boughton 2002; Zubrick et al. 1996).

Just over a quarter (26.4 per cent) of couple families in Victoria with children live in households where neither parent has completed Year 12 or equivalent. The proportion rises to more than half (56.3 per cent) in Victorian one-parent households.¹⁴⁷ As table 4.5 shows these proportions are slightly lower but broadly similar to the proportions for equivalent households in Australia.

Table 4.5: Percentage of families with children aged 0–17 years where no parent has completed Year 12 or equivalent, Victoria and Australia, 2006¹⁴⁸

	One-parent families (%)	Two-parent families (%)
Victoria	56.3	26.4
Australia	58.2	28.0

Source: ABS 2006 Census of Population and Housing

Understanding and measuring poverty

The question of how to define and measure poverty has been a subject of considerable debate in Australia in recent years. It is generally agreed that relative measures of poverty (which define people as poor if their living standards fall below an overall community standard and they are unable to participate in societal activities) are more appropriate for use in industrialised countries such as Australia than absolute measures (which define people as living in poverty when their consumption level falls below a minimum subsistence level) (unpublished paper on poverty measurement, Department of Treasury and Finance 2007, in DEECD 2008).

Estimates of poverty have commonly been developed using income-based measures. However, these (income-based) measures have come under recent criticism as they provide snapshots of poverty at one point in time. They do not indicate the depth or severity of poverty and do not distinguish between those who are temporarily in poverty and those who are financially disadvantaged over long periods of time.

Additionally, it has been argued that income-based measures do not take into account people's own subjective definitions of what it means to be poor. Increasingly, the view is held among academics and policymakers that multi-dimensional measures of poverty should be used in favour of a reliance on any one single measure.

¹⁴⁶ Research has suggested that engaging in full-time work may be necessary to ensure that income remains above the poverty line. However, many of the jobs created over the past 20 years have been casual or part-time (Saunders 2006).

¹⁴⁷ The proportion of parents in one-parent households who have a non-school qualification of diploma level or higher is very similar to the proportion of parents in two-parent households with such a qualification. 20.9 per cent of parents in one-parent households in Victoria have a non-school qualification of diploma level or higher, compared with 20.6 per cent of parents in couple families (a non-school qualification of diploma level or higher includes diploma level, advanced diploma level, bachelor degree and postgraduate level) (ABS 2006 Census of Population and Housing).

¹⁴⁸ No parent means neither parent in a two-parent family.



Financial hardship

Indicator: Proportion of children and young people from families that ran out of food and could not afford to buy more

Food insecurity has been defined as ‘irregular access to nutritionally adequate, culturally acceptable, safe foods through local non-emergency services’ (VicHealth 2005).

Food insecurity is closely related to poverty. Groups who are at risk of food insecurity include people from low income family households, people from non-English speaking backgrounds, homeless people and people from Aboriginal and Torres Strait Islander backgrounds. Low-income groups are at risk of food insecurity, including unemployed people, single parents, those living in rental accommodation, young people and homeless people (Booth & Smith 2001).

Findings from the 2006 VCHWS, reported in the 2006 childrens’ report (DHS 2006), show that 5.8 per cent of children aged under 13 years 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 couldn’t afford to buy more.

There were significant differences between the responses of one- and two-parent families. 19.7 per cent of one-parent families reported this, compared with 3.5 per cent of two-parent families (DHS 2006).

Indicator: The proportion of families with children able to raise \$2000 within two days in an emergency

The 2007 VPHS asked respondents: ‘Can you raise \$2000 within two days in an emergency?’ The majority (87 per cent) of parents and carers reported that they could. There has been no significant change since 2005 in the proportion of parents and carers reporting this.¹⁴⁹

The 2006 VCHWS findings are similar to those from the VPHS (84.9 per cent of children aged under 13 years had parents who could raise \$2000) (DHS 2006). However, these findings point again to the relatively poorer outcomes in one-parent families. The majority (88.6 per cent) of two-parent families reported being able to raise \$2000 in an emergency compared with 62.9 per cent of one-parent families (DHS 2006).

Understanding the nature and extent of social disadvantage

Recent research carried out in partnership between the Social Policy Research Centre at the University of New South Wales, three community service organisations,¹⁵⁰ and the Australian Council of Social Service (ACOSS) has explored the measurement of, and interaction between, three dimensions of disadvantage: poverty (arising from insufficient income), deprivation (in relation to goods and services) and social exclusion (the experience of being unable to fully participate in mainstream society) (Saunders, Naidoo & Griffiths 2007).

Focus groups were held with clients of the three community service organisations and a survey of clients and of the broader community was undertaken to identify the ‘essentials of life’ for Australians. Around 670 clients of community sector welfare services and 2700 people in the broader community completed the survey. 268 of the clients (40.4 per cent) were living in households with children.

¹⁴⁹ In 2005, 85.5 per cent of parents and carers with children under 18 years reported that they could raise \$2000 in an emergency. In 2006, the proportion was 85.6 per cent.

¹⁵⁰ The three community service organisations are Anglicare (Sydney), Mission Australia and the Brotherhood of St Laurence.



The incidence of deprivation was measured by identifying those who do not have and cannot afford the items that were seen as essential by a majority of respondents to the community survey. Deprivation was found to be highest overall among Indigenous Australians, one-parent families, those in public housing and the unemployed.

Deprivation increased sharply when gross household income (adjusted for household size) fell below \$300 a week.¹⁵¹

Table 4.6 shows the incidence of deprivation for child-related essential items in the community and the client sample. Levels of deprivation are notably higher in the client sample. For example, more than a third of clients cannot afford an annual dental check for their children compared with a tenth of the community sample.¹⁵²

Table 4.6: The incidence of deprivation for child-related essential items in the community and client samples (percentages)

	Community sample (unweighted)	Community sample (weighted) ¹⁵³	Client sample (unweighted)	Client sample (weighted) ¹⁵⁴
Separate bed for each child	1.6	1.7	12.4	11.3
Separate bedroom for children over 10	6.1	6.7	20.7	19.8
Dental check-up for children	9.1	9.8	34.7	33.2
A hobby or leisure activity for children	5.7	5.7	23.8	23.1
Schoolbooks/new clothes for children	3.8	4.0	18.5	17.3
School activities/outings for children	3.5	3.6	16.2	14.5

Source: Saunders, Naidoo & Griffiths 2007

Housing tenure

Indicator: Percentage of public housing tenants who are families with children

Data from the 2006 Census of Population and Housing show that 75.1 per cent of all Victorian families with children either fully own or are purchasing their home, with 3.2 per cent in state authority housing (public housing).

As figure 4.4 shows, there are marked differences in tenure type for one- and two-parent families and also for Indigenous families. The highest proportion of families with children in public housing is Indigenous one-parent families. Lower proportions of Indigenous families, than all families, are home owners.

¹⁵¹ This is close to the 50 per cent of median income benchmark.

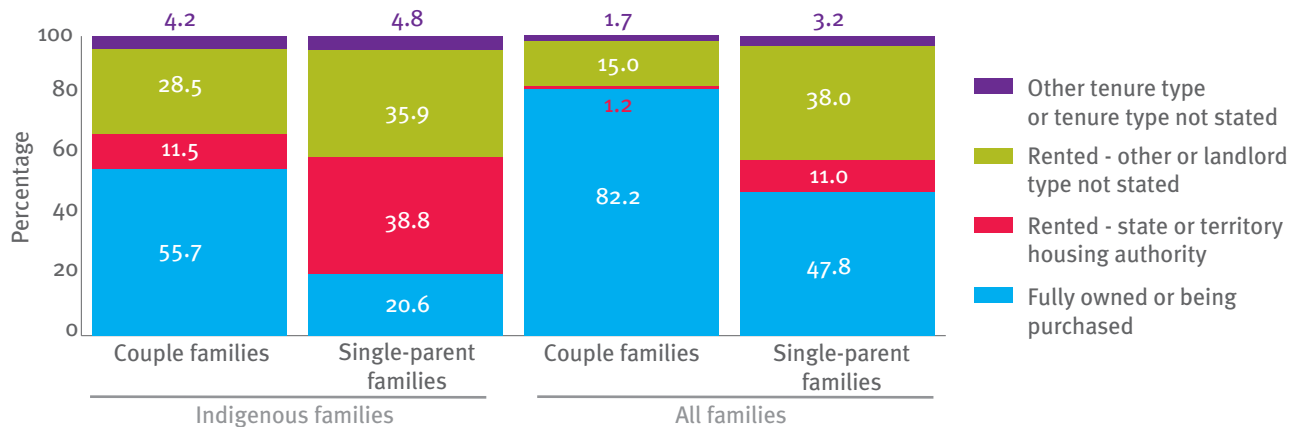
¹⁵² Another example is that almost a quarter of clients cannot afford a hobby or leisure activity for children compared to one twentieth of the community sample.

¹⁵³ Weighted by ABS population weights.

¹⁵⁴ Weighted by the age structure of the community sample.



Figure 4.4: Proportion of families with children aged 0–17 years, by tenure type, Victoria, 2006



Source: ABS 2006 Census of Population and Housing

Supporting Vulnerable People

The Government in its social policy statement *A Fairer Victoria* has committed to intervene to target the most disadvantaged Victorians. In *A Fairer Victoria*, stable accommodation is recognised as fundamental to the healthy growth and development of Victorians.

Since 1999, the Office of Housing has proactively targeted and housed the most disadvantaged Victorians through the introduction of the segmented waiting list. Further recent initiatives aimed at strengthening responses to this group are:

Support for High-Risk Tenancies Program

The Support for High-Risk Tenancies Program supports vulnerable people to maintain their social housing tenancies or other appropriate accommodation arrangements, and prevent homelessness.

This program assists people with complex needs (including mental illness, drug and alcohol, health and behavioural problems) who require intensive support from a range of different services to assist them to stay in long-term housing. Regional coordinators are employed across Victoria to improve coordination of support services.

Social Housing Advocacy Support Program (SHASP)

SHASP provides advocacy and support services to existing social housing tenants and prospective public housing tenants in order to assist them in accessing and sustaining their housing. This program aims to:

- Ensure that public housing applicants who have more complex issues are appropriately assisted to have their housing needs addressed
- Establish successful public housing tenancies
- Prevent homelessness
- Ensure the needs of social housing tenants unable to advocate on their own behalf are met.



Indicator: Public housing retention rate for families with children

Public housing tenants in Victoria pay a reduced amount of rent, known as a rebated rent, based on their household income. The amount of rent to be paid is capped at the market rent of the property.

The percentage of rebated public housing households that have a child¹⁵⁵ residing in the property has consistently decreased, from 36.3 per cent in 1999 to 28.0 per cent in 2007, reflecting a changing tenant profile towards single person households (data supplied by DHS, Housing and Community Building Division).

The retention rate¹⁵⁶ of rebated households with children has steadily increased from 76.9 per cent in 1999 to 81.8 per cent in 2007. This increase reflects a greater focus on sustaining public housing tenancies (data supplied by DHS, Housing and Community Building Division).

A boost to social housing and affordable housing

Major investment is underway to boost social housing in Victoria with the Government's commitment to deliver almost 4000 new dwellings for low income people and families by June 2011. These properties will be predominantly delivered close to public transport in safe and vibrant communities where there is easy access to jobs, training, retail and services.

Income spent on housing

Indicator: Percentage of family income spent on housing

Affordable housing is key to the wellbeing of children and young people who live at home with their families and it also plays a critical role in allowing young people to live independently.

In considering housing affordability, it is important to look not just at the costs of housing but at the relationship between costs and household income.

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

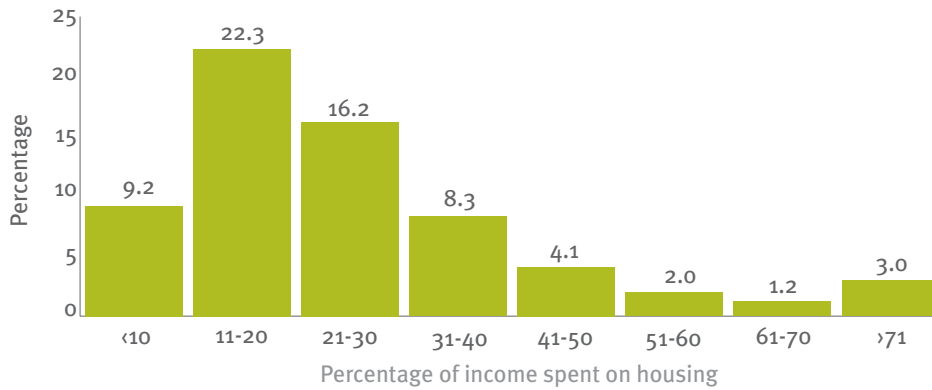
Data from the 2006 Census of Population and Housing show that the majority of families spend less than 30 per cent of income on housing (figure 4.5). However, this does not include those for whom income or housing costs were not stated or who have no housing costs.

¹⁵⁵ Children are defined as residents of a household between the ages of 0 and 18 years that are dependants of another household member.

¹⁵⁶ The retention rate has been defined as households that have resided in the property for 12 months or longer.



Figure 4.5: Percentage of families with children aged 0–17 years, by the proportion of income they spend on housing, Victoria, 2006

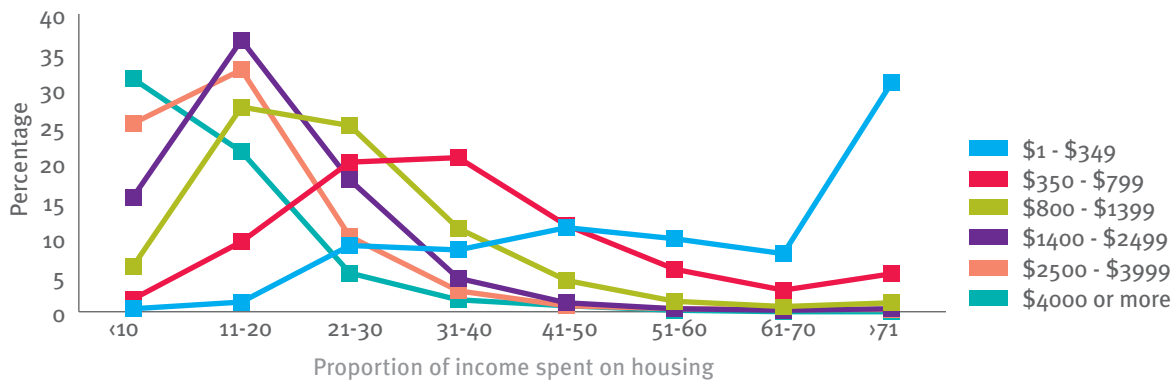


Source: ABS 2006 Census of Population and Housing

As figure 4.6 shows, households with the highest incomes (\$4000 or more) are more likely than other households to spend smaller proportions of their income on housing, whereas households with the lowest incomes (\$1–349) are more likely to spend a larger proportion of their income on housing.

In general, the lower the household income, the greater the proportion of the income that is spent on housing costs.¹⁵⁷

Figure 4.6: Proportion of families with children aged 0–17 years, by weekly household income and the proportion of income that is spent on housing, Victoria, 2006



Source: ABS 2006 Census of Population and Housing

¹⁵⁷ It is important to note here that homeowners and tenants may face very different issues and concerns in relation to housing costs and affordability.



Housing affordability: research by the Urban Development Institute of Australia

A recent study by the Urban Development Institute of Australia (UDIA) in 70 designated population centres, identified areas that were affordable, and areas that had some constraints or were seriously unaffordable. This categorisation was based on the capacity of households on average incomes to purchase specified percentages of the housing sold in the local area.

The study identified a clear shift from a high level of affordability (across the 70 centres) in 2001 to a lack of affordability in 2006. This shift was due to the marked increase of housing prices in relation to income, land supply constraints and an increase in interest rates (Urban Development Institute of Australia 2007).

Homelessness

Causes of homelessness and impacts on children and young people

Homelessness can arise from a combination of factors, including a shortage of affordable housing, poverty, unemployment and discrimination. Family conflict, with violence and abuse, social isolation, mental illness and breaks from formal education can also increase the likelihood of a person becoming homeless (AIHW 2005a). Many homeless young people have experienced family breakdown (DHS 2006).

Homeless children and young people commonly face multiple forms of disadvantage, including poverty, poor access to health care, lower participation in education and poor employment prospects. Children who are homeless tend to have less time in school and lower immunisation rates. They may also experience low self-esteem, and may have behavioural problems (Efron et al. 1996; Molner et al. 1990). Young homeless people may be more likely to engage in risk-taking behaviours, including drug and alcohol abuse and unsafe sex (Sibthorpe et al. 1993).

Defining homelessness

The definition of homelessness has been subject to considerable debate. In Australia, there is an emerging consensus that supports the use of a 'cultural definition' that includes three levels of homelessness:

- Primary homelessness: people without conventional forms of accommodation
- Secondary homelessness: people living in forms of temporary accommodation
- Tertiary homelessness: people who live permanently in private boarding houses without their own bathroom or kitchen and without security of tenure (Chamberlain et al. 2007).

This cultural definition is used by the ABS to quantify the homeless population. In addition, the SAAP uses a 'service delivery definition' that allows welfare agencies to assist people who are experiencing housing difficulties.¹⁵⁸

Homelessness in Victoria

Data on homeless children and young people in Victoria is derived from two sources:

- SAAP data on the number of families with children receiving SAAP assistance
- Data from the National Census of Homeless School Students and the SAAP data collection on the number and rate of homeless youth, cited in the 2008 report of the National Youth Commission Inquiry into Youth Homelessness (National Youth Foundation 2008).

SAAP aims to provide transitional supported accommodation and related support services to help those who are homeless or at risk of homelessness to achieve the best possible degree of self-reliance and independence.

¹⁵⁸ This SAAP definition includes people who are living in conventional housing, but are at risk of homelessness, as well as people who are actually homeless.



SAAP children's resource workers

Children's resource workers in each DHS region assist SAAP workers to meet the needs of children accompanying their parents in homelessness services by providing secondary consultation, skills and knowledge, resource material and linkages to other essential support services.

Indicator: SAAP assistance rate for children and young people

There were 34,000 Victorians aged over 18 years who received assistance from SAAP in 2006–07, accompanied by 20,500 children.¹⁵⁹ The rate per 1000 for accompanying children was 17.3. A total of 3900 clients did not present as part of a family unit and accessed SAAP independently (table 4.7).

Table 4.7: Number of children aged 0–17 accessing SAAP services, Victoria, 2006–07

	Number of individuals
Clients	3,900
Accompanying children	20,500
Total	24,400

Source: AIHW 2008b

For the accompanying children, there were 32,250 support periods,¹⁶⁰ with 9200 of them involving accommodation.¹⁶¹

The majority (42.6 per cent) of accompanying children were aged 0–4 years. The 5–9 and 10–14-year-olds made up 27.5 per cent and 22.7 per cent respectively, with the remaining 7.2 per cent aged 15–17 years. ATSI children accounted for 9.8 per cent of accompanying children (AIHW 2008b).

The Creating Connections – Youth Homelessness Action Plan Stage 2 (2006–10)

The Youth Homelessness Action Plan Stage 2 provides a platform for the strategic development of homelessness services to young people aged 15–25 years and builds on the Government's Homelessness Strategy and Youth Homelessness Action Plan – Stage 1.

The Stage 2 action plan outlines four new directions for homelessness services:

- A strong focus on early intervention and interdependence
- Tailored accommodation and housing support options for each individual homeless young person
- Greater access to complementary services for homeless young people with complex needs
- Enhanced youth homelessness service capacity.

The plan includes 10 actions in support of these new directions.

¹⁵⁹ The number of accompanying children relates to the first visit for that child.

¹⁶⁰ 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.

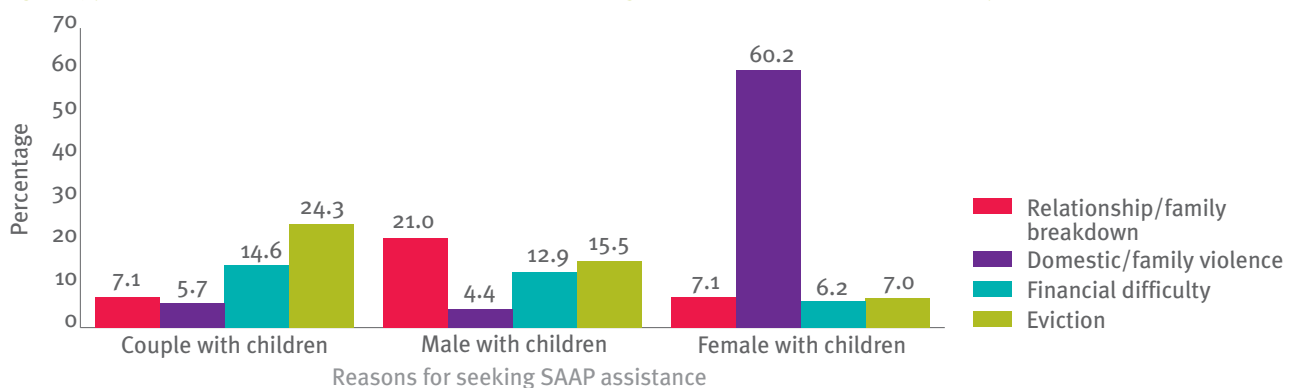
¹⁶¹ Almost 30 per cent of the children who required assistance required it in the form of accommodation.



Reasons for seeking SAAP assistance

For families with children, the main reasons for seeking assistance varied with family type. For a couple with children, the most common reason (24.3 per cent) was being evicted or being asked to leave their accommodation, followed by experiencing financial difficulty¹⁶² (14.6 per cent). For males with children, relationship or family breakdown (21 per cent) was the main reason for seeking assistance, followed by being evicted or asked to leave their accommodation (15.5 per cent). For females with children, the vast majority (60.2 per cent) were seeking assistance due to family violence. The next closest reason (7.1 per cent) was relationship or family breakdown (figure 4.7).

Figure 4.7: Main reasons for families with children seeking SAAP services, Victoria, 2006–07



Source: AIHW 2008b

Indicator: Percentage of clients receiving emergency housing services who are aged 12–18 years

Table 4.8 below shows that in 2006 there were 3896 homeless young people aged between 12 and 18 years in Victoria, representing a rate of 8 per 1000 young people.

Victoria and New South Wales have the lowest rate of homeless youth of all the Australian states and territories.

Table 4.8: Number and rate (per 1000) of youth homelessness 12–18 years, by state and territory, 2006

	NSW	Vic	ACT	Qld	SA	WA	TAS	NT	All
Estimated number	4987	3896	307	4469	2129	4280	770	1102	21,940
Rate	8	8	10	11	15	21	16	50	11

Source: National Census of Homeless School Students and SAAP Client Collection data, in National Youth Foundation 2008

The rate of youth homelessness in Victoria has also decreased between 2001 and 2006 (from a rate of 10 per 1000 to 8 per 1000) in line with an overall national decrease.¹⁶³

¹⁶² This includes 'gambling, budgeting issues, rent too high, other'.

¹⁶³ Across Australia the rate of youth homelessness has decreased from 14 per 1000 in 2001 to 11 per 1000 in 2006.



Explaining the decline in youth homelessness 2001 to 2006

While youth unemployment declined from 18 per cent in 2001 to 15 per cent in 2006, Chamberlain and Mackenzie (2007) note that this decline was not large or sudden enough to explain the decline in youth homelessness. They conclude, instead, that the decline in youth homelessness is more likely to be linked to an increase in early intervention services targeting homeless and at-risk teenagers (Chamberlain and Mackenzie 2007, in National Youth Foundation 2008).

These initiatives include the Australian Government Reconnect program which aims to promote reconciliation between homeless young people (and those at risk of homelessness) and their families and to improve the engagement of these young people in employment, education and training.

In addition, the National Youth Foundation Inquiry report notes that Victoria has developed several early intervention services, including the mandating of the Family Reconciliation and Mediation Program to undertake early intervention where there is no access to Reconnect, the rebuilding of a complement of Student Welfare Coordinators in secondary schools, and the development of the School Focused Youth Service (National Youth Foundation 2008).



4.3 Support from services

Summary

- The percentage of women who are given appropriate interventions in relation to smoking in pregnancy has increased (from 2003–04 to 2006–07).
- 27.5 per cent of standard primiparae in public hospitals had a caesarean birth in 2004 (26.9 per cent in 2003). The percentage was higher in private hospitals (37.4 per cent in 2003; 37.8 per cent in 2004).
- There were 1201 hospital admissions for infants aged less than one year for gastroenteritis in 2005–06 (a rate of 19.5 per 1000). This represents a marked increase from previous years.
- The proportion of infants receiving a maternal and child health home consultation is stable, with a slight increase in 2006–07. The proportion of children attending the 3.5-year ages and stages visit has increased, from 49.5 per cent in 2000–01 to 57.8 per cent in 2006–07. ATSI children generally attend maternal child health centres at a lower rate than Victorian children overall, although the difference in attendance is small.
- Rates of kindergarten participation for 4-year-olds are high (92.4 per cent in 2008) with slightly higher rates in rural than in metropolitan areas (93.0 per cent, compared with 92.1 per cent).
- The percentage of Prep children, in participating schools, who received a primary health assessment (2002 to 2007), is fairly stable at around 90 per cent. A lower percentage of Aboriginal, than all children, received the primary health assessment.
- Parental satisfaction with government schools is consistently high.
- Child protection re-reporting rates have shown a slight decrease for all children (aged 0-17 years) from 2001–02 to 2006–07. However, the re-reporting rate for Aboriginal young people is consistently higher than that for all children.
- The 2006–07 re-substantiation rate for all children was 16.9 per cent and the re-substantiation rate for Indigenous children was 25.2 per cent. The re-substantiation rate for all children has decreased slightly over the past five years.
- In 2006–07, the percentage of substantiations within three months of a decision not to substantiate was 2.3 per cent for all children and 3.6 per cent for Aboriginal children. For all children this percentage has decreased slightly over the past four years.
- There appears to be a small increasing overall trend in the rate of care and protection orders for all children between 30 June 2001 and 30 June 2007. The rate of care and protection orders in Indigenous children has declined from 30 June 2006 to 30 June 2007. However, it remains much higher in Indigenous children than in all children.
- In Victoria and across Australia, there is a small increasing trend in the number of children in out-of-home care, with rates consistently higher among Indigenous children.
- There is an increasing trend in the proportion of children exiting care who have had three or more placements in care. In recent years, Indigenous children exiting care have been less likely than all children to have had three or more placements in care.
- The proportion of children aged under 12 years in out-of-home care who are placed with relatives or kin has increased from 31.7 per cent of children at 30 June 2002 to 40.9 per cent at 30 June 2007.
- At June 2007, 62 per cent of Aboriginal children in out-of-home care were placed with family of Aboriginal carers. The proportion of Aboriginal children who are placed in accordance with the ACPP has increased from 56 per cent in 2001.



Prenatal and infant health services

Smoking interventions with pregnant women

Indicator: Rate of pregnant women offered appropriate smoking interventions in hospitals

Alcohol and smoking use in pregnancy are known risk factors for low birth weight.

2006 VCHWS data on the percentage of women who report smoking during pregnancy is included earlier in this report. There is no updated data available on women's smoking in pregnancy. However, trend data from the Victorian Maternity Services Performance Indicators (VMSPI) (2006–07) suggest that there has been some increase in the rate of women who are being offered antenatal interventions in public hospitals related to smoking.

Two indicators are used to measure this:

A: The rate of women given appropriate interventions in relation to smoking at their first antenatal visit prior to 20 weeks gestation.

B: The rate of women – who were identified as smokers or recent quitters at their first antenatal visit, who attend clinic again prior to 20 weeks gestation and were given further appropriate interventions in relation to smoking.

As table 4.9 shows, the rate of women given appropriate interventions in relation to smoking at their first antenatal visit prior to 20 weeks gestation is high (96.3 per cent) and has increased from 2003–04.

The percentage of women who were identified as smokers or recent quitters at their first antenatal visit and who attended clinic again prior to 20 weeks gestation and were given further appropriate interventions in relation to smoking, shows a marked increase between 2003–04 and 2006–07.

Table 4.9: Percentage of pregnant women who are given appropriate interventions in relation to smoking as measured by two indicators – Part A and Part B, Victoria 2003–04 to 2006–07

	Indicator A (%)	Indicator B (%)
2003–04	90.1	56.8
2004–05	98.1	63.3
2005–06	95.8	70.0
2006–07	96.3	82.6

Source: Department of Human Services 2007

Caesarean sections

Indicator: Rate of caesarean sections in standard primiparae in public hospitals

There is an increasing trend in the occurrence of caesarean sections in Australia. However, there has been little action to address this issue (Dietz & Peek 2004). There is also no consensus on what might be an appropriate rate of caesarean section, as information is lacking on the outcomes of both lower and higher rates (Enkin et al. 2001; Li et al. 2003).¹⁶⁴

¹⁶⁴ It is possible that lowering the caesarean section rate could increase adverse outcomes for the mother and infant, with an increase in uterine rupture and birth injury. However, an increased caesarean section rate may not be associated with better maternal outcomes (Li et al. 2003). There is also some evidence that having a caesarean section for the first pregnancy can confer risks for the second and subsequent pregnancies, which are primarily associated with labour (Taylor et al. 2005).



Rates of caesarean sections in all confinements have increased from 15.3 per cent in 1985 to 29.5 per cent¹⁶⁵ in 2004 (DHS 2005).

The VCAMS indicator measures the rate of caesarean sections in standard primiparae, a subset of the obstetric population that is at low risk for intervention and adverse outcome. This subset represents uncomplicated pregnancies; therefore intervention and complication rates should be low and consistent across all hospitals.

A total of 27.5 per cent of standard primiparae in Victoria’s public hospitals had a caesarean birth in 2004, compared with 26.9 per cent in 2003. The percentage of standard primiparae having caesarean births was higher in private hospitals (37.4 per cent in 2003 and 37.8 per cent in 2004) (table 4.10). The likelihood of having a caesarean section increased with maternal age in both public and private hospitals.

Table 4.10: Percentage of caesarean sections in standard primiparae, Victorian public and private hospitals, 2003 and 2004

	Public hospitals (%)	Private hospitals (%)
2003	26.9	37.4
2004	27.5	37.8

Source: DHS Maternity Services Data Unit

Hospital admissions for gastroenteritis

Indicator: Hospital admissions for gastroenteritis in children under 1 year of age

Ambulatory care sensitive conditions (ACSCs), such as gastroenteritis, are conditions for which hospitalisation is thought to be preventable. ACSC hospitalisations therefore represent indirect measures of the effectiveness of primary care, and may be influenced by a range of factors, including disease prevalence, propensity to seek primary health care (parental and child factors), socioeconomic barriers to care and hospital utilisation patterns (DHS 2001).

In Victoria in 2005–06, 1201 infants aged less than 1 year were admitted to hospital for gastroenteritis, representing a rate of 19.5 per 1000.

Figure 4.8 shows the hospital admission rate (per 1000 population) for gastroenteritis in infants less than 1 year, from 2001–02 to 2005–06. The rate appears to show a marked increase from 2004–05 to 2005–06. Future data will confirm whether this actually represents an increasing trend.

Figure 4.8: Hospital admission rate (per 1000 population) for infants less than 1 year for gastroenteritis, Victoria, 2001–02 to 2005–06



Source: Victorian Admitted Episodes Dataset, ABS 2008a

¹⁶⁵ Fifteen per cent of these were elective caesarians and 14 per cent were emergency caesarians.



Maternal and child health services

Indicator: Proportion of infants receiving a maternal and child health service home consultation

Indicator: Proportion of infants enrolled at maternal and child health service

Indicator: Proportion of children attending the 3.5-year ages and stages visit

Maternal and child health services have an important role to play in providing information and support for parents and carers of children aged 0–4 years. There is a strong relationship between immunisation, breastfeeding and maternal and child health programs. Strategies to increase attendance and access to maternal and child health services may increase immunisation coverage (Sloman et al. 1999) and breastfeeding rates.

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, social and emotional factors affecting young children’ (DHS 2004). Ages and stages consultations occur from birth to 3.5 years of age and provide information and support relevant to individual child development and family support.

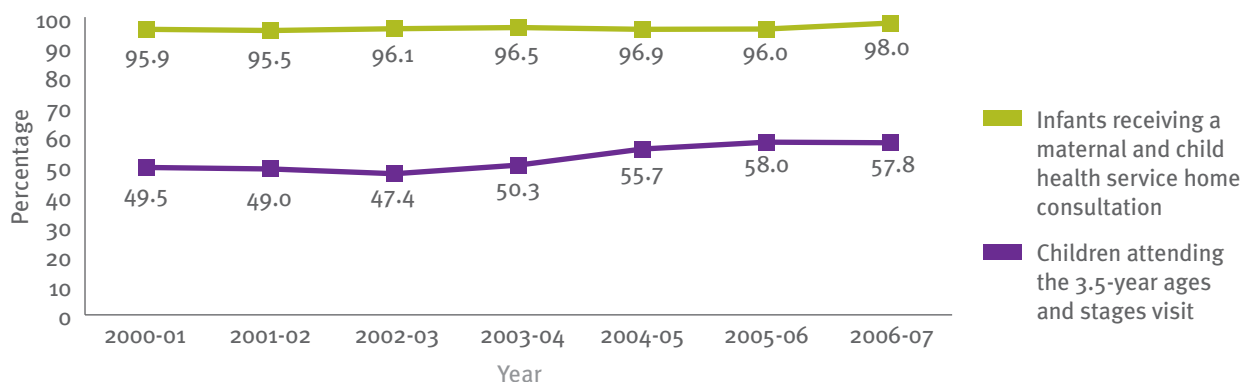
Participation in key ages and stages visits

Figure 4.9 shows participation rates (from 2000–01 to 2006–07) for the following key ages and stages maternal health care visits:

- Infants receiving a maternal and child health service home consultation
- Children attending the 3.5-year ages and stages visit.

The proportion of infants receiving a maternal and child health home consultation shows a stable trend, with a slight increase in 2006–07. The proportion of children attending the 3.5-year ages and stages visit shows an upward trend, increasing from 49.5 per cent in 2000–01 to 57.8 per cent in 2006–07.

Figure 4.9: Participation in key ages and stages maternal health care visits, Victoria, 2000–01 to 2006–07

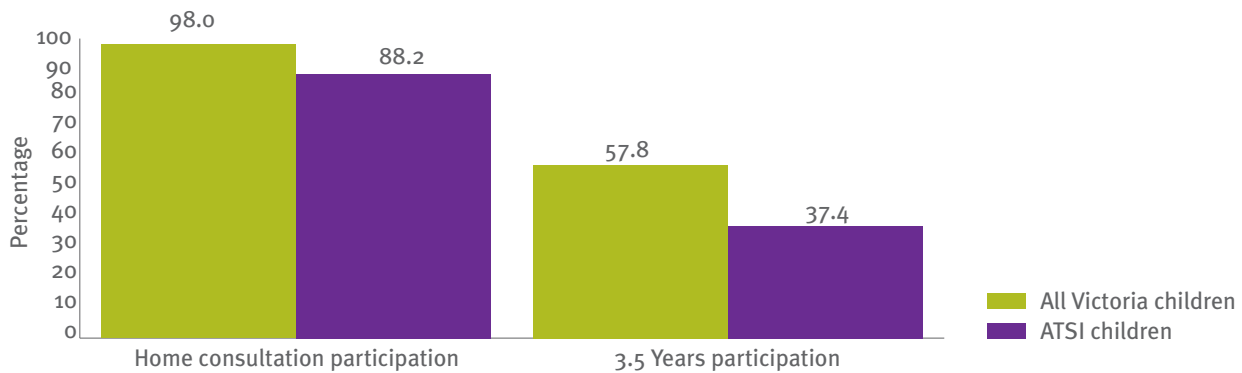


Source: DHS Maternal and Child Health Service Database and DHS Maternal and Child Health Services Annual Report 2006–07

Data for the financial year 2006–07 indicate that Indigenous children participate 10 per cent less than Victorian children generally in the home consultation visit and 20 per cent less (than Victorian children generally) in the 3.5 years ages and stages visit (figure 4.10).



Figure 4.10: Participation rates for key ages and stages maternal health care visits, ATSI children and all children, Victoria, 2006–07



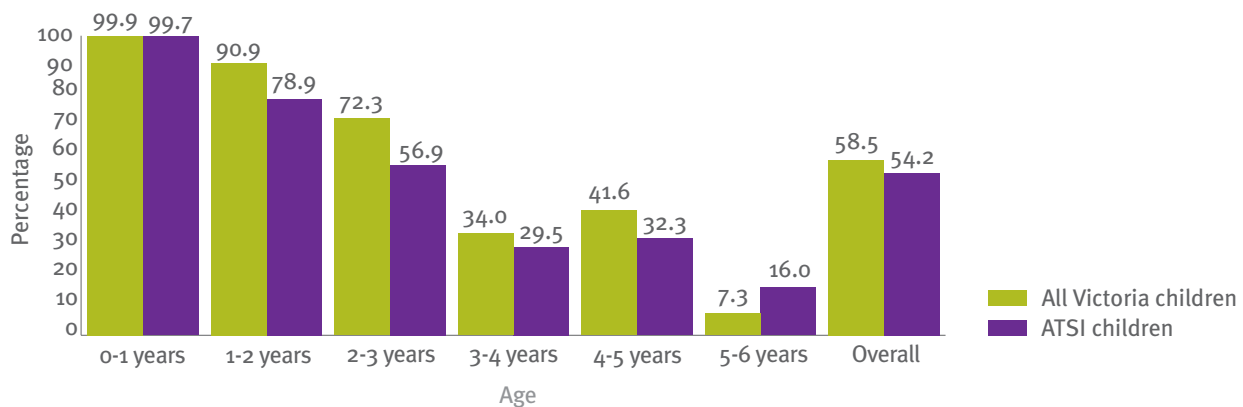
Source: DHS Maternal and Child Health Database and DHS Maternal and Child Health Services Annual Report 2006–07

Participation by age and Indigenous status

Figure 4.11 provides information about the participation of children in maternal child health services, where participation is defined as attending a maternal child health services centre at least once during the previous 12 months.

The overall participation rate for Indigenous children is 54.2 per cent, compared with an overall participation rate for all Victorian children of 58.5 per cent.¹⁶⁶

Figure 4.11: Participation of children in maternal child health services, by age and ATSI status, Victoria, 2006–07



Source: DHS Maternal and Child Health Services Annual Report 2006–07

Although the participation rate overall is lower for Indigenous children compared to non-Indigenous children, the participation rate has increased for younger Indigenous children between 2005–06 and 2006–07 (table 4.11).

¹⁶⁶ Indigenous children attend Maternal Child Health Centres at a lower rate than Victorian children overall, with the exception of the attendance of 5–6-year-olds (who are attending at a rate double that of all Victorian children).



Table 4.11: Participation of children in maternal child health services, by age and ATSI status, Victoria, 2006–07

Key age and stage visit	ATSI participation rate 2005–06 (%)	ATSI participation rate 2006–07 (%)
Home visit	77.6	85.1
2 weeks	69.8	77.0
4 weeks	65.0	74.2
8 weeks	65.3	74.2
4 months	63.4	66.7
8 months	56.5	57.2
12 months	49.8	53.4
18 months	45.0	43.0
2 years	43.1	43.0
3.5 years	47.2	36.8

Source: DHS Maternal and Child Health Services Annual Report 2006-07

Neighbourhood Renewal

Neighbourhood Renewal is working with residents and a broad range of partners to reduce health inequalities across the state. Neighbourhood Renewal’s partners include non-government organisations and community groups, government agencies, schools; recreation clubs and commercial businesses.

The Local service providers work closely with communities to improve local service delivery and develop health promotion strategies that are responsive to local needs.

The local action plans are built around six practical objectives recognising the social determinants of health and include:

- Increasing community pride and participation
- Enhancing housing and the physical environment
- Lifting employment and learning opportunities and expanding local economies
- Improving personal safety and reducing crime
- Promoting health and wellbeing
- Improving government responsiveness

Neighbourhood Renewal is a focus area for the Victorian Government’s health promotion priorities (2007–12). These were developed by VicHealth in partnership with Rural and Regional Health and Aged Care Services. Through these health promotion priorities, Neighbourhood Renewal works in partnership with services to address locally identified needs.

To improve health and reduce health inequalities, Neighbourhood Renewal is focusing on the following seven priority areas:

- Promoting physical activity and active communities
- Promoting accessible and nutritious food
- Promoting mental health and wellbeing
- Reducing tobacco-related harm
- Reducing and minimising harm from alcohol and other drugs
- Safe environments to prevent unintentional injury
- Sexual and reproductive health



Early education and care services

Indicator: Proportion of children attending educational program prior to school

Indicator: Kindergarten participation rate

Indicator: Proportion of children attending kindergarten whose placement attracts a kindergarten fee subsidy

Many children in Australia have access to formal early learning programs through attendance at child care or kindergarten. Kindergarten is a planned education and developmental program for children two years before they begin full-time primary education. A degree qualified early childhood teacher plans and delivers the program. Kindergarten programs are delivered in a variety of settings.

The effects on children of kindergarten attendance have been well researched. While there is general agreement that attendance has positive social, emotional, cognitive and linguistic effects (Fleer et al. 2006) what makes an effective kindergarten program and the extent of demonstrable positive outcomes is the subject of much debate.

Risk factors for not attending kindergarten include low socioeconomic status, belonging to a minority group and having a developmental disability (Mead 2004). The paradox is that the children who have the most need to attend do not attend (Mead 2004), with poor children benefiting the most from attending kindergarten (Fantuzzo et al. 2005). The majority of Indigenous children fall into this category and teaching styles in many of our services are inappropriate for their learning (Freeman 2006).

Table 4.12 shows the percentage of the 4-year-old population enrolled at kindergarten (defined as the participation rate) in 2008 in Victorian metropolitan and rural areas, and in Victoria as a whole. Overall rates of participation are high (92.4 per cent) with slightly higher rates in rural than in metropolitan areas (93.0 per cent, compared with 92.1 per cent).

Table 4.12: Participation of 4-year-olds at kindergarten, metropolitan and rural Victoria, 2008

	First-year enrolments	Population aged 4 ¹⁶⁷	Participation rate (%)
Metropolitan Victoria	43,047	46,716	92.1
Rural Victoria	15,771	16,966	93.0
Victoria	58,818	63,682	92.4

Source: DEECD Children's Services Online (CHISOL) database

Based on first and second year enrolments, the proportion of children attending kindergarten whose placement attracts a kindergarten fee subsidy was 27.3 per cent in 2008. This proportion has remained relatively stable since 2000, ranging from 25.9 to 29.4 per cent.

For Indigenous children, data from the SEHQ analysis showed that parents of children of ATSI background were more likely to report that their children had not attended kindergarten (10.1 per cent) compared to the total sample (6.7 per cent). In addition, 7.5 per cent of children who did not live with both parents did not attend kindergarten, compared to 5.4 per cent of children who lived with both parents (Griffin et al. 2006).

¹⁶⁷ The population aged 4 is based on the ABS estimated resident population of 3-year-olds in the previous year (2007).



Extending Access to Kindergarten Programs and Playgroups

Taking part in high quality early childhood and kindergarten programs improves children's subsequent learning, health and behaviour, with positive effects extending right into adult life.

Additional support for up to 2000 children known to child protection to attend 3-year-old kindergarten has been provided so they can be school ready.

Greater investment in playgroups will support a further 1700 children in their socialisation and development.

By targeting this area the Victorian Government has:

- Helped almost 6000 children with disabilities and additional needs to actively take part in quality learning in kindergartens each year since 2002–03
- Effectively made kindergarten free for low-income families, with the \$730 kindergarten fee subsidy now available for around 17,000 4-year-olds
- Published the Koori Kindergarten Inclusion Kit to promote the value of kindergarten to Indigenous parents and get more Indigenous children to participate
- Provided free access to up to 10 hours of kindergarten per week for 3-year-old Koori children from low-income families.

Early childhood intervention services

Indicator: Proportion of families who are satisfied with the service provided by Early Childhood Intervention Services (ECIS)

Indicator: Proportion of support plans that are completed within four weeks of the commencement of ECIS

ECIS aim to improve the lives of young children with disability or developmental delay and their families. For children, the ultimate goal of these services is to enable their active and successful participation in a variety of settings, including their homes, playgroups, child care, kindergarten, community and school. For families, the ultimate goal is to enable them to provide care for their child, to foster, promote and support their child's learning and development and to have access to the resources they need in order to participate in family and community activities (Bruder & Bailey 2005).

Satisfaction is generally considered to be one indicator of the effectiveness of early childhood intervention services. This perspective is consistent with the belief that family centred practices are a key feature of high-quality early childhood intervention services.

The Family Service and Support Plan underpins the development and delivery of all aspects of early childhood intervention services.

Data are not currently available for these two ECIS indicators.

Key components of a responsive Family Service and Support Plan

A Family Service and Support Plan that is responsive to the individual requirements of service users must include the following: identification of family concerns, priorities and resources; identification of family and child activity settings; functional assessment of the child's development; collaborative development of expected outcomes; assignment of responsibilities; identification of strategies to implement the plan; and evaluation to ensure quality and achievement of outcomes (Bruder 2001).



Primary and secondary schooling

The Victorian Primary School Nursing Program

Indicator: Proportion of children in first year of primary school who have been assessed by the school nurse

The Victorian Primary School Nursing Program aims to promote health and to assist in the early identification of health and wellbeing issues in school children. The program employs primary school nurses to conduct a health assessment of all students in participating schools in their first year of school, including universal vision screening and targeted hearing screening. School nurses also provide follow up contact with parents, respond to referrals from school staff and refer on to relevant health practitioners.

Figure 4.12 shows the percentage of Prep children, in participating schools, who received a primary health assessment, 2002 to 2007. For all children the percentage is fairly stable over the six-year period, at around 90 per cent, with a dip in 2006 to 85.3 per cent. The percentage of Aboriginal children who received the primary health assessment is much lower than the percentage of all children.

Figure 4.12: Percentage of Prep children who had a Primary Health Assessment, Victoria, 2002 to 2007



Source: Department of Human Services 2008

Indicator: Primary school aged students who required follow-up were seen by the school nursing program

The School Nursing Program carries out follow-up assessments of children with previously identified health conditions to check progress and health gain. All children who were assessed as being in need of follow-up at the health assessment were followed up by the School Nursing Program.

Parental satisfaction with schools

Indicator: Level of parental satisfaction with schooling

Data collected annually from government schools, using a parent opinion survey, provides a summary of parental satisfaction with school practices.

The parental scores for general satisfaction with government primary and secondary schools, from 2001 to 2006, are given in table 4.13. The scores are reported on a scale from 1 (strongly disagree) to 7 (strongly agree).

Parental satisfaction with government schools is consistently high in both the primary and secondary sector.¹⁶⁸

¹⁶⁸ It should be noted that the mean is reported from 2001 to 2005 and the median is reported in 2006.



Table 4.13: Parent opinion about government primary and secondary schools, Victoria, 2001 to 2006

General satisfaction	2001	2002	2003	2004	2005	2006
Primary	5.2	5.3	5.3	5.3	5.3	5.9
Secondary	5.2	5.3	5.3	5.3	5.3	5.3

Source: School Management Benchmark Reports, 2001 to 2006

Young people’s access to services

Indicator: Proportion of young people who feel that they can access physical health services when needed

Indicator: Proportion of young people who feel that they can access mental health services when needed

Indicator: Proportion of young people who feel that they can access dental services when needed

Availability and affordability of services are important influences on health and wellbeing. The research findings below relate principally to young people’s access to mental and sexual health services and dental services and are principally derived from the 2007 young people report (DEECD 2008). Much of this data has a focus on young people in rural areas, is from qualitative studies, and is not generalisable. However, it does provide some valuable insights into young people’s views and perspectives on service access. Further information about young peoples’ views on access to services will be collected in the Adolescent Health and Wellbeing Survey.

Mental health services and young people

Access to health services has been identified as problematic for rural young people, (Kenyon et al. 2001, Wyn et al. 1998, in DEECD 2008). Research suggests that there is a lack of access to, and availability of, mental health services, especially specialist services, in rural areas. Barriers include stigma, lack of anonymity, logistical difficulties (cost, availability of transport), lack of acknowledgement of mental health issues, self-reliance and myths indicating that mental illness is a form of insanity (Francis et al. 2006; Hodges et al. 2007, in DEECD 2008).

Concerns about confidentiality and ‘being known’ are particularly high for young people living in rural areas, particularly for services that may be stigmatised such as sexual health or mental health services. Social visibility is higher in rural communities (Francis et al. 2006; Wilkinson 1991, in DEECD 2008) and the lack of anonymity also means that any social stigma follows a young person in all aspects of community life (Bourke et al. 2004; Francis et al. 2006, in DEECD 2008).

Sexual health services

The majority of testing and treatment for STIs in Australia occurs in general practice (Australian Government Department of Health and Ageing 2005, in DEECD 2008). Research has identified the major barriers to young people accessing health services, particularly for STI testing, are concerns about confidentiality and trust, such as general practitioners (GPs) disclosing information to parents or being identified by other patients or by staff at the clinic (King & Chown 2004, in DEECD 2008). A report on young women and sexual health found that some young women did not know where to go to obtain information about sexual health (Girls Incorporated 2001, in DEECD 2008).

Other barriers include concerns about the attitude of the GP, for example that the GP will have a judgemental or unsympathetic attitude. Young people can also be intimidated by the appearance of the clinic and the attitude of staff. Cost may be a barrier to young people who do not understand the Medicare system, do not have their own Medicare card or are unable to pay for consultations in clinics that do not bulk bill.



A study on young people from rural towns in Australia found that over half of students perceived youth centres, sexual health clinics, family planning clinics and community health centres as difficult to access. While 60 per cent of female students indicated they would prefer to discuss personal sexual issues with a female doctor, 36 per cent thought that female doctors were difficult to access (Hillier et al. 1996, in DEECD 2008).

Dental services

There are no Victorian data on young people's views on their access to dental services. National survey data suggest that the majority of young people (63 per cent) attend the dentist at least once a year and that these visits are usually made for routine checkups. Despite this, there is a significant minority of young people who could be considered outside the dental care system. These young people are highly likely to be eligible for public dental services but attend only when a problem occurs (Spencer & Harford 2007, in DEECD 2008).

Around a quarter (23 per cent) of young people report avoiding or delaying dental visits because of the cost. Problems completing a recommended course of care because of the cost are reported by 11.6 per cent, and a quarter of young people state they would have trouble paying a \$100 dental bill (Slade et al. 2007, in DEECD 2008).

Young people from rural and remote locations are less likely to report visiting a dentist within the past 12 months, compared with urban dwellers. In addition, rural and remote young people have a lower average frequency of attendance per year (2.1 and 1.8 per cent respectively) compared with their urban counterparts (2.6 per cent) (Slade et al. 2007, in DEECD 2008).

There is little Australian research that has sought to investigate the way young people think and talk about their oral health. A recent qualitative New Zealand study explored adolescents' (13–18 years) views of oral health to understand their low participation in government-subsidised dental services (Fitzgerald et al. 2004, in DEECD 2008). Interestingly, while the young respondents were eligible for subsidised dental care, they held negative views of dental care based on cost issues. The dental surgery environment was reported to be a major disincentive to dental attendance. Perceptions of oral health were focused on functional and cosmetic models of health and advertising of commercial oral products was a major source of dental health information. A Swedish qualitative study found similar perceptions (Ostberg et al. 2002, in DEECD 2008).

Family and community support services

Indicator: Number of families accessing Family and Community Support Services

Family Services aim to promote the safety, stability and wellbeing of vulnerable children, young people and their families, and to support the building of child, family and community capacity and resilience. Family Services (together with Family Support Innovation Projects) provide a range of activities, including intake, active engagement, assessment, casework (community-based case management), counselling, in-home support and group work, as well as providing other support and information activities where appropriate.

Family Support Innovations Projects commenced in 2003 and will be expanded across Victoria by 2008–09. The projects aim to help vulnerable children, young people and families earlier, with the aim of avoiding future child protection involvement.

In the 2005–06 financial year, 22,878 families accessed family services. Parenting, relationship and behaviour¹⁶⁹ issues were the most frequent issues identified by the families who accessed Family Services, followed by issues relating to mental health, (and equally) family violence and financial/household concerns.

¹⁶⁹ Issues relating to behaviour were frequently identified in families with young people aged 12–24 years, although not so frequently in families where the presenting person was aged 12–24 years.



Child FIRST

Strengthening earlier intervention for vulnerable families continues to progress with the statewide roll-out of Child FIRST (Child and Family Information, Referral and Support Teams) providing an accessible intake to Family Services within a sub-regional catchment. These teams will be operational in 16 catchments in 2008. The final 8 Child FIRST sites will commence in 2009, across 24 sub-regional catchments, to complete the statewide roll-out of Child FIRST.

Child FIRST aims to:

- Ensure that vulnerable children and their families receive priority access to relevant services to support the child's healthy development and improve parenting capacity
- Promote earlier and more appropriate referral pathways within and between services, to connect vulnerable children and families with the services and supports to address their needs and prevent inappropriate child protection intervention
- Provide intake into an integrated family services system at the sub/regional level
- Provide access to a range of services differentiated to the needs of the family that positively improve the outcomes for children and young people. This will include services coordinated by Integrated Family Services and with other relevant sector services such as universal services, Mental Health, Drug and Alcohol, Family Violence and Housing and Homelessness Services.

Child protection services

Indicator: Proportion of children who are the subject of a report to Child Protection within 12 months of a previous report

As noted in Section 2.3, reports to Child Protection Victoria are assessed and either referred to appropriate support services or if appropriate, sent for child protection investigation or closed. A re-report occurs when a child is reported to Child Protection and there have been one or more previous reports for that child during the preceding 12 months.

In 2006–07, there were 29,518 children aged 0–17 years reported to Child Protection. This included 2160 reports about Aboriginal children.

The 2006–07 re-reporting rate for all children was 31.6 per cent and the re-reporting rate for Aboriginal children years was 43.0 per cent.

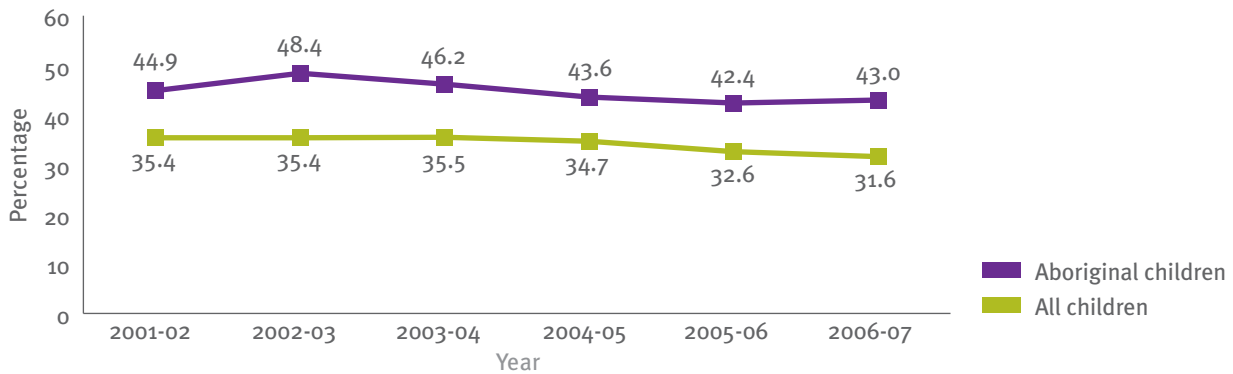
Figure 4.13 shows that re-reporting rates have slightly decreased for all children from 2001–02 to 2006–07.¹⁷⁰ The re-reporting rate for Aboriginal children is consistently higher than that for all children.¹⁷¹

¹⁷⁰ Throughout 2005–06 and 2006–07, Victoria introduced a major new data system, which was rolled out across the state by mid-2008. In parallel, the *Children, Youth and Families Act 2005*, which commenced in April 2007, introduced new service pathways and processes in Victorian child protection and family services to support earlier intervention and prevention for vulnerable children and their families. Due to these new service and data reporting arrangements, Victorian data relating to re-reporting for 2005–06 onwards may not be fully comparable with data from previous years.

¹⁷¹ It should be noted that there are a high number of reports each year for whom Aboriginal status is not reported (over 5 per cent of all reports).



Figure 4.13: Rate (percentage) of child protection re-reports among children aged 0–17 years, Victoria, 2001–02 to 2006–07



Source: DEECD calculations, based on DHS, CRIS database

Indicator: Proportion of re-substantiations within 12 months

This indicator measures the percentage of children who are re-substantiated with 12 months of case closure. It is an important indicator of the extent to which child protection intervention has been effective in keeping children who have been assessed to be at risk safe from further harm in the short and longer term.

In 2006–07, there were 1128 re-substantiations for children aged 0–17 years. This included 174 re-substantiations for Aboriginal children.

The 2006–07 re-substantiation rate for all children was 16.9 per cent and the re-substantiation rate for Aboriginal children was 25.2 per cent.¹⁷²

As figure 4.14 shows, the re-substantiation rate for all children has decreased slightly over the past five years.

Figure 4.14: Rate (percentage) of child protection re-substantiations among children aged 0–17 years, Victoria, 2002–03 to 2006–07



Source: DEECD calculations, based on DHS, CRIS database

Note: This data differs from data published by AIHW owing to the use of different methodologies/counting rules

¹⁷² It should be noted that there continues to be a number of young people who have had substantiated child abuse/harm/neglect and for whom Aboriginal status is unknown.



Indicator: Proportion of children who are the subject of child abuse substantiations within three months after an initial decision not to substantiate

As noted earlier, 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.

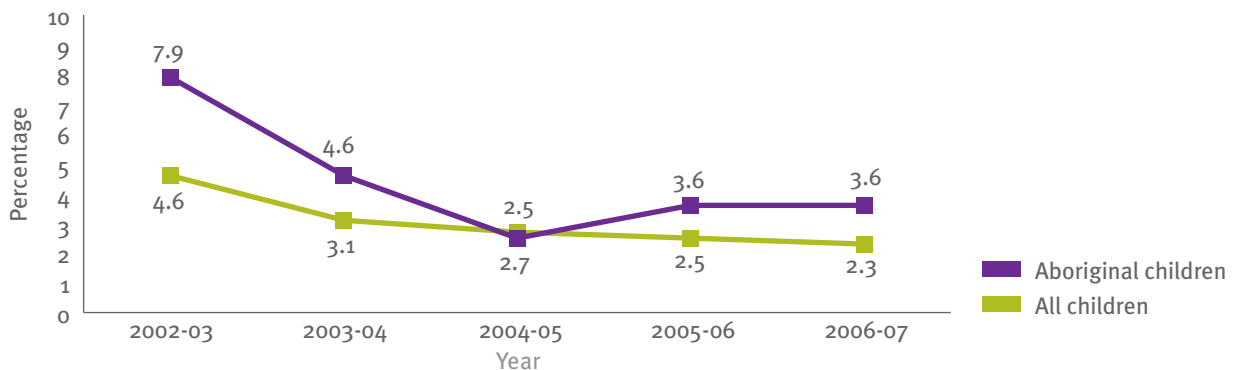
This indicator measures the percentage of children who were the subject of an investigation that led to a decision not to substantiate, but who were subsequently the subject of a substantiation within three months of case closure (and a decision not to substantiate).

In 2006–07, there were 152 substantiations for children (aged 0–17 years) within three months of previous case closure for that child with a decision not to substantiate. This included 25 substantiations for Aboriginal children.

The 2006–07 percentage of substantiations within three months of a decision not to substantiate for all children was 2.3 per cent and for Aboriginal children was 3.6 per cent.^{173, 174}

As figure 4.15 shows, this percentage has decreased slightly since 2002–03 for all children.

Figure 4.15: Percentage of child protection substantiations following decision not to substantiate among children aged 0–17 years, Victoria, 2002–03 to 2006–07



Source: DEECD calculations; based on DHS, CRIS database

Children on care and protection orders

Indicator: Rate of children on care and protection orders

Most families and children who come in contact with Child Protection are referred to support services, including parenting education, family mediation and counselling and in-home family support. Sometimes, where there are serious concerns about the child’s safety and wellbeing, further intervention is required, and a Child Protection practitioner may apply to the Children’s Court for a care and protection order.

There has been a substantial increase in the number of care and protection orders across Australia since 1997. This increase may be attributable to a greater awareness of abuse and neglect and to the cumulative effect of a growing number of children who enter care at an early age and are on orders until they are 18 years of age (AIHW 2008a).

¹⁷³ The small number of Aboriginal young people should be noted as small fluctuations can influence large percentage change.

¹⁷⁴ It should be noted that there continues to be a number of young people who have had substantiated child abuse/harm/neglect and for whom Aboriginal status is unknown.

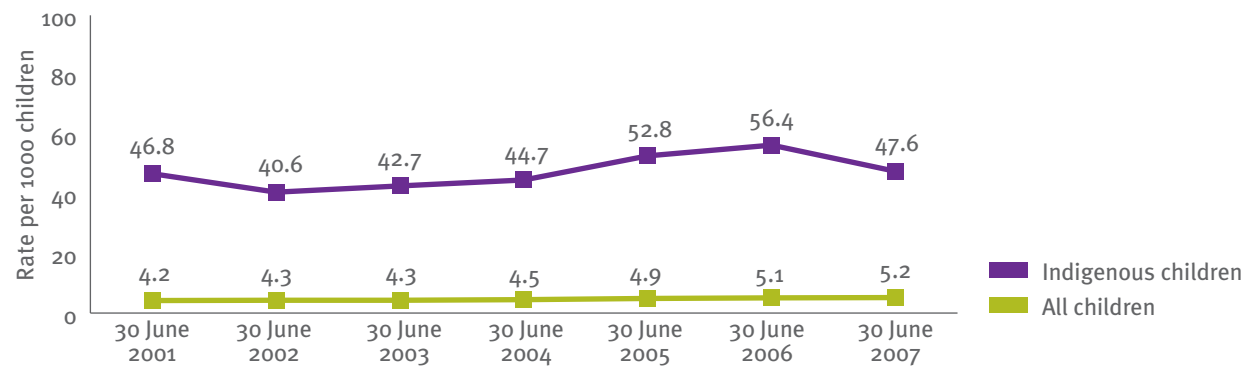


In 2006–07, there were 7301 children aged 0–17 years on care and protection orders in Victoria, a rate of 5.2 per 1000 children. Of these 623 were Indigenous representing a rate of 47.6 per 1000 children (AIHW 2008a). Indigenous children in Victoria were nine times more likely to be on a care and protection order than all children.

Across Australia, Indigenous children were 5.6 times more likely than all children to be on a care and protection order (AIHW 2008a).¹⁷⁵

Figure 4.16 shows that there appears to be a small increasing overall trend in the rate of care and protection orders for all children in Victoria, from 30 June 2001 to 30 June 2007. The rate of care and protection orders in Indigenous children has declined from 2006 to 2007. However, the rate remains much higher in Indigenous children than in all children (figure 4.16).

Figure 4.16: Rate (per 1000) of children aged 0–17 years on a care and protection order, Victoria, 30 June 2001 to 30 June 2007



Source: AIHW 2002, 2003, 2004, 2005b, 2006, 2007a and 2008a

Services for children in out-of-home care

Indicator: Rate of children in out-of-home care

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

Across Australia there is an increasing trend in the rate of children in out-of-home care. Indigenous children and young people are much more likely to be in out-of-home care than other children and young people (AIHW 2008).

There are some indications that children with a disability may be over-represented in the population of children in out-of-home care. While 7 per cent of Victorian children have a disability (ABS 2004, in DHS 2006), unpublished data from the Department of Human Services show that 10 per cent of the current care population enter care with some form of disability or developmental delay. Among those children entering care for the first time in 2007–08 the prevalence of disability was even higher, at 15.4 per cent.

In Victoria at 30 June 2007, there were 5052 children aged 0–17 years in out-of-home care, a rate of 4.3 per 1000 children. Of these children, 626 were Indigenous, representing a rate of 47.8 per 1000 children.

¹⁷⁵ In 2006–07, the rate (per 1000 children) of children on a care and protection order in Australia was 6.0 for all children and 33.4 for Indigenous children.

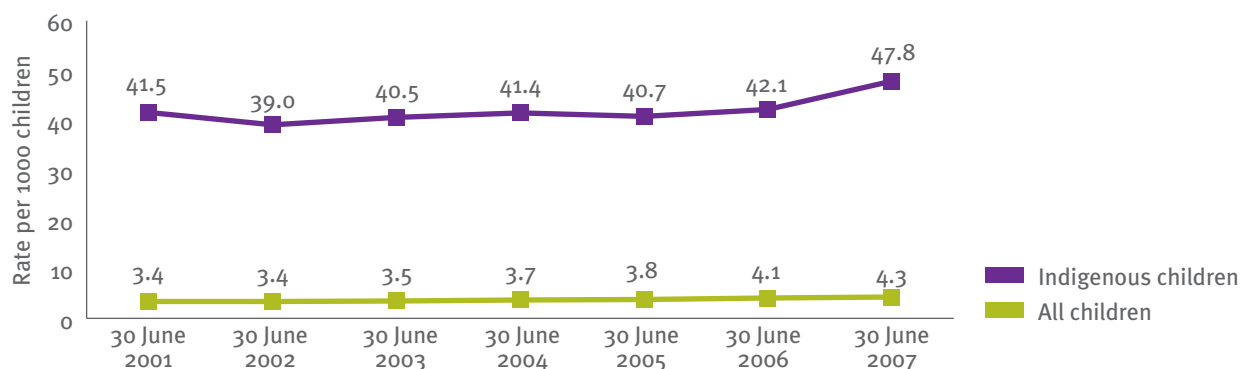


Indigenous children in Victoria were 11.1 times more likely to be in out-of-home care than all children. Across Australia, Indigenous children were 6.2 times more likely to be in out-of-home care than all children (AIHW 2008).¹⁷⁶

Analysis of trend data shows that, in line with the national picture, there is an increasing trend in Victoria in the rate of children in out-of-home care. These rates are also consistently higher among Indigenous children than all children (figure 4.17).

It is important to note, however, that the number of children entering care is not increasing – in fact, there has been a slight decline. The growing number of children in care reflects longer average stays in care, and this may also contribute to (and perhaps also be a result of) increasing numbers of placement changes.

Figure 4.17: Rate (per 1000) of children aged 0–17 years in out-of-home care, Victoria, 30 June 2001 to 30 June 2007



Source: AIHW 2002, 2003, 2004, 2005b, 2006, 2007a and 2008a

Placement stability

Research points to some clear differences in the experiences of those children leaving care who achieve positive outcomes and those whose outcomes are negative. Many of the factors that are associated with positive outcomes concern the stability of children's care and education arrangements (Centre for Excellence in Child and Family Welfare 2005, in DEECD 2008).

Indicator: Number of out-of-home care placements for children on a care and protection order when exiting out-of-home care

In 2006–07, a total of 1255 children (who were on a care and protection order) exited care. Of these, 450 (35.9 per cent) had had three or more placements. 209 of these children were Indigenous, and 70 (33.5 per cent) of these had had three or more placements.

Figure 4.18 shows the percentages of Indigenous and non-Indigenous children and young people exiting care in Victoria who have had three or more placements (2001–02 to 2006–07). The figure suggests that there is an increasing overall trend in the proportion of children exiting care who have had three or more placements.

However, in recent years (2005–06 and 2006–07) Indigenous children exiting care have been less likely than all children to have had three or more placements.

As noted above, this data may partly reflect the fact that children who do enter care spend longer periods in care.

¹⁷⁶ At 30 June 2007, the rate of children in out-of-home care in Australia was 5.8 per 1000 children and 36.1 per 1000 children for Indigenous children.



Figure 4.18: Percentage of children on a care and protection order exiting care who had three or more placements among children aged 0–17 years, Victoria, 2001–02 to 2006–07



Source: Data supplied by DHS

Victorian programs to improve the stability of children and young people in out-of-home care

The out-of-home care service system in Victoria is investing in various programs to assist in improving stability for young people – therapeutic foster care and Take Two are both programs which target this issue. Recent additional investment in home-based care services was targeted at ensuring carers receive adequate levels of support – thus strengthening their ability to maintain placements when significant challenges arise. A major thrust of our legislative reforms has also been to improve children’s stability, with the stability planning provisions of the new legislation and associated practice advice and training emphasising the need for all staff involved in these services to focus efforts on achieving stability in timely ways.

Out-of-home care is currently under review with the aim of developing a long-term review strategy for out-of-home care. The review will present a framework for service reform and improvement targeted at:

- Stronger early intervention to further prevent the need for children to enter state care
- Improving support for children and birth families to enable successful return home from care
- Ensuring an adequate supply of out-of-home care placements when required
- Improving the short- and long-term outcomes for children in state care via provision of better quality out-of-home care services and improved access to a range of essential services, including health and education

Placement in home-based care and with relatives or kin

Indicator: Proportion of all children aged under 12 years in out-of-home care who are placed in home-based care

Indicator: Proportion of all children aged under 12 years in out-of-home care who are placed with relatives/kin

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

As table 4.14 shows, the vast majority of children aged under 12 in Victoria are placed in home-based care (97.6 per cent at 30 June 2007).



Table 4.14: The number and percentage of children under 12 years in home based care, Victoria, 30 June 2002 to 30 June 2007

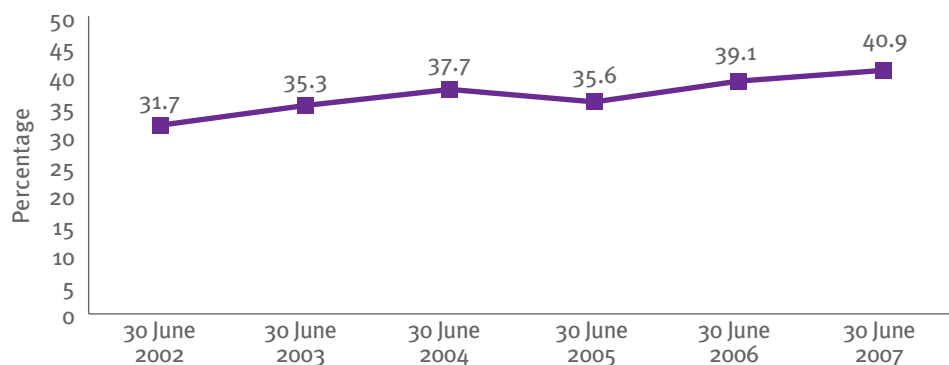
	30 June 2002		30 June 2003		30 June 2004		30 June 2005		30 June 2006		30 June 2007	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Residential care	95	4.1	78	3.2	78	3.1	67	2.6	70	2.4	72	2.4
Relatives/kin	737	31.7	853	35.3	962	37.7	929	35.6	1119	39.1	1245	40.9
Total home-based*	2227	95.9	2337	96.8	2477	96.9	2539	97.4	2789	97.6	2974	97.6
Total in out-of-home care	2322	100.0	2415	100.0	2555	100.0	2606	100.0	2859	100.0	3046	100.0

* Total home-based care includes relatives/kin

Source: Data supplied by DHS

There is an increasing trend in the percentage of children under 12 in out-of-home care in Victoria who are placed with relatives/ kin, increasing from 31.7 per cent of children at 30 June 2002 to 40.9 per cent of children at 30 June 2007 (figure 4.19).

Figure 4.19: Percentage of children under 12 years in out-of-home care who are placed with relatives/kin, Victoria, 30 June 2002 to 30 June 2007



Source: Data supplied by DHS

Indicator: Proportion of Aboriginal children in out-of-home care who are placed in accordance with the Aboriginal Child Placement Principle

The Aboriginal Child Placement Principle (ACPP) is a nationally agreed standard used in determining the placement of Aboriginal children in out-of-home care. The principle aims to enhance and preserve Aboriginal children’s sense of identity by ensuring that they maintain strong connections with their family, community and culture.

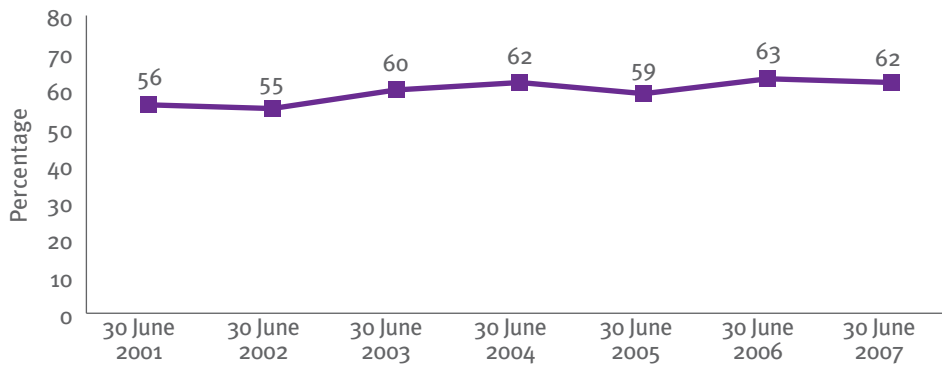
The ACPP outlines preferences for the placement of Aboriginal children when they are placed outside their immediate family. In order, these preferences are:

- Placement with the child’s extended family (which includes Aboriginal and non-Aboriginal relatives and kin)
- Placement within the child’s Aboriginal community
- Placement with other Aboriginal people.



Compliance with the ACPP was 62 per cent at 30 June 2007, compared with 56 per cent in 2001 (figure 4.20). The limited availability of Aboriginal foster care and residential care placement is a significant contributing factor to the relatively low rate of ACPP compliance in Victoria (DHS 2008).¹⁷⁷

Figure 4.20: Percentage of Aboriginal children and young people aged 0–17 years, who are placed in out-of-home care in compliance with the ACPP, Victoria, 30 June 2001 to 30 June 2007



Source: Department of Human Services 2008

The principle of the ACPP has been endorsed by the Secretariat of National Aboriginal and Islander Child Care Agencies (SNAICC) and is now included in the *Children Youth and Families Act 2005* (CYFA). This means that practitioners in Child Protection, community service organisations and the Children’s Court must take account of the ACPP (s. 13 CYFA) when placing an Aboriginal child in out-of-home care.

¹⁷⁷ New South Wales, Western Australia, South Australia and the ACT have higher levels of compliance with the ACPP than Victoria. Queensland has a comparable level of compliance (to Victoria) and Tasmania and the Northern Territory have lower levels of compliance (AIHW 2008).



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Appendix 2: Key survey sources and data reports

Victorian surveys

The 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 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 Prep 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 5–7-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 at <http://www.education.vic.gov.au/ocecd/earlychildhood/library/publications/primary/sehq.html>



The 2006 Victorian Child Health and Wellbeing Survey

The Department of Education and Early Childhood Development is currently developing a comprehensive, across government, system to monitor and report on the safety, health, development, learning and wellbeing of children and young people against the Victorian Child and Adolescent Outcomes Framework. The system is known as the Victorian Child and Adolescent Monitoring System (VCAMS).

As part of the VCAMS, a rolling program of new data collections is underway to address data gaps. The new data collections include the Victorian Child Health and Wellbeing Survey (VCHWS). The VCHWS has been designed to support reporting on outcomes relating to child health, nutrition (including breastfeeding), oral health, child activities, reading, child behaviour, family functioning, parental health, parental mental health and health in pregnancy. The first VCHWS was completed in March 2006, the survey will be repeated during 2009.

During the 2006 survey, 5000 computer assisted telephone interviews were carried out with the parents and carers of Victorian children aged under 13 years. A sample of telephone numbers was generated using random digit dialling, stratified by Departmental region to ensure an appropriate representation across the state. All private households with a landline and where a child aged under 13 years usually lived were considered to be in-scope for the survey. Interviews were conducted in English only. The survey response rate, defined as the proportion of positively screened households where an interview was completed, was 86.6 per cent.

A full technical report on the 2006 Victorian Child Health and Wellbeing Survey can be found at: www.education.vic.gov.au/about/directions/children/newdata.htm

On Track survey

The On Track survey is an annual telephone survey of Year 12 completers and early leavers in Victoria. School leavers from the previous year are contacted between April and May and destinations data are collected on two basic dimensions: education and training; and employment and occupation.

The On Track survey is designed to provide a valuable tool for guiding program policies both at the government and school level and at a local or regional level. The program enables schools to monitor how their students fare in a context of rapid labour market change and complex educational pathways. It is thus possible for schools to see, for example, how many exiting students are working, but also undertaking training, and how many are in tertiary study, but also have a job.

On Track also collects background information on students, so that the destinations of particular subgroups can be considered such as those of Indigenous students. Transition differences between regions in Victoria are also documented in this report. This information is valuable not only for schools, but also for the Local Learning and Employment Networks (LLEN), regions, VET providers (particularly TAFE institutes) and for government agencies.

The annual On Track survey, conducted by the Australian Council for Educational Research for the Department of Education and Early Childhood Development, surveyed more than 33,000 young people who completed the Victorian Certificate of Education, the International Baccalaureate, or the Victorian Certificate of Applied Learning (Intermediate or Senior).

Victorian Population Health Survey

The Victorian Population Health Survey (VPHS) is an important component of the population health surveillance responsibilities of the Victorian Department of Human Services. During the annual survey, computer-assisted telephone interviews are carried out on the health of Victorians aged over 18 years. Within the survey, respondents are asked to indicate if they have any children aged 18 years or younger.

Telephone interviewing is undertaken between August and December each year. The survey samples are generated using random digit dialling. All private Victorian households with a land line are considered in-scope for the survey. It should be noted that some population groups, such as homeless people, the frail and aged or people with disabilities may be excluded from participating in telephone interviews.

The most recent VPHS report can be viewed at: www.health.vic.gov.au/healthstatus/vphs_current.htm



Analysis of Victorian data from the Healthy Neighbourhoods School Survey

The Healthy Neighbourhoods Project was a large study undertaken in 2006 to look at the health and wellbeing of children and teenagers across Victoria, Queensland and Western Australia. Communities stratified by socioeconomic status and urban/rural location were randomly selected to take part in the project. During 2006, over 3500 young people in Years 6 and 8 were surveyed from 10 urban and eight rural local government areas across Victoria and these data were used to produce the analysis for this report.

The Healthy Neighbourhoods School Survey (HNSS) consisted of a computer-based questionnaire and the measurement of height, weight, blood pressure and pulse rate. The questionnaire was designed to provide information on rates of health and social problems experienced by young people and, in addition, provide information on the risk and protective (influencing) factors that predict these problems. The aim of the project was to examine whether the causes of common adolescent health and behaviour problems (including mental illness, substance abuse, unhealthy weight, school and conduct problems) vary across different socioeconomic strata.

The commissioned analysis of HNSS Victorian data provides important information for this report about the health and wellbeing of young people (aged 11–13 years) as a whole, and by subgroup (age, gender, ATSI status, language spoken at home, urban/rural location and socioeconomic status). The sample was weighted according to its location and socioeconomic status so that the data estimated a representative sample of young people from the Victorian population.

Healthy Neighbourhoods was funded by a three-year grant from the National Health and Medical Research Council (NHMRC). The researchers are based at the Murdoch Children's Research Institute at the Royal Children's Hospital (Vic), Griffith University (Qld), the Telethon Institute for Child Health Research (WA) and Curtin University of Technology (WA).

Participation rates of Victorian young people and sample sizes for all subgroups are provided below.

Participation rates¹⁷⁸

Year level	Number	Consent forms returned N (%)	Parent consent	Survey complete N (%)	Measurements complete N (%)
6	3468	2437 (70)	2211 (64)	2057 (59)	1963 (57)
8	4162	2222 (53)	1950 (47)	1751 (42)	1648 (40)
Total	7630	4659 (61)	4161 (55)	3808 (50)	3611 (47)

Sample sizes¹⁷⁹

Age ¹⁸⁰	10	11	12	13	14	Total
N (%)	20 (0.5)	1049 (27.9)	1782 (47.4)	884 (23.5)	22 (0.6)	3757

Gender	Male	Female	Total
N (%)	1852 (48.8)	1941 (51.2)	3793

Status	ATSI	Non-ATSI	Total
N (%)	75 (2.0)	3625 (98.0)	3700

Language	English	Other	Total
N (%)	3197 (85.9)	526 (14.1)	3723

Location	Urban	Regional	Total
N (%)	1939 (51.1)	1854 (48.9)	3793

SES level	Lowest	2	3	4	Highest	Total
N (%)	766 (20.2)	703 (18.5)	825 (21.8)	917 (24.2)	582 (15.3)	3793

¹⁷⁸ The main reasons for non-participation were (a) failure to return consent form, (b) absence from school on the day of the survey and (c) parental non-consent.

¹⁷⁹ It should be noted that some students did not answer every question or participate in both parts of the survey.

¹⁸⁰ Due to the small number of students who were 10 and 14 years of age, the results of the analysis by age are limited to those aged 11–13 years.



Key data reports

Child Protection Australia

This report is prepared annually by the AIHW and provides comprehensive information on state and territory child protection and support services. The 2006-07 report includes data for 2006-07 together with trend data relating to child protection notifications, investigations and substantiations, children on care and protection orders and children in out-of-home care. Information on the age, sex and Indigenous status of children in the child protection system is included, and for child protection substantiations the report also includes data on the family type and source of notification. Information is presented on the types of order and living arrangements for children on care and protection orders, and for children in out-of-home care there are data on types of placement and length of time in out-of-home care.

Juvenile Justice in Australia

This report is prepared annually by the AIHW and provides information about young people in juvenile justice in Australia. The 2006-07 report was the fourth report. It presents information about the characteristics of young people in community-based supervision and detention in 2006-07, together with patterns of supervision over time and analyses of trends. The report data derive from the Juvenile Justice National Minimum Data Set, which is based on the experience of the young person within supervision rather than on legal orders and contains data from 2000-01.



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Overweight and obesity

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