

## WELLINGTON BEST START

### BEST START INDICATORS AND SUPPORTING DATA

NOVEMBER 2010

*This report was prepared as resource to assist Wellington Primary Care Partnership and Wellington Working Together Partnership to choose two Best Start Indicators for Wellington Best Start. This report will highlight population data on children and families within the Wellington Shire based on the 15 Best Start Indicators. It is envisaged that Wellington Best Start will work with communities, parents and service providers to improve universal early years services based on the two indicators chosen.*

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## INTRODUCTION

### WHAT IS 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 Victorian children (0-8 years). It supports communities, parents and service providers to improve universal early years services so they are responsive to local needs. Best Start has a strong emphasis on prevention and early intervention.

The health and wellbeing of children during early developmental years can play a critical role in establishing good health and the skills necessary to achieve optimum health throughout life. Some of the factors that may influence a child's physical health, emotional and mental wellbeing are the socioeconomic environment of the child's family, community, physical environment, and access to services.

### BEST START INDICATORS

Best Start is focused on achieving significant improvements in outcomes for all children. Positive impacts will be felt throughout a child's life into adulthood and across generations as today's children become parents in the future.

The indicators used to monitor and assess outcomes have been chosen as the Best Start measures because they:

- are known to have a strong evidence base linking them to improved health, development, learning and wellbeing outcomes for children
- are collected regularly through existing data processes
- are susceptible to change within the short to medium term
- provide consistent measurement across diverse project sites

The Best Start Indicators, listed below, are grouped under the domains of health and wellbeing, learning and development, and safety. This report will present data on the 15 Best Start indicators:

#### A. Health and Wellbeing

1. Increased rate of breastfeeding
2. Decreased rate of women smoking during pregnancy
3. Decreased rate of children exposed to tobacco smoke in the home
4. Increased rates of immunisation
5. Increased attendance at maternal and child health
6. Increased rate of children who are protected from summer sun
7. Increased rate of children who participate in physical activity
8. Proportion of children who clean their teeth at least twice a day

**B. Learning and Development**

9. Increased rate of parents reading to their children
10. Increased participation in kindergarten
11. Reduced absences from primary school
12. Improved reading, writing and numeracy

**C. Safety**

13. Decreased rate of re-notifications to child protection
14. Decreased rate of unintentional injury
15. Proportion of children whose parents report high levels of social support

**DATA SNAPSHOT – WELLINGTON SHIRE**

**POPULATION**

The Shire of Wellington is a Local Government Area in Victoria, Australia. It is located in the Eastern part of the state. It has an area of 10,924 square kilometres, and a population of 42, 576.<sup>i</sup> The Shire of Wellington is likely to have a relatively stable population over the next 20 years, although there are likely to be population gains and losses in different parts of the Shire<sup>ii</sup>.

Below is data on the population of Wellington and expected population projection. Overall there is a slight decline in children aged 0 to 14 by 2016, however progressing through the age group there is a significant increase in population.

**Age group**

Age Group	2006		2011		2016	
	No.	%	No.	%	No.	%
0-4	2,379	5.7	2,413	5.6	2,455	5.5
5-14	5,868	14.1	5,307	12.3	5,130	11.6
15-24	5,254	12.6	5,479	12.7	5,098	11.5
25-34	4,589	11.0	4,675	10.9	4,958	11.2
35-49	8,769	21.1	7,856	18.3	7,331	16.5
50-59	6,204	14.9	6,628	15.4	6,395	14.4
60-69	4,131	9.9	5,445	12.7	6,592	14.9
70-84	3,711	8.9	4,257	9.9	5,144	11.6
85+	686	1.6	946	2.2	1,215	2.7
<b>Total</b>	<b>41,591</b>	<b>100.0</b>	<b>43,007</b>	<b>100.0</b>	<b>44,317</b>	<b>100.0</b>

*Source: Department of Planning and Community Development (DPCD), Victoria in Future 2008, 2010*

Wellington Shire Municipal Early Years Plan, reports that there are approximately 4,544 children 0-8 years in the Wellington Shire (based on 2006 Census Data). Wellington Shire is ranked 38 out of 79 Local Government Areas in terms of the number of Victorian children aged 0-8 years<sup>iii</sup>.

Below is a table outlining data population of children aged 0-4 and 5-9 years living in small townships in Wellington Shire. The below data is based on the 2006 Census:

**DEMOGRAPHIC DATA BY TOWN**

	Sale	Maffra	Heyfield	Stratford	Rosedale	Wurruk
<b>Population</b>						
Population Males 0-4	445	113	56	34	32	34
Population Females 0-4	435	130	47	39	28	37
Total 0-4	880	243	103	73	60	71
Percentage of population	7%	6%	7%	5%	6%	10%
Population Males 5-9	509	158	39	53	28	23
Population Females 5-9	475	124	40	48	35	29
Total 5-9	984	282	79	101	63	52
Percentage of population	8%	7%	6%	7%	6%	7%
<b>DEMOGRAPHIC DATA BY TOWN</b>						
	Boisdale	Loch Sport	Seaspray	Dargo	Coongulla	Longford
<b>Population</b>						
Population Males 0-4	11	8	9	3	3	41
Population Females 0-4	21	9	9	9	3	27
Total 0-4	32	17	18	12	6	68
Percentage of population	6%	2%	10%	10%	2%	7%
Population Males 5-9	14	13	3	0	3	33
Population Females 5-9	23	7	4	3	0	29
Total 5-9	37	20	7	3	3	62
Percentage of population	6%	3%	4%	5%	2%	7%

	Port Albert	Yarram	Gormandale	Hollands Landing
<b>Population</b>				
Population Males 0-4	3	42	24	12
Population Females 0-4	4	36	19	15
Total 0-4	7	78	43	27
Percentage of population	3%	5%	6%	5%
Population Males 5-9	6	44	32	29
Population Females 5-9	6	49	27	23
Total 5-9	12	93	59	52
Percentage of population	5%	6%	8%	8%

Source: Wellington Shire Municipal Early Years Plan 2010

### Aboriginal Children and Families

There are approximately 436 Aboriginal persons in Wellington Shire. This represents 1.1 per cent of the total population of Wellington<sup>iv</sup>. Below is a table outlining Aboriginal population compared to total population of Wellington Shire. The below data is based on the 2006 Census:

#### Aboriginal population of Wellington (S), the Gippsland region and Victoria, 2006.

	Aboriginal population			Total Population		
	Children aged 0 to 8 years	Total (all ages)	Percentage children aged 0 to 8 years	Children aged 0 to 8 years	Total (all ages)	Percentage children aged 0 to 8 years
Wellington (S)	96	436	22.0	4,395	40,079	11.0
Gippsland Region	734	3,072	23.9	26,212	238,907	11.0
Victoria	6,650	30,143	22.1	556,791	4,932,422	11.3

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

*Source: Department of Education and Early Childhood Development (DEECD), Early Childhood Community Profile, Shire of Wellington 2010*

Below is a table of Aboriginal families with children compared to all families with children in Wellington Shire. In summary of the 4,910 families counted in Wellington with dependent children, 101 were Aboriginal families, representing 2.1 per cent of all families with dependent children in Wellington Shire.

	Families with dependent children			Families with at least one child aged 0 to 8 years		
	Aboriginal families	All families	Percentage Aboriginal	Aboriginal families	All families	Percentage Aboriginal
Wellington (S)	101	4,910	2.1	64	2,571	2.5
Gippsland Region	714	28,707	2.5	477	15,225	3.1
Victoria	7,222	623,647	1.2	4,654	336,092	1.4

*Source: Census of Population and Housing, ABS, 2006.*

*Source: Department of Education and Early Childhood Development (DEECD), Early Childhood Community Profile, Shire of Wellington 2010*

### MEASURING DISADVANTAGE

The Australian Bureau of Statistics (ABS) produces the Socio-Economic Indexes for Areas (SEIFA). These indexes are derived from data collected in the Census of Population and Housing. SEIFA 2006 comprises four indexes that measure different aspects of socio-economic conditions by geographic areas. The Index of Relative Socio Economic Disadvantage (IRSED) is one part of SEIFA. It allows users to identify geographic areas that are relatively disadvantaged.

IRSED is derived from Census attributes believed to reflect disadvantage, such as:

- low income
- low educational attainment
- high unemployment
- proportion of work force in relatively unskilled occupations

The ABS standardises the IRSED scores for Census Collection Districts so that the average IRSED score across Australia is 1000 and the middle two-thirds of IRSED scores will fall between 900 and 1100.

While a low IRSED score indicates that the LGA is more disadvantaged than another with a higher score, there is no particular score below which an area is classified as disadvantaged and above which it is classified as not disadvantaged.

The IRSED score for Wellington is 978. Wellington was ranked 26 out of 79 LGAs in Victoria. A rank of 1 was assigned to the most disadvantaged LGA in Victoria. Below is a table of other LGA within Gippsland Region<sup>v</sup>.

LGA in Gippsland region	2006 SEIFA index of disadvantage
Latrobe (C)	950.7
East Gippsland (S)	962.9
<b>Wellington (S)</b>	<b>978.2</b>
Bass Coast (S)	978.7
Baw Baw (S)	1000.8
South Gippsland (S)	1001.2

*Source: Derived from East Gippsland SEIFA index of disadvantage Local Government Areas in Regional Victoria (ranked from greatest to least disadvantaged)*

Whilst Wellington appears to be a reasonably advantaged area some areas within Wellington Shire are in the most disadvantaged category of the 1st decile<sup>vi</sup>. These areas are:

- within the Sale city boundary
- within the Loch Sport town boundary
- within the Heyfield town boundary
- within the Yarram town boundary

### **DATA LIMITATIONS**

While preparing this report there were some gaps in finding data based on the Wellington Shire to support the Best Start Indicators. Overall there was little information on some health and wellbeing concerns such as children protected from the sun; children participating in physical activity and children who clean their teeth at least twice a day. To compensate for this limitation, data was obtained from broader region data in which Wellington Shire is contained.

Other limitations include:

- The year the data was collated and published – some of the data reported are approx 4 years to 12 months old and therefore may not provide an accurate reflection on the current needs of the community.
- Majority of the data presented in this report is based on Wellington Shire, Gippsland Region or State-wide. It was difficult to find data specifically on local townships such as Sale, Wurruk, and Dargo. Furthermore, Wellington Shire is diverse in size and population and some areas of Wellington are considered more disadvantaged.

## BEST START INDICATORS AND SUPPORTING DATA

### A. HEALTH AND WELLBEING

#### 1. Increased Rate Of Breastfeeding

##### Description:

Having a baby means making many choices. One of the most important and far-reaching ones expectant mothers have to make is about the way they will feed their new baby.

##### Benefits of Breast Milk:

- Protects your baby from illness and infection
- Provides the correct food for your growing baby
- Aids the development of your baby's eyesight, speech and intelligence
- Promotes a special loving bond between mother and baby
- The colostrum your baby receives in the first few days, and the breast milk that follows, contain antibodies that provide resistance to infection.
- Breastfeeding helps your body return to its pre-pregnant state more quickly. Many women also find they lose excess weight while breastfeeding.

##### Babies who are not breastfed:

- Have a higher risk of cot death
- Have an increased likelihood of allergy
- Women who have not breastfed their babies have an increased risk of cancer of the breast and ovaries, heart disease and osteoporosis.
- Cost more money - you need to buy expensive infant formulas and feeding equipment. Non-breastfed babies are more likely to fall ill, costing more to the family and the community in medical bills
- The unique combination of fatty acids and other components in breast milk contribute to optimal brain development, so lack of these in artificially-fed babies may result in lower intelligence.

Current National Health and Medical Research Council (NHMRC) recommendations are for sole breastfeeding until six months of age, and continuation of breastfeeding until age two or beyond with appropriate complementary feeds (NHMRC, 2003). Nevertheless, a recent parliamentary inquiry noted that only a small proportion of Australian babies are exclusively breastfed to six months of age (House of Representatives, 2007). Various reasons were suggested, including inconsistency of advice; beliefs about infant formula; and the level of community support. The report also noted that "with the right advice and appropriate support it seems that many would breastfeed for longer" (HoR, 2007, p.4)<sup>vii</sup>.

**Data:**

Below is a table of 2001 to 2010 on breastfeeding rates\* of women within this Wellington Shire, and more specifically who attended Central Gippsland Health Service. This table was prepared by Maternal Child Health Nurse and Lactation Consultation Sue Gray.

\* Rates are inclusive of exclusive and predominantly breastfed.

**Table A:**

	Discharge	2 weeks	3 months	6 months
Yr 00 01	86.25	80.60	59.32	48.21
Yr 01 02	78.11	73.89	55.79	42.95
Yr 02 03	81.74	79.41	61.15	47.77
Yr 03 04	84.70	78.10	57.60	46.00
Yr 04 05	84.70	78.10	57.60	46.00
Yr 05 06	79.70	76.00	51.50	38.20
Yr 06 07	78.20	69.40	53.80	41.20
Yr 07 08	77.30	70.30	49.30	38.60
Yr 08 09	75.50	68.60	47.30	36.40
Yr 09 10	74.00	67.00	47.50	37.50

Source: Data Information provided by Sue Gray, Maternal Child Health Nurse and Lactation Consultant, CGHS

Below is data on women who fully (table 1) and partially (table 2) breastfed during the period of 2008 to 2009.

Table 1: Breast feeding rates for fully breastfed, Gippsland 2008-09

LGA	Total records	On discharge (%)	At 2 Weeks (%)	At 3 Months (%)	At 6 Months (%)
Bass Coast	334	83.5	75.1	56.9	43.1
Baw Baw	536	82.3	75.7	57.5	41.6
East Gippsland - GLCH	392	79.1	72.2	52.0	42.1
East. Gippsland –ORH	76	78.9	68.4	57.9	48.7
Latrobe	1,002	76.1	64.5	43.7	31.2
South Gippsland	302	81.8	74.2	52.0	38.4
Wellington – CGHS	494	75.5	68.6	47.4	36.4
Wellington - YDHS	37	78.4	54.1	45.9	21.6
<b>Total</b>	<b>3,173</b>	<b>78.9</b>	<b>70.0</b>	<b>50.2</b>	<b>37.4</b>

Source: Department of Human Services, Gippsland, Regional Initiative, Gippsland Health Online, Wellington, Breastfeeding rates Gippsland by LGA 2008-09

Table 2: Breast feeding rates for partially breastfed, Gippsland 2008-09

LGA	Total records	On discharge (%)	At 2 Weeks (%)	At 3 Months (%)	At 6 Months (%)
Bass Coast	334	1.5	3.6	4.5	3.9
Baw Baw	536	7.1	9.5	8.2	7.5
East Gippsland	392	5.9	6.9	4.3	3.3
East. Gippsland –ORH	76	5.3	7.9	6.6	2.6
Latrobe	1,002	6.7	7.9	4.3	3.3
South Gippsland	302	5.6	7.9	9.3	7.3
Wellington – CGHS	494	5.1	6.5	7.3	5.1
Wellington - YDHS	37	8.1	8.1	5.4	5.4
<b>Total</b>	<b>3,173</b>	<b>5.7</b>	<b>7.4</b>	<b>6.0</b>	<b>4.7</b>

Source: Maternal & Child Health Services Annual Report 2008-09, Department of Education and Early Childhood Development, 2010

Source: Department of Human Services, Gippsland, Regional Initiative, Gippsland Health Online, Wellington, Breastfeeding rates Gippsland by LGA 2008-09

#### Recommendations:

Wellington Best Start is currently working towards increasing the rate of breastfeeding. As outlined in the data, breast feeding rates have remained below 50% for the last 10 years. It is important that Wellington Best Start continue to address this indicator to ensure numbers increase significantly in the Wellington community.

## 2. Decreased Rate of Women Smoking During Pregnancy

### Description:

Smoking (and second hand smoking) during pregnancy is harmful for the mother and her unborn child. There are approximately 200 toxins found in cigarettes, including nicotine, carbon monoxide and cyanide. These substances have been found to cross the placenta and reach the baby.

Consequences of smoking during pregnancies include:

- Cigarette smoking restricts blood vessels therefore reducing the amount of nutrients and oxygen reaching the baby. This leads to a lower birth weight and a baby more prone to becoming ill after birth.
- Smoking during pregnancy increases the chances of genetic abnormalities of the baby. There has been associations made between pregnant women smoking and increased chance of cleft lip, cleft palate, problems with bowel, eyes, ears and spinal cord. There are also increased abnormalities found with the placentas.
- There have been links made between women smoking during pregnancy and their children developing respiratory problems, such as asthma, later in childhood<sup>viii</sup>.

### Data:

Quit Victoria reported<sup>ix</sup>:

- 23% of women who were pregnant and or breastfeeding were smokers.
- For all women aged 20-39, around 26% of women aged smoke regularly (daily or weekly). In Australia round 58,000 babies are born to mothers who smoked throughout their pregnancy.
- 11% of women, being pregnant or wanting to start a family is a factor that motivates them to change their smoking behaviour.
- Approximately 20-30% of women who were smokers quit when they find out they are pregnant, the majority quit within the first three months of pregnancy. They quit because they are concerned about the health of the baby, and secondly their health. Some women may quit as they prepare to become pregnant and many others quit as soon as they learn that they are pregnant.

Smoking during pregnancy accounts for:

- 11% of all ectopic pregnancies (where the pregnancy occurs in the fallopian tube and results in miscarriage)
- 9% of all miscarriages (spontaneous abortions)
- The risk of miscarriage increases with the number of cigarettes smoked and the age the mother commenced smoking.
- 15% of all antepartum hemorrhage (bleeding from the vagina 24 weeks to up until birth)
- 21% of all premature rupture of the membranes (early breaking of the waters)
- 23% of all low birth weight babies (low birth weight means under 2,500 gms)

- 9% of stillbirths
- 34% of all SIDS deaths

Below table is a breakdown of mothers who smoked during their pregnancy, by stage of pregnancy. Overall, 26.5% (upper percentage) of Victorian women continued to smoke once they found out that they were pregnant.

### Smoking during pregnancy

Proportion of children whose mothers smoked during pregnancy, by stage of pregnancy (children under two years)

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
Early pregnancy: pre-recognition	21.9	18.5	25.4
Early pregnancy: post-recognition	12.1	9.4	14.8
Late pregnancy: post-recognition	9.3	6.8	11.7

Source: Department of Human Services, 2006 Victorian Child Health and Wellbeing Survey: Technical Report

The below data does is not specifically related to ‘smoking rates in pregnant women’, however it provides a snapshot of where Wellington Shire ranks on smoking related mortalities, which may provide a correlation to the communities perception of smoking. According to the Cancer Council Victoria, Wellington Shire ranked 3<sup>rd</sup> out of 79 Victorian Region of ‘Deaths attributable to smoking’. Below is a list of Shires within the Gippsland Region, and what position they ranked compared to Wellington Shire:

Rank	Shires	Percentage of Deaths attributable to Smoking
3 <sup>rd</sup>	Wellington Shire	14.0 %
6 <sup>th</sup>	Bass Coast Shire	13.6%
22 <sup>nd</sup>	East Gippsland Shire	13.0 %
23 <sup>rd</sup>	Latrobe City	12.9%
39 <sup>th</sup>	Baw Baw Shire	12.3 %
43 <sup>rd</sup>	South Gippsland Shire	12.3%

Source: The Big Kill, The Cancer Council Victoria, Local Government Area, 2008

For the full list of ‘LGA Deaths attributable to smoking’ visit

<http://www.quit.org.au/thebigkill/ranking.asp?ContainerID=tbklga&ContentID=wellingtonshirecouncil>

According to Birthing Outcomes System (BOS), courtesy of Central Gippsland Health Service (CGHS) Sale (retrieved on 11/10/10), below are two tables of data of women who birthed at CGHS and the rates of women who smoked and did not smoke, as well as those who ceased and did not cease smoking during their pregnancy.

<b>Date Period:</b>	<b>1/1/09 to 1/1/10</b>		
<b>Women admitted during period:</b>	514		
<b>Women who did not smoke:</b>	338 or 65.75 %		
<b>Women who smoked:</b>	176 or 34.24 %	<b>Of whom Ceased before pregnancy:</b>	36 or 20.45%
		<b>Ceased during pregnancy:</b>	24 or 13.63 %
		<b>Did not Cease during pregnancy:</b>	116 or 65.9%

<b>Date Period:</b>	<b>2/1/10 to 1/10/10</b>		
<b>Women admitted during period:</b>	420		
<b>Women who did not smoke:</b>	283 or 67.38 %		
<b>Women who smoked:</b>	137 or 32.61 %	<b>Of whom ceased before pregnancy:</b>	24 or 17.51 %
		<b>Ceased during pregnancy:</b>	20 or 14.59%
		<b>Did not cease during pregnancy:</b>	93 or 67.88%

*Source: Birthing Outcomes System (BOS), courtesy of Central Gippsland Health Service (CGHS) Sale (retrieved on 11/10/10)*

**Recommendations:**

Overall, the last two periods (01/01/2009 to 01/01/2010 and 02/01/2010 to 01/10/2010) there has been an increase in rates of women who smoked prior to their pregnancy and did not cease smoking during pregnancy. There may be a correlation of the high smoking rates during pregnancy with the high smoking related mortalities in the Wellington Shire and the communities perception of smoking. Therefore in order to positively influence the rate of women smoking during their pregnancy, further health promotions targeted at people who smoke in the Wellington community may be more appropriate in the initial stages.

### 3. Decreased Rate of Children Exposed to Tobacco Smoke in the Home

#### Description:

Tobacco smoking is the largest single preventable cause of death and disease in Australia (Cancer Council 2006). Smoking is a key risk factor for the three diseases that cause most deaths in Australia: heart disease, stroke and lung cancer. Smokers are also at increased risk of developing chronic obstructive pulmonary disease and reduced lung function (DoHA 2006)<sup>x</sup>.

People who are exposed to and or start smoking when they are young are more likely to smoke heavily, or become more dependent on nicotine increasing their risk to smoking-related illness or death<sup>xi</sup>.

#### Data:

2006 Victorian Child Health and Wellbeing Survey reported that an average of 31.9% of adults who have children (aged 0 to 13 years) regularly smoke. Of those adults who smoke, approx 79% of them smoke outside, and approx 13% smoke inside.

#### Household smoking status (birth to <13 years)

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
No smoker	68.1	66.5	69.6
Regular smoker/ s	31.9	30.4	33.5

#### Do the regular smokers in smoking households... (birth to <13 years)

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
Always smoke outside the house	78.8	76.3	81.2
Usually smoke outside the house	8.1	6.5	9.7
Sometimes smoke inside and sometimes outside	9.4	7.7	11.0
Usually smoke inside the house	2.1	1.1	3.0
Always smoke inside the house	1.7	0.8	2.5

Source: Department of Human Services, 2006 Victorian Child Health and Wellbeing Survey: Technical Report

Wellington Shire has the highest rates of deaths attributable to tobacco smoking within the Gippsland region.

Table2: Number of deaths attributable to tobacco smoking by LGA 2002-05

	Bass Coast	Baw Baw	East Gippsland	Latrobe	South Gippsland	Wellington
Lung cancer	13	12	18	24	10	21
Mouth & throat cancer	0	1	1	1	1	1
Other cancers	4	4	6	7	3	4
Heart disease	6	7	9	14	6	9
Stroke	2	2	3	4	1	2
Chronic bronchitis & emphysema	10	8	13	21	7	10
<b>Total deaths</b>	<b>36</b>	<b>34</b>	<b>51</b>	<b>71</b>	<b>28</b>	<b>47</b>

Source: Department of Human Services, Gippsland, Regional Initiative, Gippsland Health Online, Mortality attributed to tobacco smoking, Gippsland Region by LGA 2002 - 2005

Although the below data does not specifically relate to 'children exposed to tobacco smoke in the home', it provides a snapshot of where Wellington Shire ranks on smoking related mortalities, which may provide a correlation to the communities perception of smoking. According to the Cancer Council Victoria, Wellington Shire ranked 3<sup>rd</sup> out of 79 Victorian Region of 'Deaths attributable to smoking'. Below is a list of Shires within the Gippsland Region, and what position they ranked compared to Wellington Shire:

Rank	Shires	Percentage of Deaths attributable to Smoking
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Source: The Big Kill, The Cancer Council Victoria, Local Government Area, 2008

For the full list of 'LGA Deaths attributable to smoking' visit

<http://www.quit.org.au/thebigkill/ranking.asp?ContainerID=tbklga&ContentID=wellingtonshirecouncil>

Data taken from ‘Synthetic Estimates of Prevalent Cases of Selected Diseases and Risk Factors, Wellington LGA’, report that there were approximately 5275 adults who smoked on a daily basis in Wellington Shire.

**1. Estimated number of daily smokers**

<b>Age</b>	<b>Females</b>	<b>Males</b>	<b>Total</b>
0-1 years	No data	No data	No data
2-5 years	No data	No data	No data
6-9 years	No data	No data	No data
10-13 years	No data	No data	No data
14-17 years	107	80	187
18-24 years	243	325	565
25-34 years	396	569	958
35-44 years	537	612	1148
45-54 years	567	680	1244
55-64 years	312	439	743
65+ years	297	323	617
18+ years	2351	2949	5275

*Source: Department of Human Services, Gippsland, Regional Initiative, Gippsland Health Online, Wellington, Estimates of Prevalent Cases of Selected Diseases and Risk Factors.*

**Recommendations:**

Although there is limited data on rates of children exposed to tobacco smoke in the home within the Wellington Shire, it is apparent that Wellington Shire has the highest recorded deaths attributable to tobacco smoking, and is ranked third highest in Victoria of recorded deaths attributable to tobacco smoking. As mentioned earlier Wellington Shire requires additional health promotions and distribution of anti smoking material to support people to quit smoking and improve the community’s perception of smoking.

#### 4. Increased Rates of Immunisation

##### Description:

Immunisation is a simple, safe and effective way of protecting your child and yourself against some diseases which can cause serious illnesses and sometimes death. If your child is protected he or she will not be able to pass the infection on to other people, especially very young babies who are not yet fully immunised.

It is now widely acknowledged that vaccination is critical for the prevention and eradication of disease. For optimal results, it is important that children receive all required immunisations in a timely manner. However, although vaccination coverage has improved, considerable proportions of children are under vaccinated or receive delayed vaccination<sup>xii</sup>.

Vaccine coverage needs to exceed 90 per cent to achieve and maintain the level of community immunity necessary to interrupt the ongoing transmission of vaccine preventable diseases (Lister, McIntyre, Burgess & O'Brien, 1999)<sup>xiii</sup>.

Below is a table of age-appropriate time and what vaccine is given to child (aged 0 to 4 years):

AGE	VACCINE
<b>Birth</b>	Hepatitis B (hepB)
<b>2 months</b>	Hepatitis B (hepB) Diphtheria, tetanus and acellular pertussis (DTPa) <i>Haemophilus influenzae type b (Hib)</i> Inactivated poliomyelitis (IPV) Pneumococcal conjugate (7vPCV) Rotavirus
<b>4 months</b>	Hepatitis B (hepB) Diphtheria, tetanus and acellular pertussis (DTPa) <i>Haemophilus influenzae type b (Hib)</i> Inactivated poliomyelitis (IPV) Pneumococcal conjugate (7vPCV) Rotavirus

<b>6 months</b>	Hepatitis B (hepB) Diphtheria, tetanus and acellular pertussis (DTPa) <i>Haemophilus influenzae type b (Hib)</i> Inactivated poliomyelitis (IPV) Pneumococcal conjugate (7vPCV) Rotavirus
<b>12 months</b>	Hepatitis B (hepB) <i>Haemophilus influenzae type b (Hib)</i> Measles, mumps and rubella (MMR) Meningococcal C (MenCCV)
<b>12-24 months</b>	Hepatitis A (Aboriginal and Torres Strait Islander children in high risk areas)
<b>18 months</b>	Varicella (VZV)
<b>18-24 months</b>	Pneumococcal polysaccharide (23vPPV) (Aboriginal and Torres Strait Islander children in high risk areas) Hepatitis A (Aboriginal and Torres Strait Islander children in high risk areas)
<b>4 years</b>	Diphtheria, tetanus and acellular pertussis (DTPa) Measles, mumps and rubella (MMR) Inactivated poliomyelitis (IPV)

**Data:**

Below is a table of children fully immunised in Gippsland LGA's, June 2010.

	<b>12-&lt;15 months</b>	<b>24-&lt;27 months</b>	<b>60-&lt;63 months</b>
Bass Coast	87.8 %	93.8 %	89.6 %
Baw Baw	89.1 %	94.8 %	94.2 %
East Gippsland	90.5 %	92.8 %	91.1 %
Latrobe	93.6 %	94.4 %	91.8 %
South Gippsland	94.6 %	93.3 %	87.3 %
Wellington	96.3 %	96.1 %	93.8 %
<b>Gippsland</b>	<b>92.3 %</b>	<b>94.3 %</b>	<b>91.7 %</b>
<b>Victoria</b>	<b>92.1 %</b>	<b>93.0 %</b>	<b>91.2 %</b>

Source: Department of Human Services, Gippsland, Regional Initiative, Gippsland Health Online, Wellington, Childhood Immunisation Gippsland by LGA June 2010

**Recommendations:**

Overall the number of children immunised within the Wellington Shire has remained reasonable, with the Wellington Shire rates being one of the highest in the Gippsland region, and higher than the state average. It can be assumed that the current Wellington initiatives are appropriate and only encouragement and general promotion by members of the partnerships is necessary to maintain or improve the rates.

## 5. Increased Attendance at Maternal and Child Health (MCH)

### Description:

High-quality antenatal care is seen as a fundamental right of all women to safeguard their health and that of their infants (World Health Organisation, 1994). There is an extensive international evidence base addressing effective interventions to improve maternal and child health wellbeing (AIHW, 2002). However, interventions that have been successful in mainstream settings have not necessarily translated into improved health in families of low socio-economic status and members of certain ethnic minority groups<sup>xiv</sup>.

The Maternal and Child Health Service is free for all Victorian families with children under six and is there to help you give your child a good start in life.

The Maternal and Child Health Service offers you:

- Support, information and access to professional advice on everything from child behaviour and nutrition to breastfeeding and family planning;
- The chance to identify any problems in your child's health and development;
- The chance to meet other parents in your area and access to parent and community groups;
- Further support and assistance for those who need it;

There are maternal and child health centres in every local government area in the state. These centres are staffed by highly qualified maternal and child health nurses supported by a range of other health professionals and specialist services (DEECD, Maternal and Child Health, 2010).

### Data:

As reported in 'Maternal Child Health Services Annual Report Gippsland Region 2008-2009', there were approximately 457 women who gave birth at Central Gippsland Based Hospital. Below is a breakdown of the percentage of the women (457) who engaged with Maternal Child Health Services.

Local Government Area/Agency	Home Consultation %	2 Weeks %	4 Weeks %	8 Weeks %	4 Months %	8 Months %	12 Months %	18 Months %	2 Years %	3.5 Years %
Bass Coast	94.4	84.4	81.6	86.5	76.0	73.3	72.0	63.4	51.9	49.4
Baw Baw	95.4	92.3	89.4	87.3	84.6	78.7	79.2	73.0	70.3	63.1
East Gippsland - GLCH	100.0	98.9	98.6	93.8	94.6	89.0	86.1	65.8	70.4	53.5
East Gippsland - ORH	95.7	92.8	76.8	91.3	95.7	70.3	86.9	53.5	50.0	68.1
La Trobe	99.7	95.0	90.3	92.1	87.0	78.1	79.6	65.4	62.1	56.6
South Gippsland	101.0	94.8	92.0	87.2	81.9	85.8	88.5	77.6	78.7	69.8
Wellington - CGHS	96.5	94.8	92.6	95.9	95.2	82.4	78.6	70.8	75.1	68.9
Wellington - YDHS	91.5	87.2	91.5	100.0	93.6	107.1	73.8	74.2	71.2	74.7
<b>Total for Region</b>	<b>97.9</b>	<b>93.8</b>	<b>90.6</b>	<b>91.1</b>	<b>87.5</b>	<b>80.7</b>	<b>80.4</b>	<b>68.4</b>	<b>67.1</b>	<b>60.1</b>

Source: Maternal & Child Health Services Annual Report: 2008-2009, Gippsland Region.

The two tables below identify families that accessed MCH services and required the following counselling for their child's health and wellbeing and mother or families wellbeing. In summary the top three counselling support provided to mother or families (regarding their child's wellbeing) within the Wellington area included: 'nutrition altered', 'illness' and 'development'. The top three counselling support provided to mother or families within the Wellington area included: 'Emotional', 'Physical' and 'Social Interaction Impaired'.

### Count of Reasons for Counselling (Mother or Family)

Local Government Area/Agency	Emotional	Physical	Social Interaction Impaired	Domestic Violence	Family Planning	Total
Bass Coast	265	165	27	2	7	466
Baw Baw	58	13	4	1	4	80
East Gippsland - GLCH	123	79	4	3	1	210
East Gippsland - ORH	42	45	3	5	1	96
La Trobe	306	142	232	7	25	712
South Gippsland	16	7	0	0	2	25
Wellington - CGHS	642	111	95	10	0	858
Wellington - YDHS	4	9	0	0	0	13
<b>Total for Region</b>	<b>1,456</b>	<b>571</b>	<b>365</b>	<b>28</b>	<b>40</b>	<b>2,460</b>

### Count of Reasons for Counselling (Child)

Local Government Area/Agency	Visual	Auditory	Communication	DDH	Congenital Anomaly	Growth	Development	Potentially Disabling Condition	Accident	Illness	Nutrition Altered	Dental/ Oral	Total
Bass Coast	2	6	30	1	21	112	280	61	4	234	220	3	974
Baw Baw	1	2	4	0	1	3	4	2	0	7	10	2	36
East Gippsland - GLCH	7	14	39	4	1	17	22	37	2	51	46	11	251
East Gippsland - ORH	7	9	19	1	4	38	56	1	2	37	81	4	259
La Trobe	16	49	97	8	25	59	136	51	35	213	248	30	967
South Gippsland	0	1	3	0	0	7	5	1	0	20	24	0	61
Wellington - CGHS	22	44	55	9	16	40	68	48	12	72	112	47	545
Wellington - YDHS	1	0	2	1	0	1	1	2	1	5	0	4	18
<b>Total for Region</b>	<b>56</b>	<b>125</b>	<b>249</b>	<b>24</b>	<b>68</b>	<b>277</b>	<b>572</b>	<b>203</b>	<b>56</b>	<b>639</b>	<b>741</b>	<b>101</b>	<b>3,111</b>

Source: Maternal & Child Health Services Annual Report: 2008-

*2009, Gippsland Region*

**Recommendations:**

Unlike other indicators, no single intervention in Best Start Evidence Guide was identified to increase attendances at Maternal and Child Health (MCH) services. Instead the Evidence Guide identified a holistic approach to antenatal care would lead to a positive increase in attendance rates.

In addition there is a strong link between immunisation, breastfeeding and MCH programs. Therefore if one of the following indicators; increasing breastfeeding rates, increasing immunisation rates and increasing attendance at MCH, were chosen there is the possibility that the remaining two mentioned indicators would also benefit.

## 6. Increased rate of children who are protected from summer sun

### Description:

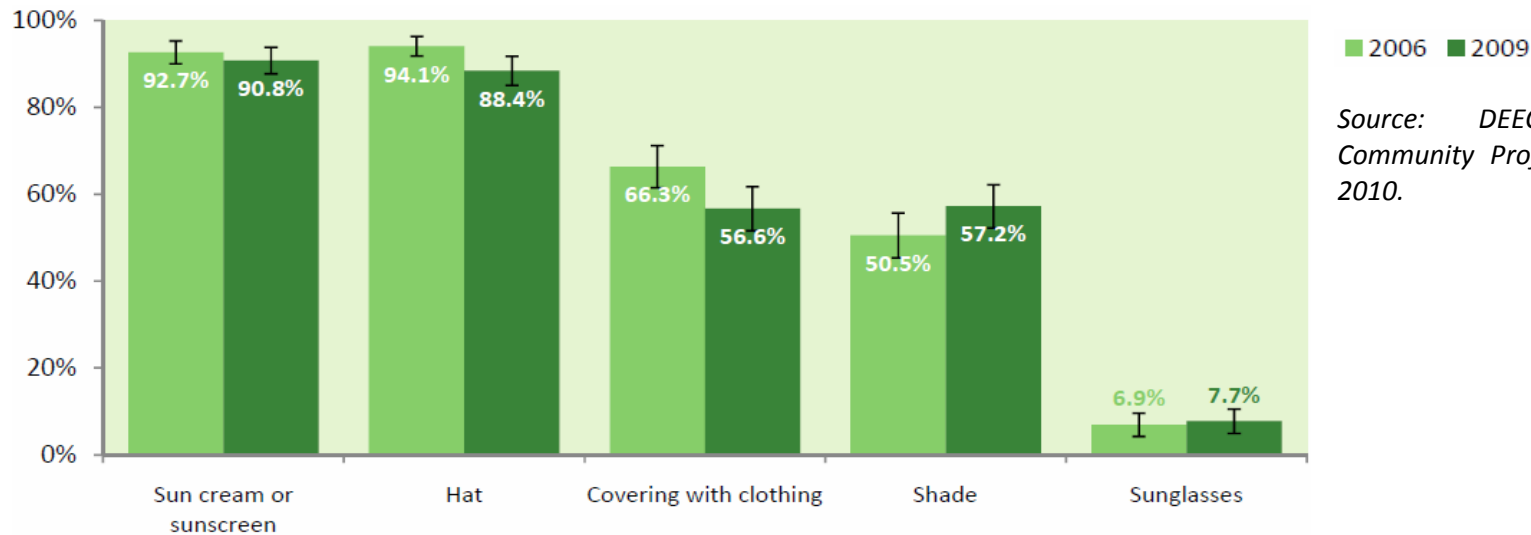
Exposure to sunlight is the main cause of melanoma and an important cause of skin cancer. Australia has the highest rates of skin cancer in the world with one in two Australians affected at some stage during their lifetime. Too much exposure to ultraviolet (UV) radiation can cause injuries such as sunburn, skin damage and skin cancer. The damage done to the skin from even one episode of overexposure to the sun can never be repaired. Most UV related injuries can be prevented by using a combination of sun protection measures<sup>xv</sup>.

### Data:

Early Childhood Community Profile for Wellington Shire reports:

- In the Gippsland region, the proportion of parents who reported protecting their child from the sun everyday in the summer months in 2009 (83.4%) was higher, but not significantly different to than that reported in 2006 (79.3%).
- Based on the 2009 VCHWS survey results, the proportion of children aged 0 to 12 years in the Gippsland region whose parents were reported to protect them from the sun everyday in the summer months (83.4%) was more than that reported across Victoria (81.7%)<sup>xvi</sup>.

Below is a table of 'Most common forms of sun protection reported by parents in Gippsland Region' and the changes from 2006 to 2009.



Source: DEECD Early Childhood Community Profile, Shire of Wellington, 2010.

**Recommendations:**

During the period of 2006 and a review in 2009, the rates of children unprotected from the sun have remained consistent within Gippsland Region. Although it is difficult to determine the rates within the Wellington Shire, it can be assumed that the rates would be similar. It is difficult to provide recommendation on whether it is appropriate for Wellington Best Start to pursue this indicator without further consultation and obtaining Wellington Shire data.

## 7. Increased rate of children who participate in physical activity

### Description:

Promoting physical activity and reducing sedentary activity at early ages is important for improving children's fitness and reducing the prevalence of overweight and obesity in Australian children. It is especially important that there is a strong evidence base for strategies to promote physical activity among young children, and that the settings in which these strategies can be delivered are clearly identified (Timperio, Salmon and Ball, 2004)<sup>xvii</sup>.

According to Vicsports (2010) the following physical, emotional and social benefits of children are:

#### Physical health benefits for children

- Improved fitness, strength, flexibility and coordination;
- Improved general health and assistance in weight management;
- Development of a wide range of motor skills;
- Healthy growth and development of the cardio respiratory system as well as the bones and muscles of children;
- Establishment of healthy behaviours that young people will carry throughout their lives, such as better eating habits and decreased likelihood of smoking.

#### Mental health benefits for children

- Improved self esteem and confidence;
- Reduction in stress, anxiety and depression;
- Improved mood and sense of wellbeing;
- Improved concentration, enhanced memory and learning, and better performance at school;
- Reduced feelings of fatigue and depression; and
- Improved psychological wellbeing and mental awareness.

#### Social benefits for children

- Development of communication, interpersonal, leadership and co-operation skills;
- Creation of lasting friendships;
- Increased interest in accepting responsibility;
- Teaches them how to deal with winning and losing;
- Provides a vehicle for responsible risk taking;
- Helps build social skills among children and may deter anti social behaviour;

- Helps young people develop self-discipline and leadership<sup>xviii</sup>.

In general there are approximately 35 registered sports and recreational club for children aged 0 < 12 years within the Wellington Shire<sup>xix</sup>. In addition to that, children and families have access parks, playgrounds and play spaces in their local neighbourhoods.

**Data:**

There was limited data on children within the Wellington Shire who participate in physical activity. However Department of Health and Department Human Services produced reports which highlight physical activities of children in Victoria and children who are overweight and obese within the Wellington Shire.

The below table highlight the percentage of Victoria children aged five to thirteen who have engaged in at least one hour of daily physical activity.

How often children are active for at least one hour a day  
(Five to <13 years)

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
Everyday	71.2	69.2	73.1
Five or six days	12.2	10.8	13.6
Four days	6.3	5.2	7.4
Three days	5.4	4.4	6.4
Two days	2.6	1.9	3.2
One day	1.1	0.6	1.5
No days	0.8	0.4	1.1
Don't know	0.5	0.2	0.9

Source: Department of Human Services, 2006 Victorian Child Health and Wellbeing Survey: Technical Report

Although not specific to physical activity, there is some relevance on data regarding children's nutrition. Below are three tables on Victoria children's fruit and vegetable intake compared to fries and takeaway food:

**Children meeting minimum guidelines for fruit and vegetable intake (four to <13 years)**

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
Fruit intake	87.5	86.2	88.9
Vegetable intake	38.6	36.6	40.6

**Consumption of fries: times per week (one to <13 years)**

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
Less than once	18.6	17.2	20.0
Once to three	54.1	52.3	55.8
Four to five	11.7	10.5	12.8
More than five	8.0	7.0	9.0
Rarely/ never	7.7	6.8	8.6

**Consumption of takeaways: times per month (one to <13 years)**

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
Once or twice	57.9	55.8	60.0
Three or four times	2.3	1.6	2.9
Five times or more	11.5	10.1	12.9
Rarely	17.5	15.9	19.2
Never	10.7	9.5	12.0
Don't know	0.1	0.0	0.1

Source: Department of Human Services, 2006 Victorian Child Health and Wellbeing Survey: Technical Report

The following data (dated June 2006) represents the number of children and adults who are classified as overweight or obese within the Wellington Shire.

**4. Estimated number overweight**

**5. Estimated number obese**

Age	Females	Males	Total	Females	Males	Total
0-1 years	No data	No data	No data	No data	No data	No data
2-5 years	139	146	No data	48	44	No data
6-9 years	183	168	No data	67	65	No data
10-13 years	282	228	No data	86	89	No data
14-17 years	148	189	No data	65	60	No data
18-24 years	296	403	666	87	71	159
25-34 years	422	903	1295	257	312	568
35-44 years	547	1291	1830	420	515	934
45-54 years	872	1429	2291	637	630	1264
55-64 years	843	1273	2102	517	598	1112
65+ years	1062	1364	2450	607	488	1088
18+ years	4042	6663	10635	2525	2613	5125

*Source: Department of Human Services, Gippsland, Regional Initiative, Gippsland Health Online, Wellington, Estimates of Prevalent Cases of Selected Diseases and Risk Factors.*

As mentioned earlier, according to ‘Wellington Shire Municipal Early years Plan’ there were approximately 4,544 children aged 0 to 8 years residing in the Wellington Shire (based on 2006 Census Data). Of the population approx 1146 children (aged 2 to 13 years) or approx 858 children (aged 6 to 13 years) are classified as either overweight or obese.

**Recommendations:**

Further promotional work of community and universal services which promote healthy eating and physical activity is required to ensure children within the Wellington Shire develop happy and healthy.

## 8. Proportion Of Children Who Clean Their Teeth At Least Twice A Day

### Description:

Oral disease is largely preventable, but many children still suffer from tooth decay (dental caries). This can mean pain, sleepless nights and sometimes major dental treatment including extraction of teeth under a general anaesthetic. Tooth decay in the baby teeth can mean that a child will develop tooth decay in the adult (permanent) teeth, it is important that they adopt good oral hygiene habits early in life.

Keeping children’s teeth and mouth healthy includes:

- Eating a wide variety of nutritious foods and encouraging healthy eating behaviours that can contribute to good oral health and wellbeing.
- Encourage children to drink plenty of tap water and plain milk.
- Encourage children to clean their teeth at least twice a day, once in the morning and once at night.
- Oral health check-ups should start as soon as the first tooth appears and no later than 12 months of age. How often your child should visit will be recommended by the dentist or other oral health professional<sup>xx</sup>.

More than three quarters of Victorians now drink water with either naturally-occurring or added fluoride. Water fluoridation is an effective, inexpensive and socially equitable way to reduce tooth decay in children and adults. However according to Gippsland Waters the following towns within the Wellington Shire have fluoride added to their water supply<sup>xxi</sup>.

Maffra, Stratford, Sale

### Data:

As identified above, healthy teeth and mouth are more than just visits to the dentist. Below are data collated by 2006 Victorian Child Health and Wellbeing Survey, on children eating and drinking habits, and data of children visit their local dentist.

Fruit and Vegetable / Milk / Drink Water than Soft Drink / Drink Milk than Soft Drink:

**Children meeting minimum guidelines for fruit and vegetable intake (four to <13 years)**

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
Fruit intake	87.5	86.2	88.9
Vegetable intake	38.6	36.6	40.6

Whole milk consumption by age (one to <13 years)

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
One to <five years	82.6	80.3	84.8
Five to <nine years	76.3	73.5	79.0
Nine to <13 years	68.1	65.2	70.9

Proportion of children who drink more water than soft drinks (two to <13 years)

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
All (two to <13 years)	76.7	75.1	78.2
Two to <five years	77.2	74.3	80.0
Five to <nine years	77.2	74.6	79.9
Nine to <13 years	75.8	73.2	78.3

Proportion of children who drink more milk than soft drinks (one to <13 years)

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
All children (one to < 13 years)	60.9	59.1	62.6
Two to <five years	69.4	66.7	72.2
Five to <nine years	58.7	55.5	61.8
Nine to <13 years	55.0	52.0	58.0

Source: Department of Human Services, 2006 Victorian Child Health and Wellbeing Survey: Technical Report

Below are data collated by Victorian Child Health and Wellbeing Survey 2006, on proportion of Victorian children (aged 2 to 5, 5 to 9 and 9 to 13 years old) brushing their teeth twice a day:

**Proportion of children who brush their teeth at least twice a day, by age**

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
All children (two to < 13 years)	70.4	68.1	72.1
Two to < five years	56.8	53.4	60.1
Five to < nine years	74.8	72.0	77.5
Nine to < 13 years	75.8	73.2	78.3

**Frequency of tooth cleaning (two to < 13 years)**

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
Never	0.1	0.0	0.3
Less than once a day	1.5	1.1	1.9
Less than once a day	27.0	25.4	28.6
Twice a day	68.3	66.6	70.0
More than twice a day	2.1	1.6	2.6
Tooth cleaning not started or no teeth	0.1	0.0	0.2
Don't know	0.9	0.5	1.2

Source: Department of Human Services, 2006 Victorian Child Health and Wellbeing Survey: Technical Report

As identified earlier, children from about 12 months of age should have an oral health check up with further check-ups based on recommendations made by dentist. Despite this approx 30% of Victorian children have never been to the dentist.

**Children who have never been to the dentist by age (six months to <13 years)**

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
All children (6 months to <13 years)	30.2	28.6	31.7
One to <five years	71.0	68.3	73.6
Five to <nine years	13.0	10.8	15.2
Nine to <13 years	1.3	0.6	2.1

Source: Department of Human Services, 2006 Victorian Child Health and Wellbeing Survey: Technical Report

Ambulatory care sensitive conditions (ACSCs) are those for which hospitalisation is thought to be avoidable with the application of public health interventions and early disease management, usually delivered in ambulatory setting such as primary care. High rates of hospital admissions for ACSCs may provide indirect evidence of problems with patient access to primary healthcare, inadequate skills and resources, or disconnection with specialist services<sup>xxii</sup>.

Hospital admission rates for dental conditions are amongst the top five ambulatory care sensitive conditions in rural Victoria. This means that amongst the causes of hospitalisation that shouldn't be necessary, dental conditions were very prominent. Data on hospital admission of children aged 0 to 4 years in Wellington Region shows that 'dental conditions' ranked 3<sup>rd</sup> as avoidable hospital admission had the person engaged with early public health intervention. Children aged 5 to 9 years in Wellington Region shows that 'dental conditions' ranked 1<sup>st</sup> as avoidable hospital admission had the person engaged with early public health intervention.

The following tables demonstrate a representation of the mentioned data:

**Table: Children aged 0 to 4 years, Wellington Region**

All individual ACSCs for selected year						
	Number of Admissions	Standardised Rate per 1,000 Persons	Lower limit of 95% CI	Upper limit of 95% CI	Average Bed days	Total Bed Days
Ear, nose and throat infections	42	16.63	11.64	21.63	1.64	69
Asthma	37	14.90	10.14	19.66	1.54	57
Dental conditions	28	11.28	7.13	15.43	1.11	31
Convulsions and epilepsy	11	4.24	1.74	6.73	1.27	14

**Table: Children aged 5 to 9 years, Wellington Region**

All individual ACSCs for selected year						
	Number of Admissions	Standardised Rate per 1,000 Persons	Lower limit of 95% CI	Upper limit of 95% CI	Average Bed days	Total Bed Days
Dental conditions	82	30.25	23.80	36.70	1.00	82
Ear, nose and throat infections	16	5.98	3.06	8.90	1.69	27
Asthma	5	1.87	0.23	3.50	1.20	6

Source: Department of Human Services, VHISS, ACSC 2006, Local Government Area Wellington, age group 0 to 4 and 5 to 9, 2008-09

**Recommendations:**

Based on the presenting data in Wellington Shire, the communities' understanding of oral health and more specifically children's oral health is poor. Further review of the current service and promotional work is necessary to identify communication strengths and weaknesses and implement innovative changes to the services.

**B. LEARNING AND DEVELOPMENT**

**9. Increased rate of parents reading to their children**

**Description:**

Research shows that reading to children from an early age creates a safe and stimulating environment that fosters language, thinking and literacy development – both at home and in the classroom.

Reading within the home works to the educational advantage of all children regardless of their economic, racial, ethnic and educational background (Epstein, 1996 cited in Persampieri, 2006)<sup>xxiii</sup>.

However despite the benefits of parents or caregivers reading to their children risk factors exist which impede on their ability. They include:

- Parents / Caregivers poor level of literacy
- Lacked the teaching behaviour of reading a book (was no enthusiastic, encouraged play and imagination, and pull out the meaning of the book). This is statistically prominent in families from low socio economic status. It was estimated in one study that a typical middle-class child enters first grade with 1,000 to 1,700 hours of one-to-one book sharing experience while a typical low socio-economic child experiences just 25 hours (Adams, 1990 cited in Lonigan and Whitehurst, 1998).
- Aboriginal and Torres Strait Islander children – children are more likely to have parents of low literacy, and low socio-economic status. Also Aboriginal and Torres Strait Islander children often struggle with the delivery of education in Australian schools. The National Review of Education for Aboriginal and Torres Strait Islander Peoples (1994) reports that the instructional strategies used to develop literacy skills fail to meet the educational, social and cultural needs of Aboriginal and Torres Strait Islander children and their families (Freeman, 2006) xxiii.

**Data:**

Below is data from 2006 Victorian Child health and Wellbeing Survey, of Victorian Children aged six months to 13 years who are read to by a family member:

Children who are read to from a book (six months to <13 years)

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
Not at all	27.9	26.3	29.4
One or two days	12.5	11.4	13.7
Three to five days	16.2	14.9	17.5
Six or seven days	43.1	41.4	44.8
Don't know	0.3	0.1	0.4

Below is data from 2006 Victorian Child Health and Wellbeing Survey, of Victorian Children aged six months to 13 years who are read to from a book almost everyday:

Children who are read to from a book, almost everyday (six or seven days), by age (six months to <13 years)

	Estimate (percentage)	95 per cent CI	
		lower (percentage)	upper (percentage)
Six months to <one year	49.6	41.4	57.9
One to <five years	71.9	69.3	74.6
Five to <nine years	48.4	45.2	51.7
Nine to <13 years	10.8	44.9	12.6

Source: Department of Human Services, 2006 Victorian Child Health and Wellbeing Survey: Technical Report

According to the 2009 Victorian Child Health and Wellbeing Preliminary findings:

48.3% (46.6 - 50.0%) of children aged from 6 months to 12 years were being read to on a daily basis by a family member. This was slightly higher than the 43.1% (41.4 - 44.8%) of children who were read to on a daily basis in 2006. Not surprisingly, preschool children were most likely to be read to by a family member. 76.4% (73.9 - 79.0%) of children aged 1 to 4 years were read to on a daily basis in 2009.

On average, children aged 5 to 12 years of age read to themselves for pleasure for an estimated 4.5 hours a week<sup>xxiv</sup>.

**Australian Early Development Index (AEDI)** is a measure of how young children are developing in different communities. Like a census, it involves collecting information to help create a snapshot of early childhood development across Australia. The AEDI measures five areas, or domains, of early childhood development:

- Physical health and wellbeing
- Social competence
- Emotional maturity
- Language and cognitive skills (school-based)
- Communication skills and general knowledge<sup>xxv</sup>

The AEDI was completed in Wellington between 1 May and 31 July 2009. Summary statistics for this section include all children who reside in the community and were involved in the data collection. Results are reported at a Local Community level.

To maintain confidentiality results for a Local Community will not be included if there are insufficient numbers of children. There were no available data for the following Local Communities:

Airly, Alberton, Binginwarri, Boisdale, Briagolong, Cobains, Cowwarr, Dargo, Denison, Devon North, Fulham, Glenmaggie, Golden Beach, Gormandale, Hollands Landing, Jack River, Langsborough, Loch Sport, Longford, Manns Beach, McLoughlins Beach, Nambrok, Port Albert, Tinamba, Won Wron, Woodside, Wurruk<sup>xxvi</sup>.

Below is a breakdown of the number of children who participated in the AEDI and what town (local community) they reside in.

Wellington*	494	49.4 %	50.6 %
<b>Local Community</b>			
Heyfield	31	58.1%	41.9%
Maffra	71	52.1%	47.9%
Rosedale	20	35.0%	65.0%
Sale	191	51.8%	48.2%
Stratford	38	34.2%	65.8%
Yarram	23	43.5%	56.5%

\* AEDI Community results include children from AEDI Local Communities that may not be listed in this table. Refer to Section 3.

Source: Australian Early Development Index (AEDI) Community Profile Wellington, VIC, May 2010

Below is a table of children who participated in the AEDI for Wellington Shire whose parents were actively engaged with the school in supporting their child's learning, and who regularly read or encouraged reading at home:- *Please note the average age of children completing this survey was 5 years and 11 months*)

	Often or very true Number (%)	Sometimes or somewhat true Number (%)	Never or not true Number (%)	Don't know Number (%)
Children whose parent(s)/caregiver(s) are actively engaged with the school in supporting their child's learning	375 (76.1%)	84 (17.0%)	n/a	n/a
Children who are regularly read to/encouraged in their reading at home	405 (82.2%)	66 (13.4%)	16 (3.2%)	6 (1.2%)

(Source: AEDI Community Profile Wellington, VIC, May 2010)

Overall of the 494 children surveyed, 405 children were often regularly read to or encouraged to read.

Parent education is a commonly used indicator of child's learning and development. The performance of children in school, associated with a child's intellectual development can be influenced by both the educational level attained by the mother and the average number of years of education in the household.

According to 2010 Best Start Atlas, the following couple families with children and one-parent families with children within Wellington Shire are:

- 32.5% or more of couple families with children aged 0 to 8 years, neither parent had completed Year 12 or equivalent;
- 65.1 % or more of one-parent families with children aged 0 to 8 years, parent had completed Year 12 or equivalent;

*(Source: DEECD Best Start Atlas Children aged 0-8 years in Victoria 2<sup>nd</sup> Edition, 2010)*

**Recommendations:**

The data presented provides a snap shot on rates of parents reading to their children. Despite the data being a small representation of children within Wellington Shire, it's a starting point to identify community strengths and weaknesses. Overall, further promotional work may need to occur to encourage the benefits of parents and caregivers reading to their children on a regular basis, and more specifically further promotional work on the developmental benefits of reading to an infant. In addition, as Wellington Shire is classified as socially disadvantaged community it would benefit the community and universal service providers to provide resources which assist in improving parents and caregivers 'teaching behaviour' when reading a book.

## 10. Increased participation in Kindergarten

### Description:

There is general consensus that there are positive social, emotional, cognitive and linguistic effects for children who attend kindergarten. Kindergarten programs are designed to improve your child's development in the following key areas:

- Social skills – children learn how to play with other children in a calm, sharing and rewarding way
- Self-awareness and respect for others
- Emotional skills, for example understanding their feelings
- Language, literacy and numeracy skills, such as reading stories and counting objects
- A joy for learning and group activities, such as talking, drawing and making things together with other children their own age
- Ability to make new friends
- Exposure to new ideas and concepts

Kindergarten also provides families with access to:

- support and assistance for children with special needs
- Resources and links to community support services<sup>xxvii</sup>.

Within the Victorian setting in 2007 the responsibility for kindergartens moved from the then Department of Human Services (DHS) to the newly-created Department of Education and Early Childhood Development (DEECD). The Victorian Government funds kindergarten and many child care services to provide a kindergarten program to children in the year before they go to school (Harrington, 2008). At the state level, the Victorian government has introduced subsidies for low income families to assist them with kindergarten fees. Also Inclusion Support Services are available to assist children with severe disabilities to participate in kindergarten. Indigenous children of kindergarten age are also assisted through the Koori Early Childhood Education Program aimed at increasing access to kindergarten for Aboriginal and Torres Strait Islander families (Department of Education and Early Childhood Development, Victoria, 2008)<sup>xxviii</sup>.

### Data:

Data obtained from the 2010 Best Start Atlas identified children aged 3-5years enrolled in kindergarten within each Local Government Area in Gippsland. The following data is based on 2006 Census.

\* Please note: Kindergarten participation must be interpreted with some caution. Participation rate is distorted to the extent that children attend kindergarten outside the LGA where they usually reside, which means some percentages will be over 100 per cent. It is also sensitive to the extent that some children attend four year old kindergarten when they are actually younger or older than age four.

Region	% of children aged 3 to 5 years enrolled in kindergarten
Wellington	85.3 to 92.6
East Gippsland	92.6 to 102
Latrobe	92.6 to 102
Baw Baw	92.6 to 102
South Gippsland	Less than 85.3

(Source: Best Start Atlas, Map 5.3a, 2010)

Report conducted by Wellington Shire on Achieving universal access to 15 hours of Early Education, highlighted the following data on kindergarten participation in Wellington Shire:

- DEECD data on kindergarten participation in the Shire shows that participation was stable between 2006 (90.0 per cent) and 2007 (89.8 per cent). This was followed by an increase in participation in 2008 (96.9 per cent) and a subsequent decline of 12.6 per cent in 2009 to 84.3 per cent.
- The 2009 participation rate is below that of the Gippsland region (94.4 per cent), rural Victoria (94.1 per cent) and the state-wide participation rate (92.7 per cent)<sup>xxix</sup>.

There are 16 funded services in the Wellington Shire, all of which have a capability to implement Universal Access. However the following barriers impact on participation rates:

- The distance required to travel to kindergarten affects many families, especially those residing outside of the major towns in outlying and remote areas, who do not have access to close, affordable and regular public transport.
- The cost of kindergarten participation can be a barrier. It can be overcome for those families who are eligible for a fee subsidy, including families with a health care card, families with more than one child attending kindergarten in the same year and indigenous families with early years children.
- Home schooling is prevalent in the Shire, resulting in an intentional non use of universal early years services
- Lack of available places
- Parents enrolling their children in kindergarten where they work, as suppose to where they live
- Insufficient qualified staff
- Insufficient support for children with special needs

- Aboriginal and Torres Strait Islander children are eligible for a fee subsidy; however some indigenous families do not want their children identified. This means that it is likely that there are indigenous children who would benefit from kindergarten participation but are not accessing it <sup>xxix</sup>.

**Recommendations:**

Despite fees subsidy and specialised funding schemes for child protection clients and indigenous families, Wellington Shire kindergarten enrolment numbers remain one of the lowest in the Gippsland region. Although Wellington Shire rates are above 85%, further emphasis should be put in place to address the barriers on participation. Further review needs to occur on the reported 12 % drop in participation rates from 2008 to 2009 and identify if this is a trend for 2010.

## 11. Reduced absences from primary school

### Description:

Attending school everyday is crucially important for a student’s education and social skills. Non-attending students are placed in disadvantage both socially and academically. They miss out on critical stages of interaction and development with their peers and at the same time minimise the likelihood of academic progress and success. This can compound issues of low self-esteem, social isolation and dissatisfaction that could well have triggered non-attendance in the first place (Bond, 2004). Prolonged non-attendance can have harmful effects for the child in later life. A recent Auditor General report stated, ‘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)<sup>xxx</sup>.

Students’ families and communities can also suffer many immediate and long-term consequences as a result of continued absenteeism. For the family it may mean a continuation of the poverty cycle and unemployment and also contribute to family discord, additional stress, encounters with the juvenile justice system and physical or mental illness. For the community it may mean contact with the police, drug abuse, violence, jail time, use of a range of already stretched services and unemployment, welfare dependence, lost tax revenue, illness or homelessness (Bonzos, 2005)<sup>xxx</sup>.

### Data:

Data obtained from the 2010 Best Start Atlas identified children in grade Prep to Grade 2 enrolled in Government school within each Local Government Area within Gippsland. The data below is an average number of children absent from school, based on 2006 ABS statistics.

Region	Average Number of absence days		
	Prep	Grade 1	Grade 2
Wellington	12 to 12.9 days	11.4 to 12.2 days	10.4 days *
East Gippsland	15.2 or more days	14.3 days or more	13.5 or more
Latrobe	13.9 to 15.2 days	12.2 to 13 days	13.5 or more
Baw Baw	12 to 12.9 days	12.2 to 13 days	11.5 to 11.9 days
South Gippsland	12 to 12.9 days	11.4 to 12.2 days	11.9 to 12.5 days

\* ranked 2<sup>nd</sup> lowest rates in the state;

Source: Department of Education and Early Childhood Development, Best Start Atlas 2<sup>nd</sup> Edition, Map 5.4a, 5.5a, 5.6a, 2010

Below is data student attendance collated from 'My School' website on Government and Non-Government Primary School within the Wellington Shire.

*Please note the data is calculated using Prep to grade 6 (or Year 12 if applicable) for the full 2008 year and is not directly comparable to others.*

AREA	SCHOOL	TOTAL ENROLMENTS	YEAR RANGE	STUDENT ATTENDANCE RATE
<b>Sale</b>	Araluen Primary School	194	P – 6	93 %
	Guthridge Primary School	215	P – 6	92 %
	Sale (545) Primary School	549	P – 6	93 %
	St Thomas' School	233	P – 6	91 %
	St Mary's School	165	P – 6	91 %
	Gippsland Grammar	984	P – 12	94 %
<b>Airly</b>	Airly Primary School	22	P – 6	93 %
<b>Cobains</b>	Cobains Primary School	35	P – 6	95 %
<b>Wurruk</b>	Wurruk Primary School	37	P – 6	91 %
<b>Cowwarr</b>	Cowwarr Primary School	38	P - 6	93 %
<b>Rosedale</b>	Rosedale Primary School	107	P – 6	93 %
<b>Bundalaguah</b>	Bundalaguah Primary School	48	P – 6	94%
<b>Maffra</b>	Maffra Primary School	287	P – 6	94 %
	St Mary's School	141	P – 6	94 %
<b>Boisdale</b>	Boisdale Consolidated School	180	P – 6	92 %
<b>Heyfield</b>	Heyfield Primary School	130	P – 6	93 %
	St Michael's School	75	P – 6	93 %
<b>Nambrok</b>	Nambrok-Dennison Primary School	98	P – 6	89 %
<b>Stratford</b>	Stratford Primary School	105	P – 6	94 %
	St Patrick's School	127	P – 6	95 %
<b>Briagolong</b>	Briagolong Primary School	69	P – 6	94 %
<b>Lochsport</b>	Lochsport Primary School	26	P – 6	91 %
<b>Longford</b>	Longford Primary School	139	P – 6	91 %
<b>Woodside</b>	Woodside Primary School	47	P – 6	94 %
<b>Seaspray</b>	Seaspray Primary School	23	P – 6	94 %

*Source: My School website, School Profile, 2010*

**Recommendations:**

Overall data on student absenteeism rates within the Wellington Shire remain good compared to other Local Government Areas within Gippsland. Primary School students attend approximately 40 weeks of school per year. This rate is different for prep students who commence the first month of primary school at 4 days a week, and transition to 5 days a week by March. Taking this into account, the rate of school absenteeism in Prep grade is significantly high; despite the overall performance of school absenteeism not being of a concern. Therefore further work may be necessary to improve Prep attendance, and assess whether low attendance rate is impacted by school readiness, not attending preschool or a combination.

## 12. Improved reading, writing and numeracy

### Description:

Proficiency in reading, writing and mathematics are essential skills for day-to-day life, educational opportunities and employment prospects. Poor reading skills can have a detrimental effect on a student's academic pathway and have also been associated with behavioural and emotional problems including aggressive behaviour and poor self-concept (Good et al., 1998 cited in Persampieri et al., 2006, cited in DEECD, 2006). The relationship between literacy skills and later social exclusion has been well established (Bird and Akerman, 2005, Let's Read, 2004, cited in DEECD, 2006) and poor literacy is associated with loss of employment opportunities, low income and the consequent disadvantage in housing and health<sup>xxxi</sup>.

Educational qualifications are becoming more important as the number of low skill jobs decrease. In Australia, it has been shown that students who fail to complete school have restricted job opportunities and are more likely to experience longer periods of unemployment (Lamb et al., 2000 cited in DEECD, 2006). Early school experiences are important and can have a lasting impact on a person's attitude to education and training and confidence in their learning abilities (Frigo et al., 2003 cited in DEECD, 2006)<sup>xxxi</sup>.

In general, Australian students are reported to have high literacy and numeracy levels. However there are some populations that are at a disadvantage. Indigenous children, boys, children in remote areas and children from low socioeconomic status background often do not achieve the same educational outcomes as other students and are more likely to be early school leavers (Hunter and Schwab, 2003, Lamb et al., 2000 cited in DEECD, 2006)<sup>xxxi</sup>.

### Data:

Below is a table with data obtained from 2010 Best Start Atlas, which reported on the percentage of:

- Prep children in Government schools scoring 90% or more on Level 5 Reading Assessment, within each LGA in Victoria, 2006
- Year 1 children in Government schools scoring 90% or more on Level 15 Reading Assessment, within each LGA in Victoria, 2006
- Year 2 children in Government schools scoring 90% or more on Level 20 Reading Assessment, within each LGA in Victoria, 2006

Region	Prep (%)	Grade 1 (%)	Grade 2 (%)
Wellington	71.7 to 77.4	84.9 to 88.9	93.7 to 95.8
East Gippsland	Less than 71.7	80.4 to 84.9	93.7 to 95.8
Latrobe	71.7 to 77.4	80.4 to 84.9	93.7 to 95.8
Baw Baw	77.4 to 81.7	84.9 to 88.9	91.3 to 93.7
South Gippsland	81.7 to 89.1	88.9 to 92.4	93.7 to 95.8

*Note: Accuracy of reading was replaced with the English Online Interview from 2009 onwards. 2008 will be the last year for which Reading Accuracy is assessed using percentage accuracy scores at recommended text levels*

In summary, within the Wellington Shire there are approximately;

- 30 % of prep grade students are not able to score above 90 % of level 5 reading assessments;
- 15 % of grade 1 students are not able to score above 90 % of level 15 reading assessments;
- 7 % of grade 2 students are not able to score above 90 % of level 20 reading assessments;

The 'National Assessment Program - Literacy and Numeracy (NAPLAN)' assesses all students in Australian schools in Years 3, 5, 7 and 9. These tests are undertaken at state based level. In Victoria, testing is undertaken in all Government schools, but is optional at Catholic and Independent schools<sup>xxxii</sup>.

NAPLAN scores for each domain (reading, writing, spelling, grammar and punctuation and numeracy) for Government Schools in Victoria are recorded on 'My School' website. Below is a table prepared of Government Schools within the Wellington Shire and the NAPLAN 2009 scores in each domain for year 3 students.

Please note number in **Red** is the average score for Australian School.

Selected school's average is <b>substantially below</b> these schools' average	Selected school's average is <b>below</b> these schools' average	Selected school's average is <b>close to</b> these schools' average	Selected school's average is <b>above</b> these schools' average	Selected school's average is <b>substantially above</b> these schools' average
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AREA	SCHOOL	NAPLAN SCORES FOR EACH DOMAIN FOR YEAR 3 STUDENTS				
		Reading <b>411</b>	Writing <b>414</b>	Spelling <b>405</b>	Grammar & Punctuation <b>420</b>	Numeracy <b>394</b>
Sale	Araluen Primary School	397	380	417	394	399
	Guthridge Primary School	421	396	384	429	394
	Sale (545) Primary School	397	402	373	394	373
	St Thomas' School	439	417	396	452	414
	St Mary's School	409	408	403	419	385
	Gippsland Grammar	470	444	446	467	441
Airly	Airly Primary School	Student population below reporting threshold				
Cobains	Cobains Primary School	487	401	395	448	402
Wurruk	Wurruk Primary School	Student population below reporting threshold				
Cowwarr	Cowwarr Primary School	495	476	442	502	498
Rosedale	Rosedale Primary School	463	415	470	465	449

<b>Bundalaguah</b>	Bundalaguah Primary School	411	394	374	397	406
<b>Maffra</b>	Maffra Primary School	392	412	388	404	378
	St Mary's School	396	418	400	414	427
<b>Boisdale</b>	Boisdale Consolidated School	357	379	327	350	338
<b>Heyfield</b>	Heyfield Primary School	412	394	400	417	418
	St Michael's School	425	448	414	453	398
<b>Nambrok</b>	Nambrok-Dennison Primary School	368	413	405	398	373
<b>Stratford</b>	Stratford Primary School	420	415	392	384	396
	St Patrick's School	431	405	425	418	436
<b>Briagolong</b>	Briagolong Primary School	438	435	410	426	398
<b>Lochsport</b>	Lochsport Primary School	344	355	302	338	305
<b>Longford</b>	Longford Primary School	380	393	401	402	349
<b>Woodside</b>	Woodside Primary School	476	466	439	474	455
<b>Seaspray</b>	Seaspray Primary School	459	408	384	462	404
<b>TOTAL</b>		Average: 6 Below: 3 Subs Below: 2 Above: 1 Subs Above: 2	Average: 7 Below: 4 Subs Below: 3 Above: 4 Subs Above: 3	Average: 7 Below: 5 Subs Below: 2 Above: 2 Subs Above: 1	Average: 5 Below: 5 Subs Below: 2 Above: 2 Subs Above: 2	Average: 7 Below: 3 Subs Below: 3 Above: 1 Subs Above: 3

Source: My School website, School Profile, 2010

Overall data on children's reading writing and numeracy skills within the Wellington Shire are reasonable compared to other Local Government Areas within Gippsland. However similar to school absenteeism, Prep students have performed low on reading performance.

In the context of prep grade students, there is a strong link between the following indicators; increasing attendance rate in kindergarten, reducing school absenteeism and improving reading writing and numeracy skills. Therefore if one of the mentioned indicators were chosen there is the possibly that the remaining two mentioned indicators would also benefit as well as improving school readiness in children.

## C. SAFETY

### 13. Decreased rate of re-notifications to child protection

#### Description:

Children who are abused or neglected or have a parent who cannot protect or care for them adequately may be notified to child protection authorities. Abuse is substantiated if there is reasonable cause to deem that a child has been, is being, or is likely to be abused or neglected or otherwise harmed<sup>xxxii</sup>.

Child abuse and neglect can be related to a number of risk factors including:

- significant parenting problems that may be affecting the child's development
- serious family conflict, including family breakdown
- families under pressure due to a family member's physical or mental illness, substance abuse, disability or bereavement
- young, isolated and/or unsupported families
- significant social or economic disadvantage that may adversely impact on a child's care or development

State and territory departments responsible for child protection have been concerned about rising rates of re-notifications and re-substantiations. The Victorian Department of Human Services undertook detailed research and analysis of children in their child protection system (VDHS 2002). The study found that key underlying features, such as low income, substance abuse, mental health issues and the burdens of sole parenting, which led to some families coming into contact with child protection systems, were complex and chronic<sup>xxxii</sup>.

The client re-notification rate is the number of clients re-notified within twelve months as a percentage of the total number of clients notified during the reference period. A client is classified as being 're-notified within 12 months' if one or more additional notifications were made during the 12 months prior to the most recent notification made for that client<sup>xxxii</sup>.

In November 2009 an Ombudsman Report on the Victorian Child Protection System was conducted, which resulted in 42 recommendations. The Department of Human Services accepted the recommendations and has commenced initiatives to improve the system.

These initiatives include:

- 101 new frontline, professional child protection workers
- A specialist intervention team to tackle child protection trouble spots
- 70 new staff to provide assistance and supervision to children safely placed with their extended family
- \$2.8 million recruitment and quality training campaign for experienced child protection workers
- \$4.7 million boost to Child FIRST to connect an additional 1,760 families to early intervention services
- Two new principal practitioners to improve decision making, enhance skills and overview regional case practice

- Additional training for child protection workers for dealing with sexual offenders and interventions with infants
- Development of a regional audit and monitoring system to improve regional operations, services and consistency in decision making.
- The Attorney-General will ask the Law Reform Commission to review options for overhauling court processes in relation to child protection matters. The government will also establish a taskforce to report back, in three months, on measures to immediately reduce court time and bring in less adversarial processes<sup>xxxiii</sup>.

In addition to the above mentioned initiatives, Department of Human Services intend to invest a further \$3.8 million to provide for an early childhood development worker in each of the 24 Child FIRST catchments. This will provide targeted interventions for vulnerable babies and infants aged 0-5 years by building stronger partnerships between Child FIRST and universal early childhood services such as kindergarten and maternal and child health services<sup>xxxiv</sup>.

**Data:**

As reported in 2010 Best Start Atlas in 2005–06:

- 30.9 per cent of child protection notifications for children aged 0 to 8 years in Victoria were re-notifications. The percentage was higher in regional Victoria (34.2 per cent) than in metropolitan Melbourne (28.7 per cent).

Compared to 2000–01, the percentage of re-notifications has decreased in regional Victoria (36.0 per cent to 34.2 per cent) and in metropolitan Melbourne (31.7 per cent to 28.7 per cent).

Below is data obtained from ‘Best Start Atlas 2010’, of ‘Children aged 0 to 8 years re-notified to child protection services during 2005–06 within Gippsland region:

Region	% No of children re-notified to CP
Wellington	33.7 to 42.9
East Gippsland	33.7 to 42.9
Latrobe	42.9 or more
Baw Baw	29.3 to 33.7
South Gippsland	29.3 33.7

Source: Department of Education and Early Childhood Development, Best Start Atlas 2<sup>nd</sup> Edition, map5.10 a

Below is a table of data prepared by Central DHS Family Services of number of previous reports (re-notifications) to child protection during 2008 to 2009. Overall there were approximately 638 families in Wellington reported to child protective services, and of those, 421 families or approx 65% were renotified to protective services. A data limitation is the children recorded in the table are aged 0 to 17 years old.

**Number of Previous Reports**

Client LGA	Indigenous Status	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15+	Total
Wellington	ATSI	10	8	4	3	4	6	8	8	3	7	0	0	0	0	0	0	61
	Not ATSI	207	114	80	41	33	22	22	22	12	9	7	2	3	3	0	0	577
<b>Total</b>		<b>217</b>	<b>122</b>	<b>84</b>	<b>44</b>	<b>37</b>	<b>28</b>	<b>30</b>	<b>30</b>	<b>15</b>	<b>16</b>	<b>7</b>	<b>2</b>	<b>3</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>638</b>
<b>Gippsland Total</b>		<b>1356</b>	<b>795</b>	<b>566</b>	<b>398</b>	<b>294</b>	<b>203</b>	<b>173</b>	<b>135</b>	<b>132</b>	<b>105</b>	<b>68</b>	<b>34</b>	<b>32</b>	<b>18</b>	<b>18</b>	<b>18</b>	<b>4345</b>
<b>State-wide</b>		<b>17030</b>	<b>7979</b>	<b>5034</b>	<b>3545</b>	<b>2529</b>	<b>1836</b>	<b>1331</b>	<b>977</b>	<b>731</b>	<b>566</b>	<b>412</b>	<b>281</b>	<b>176</b>	<b>120</b>	<b>115</b>	<b>210</b>	<b>42872</b>

Source: Central DHS Family Services, Number of Previous Reports, 2008- 2009 (Unpublished)

**Recommendations:**

As outlined earlier, the 2009 Ombudsman Report on the Victorian Child Protection System resulted in new initiatives being introduced to improve on the service. Despite there being a need to address re-notification rates in Wellington, potentially the role of the ‘Early Childhood Development Worker’ in Wellington Child FIRST is able to address these issues with Wellington Partnerships providing support.

#### 14. Decreased rate of unintentional injury

##### Description:

Injury in childhood is the most frequent cause of death for Australian children aged one to 14 years and the second most common reason for admission to hospital. Around 300 children die each year due to accidental injuries (AIHW, 2005). Most of these deaths are caused through transport accidents, drowning and falls, while most hospitalisations are due to falls, cutting, choking, dog bites, transport accidents, poisoning and burns or scalds<sup>xxxv</sup>.

The type of injury risk varies according to a child’s age. For example, medicinal poisoning, near-drowning and burns/scalds are concentrated in early childhood, while children in the early years of school are more likely to be injured in falls or pedestrian accidents. The safety of babies and toddlers depends largely on their home and childcare environments and the attitudes and behaviours of the adults who care for them regularly. Once children start school, injury risks can be reduced by providing adequate supervision, appropriate safe role models and training to instil self-protective attitudes and behaviours (Mercy et al., 2003)<sup>xxxv</sup>.

Overall universal safety strategies for decreasing unintentional injuries include<sup>xxxv</sup>:

- Bicycle helmets
- Child-resistant closures on medicines and other poisons
- Child restraints in vehicles
- Pool fencing
- Safe tap water temperatures — less than 50 degrees Celsius
- Smoke alarms
- Traffic calming including area-wide measures, speed humps and reduced speed limits

##### Data:

Below is data of children aged 0 to 14 who presented at the Emergency Department at Central Gippsland Health Service. As this is the only Emergency Department within the Wellington Shire, the data below is able to provide snapshot of rate of unintentional injuries in Wellington.

##### Unintentional injury presentations to emergency department, Central Gippsland Health Service, Age Group 0 to 14 years, 2008/09

Cause of injury - Males		Age Group 00-14	Cause of injury - Females		Age Group 00-14
1	Fall <1 metre or no height information	210	1	Fall <1 metre or no height information	146
2	Other specified external cause	125	2	Other specified external cause	94
3	Cutting piercing object	63	3	Fall >1 metre	41
4	Struck by or collision with object	50	4	Cutting piercing object	25

5	Fall >1 metre	40	5	Struck by or collision with object	22
6	Struck by or collision with person	28	6	Unspecified external cause	13
7	Motorcycle - driver	18	7	Motor vehicle - passenger	8
8	Unspecified external cause	18	8	Contact burn (hot object or substance)	8
9	Contact burn (hot object or substance)	16	9	Struck by or collision with person	8
10	Motor vehicle - passenger	11	10	Horse related (fall struck/bitten by)	7
11	Pedal cyclist - rider or passenger	11	11	Dog related	5
12	Other animal related	7	12	Motorcycle - driver	<5
13	Motorcycle - passenger	<5	13	Pedal cyclist - rider or passenger	<5
14	Other transport-related circumstance	<5	14	Submersion or drowning - other	<5
15	Fire flames smoke	<5	15	Other threat to breathing	<5
16	Poisoning - other or unspecified subst	<5	16	Fire flames smoke	<5
17	Dog related	<5	17	Poisoning - medication	<5
18	Hot conditions (natural origin)	<5	18	Other animal related	<5
			19	Machinery	<5
<b>Total</b>		<b>607</b>	<b>Total</b>		<b>394</b>

Source: Victorian Emergency Minimum Dataset (VEMD). Public hospital admissions only

Notes: Cells with values less than five have been suppressed to maintain the anonymity of individual patients.

The following injuries were removed from the original table as they scored 0:- Motor vehicle driver, pedestrian, horse related, drowning pool/other, scalds, poisoning medication, firearm, machinery, and electricity.

It is important to compare the above data of unintentional injuries for children with Wellington ACSC data on avoidable\* hospital admission.

\* avoidable with the application of public health interventions and early disease management

### Age Group: 0 to 4 years, 2008/09

All individual ACSCs for selected year						
	Number of Admissions	Standardised Rate per 1,000 Persons	Lower limit of 95% CI	Upper limit of 95% CI	Average Bed days	Total Bed Days
Ear, nose and throat infections	42	16.63	11.64	21.63	1.64	69
Asthma	37	14.90	10.14	19.66	1.54	57
Dental conditions	28	11.28	7.13	15.43	1.11	31
Convulsions and epilepsy	11	4.24	1.74	6.73	1.27	14

**Age Group: 5 to 9 years, 2008/09**

All individual ACSCs for selected year						
	Number of Admissions	Standardised Rate per 1,000 Persons	Lower limit of 95% CI	Upper limit of 95% CI	Average Bed days	Total Bed Days
Dental conditions	82	30.25	23.80	36.70	1.00	82
Ear, nose and throat infections	16	5.98	3.06	8.90	1.69	27
Asthma	5	1.87	0.23	3.50	1.20	6

*(Source: DHS, VHISS, ACSC 2006, Local Government Area Wellington, age group 0 to 4 and 5 to 9, 2008-09)*

**Recommendations:**

Based on the above data, the most common form of unintentional injuries in Wellington Shire includes falls, cutting and piercing. However it is important to note that the rates of avoidable hospital admission, especially infections, are high and should be considered as a form of unintentional injury (in the context of a health concern).

Ongoing promotional work is needed to ensure families are aware of universal safety strategies, especially strategies addressing falls and cutting.

It is important to note that avoidable hospital admission rates could potentially decrease if the community pursued the indicators ‘increasing breastfeeding rates’, ‘decrease rates of children exposed to tobacco smokes in the home’ or improving oral hygiene in the community.

## 15. Proportion of children whose parents report high levels of social support

### Description:

The concept of social support is a broad and emerging area covering themes of social isolation and loneliness to themes of social networking, social capital, and community building and development. However, little research has been conducted in the area of parental social support. This is for a variety of reasons<sup>xxxvi</sup>.

These include:

- There are few interventions that directly target improvements in social support as a primary focus or outcome;
- There are few interventions designed to help parents directly and independently of their children; and
- That the issue of social support is usually subsumed within a mental illness agenda.

Data from the first wave of the Longitudinal Study of Australian Children (LSAC) indicates that parents who lack social support are more likely to experience psychological distress (Zubrick, et al., 2008). Primary carers (generally mothers) who reported that they did not receive adequate support from family and friends were 2.5 times more likely to report clinically significant symptoms of distress<sup>xxxvi</sup>.

Young parents, single parents and those born outside Australia were more likely than other participants to report low levels of ‘community connectedness’, while higher levels were associated with increasing income, education and Socio-Economic Indexes for Areas (SEIFA) ratings, married intact families and employed primary carers<sup>xxxvi</sup>.

### Data:

Department of Planning and Community Development (DPCD) conduct biennial data reports on how residents rate their Local Government Area. The report is based on ‘four overarching characteristics’ which was identified by DPCD on what makes a strong community. They include:

- Local area amenity – “pleasantness”, proximity to shops/facilities, quality infrastructure (roads, schools, open space, broadband, etc);
- Assets – economic resources, natural resources, human resources (people with skills), etc;
- Networks – community participation, inclusion of all population groups; and
- Strong governance – strong leadership and decision-making that ensures the equitable use and development of a community’s amenity, assets and networks<sup>xxxvii</sup>.

Overall the biennial reports are intended to help communities to better understand local areas and plan more effective initiatives in response to local needs.

Below is a summary of 2008 findings based on Local Government Areas within the Gippsland Region. Please note there are 4 indicators and approx 20 tables of data outlined in 'Indicator of Community Strength at the Local Government Areas Level in Victoria 2008'. For the purpose of this report, I have taken data which I have considered relating specifically to parents perception of social and community support within their local region.

	The % of residents that feel their area has good facilities and services like shops, childcare, schools, libraries	The % of residents that feel their area has a wide range of community and support groups	The % of residents that feel their area has an active community, where people do things and get involved in local issues/activities	The % of residents that feel they can get help from friends, family and neighbours when needed	The % of residents who feel safe on their streets alone after dark	The % of residents that feel valued by society
East Gippsland	72.1 to 77.8 %	66 to 73 %	64.9 to 71.5 %	86.24 to 90.24 %	68.9 to 74 %	52.7 % to 56.3 %
<b>Wellington</b>	72.1 to 77.8 %	63.2 to 66 %	64.9 to 71.5 %	91.13 to 92.42 %	62.5 to 68.9 %	44 to 48.7 %
Latrobe Valley	72.1 to 77.8 %	66 to 73 %	64.9 to 71.5 %	91.13 to 92.42 %	55.5 to 62.5 %	44 to 48.7 %
Baw Baw	77.8 to 82 %	63.2 to 66 %	71.5 to 76.7 %	92.42 to 93.68 %	62.5 to 68.9 %	52.7 % to 56.3 %
South Gippsland	48.8 to 72.1 %	63.2 to 66 %	71.5 to 76.7 %	93.68 to 96.18 %	68.9 to 74 %	52.7 % to 56.3 %

Source: DPCD, Indicators of community strength at the local government area level in Victoria 2008, 2010

### Recommendations:

Based on the above data, a third of the population surveyed in Wellington Shire identified that their community does not have a wide range of social supports or feel that they can get involved in local issues or activities. This is compounded by over half of the population surveyed did not feel a valued member of their community and a third not feeling safe on their streets alone after dark. However strength to draw upon is residents feel that they can get help from their family friends and neighbourhood. By increasing social supports in parents and promoting them through universal programs, it will assist in parents to feel like a valued member of their community, which they may reciprocate to their children and extended family and friends.

In addition by choosing to increase the levels of social supports for parents it will indirectly benefit other indicators in 'health and wellbeing' and 'learning and development'. For example if this indicator was chosen potentially there may be an increase in the rates of families engaging with universal services such as Maternal Child Health or Preschool/Kindergarten, or possibly engage with local community groups which encourages lifestyle choice which is healthy and promotes learning and development.

**APPENDIX:**

<sup>i</sup> Australian Bureau of Statistics, National Regional Profile: Wellington (S) (Local Government Area), at <http://www.abs.gov.au/ausstats/abs@.nsf/lookup/LGA26810Main+Features12004-2008>.

<sup>ii</sup> Department of Planning and Community Development, Victoria in Future 2008, at [http://www.dpcd.vic.gov.au/data/assets/pdf\\_file/0004/32296/Wellington.pdf](http://www.dpcd.vic.gov.au/data/assets/pdf_file/0004/32296/Wellington.pdf)

<sup>iii</sup> Draft Municipal Early Years Plan 2009-2011, Wellington Shire Council 2010, p.15.

<sup>iv</sup> Department of Education and Early Childhood Development, Early Childhood Profile, Shire of Wellington 2010, pg. 8.

<sup>v</sup> Australian Bureau of Statistics, Census Population and Housing: Socio-Economic Indexes for Areas (SEIFA), at [http://www.abs.gov.au/websitedbs/D3310114.nsf/home/Seifa\\_entry\\_page](http://www.abs.gov.au/websitedbs/D3310114.nsf/home/Seifa_entry_page)

<sup>vi</sup> Draft Municipal Early Years Plan 2009-2011, Wellington Shire Council 2010, p.18.

<sup>vii</sup> Department of Education and Early Childhood Development, Catalogue of Evidence, Early Childhood Indicators, Breastfeeding, at <http://www.education.vic.gov.au/healthwellbeing/childyouth/catalogue/sections/breastfeeding.htm>

<sup>viii</sup> Jane Palmer, Pregnancy Birth and Beyond, Smoking in Pregnancy, at <http://www.pregnancy.com.au/resources/topics-of-interest/pregnancy/smoking-in-pregnancy.shtml>

<sup>ix</sup> Quit, Motherhood and Smoking, Statistics, at [http://www.quit.org.au/article.asp?ContentID=media\\_bkground\\_motherhood](http://www.quit.org.au/article.asp?ContentID=media_bkground_motherhood)

<sup>x</sup> Australian Bureau of Statistics, Tobacco Smoking in Australia: A Snapshot, 2004-05, at <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4831.0.55.001/>

<sup>xi</sup> Department of Human Services, The Victorian drug statistics handbook 2006: Patterns of drug use and related harm in Victoria, pg. 206.

<sup>xii</sup> Department of Education and Early Childhood Development, Catalogue of Evidence, Early Childhood Indicators, Immunisation, at <http://www.education.vic.gov.au/healthwellbeing/childyouth/catalogue/sections/immunisation.htm>

<sup>xiii</sup> Department of Education and Early Childhood Education, best Start Atlas: Children aged 0-8 years in Victoria (2<sup>nd</sup> Edition), pg. 132.

- xiv Department of Education and Early Childhood Development, Catalogue of Evidence, Early Childhood Indicators, Maternal and Child Health Services, at <http://www.education.vic.gov.au/healthwellbeing/chilyouth/catalogue/sections/mchservices.htm>
- xv Department of Education and Early Childhood Development, Catalogue of Evidence, Early Childhood Indicators, Sun Protection, at <http://www.education.vic.gov.au/healthwellbeing/chilyouth/catalogue/sections/sunprotection.htm>
- xvi Department of Education and Early Childhood Development, Early Childhood Community Profile, Shire Wellington 2010, pg. 46
- xvii Department of Education and Early Childhood Development, Catalogue of Evidence, Early Childhood Indicators, Physical Activity, at <http://www.education.vic.gov.au/healthwellbeing/chilyouth/catalogue/sections/physicalactivity.htm>
- xviii VicSports, Facts and Stats, Benefits of Physical Activity at <http://www.vicsport.asn.au/Assets/Files/WADSR%20-%20Benefits%20of%20Physical%20Activity.pdf>
- xix GippSport & Sportslink Gippsland, Activity Search, Wellington 0 to 12 years, at <http://gippsland.sportslink.org.au/DirectoryEx/search.asp>
- xx Dental Health Service Victoria, Dental Advice – Advice for Children, at <http://www.dhsv.org.au/dental-advice/general-dental-advice/children/>
- xxi Gippsland Waters, Drinking Water Quality, Fluoridation, at <http://www.gippswater.com.au/OurServices/Water/DrinkingWaterQuality/tabid/167/Default.aspx>
- xxii Department of Human Services, Health Status Home, ambulatory care sensitive conditions, VHISS Interactive Reports, at <https://hns.dhs.vic.gov.au/3netapps/vhisspublicsite/ViewContent.aspx?TopicID=1&SubTopicID=10>
- xxiii Department of Education and Early Childhood Development, Catalogue of Evidence, Early Childhood Indicators, Reading Writing and numeracy, at <http://www.education.vic.gov.au/healthwellbeing/chilyouth/catalogue/sections/literacy.htm>
- xxiv Department of Education and Early Childhood Development, Preliminary Findings: 2009 Victorian Child health and Wellbeing Survey, ph. 13.
- xxv Australian Early Development Index (AEDI), About the AEDI, at [http://www.rch.org.au/aedi/about.cfm?doc\\_id=13152](http://www.rch.org.au/aedi/about.cfm?doc_id=13152)

<sup>xxvi</sup> Australian Early Development Index (AEDI), AEDI Wellington Community, Victoria, at <http://maps.aedi.org.au/lga/vic/26810>

<sup>xxvii</sup> Department of Education and Early Childhood Development, Childcare and Kindergarten, at <http://www.education.vic.gov.au/earlychildhood/careandkinder/default.htm>

<sup>xxviii</sup> Department of Education and Early Childhood Development, Best Start Atlas: Children aged 0 – 8 years in Victorian (2<sup>nd</sup> Edition) 2010, pg. 106

<sup>xxix</sup> Impact Consulting Group, Municipal Planning for Achieving Universal Access to 15 Hours Early Childhood Education in the Wellington Municipality, 2010, pg. 8

<sup>xxx</sup> Department of Education and Early Childhood Development, Catalogue of Evidence, Early Childhood Indicators, Absenteeism, at <http://www.education.vic.gov.au/healthwellbeing/childyouth/catalogue/sections/absenteeism.htm>

<sup>xxxi</sup> Department of Education and Early Childhood Development, Best Start Atlas: Children aged 0 – 8 years in Victorian (2<sup>nd</sup> Edition) 2010, pg. 118

<sup>xxxii</sup> Department of Education and Early Childhood Development, Best Start Atlas: Children aged 0 – 8 years in Victorian (2<sup>nd</sup> Edition) 2010, pg.126 – 127

<sup>xxxiii</sup> Department of Human Services, Report into Child Protection, 27 November 2009, at <http://www.dhs.vic.gov.au/about-the-department/news-archive/report-into-child-protection>

<sup>xxxiv</sup> Department of Human Services, Strengthening Child Protection, November 2009

<sup>xxxv</sup> Department of Education and Early Childhood Development, Catalogue of Evidence, Early Childhood Indicators, Injury, at <http://www.education.vic.gov.au/healthwellbeing/childyouth/catalogue/sections/injury.htm>

<sup>xxxvi</sup> Department of Education and Early Childhood Development, Catalogue of Evidence, Early Childhood Indicators, Parenting Support, at <http://www.education.vic.gov.au/healthwellbeing/childyouth/catalogue/sections/parenting.htm>

<sup>xxxvii</sup> Department of Planning and Community Development, Indicators of community strength at the local government area level in Victoria 2008, January 2010, pg. 4