



**Aboriginal Services Plan
Key Indicators 2006/07**

May 2008

Published by the Koori Human Services Unit, Policy and Strategic Projects Division Victorian Government,
Department of Human Services Melbourne, Victoria

May 2008

© Copyright State of Victoria 2008, Department of Human Services

This publication is copyright. No part may be reproduced by any process except in accordance with the
provisions of the *Copyright Act 1968*.

Authorised by the State Government of Victoria, 50 Lonsdale Street Melbourne.

Printed by BigPrint, 50 Lonsdale Street, Melbourne

This document may also be downloaded from the Department of Human Services web site at: www.dhs.vic.gov.au
or the Koori Health website <http://www.health.vic.gov.au/koori/>

Contents

Acronyms and abbreviations used in this report	v
Overview	1
Overcoming Indigenous Disadvantage Framework	1
– Priority outcomes	1
– Headline indicators	2
– Strategic areas for action	3
Indicators used in this report	6
Areas of Department of Human Services responsibility	7
Data availability and quality	8
Victorian Aboriginal population	8
Strategic Action Area 1: Early Child Development and Growth	10
Indicator 1: Perinatal mortality	11
Indicator 2: Low birth weight babies	13
Indicator 3: Maternal age	16
Indicator 4: Immunisation rate	19
Indicator 5: Use of Maternal and Child Health Services	21
Strategic Action Area 2: Early School Engagement and Performance – Kindergarten to Year 3	23
Indicator 6: Screening for hearing loss	23
Indicator 7: Kindergarten enrolments	25
Strategic Action Area 3: Positive Childhood and Transition to Adulthood	28
Indicator 8: Child Protection	28
Indicator 9: Aboriginal youth in the Youth Justice system	34
Strategic Action Area 4: Substance Use and Misuse	38
Indicator 10: Use of Alcohol and Drug Services	38
Strategic Action Area 5: Functional and Resilient Families and Communities	48
Indicator 11: Disability Services	48
Indicator 12: Supported Accommodation Assistance Program	51
Indicator 13: Housing	52
Indicator 14: Aged Care	55
Health	60
Indicator 15: Life expectancy	60
Indicator 16: Common health conditions	62
Indicator 17: Community health	86

Appendix 1: Data availability and quality

88

Appendix 2: List of Tables

94

Appendix 3: List of Figures

96

Acronyms and abbreviations used in this report

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
ACSASS	Aboriginal Child Specialist Advice Service
ACCHOs	Aboriginal Community Controlled Health Organisations
ACPP	Aboriginal Child Placement Principle
ACIR	Australian Childhood Immunisation Register
ACSC	Ambulatory Care Sensitive Conditions
AHV	Aboriginal Housing Victoria
AHLO	Aboriginal Hospital Liaison Officer
AHPACC	Aboriginal Health Promotion and Chronic Care
AIHW	Australian Institute of Health and Welfare
ARHP	Aboriginal Rental Housing Program
ASP	Aboriginal Services Plan
CACP	Community Aged Care Package
CASIS	Child Protection Client and Service Information System
CCCC	Counselling, Consultancy and Continuing Care Service
CHC	Community Health Centre
COAG	Council of Australian Governments
CRIS	Client Record Information System
CWSA	Child Well being and Safety Act 2005
CYPA	Children and Young Persons Act 1989
CYFA	Children, Youth and Families Act 2005
DECD	Department of Education and Early Childhood Development
DHS	Department of Human Services
DHSV	Dental Health Services Victoria
EACH	Extended Aged Care at Home
ENT	Ear Nose and Throat
FPP	Family Planning Program
HACC	Home and Community Care
ICAP	Improving Care for Aboriginal and Torres Strait Islander Patients
IHSY	Innovative Health Services for Homeless Youth
KECEP	Koori Early Childhood Education Program
KECFO	Koori Early Childhood Field Officer
KPSA	Koori Preschool Assistants Program
M&CHS	Maternal and Child Health Service
MDS	Minimum Data set



NIDS	National Illicit Drugs Strategy
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OID	Overcoming Indigenous Disadvantage Report
OoH	Office of Housing
PDCU	Perinatal Data Collection Unit
RBDM	Registry of Births, Deaths and Marriages
RGS	Rental General Stock
SAAP	Supported Accommodation Assistance Program
VACCA	Victorian Aboriginal Child Care Agency
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VACKH	Victorian Advisory Council on Koori Health
VACSAL	Victorian Aboriginal Community Services Association Ltd
VAEAI	Victorian Aboriginal Education Association Incorporated
VAED	Victorian Admitted Episodes Data set
VAHS	Victorian Aboriginal Health Service
VIAF	Victorian Indigenous Affairs Framework
YTC	Youth Training Centre

Throughout this report the term Aboriginal refers to both Aboriginal and Torres Strait Islander people. Aboriginal is used in preference to Indigenous, but Indigenous is retained when it is part of the title of a report or program. Koori refers to Aboriginal people from the south eastern part of Australia. As not all Aboriginal people in Victoria are Koori, Koori is used only when part of the title of a report or program.

Overview

Aboriginal Services Plan Key Indicators 2006/07 is the sixth report by the Department of Human Services (DHS) against the Aboriginal Services Plan¹ 2004. The Plan outlines the department's commitment to improve the health and wellbeing of Aboriginal Victorians by better focusing resources and working in close partnership with Aboriginal people, organisations and communities. *Aboriginal Services Plan Key Indicators* is an integral part of the reporting and monitoring regime established as part of the Plan.

The Aboriginal Services Plan 2008–2010 has now been released. The updated Plan targets specific priority areas where DHS will work to improve outcomes. The Plan positions Aboriginal culture and identity at its core and focuses on what DHS can do in partnership with Aboriginal communities and key stakeholders to improve life expectancy and quality of life in this context. The *Aboriginal Services Plan Key Indicators 2006/07* looks forward to areas of the updated Plan.

Like earlier reports, this report is presented against the national *Overcoming Indigenous Disadvantage* (OID) framework,² which emphasises that issues facing Aboriginal families and communities are interconnected.

The purpose of this report is to provide a summary of key indicators measuring the service usage and outcomes for Aboriginal people in areas for which DHS was responsible in 2006/07³.

The Overcoming Indigenous Disadvantage (OID) framework

On a national level, the Council of Australian Governments (COAG) commissioned work to develop indicators of Indigenous disadvantage relevant to all governments and Indigenous stakeholders. These indicators enable demonstration of the impact of program and policy interventions.⁴ It is anticipated that over time the indicators will lead and influence Indigenous policy directions in both national and individual jurisdictions and provide strategic advice to COAG on measures to improve Indigenous outcomes.

The *Victorian Indigenous Affairs Framework 2006 (VI AF)* has been developed as a whole-of-government approach to addressing Indigenous disadvantage.⁵ It is comprised of the following four elements, which are designed to achieve the Victorian Government's overarching goal to raise life expectancy and quality of life for Indigenous Victorians:

- Principles for reform
- Strategic policy framework
- Performance framework
- Partnership coordination and management framework.

Many of the Key Indicators in this report are included in the VI AF performance framework.

The OID framework underpins the VI AF and will be used to measure the Victorian Government's progress against the key strategic change indicators. Key features of the OID framework are outlined below.

Priority outcomes

These priority areas reflect a vision for how life should be for Indigenous people that is shared by governments and Indigenous people alike. The outcomes are linked and should not be viewed in isolation from each other.

¹ Department of Human Services, 2004. *Aboriginal Services Plan*. DHS, Melbourne.

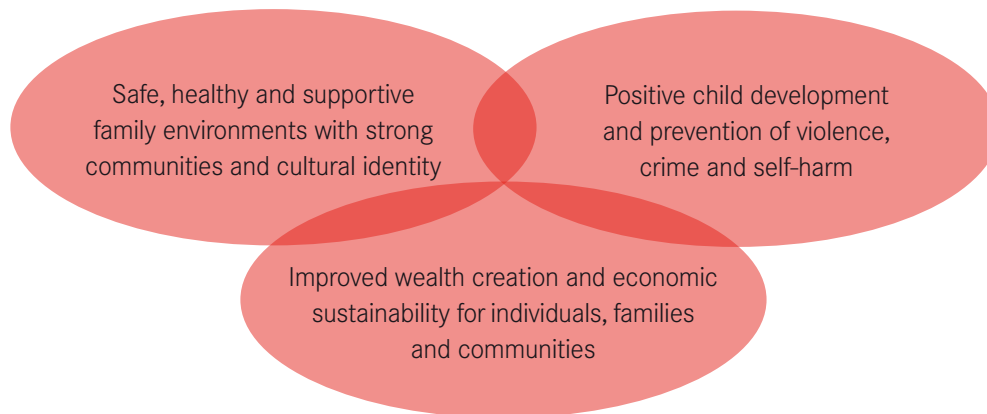
² Steering Committee for the Review of Government Service Provision 2007, *Overcoming Indigenous Disadvantage: Key Indicators 2007*, Productivity Commission, Canberra, p.7. This is the third report of this series. [OID 2007]

³ The report covers the areas for which DHS was responsible during 2006/07. DHS was restructured in August 2007 and services for young children, such as Maternal and Child Health, Kindergartens and School Nursing moved to the Department of Education and Early Childhood Development (DECD).

⁴ OID 2007 p.1

⁵ Department for Victorian Communities 2006, *The Victorian Government Indigenous Affairs Report July 2004–June 2005*, Department for Victorian Communities, Melbourne, 2006. <http://www.dvc.vic.gov.au/aav/>

Figure 1: OID Priority outcome areas.



Sitting beneath the priority outcomes are two tiers of indicators: headline indicators and strategic areas for action. The goal is that improvements in these will, in time, make it possible to overcome the sources of disadvantage which currently lead the circumstances of many Indigenous people and communities to fall short of the priority outcomes.⁶

Headline Indicators

The OID report focuses on twelve headline indicators. 'They are measures of the major social and economic outcomes that need to improve if the vision of an Australia in which Indigenous people enjoy the same opportunities and standards of living as other Australians is to be achieved.'⁷ The OID headline indicators that applied in full or part to DHS responsibilities in 2006/07 are highlighted. The elements of the indicators are highly inter-related. Actions across a range of areas might be required to improve a single indicator.

- 1 **Life expectancy at birth**
- 2 **Disability and chronic disease**
- 3 Years 10 and 12 retention and attainment
- 4 Post secondary education participation and attainment
- 5 Labour force participation
- 6 Household and individual income
- 7 Home ownership
- 8 **Suicide and self-harm**
- 9 **Substantiated child abuse and neglect**
- 10 **Deaths from homicide and hospitalisations for assault**
- 11 Family and Community Violence
- 12 Imprisonment and **juvenile detention rates**.⁸

⁶ OID 2007 p.7.

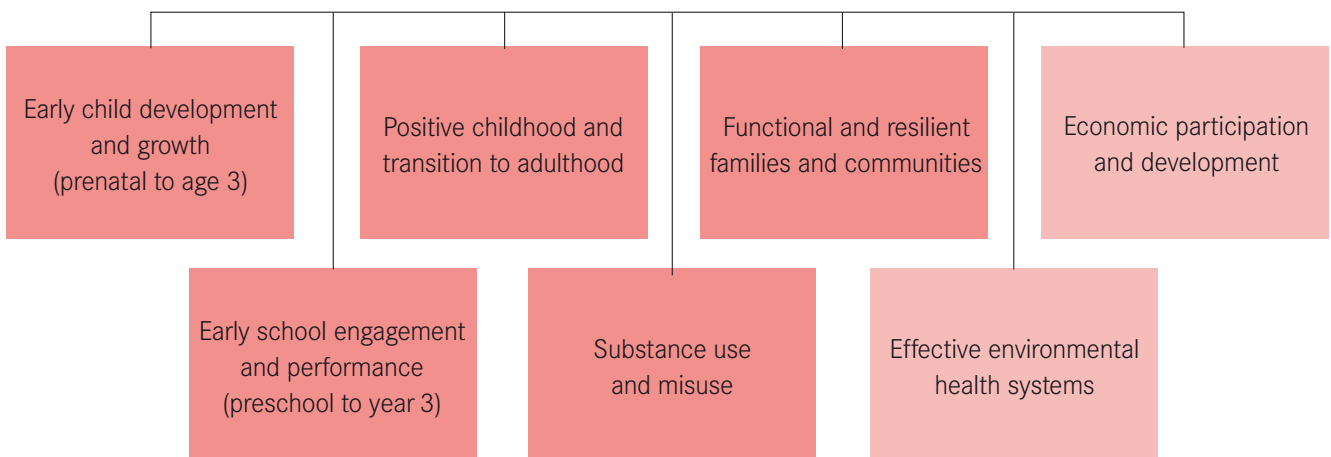
⁷ OID 2007 p.10.

⁸ OID 2007 p.10.

Strategic areas for action

The OID strategic areas for action have been selected for their potential to have a significant and sustainable impact in reducing Aboriginal disadvantage and for their amenability to policy action. DHS responsibilities are highlighted⁹.

Figure 2: OID strategic areas for action.



Victorian Indigenous Affairs Framework

The Victorian Indigenous Affairs Framework (VIAF)¹⁰ aims to integrate Government efforts to achieve improved outcomes in priority areas consistent with OID. The VIAF comprises:

- Principles for reform
- Strategic policy framework
- Performance framework
- Partnership co-ordination and management framework

The VIAF Strategic Areas for Action, with DHS responsibilities highlighted, are:

1. **Improve maternal health and early childhood health and development**
2. Improve literacy and numeracy
3. Improve Year 12 completion or equivalent qualification and develop pathways to employment
4. **Prevent family violence and improve justice outcomes**
5. Improve economic development, settle native title claims and address land access issues
6. Build Indigenous capacity

⁹ DHS responsibilities refer to the areas for which DHS was responsible in 2006/07. Changes in the machinery of government in August 2007 saw some early childhood responsibilities move to the Department of Education and Early Childhood Development.

¹⁰ Aboriginal Affairs Victoria 2006, *Improving the lives of Indigenous Victorian: Victorian Indigenous Affairs Framework*, Department for Victorian Communities, Melbourne.

Within Strategic Action Areas 1 and 4 are the following strategic change indicators:

1. Improve maternal health and childhood development:
 - 1.1 **Reduce reported smoking and alcohol use in pregnancy by Indigenous mothers.**
 - 1.2 **Reduce the Indigenous perinatal mortality rate.**
 - 1.3 **Increase the percentage of Indigenous babies with birth weight at or above 2500 grams.**
 - 1.4 **Increase the Indigenous four year old kindergarten participation rate.**
 - 1.5 **Reduce the rate of indigenous child protection substantiations.**
4. Prevent family violence and improve justice outcomes
 - 4.1 Increase in police responding to and taking action on any Indigenous family violence incident reported to them.
 - 4.2 Reduce repeat police call outs for Indigenous family violence incidents
 - 4.3 **Reduce the number of times Indigenous youth are processed by police.**
 - 4.4 Increase the proportion of Indigenous people cautioned when processed by police.
 - 4.5 Reduce the proportion of Indigenous people remanded in custody.
 - 4.6 Reduce the proportion of Indigenous adults sentenced to prison rather than other orders.
 - 4.7 **Reduce the proportion of Indigenous adults/ youth who are convicted within two years of their previous conviction.**

The OID/ VIAF strategic areas for action are outlined below, with a summary of current status in Victoria.

1. Early child development and growth [VIAF area 1]

Early childhood covers the period from before birth to 3 years. Health and educational outcomes in later life are greatly influenced by the health, growth and development of children in their first three years of life. A wide range of social, cultural, physical and economic factors influence the health of children.¹¹ The key indicators within this period are: perinatal mortality, birth weight of babies, maternal age, immunisation coverage and use of the Maternal and Child Health Service. For this age group immunisation and use of the Maternal and Child Health Service are preventative measures for later health and welfare issues.

- Perinatal mortality (stillbirths and deaths before 28 days) is much higher among babies of Aboriginal mothers but has fallen from the peak of 33.2 deaths per 1000 births reached in 2003.
- The rate of low birth weight babies (less than 2500g) born to Aboriginal mothers is higher than the rate for babies of non-Aboriginal mothers. These babies are at higher risk of illness and death as infants, and also at higher risk of developing cardiac disease and kidney disease as adults.
- Aboriginal mothers are younger than the Victorian average and the rate of teenage confinements is very much higher.
- Aboriginal families' use of the Maternal and Child Health Service is increasing.
- The rate of immunisation among Aboriginal children is increasing.

2. Early school engagement and performance [VIAF areas 1 and 2]

The extent to which Aboriginal children begin formal learning at an early age, attend school regularly, and are safe, healthy and supported by their families and communities, all have a bearing on educational outcomes. Research shows that the children most likely to have learning difficulties often have nutritional, hearing, or other health problems.¹² DHS contributes to early school engagement and performance through its funding of kindergarten places and associated support services.

¹¹ OID 2007 p. 27.

¹² OID 2007 p. 32

- The number of Aboriginal children enrolled in kindergarten has increased between 2000 and 2007, but is lower than the number of children subsequently attending school. The estimated kindergarten participation rate is lower for Aboriginal children than non-Aboriginal children.
- Aboriginal children are more likely to have ear infections and hearing loss.

3. Positive childhood and transition to adulthood [VIAF areas 1, 2, 3 and 4]

The later years of childhood, adolescence and the transition to adulthood are critical phases in a person's development. There are strong links between positive childhood and transition to adulthood. Outcomes in these years can have far reaching consequences. Good educational outcomes for young Aboriginal people will enhance their opportunities as adults. Young people who avoid the Youth Justice system are less likely to become involved in the adult correctional system and the cycle of re-offending.¹³

- Aboriginal children are more likely to be involved at all stages of the Child Protection system, including substantiations of child abuse.
- Aboriginal youth are more likely to be involved in the Youth Justice system.

4. Substance use and misuse

Substance use and misuse can have far reaching effects on a person's quality of life and health, and on those around them. Life expectancy, disability, employment, income, imprisonment, domestic violence and sexual abuse are all headline indicators affected by substance use and misuse.¹⁴

- Aboriginal people are more likely to smoke and to use alcohol to excess.
- Aboriginal people are admitted more frequently to hospital for alcohol and drug related conditions.

5. Functional and resilient families and communities

Families and communities are the mainstay of our society. The extent to which either is dysfunctional can have direct impacts on a range of outcomes for Aboriginal people, including life expectancy, education, imprisonment, violence, employment and income. Dysfunctional families and communities can lead to breakdown in relationships and social alienation – significant factors leading to Aboriginal disadvantage.¹⁵

- Aboriginal people have a higher rate of use of disability services.
- Aboriginal people have a higher rate of use of Supported Accommodation Assistance Program (SAAP) services.
- Aboriginal people are more likely to use certain types of Home and Community Care (HACC) services and less likely to use Aged Care Assessment Services (ACAS).
- Aboriginal people are more likely to use public housing. The provision of adequate housing is a major factor affecting health. Aboriginal households comprise 4% of the total number of households using public housing.

Health

- The life expectancy of Aboriginal people is estimated to be approximately 19 years lower than for the total Victorian population.¹⁶
- The most recent estimates indicate that life expectancy at birth is 60.0 years for Aboriginal men compared to the Victorian average of 79.3 years, and 65.1 years for women compared to 83.7 years. Life expectancy is influenced by a number of factors, including rates of morbidity and access to appropriate services.

¹³ OID 2007 p. 36

¹⁴ OID 2007 p. 41

¹⁵ OID 2007 p.44

¹⁶ Australian Bureau of Statistics (ABS) 2007, *Deaths Australia 2006*, Cat.no. 3302.0. Canberra: ABS, p77, Table 9.8; and Australian Bureau of Statistics, 2007, *Life Tables Victoria 2004–2006*, Cat.no. 3302.2.55.001, available online at www.abs.gov.au.

- Aboriginal people have generally poorer health than non-Aboriginal people and are more frequently hospitalised. Diabetes, renal failure, cardiovascular diseases and respiratory diseases are the most common chronic conditions in Aboriginal people and among the most common causes of death.
- Aboriginal people are admitted to hospital for diabetes-related illnesses more frequently and at younger ages than non-Aboriginal people.
- The rate of admissions for renal dialysis for Aboriginal women aged 45–64 is almost 10 times the non-Aboriginal rate. For men of that age it is almost 5 times the non-Aboriginal rate.
- Aboriginal people often develop chronic diseases at an earlier age than non-Aboriginal people. The rate of hospital admissions of Aboriginal people for cardiovascular disease begins to increase steeply by 25–44 years. For non-Aboriginal people the rate increases between 45 and 64 years. The rate of admission for respiratory diseases increases from 45 years, whereas the rate of admission for non-Aboriginal people does not begin to increase until 65 years.

Indicators used in this report

The indicators used in this report are selected by DHS as relevant to reporting on progress against the department’s Aboriginal Services Plan 2004–06. These indicators are grouped under the OID strategic areas for action. Both outcome-based indicators and output or service usage indicators are presented.

Table 1: Indicators used in this report.

1 Early childhood development and growth	2 Early school engagement and performance	3 Positive childhood and transition to adulthood
1. Perinatal mortality 2. Low birth weight 3. Maternal age 4. Immunisation 5. Maternal and Child Health Service (MCHS)	6. Screening for hearing loss 7. Kindergarten enrolments	8. Child protection <ul style="list-style-type: none"> • Substantiations • Protection orders • Out of home care • Compliance with Aboriginal Child Placement Principle (ACPP) 9. Youth Justice
4 Substance use and misuse	5 Functional and resilient families and communities	
10. Alcohol and drug services <ul style="list-style-type: none"> • Community based • Hospital admissions 	11. Disability Services 12. Supported Accommodation Assistance Program (SAAP) 13. Housing <ul style="list-style-type: none"> • Waiting list • Rental households 14. Aged Care <ul style="list-style-type: none"> • Home and Community Care (HACC) • Aged Care Assessment Service (ACAS) 15. Life expectancy	16. Common health conditions– <ul style="list-style-type: none"> • Mental Health • Ear, Nose and Throat diseases • Respiratory diseases • Infectious diseases • Circulatory diseases • Oral disease • Diabetes • Renal disease • Injury 17. Community Health

Areas of DHS responsibility

DHS is responsible for the funding or delivery of a range of health, housing, aged care and community services, including disability and children's services, in Victoria.

The indicators in this report relate to the functions of 6 program-related divisions within DHS in 2006/07. Their responsibilities are outlined below:

- **Metropolitan Health and Aged Care Services (MHACS)**

- state wide policy and program direction for acute, sub-acute, ambulance and mental health services
- the full range of health and aged care services in metropolitan Melbourne
- Indicator: 16 Common health conditions (hospital admissions)

- **Rural and Regional Health and Aged Care (RRHACS)¹⁷**

- state wide policy and program direction for aged and home care, primary health, dental health and public health
- the full range of health and aged care services in rural and regional Victoria

- Indicators:
- 1 Perinatal mortality
 - 2: Low birth weight
 - 3: Maternal age
 - 4: Immunisation
 - 10: Alcohol and Drug Services
 - 14 Aged care including Home and Community Care (HACC)
 - 16 vi Dental health
 - 17 Community health

- **Disability Services**

- a range of supports and services for people in Victoria with intellectual, physical, sensory and dual disabilities, neurological impairments and acquired brain injury.
- Indicator: 11 Disability services

- **The Office for Children**

- the policy framework and programs for Victoria's children, young people, families and vulnerable individuals.
- Indicators: 5 Maternal and Child Health Service
- 6 Hearing screening
- 7 Kindergarten enrolments
- 8 Child Protection
- 9 Youth Justice

- **The Office of Housing**

- the delivery of secure, affordable and appropriate housing to low income Victorians. Its services include: crisis, medium term and long term housing; assistance with private rental accommodation; and home ownership assistance.
- Indicators: 12 Supported Accommodation and Assistance Program (SAAP)
- 13 Housing

While this report covers data, services and strategies for 2006/07, information on departmental initiatives to be implemented from July 2007 has been provided to assist the reader.

¹⁷ The responsibilities are those applicable to 2006/07. In August 2007 part of Office for Children moved to the Department of Education and Early Childhood Development, and Mental Health and Drugs Division was established as a separate division, including the former Mental Health and Drugs Policy branches from MHACS and RRHACS. Its functions encompass public sector policy, program and service and workforce development in relation to mental health and drug matters.

Data availability and quality

Data reported in *Aboriginal Services Plan Key Indicators 2006/07* are drawn from service utilisation data collected by the Department. As the accuracy of Aboriginal identification by service providers varies, the data presented here should be taken as indicative rather than absolute. In addition, where data are presented in the form of rates per population, the population base is taken as the estimated residential Aboriginal population reported in the Australian Bureau of Statistics Census 2006, which is considered to underestimate the Aboriginal population.

Annual data from some data collections are available on a calendar year basis while others are available on a financial year basis. This report includes an assessment of the characteristics and quality of data for each performance indicator and notes whether data relate to calendar year or financial year.

The most recent financial year data reported here are for 2006/07, while calendar year data are reported up to 31 December 2007. Multiple calendar years are shown as 2006–2007 and financial years as 2006/07.

An analysis of data availability and quality is provided in Appendix 1.

Age structure of the Victorian Aboriginal population

The Victorian Aboriginal population is younger than the non-Aboriginal population. Almost half the Aboriginal population is aged less than 20 years, while only one quarter of the non-Aboriginal population is aged less than 20 years. Fourteen percent of the non-Aboriginal population is aged over 65 years, whereas only 4 percent of the Aboriginal population is over 65 years. Almost half the Aboriginal population is located in rural regions.

Services for children and young people are particularly relevant to the Aboriginal community. However, the aged population is increasing in number and it is anticipated that demand for services such as hospital admissions and HACC will increase accordingly.

Figure 3: Percentage of Victorian Aboriginal and non-Aboriginal population by age group, 2006.

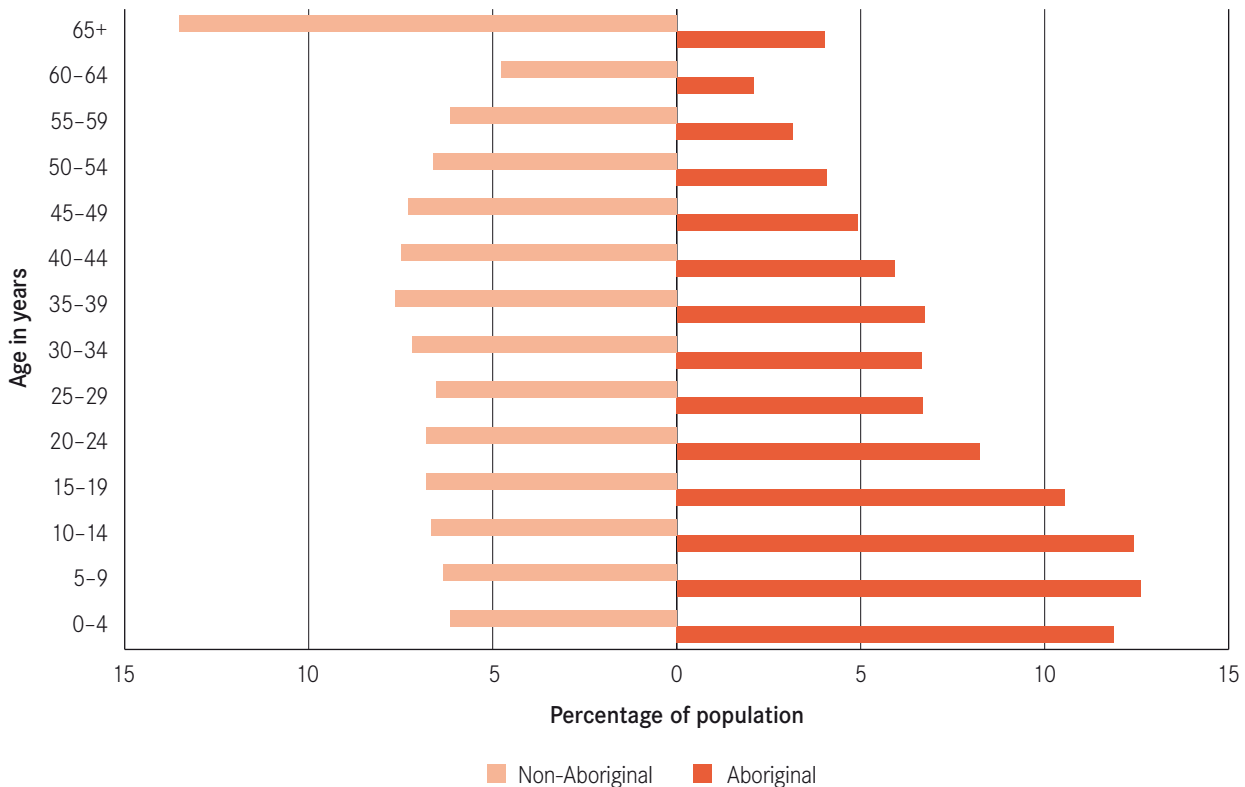


Table 2: Age structure of Victorian Aboriginal population, 2006.¹⁸

Age in years	Population			
	Aboriginal	Non-Aboriginal	Aboriginal (%)	Non-Aboriginal (%)
0-4	3,583	285,373	11.89%	6.16%
5-9	3,799	294,106	12.60%	6.34%
10-14	3,740	308,913	12.41%	6.66%
15-19	3,183	315,077	10.56%	6.80%
20-24	2,482	315,259	8.23%	6.80%
25-29	2,016	302,609	6.69%	6.53%
30-34	2,007	333,536	6.66%	7.19%
35-39	2,029	354,941	6.73%	7.66%
40-44	1,791	347,519	5.94%	7.50%
45-49	1,481	338,690	4.91%	7.31%
50-54	1,234	306,723	4.09%	6.62%
55-59	953	285,353	3.16%	6.15%
60-64	631	220,848	2.09%	4.76%
65+	1,211	627,332	4.02%	13.53%
Total	30,140	4,636,249	100.00%	100.00%

¹⁸ Australian Bureau of Statistics, 2006, *2006 Census of Population and Housing*, cat. no. 2068.0, ABS, Canberra. <http://www.abs.gov.au/>

Strategic action area 1: Early child development and growth

Research has demonstrated that the foundations of adult health are laid in early childhood and before birth¹⁹, and poor circumstances during pregnancy are known to contribute to a range of childhood disabilities and medical conditions and to a propensity for ill health in later life.²⁰

Five indicators have been selected for this strategic action area. They are:

1. perinatal mortality
2. low birth weight babies
3. immunisation
4. maternal age
5. use of Maternal and Child Health Service.

Strategies

In Victoria, **Best Start** aims to improve the health, development, learning and well-being of all children across Victoria from pregnancy through transition to school (children 0–8 years of age).

Best Start supports communities, parents, families and service providers to improve universal local early years service systems. These improvements facilitate:

- better access to child and family support, health services and early education
- the capacity and confidence of parents-to-be, parents and families to care for children and help them to enjoy parenting
- communities to become more child friendly.

This means that children can be given the best possible start for their future health, education and social well-being.

Aboriginal Best Start was developed in three phases:

1. The development of the Aboriginal Best Start Status report by the Victorian Aboriginal Community Services Association Limited (VACSAL) in partnership with the Victorian Aboriginal Education Association Incorporated (VAEAI) and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO)²¹. The report was prepared to direct the Aboriginal Best Start demonstration projects, and provides:
 - a summary of the outcomes of consultation with parents and communities
 - a profile of the health and wellbeing status of Aboriginal children from birth to eight years
 - an overview of the research and models of practice relevant to the Aboriginal community
 - an exploration of potential practice solutions to inform the recommendation for the core components of the Aboriginal Best Start and mainstream projects.

Local partnerships of education, health and family services providers, Aboriginal service providers, parents and Elders have been formed to develop and implement an action plan to address local need.

2. In the second phase Aboriginal Best Start demonstration projects were implemented in Horsham and Morwell in 2004/05.
3. Four additional Aboriginal Best Start partnerships were established in Geelong, Bairnsdale, Echuca and Dandenong/Casey in 2005/06.

¹⁹ Wilkinson, R and Marmot, M (eds) 2003, *Social determinants of health: the solid facts*. 2nd edn, World Health Organisation, Copenhagen, Denmark. Quoted in Department of Human Services, 2006, *The State of Victoria's Children report 2006 ; every child, every chance*. p.32.

²⁰ The indicators used in OID 2007 Early child development and growth include injury and preventable disease, infant mortality, birth weight, hearing impediments and children with tooth decay. The indicators used in this report are those for which DHS has high quality data.

²¹ See http://www.beststart.vic.gov.au/project_aboriginal.htm

Koori Maternity Services Strategy

Within the broader Maternity Services Strategy, the Koori Maternity Services Strategy aims to provide culturally appropriate support to Aboriginal women throughout pregnancy and in the postnatal period, and to create partnerships between maternity services and Aboriginal women.

In Home Support

Funded under *A Fairer Victoria 2005*, the in-Home Support program aims to improve the health, development, learning and wellbeing of Aboriginal children 0–3 years, as well as strengthen, support and improve parenting capacity for Aboriginal parents and families that is respectful of their cultural identity. All parents are able to participate in group and community activities that promote knowledge about health, wellbeing, safety and childhood development. Families identified as requiring more intensive parenting support are provided with individual support from an In Home Support worker.

Indicator 1: Perinatal mortality

Perinatal mortality measures the rate of stillbirths (foetal deaths of more than 20 weeks gestation or 400g) and neonatal deaths (deaths of liveborn infants within 28 days of birth). Stillbirths and neonatal deaths are not presented separately because of the small numbers involved²².

Perinatal mortality rates are important measures of the health of mothers and babies and also of general health and wellbeing in the community. As well, they are indicators of the quality of antenatal care, the effectiveness of obstetric services and the quality of infant care in the hospital and the community. Recent analysis using an area-based measure of socio-economic position²³ has shown that children from the most disadvantaged areas are twice as likely to die as those from the least disadvantaged areas.

Causes of perinatal mortality include preterm birth, foetal growth restriction, congenital malformations, specific obstetric complications, antepartum haemorrhage and maternal complications.²⁴ Many perinatal deaths are unexplained. Particular risk factors for babies of Aboriginal mothers include underutilisation of antenatal services, younger mothers (under 20 years), lack of empowerment leading to low self esteem and stress, and socioeconomic factors affecting Aboriginal women and families.²⁵

Perinatal mortality rates for babies born to Aboriginal mothers are significantly higher than those for non-Aboriginal mothers.

The higher rate of perinatal deaths of Aboriginal babies appears in both Victorian and national data²⁶. In Victoria such small numbers are involved that the numbers can fluctuate from year to year and no trend can be reliably determined.

²² Perinatal mortality is used rather than infant mortality because of the better quality data collected through the Perinatal Data Collection Unit. At present only a small percentage of Aboriginal deaths in Victoria are registered as Aboriginal.

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

Department of Human Services, *The State of Victoria's Children Report 2006, every child, every chance*. p.33, based on Australian Institute of Health and Welfare 2007, *Australia's health 2006*, AIHW cat.no. AUS 73, AIHW, Canberra, section 5.3, p 280.

²⁴ ABS 2007, *Causes of death 2005*, ABS cat.no. 3303.0, p41, ABS, Canberra.

²⁵ NSW Department of Health 2003, *NSW Aboriginal Perinatal Health Report*, NSW Department of Health, Sydney 2003, p25. <http://www.health.nsw.gov.au/pubs/aboriginal>

²⁶ National data available in AIHW National Perinatal Statistics Unit 2005, *Australia's mothers and babies 2003*, AIHW cat. no. PER 29, AIHW NPSU, Sydney. (Perinatal Statistics Series No. 16) p.66, <http://www.npsu.unsw.edu.au/ps16.pdf>

Strategies

The **Koori Maternity Services Strategy** provides culturally appropriate support to Aboriginal women throughout pregnancy and in the postnatal period through the employment of Aboriginal health workers and midwives, outreaching from 11 Aboriginal community controlled health organisations. The principal focus is on increased access to antenatal care, postnatal support and hospital liaison for births as a means of improving health and wellbeing outcomes for Aboriginal women and babies. Access to antenatal care is one of the critical factors in positive maternity outcomes for mothers and babies. This program addresses ease of access and affordability of antenatal care for Aboriginal women.

The graph and table below show the Victorian Aboriginal and non-Aboriginal perinatal mortality rates. The non-Aboriginal rate decreased slightly between 1996–1998 and 2006. The Aboriginal rate increased between 1999 and 2004, to a peak of 33.2 in 2003 but returned to the 1996–1998 rate in 2005 and 2006. Some fluctuations are the natural result of variations in very small numbers. It is also likely that the lower rates in earlier years were partly the result of incomplete data collection relating to Aboriginal mothers and babies.

Figure 4: Perinatal mortality rates, 1996–2006.

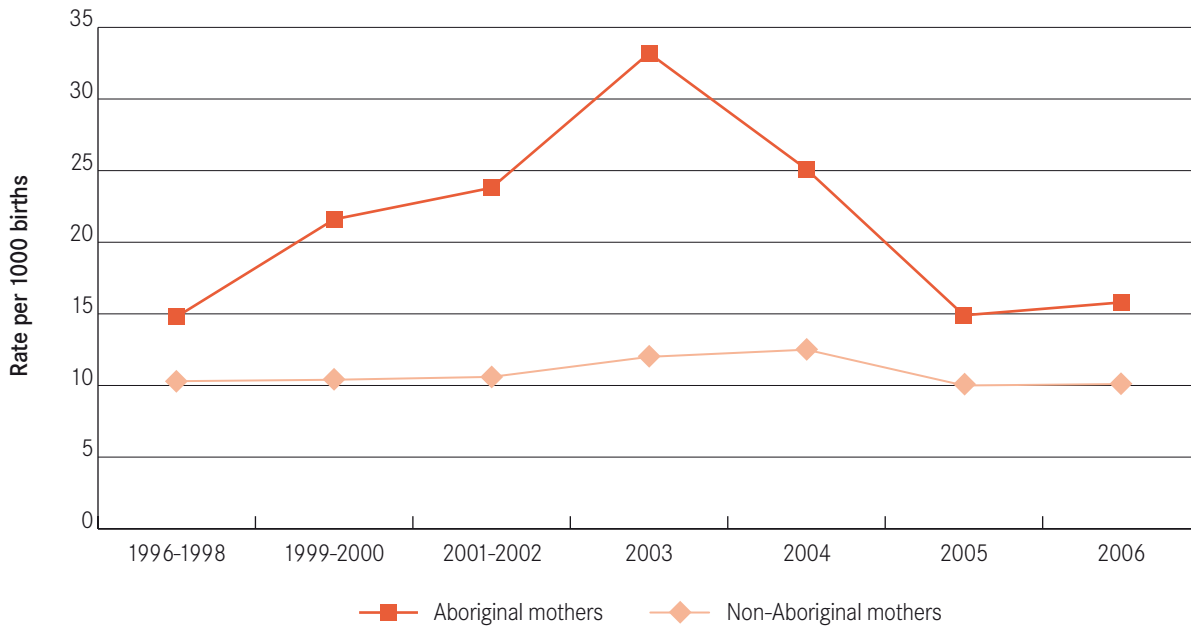


Table 3: Perinatal mortality rates per 1,000 births, 1996–2006.²⁷

Mortality rates per 1000 births	1996–1998	1999–2000	2001–2002	2003	2004	2005	2006
Aboriginal mothers	14.8	21.6	23.8	33.2	25.1	14.9	15.8
Non-Aboriginal mothers	10.3	10.4	10.6	12.0	12.5	10.0	10.1

Source: Perinatal Data Collection Unit

²⁷ Riley, M. and Halliday, J., 1999, *Births in Victoria 1996–1998*, Perinatal Data Collection Unit, Department of Human Services, Melbourne. <http://health.vic.gov.au/perinatal/>

Riley, M., Davey M-A and King, J., 2005, *Births in Victoria 2003–2004*, Perinatal Data Collection Unit, Department of Human Services, Melbourne, and unpublished data Perinatal Data Collection Unit, 2003, 2004. Births in Victoria 2005 and 2006 available on website: www.health.vic.gov.au/perinatal. Data are pooled for calendar years 1996–1998, 1999–2000 and 2000–2001.

Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2005, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2005*, ABS cat. no. 4704.0 and AIHW cat. no. IHW 14, ABS, Canberra, from <http://abs.gov.au>

Australian Institute of Health and Welfare, National Perinatal Statistics Unit, 2003, *Australia's mothers and babies 2000*, AIHW cat. No. PER 21, AIHW NPSU, Canberra, from <http://www.npsu.unsw.edu.au/ps12.pdf>.

Indicator 2: Low birth weight babies

Low birth weight is an indicator of the general health of a newborn baby and the key determinant of infant survival, health and development. Low birth weight babies are at greater risk of dying during their first years of life. They also have greater risks of hospitalisation and neonatal death, physical and neurological complications and the development of psychosocial problems.

Low birth weight babies are those born weighing less than 2,500 grams. The average weight of a newborn baby is 3,450 grams. Babies born at less than 2,500 grams are at higher risk of disease and death as infants and as well as higher risk of developing conditions such as cardiac disease and kidney disease leading to renal failure as adults.

Low birth weight can be the result of preterm birth, foetal growth restriction or a combination of the two. A range of factors can impact on a baby's birth weight, including duration of pregnancy, socioeconomic disadvantage, smoking and other risk behaviours, illness during pregnancy, multiple pregnancy, the size and age of the mother, the number of babies previously born to the mother and the mother's nutritional status,

Babies born to Aboriginal mothers are on average lighter than babies born to non-Aboriginal mothers, whether full-term or preterm, although Aboriginal women are more likely to have preterm babies.

The rate of low birth weight babies to Aboriginal mothers is significantly higher than the rate to non-Aboriginal mothers.

The higher rate of low birth weight babies to Aboriginal mothers is thought to be due in part to a greater likelihood of more accurate identification of very small or ill babies as Aboriginal, and in part to an actual increase in the number of low birth weight babies, which might be caused partly by poor maternal health.

Strategies

The **Koori Maternity Services Strategy** provides culturally appropriate support to Aboriginal women throughout pregnancy and in the postnatal period through the employment of Aboriginal health workers and midwives, outreaching from 11 Aboriginal community controlled health organisations.

Although only preliminary data are available, there are indications that the Koori Maternity Services Strategy is succeeding in reducing the rate of low birth weight babies through better antenatal care.

VIAF Strategic Change Indicator 1.1 aims to reduce the reported smoking and alcohol use in pregnancy by Aboriginal mothers. Smoking in pregnancy is a major contributing factor for low birth weight, as well as being associated with premature birth, stillbirth, some birth defects and sudden infant death syndrome. Victorian data indicates that 38% of Aboriginal mothers smoked at the time of birth compared to 9% of non-Aboriginal mothers²⁸. Cessation of smoking prior to becoming pregnant or early in pregnancy results in foetal growth and perinatal morbidity rates almost identical to babies born to non-smokers.²⁹ Reducing smoking prevalence is one of the few interventions shown to reduce low birth weight and pre-term births.³⁰

²⁸ Victorian Admitted Episodes Dataset (VAED), 2006/07.

²⁹ Ahlsten et al. Cessation of smoking during pregnancy improves foetal growth and reduces infant morbidity in the neonatal period, *Acta Paed*, 1993:82 (2).

³⁰ Lumley, J. Overview of current research and direction on health effects of smoking and benefits of quitting during pregnancy in: Australian Medical Association, *Smoking and Pregnancy – a national consensus conference*. Canberra 1999.

Figure 5 and Table 4 show the percentage of babies with a low birth weight born in Victoria. The rate of low birth weight babies to non-Aboriginal mothers has grown slowly from 6.3% in 1996 to 7.0% in 2005. The rate of low birth weight babies born to Aboriginal mothers has been increasing since 1996 from 11.0% 1996 to 13.4% 2006, with a peak of 17.1% in 2004.

Figure 5: Percentage of babies with low birth weight, 1996–2006.

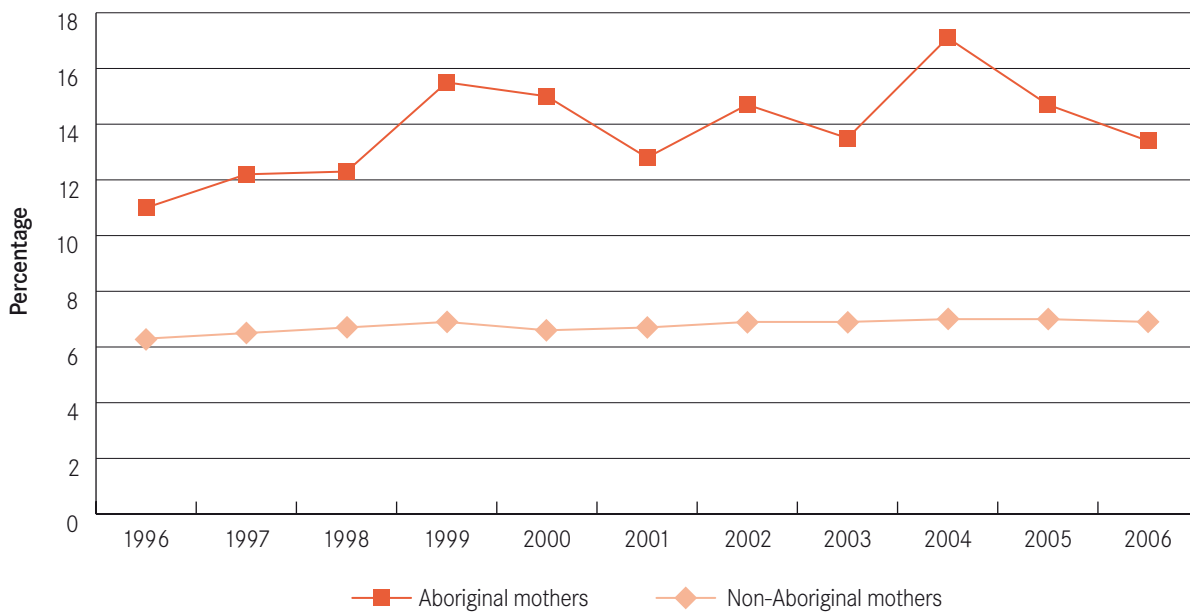


Table 4: Percentage of babies with low birth weight, 1996–2006.³¹

Year	Percentage of babies	
	Aboriginal mothers	Non-Aboriginal mothers
1996	11.0	6.3
1997	12.2	6.5
1998	12.3	6.7
1999	15.5	6.9
2000	15.0	6.6
2001	12.8	6.7
2002	14.7	6.9
2003	13.5	6.9
2004	17.1	7.0
2005	14.7	7.0
2006	13.4	6.9

³¹ *Births in Victoria 1996–1998 – 2003–2004* and unpublished data from PDCU for 2005 and 2006. Includes babies of Aboriginal mothers only. Data on babies with Aboriginal fathers and non-Aboriginal mothers is not available. Koori Hospital Liaison Officer database. Published in Department of Human Services 2006, *Koori Health Counts: information from the reports of the Aboriginal Hospital Liaison Officers 2004/05: Improving Care for Aboriginal and Torres Strait Islander Patients Program (ICAP)*, Melbourne, 2006. <http://www.health.vic.gov.au/koori>

Figure 6 and Table 5 show the distribution of babies by birth weight. The percentage of Aboriginal babies is higher than the percentage of non-Aboriginal babies in all birth weight groups up to 2,999 grams. This is particularly evident among babies weighing 2500–2999 grams. The most common weight group for all babies is 3000–3499 grams. However, babies of Aboriginal mothers are evenly divided between 2500–2999 grams and 3500–3999 grams, whereas babies of non-Aboriginal mothers are twice as likely to weigh 3500–3999 grams than 2500–2999 grams. There has been no significant change in weight distribution since 2000.

Figure 6: Distribution of babies by birth weight, 2006.

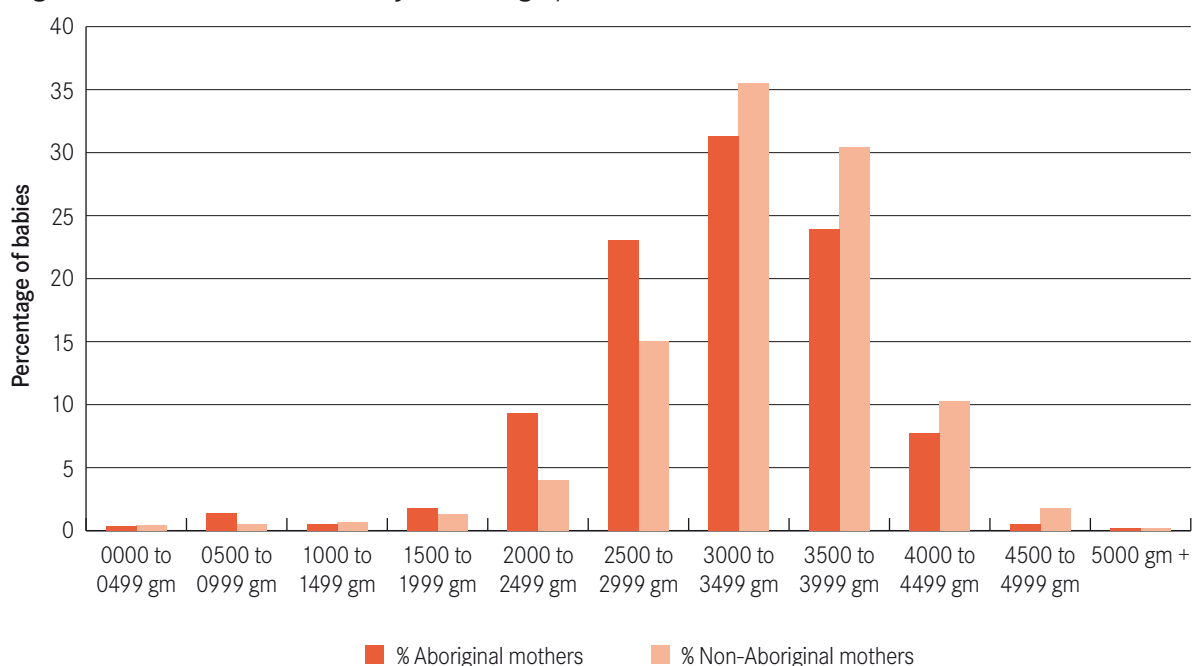


Table 5: Percentage of births by birth weight, 2000–2006.

Weight in grams	Year	<2500g	2500–2999g	3000–3499g	3500–3999g	4000+g
		Percentage of births				
Aboriginal mothers	2000	15.0	21.1	35.0	21.8	7.4
	2001	12.8	23.0	30.6	23.8	9.7
	2002	14.7	21.1	32.5	22.6	9.0
	2003	13.5	23.0	36.9	17.9	7.2
	2004	17.1	23.0	30.8	19.8	9.1
	2005	14.7	22.9	30.7	20.6	11.2
	2006	13.4	23.0	31.3	23.9	8.4
Non-Aboriginal mothers	2000	6.6	15.4	36.1	30.2	11.8
	2001	6.7	15.4	35.8	30.3	11.9
	2002	6.9	15.3	35.7	30.2	11.9
	2003	6.9	15.2	35.6	30.2	11.9
	2004	7.0	15.0	35.0	30.7	12.3
	2005	7.0	15.2	35.3	30.5	11.9
	2006	6.9	15.0	35.5	30.4	12.2

Indicator 3: Maternal age

Young mothers (under 20 years) and older mothers (over 35 years) are more likely to have low birth weight babies (see Indicator 2) and/or complications of pregnancy. Younger mothers are also less likely to have completed school or to be employed, leading to poorer socio-economic status.

Aboriginal women in Victoria give birth at younger ages than non-Aboriginal women. The percentage of Aboriginal women under 20 years giving birth has always been higher than the percentage of non-Aboriginal women. This is the case in all states and territories, although Victoria has a smaller percentage of mothers, both Aboriginal and non-Aboriginal, under 20 years than other jurisdictions. Most women under 20 years giving birth in Victoria are aged 18–19 years. There are few mothers aged less than 18 years.

In 2006 18 per cent of Aboriginal women giving birth in Victoria were aged under 20 years. Only 3 per cent of non-Aboriginal women giving birth were aged under 20 years.

Figure 7 and Table 6 show that the percentage of Aboriginal women under 20 years giving birth has increased in the last ten years, but has decreased since the peak of 22% between 2001 and 2004. Some of the increase is the result of better identification of women as Aboriginal.

Figure 7: Percentage of women giving birth aged less than 20 years, 1996–2006.

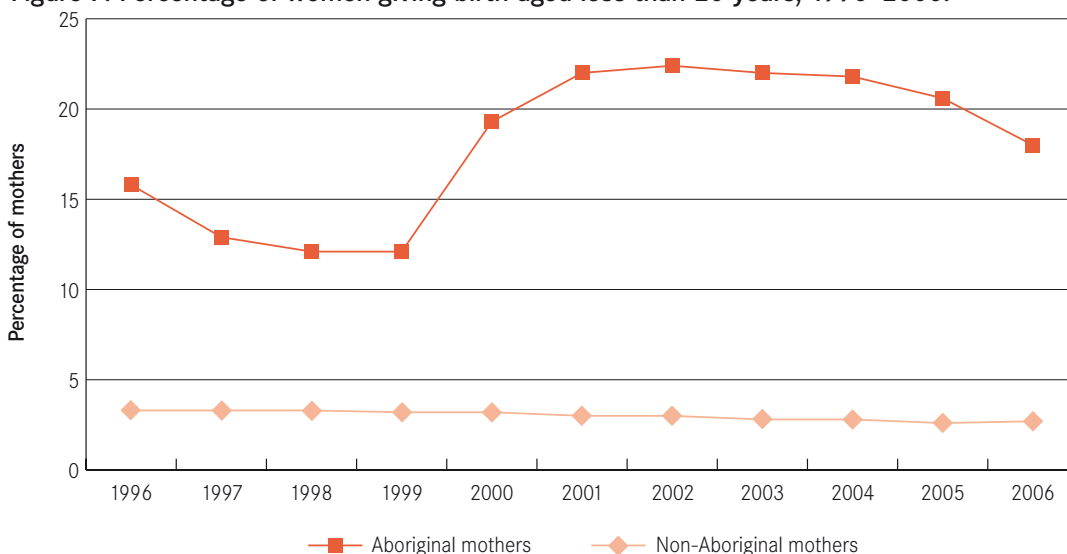


Table 6: Percentage of women giving birth aged less than 20 years, 1996–2006.³²

Year	Percentage of women	
	Aboriginal	Non-Aboriginal
1996	15.8	3.3
1997	12.9	3.3
1998	12.1	3.3
1999	12.1	3.2
2000	19.3	3.2
2001	22.0	3.0
2002	22.4	3.0
2003	22.0	2.8
2004	21.8	2.8
2005	20.6	2.6
2006	18.0	2.7

³² Births in Victoria 1996–1998 – 2003–2004 and unpublished data from PDCU.

Figure 8 and Table 7 show that between 2002 and 2006 the percentage of women in the younger age groups has decreased and the percentage in the older age groups has increased. For Aboriginal women the greatest decrease is among women aged under 20 years and the greatest increase is among women aged 30-34 years.

Figure 8: Age profile of mothers, 2002 and 2006.

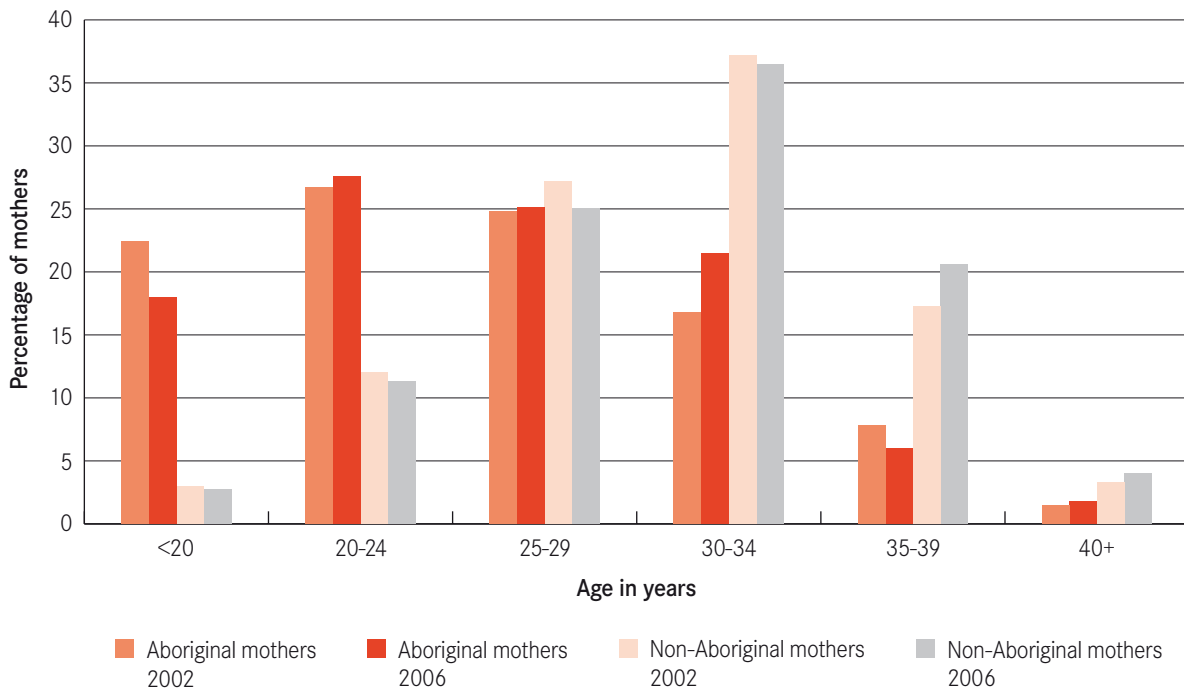


Table 7: Age profile of mothers, 2002–2006.³³

Age in years	Percentage of Aboriginal mothers			Percentage of Non-Aboriginal mothers		
	2002	2004	2006	2002	2004	2006
<20	22.4	21.8	18.0	3.0	2.8	2.7
20–24	26.7	30.3	27.6	12.0	11.2	11.3
25–29	24.8	23.0	25.1	27.2	25.8	25.0
30–34	16.8	15.6	21.5	37.2	37.7	36.5
35–39	7.8	8.7	6.0	17.3	18.8	20.6
40+	1.5	0.5	1.8	3.3	3.5	4.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

³³ Births in Victoria 2001–2002 – 2003–2004, and unpublished data from PDCU.

Rate of teenage confinements

Figure 9 and Table 8 show that the rate of confinements among women aged less than 20 years is very much higher for Aboriginal women than non-Aboriginal women. This is most marked among the youngest mothers (15 years or less). The differences in rates of confinement decrease among older teenagers.

Figure 9: Rates of confinements per 1000 population, 2000–2006.

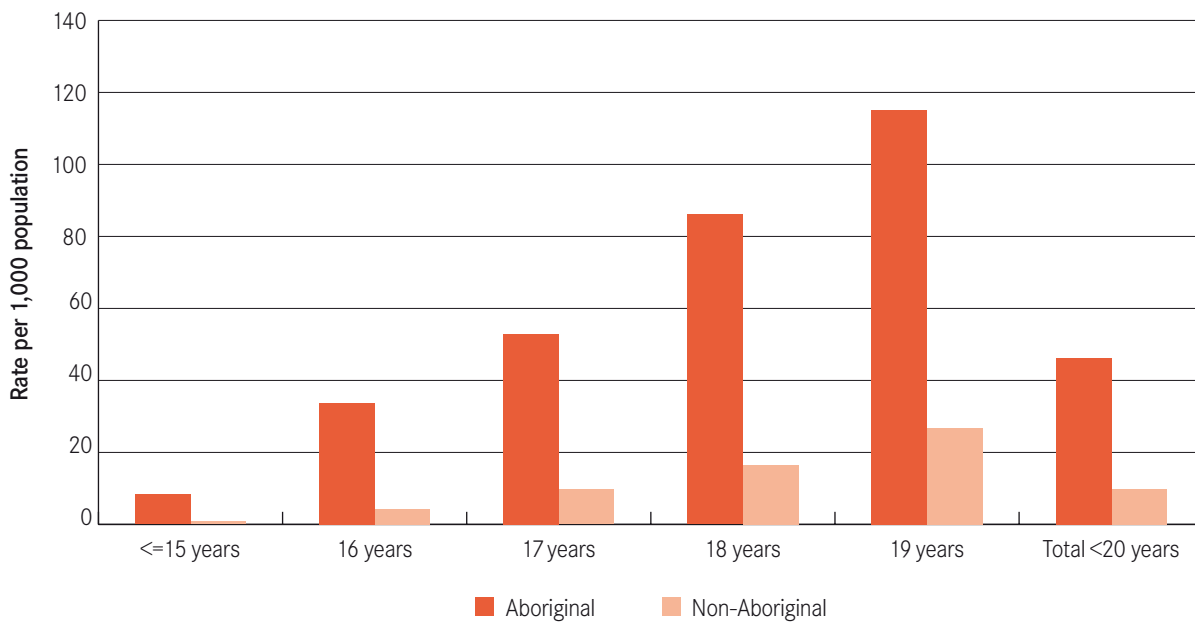


Table 8: Rates of confinements per 1000 population, 2000–2006.

Age in years	Rate of confinements		
	Aboriginal mothers	Non-Aboriginal mothers	Rate ratio
<=15	8.3	0.8	10.6
16	33.8	4.3	7.9
17	53.0	9.7	5.5
18	86.1	16.5	5.2
19	115.1	26.9	4.3
Total <20 years	46.3	9.8	4.7

Source: PDCU and ABS Census 2006.

Note: Confinements from 2000 to 2006 have been aggregated. Rate per 1000 population uses ABS Census 2006.

Indicator 4: Immunisation rate

Immunisation protects against a number of serious infectious diseases. Children who are not immunised are at increased risk of contracting infectious diseases or suffering more serious complications. Older children who are not appropriately immunised can also infect children who are too young to be immunised or who cannot be immunised due to medical conditions.

Fully immunised children are those who have received all standard immunisations appropriate to their age. Children are routinely immunised free of charge against hepatitis B, rotavirus, diphtheria, tetanus, pertussis, polio, pneumococcal, *haemophilus influenzae* type b (Hib), measles, mumps, rubella, meningococcal C and varicella.

Immunisation of children is recorded on the national Australian Childhood Immunisation Register (ACIR).

The number of Aboriginal children immunised in each age group is increasing as more children are identified as Aboriginal and are enrolled in Medicare Australia. Their immunisation records are required to be added to the Australian Childhood Immunisation Register following each scheduled vaccination.

Table 9: Percentage of children immunised by age and reported to ACIR, 2002/03–2006/07.³⁴

Age in months	Number of children			
	Aboriginal children on register	Aboriginal children fully immunised (%)	Non-Aboriginal children on register	Non-Aboriginal children fully immunised (%)
2002/03				
12–15	476	87.2%	60,154	92.2%
24–27	382	87.4%	60,334	90.2%
72–75	1,587	86.9%	62,549	85.3%
2003/04				
12–15	478	88.1%	60,546	91.7%
24–27	542	89.7%	61,035	92.5%
72–75	1,469	84.4%	61,942	85.9%
2004/05				
12–15	782	88.1%	61,664	91.5%
24–27	586	94.0%	61,548	92.6%
72–75	1,965	87.3%	62,389	86.1%
2005/06				
12–15	676	84.2%	62,437	91.4%
24–27	776	93.7%	62,481	93.2%
72–75	791	87.1%	63,592	87.1%
2006/07				
12–15	660	85.6%	65,182	91.6%
24–27	691	91.0%	63,191	93.6%
72–75	550	85.6%	63,130	90.7%

³⁴ Australian Childhood Immunisation Register, September 2003, September 2004, September 2005, September 2006 and September 2007. Data are produced quarterly by ACIR and have been aggregated into financial years for this table.

Table 10: Number of Aboriginal children fully immunised and reported to ACIR, 2000/01–2006/07.³⁵

Age of children	12–15 months	24–27 months	72–75 months
Date data processed	Number of children		
31.03.2001	22	351	N/A
30.06.2001	21	606	N/A
30.09.2001	29	630	N/A
31.12.2001	N/A	N/A	N/A
31.03.2002	52	41	N/A
30.06.2002	72	53	360
30.09.2002	N/A	N/A	N/A
31.12.2002	99	81	526
31.03.2003	123	83	531
30.06.2003	128	106	282
30.09.2003	126	112	248
31.12.2003	120	127	237
31.03.2004	107	140	322
30.06.2004	106	132	544
30.09.2004	145	143	366
31.12.2004	194	142	620
31.03.2005	177	139	318
30.06.2005	204	143	514
30.09.2005	207	162	513
31.12.2005	207	211	402
31.03.2006	145	178	113
30.06.2006	155	197	139
30.09.2006	169	190	137
31.12.2006	154	205	134
31.03.2007	161	165	143
30.06.2007	159	155	148
30.09.2007	186	166	125

³⁵ ACIR, September 2007. Data were not available for the quarters reported on 31.12.2001 or 30.09.2002. Data on children aged 72–75 months were not available until the quarter reported 30.06.2002. Children are included on the Register if they have received any immunisation. Data are processed 3 months after the collection date, so that data processed on 30.09.2007 refer to children aged 12–15 months on 30.06.2007. There were significant issues with the accuracy of immunisation data for children 72–75 months until 31.12.2005.

Indicator 5: Use of Maternal and Child Health Services

The Maternal and Child Health Service (MCHS) is a universal service for all Victorian families with children from birth to school age. The Service focuses on the early detection, intervention and prevention of physical, emotional and social issues affecting young children and their families. The Service offers support, information and advice regarding parenting, child health and development, child behaviour, maternal health and well-being, child safety, immunisation, breastfeeding, nutrition and family planning.

The indicator measures the number of Aboriginal children aged 0–1 year and 1–2 years who have used the Maternal and Child Health Service in a given financial year. Ninety-eight per cent of all parents and their babies use the service. Aboriginal parents have a lower rate of use of the Service, but this has been increasing over the past 5 years.

Aboriginal use of the Maternal and Child Health Service has increased between 2001/02 and 2006/07.

Figure 10: Aboriginal children using Maternal and Child Health Service, 1999/00–2006/07.

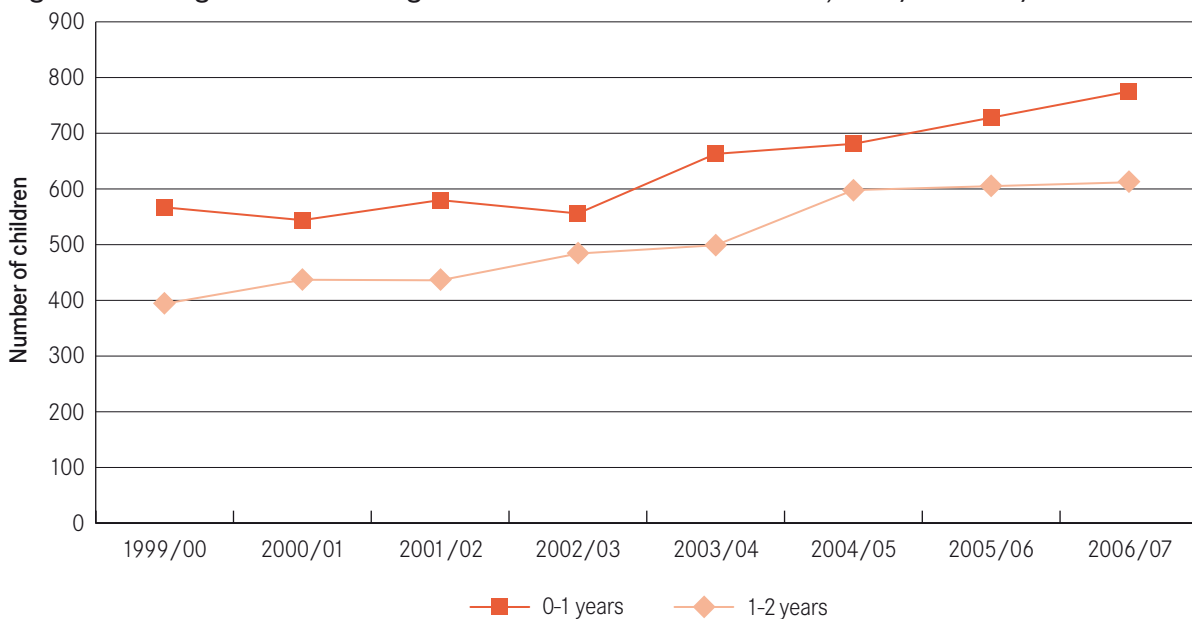


Table 11: Aboriginal children using Maternal and Child Health Service, 2001/02–2006/07.³⁶

Age in years	Number of children					
	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
0–1 years						
Total Aboriginal record cards	581	559	668	692	749	777
Total active Aboriginal children	580	556	663	681	728	775
Percentage active Aboriginal children	99.8%	99.5%	99.3%	98.4%	97.2%	99.7%
Percentage all active children						99.9%
1–2 years						
Total Aboriginal record cards	543	637	643	724	763	776
Total active Aboriginal children	436	484	499	598	605	612
Percentage active Aboriginal children	80.3%	76.0%	77.6%	82.6%	79.3%	78.9%
Percentage all active children						90.9%

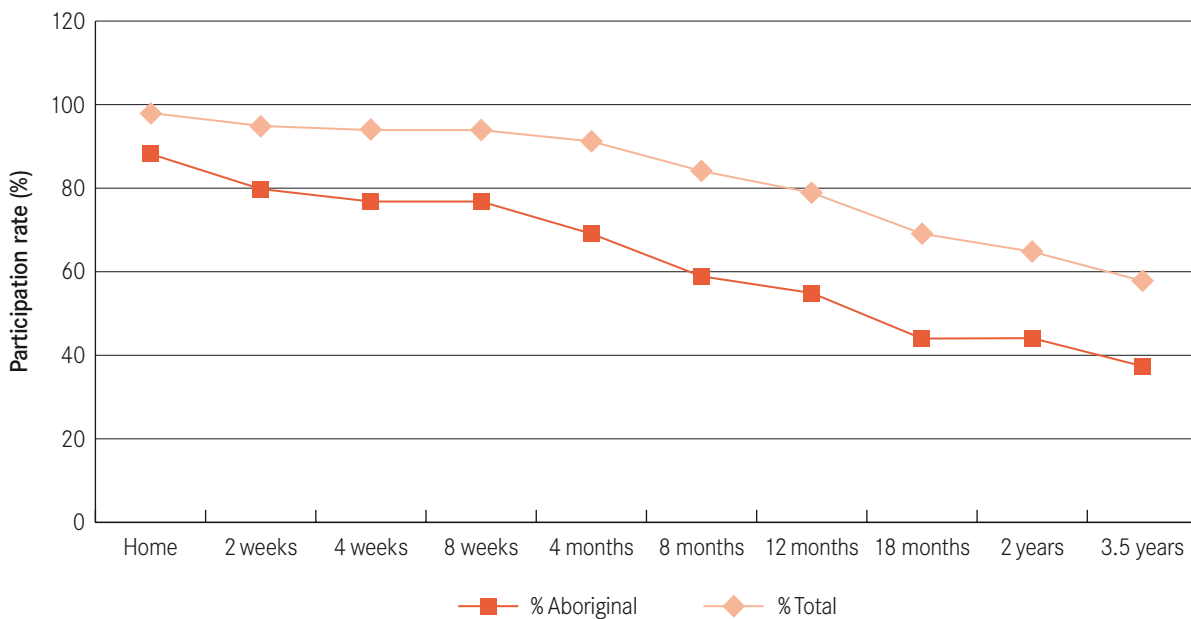
³⁶ Maternal and Child Health Service data, 2006/07. Active children are those who have used MCHS at any time in the past financial year. Note that MCHS use by all parents decreases after the first year.

Use of the Maternal and Child Health Service is scheduled for specific times in the child's early years: i.e. the initial home consultation; 2, 4 and 8 weeks; 4, 8, 12 and 18 months; 2 years and 3.5 years. Although the number of all children and families using the service decreases as the child grows older, the decrease is greater among Aboriginal families, where use of the service falls quickly to the point where less than half use the service after 12 months, compared to 58% of non-Aboriginal families still using the service at 3.5 years.

Table 12: Maternal and Child Health Service key ages and stages visits, 2006/07.

Age	Aboriginal children		Non-Aboriginal children	
	Number	Percentage	Number	Percentage
Home consultation	685	88.2%	66,384	98.0%
2 weeks	620	79.8%	64,348	94.9%
4 weeks	597	76.8%	63,686	93.9%
8 weeks	597	76.8%	63,668	93.9%
4 months	537	69.1%	61,872	91.2%
8 months	457	58.9%	56,765	84.1%
12 months	426	54.9%	53,268	78.9%
18 months	346	44.0%	45,686	69.1%
2 years	352	44.1%	42,155	64.8%
3.5 years	255	37.4%	37,556	57.8%

Figure 11: Maternal and Child Health Service participation rates by age, 2006/07.



Strategic action area 2: Early school engagement and performance—kindergarten to year 3

The indicators in this section are concerned with some of the factors that create barriers to achievement in the early years of schooling. Actions to improve the indicators have the potential to improve outcomes in the immediate, medium and long term for Aboriginal children³⁷.

The indicators included in this section are those for which DHS provides services:

- hearing loss
- four year old kindergarten enrolments.

Indicator 6: Screening for hearing loss

Hearing loss can be congenital, or develop later in life as the result of injury, disease or natural degeneration of the eardrum.

Ear infections in Aboriginal children are very common, much more common than in the non-Aboriginal population, and cause the bulk of the hearing problems faced by Aboriginal people, even into adulthood. They cause considerable morbidity with lifelong consequences and are, to a great extent, preventable and treatable.³⁸

One of the most common ear conditions is otitis media, which is an infection and inflammation of the middle ear, impairing hearing by causing the eardrum to bulge with fluid or burst.

Aboriginal people have some of the highest rates of severe and persistent otitis media in the world. Otitis media often first occurs in very young babies and continues to adulthood. In non-Aboriginal people onset is later and the condition is more likely to be resolved in childhood.

Otitis media can cause short and long term hearing loss, thereby affecting social development, language and educational performance. Infections and hearing loss may vary over time so that point of time screening does not always reveal the extent of potential hearing loss. Data are only available at present for point of time hearing loss.

Strategies

The Maternal and Child Health Service and the School Nursing Service carry out screening for ear infections and hearing loss routinely.³⁹ The Maternal and Child Health Service highlights and discusses hearing with parents when the infant is two weeks of age, to identify those infants at risk of hearing loss. This is followed up with immediate referral to an audiology service if required.

The School Nursing Program offers a universal primary health service to all state, Catholic and independent schools who participate in the program. All children in the first year of school (Prep) are offered a health assessment including a hearing assessment where indicated, by information provided in the School Entrant Health Questionnaire (SEHQ). All children identified as Aboriginal are screened for hearing, which may include an inspection of the ear canal. Children with any symptoms or risk following the screening test are referred to audiology services. Aboriginal children are more likely to be referred for follow-up than non-Aboriginal children.

The Commonwealth Office for Aboriginal and Torres Strait Islander Health (OATSIH) has four regional hearing coordinators in Victoria, whose role is to assist Aboriginal Health Workers in Aboriginal Community Controlled Health Organisations (ACCHOs) to conduct hearing screening programs.

³⁷ OID 2007, p 6.1. Hearing screening is included in this section as the most comprehensive screening is carried out in the first year of school.

³⁸ *Aboriginal Primary Health Care: an evidence-based approach*. Sophia Couzos and Richard Murray for the Kimberley Aboriginal Medical Services Council. 2nd edn. Oxford, 2003.

³⁹ Universal neonatal screening for congenital hearing loss is conducted at Royal Women's Hospital, Mercy Hospital for Women, Royal Children's Hospital and Monash Medical Centre.

Of the children who have a primary health assessment, a higher proportion of Aboriginal children are screened for hearing problems than non-Aboriginal children. Aboriginal children are more likely to be referred for follow-up after screening.

However the percentage of Aboriginal children being referred has decreased from 13.81% in 2002 to 7.82% in 2007.

Table 13: Hearing screening by School Nursing Service, 2002–2007^{40, 41}

	2002	2003	2004	2005	2006	2007
Number of children in Prep						
Total	63,155	61,944	61,862	60,908	61,772	61,573
Aboriginal children	630	579	718	680	703	738
Number of Prep children who had a Primary Health Assessment						
Aboriginal	517	435	461	478	441	476
Non-Aboriginal	56,621	54,900	54,954	55,509	51,974	54,351
Not stated/ unknown	613	447	323	304	284	326
Total	57,751	55,782	55,738	56,291	52,699	55,153
Number of Prep children screened for hearing						
Aboriginal	507	430	454	467	438	473
Non-Aboriginal	29,156	27,228	28,784	30,463	29,986	33,316
Not stated/ unknown	403	261	187	189	184	207
Total	30,066	27,919	29,425	31,119	30,608	33,996
Number of children referred for follow-up of hearing						
Aboriginal	70	35	36	35	34	37
Non-Aboriginal	2,125	1,881	1,995	1,840	1,794	1,711
Not stated/ unknown	51	21	10	14	5	7
Total	2,246	1,937	2,041	1,889	1,833	1,755
Percentage of children screened who were referred for follow-up of hearing						
Aboriginal	13.81%	8.14%	7.93%	7.49%	7.76%	7.82%
Non-Aboriginal	7.29%	6.91%	6.93%	6.04%	5.98%	5.14%
Total	7.47%	6.94%	6.94%	6.07%	5.99%	5.16%

⁴⁰ Total number of children in Prep includes only children at schools registered with the School Nursing Program.
Total number of Prep children who had a Primary Health Assessment includes school entrants and new enrolments.
Referred for follow-up includes referrals to allied health, audiologist, general practitioners, medical agencies, others.

⁴¹ Data from the School Nursing Information System (SNIS) de-identified database.
Data are collected at time of Prep Assessment, from schools registered with the School Nursing Program

Indicator 7: Kindergarten enrolments

Kindergarten education is provided for some three year olds and the majority of four year olds either in sessional kindergartens that are often organised through local parent-managed associations or in long day care settings. Early participation in education provides young children with opportunities to develop socially and there is growing recognition that it has a significant bearing on their future educational performance.⁴²

Learning in the early years provides the foundation for later learning and sets children on a path for school, work and life. The experiences and relationships a young child has can actually affect the development of the brain.

In recognition of the importance of the early years, Victoria provides funding for all children to participate in one year of kindergarten in the year before entering formal school⁴³. Kindergarten programs employ qualified early childhood teachers. A second year of kindergarten is available for children meeting specific criteria⁴⁴.

The number of children identified as Aboriginal and enrolled at kindergarten has increased between 1999 and 2007. However, the estimated kindergarten participation rate is lower for Aboriginal children than non-Aboriginal children.

Strategies

The Koori Early Childhood Education Program (KECEP) aims to support Aboriginal children and their families with their access to, and participation in kindergarten programs. It aims to increase the number of Aboriginal children attending kindergarten, and encourages all kindergarten programs to become more culturally relevant for Aboriginal children and their families.⁴⁵

KECEP has three main components:

- Koori Preschool Assistants Program (KPSA)
- Koori Early Childhood Field Officers Program (KECFO) and
- KECEP State Coordinator.

The Koori Preschool Assistants Program (KPSA) aims to support the attendance of Aboriginal children in kindergarten. This includes supporting the attendance of Aboriginal children in kindergarten programs, encouraging Aboriginal community involvement in the development and delivery of kindergarten services for Aboriginal children, and assisting in the development of kindergarten programs that embrace Aboriginal culture.

The Koori Early Childhood Field Officers Program (KECFO) promotes the value of kindergarten programs within Aboriginal communities. The role of the KECFO is to arrange cultural awareness programs and resources for kindergarten providers and to liaise with families who are Aboriginal and kindergartens to promote participation of Aboriginal children in kindergartens. KECFOs also identify local barriers to Aboriginal participation in kindergarten and provide a solution-focused link to overcome these barriers.

The KECEP State Coordinator provides support, information, training and assistance to those working with Aboriginal children in kindergartens. This component of the program provides policy direction and program linkages to the Early Years Services Branch about Koori Early Childhood Education. It links with Department of Human Services regional offices to provide policy advice and information about the KECEP program and support for KECFOs and KPSAs in promoting the participation of Aboriginal children and their families in kindergarten programs. The KECEP coordinator supports policy direction that informs effective pathways for Aboriginal children in their transition experiences from kindergarten to school.

⁴² OID 2007, p.26. See also p6.1.

⁴³ It is not compulsory for children to attend kindergarten before attending school. In addition some children attending long day care with kindergarten-type programs are not recorded as attending kindergarten. Not all Aboriginal children are recorded as Aboriginal.

⁴⁴ In January 2008 the Department of Education and Early Childhood Development introduced an initiative to enable 3 year old Aboriginal children with concession cards to access up to 10 hours per week funded early childhood program.

⁴⁵ Department of Human Services, 2005. *Supporting Aboriginal and Torres Strait Islander children in kindergarten*, DHS, Melbourne. <http://www.office-for-children.vic.gov.au/>.

In the table and figures below the years refer to two calendar years. Kindergarten enrolments are the first year of the pair and school grade prep enrolments are the second year.⁴⁶

Figure 12: Aboriginal children four year old kindergarten participation rate, 1999–2006.

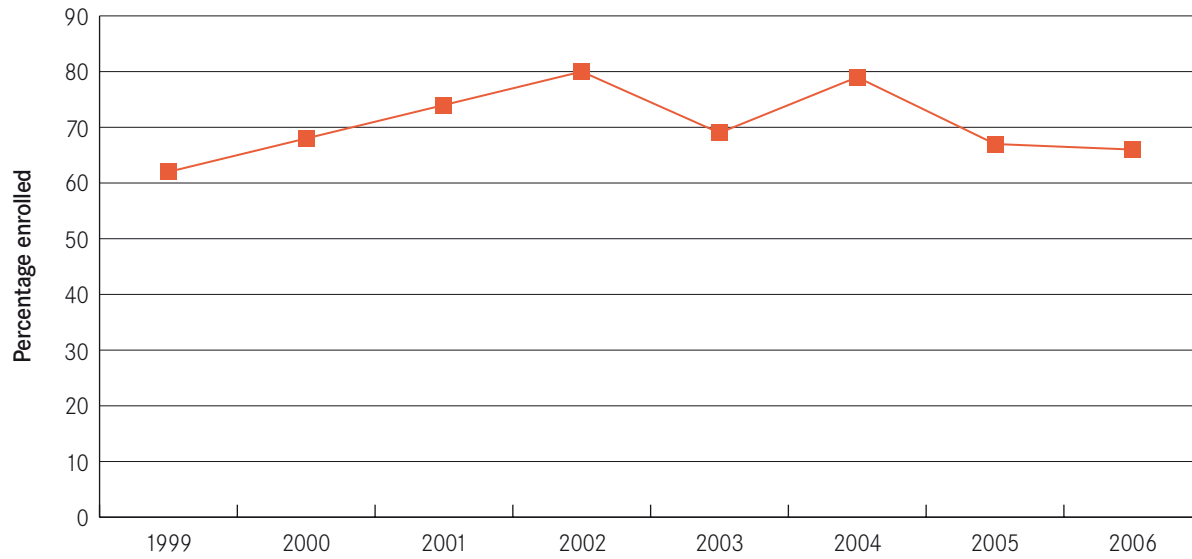
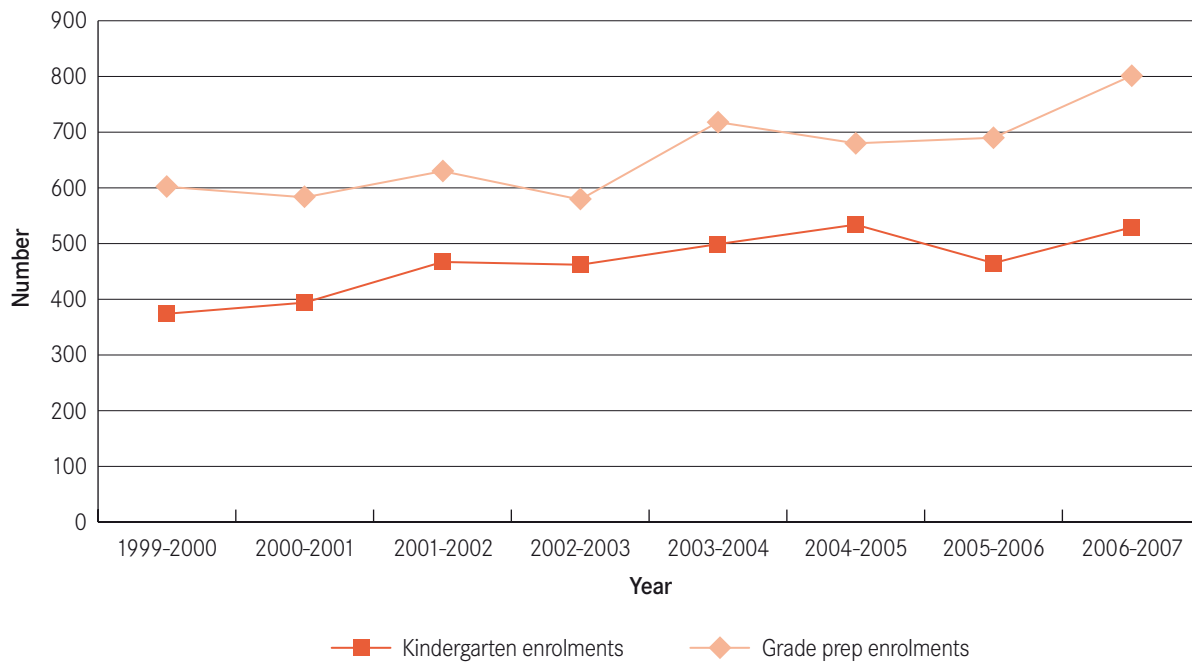


Figure 13: Aboriginal kindergarten enrolments compared to Prep enrolments a year later, 1999–2007.



⁴⁶ All data refers to enrolments, not attendance.

Table 14: Participation rate of Aboriginal children in kindergarten, 1999–2007 ⁴⁷.

Kindergarten enrolments		Grade Prep enrolments		Kindergarten participation rate
Year	Number	Year	Number	Percent
1999	374	2000	602	62%
2000	394	2001	583	68%
2001	467	2002	630	74%
2002	462	2003	579	80%
2003	499	2004	718	69%
2004	534	2005	680	79%
2005	465	2006	690	67%
2006	529	2007	801	66%
2007	504	2008	*	*

* Data was not available at time of printing the report.

⁴⁷ Kindergarten data from Children’s Services On Line (CHISOL) enrolment data, taken as annual census. The number of Preps includes those in government, independent and Catholic schools. Data source DE&ECD. Both kindergarten and prep numbers include children repeating that level. The school census is held in August of each year.

Strategic action area 3: Positive childhood and transition to adulthood

Within the OID framework this strategic area for action reflects the continuing importance of educational outcomes through childhood to early adulthood and ways in which alternatives to detention for youth offenders contribute to reducing recidivism.⁴⁸ The indicators included in this strategic action area are:

- Years 5 and 7 literacy and numeracy
- retention at Year 9
- Aboriginal cultural studies in school curriculum and involvement of Aboriginal people in development and delivery of Aboriginal studies
- youth diversions as a proportion of all youth offenders
- transition from school to work.

This strategic area focuses on children and young people from childhood to adolescence and is covered within DHS by the Child Protection⁴⁹ and Youth Justice systems. The educational outcomes, school curriculum and transition from school to work do not fall within the scope of DHS.

Indicator 8: Child protection

The Child Protection Service provides child-centred family-focused services to protect children and young people from significant harm as a result of abuse or neglect within the family unit and to ensure that children and young people receive services to deal with the impact of abuse and neglect on their wellbeing and development. The Child Protection Service is based on the principle that the best protection for children is usually within the family, however, the paramount consideration is the child's safety and well being.

The role of the Child Protection Service is to:

- receive reports from people who believe on reasonable grounds that a child is in need of protection because of abuse and neglect
- provide advice where people report such concerns
- investigate matters where it is believed that a child is at risk of significant harm
- refer children and families to services to assist parents and carers in providing for the ongoing safety and well being of the children
- take matters before the Children's Court if the child's safety cannot be ensured within the family
- supervise children on legal orders granted by the Children's Court.

The rate of involvement with the Child Protection system is measured by the rate of substantiations, children on protection orders and children in out-of-home care. Aboriginal children have a greater rate of involvement with all levels of Child Protection than non-Aboriginal children.

⁴⁸ OID 2007, p7.1. Positive childhood and transition to adulthood.

⁴⁹ In OID 2007 Child Protection is included in Strategic Action Area 5 – Functional and resilient families and communities – which focuses on the problems in families and communities which can lead to breaks in schooling and education, disrupted social relationships and social alienation, with implications for unemployment, alcohol abuse, criminal activity, violence and suicide.

Strategies

The **Protocol between DHS and the Victorian Aboriginal Child Care Agency (VACCA) 2002** facilitates contact between DHS and VACCA to ensure that a culturally appropriate and effective response to protecting Aboriginal children and young people from harm is provided on a state wide and consistent basis.

The **Aboriginal Child Placement Principle** governs the practice of Child Protection workers when placing Aboriginal children and young people in out-of-home care.

The **Aboriginal Family Preservation Program** works closely with families to address safety concerns and enhance parenting skills, thereby enabling their children to remain at home or facilitating their reunification with family. Child Protection, community service organisations and the Aboriginal Family Preservation Programs work together to ensure that the safety and well being needs of Aboriginal children are responded to in a way that is culturally engaged and strengthens the connectedness of family and community.

The **Aboriginal Family Decision Making** services enable extended family and respected community Elders to participate in decision making about care and protection of children and young people in their community.

The **Aboriginal Child Specialist Advice and Support Service (ACSASS)** is a statewide consultation and advice service for child protection workers involved with Aboriginal families. The service aims to assist child protection workers to comply with the Aboriginal Child Placement Principle and to meet the requirements under the Children and Young Persons Act regarding decision making and care arrangements.

The **Aboriginal Family Support Innovation Projects** aim to divert a significant proportion of Aboriginal families notified to child protection services to community-based services, as well as minimise renotifications of Aboriginal children and young people and the progression of families into the child protection system.

Budget initiatives 2006/07

The number of community based Family Support Innovation Projects, which provide long-term help to families that have ongoing complex problems, will be increased. The projects are helping Victoria to reduce the number of child abuse notifications.

The intent of the ***Children, Youth and Families Act 2005*** is to maintain Aboriginal children within their families and communities and, where this is not possible, to ensure an ongoing connection with their families, communities and culture.⁵⁰

⁵⁰ Office for Children: The Children, Youth and Families Act 2005, <http://www.office-for-children.vic.gov.au/statewide-outcomes/library/legislation>

8 i: Child protection substantiations

Substantiation is the determination that a child or young person is ‘in need of protection’ as defined in Section 162 of the *Children Youth and Families Act 2005*, following a period of investigation of the subject matter of a report and information arising through that investigation. Table 15 below illustrates child protection substantiations as a rate per 1,000 of population for Aboriginal and non-Aboriginal children.⁵¹

- A high proportion of Aboriginal children are assessed as being in need of protection from abuse or neglect.
- The rate of substantiation is significantly higher for Aboriginal children than for non-Aboriginal children.
- Although the rate dropped significantly from 2000/01 to 2001/02, the rates increased from 2001/02 to 2005/06 before dropping in 2006/07.

Figure 14: Rate of child protection substantiations, 1999/00–2006/07.

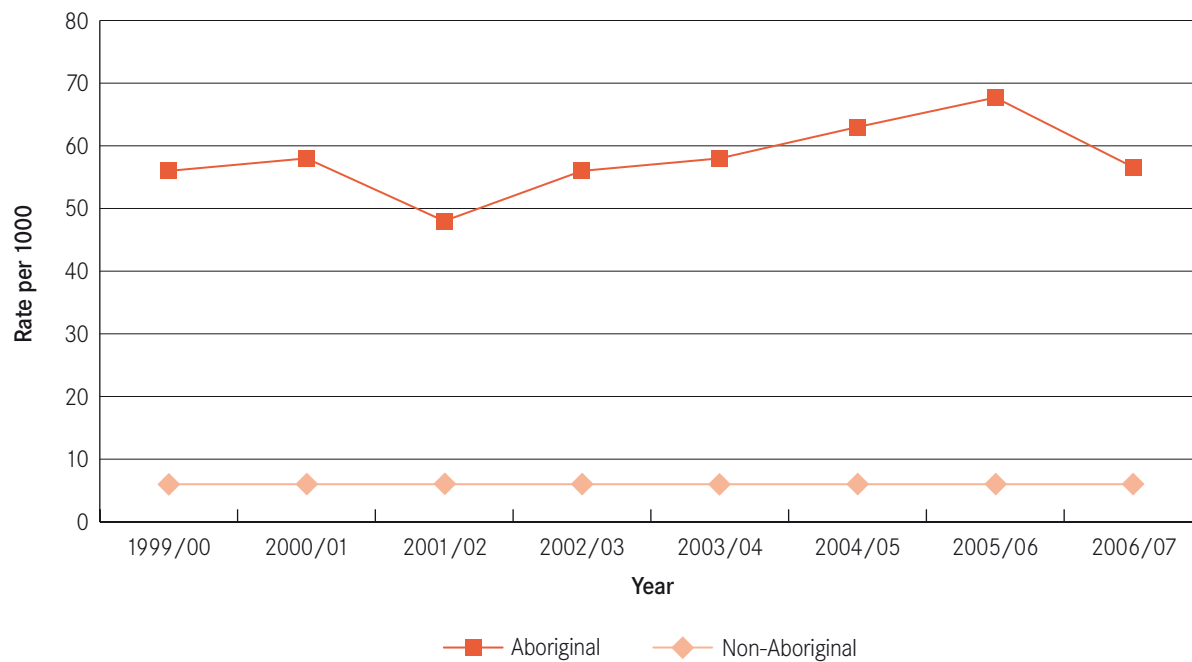


Table 15: Rate of child protection substantiations, 1999/00–2006/07⁵²

Rate per 1000	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
Aboriginal	56	58	48	56	58	63	68	57
Non-Aboriginal	6	6	6	6	6	6	6	5
Rate ratio	9	10	8	9	10	11	11	9

⁵¹ Comparative national data is available in Australian Institute of Health and Welfare, 2008. *Child Protection Australia 2006–07*, AIHW cat. no. CWS 31. Canberra: AIHW (Child Welfare Series no. 43). Tables 2.6 and 2.8., <http://www.aihw.gov.au/publications/cws/cpa06-07/cpa06-07.pdf>. In Victoria, it is estimated that there is an undercount of Aboriginal people in the Census. Relative undercounting of the population artificially inflates placement data expressed as a rate per 1,000 of the population. This applies to all child protection data rates for Indicator 8.

⁵² Final data obtained by transferring data from Client and Services Information Systems database, 2007, to Client Record Information System, 2007. Final data extracted from Client Record Information System, 2007

8 ii: Children on protection orders

If a child has been the subject of a child protection substantiation, there is often, though not always, the need for continued involvement through a protection order. Both Child Protection (in considering a protection application) and the court (in making a protection order) must ensure all reasonable steps have been taken to meet the child’s safety and wellbeing needs without statutory intervention. Recourse to the court is usually a last resort. There are a number of different types of protection orders. In Victoria they include guardianship, custody, supervision and interim protection orders.⁵³

The rate at which Aboriginal children are placed on protection orders remains significantly higher than that of non-Aboriginal children.

Figure 15: Rate of protection orders, 1999/00–2006/07.

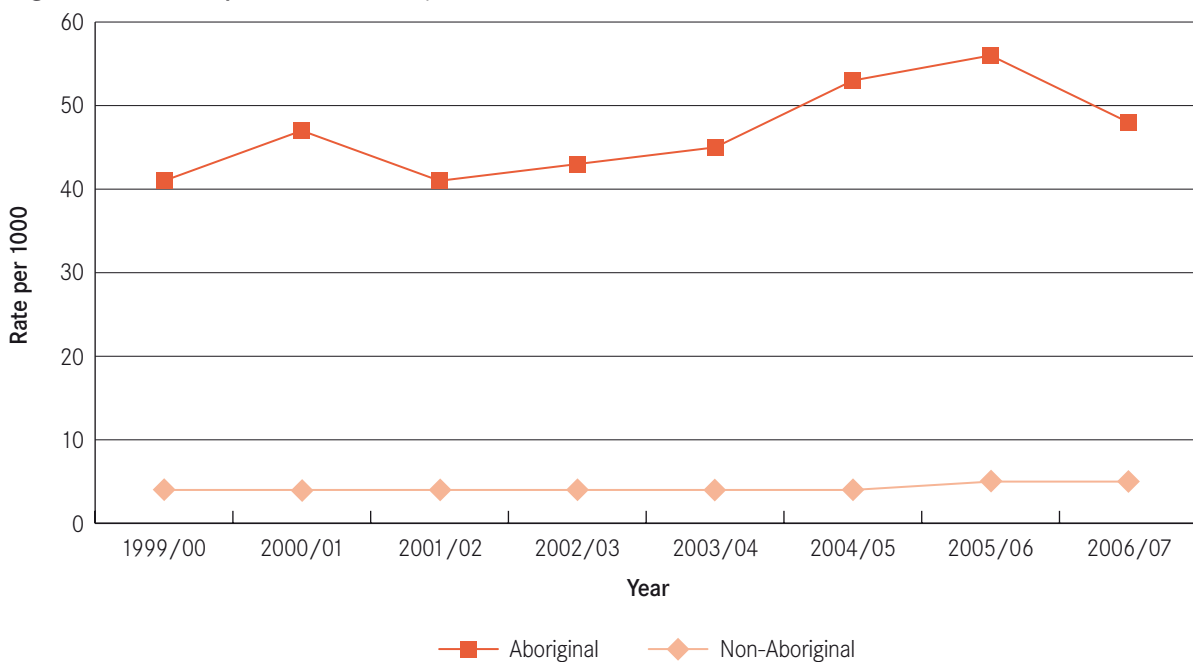


Table 16: Rate of Aboriginal children on protection orders, 1999/00–2006/07.⁵⁴

Rate per 1000	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
Aboriginal	41	47	41	43	45	53	56	48
Non-Aboriginal	4	4	4	4	4	4	5	5
Rate ratio	10	12	10	11	11	12	11	9

⁵³ Comparative national data is available in *Child Protection Australia 2006–07*, Tables 3.9 and 3.10.

⁵⁴ Final data obtained by transferring data from Client and Services Information Systems database, 2007, to Client Record Information System, 2007. Final data extracted from Client Record Information System, 2007.

8 iii: Children in out-of-home care

Out-of-home care includes kinship placement, foster care/home-based care and residential/group home placements. The child or young person might be placed on a voluntary basis or through a child protection court order.

The rate at which Aboriginal children are placed in out-of-home care remains high. In Victoria, the rate at which Aboriginal children are placed in out-of-home care is 12 times higher than the rate for non-Aboriginal children.

The significant increase in the rate of placement of Aboriginal children from 1999/2000 to 2000/01 is attributed to corrections made from an audit of child protection records and data systems for Aboriginal client status, resulting in a higher but more accurate representation of the number of Aboriginal children in out-of-home care.⁵⁵

Figure 16: Rate of children in out-of-home care, 1999/00–2006/07



Table 17: Rate of children in out-of-home care, 1999/00–2006/07.⁵⁶

Rate per 1000	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
Aboriginal	28	42	39	41	41	41	42	48
Non-Aboriginal	3	3	3	3	3	3	4	4
Rate ratio	9	14	13	14	14	14	11	12

⁵⁵ Reports are published by the Australian Institute of Health and Welfare (2007). In Victoria, it is estimated that there is an undercount of Aboriginal people in the Census. Relative undercounting of the population artificially inflates placement data expressed as a rate per 1,000 of the population.

⁵⁶ Client Record Information Systems, 2007. Data for DHS North & West region collected from the Funded Agency Client transaction Database, 2007. Comparative national data in *Child Protection Australia 2006–07*. Table 4.7 p.61 and Table 4.8, p.62.

8 iv: Compliance with the Aboriginal Child Placement Principle (ACPP)

The Aboriginal Child Placement Principle (ACPP) outlines preferences for the placement of Aboriginal children when they are placed outside their immediate family. In order, these preferences are:

- Placement with the child’s extended family (which includes Aboriginal and non-Aboriginal relatives and kin)
- Placement within the child’s Aboriginal community
- Placement with other Aboriginal people.

Compliance with the Aboriginal Child Placement Principle was 62 per cent at 30 June 2007. This rate is similar to previous years.

The ACPP is a measure of process, not of outcome, however, there are no data which measure compliance with the principle directly. Placement outcome is used as a proxy measure.

At June 2007, 38 per cent of Aboriginal children in out-of-home care in Victoria were not placed with family or Aboriginal carers. This continues the decrease in the rate of non-compliance from 2001 (44 per cent) and 2002 (45 per cent) and is similar to the rate from 2003 to 2006. The limited availability of Aboriginal foster care (other Aboriginal family) and residential care placements is a significant contributing factor to the low rate of ACPP compliance in Victoria.

Figure 17: ACPP compliance, 2001–2007.

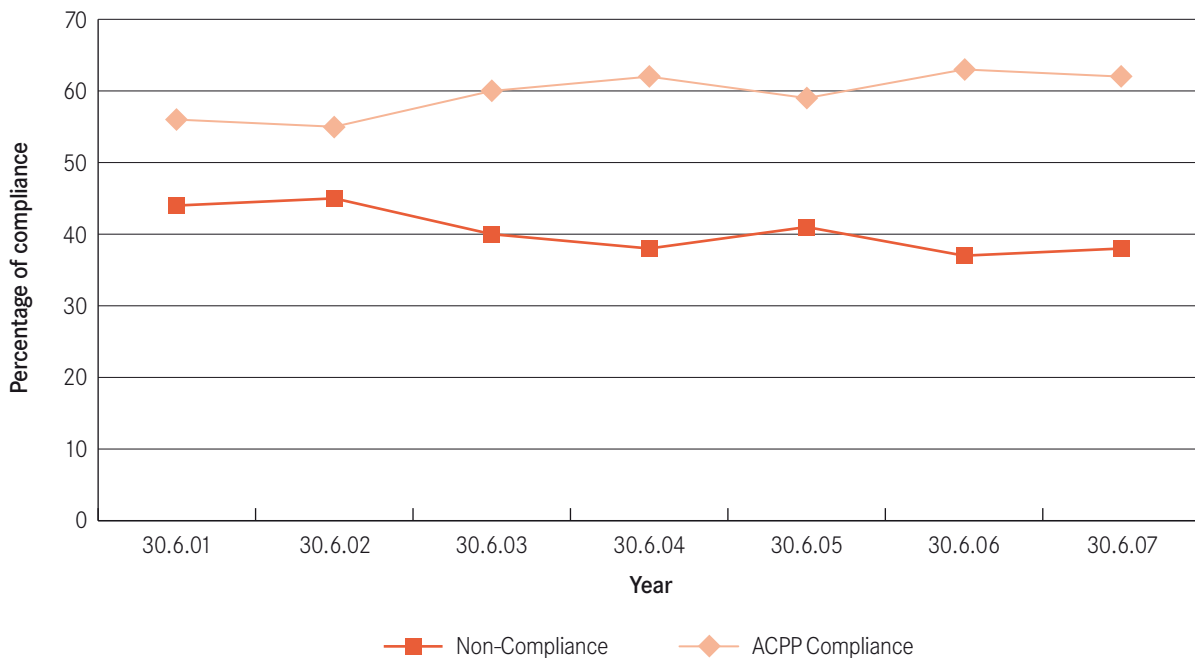


Table 18: Aboriginal out-of-home care placements and compliance with ACP, by type, 2001–2007 (Victoria).⁵⁷

Percentage placed	30.06. 2001	30.06. 2002	30.06. 2003	30.06. 2004	30.06. 2005	30.06. 2006	30.06. 2007	ACPP Compliance
Aboriginal relative	20	18	24	20	27	27	22	Yes
Non-Aboriginal relative	11	13	15	16	14	15	18	Yes
Other Aboriginal	25	20	17	23	16	17	18	Yes
Aboriginal residential care	0	4	3	2	2	3	3	Yes
Other non-Aboriginal	34	36	35	31	36	33	35	No
Non-Aboriginal residential care	10	9	6	7	5	5	3	No
Non-compliance	44%	45%	40%	38%	41%	37%	38%	
ACPP compliance	56%	55%	60%	62%	59%	63%	62%	

Indicator 9: Aboriginal youth in the Youth Justice system

The aim of the youth justice system is to ensure care, custody and supervision for young offenders through the provision of programs which will assist them to develop the knowledge, skills and attitudes to manage their lives effectively without further offending and to provide mechanisms, resources and direction to achieve this. This is provided through a comprehensive and evidence-based Case Practice Framework.

The age jurisdiction for the youth system is from 10–17 years inclusive. The inclusion of 17 year olds came into effect on 1 July 2005.

The youth justice system in Victoria takes a strong diversionary approach to managing children and young people who enter the criminal justice system. This is reflected in the legislation and in the manner in which young people are dealt with from the initial point of contact with the police through to completion of any order imposed by the court.

As part of the diversionary approach, Victoria has a unique sentencing option known as the “dual track” system that provides for the adult court to sentence a young person aged 18 to 20 years to a youth justice administered Youth Training Centre (YTC) custodial order as a direct alternative to a sentence of imprisonment.

Although the number of Aboriginal youths in the youth justice system is not very high, the rate of involvement for Aboriginal youth is much higher than for non-Aboriginal youth and varies greatly between regions.

The indicator provides a snapshot of the number of Aboriginal youth justice clients on custodial and non-custodial orders at June 2002, June 2003, June 2004, June 2005, June 2006 and June 2007. The number and rate of Aboriginal clients in the youth justice system is a measure of a high level of disadvantage in the community.

Aboriginal youth are involved with the youth justice system at 11 times the rate of non-Aboriginal males and 17 times the rate of non-Aboriginal females.

Strategies

Koori Youth Justice Program

The Koori Youth Justice Program was established in 1992 and has expanded over the years to all DHS regions. The program currently has 16 community Aboriginal workers based mainly in Aboriginal organisations and has three Koori Youth Justice workers (one in each of the three youth justice custodial centres). A central Aboriginal program adviser in the Youth Services & Youth Justice Branch (YS&YJB) within the Children, Youth and Families Division in DHS, is also employed under the Koori Youth Justice Program.

⁵⁷ Compliance with ACP is measured at a point of time, i.e. 30 June each year, not across a financial year.

The role of Koori Youth Justice workers is both preventative and responsive. Clients include young people who are the subject of orders from the criminal division of the Children's Court; young adults in the dual track system; and, as case loads permit, Aboriginal youth who are at risk of offending and those who have committed minor offences and received Police diversions or cautions.

Koori Youth Justice workers develop Aboriginal Cultural Support Plans for clients, provide practical support to clients and their families and support other youth justice workers in assessing, planning and setting goals for Aboriginal clients. Many of the workers also develop preventative programs such as organising sporting and recreational programs and taking an active role in coaching and transporting youth to these events. Workers have also arranged cultural camps for the youths to enable them to engage with Elders, and have taken Aboriginal youth on the police High Challenge camps.

Aboriginal Cultural Support Plans

The purpose of the Aboriginal Cultural Support Plan (ACSP) is to ensure that young Aboriginal people in the youth justice system have access to Aboriginal workers and other cultural supports.

Young Aboriginal people should be given every opportunity to feel proud of their culture and know where they belong. The ACSP will be an integral part of the client assessment and planning, and provide an important cultural connection component of the assessment process. It is the role of the community Aboriginal worker to develop the ACSP in consultation with the case manager. The case managers should ensure that they seek cultural input from the Aboriginal workers to assist in diverting young Aboriginal people from the youth justice system

Children's Koori Court

The Children's Koori Court commenced operating in October 2005 at the Melbourne Children's Court. The Children's Koori Court was created in response to the successful review of the adult Koori Courts in Broadmeadows and Shepparton with the objective of ensuring greater participation of the Aboriginal community in the diversion of Aboriginal people from the youth justice and criminal justice system.

Budget initiatives 2006/07

Koori Intensive Bail Support Program

The Koori Intensive Bail Support Program is for young people from the adult system and the Children's Court (on deferral of sentence status) who are at high risk of breaching bail and/or re-offending and are deemed likely to be remanded in custody. There are three positions employed by youth justice offices in the North and West Metropolitan, Hume and Gippsland regions.

Youth Justice staff have responsibility for supervising and case managing the young people. Case management activities include assessing the range of youth and family needs and accessing appropriate services, as well as providing case and court reports and advice to the Courts. The Program provides intensive support for up to 6–8 young people at any one time.

Koori Early School Leavers and Youth Employment Program

The Koori Early School Leavers and Youth Employment Program is an Aboriginal Justice Agreement (AJA2)⁵⁸ funded initiative designed to divert young Aboriginal people from the youth justice system by focusing on the key risk factors, particularly lack of engagement with school or other learning opportunities. The program also aims to divert young Aboriginal people from the youth justice system, once they have entered it, by supporting the young person to re-engage with a learning institution,

⁵⁸ The Aboriginal Justice Agreement Phase 2 was established in June 2006. It is a recommitment to the work undertaken pursuant to the Victorian Aboriginal Justice Agreement: Phase 1 (2000–2004). The AJA involves collaboration and partnership between the Victorian Government and Aboriginal community representatives regarding justice outcomes. The aim of the AJA has 2 components: to minimise Aboriginal over-representation in the criminal justice system by improving accessibility, utilisation and efficacy of justice-related programs and services in partnership with the Aboriginal community; and to have an Aboriginal community that has the same access to human, civil and legal rights, living free from racism and discrimination and experiencing the same justice outcomes through the elimination of inequalities in the justice system.

be that school, training, vocation or alternative education environment. DHS is currently funded by AJA2 to establish two Aboriginal-specific programs, one in North and West Metropolitan region and one in the Loddon Mallee region (Mildura), for Aboriginal youth aged 10 to 20 years. Aboriginal organisations will operate these programs and will receive referrals from youth justice units as well as from families, schools and other community organisations.

The Koori Pre and Post Release Program

The Koori Pre and Post Release Program is made up of three components: the Koori Statewide Coordinator, the Koori Intensive Post Release program and the delivery of cultural programs in the three youth justice custodial centres.

Koori Statewide Coordinator

The purpose of this position is to provide coordination across the Youth Justice Program by ensuring effective services are available to young Aboriginal people in custody as part of pre release planning, in reports to the Youth Parole Board, during Youth Parole Board hearings and in post release. This position will be physically located in the North and West Metropolitan region but will have a statewide focus.

Koori intensive support practitioner (post release)

The Koori Intensive Support Practitioner (Post Release) is a specialist role and will provide intensive and innovative culturally based case-management support to Aboriginal young people being released from Youth Justice custodial centres. The practitioner will provide direct outreach casework, information and reports to the Youth Parole Board and will be part of a team approach responsible for time limited intensive supervision and case-management of a small caseload of Aboriginal youth. Case-management support to Aboriginal youth will focus on developing family support, community development and linkages to specialist services that target support to Aboriginal communities. The practitioners will work closely with the Koori Statewide Coordinator.

There are three Koori intensive support practitioners based in the North and West Metropolitan, Hume (Shepparton) and Gippsland (LaTrobe) regions.

Cultural Programs

Aboriginal cultural programs are regularly offered in the three Youth Justice Custodial Centres. The programs are tailored to meet the requirements of the demographics of each centre. Program themes include educational, cultural identity and wellbeing components and are facilitated by Aboriginal people for Aboriginal custodial clients and other clients who wish to enhance their understanding of Aboriginal culture.

Yannabil Program

'Yannabil' is the Woiwurrung language word for visitor. Yannabil is a visitors' program for young Aboriginal people in Victoria's three youth justice custodial centres.

The purpose of the Yannabil program is to provide an additional level of cultural and personal support to young Aboriginal people detained in youth justice custodial centres. The program will help ensure the wellbeing and safety of young Aboriginal people in custody by providing support to the youth justice system through the provision of feedback to management in each youth justice custodial centre.

Figure 18: Rates of youths on youth justice orders by type, June 2002–June 2007.

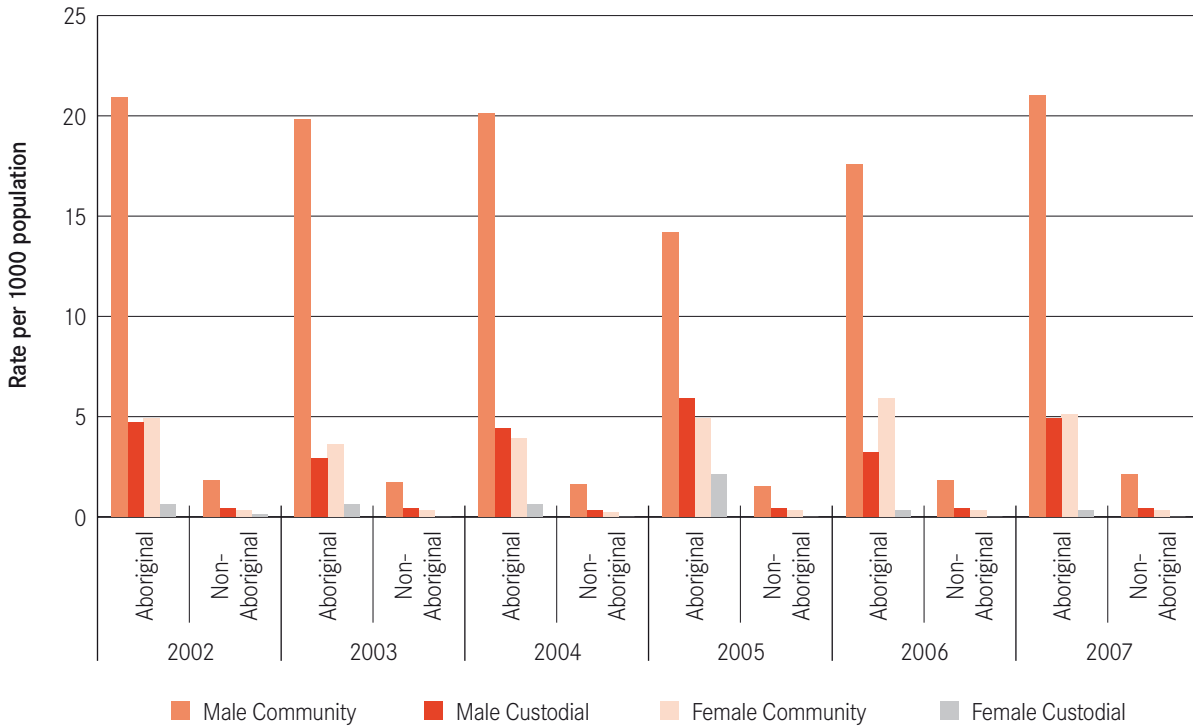


Table 19: Rates of youths on youth justice orders by type, June 2002–June 2007⁵⁹

Rate per 1000	Male		Female	
	Community	Custodial	Community	Custodial
June 2002				
Aboriginal	20.9	4.7	4.9	0.6
Non-Aboriginal	1.8	0.4	0.3	0.1
June 2003				
Aboriginal	19.6	2.9	3.6	0.6
Non-Aboriginal	1.7	1.4	0.3	0.0
June 2004				
Aboriginal	20.1	4.4	3.9	0.6
Non-Aboriginal	1.6	0.3	0.2	0.0
June 2005				
Aboriginal	14.2	5.9	4.9	2.1
Non-Aboriginal	1.5	0.4	0.3	0.0
June 2006				
Aboriginal	17.6	3.2	5.9	0.3
Non-Aboriginal	1.8	0.4	0.3	0.0
June 2007				
Aboriginal	21.0	4.9	5.1	0.3
Non-Aboriginal	2.1	0.4	0.3	0.0

⁵⁹ Victorian juvenile justice report, as at 30 June 2002, 2003, 2004, 2005, 2006, 2007. Data include children and youths aged 10–20 years inclusive, and are presented as rate per 1000 population. Data are not compatible with earlier reports, owing to the introduction of a new information system. Data now include persons on remand. Previously published data from June 2006 have been revised.

Strategic action area 4: Substance use and misuse

Substance use and misuse has the potential to impact on all of the headline indicators included in this report. Reducing substance misuse can significantly reduce the level of assaults and homicides and the level of disability, while improving the overall health and wellbeing of a population. A reduction of substance use might also increase educational attainment, household and individual income levels, and reduce crime and imprisonment rates.⁶⁰

Indicator 10: Use of Alcohol and Drug services

Cigarette smoking, excessive alcohol consumption and illicit drug use are associated with increased morbidity and mortality. High levels of alcohol consumption can lead to dependence syndrome and alcohol cirrhosis. The use of alcohol by pregnant women can adversely affect the health of their unborn baby. Excessive alcohol consumption at the family and community level contributes to interpersonal/domestic violence, financial problems, child abuse and neglect, and family breakdown.

There has been a strong causal relationship between tobacco consumption and multiple chronic diseases, including coronary heart disease, stroke, chronic respiratory tract diseases and pregnancy-linked conditions such as low birth weight. Passive smoking has been linked with higher rates of respiratory illness, sudden infant death syndrome (SIDS), asthma in children, lung cancer and heart disease in adults.⁶¹

In 2002, just over half of the Aboriginal population aged 15 years and over were cigarette smokers. In each age group a slightly higher percentage of men than women were smokers.⁶² The National Drug Household Survey of 2001 showed that the prevalence of smoking among Aboriginal people was twice that of non-Aboriginal people.⁶³

In 2002, 15 per cent of Aboriginal people aged 15 years and over reported risky/high-risk alcohol consumption in the last 12 months, a similar proportion to non-Aboriginal adults. The rate was higher for males than for females.⁶⁴ The National Health Survey of 2001 found that over 29 per cent of adult drinkers who are Aboriginal were in the risky or high-risk category for alcohol consumption, compared with 17 per cent of non-Aboriginal drinkers.⁶⁵

Aboriginal people more often receive treatment for alcohol and drug related conditions than non-Aboriginal people.

In 2002, just over half of the Aboriginal population aged 15 years or over were cigarette smokers.

The *National Health Survey of 2001* found that over 29 per cent of Aboriginal adult drinkers were in the risky or high-risk category for alcohol consumption, compared with 17 per cent of non-Aboriginal drinkers.

Services

Mainstream alcohol and drug treatment services provide community-based assessment, community and residential treatment and community rehabilitation programs. Agency-based services include: counselling; consultancy and continuing care service (CCCC); outreach; day programs; alcohol and drug supported accommodation; antenatal and post natal support; peer support; residential rehabilitation; post withdrawal linkages; residential, outpatient, rural and home based withdrawal; mobile overdose response; specialist pharmacotherapy and education. There are support services for families as well as youth-specific services.

Aboriginal-specific alcohol and drug treatment services are provided to Aboriginal people who are affected (either directly or indirectly) or who are at risk of being affected by alcohol and/or other drugs.

⁶⁰ OID 2007, p. 8.1.

⁶¹ OID 2007, pp. 8.2-8.3

⁶² ABS 2004, *National Aboriginal and Torres Strait Islander Social Survey 2002*, ABS cat. no. 4714.0, p.8. 54% of the Victorian sample were current smokers. <http://www.abs.gov.au/> See also ABS 2006, *National Aboriginal and Torres Strait Islander Health Survey, 2004/05*, ABS cat. no. 4715.0.

⁶³ AIHW 2004, *Australia's Health 2004*. Canberra, AIHW, cat. no. AUS 44, p.203. <http://aihw.gov.au/>

⁶⁴ ABS 2004, *National Aboriginal and Torres Strait Islander Social Survey 2002*, ABS cat. no. 4714.0, p.8.

⁶⁵ AIHW 2004, *Australia's Health 2004*, Canberra, AIHW, p.203.

Strategies

The **Koori Community Alcohol and Drug Resource Centres** were developed as a response to the *Royal Commission into Aboriginal Deaths in Custody*⁶⁶ as an alternative to incarceration in police cells for people who are affected by alcohol and other drugs in public. DHS funds 7 Koori Community Alcohol and Drug Resource Centres to provide assistance to intoxicated people as an alternative to incarceration.

DHS also funds 24 **Koori Community Alcohol and Drug Worker** positions located within Aboriginal Community Controlled Health organisations (ACCHOs) and mainstream organisations. The positions are funded to provide referral to treatment and to conduct prevention activities such as: provide information and education to the Aboriginal community; provide advice to Aboriginal health organisations on alcohol and other drugs; counsel, support and advocate on behalf of Aboriginal people affected by alcohol and other drugs; and liaise with generalist health and welfare agencies to ensure a continuum of care for Aboriginal people affected by alcohol and other drugs.

Other Aboriginal Alcohol and Drug initiatives include **Koori Alcohol and Drug workforce development**, and projects under the National Illicit Drug Strategy (NIDS) Diversion Initiative. Custodial Alcohol and Drug Nurses provide drug and alcohol treatment support services to prisoners in police cells and young people in secure welfare facilities. This is not an Aboriginal-specific program but many Aboriginal people benefit.

The **Koori Youth Alcohol and Drug Healing Service** is a residential rehabilitation service for Aboriginal youth aged 15 to 20 years, with alcohol and other drug problems. There is an interim 6-bed service operating pending the finalisation of a permanent 12 bed facility. The program contains Aboriginal cultural components, provides support, linkages and mentoring, and prepares young people for entry into the community.

The establishment of Koori Courts⁶⁷ in Victoria has allowed for the imposition of more culturally appropriate sentencing orders. Difficulties engaging Aboriginal offenders with drug diversion programs and with alcohol and drug treatment agencies have been an ongoing issue. Under the Commonwealth/State Illicit Drug Diversion Initiative (IDDI), Koori Alcohol and Drug Diversion Workers provide linkages and support to the Aboriginal community and are based in drug treatment agencies located near the Koori Courts. They have a unique role in linking Aboriginal offenders with drug treatment services, both Aboriginal-specific and mainstream.

The Koori Alcohol and Drug Network facilitates regular meetings of DHS and Commonwealth funded Koori Alcohol and Drug Workers for professional development activities.

Aboriginal Alcohol and Drug projects

A kit for Aboriginal health workers to support pregnant women has been prepared. The kit **Healthy pregnancies, Healthy babies** adopts an holistic approach to the development of healthy babies, including alcohol and drug use during pregnancy, with the message "less is better, none is best". A staff training program is also provided in 5 locations across Victoria.

Indigenous Drug Prevention Research Action Plan

The Premier's Drug Prevention Council (PDPC) commissioned research relevant to the prevention of alcohol and drug related harm. The resulting report, *Aboriginal drug prevention research – stock-take and gap analysis*, identifies a significant gap in available evidence and in addition provides a framework and principles for the development of future research priorities.

⁶⁶ Royal Commission into Aboriginal Deaths in Custody, 1991, *Royal Commission into Aboriginal Deaths in Custody National Report: Volumes 1-5*, Australian Government Publishing Service: Canberra.

See also Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody, 2005, *Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody: review report*, Victorian Government Printer, Melbourne.

⁶⁷ See Indicator 9 Youth Justice

La Trobe University, working with Onemda (University of Melbourne) and VACCHO, was commissioned by the PDPC to develop an Indigenous Drug prevention Research Action Plan. This involves a review of drug prevention research published over the last 5 years which is relevant to the Victorian Aboriginal community. The resulting report forms the first part of a three phase process.

The second phase involves a series of community consultations in metropolitan, rural and regional Victoria. The results of phase one and phase two will then be analysed, and future trends and issues pivotal to Aboriginal drug prevention research will be identified through a priority setting process.

Strategies for 2007/08

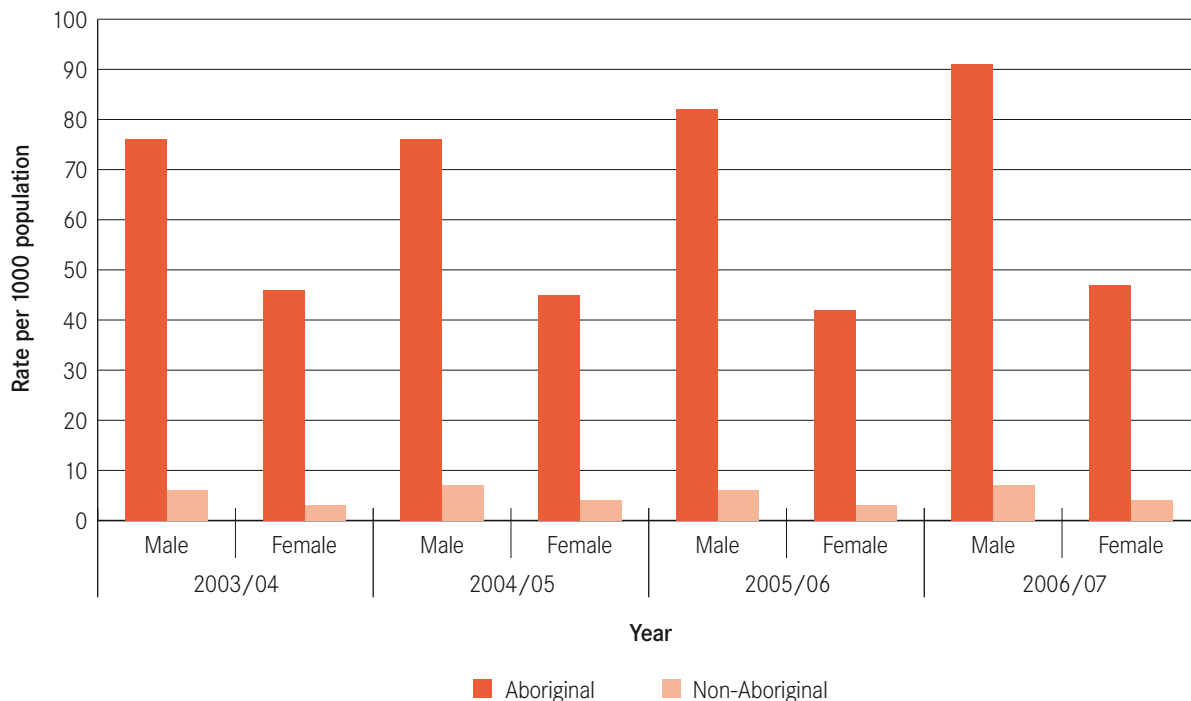
The government has established a ministerial taskforce on alcohol and public safety which will oversee the finalisation of the Victorian Alcohol Action Plan (VAAP). The Plan will include consideration of issues which will affect the Aboriginal community.

Following completion of the VAAP, the Victorian government will consult further with the Aboriginal community on long-term strategies to reduce the effects of alcohol.

Indicator 10 i: Alcohol and drug community-based service usage

Aboriginal people use community-based alcohol and drug services at 14 times the rate per population of non-Aboriginal people. Both Aboriginal and non-Aboriginal clients use approximately 1.8 courses of treatment per person per year.⁶⁸

Figure 19: Rate of Alcohol and Drug community-based clients, 2003/04–2006/07.



In 2006/07, approximately 2,100 Aboriginal clients were reported as receiving almost 4,000 alcohol and drug courses of treatment. This figure is likely to be significantly under reported due to inconsistent data collection. In all, 7% of all clients receiving government funded alcohol and drug treatment in Victoria were identified as Aboriginal. However, a significant proportion of clients (9%) are reported as unknown against Aboriginal status.

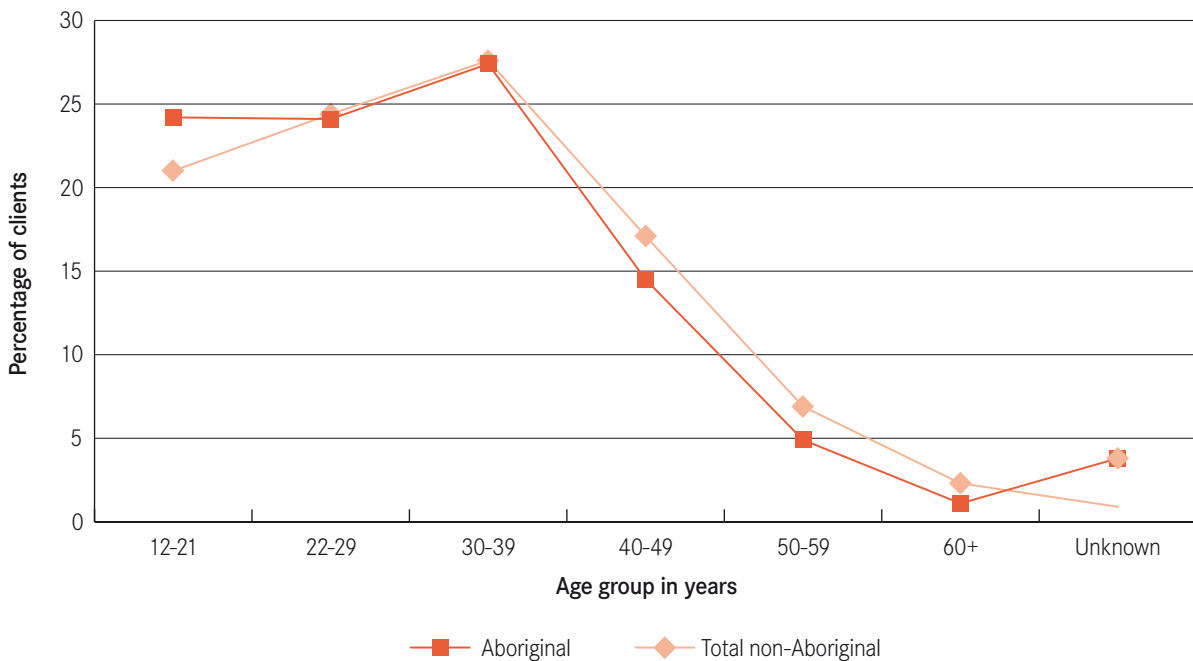
⁶⁸ Clients include both users and non-users. Some Agencies provide services like “Family counselling”, “Parent Support program”. There are also education/training type services, which service non-users. The majority of clients are receiving treatment for ‘own drug use’, but services are provided to support non-users affected by drug use.

Table 20: Rate of Alcohol and Drug community-based clients and course of treatment, 2003/04–2006/07.⁶⁹

Rate per 1000	2003/04		2004/05		2005/06		2006/07	
Clients	Male	Female	Male	Female	Male	Female	Male	Female
Aboriginal	76	46	76	45	82	42	91	47
Non-Aboriginal	6	3	7	4	6	3	7	4
Courses of treatment								
Aboriginal			137	81	148	89	171	92
Non-Aboriginal			12	7	12	7	12	7

The majority of both Aboriginal and non-Aboriginal clients are aged in the 12–21, 22–29 and 30–39 years age groups. Aboriginal clients are slightly younger than non-Aboriginal clients. However, when the age distribution of clients is considered as a rate per 1000 population, older clients (aged 40–49) have the same rate per 1000 population as the youngest age group (12–21 years). In all age groups the Aboriginal rate is much higher than the non-Aboriginal rate.

Figure 20: Percentage of clients of community-based Alcohol and Drug services by age group, 2006/07.



⁶⁹ 2006/07 Alcohol and Drug Information System (ADIS) data. Non-Aboriginal includes both “non-Aboriginal” and “not stated”.

Figure 21: Clients of community-based Alcohol and Drug services as rate per 1000 population, 2006/07.

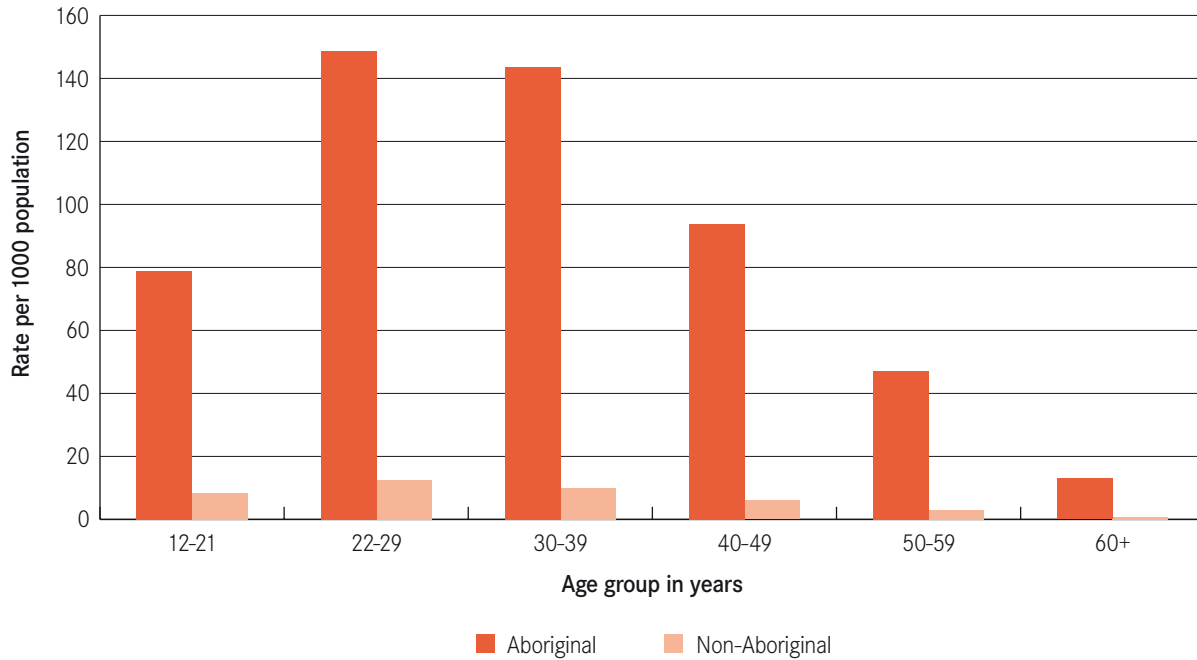


Table 21: Clients of community-based Alcohol and Drug Services by age, 2006/07.

Age in years	Number of clients		Percentage		Rate per 1000		
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal	Rate ratio
12-21	513	5,548	24.2%	21.0%	78.8	8.4	9.4
22-29	510	6,441	24.1%	24.4%	148.7	12.4	12.0
30-39	580	7,283	27.4%	27.6%	143.7	10.0	14.4
40-49	307	4,325	14.5%	17.1%	93.8	6.0	15.6
50-59	103	1,837	4.9%	6.9%	47.1	3.0	15.7
60+	24	646	1.1%	2.3%	13.0	0.7	18.6
Unknown age	80	337	3.8%	0.9%			
Total	2,117	26,417	100.0%	100.0%	99.5	6.8	14.6

Agency types

Aboriginal clients use both Aboriginal-specific and non-Aboriginal agencies. As not all Aboriginal agencies report activity, use of Aboriginal agencies is likely to be higher than the 33% recorded. A small number of non-Aboriginal clients also use Aboriginal-specific services.

Figure 22: Use of Alcohol and Drug agency types by Aboriginal people, 2006/07.

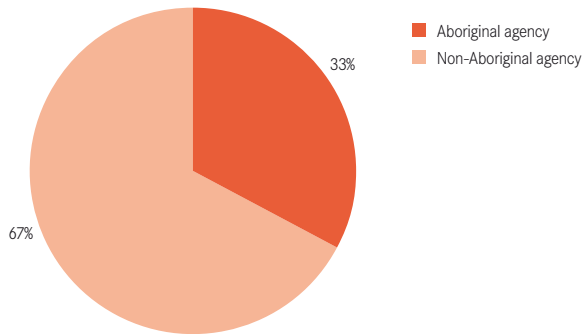


Table 22: Use of agency types, 2006/07.

Clients	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Aboriginal agency	714	32.9%	24	0.1%	738	2.6%
Non-Aboriginal agency	1,458	67.1%	26,057	99.9%	27,515	97.4%
Total	2,172	100.0%	26,081	100.0%	28,253	100.0%

Service types

Courses of Alcohol and Drug treatment are grouped into:

- counselling, consultancy and continuing care (CCCC)
- community, including Koori Community Alcohol and Drug Services
- residential

Aboriginal clients are most likely to use community-based services, including Aboriginal-specific services. Aboriginal clients are less likely than non-Aboriginal clients to use CCCC or residential services.

Figure 23: Use of Alcohol and Drug treatment service types, 2006/07.

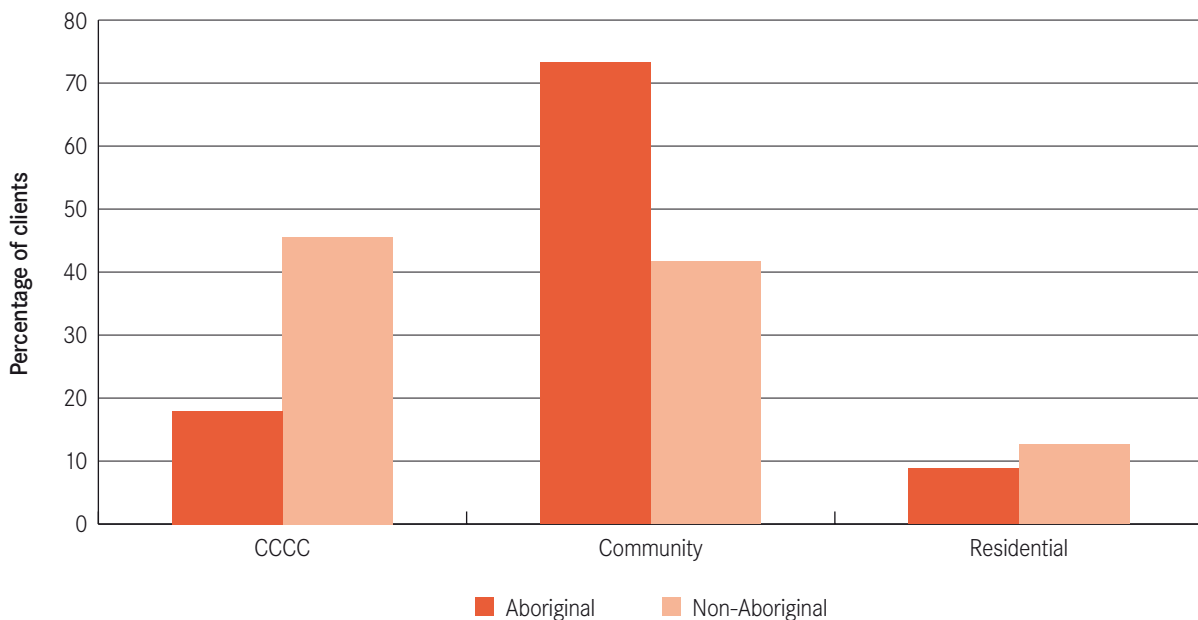


Table 23: Use of Alcohol and drug treatment service types, 2006/07.

Clients	CCCC		Community		Residential	
	Number	%	Number	%	Number	%
Aboriginal	710	18.0%	2,897	73.3%	347	8.8%
Non-Aboriginal	21,364	45.6%	19,563	41.8%	5,945	12.7%
Total	22,074	43.4%	22,460	44.2%	6,292	12.4%

Indicator 10 ii: Alcohol and drug related hospital admissions 2004/05–2006/07

Persons are admitted to hospital for physical reactions or illnesses due to alcohol and drug use. These include drug overdoses, alcohol dependence and cirrhosis. People admitted for alcohol-related conditions are usually older than people admitted for drug related conditions. The age groups with the highest rates of admission for alcohol-related conditions are 25–44 and 45–64 years, while the highest rates of admission for drug-related conditions are among people 15–24 and 25–44 years.

Aboriginal people are admitted to hospital for alcohol and drug related conditions more frequently than non-Aboriginal people. The rate of male admissions is approximately twice that of female admissions, for both Aboriginal and non-Aboriginal people. Persons admitted for alcohol-related conditions are older than those admitted for drug-related conditions.

Alcohol

The rate of alcohol-related hospital admissions of Aboriginal men is higher than the rate for non-Aboriginal men of all ages. While the rate of admissions has increased in all age groups over the past 3 years, the increase has been greater among those aged 45–64 years. This age group now has the highest rate of male cases, though not the highest rate of admissions. The female rate of admissions is lower than the male rate for all age groups, however Aboriginal women have higher rates of admissions than non-Aboriginal women. Women aged 45–64 years have retained the highest rate of admissions. Persons aged 25–44 years and 45–64 years have higher numbers of admissions per person than older or younger persons.

Figure 24: Rate of male alcohol-related hospital admissions, 2004/05–2006/07.

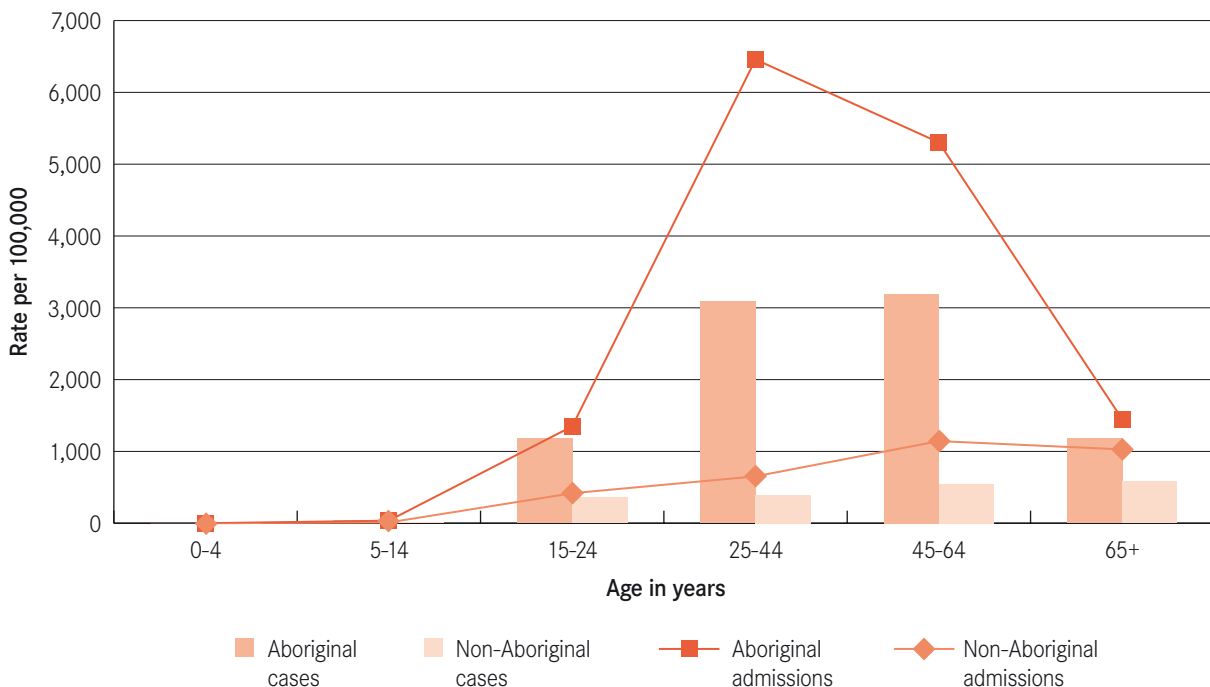


Table 24: Rate of male alcohol-related hospital admissions, 2004/05–2006/07.⁷⁰

Males	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
Age in years				
00–04	0	0	0	0
05–14	36	10	36	11
15–24	1,179	357	1,349	418
25–44	3,088	396	6,458	653
45–64	3,193	546	5,303	1,144
65+	1,178	582	1,449	1,028

Figure 25: Rate of female alcohol-related hospital admissions, 2004/05–2006/07.

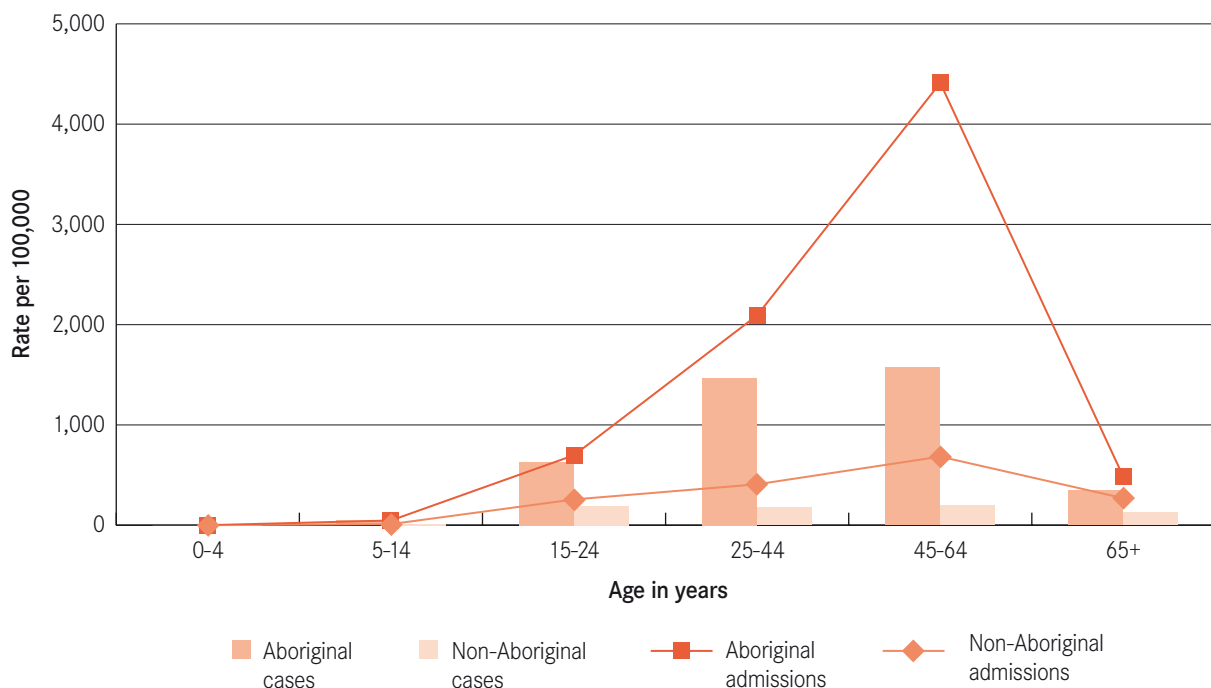


Table 25: Rate of female alcohol-related hospital admissions, 2004/05–2006/07.

Female	Cases, rate per 100,000		Admissions, rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
Age in years				
00–04	0	0	0	0
05–14	47	11	47	11
15–24	631	193	698	257
25–44	1,468	179	2,093	408
45–64	1,573	199	4,411	684
65+	344	129	482	269

⁷⁰ Hospital admission data are taken from the Victorian Admitted Episodes Dataset (VAED). Cases refers to individuals admitted to hospital between 2004/05–2006/07. Admissions refers to occasions of service. An individual can have multiple admissions

Drugs

The rate of drug-related hospital admissions for Aboriginal men is higher than the non-Aboriginal rate and peaks for males 25–44 years. This is also the peak age group for non-Aboriginal males, whereas previously the highest admission rates for non-Aboriginal males were among those aged 15–24 years.

The rate of drug-related hospital admissions for Aboriginal women is very similar to the admission rate of Aboriginal men across all age groups. The rate of admissions of Aboriginal women is higher than the rate of female non-Aboriginal admissions.

Figure 26: Rate of male drug-related hospital admissions, 2004/05–2006/07.

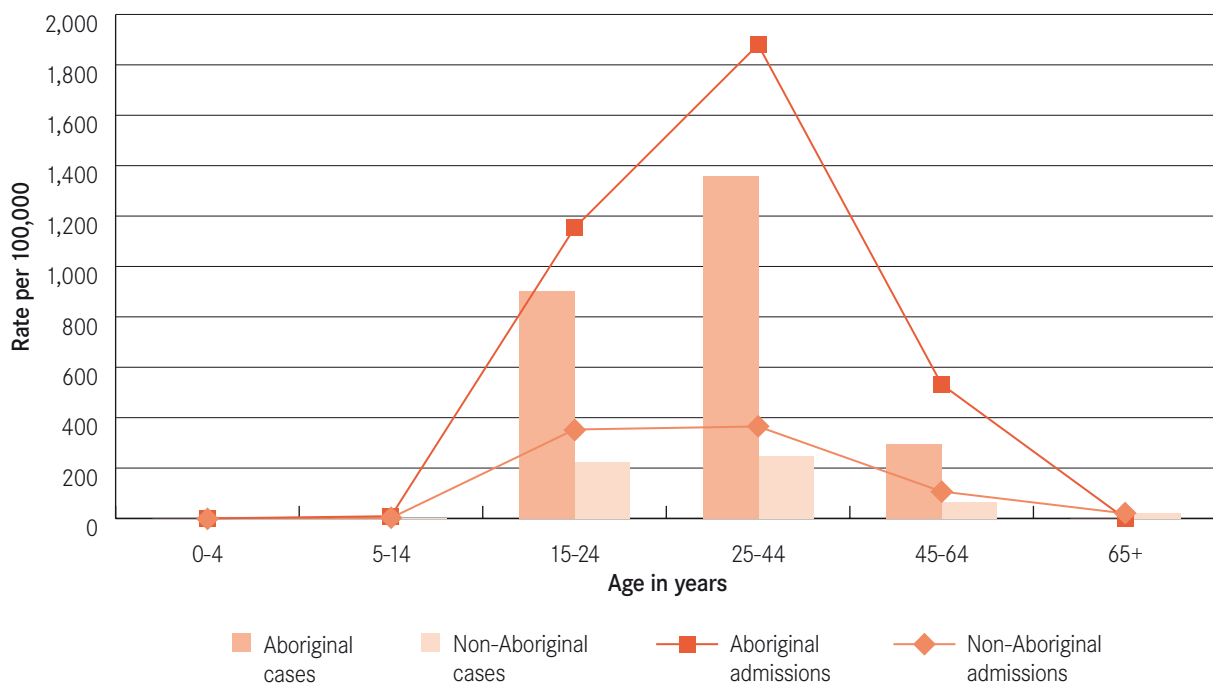


Table 26: Rate of male drug-related hospital admissions, 2004/05–2006/07.

Male Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
00–04	0	2	0	2
05–14	9	2	9	2
15–24	904	224	1,153	353
25–44	1,359	249	1,880	365
45–64	296	64	532	107
65+	0	20	0	20

Figure 27: Rate of female drug-related hospital admissions, 2004/05–2006/07.

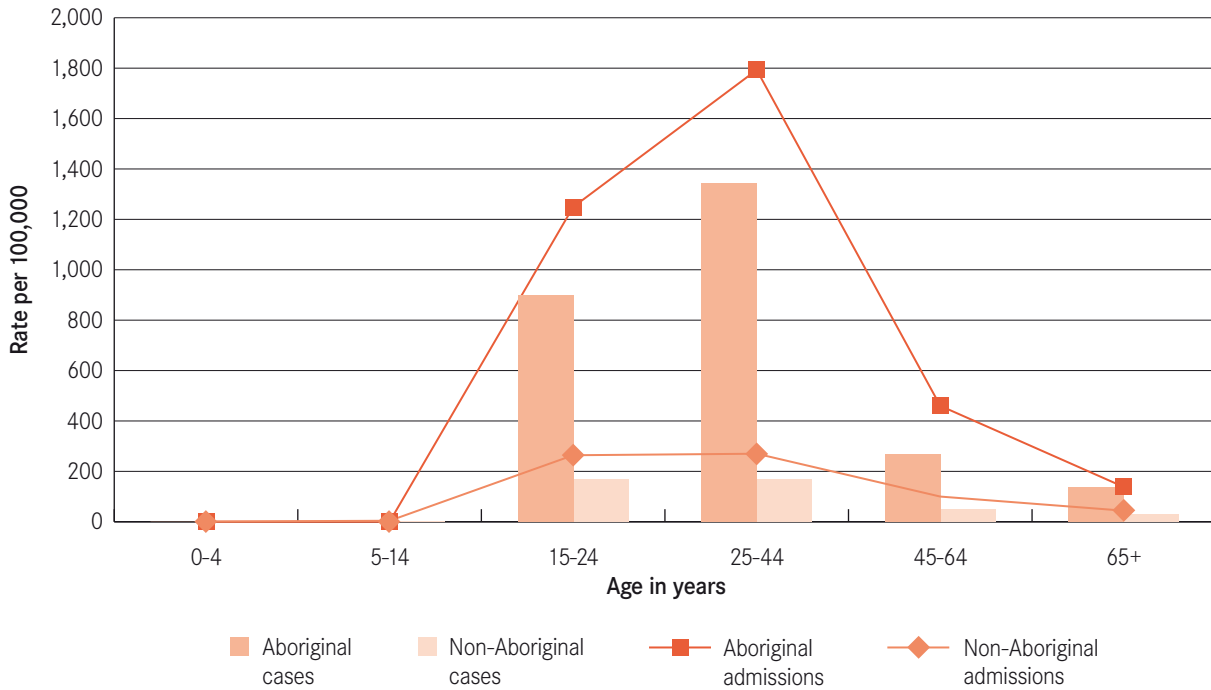


Table 27: Rate of female drug-related hospital admissions, 2004/05–2006/07.

Female Age group years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
00-04	0	1	0	2
05-14	0	3	0	4
15-24	900	168	1,249	264
25-44	1,343	168	1,793	270
45-64	269	51	460	100
65+	138	28	138	44

Strategic action area 5: Functional and resilient families and communities

Functional and resilient families and communities are generally seen as being fundamental to the physical and mental health of adults and children. Characteristics of such families and communities may include: a caring, protective and supportive environment; positive health outcomes and cultural awareness.⁷¹

Indicators in this strategic action area include:

- disability services
- aged care
- life expectancy
- housing and
- health.

Indicator 11: Disability Services

Disability is defined as an impairment, activity limitation or participation restriction, which has lasted, or will last for 6 months or more, and restricts everyday activities. Approximately 20% of the Australian population have some level of disability⁷².

There are many different types of disability. Disabilities can be caused by a genetic condition, an illness or an accident, and include⁷³:

- intellectual disability
- physical disability
- sensory disability
- acquired brain injury
- neurological impairment
- dual disability (one of the above and a psychiatric disability)
- disabilities that are unrelated to ageing.

The Aboriginal population has a higher rate of disability than the non-Aboriginal population, in part due to a higher rate of disabling health conditions, including diabetes, respiratory and circulatory diseases^{74,75}. Standardised rates of disability or long term health conditions for the non-remote Aboriginal population are 1.4 times higher than those for the non-Aboriginal population. Higher rates of illness and disability in the Aboriginal population are reflected in higher rates of disability service utilisation.

Aboriginal people have higher rates of disability than the non-Aboriginal population and are more likely to use disability services.

Disability Services Division provides a range of disability services including individual support, community participation and inclusion, congregate care, primary support, shared supported accommodation and specialist services. Clients may be in receipt of more than one service and may receive services in more than one region.

⁷¹ OID 2007, p.9.1

⁷² Australian Institute of Health and Welfare 2007, *Australia's Welfare 2007*, cat.no. AUS 93, AIHW, Canberra, p.155.

⁷³ <http://www.disability.vic.gov.au/dsonline>

⁷⁴ ABS. AIHW 2006, *The health and welfare of Australia's Aboriginal and Torres Strait Islander people 2005s*, Cat no 4704.0, ABS, Canberra. p55.

⁷⁵ ABS 2002, *National Aboriginal and Torres Strait Islander Social Survey 2002*, Cat. no. 4714.0, ABS, Canberra, 2004, table 10. In this survey 30.4% of Aboriginal people aged 15–49 years reported some level of disability, and 64.8% of Aboriginal people aged 50 years or over reported some level of disability.

Individual Support

Individually tailored packages of support enabling people living with a disability, and families and carers of people living with a disability, to access support based on choice.

Community Participation and Inclusion

Services aimed at addressing individual needs and promoting community building to further independence, community participation and inclusion. Provision of support to facilitate transition from the school system to the community is also included in this output.

Congregate Care

Congregate Care provides a high quality, responsive and specialised residential support service for people with an intellectual disability that promotes individual choice, community inclusion, the development of skills and opportunities that reflect the person's aspirations and needs and that addresses the requirements of people with intensive and specialised support requirements.

Primary Support

A range of programs and services aimed at maintaining and increasing the functional independence of people and supporting primary care giving relationships by providing supports for families and carers. This includes support with intervention services for people with highly complex and challenging behaviours.

Shared Supported Accommodation

Shared Supported Accommodation provides high quality support to people with a disability living in community-based accommodation that promotes individual choice, community inclusion and the development of skills and opportunities that reflect the person's needs and aspirations.

Behaviour Intervention Services

Behaviour Intervention Services includes a range of client-focused services that may be directly delivered by DHS or be provided by community service organisations or private practitioners. The types of services provided include assessment, implementation and review of specialist "therapeutic interventions", which relate to addressing the individual's challenging behaviours or the need for human relations training, counselling or support.

Strategies

Disability Services growth funding is allocated on the basis of individual requirements and Aboriginal people with disabilities, like other clients, are provided with supports based on their individual needs. Supports focus on enhancing social connections and achieving outcomes important to the individuals and their families.

Aboriginal people use disability services more frequently than non-Aboriginal people at all ages. The rate of use is higher for males than females.

Figure 28: Rate of disability service usage, 2006/07.

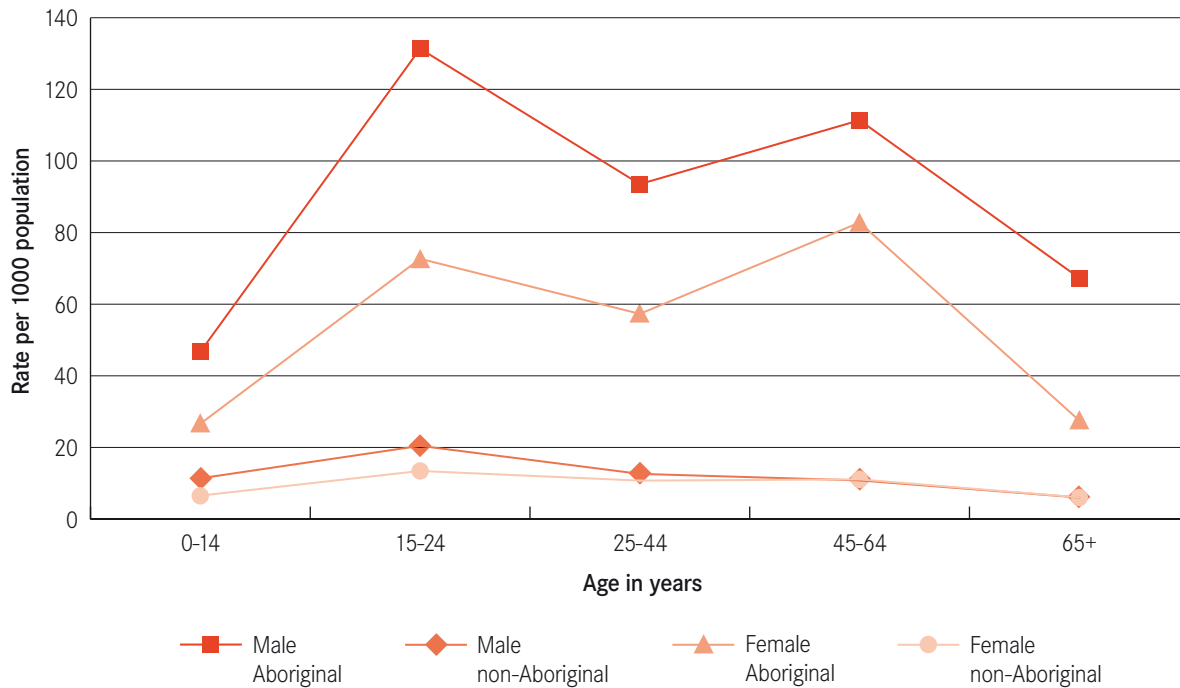


Table 28: Number of clients by age group and Aboriginality, 2006/07⁷⁶.

Number	Male		Female		Total
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal	
Age in years					
0-14	260	5,486	148	2,994	8,888
15-24	370	6,949	207	4,411	11,937
25-44	350	8,712	235	7,740	17,037
45-64	234	6,422	182	6,816	13,654
65+	35	1,796	19	2,273	4,123
Total	1,249	29,365	791	24,234	55,639

Table 29: Rate of use of disability services, 2006/07.

Rate per 1000 population 2006	Male		Female		Total
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal	
Age in years					
0-14	46.7	11.4	26.6	6.5	9.4
15-24	131.3	20.4	72.7	13.4	17.7
25-44	93.5	12.6	57.3	10.7	12.0
45-64	111.4	10.8	82.8	11.1	11.2
65+	67.3	6.0	27.5	6.1	6.1
Total	84.7	12.2	51.4	9.7	11.3

⁷⁶ This includes all persons in receiving Disability services in 2006/07. Each person is counted only once. The population is from ABS Census 2006. Person whose Aboriginal status was "Not stated" are included with those identified as non-Aboriginal. Many people identifying themselves as having a disability do not require or receive specific services.

Indicator 12: Supported Accommodation Assistance Program

The Supported Accommodation Assistance Program (SAAP) assists people who are homeless or at imminent risk of homelessness including, young people, single people, families and women and children escaping family violence.

A range of services are offered including supported accommodation, counselling, advocacy, links to health, education and employment services, outreach support and meal services.

Strategies

Indigenous SAAP Network

The department funds Aboriginal-specific responses within 13 auspice agencies across Victoria. There are 37 funded positions to assist Aboriginal families and individuals who are homeless.

These agencies meet quarterly to form the Indigenous SAAP Network. The Aboriginal organisation Ngwala Willumbong is funded by the department to employ one worker to coordinate the Aboriginal SAAP Network and deliver four sector forums each year. The worker actions the priorities identified by the Network, in conjunction with DHS, in order to identify problems and develop strategies to address homelessness within Indigenous communities, including:

- providing input to DHS to refine programs to more appropriately meet the housing and support needs of Aboriginal communities experiencing homelessness, housing crisis or overcrowding;
- representing the homelessness and housing needs of their communities;
- providing comment on policy and practice based on this knowledge; and
- developing reliable and consistent practice and service outcomes across Victoria.

Indigenous Young People Leaving Care Initiative

The Victorian Government's *Youth Homelessness Action Plan* funded a specific Indigenous Young People Leaving Care initiative to address the considerable social marginalisation often experienced by Indigenous young people. In 2006/07, the Victorian Aboriginal Child Care Agency (VACCA) was funded by the department to trial a new early intervention model specifically designed to assist Indigenous young people who are leaving care to establish themselves independently.

Figure 29: Aboriginal SAAP clients, 1999/00–2005/06.

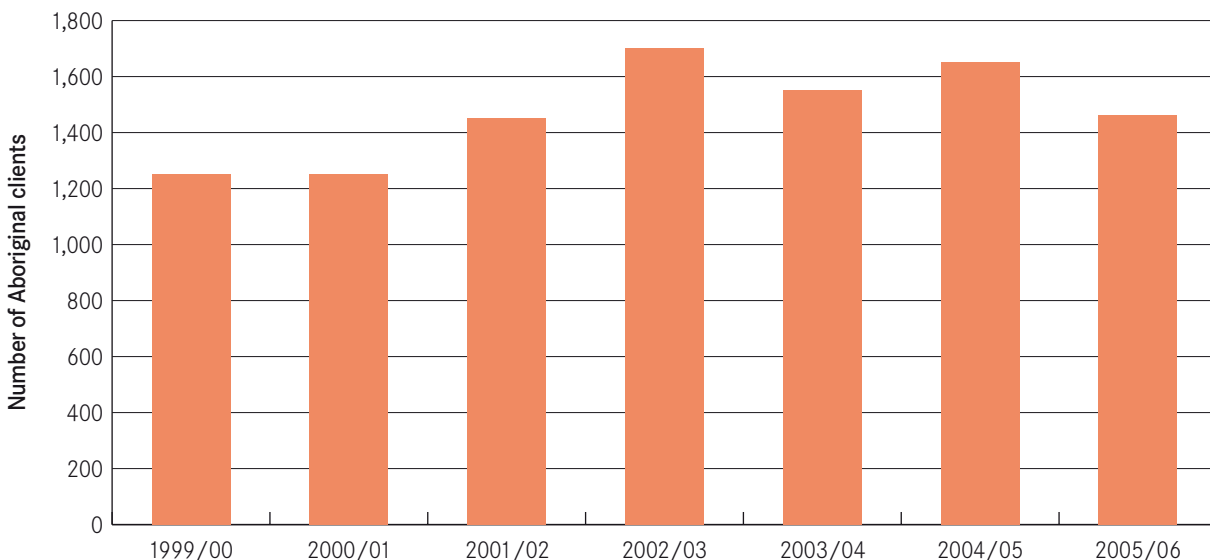


Table 30: Aboriginal SAAP clients, 1999/00–2005/06

Clients	Number of Aboriginal clients	Percentage of total SAAP clients
1999/00	1,250	4.6%
2000/01	1,250	4.9%
2001/02	1,450	5.1%
2002/03	1,700	5.8%
2003/04	1,550	4.5%
2004/05	1,650	4.6%
2005/06	1,461	4.7%

Note: As at February 2008, 2006/07 SAAP data was not available.

Indicator 13: Housing

Access to affordable and appropriate housing is fundamental to the health and wellbeing of individuals, families and communities. Further, the provision of affordable, safe, well-designed and appropriately maintained housing leads to positive outcomes in terms of health, employment and education.

For Aboriginal Victorians, access to mainstream services such as the private rental market and home ownership is often problematic. Consequently, Aboriginal Victorians require housing assistance at a greater rate than non-Aboriginal Victorians.

Aboriginal people in Victoria can access accommodation assistance through the mainstream public rental program, or the Aboriginal Rental Housing Program (ARHP) administered with the assistance of Aboriginal Housing Victoria (AHV). In addition, Aboriginal Victorians can access assistance with private rental accommodation through the Commonwealth Rent Assistance program, as well as tenancy establishment assistance through the State Government bond loan program and grants from the Housing Establishment Fund.

DHS aims to improve housing outcomes for Aboriginal Victorians by increasing the availability of public and Aboriginal-specific housing, strengthening the Aboriginal housing sector, and targeting housing programs and services to the needs of Aboriginal people.

In 2006/07, the number of Aboriginal tenants in mainstream public housing and Aboriginal housing increased, and the number of Aboriginal applicants on the public housing waiting list decreased.

Strategies

In 2006/07, Housing and Community Building acquired 51 properties for the ARHP in order to increase affordable housing opportunities for Aboriginal Victorians. These acquisitions bring the total number of ARHP properties to 1,334 at 30 June 2007. In addition, major property upgrade works were undertaken to over 60 ARHP properties, in order to improve the standard and amenity of the properties.

In order to improve Aboriginal access to mainstream housing and homelessness programs a number of initiatives were developed and implemented in 2006/07.

A statewide Indigenous Tenancies At Risk Program commenced in late 2006. This followed the evaluation of the Indigenous Tenancies at Risk pilot which was introduced in 2003 as part of the Victorian Homelessness Strategy to improve support for Aboriginal tenants at risk of eviction in public and community housing.

This program uses an intensive case management and support service model to assist Aboriginal people living in mainstream public or ARHP properties whose tenancies are at risk as a result of emerging issues such as financial difficulty, neighbourhood disputes, drug and alcohol and mental health issues. This program involves AHV, community housing and support organisations and Aboriginal housing providers.

In 2006/07, the department continued to provide training and support to Aboriginal community members and housing workers in Aboriginal Housing Organisations through the Certificate IV in social housing training. The Certificate IV provides a recognised and accredited training qualification for housing officers in Aboriginal organisations, improving competencies in tenancy and asset management and promoting more consistent practices across the State.

The department also continued to support AHV build its organisational capacity and to assist the organisation to successfully transition to the independent management of ARHP.

13 i: Public housing waiting lists

The number of Aboriginal applicants on the waiting list for public housing in Victoria increased from 1999 to 2005, and decreased in 2006 and 2007. This decrease is primarily due to a decline in new Aboriginal applications.

Figure 30: Aboriginal applicants on the public housing waiting list, 30 June 1999–2007.⁷⁷

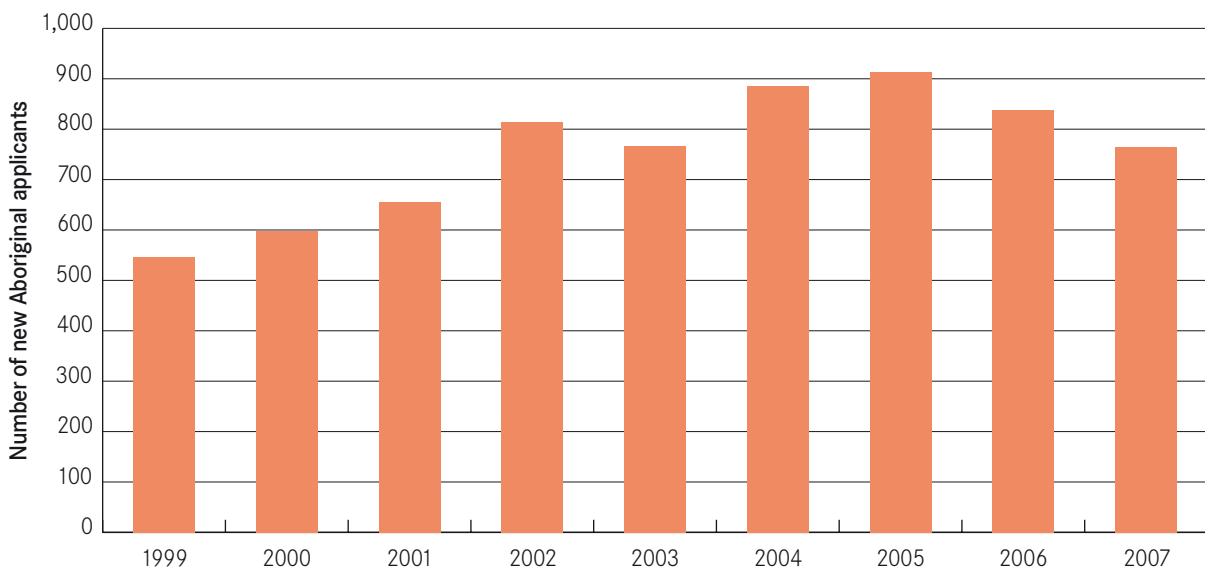


Table 31: Aboriginal applicants on the public housing waiting list, as at 30 June 1999–2007

	1999	2000	2001	2002	2003	2004	2005	2006	2007
New Aboriginal Applicants	546	598	656	815	766	886	913	838	764

13 ii: Public housing tenancies

The number of Aboriginal tenants housed in public housing in Victoria continues to increase each year in line with increases to mainstream public housing and AHV stock. The total number of Aboriginal public housing tenants in Rental General Stock (RGS) properties and AHV properties has increased by 986 since June 1999.

In 2006/07, 197 Aboriginal households were allocated to ARHP properties, and 358 Aboriginal households were allocated to Rental General Stock properties.

⁷⁷ All dates are as at 30 June of that year. All numbers housed and waiting refer to households not individuals.

Figure 31: Aboriginal tenants housed in public housing, 30 June 1999 – 30 June 2007.

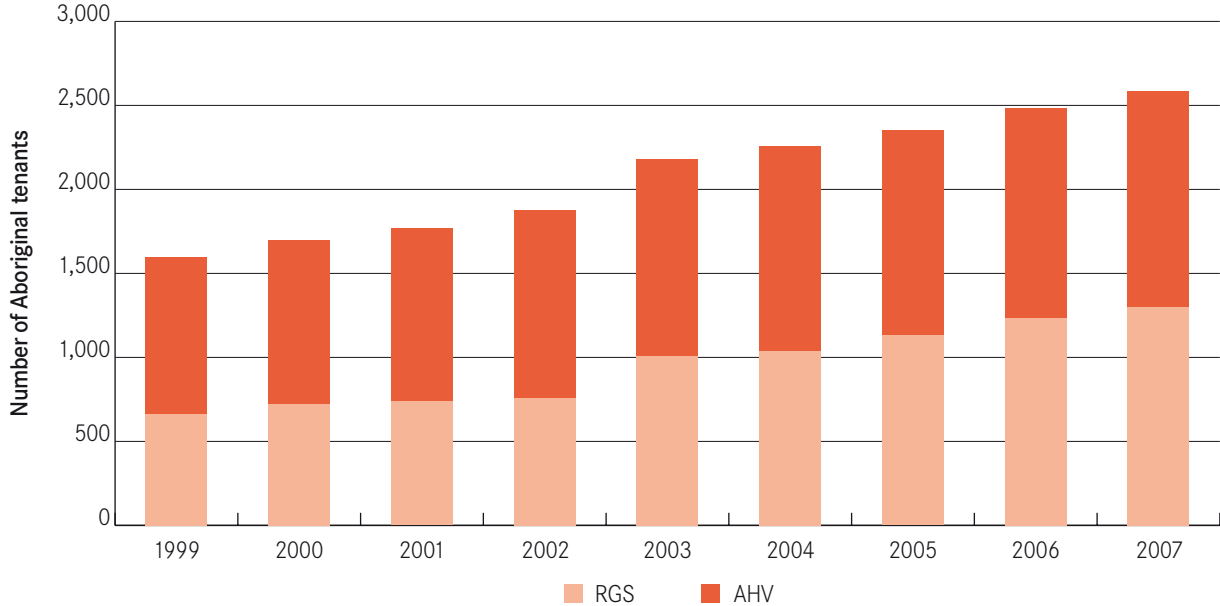


Table 32: Aboriginal tenants housed in public housing, 1999–2007.

Aboriginal tenants	1999	2000	2001	2002	2003	2004	2005	2006	2007
Housed in RGS properties	665	721	738	758	1,006	1,040	1,130	1,233	1,299
Housed in AHV properties	930	977	1,032	1,119	1,175	1,219	1,223	1,248	1,282
Total Aboriginal tenants	1,595	1,698	1,770	1,877	2,181	2,259	2,353	2,481	2,581
Total tenants	62,599	63,763	63,558	63,554	63,771	63,864	64,202	64,406	64,559

13 iii: Ratio of tenants to applicants waiting

The ratio of tenants housed to applicants on the waiting continued to increase in 2006/07. This ratio has been gradually increasing since 2004, and indicates that the demand by Aboriginal Victorians for public housing is being met successfully.

Figure 32: Tenants housed and tenants waiting, 1999–2007.

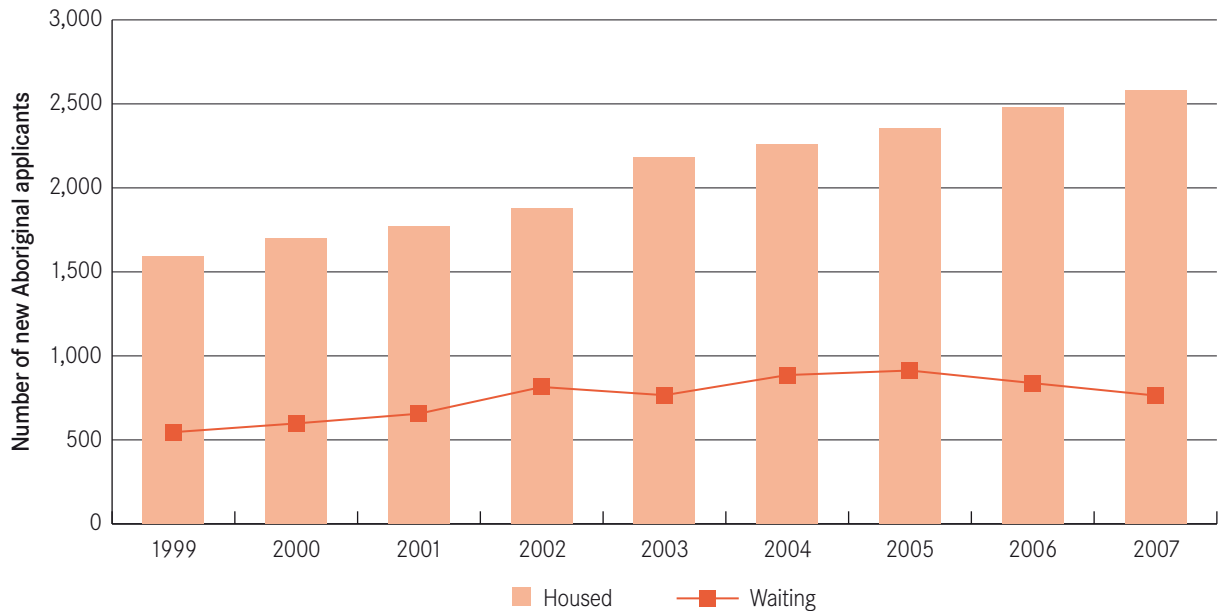


Table 33: Ratio of tenants in properties to clients on the waiting list, 30 June 1999–30 June 2007

Aboriginal tenants	1999	2000	2001	2002	2003	2004	2005	2006	2007
New applications	546	598	656	815	766	886	913	838	764
Tenants	1,595	1,698	1,770	1,877	2,181	2,259	2,353	2,481	2,581
Ratio housed to waiting	2.92	2.84	2.70	2.30	2.67	2.55	2.58	2.96	3.38

Indicator 14: Aged care

Indicator 14 i: Home and Community Care (HACC) services

The Home and Community Care (HACC) Program provides funding for services which support frail older people, younger people with disabilities and their carers. These services provide basic support and maintenance to people living at home and whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long-term residential care. The program is jointly funded by the Commonwealth and Victorian governments and administered by DHS.

HACC services are provided by over 500 independent agencies, including local government, community health centres, the Royal District Nursing Service, non-metropolitan hospitals and non-government agencies. Service types include domestic assistance, allied health, delivered meals, nursing, personal care, planned activity groups, property maintenance, and respite care.

Strategies

In 2005 DHS engaged consultants to undertake the HACC Funding Models project on a state-wide basis to test the extent of the problems encountered by Aboriginal organisations as a result of the way in which HACC program funds were allocated.

*The Aboriginal and Torres Strait Islander HACC Funding Models Project Report May 2006*⁷⁸ discusses the impact of small budgets and broad service provision expectations on Aboriginal organisations. It looks at existing models of HACC service provision and proposes models to provide options for funding sustainable HACC services for Aboriginal communities in the longer term.

As a response to the Report, DHS has developed the *Strengthening HACC in Aboriginal Communities strategy* in consultation with key stakeholders, such as the Victorian Indigenous Committee for Aged Care and Disabilities (VICACD).

The strategy aims to:

- increase access to a range of services for Aboriginal people who are eligible for those services
- strengthen HACC service responses to Aboriginal communities; and
- ensure that the HACC services delivered by Aboriginal organisations to Aboriginal communities are sustainable.

DHS has identified three themes for development:

1. Client-centred approach

- Increase access to a range of services for HACC-eligible Aboriginal people by developing formal service coordination practices between generic and Aboriginal organisations, from a culturally responsive service provision perspective.
- Funding has been approved for an 18 month service coordination project that aims to:
 - enhance HACC Aboriginal workers' knowledge and application of service coordination;
 - link Aboriginal and generic workers at the local level;
 - enhance generic workers' Aboriginal cultural awareness as it relates to HACC service provision; and
 - inform Aboriginal communities of HACC and the broader aged care service system.

⁷⁸ <http://www.health.vic.gov.au/hacc/publications/atsi>

2. Aboriginal organisation capacity building

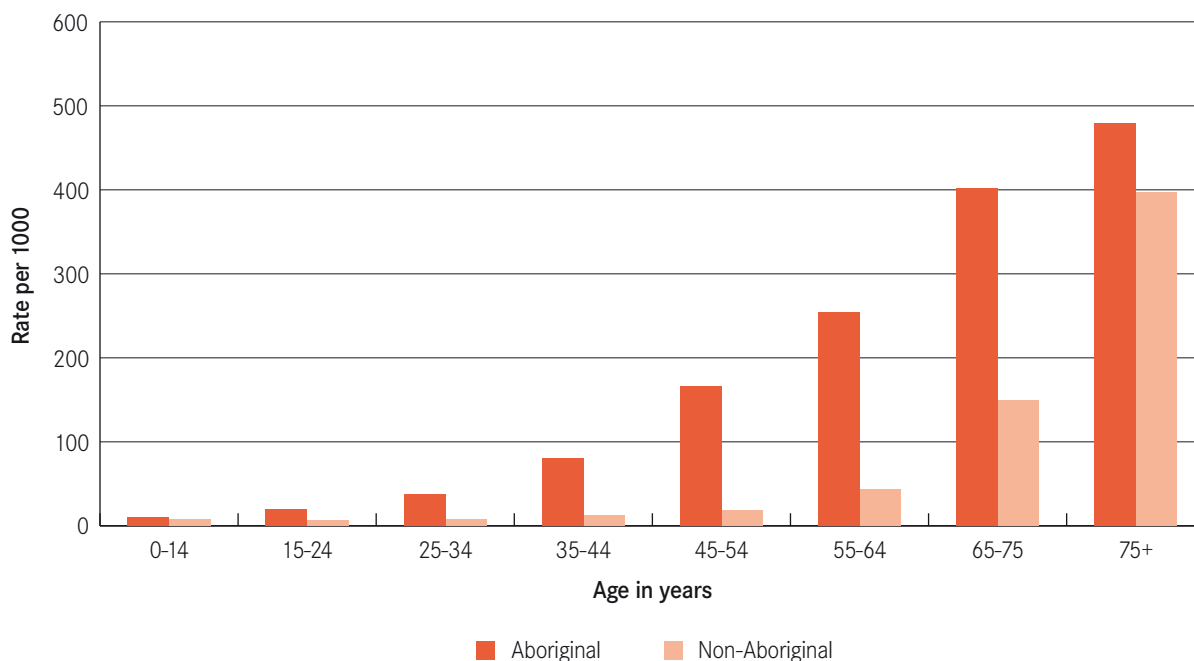
- Strengthen HACC service responses to Aboriginal communities by building the capacity of Aboriginal organisations to develop formal networks with generic organisations, to enable clients to access and navigate the service system.
- Funding has been approved for a three-year Bridging HACC Services project to enable up to four Aboriginal organisations to develop meaningful alliances with their local generic organisations to increase access for HACC eligible Aboriginal people to a range of culturally responsive and sustainable services.

3. Developing sustainable models of HACC service delivery consistent with community needs

- Ensure appropriate and sustainable HACC services to Aboriginal communities by assisting Aboriginal organisations to develop their individual HACC service model which is viable, sustainable and consistent with their local service system and Aboriginal population demographics, within a partnership model with other local providers.
- Aboriginal organisations will be invited to meet with DHS to discuss their HACC model within the context of their communities' needs and the local service system.

The DHS Aged Care Branch has been evaluating the quality of data items on Indigenous status supplied in the HACC minimum data set. Analysis of 2005/06 data has shown that some Aboriginal clients were not identified as Aboriginal (an under-count), while some non-Aboriginal clients were identified as Aboriginal (an over-count). The over-count appears to be higher than the under-count, mainly due to inaccurate records kept by generic agencies. Inconsistencies in some data items and other signs of poor quality data have been identified. The Aged Care Branch subsequently made contact with these agencies, pointed out the possible errors and inconsistencies, and asked them to check their records. This has helped improve the quality of HACC records on Aboriginal status⁷⁹.

Figure 33: HACC User Rates, 2006/07.



⁷⁹ The findings of the project have been published on the DHS HACC Web site under the title Quality of Victorian HACC Aboriginal Client Data: http://www.health.vic.gov.au/hacc/publications/aboriginal_data.htm

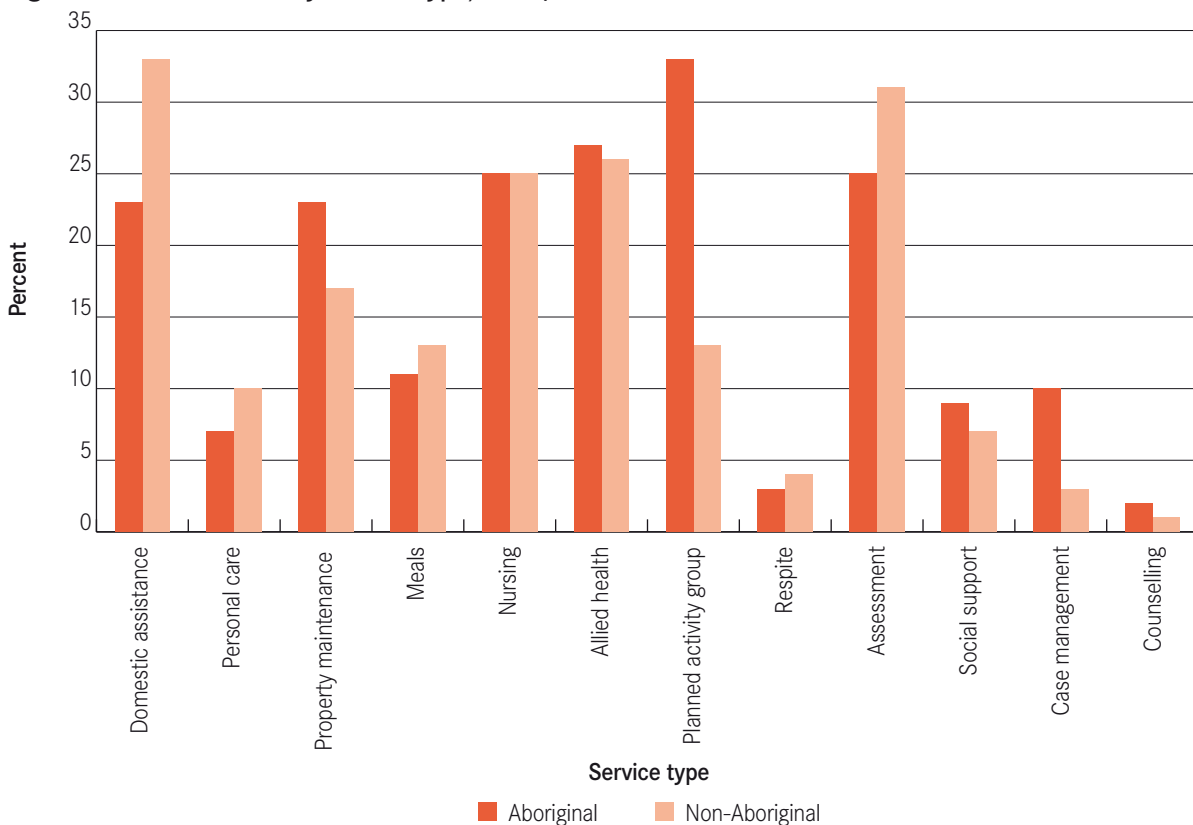
Table 34: HACC User rates, 2006/07⁸⁰

Age in years	Aboriginal		Non-Aboriginal	
	Persons receiving HACC services	Rate per 1000 population	Persons receiving HACC services	Rate per 1000 population
0-14	113	10	7,129	8
15-24	112	20	4,328	6
25-34	151	37	5,398	8
35-44	305	80	9,032	12
45-54	450	166	13,127	19
55-64	409	254	23,063	43
65-74	297	402	48,866	149
75+	227	479	130,342	397
Total	2,123	70	242,337	49

HACC services used by Aboriginal people

Aboriginal people use HACC services more frequently at younger ages than non-Aboriginal people. Aboriginal people are more likely to use property maintenance services, planned activity groups and case management than non-Aboriginal people. Individuals can access more than one type of service.

Figure 34: HACC clients by service type, 2006/07.



⁸⁰ HACC Minimum Data Set, 2006/07. Missing data on age for 1,052 Non-Aboriginal clients and 59 Aboriginal clients. Recent improvements in the quality of HACC Aboriginal client data have enabled reporting of HACC usage rates for clients aged over 65 years, which were previously unreported. Higher usage rates in all age groups for Aboriginal people are attributable to higher rates of disability, at least 2.1 times the non-Aboriginal population. While overall usage rates for Aboriginal clients appear high, rates are not consistent across all HACC service types.

Table 35: HACC clients by service type, 2006/07.

Service type	Aboriginal persons		Non-Aboriginal persons	
	Number	Percentage	Number	Percentage
Domestic Assistance	489	23%	79,783	33%
Personal Care	145	7%	24,421	10%
Property maintenance	479	23%	41,511	17%
Meals	230	11%	31,658	13%
Nursing	536	25%	61,646	25%
Allied Health	569	27%	63,938	26%
Planned Activity Group	701	33%	31,738	13%
Respite	70	3%	10,570	4%
Assessment	534	25%	75,620	31%
Social Support	193	9%	16,538	7%
Case management	209	10%	6,141	3%
Counselling	39	2%	1,322	1%

The types of agencies most commonly providing services to Aboriginal people are Aboriginal-specific HACC agencies, followed by community health and local government service providers. Individuals may use services from more than one agency.

Figure 35: HACC usage by agency type, 2006/07.

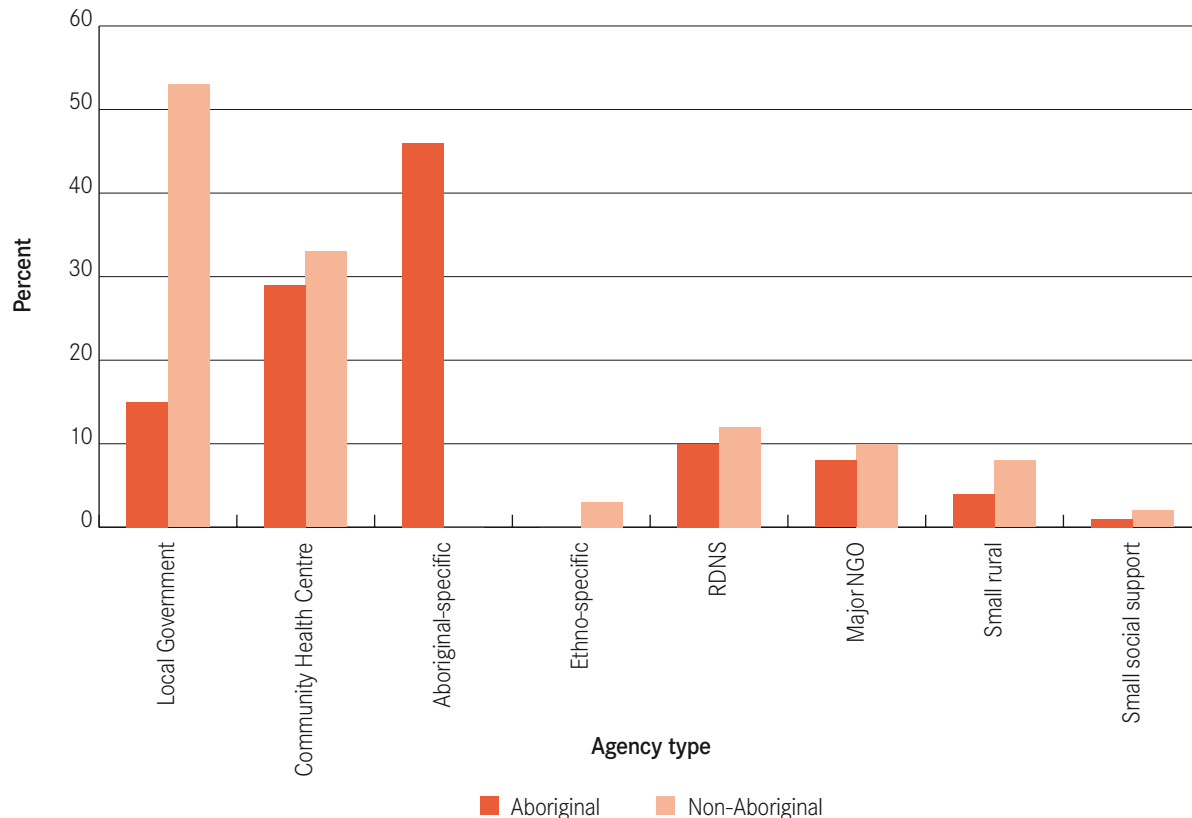


Table 36: HACC usage by agency type, 2006/07.

Agency type	Aboriginal persons		Non-Aboriginal persons	
	Number	Percentage	Number	Percentage
Local Government	319	15%	129,538	53%
Community Health Centre	607	29%	80,692	33%
Aboriginal	979	46%	127	0%
Ethno Specific	0	0%	7,207	3%
RDNS	206	10%	28,197	12%
Major NGO	166	8%	23,869	10%
Small Rural	90	4%	19,614	8%
Small Social Support	18	1%	5,294	2%

Indicator 14 ii: Aged Care Assessment Service (ACAS)

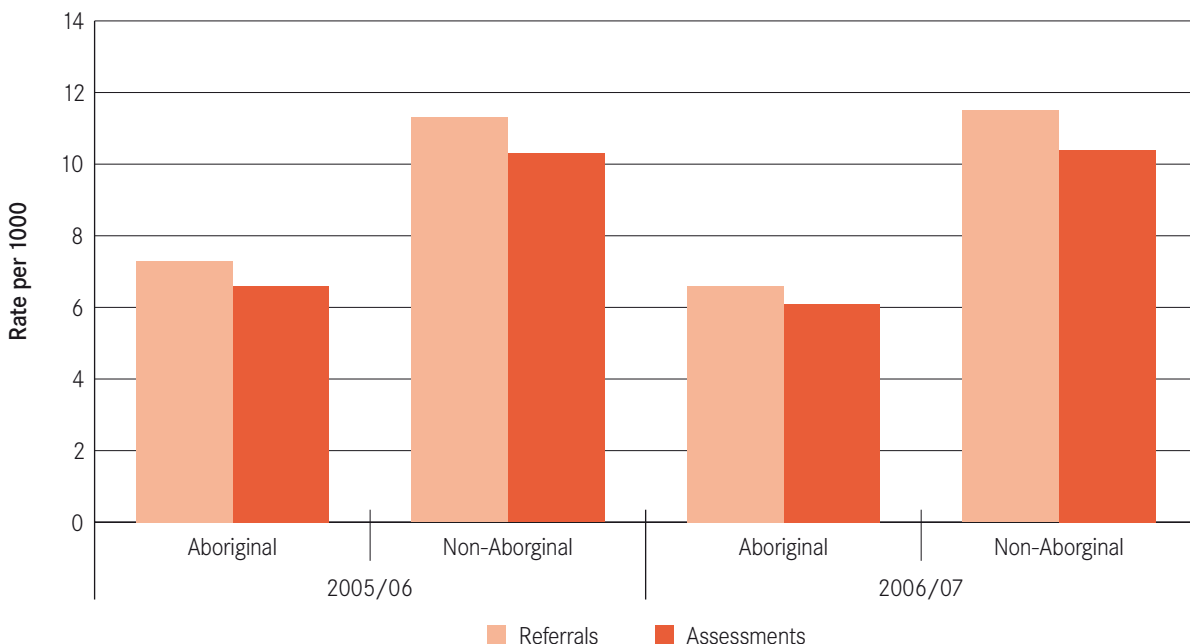
Assessment by the Aged Care Assessment Service (ACAS) is mandatory for admission to residential care, or to receive an Extended Aged Care at Home (EACH) or Community Aged Care Package (CACP), or for admission to residential respite. ACAS also refer people to community services provided under the HACC program, to the Linkages program (intensive community care packages), to rehabilitation services, both inpatient and community-based, and to general community services.

The target group for ACAS is frail older people aged over 70 years, including older Aboriginal people aged 50 to 69 years.

Aboriginal referrals to both rural and metropolitan teams were less than expected from the proportion in the population. Overall, 0.36% of all referrals involve people from Aboriginal backgrounds whilst 0.71% of the target population are Aboriginal.

The number of Aboriginal clients increased in most years between 1994/95 and 2002/03 but declined in the following three years. The number of referrals of Aboriginal people in 2006/07 was very similar to those in 2005/06.⁸¹

Figure 36: ACAS referrals and assessments, 2005/06–2006/07.



⁸¹ Aged Care Assessment Program Minimum Data Set Annual Report. Victoria 2006/07. Data quality improved greatly in 2003/04.

Table 37: ACAS referrals and assessments, 2005/06–2006/07.⁸²

Rate per 1000	Referrals	Referral rate per 1000	Assessments	Assessment rate per 1000
2005/06				
Aboriginal	203	7.3	185	6.6
Non-Aboriginal	54,428	11.3	49,585	10.3
2006/07				
Aboriginal	200	6.6	183	6.1
Non-Aboriginal	56,316	11.5	50,968	10.4

Health

Indicator 15: Life expectancy

Life expectancy is an indicator of health status and measures the average number of years a person of any given age and sex can expect to live, if current trends continue throughout his or her lifetime. Life expectancy does not reflect the current median age of death.

Studies have found life expectancy to be highly correlated with a wide range of other factors including employment, education and overall economic wellbeing.⁸³ Populations with high rates of illness and poor health status from early ages will have low life expectancy.

Life expectancy is presented separately for males and females, who have different health status and different death rates at all ages. Aboriginal females have greater life expectancy than males, but for both sexes Aboriginal life expectancy is markedly lower than non-Aboriginal life expectancy⁸⁴. Differences in life expectancy begin in the first year of life, when the death rate for Aboriginal males is twice that of non-Aboriginal males. The same differential applies to females but both Aboriginal and non-Aboriginal female rates are lower than male rates⁸⁵.

The higher rate of perinatal and infant deaths contributes to lower life expectancy. Disparities in life expectancy can be influenced by differences in income and education levels, the quality of the health system and the ability of people to access it, genetic and social factors, and environmental factors. People from lower socioeconomic groups tend to suffer from high rates of ill health and death, and are more likely to exhibit behaviour risk factors such as the consumption of tobacco and excessive alcohol, poor nutrition, and lack of exercise.⁸⁶ Lack of access to culturally appropriate services can deter people from seeking preventative care or early treatment for chronic diseases such as diabetes, renal diseases and cardiovascular diseases.

In 2006 life expectancy of Aboriginal people was estimated to be 19 years lower than for the total Victorian population.

Life expectancy at birth is 60 years for Aboriginal males compared with 79 years for males in the total population, and 65 years for Aboriginal females compared to 84 years for females in the total population.

⁸² The rate per 1000 population is based on ABS Census 2006; non-Aboriginal population aged over 70 years and Aboriginal population over 50 years (2,675 people).

⁸³ OID 2007, p.3.2, quoting Becker, G., Philipson, P., and Soares, G., 2003, *The quantity and quality of life and the evolution of world inequality*, <http://economics.uchicago.edu>

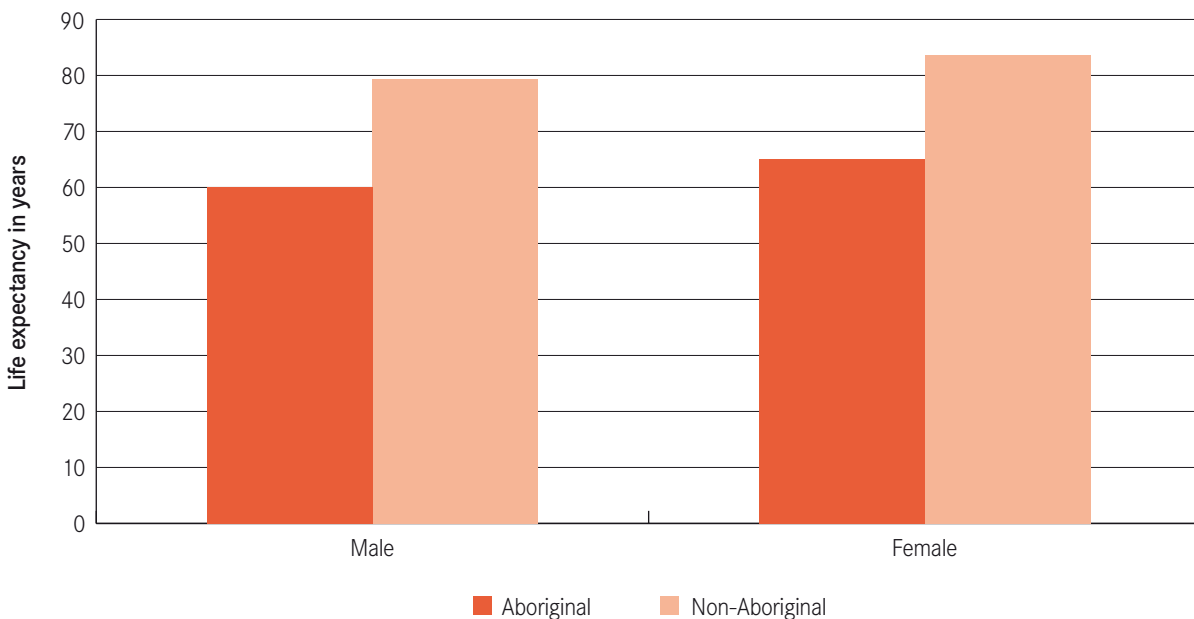
⁸⁴ In December 2007 the Council of Australian Governments (COAG) agreed to halve within a generation (assumed 25 years) the gap in life expectancy between Aboriginal and Non-Aboriginal people.

⁸⁵ Life tables for NSW/Victoria 1996–2001 including age-specific death rates provided by ABS.

⁸⁶ OID 2007, p. 3.3

Death rates of all children aged 1–15 years are low, with increases in the death rate beginning in the 15–19 year age group. The difference between Aboriginal and non-Aboriginal death rates, both male and female, becomes very evident from this age. A further increase in death rates begins for Aboriginal people at 45–49 years, whereas for non-Aboriginal people this increase does not begin until 60–64 years.

Figure 37: Life expectancy, 2006⁸⁷



Improvements in life expectancy in the general Australian population have been achieved through:

- Improved understanding of environmental factors that affect health, e.g. clean water supply, sewerage, sanitation, housing and food supply.
- Improved understanding of health risk and beneficial factors, e.g. tobacco smoking and lung cancer, sun exposure and skin cancer, work and road safety and deaths due to injury.
- Medical and surgical advances, including antibiotics, immunisation, surgical techniques.

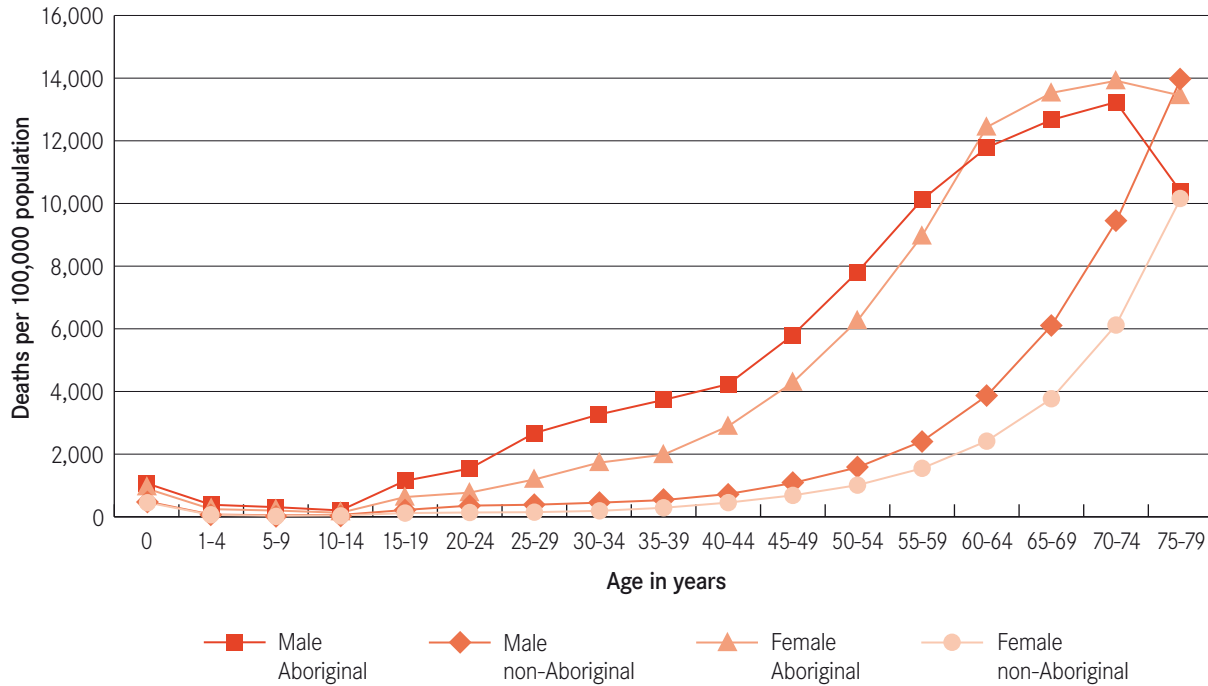
These improvements have resulted in an increase in life expectancy of approximately 1 year every 4–5 years. In the last 100 years overall life expectancy has increased by 21.4 years for males and 23.3 years for females.

The change in Aboriginal life expectancy over time is not quantifiable, due to poor death registrations of Aboriginal people and changes in the methods of deriving life expectancy from death registrations. However, unlike countries with similar Indigenous populations, Aboriginal child mortality in Australia has decreased without corresponding improvements in adult mortality and life expectancy, and in recent years in those countries Indigenous life expectancy has increased more rapidly than non-Indigenous life expectancy.⁸⁸

⁸⁷ Victorian life tables, 2004–2006. ABS 3302.2.55.001, ABS 2007; Indigenous life tables, *Deaths Australia 2006*, ABS 3302.0, Table 9.8 Abridged experimental Indigenous life tables, NSW and Victoria (including ACT and Tasmania), 1996–2001. This is the latest available Victorian Aboriginal life expectancy. ABS expects to revise these tables in 2008

⁸⁸ In New Zealand and Canada Indigenous life expectancy is 7–8 years less than non-Indigenous.

Figure 38: Death rates per 100,000 population, Victoria, 2006.



Indicator 16: Common health conditions

Health is one of the areas in which Aboriginal disadvantage is most clearly apparent. The following indicators show the conditions for which Aboriginal people are most commonly admitted to hospital. They are mental illnesses, ear, nose and throat illnesses, respiratory diseases, circulatory diseases, oral diseases, infectious diseases, diabetes, renal diseases and injury. Hospital admissions do not show the full prevalence of these conditions, as many people are not admitted to hospital.

Aboriginal people are admitted to hospital for a range of reasons, which vary by age and sex.

- Children under 14 years are most frequently admitted for respiratory diseases, ear, nose and throat diseases, oral diseases and injuries.
- Men aged 15–44 years are admitted for renal dialysis, mental disorders, including alcohol and drug related admissions (see Indicator 10) and injuries.
- Women aged 15–44 years are admitted for pregnancy-related reasons (see Indicator 3), diseases of the reproductive system, mental disorders, including alcohol and drug related admissions, renal dialysis and injuries.
- Older adults (men and women aged 45–64 years) are admitted for renal dialysis, diabetes-related admissions, circulatory and respiratory diseases.
- Men and women over 65 years are admitted for renal dialysis, respiratory diseases, diabetes-related admissions and circulatory diseases. Mental health and injury admissions are high for all adult age groups.

Overall, Aboriginal people are more likely to be admitted to hospital when very young (0–4 years) or aged 25–44 years or 45–64 years. Older children and younger adults are admitted at similar rates to the non-Aboriginal population. However, this is not the case for all causes of admission; some, such as injuries and mental disorders, show much higher rates of admission than expected for older children and younger adults.

For many health conditions Aboriginal people are admitted to hospital more frequently and at earlier ages than non-Aboriginal people.

Strategies to manage key conditions

Chronic conditions such as asthma, diabetes, coronary heart disease, chronic renal disease, chronic respiratory conditions and hypertension are managed both through condition-specific strategies and through broader strategies for the health system.

The *Hospital Demand Management Strategy* was established in October 2000 in response to increases in demand and deterioration in access to acute public hospital services. As part of this the *Hospital Admissions Risk Program* (HARP) aims to reduce the avoidable use of hospitals.

Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) combines two previously separate funding streams: the Koori Hospital Liaison Officer program and the WIES supplement for admitted Aboriginal patients, which was increased from 10% to 30% in 2004/05.

The goals of the ICAP Program are to:

- achieve accurate identification of all Aboriginal patients
- improve access by Aboriginal people to health services
- support health services providing culturally sensitive care and appropriate referrals for Aboriginal patients
- recognise that high quality and culturally sensitive health care for Aboriginal patients is a whole of health service quality issue, not just the responsibility of designated Aboriginal staff
- promote partnerships between health services and Aboriginal Community Controlled Organisations in the planning and delivery of service responses for Aboriginal patients as a means of improving access and quality.

Funded through *A Fairer Victoria 2005*, the *Aboriginal Health Promotion and Chronic Care* (AHPACC) partnership aims to increase the access Aboriginal people have to culturally appropriate chronic disease prevention and management services. The AHPACC partnership supports Community Health Services (CHSs) and Aboriginal Community Controlled Health Organisations (ACCHOs) to work collaboratively to improve health outcomes for Aboriginal people in Victoria with, or at risk of, chronic disease.

The vision of the AHPACC Partnership is that Aboriginal people in Victoria can access primary health care that is culturally respectful and addresses aspects of health including prevention, promotion and treatment, underpinned by principles of self-determination and collaboration, and endeavours to achieve a quality of life for Aboriginal people, equal with all other Victorians.

The vision of the AHPACC Partnership will be achieved through:

- increased access to primary health care services by Aboriginal Victorians
- improved clinical service delivery, coordination and continuity of care, and support for chronic disease self-management approaches
- coordinated approaches to health promotion planning, implementation and evaluation by building upon existing programs
- increased capacity of CHSs in the provision of culturally sensitive services and
- workforce development and organisational support for both Aboriginal and mainstream workers and organisations.

In the following section, more detailed information is provided on each of the most common chronic conditions in Aboriginal people.

Data are provided for Ambulatory Care Sensitive Conditions. Hospitalisation for these conditions is thought to be avoidable if preventative care and early disease management are applied, usually in the ambulatory setting.⁸⁹

In all figures and tables cases refer to individuals admitted to hospital between 2004/05 and 2006/07. Admissions refer to occasions of service.

Indicator 16 i: Mental Health

Mental health is our capacity as individuals to interact with others and our environment. A mental illness or disorder is a diagnosable illness that significantly interferes with a person's thinking, feelings and social abilities. Some common mental illnesses and disorders include:

- depression
- anxiety
- substance use disorders
- eating disorders
- psychosis

Mental health problems interfere with a person's thinking, feeling or social abilities to a lesser extent than a mental illness or disorder. The distinction between the two is based on severity and duration of symptoms. A mental health problem is commonly a temporary reaction to a stressful life event. Mental health problems can contribute to use of alcohol, drugs and gambling.

Mental health data in this section do not include alcohol and drug related admissions. These are included in Section 4, Indicator 10.

Aboriginal males aged 25–44 years and 45–64 years show very high rates of admission for mental illnesses, as do Aboriginal females at all ages over 15 years. Non-Aboriginal males and females are admitted most frequently when aged over 65 years.⁹⁰ The highest number of admissions per individual occurs for Aboriginal and non-Aboriginal females and non-Aboriginal males aged 45–64 years.

Strategies and services

Purro Birik, the Aboriginal mental health strategy, has provided a framework for improving mental health services for Aboriginal people with severe and complex problems over the last 7 years. The development of a whole of government mental health reform strategy for the next 5–10 years offers an opportunity to revise and renew the commitment to the social, emotional and spiritual well-being of Aboriginal people as part of the broader reform agenda for mental health services. The strategy is being developed in close consultation with key Aboriginal stakeholders including the Victorian Aboriginal Community Controlled Health Organisations Inc (VACCHO).

Koori Mental Health Liaison Officer positions are funded in rural community mental health services and the Royal Children's Hospital Child and Adolescent Mental Health Service to improve access to culturally sensitive services for Aboriginal people.

Aboriginal-specific mental health services for those living in metropolitan Melbourne are currently provided through the Family Counselling Service within the Victorian Aboriginal Health Service, a range of Aboriginal-specific psychiatric disability rehabilitation and support services, and Aboriginal-specific mental health beds at St Vincent's Hospital.

⁸⁹ Department of Human Services 2004, *The Victorian Ambulatory Care Sensitive Conditions Study, 2001–02*, DHS, Melbourne.
<http://www.health.vic.gov.au/healthstatus/acsc/>

⁹⁰ Persons over 65 years are frequently admitted for dementia and the rate of admission increase with age. As there are fewer Aboriginal people over 65, particularly in the oldest age groups, the rate of admission is lower.

Figure 39: Rate of male admissions for mental conditions, 2004/05–2006/07.

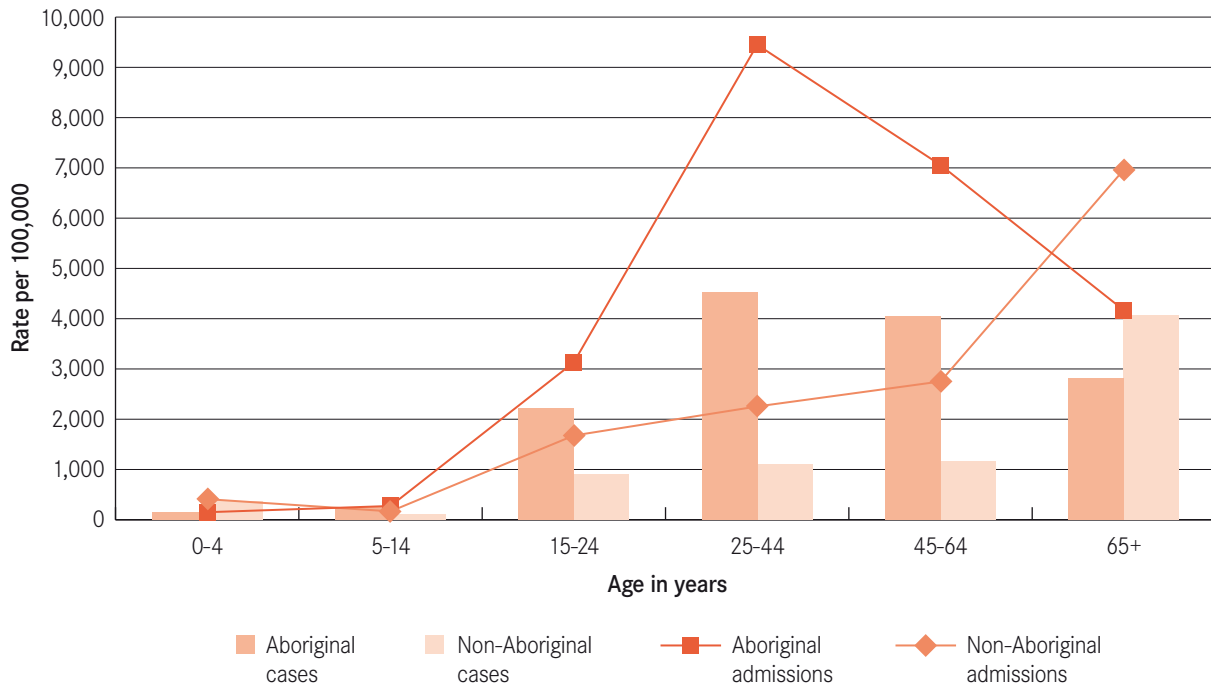


Table 38: Rate of male admissions for mental conditions, 2004/05–2006/07.⁹¹

Male Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	150	363	150	410
5-14	256	117	274	167
15-24	2,227	897	3,132	1,676
25-44	4,526	1,098	9,450	2,254
45-64	4,041	1,172	7,057	2,751
65+	2,808	4,068	4,167	6,965

⁹¹ All data on hospitals admissions have been extracted from the Victorian Admitted Episodes Dataset (VAED) for the years 2004/05 to 2006/07, and presented as a 3-year rolling average.

Figure 40: Rate of female admissions for mental conditions, 2004/05–2006/07.

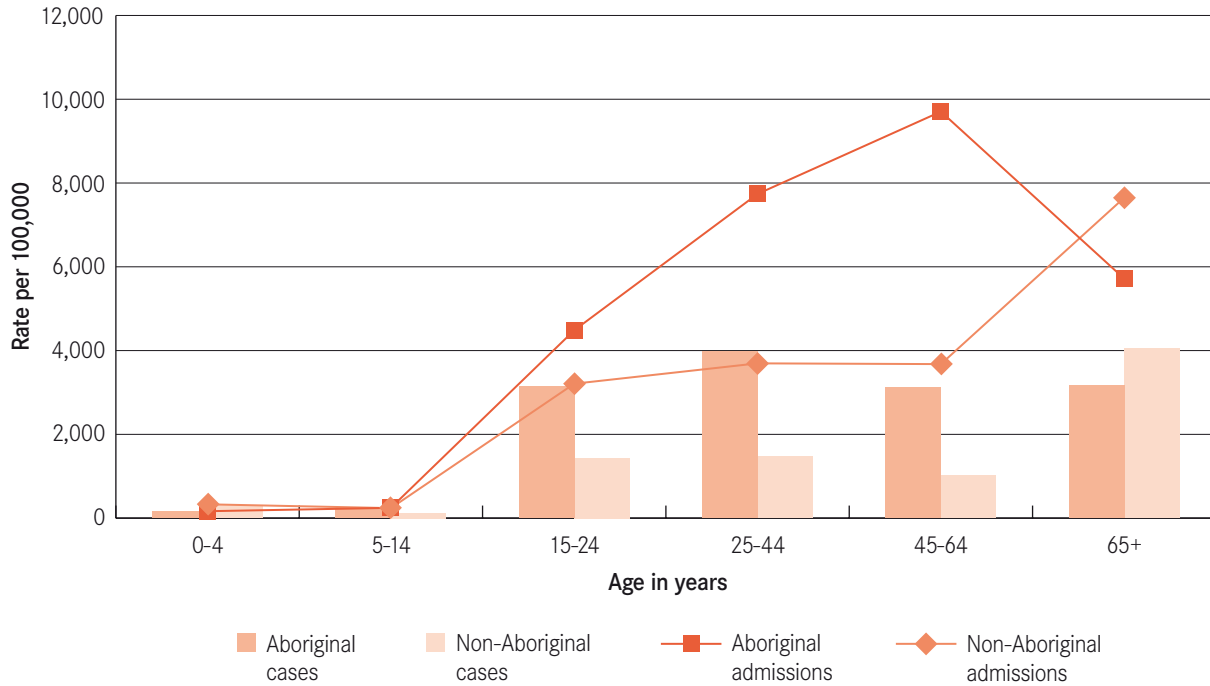


Table 39: Rate of female admissions for mental conditions, 2004/05–2006/07.

Female Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	165	294	165	330
5-14	227	125	246	239
15-24	3,141	1,438	4,484	3,209
25-44	3,986	1,477	7,739	3,695
45-64	3,126	1,025	9,705	3,677
65+	3,168	4,053	5,416	7,650

Indicator 16 ii: Ear Nose and Throat diseases

Conditions of the ear, nose and throat (ENT) are grouped together because all three parts of the body are connected via common sinus passages. The ethmoidal sinus connects the nose to the ear, and the nasopharynx to the throat.

Common problems of the ear include: deafness, ear infections such as otitis media, and sinusitis. (See also hearing loss: Indicator 6).

Factors that can disrupt the functioning of the nose are: diseases of the hormonal system, diseases of the nervous system, drugs and trauma to the nose.

A range of disorders can affect the throat: acute laryngitis caused by sudden inflammation of the larynx, chronic laryngitis, croup, throat ulcers, cancer of the throat and tonsillitis.

Persons are most frequently to be admitted to hospital for ear, nose and throat conditions when very young.

The rate of admission of Aboriginal people is similar to the non-Aboriginal rate for both males and females. Most individuals have only one admission, except for Aboriginal males aged over 65 years.

Figure 41: Rate of male admissions for ENT related conditions, 2004/05–2006/07.

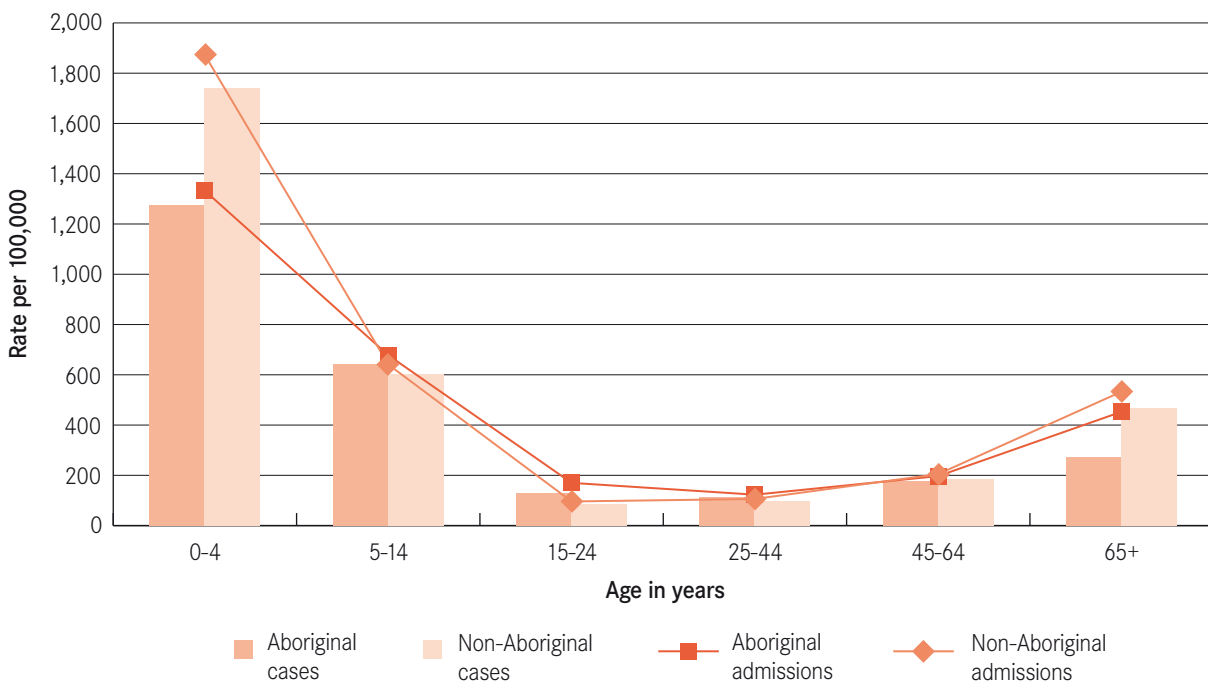


Table 40: Rate of male admissions for ENT related conditions, 2004/05–2006/07.

Male Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	1,276	1,742	1,332	1,872
5-14	641	604	678	641
15-24	131	87	170	96
25-44	115	97	123	106
45-64	178	187	197	205
65+	272	466	453	533

Figure 42: Rate of female admissions for ENT related conditions, 2004/05–2006/07.

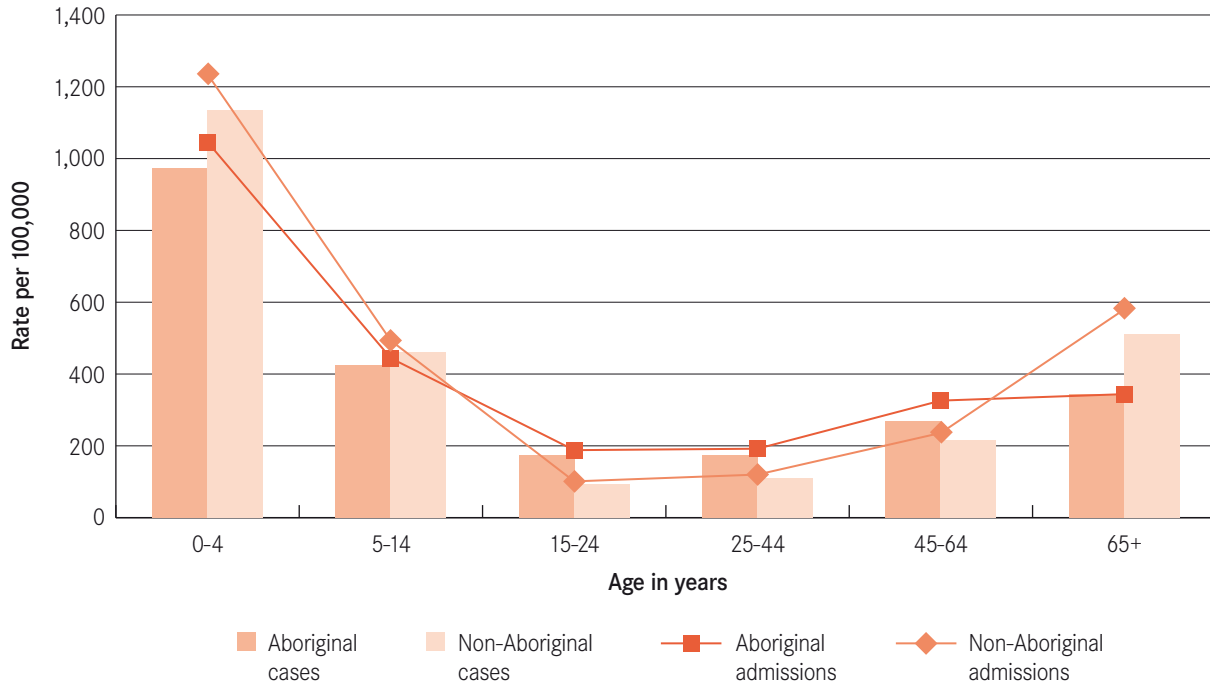


Table 41: Rate of female admissions for ENT related conditions, 2004/05–2006/07.

Female Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	973	1,135	1,046	1,235
5-14	425	462	444	493
15-24	175	94	188	101
25-44	175	109	192	120
45-64	269	216	326	236
65+	344	510	344	580

Indicator 16 iii: Respiratory diseases

The respiratory system supplies oxygen to the blood system by the uptake of oxygen and removal of carbon dioxide. Anything that prevents the breathing process from functioning properly can result in death.

Respiratory diseases can be divided into those affecting the mouth and nose (Upper Respiratory Tract Infections) and those affecting the trachea and lungs (Lower Respiratory Tract Infections). Respiratory infections can be acute or chronic.

Respiratory diseases include influenza, pneumonia, asthma, bronchitis, croup, colds, chronic obstructive airways disease (COAD) and throat diseases such as tonsillitis.⁹²

Children younger than four years of age are very frequently admitted to hospital for respiratory diseases, including croup, asthma and pneumonia. Aboriginal children are admitted more often than non-Aboriginal children. Adults are increasingly admitted for respiratory disease from age 25 years onwards. Some admissions are for vaccine-preventable respiratory diseases, such as pneumococcal disease, influenza and whooping cough. The rate ratio of Aboriginal to non-Aboriginal admissions is highest for males and females 45–64 years. The highest ratio of admissions to cases is for Aboriginal males and females aged over 45 years, and non-Aboriginal males and females over 65 years.

Figure 43: Rate of male admissions for respiratory disorders, 2004/05–2006/07.

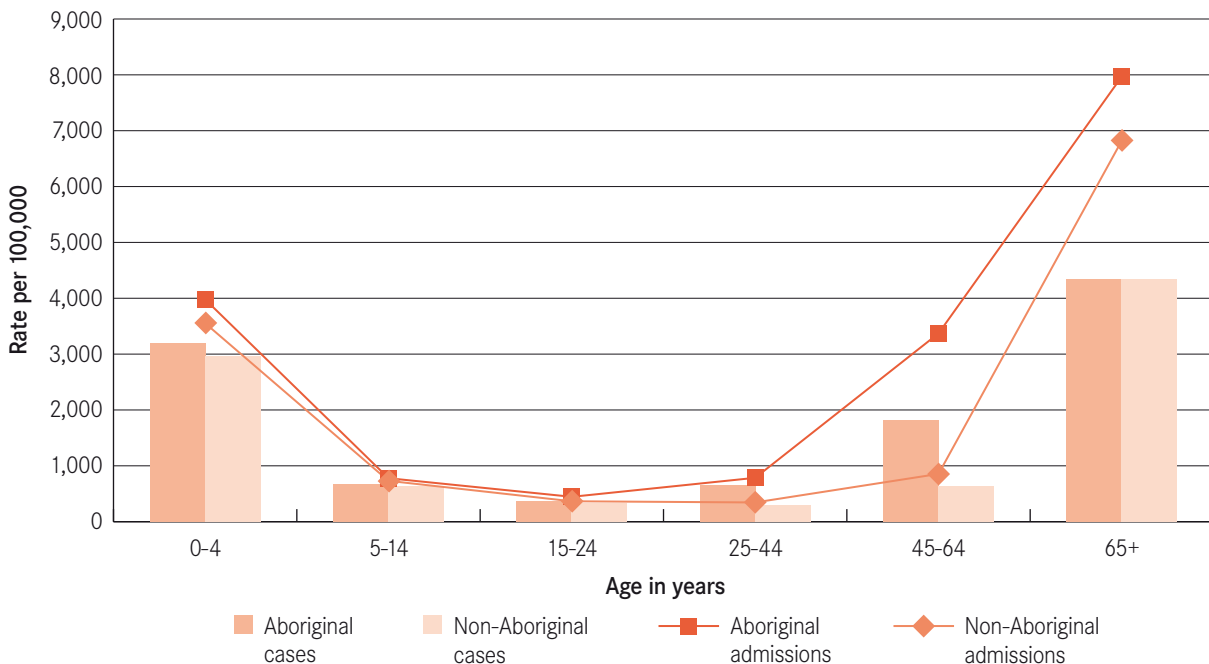


Table 42: Rate of male admissions for respiratory disorders, 2004/05–2006/07.

Male	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
Age in years				
0-4	3,191	2,968	3,979	3,553
5-14	668	629	778	731
15-24	367	331	445	365
25-44	662	301	785	344
45-64	1,813	636	3,371	855
65+	4,348	4,339	7,971	6,824

⁹² Better Health channel. <http://www.betterhealth.vic.gov.au/>

Figure 44: Rate of female admissions for respiratory disorders, 2004/05–2006/07.

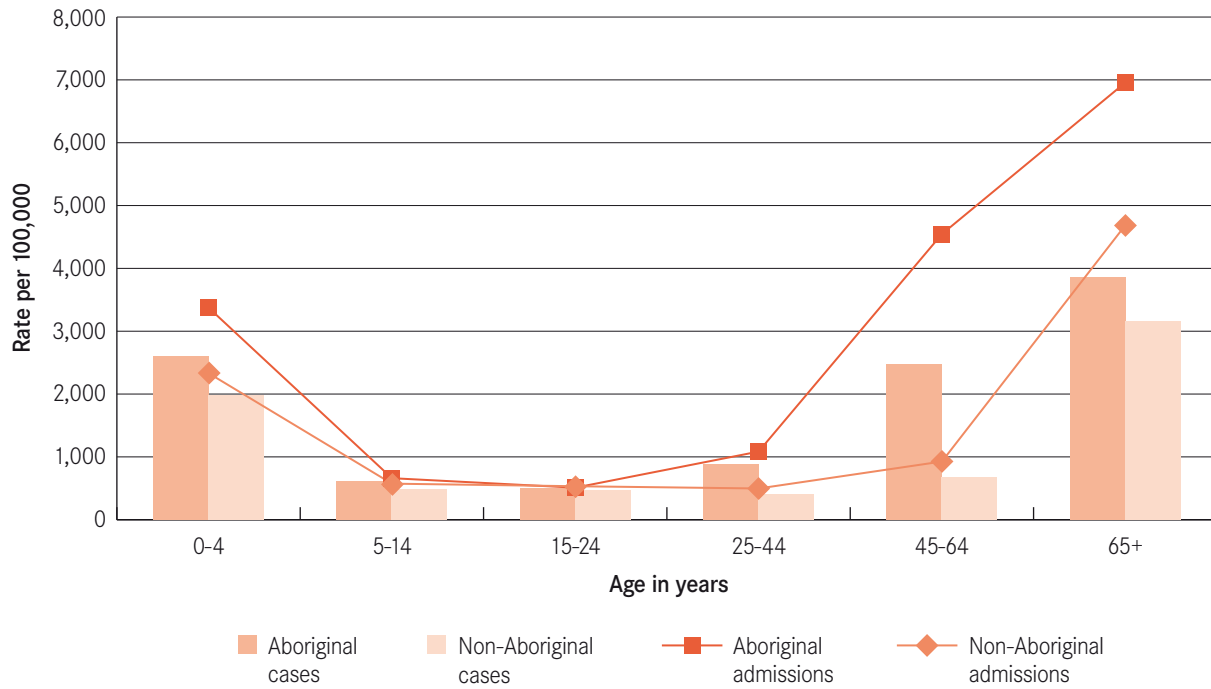


Table 43: Rate of female admissions for respiratory disorders, 2004/05–2006/07.

Female Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	2,605	1,975	3,375	2,332
5-14	605	486	661	574
15-24	497	467	510	533
25-44	876	413	1,084	497
45-64	2,474	677	4,546	926
65+	3,857	3,155	6,956	4,685

Indicator 16 iv: Infectious diseases

Infectious (communicable) diseases are diseases that can be spread directly or indirectly from one living thing to another and are caused by specific infectious agents or their toxic products. Bacteria cause diseases such as pertussis and tuberculosis; viruses cause diseases such as measles, influenza and AIDS; fungi are responsible for conditions such as tinea; protozoan parasites cause a variety of diseases including malaria; and bacterial toxins are responsible for conditions such as some forms of food poisoning.⁹³

In this report, communicable diseases have been grouped by their major mode of transmission into the following categories: blood borne diseases, sexually transmissible infections, gastrointestinal (enteric) diseases, vector borne diseases and “other” diseases. Some diseases can be transmitted in more than one way.

Blood borne diseases are caused by infectious agents that spread via blood, blood products and body fluids: these include hepatitis B, C and D. **Sexually transmissible infections** include chlamydia, donovanosis, HIV/AIDS, gonorrhoea and syphilis. **Enteric diseases** include botulism, hepatitis A and E, salmonellosis and typhoid. They can be contracted from food, water, other people, the environment or animals. **Vector borne diseases** are mostly transmitted by mosquitos and include Barmah Forest virus disease, Ross River virus disease, dengue and malaria. **Zoonotic diseases** are transmitted by animals and include brucellosis, leptospirosis, psittacosis and Q fever.

Some infectious diseases are preventable by immunisation. Diseases against which immunisation is routinely available (**vaccine preventable**) include diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, measles, mumps, rubella, influenza, hepatitis B and pneumococcal infection. Other notifiable infectious diseases include Creutzfeld-Jakob disease, invasive meningococcal disease, legionellosis, leprosy and tuberculosis.

Infectious diseases included in these figures and tables include sepsis and vaccine preventable diseases including influenza.

Most cases of infectious diseases do not require admission to hospital, so the number of admissions is always very low. Data for both hospital admissions and diseases notified through the **Notifiable Infectious Diseases Surveillance** database are presented here.

Aboriginal people are admitted more frequently for infectious diseases when aged 25–44 years and 45–64 years, and less frequently when aged over 65 years.

Admissions for infectious diseases

Figure 45: Rate of male admissions for infectious diseases, 2004/05–2006/07.



⁹³ Australian Institute of Health and Welfare 2004, *Australia's health 2004: the ninth biennial health report of the Australian Institute of Health and Welfare*, AIHW cat. no. AUS 44, Canberra, 2004

Table 44: Rate of male admissions for infectious diseases, 2004/05–2006/07.

Male	Cases: rate per 100,000		Admissions: rate per 100,000	
Age in years	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0–4	563	428	694	467
5–14	27	32	27	35
15–24	118	57	197	67
25–44	221	97	309	122
45–64	512	274	611	352
65+	996	1,208	1,358	1,457

Figure 46: Rate of female admissions for infectious diseases, 2004/05–2006/07.

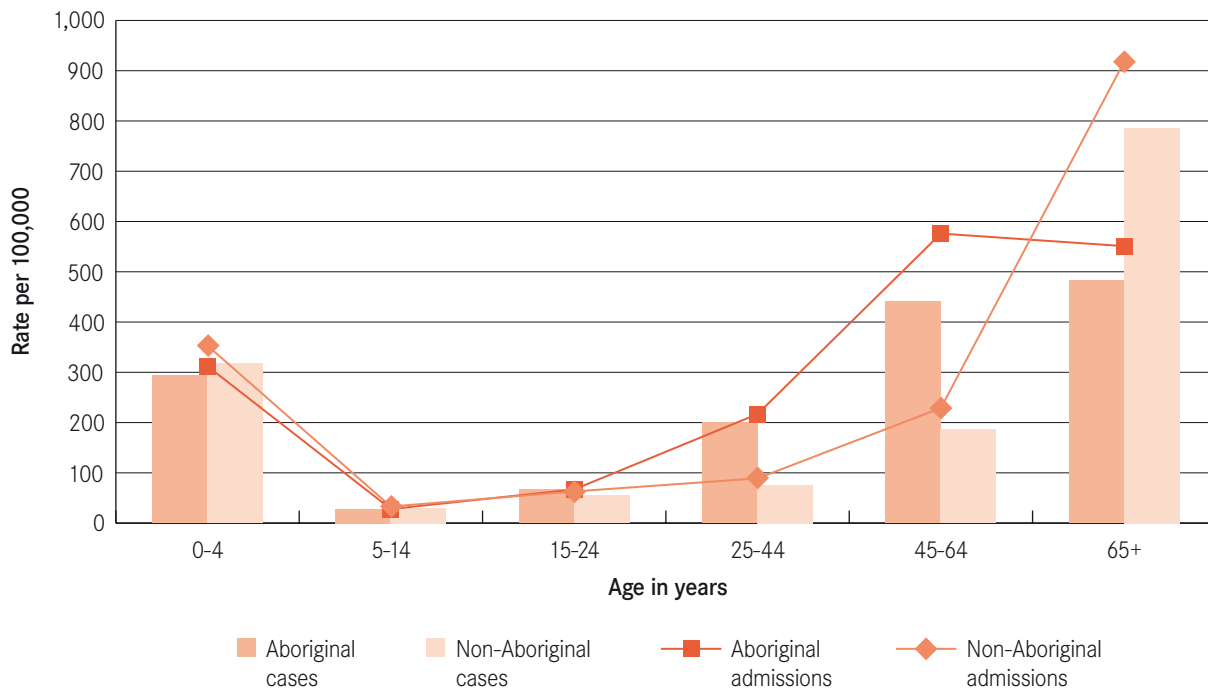


Table 45: Rate of female admissions for infectious diseases, 2004/05–2006/07.

Female	Cases: rate per 100,000		Admissions: rate per 100,000	
Age in years	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0–4	293	318	312	353
5–14	28	30	28	33
15–24	67	55	67	63
25–44	200	76	217	89
45–64	441	186	576	229
65+	482	786	551	918

Cases of Infectious Diseases

Data in the *Notifiable Infectious Diseases Surveillance* (NIDS) are collected from hospitals, general practitioners and pathologists and reported to the Communicable Diseases Control Unit. Diseases are grouped according to mode of transmission described above⁹⁴.

Data are not presented by age groups because of the small numbers of notifications identified as Aboriginal, and it is therefore difficult to make comparisons about age distribution in Aboriginal and non-Aboriginal cases. Table 46 indicates the high proportion of cases for which Aboriginal status was unable to be ascertained, particularly for blood borne and enteric diseases and sexually transmissible infections. This is because a high proportion of these cases are notified by a laboratory only; unlike medical practitioner notification forms, laboratory request forms do not contain a field for the collection of Aboriginal status.

The high number of cases for which Aboriginal status was not ascertained also means that notification rates are underestimated. However, among those diseases for which Aboriginal status was reported, notification rates for sexually transmissible infections, blood borne and vector borne diseases are approximately twice as high for Aboriginal people that non-Aboriginal people.

Figure 47: Rate of infectious diseases notifications, 2007.

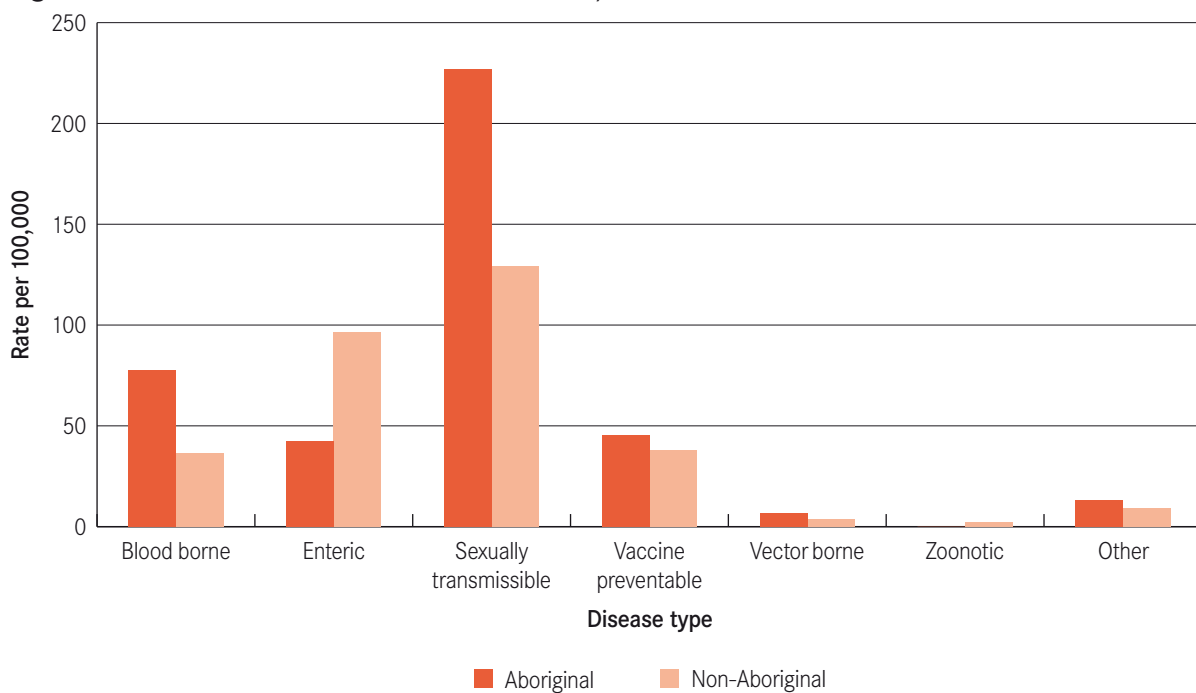


Table 46: Rate of infectious diseases notifications, 2007.⁹⁵

Disease type	Rate per 100,000		
	Aboriginal rate per 100,000	Non-Aboriginal rate per 100,000 (including unknown)	Aboriginal status unknown (%)
Blood borne	77.8	36.7	60%
Enteric	42.2	96.4	59%
Sexually transmissible	227.0	129.1	49%
Vaccine preventable	45.4	37.9	34%
Vector borne	6.5	3.7	24%
Zoonotic	0.0	2.1	7%
Other	13.0	9.4	3%

⁹⁴ Most cases of notifiable infectious diseases do not require hospital admission.

⁹⁵ Data from Department of Human Services, 2007, *Victorian Indigenous Summary Report*. <http://www.health.vic.gov.au/ideas/> The data refers to cases with a 2007 date of notification and does not include those cases in which Aboriginal status was missing or not stated.

Indicator 16 v: Circulatory diseases

The circulatory system, or vascular system, consists of the heart, blood vessels and blood, which circulate blood throughout the body, deliver nutrients and other essential materials to cells, and remove waste products. The underlying problem in circulatory system disease is atherosclerosis, a process that clogs blood vessels with deposits of fat, cholesterol and other substances that have built up in the inner lining of the vessels. It is most serious when it affects the blood supply to the heart (causing angina, heart attack or sudden death) or to the brain (which can lead to a stroke).⁹⁶

Diseases of the circulatory system include coronary heart disease, heart failure, rheumatic heart disease, stroke, peripheral vascular disease and hypertensive disease.

Cardio-vascular diseases, such as heart disease and stroke, begin to increase among Aboriginal people aged 25–44 years, and are a common cause of admission for older Aboriginal patients from age 40 years onwards. In the non-Aboriginal population the rate of cases and admissions increases after age 45–64 years. Admissions rates are higher for Aboriginal people than non-Aboriginal people aged 25–44 and 45–64 years.

Figure 48: Rate of male admissions for circulatory diseases, 2004/05–2006/07.

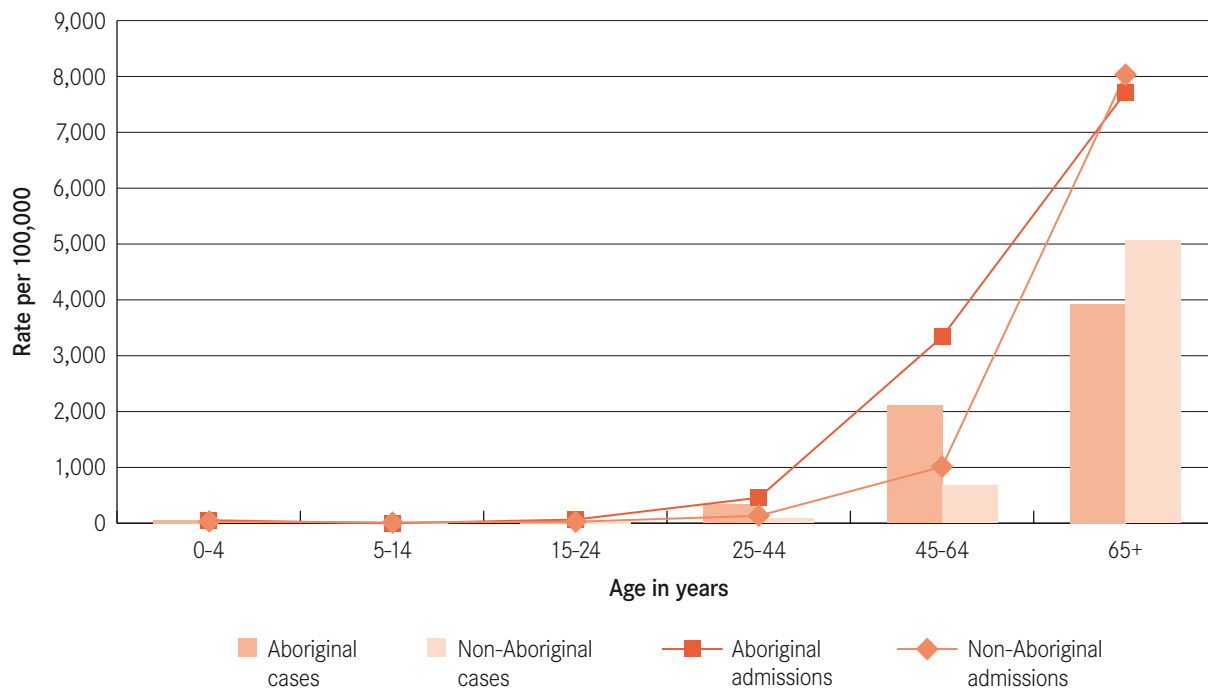


Table 47: Rate of male admissions for circulatory diseases, 2004/05–2006/07.

Male	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
Age in years				
0-4	0	21	0	26
5-14	18	8	27	13
15-24	13	21	13	29
25-44	609	172	1,006	256
45-64	2,523	1,664	4,061	2,634
65+	3,895	7,584	5,978	12,545

⁹⁶ Australian Bureau of Statistics, 2003, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*. Cat. no. 4704.0, ABS, Canberra, 2003. p 131.

Figure 49: Rate of female admissions for circulatory diseases, 2004/05–2006/07.

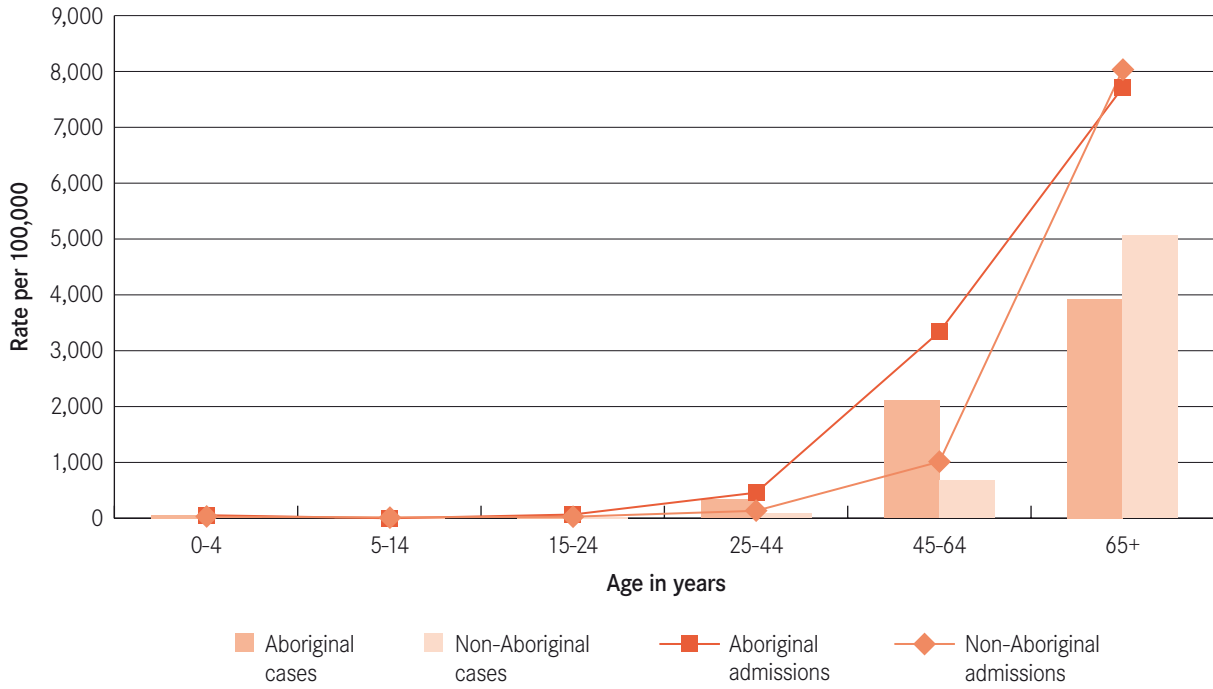


Table 48: Rate of female admissions for circulatory diseases, 2004/05–2006/07.

Female Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	55	17	55	27
5-14	0	10	0	16
15-24	54	19	67	28
25-44	333	83	458	134
45-64	2,110	680	3,337	1,012
65+	3,926	5,066	7,713	8,032

Indicator 16 vi: Oral disease

Compared to the Australian averages, Aboriginal people have twice as many caries and a greater proportion of untreated caries in children; more missing teeth in adults; and generally poorer periodontal health.⁹⁷

Victoria's public oral health system is targeted towards people in low socio-economic groups and a number of structures exist to give greater priority to special needs groups.

Health care and pensioner concession card holders and their dependants over the age of 18 are eligible for public oral health services. Priority access is given to preschool and primary school aged children and dependents of health care or pensioner concession card holders in Years 7 and 8 (14–15 year olds) who have left formal schooling. The service is free for children that are dependents of a health care or pensioner concession card holder.

There have also been a number of initiatives in Victoria aimed at improving access for Aboriginal people:

- The dental clinic at Rumbalara Aboriginal Cooperative (Mooroopna) was expanded as part of the Rural Dental Clinical School - the main campus being at Goulburn Valley Health in Shepparton. The recurrent costs of providing (public oral health) services at Rumbalara are provided by DHS. The Rumbalara clinic is also supporting the oral health workforce development among local Aboriginal people
- Murray Valley Aboriginal Cooperative is collaborating with the Mildura Aboriginal Health Service and the Swan Hill and District Aboriginal Cooperative to support their communities' access to oral health services at the Robinvale clinic (e.g. bus service)
- The department provides funding for some dentures through the Victorian Aboriginal Health Service clinic (Fitzroy) and through the Gippsland and East Gippsland Aboriginal Cooperative (Bairnsdale) clinic.

The Department of Human Services and Dental Health Services Victoria (DHSV) are represented on the Victorian Advisory Council on Koori Health (VACKH) Oral Health Subcommittee, which is also composed of representatives from the Australian Government Department of Health and Ageing and the Victorian Aboriginal Community Controlled Health Organisation. The VACKH Oral Health Subcommittee aims to improve Aboriginal oral health through improving their access to dental health services and oral health promotion initiatives.

In 2007, DHSV recruited an Aboriginal Liaison Officer to facilitate Aboriginal peoples' access to services at the Royal Dental Hospital of Melbourne. DHSV is also currently developing a Aboriginal Dental Health Plan. In some catchments, DHSV's oral health promotion program 'Smiles 4 Miles' is targeted specifically at Aboriginal communities.

Hospital admissions for oral disorders

The hospital admission rate for oral disorders is highest for young children aged 0–4 years. This is because young children require general anaesthetic for procedures that in older children and adults can be performed without general anaesthetic and hence do not require admission. The admission rate is much higher for Aboriginal children than non-Aboriginal children.

Aboriginal and non-Aboriginal rates are similar for older children and adults aged under 45 years. Aboriginal admission rates are lower for older adults.

⁹⁷ AIHW 2007, *The oral health of Aboriginal and Torres Strait Islander children*, AIHW Cat no DEN 167, Canberra, 2007. Victoria-specific data not available.

Figure 50: Rate of male admissions for oral disorders, 2004/05–2006/07.

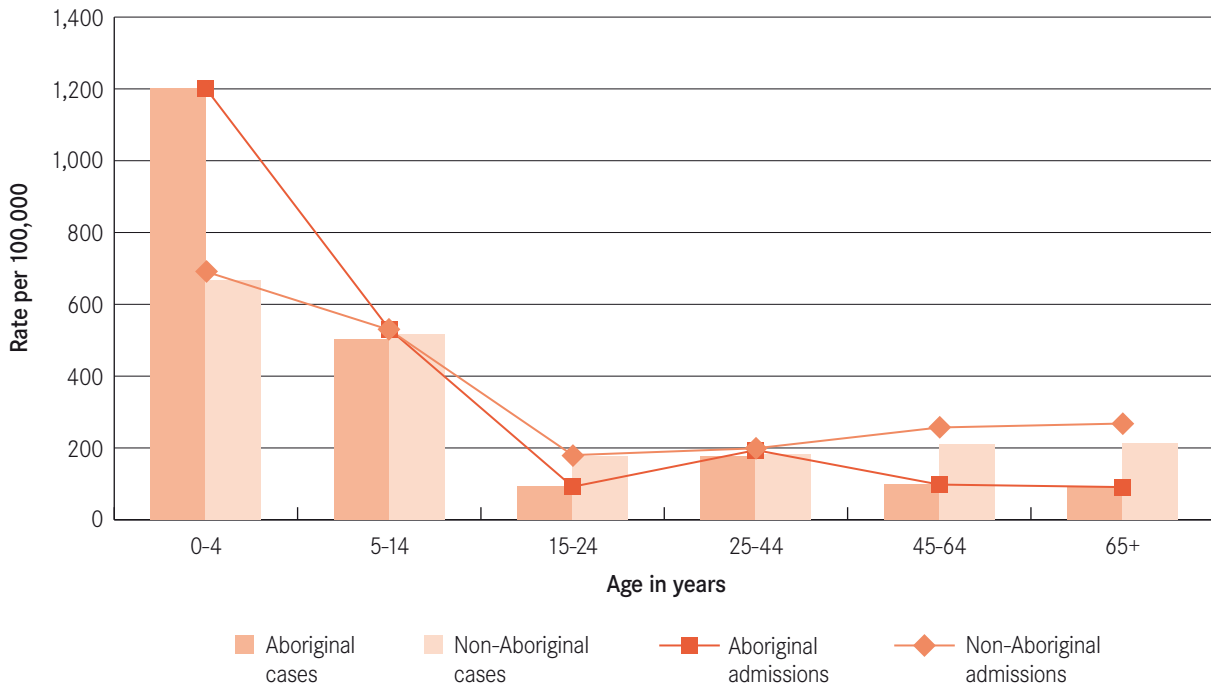


Table 49: Rate of male admissions for oral disorders, 2004/05–2006/07.

Male Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	1,201	668	1,201	691
5-14	503	516	531	529
15-24	92	177	92	180
25-44	176	183	194	199
45-64	98	209	98	257
65+	91	214	91	268

Figure 51: Rate of female admissions for oral disorders, 2004/05–2006/07.

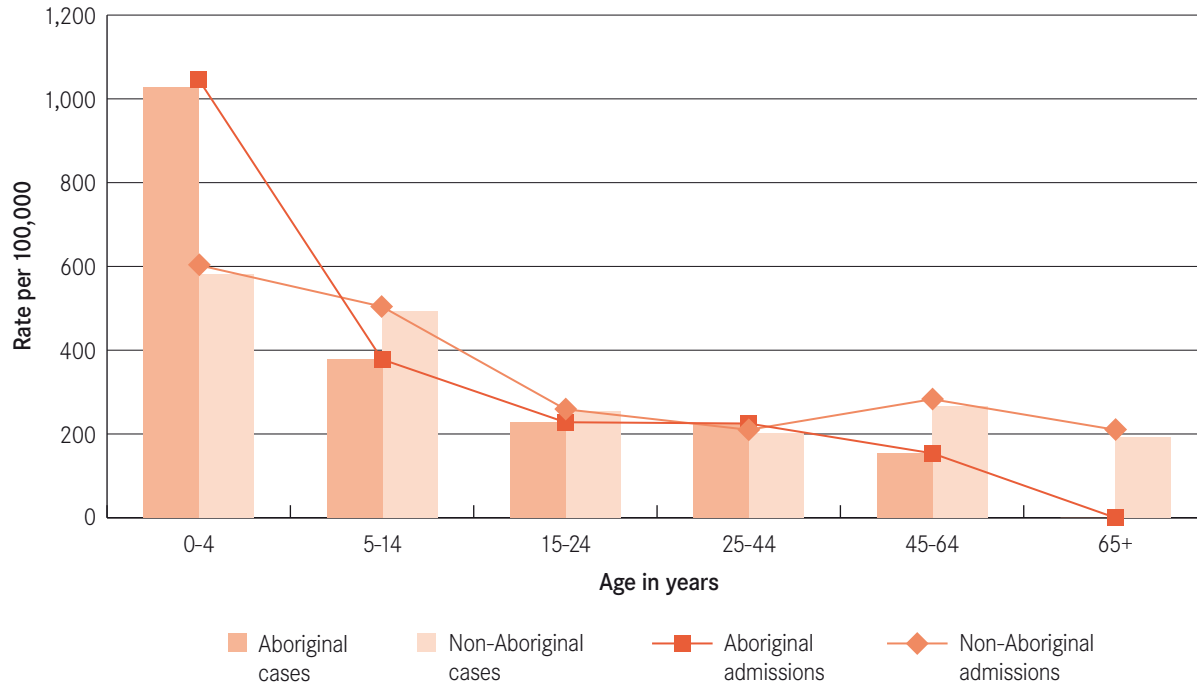


Table 50: Rate of female admissions for oral disorders, 2004/05–2006/07.

Female Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	1,028	581	1,046	603
5-14	378	492	378	504
15-24	228	255	228	259
25-44	225	202	225	210
45-64	154	266	154	283
65+	0	193	0	210

Indicator 16 vii: Diabetes

Diabetes is a long term condition in which blood glucose levels become too high because the body produces little or no insulin, or cannot use insulin properly. Insulin is a hormone produced by the pancreas that helps the body to use glucose.

There are three types of diabetes:

- Type 1 diabetes is marked by a total or near total lack of insulin. It results from the body destroying its own insulin-producing cells in the pancreas. People with this form of diabetes require daily insulin therapy to survive.
- Type 2 diabetes is marked by reduced levels of insulin, or the inability of the body to use insulin properly.
- Gestational diabetes occurs during pregnancy in about 3–8% of females not previously diagnosed with diabetes. It is a temporary form of diabetes and a marker of increased risk of developing Type 2 diabetes later in life.⁹⁸

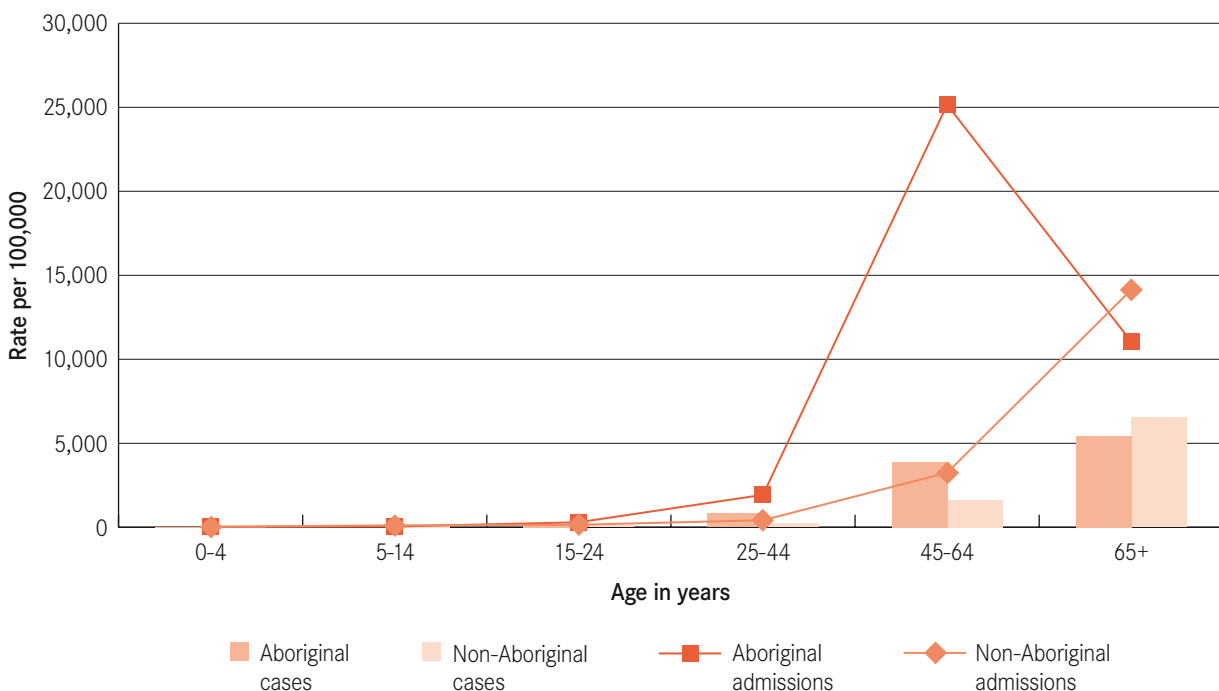
Diabetes is a major cause of ill health and hospital admissions in the Aboriginal population, both directly and through diabetes-related illnesses. It is more common among Aboriginal people than non-Aboriginal people. The incidence of diabetes in the Aboriginal population is increasing; however, the numbers shown in the tables below do not fully reflect the severity of the problem, as not all admissions of persons with diabetes will be primarily for the treatment of diabetes.

People with diabetes are more prone to certain problems and diseases, such as cardiovascular disease, glaucoma and blindness, kidney disease, neuropathy, foot ulcers and destructive periodontal disease.

The prevalence of Type 2 diabetes is considerably higher among Aboriginal people than for the total population and may be as high as 30% in some communities, compared with 7% in the general population.⁹⁹

The rate of Aboriginal admissions is higher than the rate of non-Aboriginal admissions for males 15–64 years, and for females from 15 years. The difference is particularly marked for females 45–64 years, where the Aboriginal rate is over eight times the non-Aboriginal rate, and males 45–64 years where the Aboriginal rate is seven times the non-Aboriginal rate. Aboriginal people develop diabetes at an earlier age than non-Aboriginal people¹⁰⁰.

Figure 52: Rate of male admissions for diabetes, 2004/05–2006/07.



⁹⁸ Australian Institute of Health and Welfare 2002, *Diabetes: the Australian facts 2002*. cat. no. CVD 20, AIHW, Canberra, 2002. p 3.

⁹⁹ Australian Institute of Health and Welfare 2002, *Diabetes: the Australian facts 2002*. cat. no. CVD 20, AIHW, Canberra, 2002. pp ix-xi.

¹⁰⁰ If diabetes progresses to renal failure, as is common, the number of admissions per individual can reach 155 per year.

Table 51: Rate of male admissions for diabetes, 2004/05–2006/07.

Male	Cases: rate per 100,000		Admissions: rate per 100,000	
Age in years	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0–4	19	25	19	36
5–14	37	84	46	114
15–24	197	101	301	151
25–44	821	219	1,932	421
45–64	3,903	1,613	25,153	3,249
65+	5,435	6,544	11,051	14,139

Figure 53: Rate of female admissions for diabetes, 2004/05–2006/07.

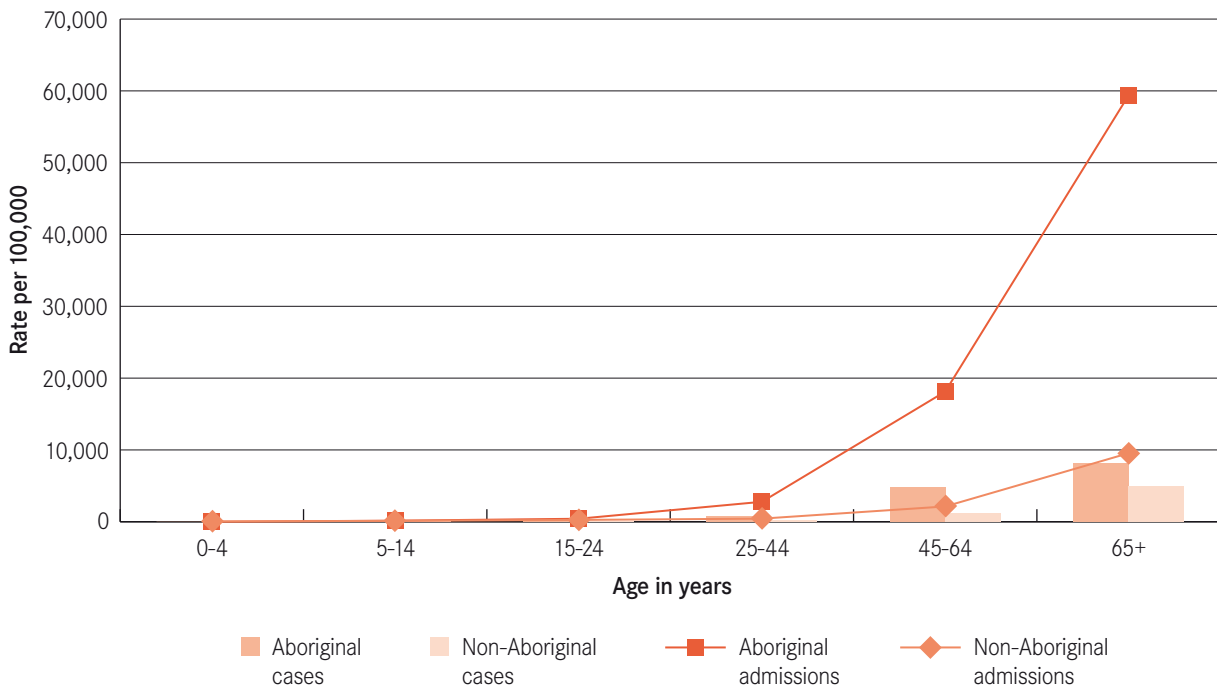


Table 52: Rate of female admissions for diabetes, 2004/05–2006/07.

Female	Cases: rate per 100,000		Admissions: rate per 100,000	
Age in years	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0–4	0	25	0	38
5–14	104	87	151	125
15–24	148	129	416	253
25–44	767	226	2,777	432
45–64	4,737	1,170	18,124	2,129
65+	8,196	4,910	59,367	9,543

Indicator 16 viii: Renal diseases

Renal diseases

Kidneys are filtering organs that process waste products that come from normal breakdown of food. If kidneys do not function properly the waste builds up in the blood and damages the body. Renal or kidney disease is a collective term to describe conditions that may lead to temporary or permanent loss of kidney function.¹⁰¹

There are a number of illnesses that can affect the kidneys (renal conditions). These include: diabetes, inflammations of the kidneys (nephritis), hereditary diseases of the kidneys, scarring of the kidneys caused by backflow of urine from the bladder and high blood pressure. In the long term, diabetes and high blood pressure can cause kidney failure. Other risk factors for renal diseases include infections, obesity and low birth weight.

If kidney function is reduced to less than 10 per cent of normal, the loss of function must be replaced by renal dialysis if a kidney transplant is not possible. Dialysis is a treatment for kidney failure that removes waste products and extra water from the blood.¹⁰²

Renal dialysis

The number of patients admitted for renal dialysis has increased steadily over the past ten years. Some of the increase in the number of admissions is due to improved reporting through both identification of Aboriginal patients and better counting of dialysis episodes. However, there has also been a real increase in renal dialysis among Aboriginal people and admissions per 1,000 population are five to seven times higher than non-Aboriginal admissions.

Although the number of Aboriginal admissions for dialysis is now very high, the number of patients on long term dialysis is low. A patient on long term dialysis might have up to 156 admissions in one year. Admissions continue until the patient receives a kidney transplant or dies. Two-thirds of Aboriginal patients receiving long term dialysis are women, most commonly aged 50–60 years, while the majority of men are aged 40–50 years. There is also a small number of patients receiving dialysis for acute renal failure. These patients typically receive dialysis only once or twice. These patients are predominantly male and are younger than long term patients.¹⁰³

The rate of admission for renal conditions is higher for Aboriginal males aged 15–64 years than non-Aboriginal males. Aboriginal females aged 25 years and above have higher rates of admission compared to non-Aboriginal females. The highest rate is that of Aboriginal females aged over 65 years. The drop in the number of admissions per individual for Aboriginal males aged over 65 years, and to a lesser extent for females, is due to lower rates of dialysis. People over 65 years are increasingly admitted for renal conditions other than dialysis.

¹⁰¹ Australian Indigenous HealthInfoNet 2003. <http://www.healthinonet.ecu.edu.au/>

¹⁰² Better Health Channel

¹⁰³ AHLO data 2005/06, Koori Health Counts 2005/06.

Figure 54: Rate of male admissions for renal diseases, 2004/05–2006/07

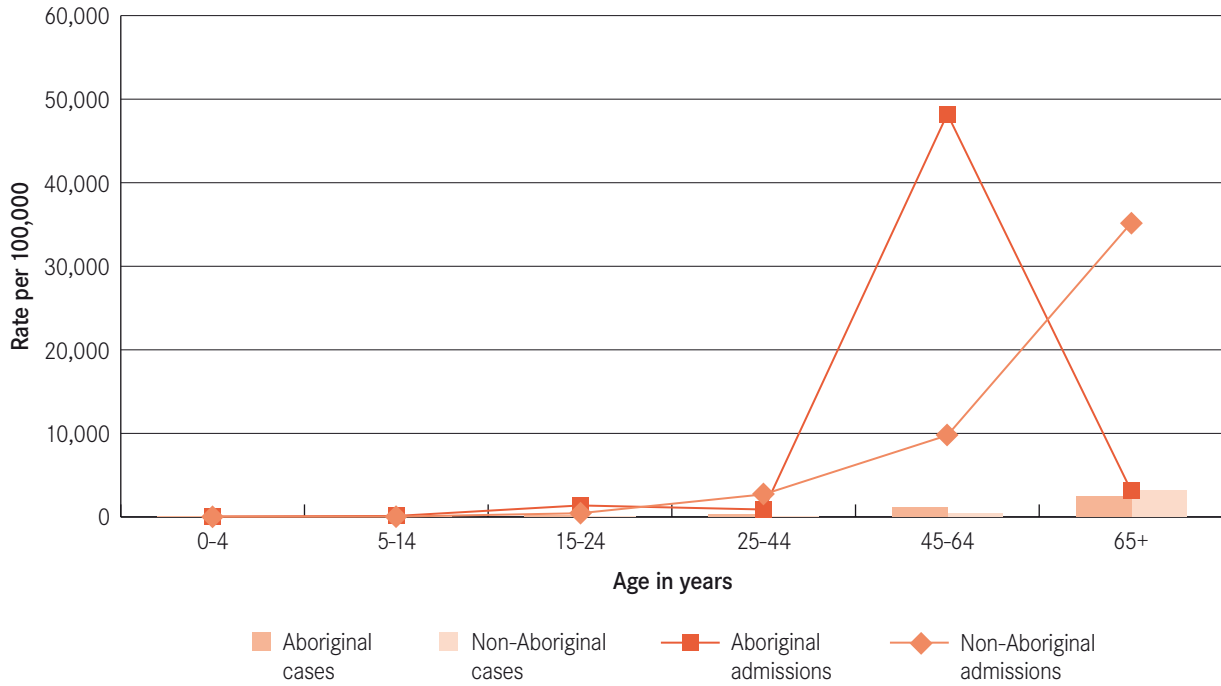


Table 53: Rate of male admissions for renal diseases, 2004/05–2006/07.

Male Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	56	22	56	26
5-14	27	9	119	41
15-24	131	25	1,376	444
25-44	265	84	891	2,706
45-64	1,163	365	48,216	9,767
65+	2,445	3,137	3,170	35,165

Figure 55: Rate of female admissions for renal diseases, 2004/05–2006/07.

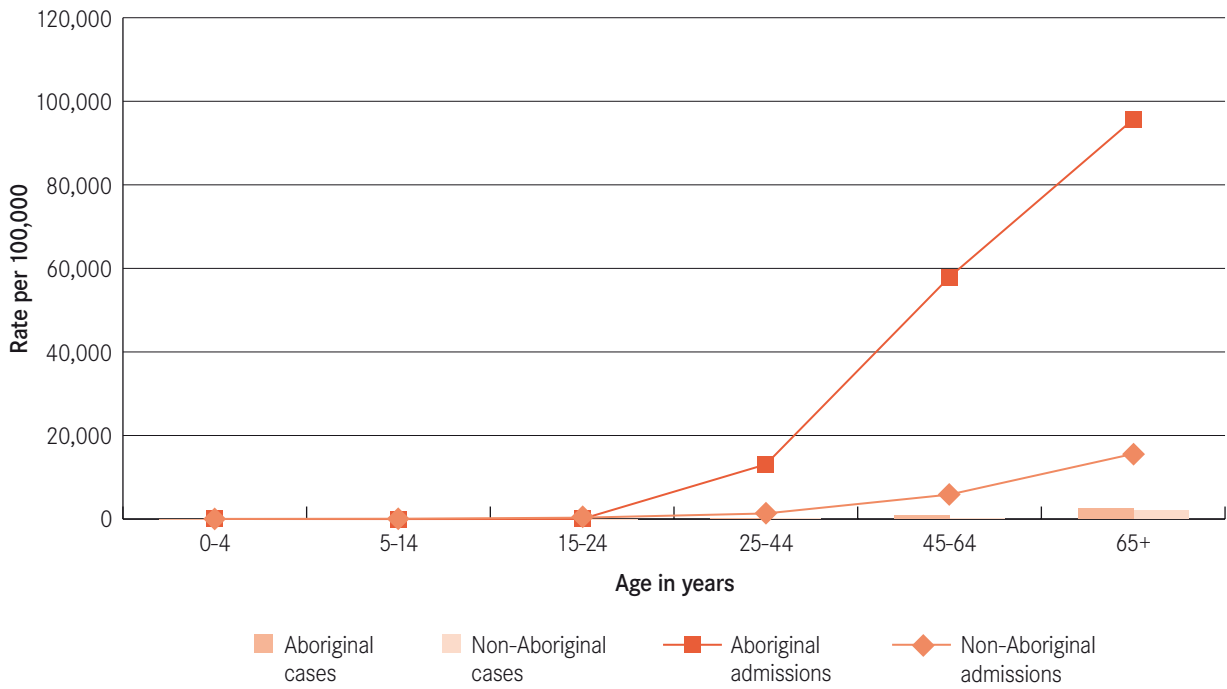


Table 54: Rate of female admissions for renal diseases, 2004/05–2006/07

Female Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	18	21	18	35
5-14	0	11	0	81
15-24	27	21	27	331
25-44	192	51	13,077	1,337
45-64	920	206	57,940	5,861
65+	2,617	2,051	95,661	15,604

Indicator 16 ix: Injury

Injuries, poisoning and burns are a major cause of admission for Aboriginal patients. The rate of admission for Aboriginal people is higher than the non-Aboriginal rate for males in all age groups except 5–14 years, and higher for females in all age groups except 5–14 years and over 65 years.

More Aboriginal males are admitted with injuries, poisonings and burns than Aboriginal women in every age group. The difference between male and female rates is greater for Aboriginal than non-Aboriginal people. This is consistent with national data.

Injuries include those caused by rail or motor vehicle accidents, other vehicle accidents, accidental poisoning, falls, accidents due to natural and environmental factors, drowning, firearms, work-related accidents, suicides, homicides and assaults.

Figure 56: Rate of male admissions for injuries, 2004/05–2006/07.

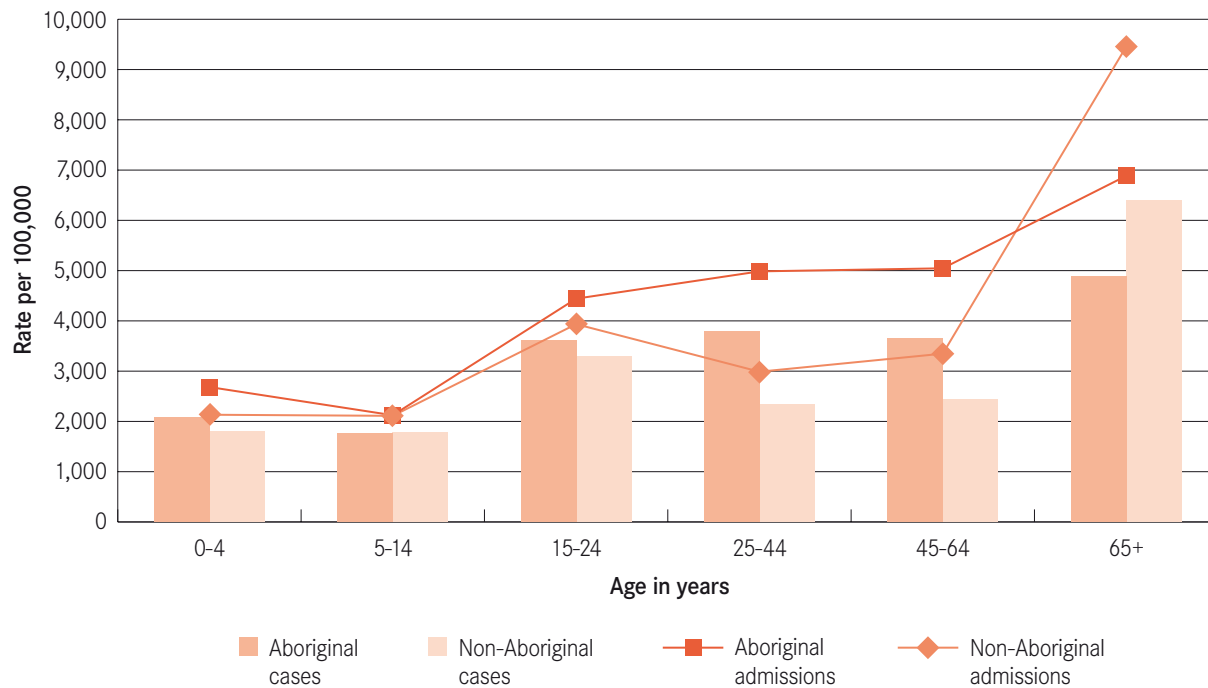


Table 55: Rate of male admissions for injuries, 2004/05–2006/07.

Male Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	2,083	1,793	2,684	2,133
5-14	1,766	1,788	2,123	2,111
15-24	3,603	3,287	4,442	3,935
25-44	3,794	2,341	4,985	2,989
45-64	3,647	2,444	5,046	3,348
65+	4,891	6,404	6,884	9,452

Figure 57: Rate of female admissions for injuries, 2004/05–2006/07.

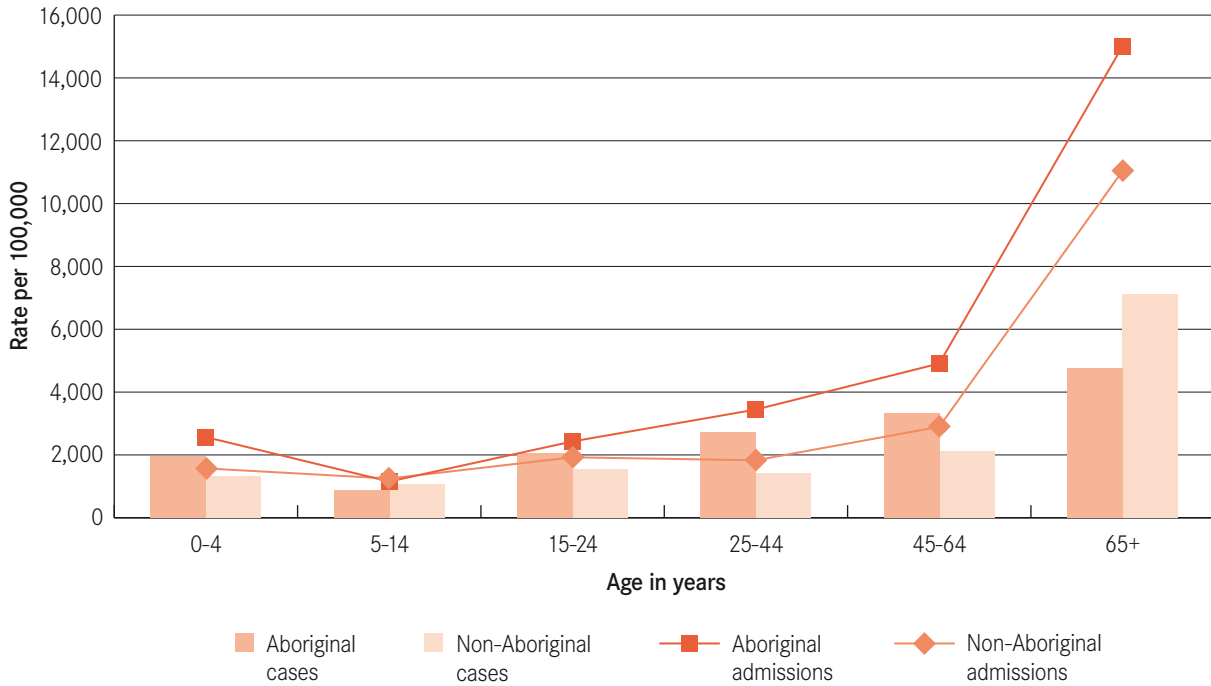


Table 56: Rate of female admissions for injuries, 2004/05–2006/07.

Female Age in years	Cases: rate per 100,000		Admissions: rate per 100,000	
	Aboriginal cases	Non-Aboriginal cases	Aboriginal admissions	Non-Aboriginal admissions
0-4	1,944	1,334	2,568	1,571
5-14	860	1,076	1,153	1,249
15-24	2,054	1,552	2,430	1,924
25-44	2,727	1,428	3,444	1,829
45-64	3,337	2,110	4,910	2,896
65+	4,752	7,121	15,014	11,042

Indicator 17: Community health

Community and Women's Health Programs improve the health and wellbeing of Victorians, and reduce demand for more specialised medical and acute hospital services. In 2006/07 over 120 agencies operated from more than 400 sites across Victoria. Services particularly relevant to Aboriginal people are provided through the following programs:

- *The Community Health Program* is delivered through independent community health centres, larger health services and non-Government organisations. Community health services provide a platform for the delivery of primary health services including allied health, nursing, counselling, drug and alcohol programs, dental, medical, post acute care, home and community care, community rehabilitation and day centres.
- Innovative Health Services for Homeless Youth (IHSY) aims to promote healthcare for homeless and otherwise at-risk young people through innovative approaches to health service delivery and increasing access to mainstream and specialist services.
- *The Family Planning Program (FPP)* aims to enable Victorians to make individual choices on sexual and reproductive health matters through the provision of a range of services that are accessible, culturally relevant and responsive to the needs of people who experience difficulty accessing mainstream services.
- Women's Health program funds three state wide and nine regional services. The program aims to improve the health and wellbeing of all Victorian women (with an emphasis on those most at risk), through the development and dissemination of health information and research and through community and professional education. Women's Health Services work directly with women and in partnership with other organisations.

Strategies

The Aboriginal Health Promotion and Chronic Care (AHPACC) Partnership supports Community Health Services and Aboriginal Community Controlled Health Organisations (ACCHOs) to work collaboratively to improve health outcomes for Aboriginal people in Victoria with, or at risk of, chronic disease. In 2006/07 priority plans were implemented with a focus on health promotion and/ or chronic disease in respective catchment populations.

There are 9 partnerships comprised of 12 community health services and 8 ACCHOs. AHPACC workers provide direct care and health promotion activities for local Aboriginal communities in both Community Health Services and the corresponding ACCHOs.

Service usage

Within the Community Health Program the types of service most frequently used by Aboriginal people are counselling/ casework, allied health and nursing. Aboriginal people use allied health services less frequently than non-Aboriginal people, but use counselling/ casework, health promotion and nursing services more frequently.

One per cent of registered clients in Community Health Programs identified themselves as being Aboriginal. Identification of Aboriginal clients is poor in most community health services.

Figure 58: Service utilisation in community health programs, 2005/06–2006/07.

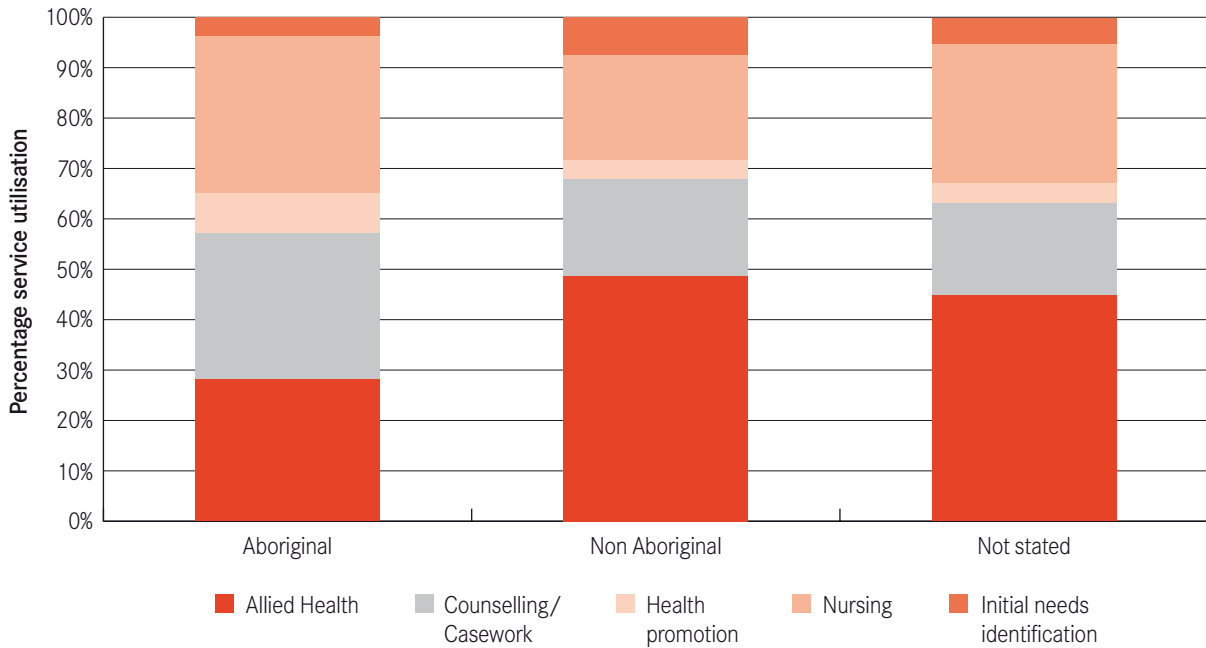


Table 57: Service utilisation in community health programs, 2005/06–2006/07.¹⁰⁴

Percentage	Allied health	Counselling/casework	Health Promotion	Nursing	Case Coordination	Initial Needs identification	Total
2005/06							
Aboriginal	25.6	30.8	11.9	31.7	N/A	N/A	100.0
Non-Aboriginal	49.2	22.6	4.4	23.8	N/A	N/A	100.0
Not Stated	45.6	22.3	3.4	28.7	N/A	N/A	100.0
2006/07							
Aboriginal	28.1	29.1	7.9	31.1	0.0	3.8	100.0
Non-Aboriginal	48.7	19.1	3.8	20.9	0.0	7.5	100.0
Not Stated	44.8	18.4	3.8	27.6	0.0	5.3	100.0

¹⁰⁴ Community and Women’s Health Clients – Multi Purpose Report and primary Care and Health Promotion Reports

Appendix 1: Data availability and quality

The quality of all Aboriginal data depends on accurate identification of clients as Aboriginal. Unless the collection of demographic data, including Aboriginal status, would compromise the delivery of services, all clients using DHS services should be asked if they identify as:

- Aboriginal
- Torres Strait Islander
- Both Aboriginal and Torres Strait Islander
- Not Aboriginal or Torres Strait Islander

Clients should be asked directly, or, in the case of babies and young children, the accompanying adult should be asked on their behalf. This data item should be checked, where feasible, on every occasion of service.

In this report the term 'Aboriginal' is used in preference to 'Indigenous'. 'Aboriginal' includes all persons identifying as Aboriginal and/or Torres Strait Islander. Data for persons identifying as Aboriginal, Torres Strait Islander, and both Aboriginal and Torres Strait Islander are not presented separately because publication of the small numbers of people in some groups could compromise privacy and confidentiality.

Even where the recording of Aboriginal status is a mandatory data item, not all agencies, either mainstream or Aboriginal-specific, comply with this requirement. Strategies are being implemented to improve the recording of Aboriginal status in all data collection systems.

Data are presented as appropriate by both calendar and financial year. Multiple calendar years are shown as 2006–2007 and financial years as 2006/07.

Strategic area 1: Early child development and growth

Data quality in children's services

It is difficult to calculate the percentage of Aboriginal children using services such as immunisation and Maternal and Child Health, as the exact number of Aboriginal babies born each year in Victoria is not known. While all newborn babies are registered, not all Aboriginal babies are registered as Aboriginal.

The table below shows the number of Aboriginal babies recorded by the major Victorian birth-related datasets. There is variation in the data and therefore the estimated total number for each year is 800 babies. All data on use of children's services should be considered against this estimate.

It must also be noted that many Aboriginal children use services without being recorded as Aboriginal. This situation is improving over time as service providers expand their collection of Aboriginal identification and strategies are put into place to support Aboriginal people's willingness to identify as Aboriginal.

Table 58: Aboriginal births in Victoria, 1999–2006¹⁰⁵

Year	Births						
	RBDM All births	RBDM births to Aboriginal mothers	PDCU births to Aboriginal mothers	VAED births to Aboriginal mothers	AHLO all Births	MCHS all births (99/00)	Census 2001 all births
1999	521	223	452	363	353	567	763
2000	452	273	377	333	303	544	746
2001	522	302	421	379	363	584	673
2002	601	344	416	411	299	559	741
2003	722	435	362		310	664	705
2004	719	429	435	441	397	681	688
2005	802	484	538	432	449	749	743
2006	782	459	569	599		777	741

Indicators 1,2,3: Perinatal Data Collection Unit (PDCU), DHS

Data about births to Aboriginal mothers and perinatal mortality are provided to PDCU by the midwives attending the births. Aboriginal status is believed to be under-identified, but the accuracy of perinatal death data, maternal age and birth weights is believed to be high. Babies with a non-Aboriginal mother and an Aboriginal father are not recorded as Aboriginal.

Data are available by calendar years and are usually pooled to avoid fluctuations caused by very low numbers. Reports might differ slightly on the number of Aboriginal mothers and/or deaths due to updating of the databases as new information becomes available. Data collected by PDCU have been confirmed by data collected by Aboriginal Hospital Liaison Officers.

Births are defined as deliveries of 20 weeks gestation or a foetus weighing more than 400g. Terminations of pregnancy and stillbirths after 20 weeks/ 400g are included.

Indicator 4: Immunisation

Immunisation providers report data, including Aboriginal status, to the Australian Childhood Immunisation Register (ACIR). Aboriginal status is not always provided. Not all Aboriginal medical services providing immunisations report to ACIR.

Immunisation data are available from ACIR for children aged 12–15 months (cohort 1), 24–27 months (cohort 2) and 72–75 months (cohort 3), which are milestones for measuring immunisation coverage at scheduled points on the National

¹⁰⁵ Registry of Births, Deaths and Marriages (RBDM). Published in Australian Bureau of Statistics (ABS) 2007, *Births Australia 2006*, ABS cat. no.3301.0 ABS, Canberra.

Perinatal Data Collection Unit (PDCU). In RBDM and PDCU births are defined as 20+ weeks gestation or weight of 400 grams. Published in *Births in Victoria*, biennial publication by Perinatal Data Collection Unit:

Riley, M. and Halliday, J., 1999, *Births in Victoria 1996–1998*, Perinatal Data Collection Unit, Department of Human Services, Melbourne.

Riley, M., Davey M-A and King, J., 2005, *Births in Victoria 2003–2004*, Perinatal Data Collection Unit, Department of Human Services, Melbourne.

Victorian Admitted Episodes Dataset (VAED).

Aboriginal Hospital Liaison Officer (AHLO) dataset, collected in 16 maternity hospitals. Published in Department of Human Services, *Koori Health Counts: Information from the reports of Aboriginal Hospital Liaison Officers for*. Koori Human Services Unit, Department of Human Services, Melbourne. Annual publication.

Maternal and Child Health Service (MCHS), collected by financial year 1999/2000 to 2006/07.

ABS Census 2006 data regressed for births before 2006 (e.g. aged 1 in 2006 = birth in 2005)

Immunisation Program. The immunisation coverage is expressed as the percentage of children fully immunised in each cohort for the various antigens. The data are available on a quarterly basis from ACIR for immunisation coverage reported for each cohort from the preceding quarter. Children are included in ACIR through enrolment in Medicare Australia, which includes an Indigenous identifier.

The expected number of Aboriginal children in each age cohort in each quarter would be 200 children, as the number of Aboriginal births each year is estimated at approximately 800. The number of children aged 12–15 months and 24–27 months immunised each quarter is approaching this number. The very large number of children immunised aged 72–75 months in each quarter in earlier years can be best explained by incorrect identification of children as Aboriginal by immunisation providers for a particular time period. These children have now progressed through the system.

It is difficult to ascertain the percentage of Aboriginal children fully immunised in each age group. The reported data show the percentage of children enrolled in Medicare Australia who are fully immunised, but not all Aboriginal children are enrolled in Medicare Australia. It should also be noted that not all Aboriginal children enrolled in Medicare Australia or immunised are recorded as Aboriginal. It may also be the case that not all immunisations administered to Aboriginal children are reported to ACIR by the immunisation provider.

Indicator 5: Maternal and Child Health Service

Data are collected by Maternal and Child Health nurses on the first contact with the family, which is usually immediately after mother and child leave hospital. Aboriginal identification is considered to be of high quality. Babies are recorded as Aboriginal if either the mother or the father identifies as Aboriginal.

Strategic action area 2: Early school engagement and performance – Kindergarten to Year 3

Indicator 6: Screening for hearing loss

Data are collected by the School Nursing Service at the time of assessment. Prep children at schools registered with the School Nursing Services are eligible for the Primary Health Assessment. Not all children participate and Aboriginality is not recorded for all children.

Children identified as Aboriginal are less likely to have a Primary Health Assessment than non-Aboriginal children. In 2007 64% of Aboriginal children had a Primary Health Assessment, as compared to 88% of non-Aboriginal children.¹⁰⁶

There is no systematic surveillance and follow-up of hearing loss in children in Victoria. The uneven quality of Aboriginal identification data compounds the difficulties of estimating the number of Aboriginal children with hearing loss.

Indicator 7: Kindergarten enrolments

It is difficult to gauge the percentage of Aboriginal children enrolled in kindergarten; however, it seems in many regions the percentage of Aboriginal children enrolled in kindergarten is lower than the percentage of non-Aboriginal children. Kindergarten data each year can be compared with school prep enrolments for the following years. The number of Aboriginal children enrolled at kindergarten is lower than the number of Aboriginal children subsequently attending school.

It is not possible to measure the number of children attending, as opposed to enrolled at kindergarten.

Data are collected through kindergarten enrolment forms. Regional Koori Early Childhood Field Officers have improved the rate of Aboriginal identification; however, it is thought that not all Aboriginal children are identified as Aboriginal.

¹⁰⁶ These rates were calculated using the number of children identified as Aboriginal by SNIS divided by the number of children in Prep (DE&T data).

Strategic action area 3: Positive childhood and transition to adulthood

Child Protection

Child Protection Data for Victoria are generated by the Client Record Information Systems. The protocols of the Aboriginal Child Placement Principle ensure that Aboriginal children are identified as accurately as possible. Current placement data are generated from funded community service organisation placement providers.¹⁰⁷

Youth Justice

The provisions of the Victorian Aboriginal Justice Agreement encourage accurate identification of Aboriginal youth in the youth justice system.

Strategic action area 4: Substance use and misuse

Alcohol and Drug community-based services

Data are collected by the Alcohol and Drug Information System (ADIS). DHS purchases drug treatment services from independent agencies. Approximately 90 agencies send to DHS separate de-identified data, which are consolidated into one database.

Aboriginal clients are identified in both mainstream and Aboriginal-specific services. Not all clients of Aboriginal-specific services are necessarily Aboriginal.

In 2006/07, approximately 2,100 Aboriginal clients were reported receiving 4000 Alcohol and Drug courses of treatment. This figure is likely to be significantly under-reported as many Indigenous Agencies do not comply with reporting requirements. In all, 7% of all clients receiving government funded Alcohol and Drug treatment in Victoria were identified as Aboriginal. However, a significant proportion of clients (10%) are reported as "Unknown" against Aboriginal status.

There is high reporting non-compliance in Aboriginal agencies and hence Aboriginal activity is significantly under-reported.

Strategic action area 5: Functional and resilient families and communities

Disability

Until 2002 data were collected from agencies through an annual census, which measured the number of clients of Disability Services on a particular day. In 2003 this was replaced by quarterly data collection. The collection is considered to be an underestimate of the number of Aboriginal clients.

Supported Accommodation Assistance Program

As it is not mandatory to collect data on Aboriginal status, the number of Aboriginal clients shown above is probably an under-representation of the actual number.

Children under 18 years accompanying an adult client are not counted separately as clients.

¹⁰⁷ The rates of children on orders and in out-of-home care were calculated using the number of children aged 0–17 years on orders or in out-of-home care at 30 June 2007 divided by the ABS estimated population aged 0–17 years at 31 March 2007. Substantiation rates were calculated using the number of children 0–16 years who were the subject of substantiations in 2006/07 divided by the ABS estimated population aged 0–16 years at 31 December 2006. The population of Aboriginal children was based on projections from the ABS 2006 Census. AIHW 2008, *Child Protection Australia 2006–07*. AIHW cat. no. CWS 31. Canberra. (Child Welfare Series no. 43)

Housing

The quality of Aboriginal identification in the housing data collection is very high. Persons applying for housing through the Aboriginal Housing Board Victoria (AHBV) must confirm that someone in the household is of Aboriginal descent and this confirmation must be signed by a recognised Aboriginal or Torres Strait Islander organisation, an Aboriginal Elder or an Aboriginal community member. This level of identification is not required for public housing applicants who wish to be recorded as Aboriginal but not access AHBV housing.

Home and Community Care (HACC)

The HACC Minimum Data Set (MDS) is based on linked client records, which collect a standard set of data items on each person who receives HACC-funded services.

Not all Aboriginal clients are correctly identified in the MDS as mainstream HACC agencies do not accurately record Aboriginal status and not all Aboriginal-specific HACC agencies report to the HACC Minimum Data Set.

The poor identification of Aboriginal people in mainstream HACC services and the failure of some Aboriginal-specific HACC services to submit data has meant data before 2003 are not of useable quality.

Aged Care Assessment Service (ACAS)

Data are taken from the ACAP Minimum Data Set. The data improved greatly in 2003/04. The rate per 1000 population is based on ABS Census 2001, non-Aboriginal population aged over 70 years and Aboriginal population over 50 years.

Life expectancy

Life expectancy is calculated from deaths registered as Aboriginal. In 2006 it was estimated only 32% of Aboriginal deaths in Victoria were registered as Aboriginal deaths. Data are pooled because of the small number of deaths. For the same reason, life expectancy can also show fluctuations from year to year.

In 2003 new experimental life tables were produced for Aboriginal people using a different method to adjust for deaths not reported as Aboriginal. Data from New South Wales and Victoria were combined for Indigenous people to produce a single figure for 1996–2001.¹⁰⁸

Hospital admissions

Data on hospital admissions are taken from the Victorian Admitted Episodes Dataset (VAED). The VAED collects data on Aboriginal status from all hospitals, but the quality of identification of Aboriginal patients is variable and many hospitals under-record the number of Aboriginal patients. However, VAED data can be used to show comparisons between Aboriginal and non-Aboriginal admission rates. The Aboriginal Hospital Liaison Officer (AHLO) dataset is collected by 23 Aboriginal Hospital Liaison Officers covering 27 Victorian hospitals. It is used to validate Aboriginal identification in data from the VAED.

Data from the VAED from 2004/05 to 2006/07 have been pooled and expressed as rates per 100,000 population. Both the rate of cases (individuals) and the rate of admissions are presented. Where the admission rate is higher than the case rate, a small number of patients are admitted multiple times for the same condition.

One of the aims of the ICAP Program is to improve the accuracy of Aboriginal identification.

Oral diseases

Data on oral diseases are collected through the VAED (see hospital admissions above) and from the School Dental Service and Adult Dental Clinics.

¹⁰⁸ Australian Bureau of Statistics, 2004, *Demography Working Paper 2004/3 – Calculating experimental life tables for use in population estimates and projections of Aboriginal and Torres Strait Islander Australians*, cat. no. 3106.0.55.003, ABS, Canberra.

Infectious diseases

Data on infectious diseases are available through the VAED (see hospital admissions above) and from the Notification of Infectious Diseases System. Notifications are made by hospitals, laboratories and doctors to the Communicable Diseases Section of the Public Health Branch, Department of Human Services. The Health (Infectious Diseases) Regulations were amended in May 2001 to include Indigenous status, and collection of this data item is slowly improving.

Communicable Diseases Section has initiated online reporting of Communicable Diseases and Indigenous status. Collaboration has occurred with the Victorian Advisory Council on Koori Health (VACKH) – Sexual Health Subcommittee and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to identify reporting issues.

Community Health

Data is collected through the Registered Client Database (SWITCH). The percentage of clients per activity has been applied to the statewide data. It should be noted that the Aboriginal identification of many clients is not collected.

Appendix 2: List of Figures

Introduction

- Figure 1 OID priority outcome areas
Figure 2 OID strategic areas for action
Figure 3 Percentage of Victorian Aboriginal population by age group, 2006

Strategic Action Area 1 **Early Child Development and Growth**

- Figure 4 Perinatal mortality rates, 1996–2006. [VIAF 1.2]
Figure 5 Percentage of babies with low birth weight, 1996–2006 [VIAF 1.3]
Figure 6 Distribution of babies by birth weight, 2006
Figure 7 Percentage of women giving birth aged less than 20 years, 1996–2006
Figure 8 Age profile of mothers, 2002–2006
Figure 9 Rate of teenage confinements, 2000–2006
Figure 10 Aboriginal children using Maternal and Child Health Service, 1999/00–2006/07
Figure 11 Maternal and Child Health Service participation rates, 2006/07

Strategic Action Area 2 **Early School Engagement Performance – Kindergarten to Year 3**

- Figure 12 Aboriginal four year old kindergarten participation rate, 1999–2006. [VIAF 1.4]
Figure 13 Aboriginal kindergarten enrolments compared to Prep enrolments a year later, 1999–2007

Strategic Action Area 3 **Positive Childhood and Transition to Adulthood**

- Figure 14 Rate of child protection substantiations, 1999/00–2006/07. [VIAF 1.5]
Figure 15 Rate of protection orders, 1999/00–2006/07
Figure 16 Rate of children in out-of-home care, 1999/00–2006/07
Figure 17 ACPP compliance, 2001–2007
Figure 18 Rates of youths on youth justice orders by type, June 2002–June 2007. [VIAF 4.3,4.4, 4.5, 4.7]

Strategic Action Area 4 **Substance Use and Misuse**

- Figure 19 Rate of Alcohol and Drug community-based clients, 2003/04 – 2006/07. [VIAF 1.1]
Figure 20 Percentage of clients of community-based Alcohol and Drug services by age group, 2006/07
Figure 21 Clients of community-based Alcohol and Drug services as rate per 1000 population, 2006/07
Figure 22 Use of agency types by Aboriginal people, 2006/07
Figure 23 Use of treatment service types, 2006/07
Figure 24 Rate of male alcohol-related hospital admissions, 2004/05–2006/07
Figure 25 Rate of female alcohol-related hospital admissions, 2004/05–2006/07
Figure 26 Rate of male drug-related hospital admissions, 2004/05–2006/07
Figure 27 Rate of female drug-related hospital admissions, 2004/05–2006/07

Strategic Action Area 5 Functional and Resilient Families and Communities

- Figure 28 Rate of disability service usage, 2006/07
- Figure 29 Aboriginal SAAP clients, 1999/00 – 2006/07
- Figure 30 New Aboriginal applicants on the public housing waiting list, 30 June 1999 – 30 June 2007
- Figure 31 Aboriginal tenants housed in public housing, 30 June 1999 – 30 June 2007
- Figure 32 Tenants housed and waiting, 1999–2007
- Figure 33 HACC user rates, 2006/07
- Figure 34 HACC clients by service type, 2006/07
- Figure 35 HACC usage by agency type, 2006/07
- Figure 36 ACAS referrals and assessments, 2005/06–2006/07

Health

- Figure 37 Life expectancy, 2006
- Figure 38 Death rates per 100,000 population, 2006
- Figure 39 Rate of male admissions for mental conditions, 2004/05–2006/07
- Figure 40 Rate of female admissions for mental conditions, 2004/05–2006/07
- Figure 41 Rate of male admissions for ENT conditions, 2004/05–2006/07
- Figure 42 Rate of female admissions for ENT conditions, 2004/05–2006/07
- Figure 43 Rate of male admissions for respiratory disorders, 2004/05–2006/07
- Figure 44 Rate of female admissions for respiratory disorders, 2004/05–2006/07
- Figure 45 Rate of male admissions for infectious diseases, 2004/05–2006/07
- Figure 46 Rate of female admissions for infectious conditions, 2004/05–2006/07
- Figure 47 Rate of infectious diseases notifications, 2007
- Figure 48 Rate of male admissions for circulatory diseases, 2004/05–2006/07
- Figure 49 Rate of female admissions for circulatory diseases, 2003/04–2005/06 2004/05–2006/07
- Figure 50 Rate of male admissions for oral disorders, 2004/05–2006/07
- Figure 51 Rate of female admissions for oral disorders, 2004/05–2006/07
- Figure 52 Rate of male admissions for diabetes, 2004/05–2006/07
- Figure 53 Rate of female admissions for diabetes, 2004/05–2006/07
- Figure 54 Rate of male admissions for renal diseases, 2004/05–2006/07
- Figure 55 Rate of female admissions for renal diseases, 2004/05–2006/07
- Figure 56 Rate of male admissions for injuries, 2004/05–2006/07
- Figure 57 Rate of female admissions for injuries, 2004/05–2006/07
- Figure 58 Service utilisation in community health programs, 2005/06–2006/07

Appendix 3: List of Tables

Overview

Table 1	Indicators used in this report
Table 2	Age Structure of Victorian Aboriginal population, 2006
Strategic Action Area 1 Early Child Development and Growth	
Table 3	Perinatal mortality rates per 1,000 births, 1996–2006. [VIAF 1.2]
Table 4	Percentage of babies with low birth weight, 1996–2006 [VIAF 1.3]
Table 5	Percentage of births by birth weight, 2000–2006
Table 6	Percentage of women giving birth aged less than 20 years, 1996–2006
Table 7	Age profile of mothers, 2002–2006
Table 8	Rates of confinements per 1000 population, 2002–2006
Table 9	Percentage of children immunised by age and reported to ACIR, 2002/03–2006/07
Table 10	Number of children who are Aboriginal fully immunised and reported to ACIR, 2000/01–2006/07
Table 11	Aboriginal children using Maternal and Child Health Service, 1999/00–2006/07
Table 12	Maternal and Child Health Service key ages and stages, 2006/07
Strategic Action Area 2 Early School Engagement Performance – Kindergarten to Year 3	
Table 13	Hearing screening by School Nursing Service, 2002–2007
Table 14	Participation rate Aboriginal children in kindergarten, 1999–2007. [VIAF 1.4]
Strategic Action Area 3 Positive Childhood and Transition to Adulthood	
Table 15	Rate of child protection substantiations, 1999/00–2006/07. [VIAF 1.5]
Table 16	Rate of children on protection orders, 1999/00–2006/07
Table 17	Rate of children in out-of-home care, 1999/00–2006/07
Table 18	Aboriginal out-of-home care placements and compliance with ACPP, 2001–2007
Table 19	Rates of youths on juvenile justice orders by type, June 2002–June 2007. [VIAF 4.3, 4.4, 4.5, 4.7]
Strategic Action Area 4 Substance Use and Misuse	
Table 20	Rate of Alcohol and Drug community-based clients and courses of treatment, 2004/05–2006/07. [VIAF 1.1]
Table 21	Clients of community-based Alcohol and Drug services by age, 2006/07
Table 22	Use of agency types, 2006/07
Table 23	Use of treatment service types, 2006/07
Table 24	Rate of male alcohol related hospital admissions, 2004/05–2006/07
Table 25	Rate of female alcohol-related hospital admissions, 2004/05–2006/07
Table 26	Rate of male drug-related hospital admissions, 2004/05–2006/07
Table 27	Rate of female drug-related hospital admissions, 2004/05–2006/07

Strategic Action Area 5 Functional and Resilient Families and Communities

Table 28	Number of clients by age, 2006/07
Table 29	Rate of disability service usage, 2006/07
Table 30	Aboriginal SAAP clients, 1999/00 – 2005/06
Table 31	Aboriginal applicants on the public housing waiting list, 30 June 1999 – 30 June 2007
Table 32	Aboriginal tenants housed in public housing, 1998/99 – 2006/07
Table 33	Ratio of tenants in properties to clients on the waiting list, 30 June 1999 – 30 June 2007
Table 34	HACC user rates, 2006/07
Table 35	HACC clients by service type 2006/07
Table 36	HACC usage by agency type, 2006/07
Table 37	ACAS referrals and assessments, 2005/06 – 2006/07

Health

Table 38	Rate of male admissions for mental conditions, 2004/05–2006/07
Table 39	Rate of female admissions for mental conditions, 2004/05–2006/07
Table 40	Rate of male admissions for ENT conditions, 2004/05–2006/07
Table 41	Rate of female admissions for ENT conditions, 2004/05–2006/07
Table 42	Rate of male admissions for respiratory disorders, 2004/05–2006/07
Table 43	Rate of female admissions for respiratory disorders, 2004/05–2006/07
Table 44	Rate of male admissions for infectious diseases, 2004/05–2006/07
Table 45	Rate of female admissions for infectious conditions, 2004/05–2006/07
Table 46	Rate of infectious diseases notifications, 2007
Table 47	Rate of male admissions for circulatory diseases, 2004/05–2006/07
Table 48	Rate of female admissions for circulatory diseases, 2004/05–2006/07
Table 49	Rate of male admissions for oral disorders, 2004/05–2006/07
Table 50	Rate of female admissions for oral disorders, 2004/05–2006/07
Table 51	Rate of male admissions for diabetes, 2004/05–2006/07
Table 52	Rate of female admissions for diabetes, 2004/05–2006/07
Table 53	Rate of male admissions for renal diseases, 2004/05–2006/07
Table 54	Rate of female admissions for renal diseases, 2004/05–2006/07
Table 55	Rate of male admissions for injuries, 2004/05–2006/07
Table 56	Rate of female admissions for injuries, 2004/05–2006/07
Table 57	Service utilisation in community health programs, 2005/06–2006/07

Appendix

Table 58	Aboriginal births in Victoria, 1999–2006
----------	--

