Childrens’ health: Parents’ perceptions

Parents’ views on the health and well being of Victorian preparatory grade children
School Entrant Health Questionnaire (SEHQ) 2000 report
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School Entrant Health Questionnaire (SEHQ) 2000 report
Foreword

Improving the health and wellbeing of Victorian children is a major priority of this Government. The School Entrant Health Questionnaire (SEHQ) 2000 Report contains information from over 55,000 Victorian parents. Analysis of the SEHQ is timely, and is complementary to existing information on children’s health and wellbeing such as the Burden of Disease findings.

The SEHQ information provides a rich source of baseline population data on Victorian children aged five to seven years at a local, regional and state level. It creates one of the largest databases available in Australia capturing parent perceptions about the health and wellbeing of children in this particular age cohort.

The findings of this report will assist Departmental program areas, both in health and education, as well as local health planning authorities and service providers, in their future policy development and planning around children’s health. The information will also contribute to the enhancement of existing programs and services that support children and families in our community, such as Maternal and Child Health, parenting support, children’s services and the School Nursing Program.

The great value of this information is that it comes from the parents of preparatory grade children. The School Entrant Health Questionnaire provides primary school nurses with valuable information about each child’s health status and highlights issues that may affect their capacity to learn. This enables early intervention strategies and additional support to be provided to children in their formative early years. In addition, it gives parents an opportunity to identify and express any concerns they have about their child’s health and wellbeing. The Government recognises and values community views and encourages policy and program planning areas to actively seek community and consumer opinion.
Acknowledgments

The project team that contributed to the production of this report included:

- Professor Patrick Griffin and Mr Hamish Coates of the Assessment Research Centre (University of Melbourne)
- Professor Gay Edgecombe of the Department of Nursing and Midwifery (RMIT University)
- Ms Kim Hider, Dr Hua Zhang, Ms Bernice Murphy, Alison Morris and Dushanka Jovanovska from the Community Health Unit of the Rural and Regional Health and Aged Care Services Division, Department of Human Services, Victoria
- Staff from Community Care, Public Health and Mental Health divisions, and Dental Health Unit, Rural and Regional Health and Aged Care Services Division, Department of Human Services, Victoria
- Ms Glenda Perry, Eastern Metropolitan Region, Department of Human Services, Victoria.

The Department of Human Services would like to thank all parents and school nurses for completing and collecting the School Entrant Health Questionnaires. Without their participation, this valuable information on the health and wellbeing of Victorian preparatory grade children would not be available.
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Glossary

ADD and HD  Attention Deficit Disorder and Hyperactivity Disorder

ATSI  Children who are identified as being of Aboriginal or Torres Strait Islander origin.

CALD  Culturally and linguistically diverse. For the purpose of this report, this term refers to children for whom English is not the main language spoken at home.

Children  The data in this report refers to preparatory grade children during their first year at primary school.

Cohort  A generational group of people. This report relates to the cohort of Victorian children aged between five to seven years.

Domain  A singular concept measured by the aggregation of multiple items. For example, the 'vision' domain consists of seven questions related to eyesight issues.

ENT specialist  Ear, nose and throat specialist

Health assessment  Registered division one nurses offer a health assessment to all children in the first year of primary school. This includes a vision screen and other assessments if parent or teacher concern is expressed.

Item  An indicator designed to measure a discrete phenomenon. An item may relate to several questions on the SEHQ.

LGA  Local government area

Morbidity  The rate of incidence of disease.

PCP  Primary Care Partnership

Preparatory  First year of primary school in Victoria. After kindergarten/day care and before year/grade one.

Parent/guardian  The SEHQ is completed by parents or guardians and returned to the school nurse. No distinction is made between parents and guardians in this report.

Scale psychometric  These refer to the ability of the set of items within a domain.

Properties  To be scalable, to reflect the underlying meaning, or construct of the domain.

SEHQ  School Entrant Health Questionnaire

SNIS  School Nursing Information System

SNP  School Nursing Program
Introduction

Parents’ concerns and perceptions about the health and wellbeing of their children are acknowledged as an important means of informing policy development, health planning and research.

The School Entrant Health Questionnaire (SEHQ) was developed and piloted in 1996–97, as part of the Victorian Department of Human Services School Nursing Program. It has been distributed each year since 1997 to the parents and guardians of preparatory grade children in most Victorian primary schools.

The SEHQ has been developed to help parents identify any concerns regarding their child’s health and wellbeing, and to assist in developing partnerships between children, parents and school nurses. The questionnaire gathers parents’ concerns and observations and provides valuable data regarding Victorian children’s health and wellbeing.

The findings presented in this report are based on parent perceptions and recollections, not on medical diagnoses or health professionals’ opinion. All questions in the SEHQ are included because they have the potential to contribute to identifying conditions that could interfere with a child’s ability to learn. Eleven domains and 52 items are included in the SEHQ. The 11 SEHQ domains are:

- general health
- medication
- immunisation
- dental health
- speech/language
- hearing
- vision
- disability
- general development
- behaviour and emotional wellbeing
- family stress

For four consecutive years (1997–2000), SEHQs from around 1,800 Victorian primary schools have been collected. In all, approximately 200,000 questionnaires have been completed by parents. The information collected from the SEHQ has created one of the largest databases available in Australia on parent perceptions about the health and wellbeing of children in the 5–7 year age cohort.

This report contains the findings from 57,474 SEHQs completed by parents during 2000. It includes the key findings from the initial analysis of the year 2000 SEHQ and detailed analysis of parents’ health identifications and concerns about their children. The report also highlights the significant contributions that the SEHQ data will have on current and future government initiatives and policy directions. Additional background information to the development and administration of the SEHQ and a copy of the SEHQ are included as appendices.
What parents tell us—key findings

This report provides responses from 57,474 parents of their concerns about, and perceptions of, their child’s health. The findings also identify the types of health professionals and health services that parents commonly access for children in early years. Particular populations or groups of children and families, where there are particular health issues or high levels of parental concern, have been identified. The key findings from the 2000 SEHQ are shown below:

• Parents rated their children as ‘generally healthy’ – 88 per cent.
• Asthma and childhood allergies were identified as the major health problems for children
  – children reported to have asthma ‘sometimes’ or ‘often’ – 21.9 per cent
  – children reported to have allergies – 7.9 per cent.
• The most common concern was about children’s teeth – 20.5 per cent.
• Children on regular medication – 7.5 per cent.
• Children diagnosed with ADD or ADHD – 1.1 per cent.
• Parents with concern about their child’s behaviour or emotional wellbeing – 10.5 per cent.
• Moderate to high levels of family stress were reported by 39.3 per cent of parents. Higher levels of family stress are related to increased concern about children’s behaviour or emotional wellbeing.
Concerns about health issues

Parents were asked if they were concerned about a range of children’s health issues. Concern for children’s teeth was the most common response (20.5 per cent). Figure 1 illustrates parent concerns and the percentage of parents that expressed concern about each issue.

Figure 1: Issues that concern parents

One of the aims of the SEHQ is to assist in developing partnerships between parents and school nurses. A key role of the school nurse is to provide information and advice to children and their parents/guardians where necessary. Following the introduction of the SEHQ, school nurses anecdotally reported that their practice had changed from having limited contact with parents to having a significant amount of contact. This is supported in data recorded by nurses in the School Nursing Information System (SNIS), which shows that in the year 2000 about half of the parents of preparatory grade children had been consulted as a result of parents raising concerns in the SEHQ or by nurses identifying concerns following the child’s health assessment (Department of Human Services, 2000a).

If specific health issues are identified in the SEHQ, the school nurse will then contact the parents to discuss the child’s care requirements. The SEHQ also gives parents an opportunity to have the school nurse contact them if they have particular concerns or issues they would like to discuss further. Figure 2 shows the particular health concerns that parents requested to speak to the school nurse about.

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Service use

Key findings in relation to service use are:

• Children who visited a general practitioner in the year prior to preparatory enrolment – 85.8 per cent.

• The next most visited health professionals were optometrists and eye doctors, paediatricians, ear, nose and throat (ENT) doctors, speech therapists, hearing service professionals, and maternal and child health nurses.

There were variations between parent identification of, and concern about, children’s health problems and their actual use of related health services. For example, of the parents who expressed concern about their child’s eyesight, 30.2 per cent of these children had not visited an eye doctor or optometrist.

Subgroup variations

Various subgroups reported higher than average levels of a number of health issues, and different to state average use of, or access to, health services. These subgroups included children identified as being of Aboriginal or Torres Strait Islander origin (ATSI), children whose main language spoken at home is not English (that is, from culturally and linguistically diverse backgrounds (CALD)), children living in single parent families, and children who were reported as not having attended kindergarten and/or day care. For example:

• single parents, parents where children were identified as being of ATSI origin, or parents where English was not the main language spoken at home expressed the most concerns about their children’s health

• children who did not speak English and children identified as being of ATSI origin had much lower rates of immunisation
• parents of children of ATSI origin or in single parent families expressed higher concern for their child’s behaviour and emotional wellbeing

• parents of children who attended kindergarten and/or day care are more likely to have taken action on their concerns about their child’s teeth, hearing and vision than those whose children had not attended.

**Metropolitan, rural and regional variations**

Further analysis by regions of the Department of Human Services identified several rural and metropolitan variations and specific regional differences, such as:

• a greater number of language and speech difficulties were identified for rural children (10.6 per cent) than for metropolitan children (9.2 per cent)

• the levels of diagnosis of Attention Deficit Disorder (ADD) and Hyperactivity Disorder (HD) identified were greater for rural children (1.4 per cent) than for metropolitan children (0.9 per cent)

• children in the Western metropolitan and Hume regions are less likely to have seen a dentist in the past two years (this percentage falls below metropolitan and rural averages for children in this age cohort)

• children who were identified with speech or language problems in the Southern or Western metropolitan regions were less likely to have seen a speech therapist than children in other regions.

**Differences between genders**

For a number of health conditions, parents reported higher rates for boys than girls. Figure 3 outlines the main health areas in which there are differences between genders. In particular, boys were more often reported to have higher levels of asthma: ‘sometimes or often’ (boys – 24.2 per cent and girls – 18.7 per cent) and language or speech difficulties (boys – 12.4 per cent and girls – 6.6 per cent).

**Figure 3: Year 2000 SEHQ gender differences**
Data context

Interpreting the findings

This section describes how the year 2000 SEHQ data have been analysed and reported under each of the 11 SEHQ domains of interest. It summarises the figures used to report results, suggests approaches for their interpretation and describes the variables used to partition the population into subgroups.

A dichotomous response alternative (that is, a ‘yes’ or ‘no’ answer) was provided for many SEHQ questions. Thus, in many instances, the percentage of parents selecting a particular response alternative is reported. In cases where parents have been given more than two response category alternatives, these have occasionally been recoded (where no loss of information occurred) to simplify the results.

It is important to view the percentage figures in the context of the groups to which they relate. Group numbers for percentages (‘N’) must always be used in interpreting the percentage, enabling comparisons to be made across subgroups. Additionally, in many instances, actual numbers are more substantively relevant than percentages.

As this is a population study for a given cohort, differences in numbers reported are real differences and are free of sampling error. This means that tests of statistical significance are not needed. So, rather than concentrating on statistical relevance, greater importance should be attached to the clinical or practical significance of subgroup differences. Depending on the issue being investigated, in certain instances, even 0.1 per cent or 0.2 per cent may represent a large number of cases or reported instances. Table 1 shows the number of children implied by particular percentage differences given certain group sizes. It shows that, in a statewide distribution of approximately 50,000 children, a proportion as small as 0.1 per cent may represent high distributions of parent concerns about certain health problems or conditions.

Table 1: Group numbers implied by percentage differences for varying subgroup sizes

<table>
<thead>
<tr>
<th>% difference</th>
<th>25,000</th>
<th>40,000</th>
<th>50,000</th>
</tr>
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<tr>
<td>0.1</td>
<td>25</td>
<td>40</td>
<td>50</td>
</tr>
<tr>
<td>1</td>
<td>250</td>
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<td>500</td>
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<td>5</td>
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</tr>
<tr>
<td>50</td>
<td>12,500</td>
<td>20,000</td>
<td>25,000</td>
</tr>
<tr>
<td>75</td>
<td>18,750</td>
<td>30,000</td>
<td>37,500</td>
</tr>
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</table>
Many findings in this report are presented in terms of Victorian state totals, with rural and metropolitan comparisons. These are sometimes ranked. In many instances, the nine Department of Human Services regions are used to provide further analysis. These regions are divided into five rural and four metropolitan regions. The five rural regions are Barwon-South Western, Grampians, Loddon Mallee, Hume and Gippsland. The four metropolitan regions are: Western, Northern, Eastern and Southern. Figure 4 shows the total number of primary schools and preparatory grade enrolments in each region for the year 2000.

Figure 4: Victorian Department of Human Services regions (Year 2000)
A number of demographic variables are used to partition the parent responses into population subgroups throughout this report. The report *Health of young Victorians* (Department of Human Services, 1998) identified definitive differences in morbidity based on gender and ATSI origin.

The report *Fitting fathers into families* (Russell, Barclay, Edgecombe, Donovan, Habib and Pawson, 1999) highlighted the issues related to single parent families, especially those families in which the child lived with the father only. Accordingly, the current analysis has divided children into those living with both parents, with their mother only, or with their father only. The results in this report can be used to calculate the results for single parents as a group, using the raw figures and percentages reported for the mother only and father only groupings. The data, however, shows sufficient differences between the two single parent groups for them to be treated separately throughout the report.

Language spoken at home is considered to be an important factor mediating children’s educational, behavioural and health characteristics. Two issues emerge on a regular basis. These are related to whether the child speaks English or whether the child comes from a CALD background. The latter issue is assessed in the SEHQ by determining whether English is the main language spoken at home.

Recent public debates have also highlighted potential issues around children’s emotional wellbeing that may be related to attendance at preschool services. The SEHQ data contains information about attendance at kindergartens and/or day care centres. Accordingly, this data was explored to determine whether there might be a relationship between attendance at these services and identification or concern about health issues. It should be noted, however, that the SEHQ is not able to distil the total time spent or determine at what age each child attended kindergarten and/or day care.

**Limitations to the interpretation of the SEHQ findings**

A number of constraints need to be considered in interpretation of the findings:

1. Most of the tables have fewer observations reported than the total numbers of children. This is due to missing responses to specific questions, which itself can be attributed to a number of factors (these factors may provide useful additional diagnostic information at a later date). While it would be possible in many instances to impute or substitute values for these observations, missing data has been left as missing in this report. In certain cases, high levels of missing data can threaten the representativeness of the group and the validity of the findings.

2. The SEHQ is a surveillance tool, used in conjunction with other information gathered by the school nurse and input from teachers’ knowledge and experience.

3. The SEHQ identifies parent concerns about children’s health problems rather than directly identifying an actual problem. The results need to be interpreted within this context.
4 The SEHQ development study (Edgecombe et al., 1997) reported the need for confirmation of scale psychometric properties. At the end of the developmental study the team was concerned that further validation of parent concerns ought to be undertaken. There remained a need to identify those areas in which the parent concerns were most accurate, and those areas where additional data was needed to assist school nurses to make appropriate and timely intervention. In 1999, a study was conducted on the hearing domain items (Heathershaw, 2000), which raised questions about the ability of this domain to detect actual hearing loss. Additional research still needs to be undertaken to fully appreciate the SEHQ data in other domains.

5 This report presents descriptive data only. Additional data such as the parent comments written on the SEHQ has not been included or analysed. Analysis of this data, together with further inferential analyses, still needs to be undertaken to gain a better understanding of the relationships among types of parent concerns about their children's health.

6 The SEHQ is currently printed only in English. Although strategies for engaging parents from CALD backgrounds are implemented at individual school levels, there may be instances where questions have been misinterpreted or where responses have not been given by parents with poor English proficiency.

7 The current report presents data at a statewide and regional level. There may, however, be important variations at a school and local government area (LGA) level that could be identified in a more detailed analysis.

8 The information presented in this report originates from the initial data analysis of the year 2000 SEHQs. Analyses have not adjusted for potentially confounding influences such as socioeconomic status and parents’ literacy skills.

Population context

It is estimated that there was a total of 64,592 preparatory enrolments in Victorian schools in the year 2000 (Department of Human Services, 2000b). Every child enrolled was given a SEHQ to take home for their parents to complete. About 5.3 per cent of the questionnaires were not returned to the school and 3.6 per cent of the questionnaires were not included due to significant errors, substantial missing data or not being available. This meant a total of 58,987 completed SEHQs were available at the time of report preparation, which represents 91.3 per cent of the preparatory grade enrolment for 2000. However, 694 parents (1.1 per cent) did not consent to the use of the data for this report, and 819 students (1.3 per cent) could not be identified as belonging to a particular region.

Therefore, the findings of this report were based on 57,474 completed SEHQs, which represents 89 per cent of preparatory grade enrolment for 2000.

Table 2 presents the distribution of year 2000 preparatory grade enrolments and completed SEHQ numbers across the nine Department of Human Services regions.
Two comparison percentages are provided. The first series of comparisons shows that each of the metropolitan regions contains almost twice as many children as each of the rural regions. The metropolitan data, therefore, makes up more than two thirds of the group for the state. The second comparison percentage shows the proportion of total SEHQ collections accounted for in the current data set.

**Table 2: Year 2000 preparatory enrolment numbers compared to SEHQ collections**

<table>
<thead>
<tr>
<th>Regions</th>
<th>Preparatory enrolments</th>
<th>% of state</th>
<th>Completed SEHQ</th>
<th>% of all enrolments</th>
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<tr>
<td>Victoria</td>
<td>64,592</td>
<td>100.0</td>
<td>57,474</td>
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<td>Metropolitan</td>
<td>44,667</td>
<td>69.2</td>
<td>39,907</td>
<td>89.0</td>
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<td>Western</td>
<td>8,274</td>
<td>12.8</td>
<td>7,521</td>
<td>90.9</td>
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<td>Northern</td>
<td>9,912</td>
<td>15.3</td>
<td>9,111</td>
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<td>Eastern</td>
<td>11,893</td>
<td>18.4</td>
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<td>14,588</td>
<td>22.5</td>
<td>12,386</td>
<td>84.9</td>
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<td>30.8</td>
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<td>5.7</td>
<td>2,829</td>
<td>76.0</td>
</tr>
<tr>
<td>Gippsland</td>
<td>3,504</td>
<td>5.4</td>
<td>2,962</td>
<td>84.5</td>
</tr>
</tbody>
</table>

**Subgroup demographics**

Table 3 shows the composition and distributions of particular subgroups of the population between regional variables. The distributions of student age and gender were highly consistent across the groups, and are therefore not included in Table 3. The mean age of the children is five years and four months, with 99.3 per cent of the group being between four and six years old. This was consistent across regions and for the state as a whole. Given this consistency, age differences are not analysed in this report. Females comprised 49.9 per cent of the data. The gender distribution compares well with the gender distributions for the general population reported by the Australian Bureau of Statistics (48.4 per cent females) for Victorian preparatory grade children (ABS, 2000).
Table 3: Population subgroup characteristics

<table>
<thead>
<tr>
<th>Regions</th>
<th>Parents</th>
<th>CALD</th>
<th>Speaks English</th>
<th>ATSI</th>
<th>Attended kinder/day care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Both</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother only</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father only</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victoria</td>
<td>52,824</td>
<td>86.1</td>
<td>13.0</td>
<td>0.8</td>
<td>54,232</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>36,781</td>
<td>86.8</td>
<td>12.4</td>
<td>0.8</td>
<td>37,588</td>
</tr>
<tr>
<td>Western</td>
<td>6,882</td>
<td>84.6</td>
<td>14.4</td>
<td>1.0</td>
<td>7,073</td>
</tr>
<tr>
<td>Northern</td>
<td>8,421</td>
<td>87.3</td>
<td>12.0</td>
<td>0.7</td>
<td>8,527</td>
</tr>
<tr>
<td>Eastern</td>
<td>10,172</td>
<td>89.3</td>
<td>10.2</td>
<td>0.6</td>
<td>10,340</td>
</tr>
<tr>
<td>Southern</td>
<td>11,306</td>
<td>85.7</td>
<td>13.3</td>
<td>0.9</td>
<td>11,648</td>
</tr>
<tr>
<td>Rural</td>
<td>16,043</td>
<td>84.5</td>
<td>14.6</td>
<td>0.9</td>
<td>16,644</td>
</tr>
<tr>
<td>Barwon-South Western</td>
<td>4,402</td>
<td>85.9</td>
<td>13.3</td>
<td>0.8</td>
<td>4,524</td>
</tr>
<tr>
<td>Grampians</td>
<td>2,385</td>
<td>84.2</td>
<td>15.0</td>
<td>0.9</td>
<td>2,487</td>
</tr>
<tr>
<td>Loddon Mallee</td>
<td>3,975</td>
<td>84.6</td>
<td>14.5</td>
<td>0.9</td>
<td>4,127</td>
</tr>
<tr>
<td>Hume</td>
<td>2,577</td>
<td>83.5</td>
<td>15.4</td>
<td>1.1</td>
<td>2,675</td>
</tr>
<tr>
<td>Gippsland</td>
<td>2,704</td>
<td>83.2</td>
<td>15.6</td>
<td>1.1</td>
<td>2,813</td>
</tr>
</tbody>
</table>

Of all parents who completed the SEHQ, 96.3 per cent reported the family structure where the child lived. A number of parents, 2,149 in all, did not respond to this question and 2,501 children had living arrangements other than those considered in this report. Within the groups studied, the majority of Victorian children (86.1 per cent) lived with both parents, 13 per cent with mother only and 0.8 per cent lived with father only. There was a slight regional variation between these figures (see Table 3).

Most children reported to be from CALD backgrounds were found in the metropolitan regions (with a mean percentage of 16.8 per cent compared with the rural average of 2.2 per cent). Western Metropolitan Region (23.7 per cent) and Northern Metropolitan Region (21.1 per cent) had the largest number of children from CALD backgrounds.

There were more children identified as being of ATSI origin in rural regions (3 per cent) compared with metropolitan regions (1.4 per cent). While there are approximately equal numbers of ATSI children in rural (413) and metropolitan (426) regions, due to the smaller total population in rural areas, the proportion of ATSI children in rural areas is significantly higher.
While there are no systematic patterns in the percentages of children attending kindergarten and/or day care across rural and metropolitan subgroups, there are observable differences between particular regions. The region with the lowest percentage of reported kindergarten and/or day care attendance was Northern Metropolitan Region (86.9 per cent) and the region with the highest percentage of attendance was Barwon–South Western Region (92.4 per cent).

The Family and Community Support Branch, Department of Human Services, conducts annual data collection of preschool participation rates in April of each year via a census. This data indicates that participation rate of eligible four year old children attending first year of preschool in the year 1999 was 91.8 per cent. Similarly, the SEHQ date has identified that the percentage of children who were reported to have attended kindergarten and/or day care prior to their preparatory grade enrolment across the state was 89.7 per cent. Of those who did not attend kindergarten and/or day care prior to their preparatory grade enrolment, 5.1 per cent were children who did not speak English. Given that the statewide percentage of children who do not speak English was only 1.5 per cent, this indicates that these children are significantly over-represented among those who did not attend kindergarten and/or day care.

A total of 97.4 per cent of parents responded to the question addressing whether English was the main language spoken at home. The proportion of children who spoke English was distributed approximately equally across the state. Western Metropolitan Region and Northern Metropolitan Region, however, did fall lower than the statewide average of 98.5 per cent for the proportion of children who spoke English. The higher proportion of children from CALD backgrounds found in these regions could provide some explanation for the lower levels of children who spoke English in these particular regions.
Domains of interest

General health

Children’s health status

Table 4 presents the distribution of parents’ responses to the question ‘How healthy is your child?’. Overall, 88 per cent of Victorian parents rated their children as ‘generally healthy’. The remaining children were classified as suffering ‘frequent minor illnesses’ (that is, six or more per year) (11.3 per cent) or ‘major illness’ (0.7 per cent). Table 4 shows variation among the regions, particularly in relation to the number of ‘frequent minor illnesses’.

Table 4: Regional distribution of children’s overall health

<table>
<thead>
<tr>
<th>Regions</th>
<th>N</th>
<th>% generally healthy</th>
<th>% minor illness</th>
<th>% major illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>55,568</td>
<td>88.0</td>
<td>11.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>38,473</td>
<td>88.1</td>
<td>11.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Western</td>
<td>7,197</td>
<td>88.0</td>
<td>11.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Northern</td>
<td>8,764</td>
<td>89.9</td>
<td>9.7</td>
<td>0.4</td>
</tr>
<tr>
<td>Eastern</td>
<td>10,587</td>
<td>85.2</td>
<td>14.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Southern</td>
<td>11,925</td>
<td>89.5</td>
<td>9.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Rural</td>
<td>17,095</td>
<td>87.8</td>
<td>11.5</td>
<td>0.7</td>
</tr>
<tr>
<td>Barwon-South Western</td>
<td>4,629</td>
<td>85.7</td>
<td>13.4</td>
<td>0.8</td>
</tr>
<tr>
<td>Grampians</td>
<td>2,547</td>
<td>88.3</td>
<td>10.7</td>
<td>0.9</td>
</tr>
<tr>
<td>Loddon Mallee</td>
<td>4,265</td>
<td>82.9</td>
<td>16.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Hume</td>
<td>2,760</td>
<td>93.0</td>
<td>6.6</td>
<td>0.3</td>
</tr>
<tr>
<td>Gippsland</td>
<td>2,894</td>
<td>92.9</td>
<td>6.7</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Table 5 shows parents’ ratings of their children’s overall health distributed across demographic variables. According to parents’ data, children who are of ATSI origin, come from a CALD background, or do not speak English, experience more minor illnesses than children from other subgroups.
Table 5: Children’s overall health across demographic variables

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>% generally healthy</th>
<th>% minor illness</th>
<th>% major illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>43,060</td>
<td>91.7</td>
<td>7.9</td>
<td>0.4</td>
</tr>
<tr>
<td>Yes</td>
<td>794</td>
<td>78.1</td>
<td>20.4</td>
<td>1.5</td>
</tr>
<tr>
<td>Parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both Parents</td>
<td>45,007</td>
<td>88.6</td>
<td>10.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Mother only</td>
<td>6,766</td>
<td>85.4</td>
<td>13.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Father only</td>
<td>435</td>
<td>87.8</td>
<td>11.0</td>
<td>1.1</td>
</tr>
<tr>
<td>CALD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6,496</td>
<td>89.1</td>
<td>10.5</td>
<td>0.4</td>
</tr>
<tr>
<td>No</td>
<td>47,141</td>
<td>88.2</td>
<td>11.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Speaks English</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>54,570</td>
<td>88.1</td>
<td>11.2</td>
<td>0.7</td>
</tr>
<tr>
<td>No</td>
<td>803</td>
<td>86.4</td>
<td>12.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Kindergarten/day care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>47,416</td>
<td>88.3</td>
<td>11.1</td>
<td>0.6</td>
</tr>
<tr>
<td>No</td>
<td>5,370</td>
<td>88.8</td>
<td>10.6</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Children’s growth

Parents were asked if they felt that their child was ‘very small’ compared to other children of the same age. Across the state, 7.5 per cent of parents responded ‘yes’ to this question. Regional responses varied from 7.1 per cent in Southern Metropolitan Region to 8 per cent for Eastern Metropolitan Region.

There were higher than average percentages of ‘yes’ responses to this question for:

- ATSI (10.7 per cent) children
- children living in single parent families (9.3 per cent – mother only and 8.7 per cent – father only)
- children from CALD backgrounds (10 per cent)
- children who did not speak English (16.3 per cent)
- children who did not attend kindergarten/day care (8.8 per cent).

Specific health conditions

Allergies

The SEHQ findings show that allergies are perceived to be an important health problem affecting Victorian preparatory grade children. Overall, 7.9 per cent of Victorian children were identified as having allergies that may require attention at school.

This figure was slightly lower than average in Barwon–South Western Region (6.6 per cent), and higher than average in the Eastern Metropolitan (9.1 per cent), Loddon Mallee (8.2 per cent) and Hume (8.1 per cent) regions. The percentage of boys reported to have allergies (8.3 per cent) was slightly higher than for girls (7.3 per cent). Allergies were reported significantly more frequently among children who
lived with their mothers only (8.8 per cent) and among children from a CALD background (8.5 per cent). The level of allergies reported was proportionally higher for children who had attended kindergarten/day care (8.1 per cent) than for those who did not (7 per cent).

Parents were also asked what their children are allergic to and how it affected their child. This additional qualitative information is not included in this report.

**Asthma**

Asthma is by far the most common health problem identified by parents of preparatory grade children. Parents rated their children as having asthma ‘never’, ‘sometimes’ or ‘often’. Statewide, 2.8 per cent of children were reported as having asthma ‘often’. Across the regions, the proportion of parents who reported children suffering with asthma often ranged between 1.9 per cent (Gippsland Region) and 3.9 per cent (Loddon Mallee Region).

There was similar regional variation in relation to the percentage of children having asthma ‘sometimes’. The state average was 19.1 per cent, while the regions varied between 17 per cent (Loddon Mallee Region) and 20.6 per cent (Grampians Region). These results are illustrated in Figure 5, which shows that almost one-fifth of children in every region suffer from asthma ‘often’ and ‘sometimes’. Loddon Mallee, Gippsland and Northern Metropolitan regions have lower incidence than state average.

**Figure 5: Percentages of children having asthma ‘often’ or ‘sometimes’ by region**
Table 6 shows the reported incidence of asthma among various subgroups of children. The table indicates that parents identified that boys, ATSI children, children who live with their mother only and children who have attended kindergarten/day care are more likely than other children to have asthma (either ‘sometimes’ or ‘often’).

<table>
<thead>
<tr>
<th></th>
<th>Often %</th>
<th>Sometimes %</th>
<th>Never %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boy</td>
<td>2.4</td>
<td>21.8</td>
<td>75.8</td>
</tr>
<tr>
<td>Girl</td>
<td>2.5</td>
<td>16.3</td>
<td>81.3</td>
</tr>
<tr>
<td><strong>ATSI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.9</td>
<td>19.0</td>
<td>79.0</td>
</tr>
<tr>
<td>Yes</td>
<td>5.5</td>
<td>22.5</td>
<td>72.0</td>
</tr>
<tr>
<td><strong>Parents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both parents</td>
<td>2.6</td>
<td>18.5</td>
<td>78.9</td>
</tr>
<tr>
<td>Mother only</td>
<td>3.7</td>
<td>21.3</td>
<td>74.9</td>
</tr>
<tr>
<td>Father only</td>
<td>1.9</td>
<td>20.0</td>
<td>78.1</td>
</tr>
<tr>
<td><strong>CALD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2.8</td>
<td>19.4</td>
<td>77.8</td>
</tr>
<tr>
<td>Yes</td>
<td>2.0</td>
<td>17.0</td>
<td>81.0</td>
</tr>
<tr>
<td><strong>Speaks English</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2.8</td>
<td>19.1</td>
<td>78.1</td>
</tr>
<tr>
<td>Yes</td>
<td>2.1</td>
<td>16.6</td>
<td>81.3</td>
</tr>
<tr>
<td><strong>Kindergarten/day care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2.8</td>
<td>17.6</td>
<td>79.6</td>
</tr>
<tr>
<td>Yes</td>
<td>2.7</td>
<td>19.2</td>
<td>78.1</td>
</tr>
</tbody>
</table>

The SEHQ results reaffirm asthma as a major health problem affecting a large number of Victorian children. Children who did not have an asthma plan were, in general, of ATSI origin, did not speak English, were from a CALD background, or lived with their fathers. From this finding, it can be inferred that consideration should be given to strategies to engage and encourage parents in those subgroups to develop asthma plans for their children. However, health promotion intervention strategies should be developed for all children with asthma that involve a whole of school approach to achieve optimal management of asthma in schools.

Parents in metropolitan regions (16.9 per cent) were more likely to indicate that they would like to speak with a school nurse about their child’s asthma than parents in rural regions (13.4 per cent). The statewide average for this item was 15.8 per cent. Figure 6 illustrates the regional variation for children with asthma.
Figure 6: Parents indicating a wish to speak with school nurse about their child’s asthma

Other health conditions

A number of health conditions that may occur around birth or prior to school entry are reported by parents through the SEHQ and are shown ranked by their reported frequency of occurrence in Table 7. A total of 6,789 Victorian preparatory grade children have or have had one of the health conditions outlined in the table.

Another measure of parental concern assessed by the SEHQ is whether parents felt that the health conditions listed in Table 7 might affect their child’s school performance. While the items listed in Table 7 have more than a 95 per cent response rate, less than two-thirds (59.1 per cent) of parents responded to whether or not they felt any conditions might affect their child’s school performance. Non-responses could simply indicate that parents are unsure or may be interpreted as the identified health issues not being perceived by parents as an issue that would affect their child’s school performance.

Table 7: Common health conditions of Victorian preparatory grade children as perceived by parents

<table>
<thead>
<tr>
<th>Health condition</th>
<th>Victoria</th>
<th>% of State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental delay</td>
<td>1,879</td>
<td>3.6</td>
</tr>
<tr>
<td>Birth abnormalities</td>
<td>1,629</td>
<td>3.1</td>
</tr>
<tr>
<td>Serious accidents or injuries</td>
<td>1,293</td>
<td>2.5</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>1,032</td>
<td>1.9</td>
</tr>
<tr>
<td>Serious infections</td>
<td>831</td>
<td>1.6</td>
</tr>
<tr>
<td>Intraventricular shunt</td>
<td>125</td>
<td>0.2</td>
</tr>
</tbody>
</table>
Across the state, 4.3 per cent of parents felt that their child’s health conditions might affect their school performance. Generally speaking, a slightly higher level of concern was expressed in rural regions (4.8 per cent) than metropolitan regions (4.1 per cent), with lowest concern expressed in Northern Metropolitan and Grampians regions (3.8 and 4 per cent respectively) and highest concern expressed by parents in Loddon Mallee and Gippsland regions (both 5.2 per cent).

Higher concern than average was expressed about boys (5.3 per cent) than girls (3.2 per cent), about children who did not speak English (5.1 per cent), and about children from single parent families (with 6.1 per cent for both mother only and father only).

**Descended testes**

An important health issue for males is whether both testes have descended. Parents were asked, if their child is a boy: ‘are both testes down in the scrotum?’. Across the state, 80.4 per cent of parents reported ‘yes’ to this question, followed by 12.6 per cent who reported a ‘don’t know’ response, and 7 per cent responding ‘no’.

Higher responses of uncertainty (‘don’t know’) were reported for children living in single parent families (18.5 per cent for living with mother only and 22.8 per cent for father only), children from CALD backgrounds (31.5 per cent), children who did not speak English (36.6 per cent) and those who did not attend kindergarten/day care (19.4 per cent).

From the findings, it appears that some parents require more information about the importance of checking whether boys’ testicles have descended. Accurate information should be more readily available for single parent families and those from CALD backgrounds who may or may not attend primary care services such as maternal and child health nurses, general practitioners or child care.

**Specific health problems**

Parents were also asked to report on health problems their children may have that could develop into more long-term chronic diseases. The reported numbers of these health problems is shown, ranked by the frequency of occurrence, in Table 8.
Table 8: Victorian children’s common health problems

<table>
<thead>
<tr>
<th>Health problem</th>
<th>Victoria</th>
<th>% of State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma (sometimes or often)</td>
<td>11,707</td>
<td>21.9</td>
</tr>
<tr>
<td>Allergies</td>
<td>4,122</td>
<td>7.9</td>
</tr>
<tr>
<td>Stomach, intestinal or absorption problems</td>
<td>425</td>
<td>0.8</td>
</tr>
<tr>
<td>Chronic lung or respiratory problems</td>
<td>262</td>
<td>0.5</td>
</tr>
<tr>
<td>Chronic joint or bone problems</td>
<td>242</td>
<td>0.5</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>218</td>
<td>0.4</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>73</td>
<td>0.1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>65</td>
<td>0.1</td>
</tr>
<tr>
<td>Arthritis</td>
<td>59</td>
<td>0.1</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>35</td>
<td>0.1</td>
</tr>
<tr>
<td>Spina Bifida</td>
<td>26</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Health service use

The SEHQ asks parents to report which health professionals their child has visited in the preceding year. The 15 health professionals presented in the SEHQ are ranked according to their statewide frequency in Table 9. The rural and metropolitan numbers of children reported to have visited a practitioner in the preceding year are listed alongside ranked state figures.

The findings show that 85.8 percent of children had visited a general practitioner. The next most visited health professionals included optometrists and eye doctors, paediatricians, ENT doctors, speech therapists, hearing service professionals, and maternal and child health nurses.
Children’s health: Parent’s perceptions

Table 9: Victorian children’s contact with health professionals

<table>
<thead>
<tr>
<th>Health professional</th>
<th>Victoria N</th>
<th>Victoria %</th>
<th>Metropolitan N</th>
<th>Rural N</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>47,373</td>
<td>85.8</td>
<td>33,085</td>
<td>14,288</td>
</tr>
<tr>
<td>Optometrist/eye doctor</td>
<td>6,982</td>
<td>14.7</td>
<td>4,836</td>
<td>2,146</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>6,687</td>
<td>13.9</td>
<td>4,766</td>
<td>1,921</td>
</tr>
<tr>
<td>Ear, nose and throat doctor</td>
<td>5,735</td>
<td>12.1</td>
<td>4,102</td>
<td>1,633</td>
</tr>
<tr>
<td>Speech therapist</td>
<td>5,327</td>
<td>11.3</td>
<td>3,271</td>
<td>2,056</td>
</tr>
<tr>
<td>Hearing services</td>
<td>4,715</td>
<td>10.0</td>
<td>3,270</td>
<td>1,445</td>
</tr>
<tr>
<td>Maternal and child health nurse</td>
<td>4,178</td>
<td>8.9</td>
<td>2,771</td>
<td>1,407</td>
</tr>
<tr>
<td>General surgeon</td>
<td>2,242</td>
<td>4.8</td>
<td>1,501</td>
<td>741</td>
</tr>
<tr>
<td>School nurse (or first aider)</td>
<td>2,062</td>
<td>4.5</td>
<td>1,491</td>
<td>571</td>
</tr>
<tr>
<td>Psychologist/psychiatrist</td>
<td>1,379</td>
<td>3.0</td>
<td>963</td>
<td>416</td>
</tr>
<tr>
<td>Bone and joint doctor</td>
<td>1,071</td>
<td>2.3</td>
<td>705</td>
<td>366</td>
</tr>
<tr>
<td>Specialist children’s services</td>
<td>997</td>
<td>2.2</td>
<td>673</td>
<td>324</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>664</td>
<td>1.4</td>
<td>426</td>
<td>238</td>
</tr>
<tr>
<td>Dietician</td>
<td>483</td>
<td>1.0</td>
<td>344</td>
<td>139</td>
</tr>
</tbody>
</table>

Medication

Victorian parents reported that 7.5 per cent of children across the state were on regular medication. This frequency varied between 6.7 per cent in Northern Metropolitan Region and 8.8 per cent in Barwon–South Western Region. A higher proportion of boys (8.5 per cent) than girls (6.4 per cent), ATSI children (11.0 per cent) and children living with their mother only (8.3 per cent) were reported to be on medication. Conversely, a lower percentage of children who come from a CALD background (5.7 per cent), children who do not speak English (5.0 per cent), and children who live with their fathers only (5.9 per cent) were on medication.

The SEHQ does not address the specific nature of medication. Instead it asks parents to provide details. Many questions on the SEHQ provide the opportunity for parents to give open-ended responses but this data has not been analysed in the report.

It is likely that this information is rich in detail and that it would be worthy of further study. As an example, during the pilot stage of the SEHQ, a range of responses from parents in regards to the medications their children were taking were collected. Responses included various asthma medications, herbs, multivitamins, Ritalin, laxatives, eczema cream, antibiotics and eye drops (Edgecombe et al., 1997).
Immunisation

Parents were asked if their child had all the recommended immunisations prior to starting school.

Parents are referred to their child’s Health record book or Certificate of Immunisation Status for Primary School Enrolment to assist them in answering this question. According to the NHMRC Australian Standard Vaccination Schedule, the recommended sequence of immunisations for this cohort of children includes:

• diphtheria/tetanus/pertussis
• oral polio vaccine (Sabin)
• Hib
• measles/mumps/rubella

The SEHQ allows parents to report their child as having had all the recommended immunisations before starting school, not having had these immunisations or ‘not sure’. Parents reported that 91.1 per cent of Victorian children were fully immunised. Just over 3 per cent (3.2) of parents stated that their children were not fully immunised. The remaining 5.6 per cent of parents were unsure of their child’s immunisation status.

Another data source for assessing child immunisation levels is the proportion of school entry certificates, collected by the Department of Education and Training (DET), that show children being fully immunised. This data indicates far lower levels of immunisation than the SEHQ data, with just 83.12 per cent of children at school entry being fully immunised. It may be assumed that the school entry certificate is a more accurate reflection of immunisation levels than the parent reported data collected through the SEHQ.

The discrepancy between these two figures suggests that parents may be uncertain about immunisation requirements and be assuming that their child has received all recommended immunisations when this is not the case. The finding points towards a need for additional parent information about the immunisation schedule.

The percentage of parents indicating that their child is fully immunised is mostly consistent across the nine department regions. However, there are substantial differences between particular groups of children. A higher proportion of ATSI children and children who did not speak English were reported not to have been immunised, or had parents who were not sure if immunisations were up to the recommended requirement at the time of school entry. Specifically:

• ATSI children who are reported by parents to have been fully immunised account for 80.5 per cent of total ATSI children. The percentage of these parents who were uncertain about their child’s immunisation status was nearly three times greater than the percentage for the Victorian population as a whole.
• Children who did not speak English had an immunisation rate of only 80 per cent and non-immunisation and uncertainty percentages for this group were significantly higher than the state average, at 11.7 per cent and 8.3 per cent respectively.

• Children who have not attended kindergarten/day care are more likely than average to be reported to not have received full immunisation by the commencement of school (5.7 per cent).

This suggests that additional parent information about the immunisation schedule and facilities for immunisation should be targeted towards ATSI families, families of children who do not speak English and families of children who do not attend kindergarten/day care.

Dental health

On average, 20.5 per cent of Victorian parents were concerned about their child’s teeth. These levels of concern varied regionally, from 19 per cent in Eastern Metropolitan Region to 22.9 per cent in Loddon Mallee Region. There were high levels of concern for:

• children identified as being of ATSI origin (31.3 per cent)
• children from single parent families (mother only – 28.5 per cent and father only – 24.6)
• children from CALD backgrounds (32.3 per cent)
• children who did not speak English (38.2 per cent)
• children who did not attend kindergarten/day care (24.8 per cent).

Parents reported that 57.5 per cent of Victorian children had visited the dentist within the last one to two years. This figure was higher for children from rural areas (59.6 per cent) than those from metropolitan regions (56.6 per cent). The term ‘dental services’ as used in this report refers to visiting a qualified dentist, not simply having a dental check conducted by a maternal and child health nurse or dental nurse.

As Figure 7 shows, there was substantial regional variation in the use of dental health services. Western Metropolitan Region (43.9 per cent) had the lowest reported use of dental services, while Loddon Mallee Region (65.7 per cent) had higher use than all other regions.

As the SEHQ could have been completed by parents at varying times during the child’s first year of preparatory grade enrolment, the findings cannot determine when the child last visited a dentist. A visit may have been prior to their school enrolment or some may have attended the school dental service early in their first year of primary school. The Victorian School Dental Service offers care on a two-year cycle to children in primary schools. Therefore, the timing of this service may have had an impact upon the responses regarding visits to the dentist within the last 1–2 years.
It was reported that the following groups of children were less likely than the state average (57.5 per cent) to have visited the dentist in the last two years:

- ATSI children (50.5 per cent).
- children living with their mothers only (47.9 per cent)
- children living with their fathers only (38.7 per cent)
- children from CALD backgrounds (37.8 per cent)
- children who do not speak English (30 per cent)
- children who do not attend kindergarten/day care (47.1 per cent).

The relationship between parents’ concerns about their child’s teeth and whether children had visited the dentist in the last 1–2 years shows that:

- of parents whose child had not visited the dentist in the past two years, 18.6 per cent had concerns about their child’s teeth
- of parents whose child had visited the dentist in the past two years, 78.5 per cent had no concerns about their child’s teeth.

While concern for children’s teeth is associated with use of dental services, the SEHQ results indicate that there are a substantial number of parents who are concerned about their children’s dental health, however, are not using dental services.
Speech/language

The SEHQ asks parents if their children have any difficulties with language or speech. Overall, 9.6 per cent of Victorian parents identified that their children had such difficulties.

Figures were generally higher in the rural regions (10.6 per cent) than they were in metropolitan regions (9.2 per cent). Analysis of the results shows that the following groups of children can be identified as also having particularly high reported levels of speech or language difficulty:

- boys (12.4 per cent), as compared to girls (6.6 per cent)
- ATSI children (13.7 per cent)
- children living with single parents (11.8 per cent mothers only, and 10.5 per cent fathers only)
- children who do not speak English (14.2 per cent).

Children living in homes where English was not the main language were identified by parents as having levels of language or speech difficulty that were lower than the state average (8.1 per cent). Possible speech or language difficulties are ranked according to their reported frequency in Table 10.

Table 10: Ordered list of speech and language difficulties

<table>
<thead>
<tr>
<th>Speech and language difficulties</th>
<th>Victoria N</th>
<th>% of state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech not clear to others</td>
<td>3,442</td>
<td>6.0</td>
</tr>
<tr>
<td>Difficulty putting words together</td>
<td>1,826</td>
<td>3.2</td>
</tr>
<tr>
<td>Difficulty finding words</td>
<td>1,781</td>
<td>3.1</td>
</tr>
<tr>
<td>Speech not clear to the family</td>
<td>1,450</td>
<td>2.5</td>
</tr>
<tr>
<td>Stutters and stammers</td>
<td>1,068</td>
<td>1.9</td>
</tr>
<tr>
<td>Reluctant to speak</td>
<td>818</td>
<td>1.4</td>
</tr>
<tr>
<td>Voice sounds unusual</td>
<td>598</td>
<td>1.0</td>
</tr>
<tr>
<td>Doesn’t understand others when they speak</td>
<td>458</td>
<td>0.8</td>
</tr>
<tr>
<td>Doesn’t understand when you speak</td>
<td>452</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Parents were asked if their child had any of the above speech or language difficulties and, if so, had they visited a speech therapist in the past year. While there was considerable regional variation in the proportion of children who had been seen by a speech therapist (as shown in Figure 8), few parents responded to this question. Non-response to this question may be interpreted as a result of parents feeling that the problem did not warrant a speech therapist visit.
Children’s health: Parent’s perceptions

Figure 8: Regional distributions of speech therapist use by children with reported language or speech difficulty

The levels of consultation with a speech therapist varied across the following groups:

- metropolitan (56.8 per cent), compared to rural (66.0 per cent)
- Gippsland and Loddon Mallee regions (each 66.5 per cent), compared to Western Metropolitan Region (51.0 per cent)
- male (60.8 per cent), compared to female (56.3 per cent)
- ATSI (35.8 per cent), compared to CALD backgrounds (29.2 per cent), and children who did not attend kindergarten/day care (50.5 per cent).

Almost 4 per cent of children whose parents identified that their children did not have speech or language problem had also been seen by a speech therapist. This may indicate that parents are slightly under-identifying these problems or that they see the problem as being resolved.

Hearing

Hearing problems, or potential problems, are assessed in a number of ways in the SEHQ. Parents are asked about family history, childhood ear infections and their concerns about their child’s hearing.

Parents are asked whether there is a family history of children born deaf or whether nerve deafness during childhood has occurred on either side of the family. A total of 2,729 Victorian parents identified a history of deafness in the family. This equates to a statewide average of 5.1 per cent of parents. The level was lower for metropolitan regions (4.7 per cent) than for rural regions (5.9 per cent). Each of the rural regions had higher than the statewide average levels of reported family deafness, ranging from 5.4 per cent in Hume Region to 6.8 per cent in the Grampians Region.
Parents were also asked to report approximately how many ear infections their children had in the previous year. Around one third of Victorian parents (34.8 per cent) reported that their children had had one or more ear infections in the previous year. More than 90 per cent (93.0) of the parents surveyed indicated that there had been no more than two infections, 5.2 per cent indicated that their child had had between three and four infections and 1.8 per cent reported more than four infections. There was little regional variation in these results. Children identified as being of ATSI origin were reported as having higher levels for four or more ear infections per year than the state average.

The percentage of Victorian parents concerned about their child’s hearing was 7.8 per cent, which is consistent across the metropolitan and rural regions. Single mothers (11.1 per cent) and parents of boys (8.3 per cent) and ATSI children (15 per cent) reported higher levels of concern about their children’s hearing. Conversely, parents of girls (7.1 per cent) and dual parent families (7.1 per cent) reported lower than state average levels of concern about their child’s hearing.

The SEHQ asks parents two questions that can be used to assess children’s use of hearing health services:

i Has your child ever been referred to an ENT specialist?

ii Has your child ever had a hearing test conducted by an audiologist?

Figure 9 illustrates the regional variations in responses to each of these questions. The state average for referral to an ENT specialist was 17.8 per cent, with rural regions averaging 17.2 per cent and metropolitan regions 18.1 per cent. The percentage of children having had a hearing test conducted by an audiologist was 28.7 per cent statewide, with rural regions averaging 29.8 per cent and metropolitan regions 28.2 per cent.
The following groups reported ENT specialist referral levels different to the state average:

- female children had fewer referrals (15.2 per cent) than male children (19.7 per cent)
- children living with their mothers only had more referrals (18.8 per cent)
- children living with their fathers only had fewer referrals (14.9 per cent)
- children from CALD backgrounds had considerably fewer referrals (11.5 per cent)
- children who did not attend kindergarten/day care had fewer referrals (14.3 per cent).

The likelihood of a child having had a hearing test conducted by an audiologist also varied across a range of factors. Boys (32.2 per cent) were more likely than girls (24.4 per cent) to have had a hearing test. Similarly, those who had attended kindergarten/day care (29.5 per cent) were more likely to have had a hearing test than those who had not (22.2 per cent).

Figure 10 shows the percentage of children who have visited ENT specialists and audiologists according to their number of ear infections. While slightly more children visit audiologists, the numbers are approximately equal. As would be expected, there is a steady increase in visits according to the number of ear infections experienced within the previous year.
Vision

Statewide 6.1 per cent of parents were concerned about their child’s eyesight, with the percentage being lower for parents in rural regions (5.5 per cent) than for parents in metropolitan regions (6.4 per cent). This variable was consistent for most subgroups except for children living with their mothers only (7.4 per cent), children who did not speak English (7.9 per cent), and children who were from a CALD background (8.9 per cent).

Parents were asked three questions to assess their children’s level of use of eye or vision services:

- Has your child ever seen an eye doctor or an optometrist?
- Has your child ever had treatment for eyesight problems?
- When was the last time your child had his/her eyesight checked?

The reported levels of eye doctor or optometrist use for each region are shown in Figure 11. While the average level of use is roughly the same in metropolitan (21.1 per cent) and rural regions (21.6 per cent), there is variation amongst individual regions. The lowest proportion of eye doctor or optometrist visits was reported in Hume (18.5 per cent) and Northern Metropolitan regions (19 per cent), while the highest reported levels of use were in Eastern Metropolitan (24.3 per cent), Gippsland (24.4 per cent) and Grampians (25.5 per cent) regions.
An average of 4 per cent of children across the state were reported to have had some form of treatment for eyesight problems (for example: glasses, patching or surgery) by 5–7 years of age. This proportion was reasonably consistent across regions and demographic variables.

There was marked regional variation in whether children had ever had their eyesight checked. Figure 12 shows the distribution of responses to this question across regions. Gippsland (53.8 per cent) and Eastern Metropolitan (53.3 per cent) regions had the highest proportion of children who had had their eyesight checked, and Western Metropolitan Region had the lowest proportion (44.6 per cent). The statewide average for this item was 48.5 per cent.
While the likelihood of having had an eyesight test was consistent across the genders, there were marked differences on a range of other demographic variables. Most significantly:

- English-speaking children (48.8 per cent) were far more likely to have had an eyesight test than their non-English speaking counterparts (25.5 per cent)
- children identified as being of ATSI descent (36.7 per cent) were less likely than non-ATSI children (48.6 per cent)
- children living with both parents (49.8 per cent) were more likely to have had a vision test than those who lived with mother only (44.1 per cent) or their father only (31.5 per cent).

Of parents whose child had attended an eye or vision services, 17.9 per cent remained concerned about their child’s eyesight. Of the parents who expressed concern about their child’s eyesight, 39.3 per cent of these children had not visited an eye doctor or optometrist.

**Disabilities**

Disability

Parents were asked whether their children had any disabilities. The percentage of children reported to have disabilities in the metropolitan regions (1.7 per cent) was slightly below the state average (2 per cent). Disability levels tended to be higher in the rural regions, however, the aggregated percentage was 2.5 per cent. The rural regions, ranked in order of the percentage of children identified as having disabilities, were:

- Gippsland Region (3.3 per cent)
- Hume Region (2.6 per cent)
- Grampians Region (2.4 per cent)
- Barwon–South Western Region (2.3 per cent)
- Loddon Mallee (2.2 per cent).

More variation was found between subgroups, with the following groups identified as having levels of disability that were lower than the state average:

- girls (1.5 per cent)
- children from CALD backgrounds (1.2 per cent)
- children who did not speak English (1.4 per cent).
Attention Deficit Disorder or Hyperactivity Disorder

Attention Deficit Disorder (ADD) or Hyperactivity Disorder (HD) was targeted through specific questions in the SEHQ. Statewide, 1.1 per cent of children were reported to have been diagnosed with ADD or HD. The regional variation in the number of children diagnosed with ADD or HD was marked, as shown in Figure 13. Parents in the Barwon–South Western (1.5 per cent), Hume (1.5 per cent) and Gippsland (2.0 per cent) regions identified the highest proportion of children diagnosed with ADD or HD. Northern Metropolitan Region (0.8 per cent) and Grampians Region (0.8 per cent) identified the lowest proportion.

Figure 13: ADD or HD regional distributions

There was also significant variation in the subgroup distribution of ADD and HD. There were higher levels of ADD or HD diagnosis for:

• boys (1.6 per cent) compared to girls (0.5 per cent)
• ATSI (1.9 per cent)
• children living with their mother only (2.2 per cent) or father only (2 per cent)
• children who had not attended kindergarten/day care (1.5 per cent).

General development

Intellectual impairment, developmental delays and learning disabilities

The SEHQ asked parents if they have been told that their child has an intellectual impairment, developmental delay or learning disability. Statewide, 3.1 per cent of parents responded ‘yes’ to this item. The results are shown in Figure 14. Gippsland (4.2 per cent), Barwon South Western (3.6 per cent) and Hume (3.3 per cent) regions had higher than average numbers of children with these conditions.
Learning difficulties

In the SEHQ, parents were asked if they thought their child had learning difficulties. Responses across regions are shown in Figure 15. Statewide, 4.7 per cent of parents responded ‘yes’ to this item. As with ADD or ADHD, a high proportion of parents in Gippsland Region expressed concern about learning difficulties (5.6 per cent).
Other general development

Additional parent concerns about their child’s general development were registered through responses to questions relating to toileting and participation in school activities.

Toileting

There was substantially more concern than the aggregate state level (8.3 per cent) about children’s toileting for:

• boys (9.3 per cent)
• children living with their mothers only (10.1 per cent).

Interestingly, there was less parental concern expressed about toileting for children who:

• lived with their fathers only (6.4 per cent)
• were from a CALD background (5.8 per cent)
• did not speak English (6 per cent)
• did not attend kindergarten/day care (7.4 per cent).

Participation in school activities

Parents were also asked if they felt their child was able to participate in school activities. The percentage of parents who were concerned that their child’s general development would affect their ability to participate in school activities is generally higher in metropolitan regions (9.1 per cent) than in rural regions (8.5 per cent), with the exception of Eastern Metropolitan Region with a lower than average rate of 8.1 per cent.

There was substantial variation from the statewide average of 8.9 per cent on a range of demographic variables:

• boys (9.5 per cent) and girls (8.1 per cent)
• ATSI (15 per cent) and non-ATSI (8.1 per cent) children
• children living with their mothers only (11.6 per cent) or fathers only (13.6 per cent), and those living with both parents (8.2 per cent)
• children from CALD diverse backgrounds (14.7 per cent)
• children who did not speak English (17.8 per cent)
• children who did not attend kindergarten/day care (12.6 per cent).
Behaviour and emotional wellbeing

Across the state, 10.5 per cent of parents indicated that they had concerns about their child’s behaviour and emotional wellbeing, with little variation occurring across different regions. Particularly high levels of parental concern about behaviour and emotional wellbeing were expressed in relation to:

- children living with mothers only (20.7 per cent) or fathers only (21.5 per cent)
- ATSI children (15.6 per cent).

When interpreting the results for this item, the finding that only 5.9 per cent of parents wished to discuss their child’s behaviour with the school nurse should be taken into consideration.

Parents were also asked to assess their child’s behaviour and emotional wellbeing by identifying whether the child displayed seven key behaviours: ‘usually/often’, ‘sometimes’ or ‘never/rarely’. The percentage of children within each group identified as showing the behaviour ‘usually/often’ is shown in Table 11.

Table 11: Percentage of key behaviours displayed ‘usually/often’ for state and regional groupings

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Victoria %</th>
<th>Rural %</th>
<th>Metropolitan %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trouble paying attention/completing an activity</td>
<td>5.4</td>
<td>5.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Temper tantrums</td>
<td>6.0</td>
<td>5.7</td>
<td>6.8</td>
</tr>
<tr>
<td>Aggressive behaviour</td>
<td>3.3</td>
<td>3.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Plays well with other children</td>
<td>86.8</td>
<td>87.3</td>
<td>85.6</td>
</tr>
<tr>
<td>Looks forward to going to school</td>
<td>85.8</td>
<td>85.8</td>
<td>85.6</td>
</tr>
<tr>
<td>Generally happy</td>
<td>91.9</td>
<td>92.1</td>
<td>91.3</td>
</tr>
<tr>
<td>Sleeps well throughout the night</td>
<td>86.2</td>
<td>86.7</td>
<td>85.1</td>
</tr>
</tbody>
</table>

Table 12 shows percentage of children whose parents have concerns about their behaviour or emotional wellbeing who have visited various health professionals. This is compared with the percentage of children whose parents do not report such concerns and who have also visited these same professionals. Children whose parents have concerns about their behaviour or emotional wellbeing are, on average, two or three times more likely to visit a health professional. They are, however, nine times more likely to have contact with psychologists or psychiatrists.
Table 12: Health professionals visited in the past year

<table>
<thead>
<tr>
<th>Health professional visited</th>
<th>Behaviour or emotional wellbeing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% No concerns</td>
<td>% Concerns</td>
</tr>
<tr>
<td>General practitioner</td>
<td>84.8</td>
<td>91.5</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>11.9</td>
<td>26.8</td>
</tr>
<tr>
<td>Optometrist/eye doctor</td>
<td>13.6</td>
<td>19.8</td>
</tr>
<tr>
<td>Speech therapist</td>
<td>9.9</td>
<td>19.3</td>
</tr>
<tr>
<td>Ear, nose and throat doctor</td>
<td>10.9</td>
<td>19.1</td>
</tr>
<tr>
<td>Hearing services</td>
<td>8.8</td>
<td>17.2</td>
</tr>
<tr>
<td>Psychologist/psychiatrist</td>
<td>1.5</td>
<td>14.8</td>
</tr>
<tr>
<td>Maternal and child health nurse</td>
<td>8.3</td>
<td>12.1</td>
</tr>
<tr>
<td>Specialist children’s services</td>
<td>1.5</td>
<td>8.1</td>
</tr>
<tr>
<td>General surgeon</td>
<td>4.4</td>
<td>7.2</td>
</tr>
<tr>
<td>School nurse</td>
<td>4.1</td>
<td>6.2</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>1.2</td>
<td>6.2</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1.2</td>
<td>3.4</td>
</tr>
<tr>
<td>Bone and joint doctor</td>
<td>2.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Dietician</td>
<td>0.9</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Family stress

In addition to parent perceptions about their child’s emotional wellbeing, the SEHQ also seeks information about family stress. Parents are asked whether their child had been affected by 17 stressful incidents, with non-response being expected due to the sensitive nature of this question. Table 13 presents the number of positive responses (N) and the statewide percentage.
Table 13: Ranked incidence of stressful family events

<table>
<thead>
<tr>
<th>Stressful family events</th>
<th>Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move to new house</td>
<td>9064</td>
</tr>
<tr>
<td>Recent divorce/separation of parents</td>
<td>5608</td>
</tr>
<tr>
<td>New baby in the house</td>
<td>5085</td>
</tr>
<tr>
<td>Death of a relative or friend</td>
<td>4976</td>
</tr>
<tr>
<td>Move to new school</td>
<td>4850</td>
</tr>
<tr>
<td>Parent’s change of job</td>
<td>3905</td>
</tr>
<tr>
<td>Child was witness to violence</td>
<td>1479</td>
</tr>
<tr>
<td>Serious illness of parent(s)</td>
<td>1457</td>
</tr>
<tr>
<td>History of abuse to parent</td>
<td>1191</td>
</tr>
<tr>
<td>Parent’s loss of job</td>
<td>1116</td>
</tr>
<tr>
<td>Alcohol or drug related problem in family</td>
<td>933</td>
</tr>
<tr>
<td>Remarriage of parent(s)</td>
<td>883</td>
</tr>
<tr>
<td>History of mental illness of parent</td>
<td>863</td>
</tr>
<tr>
<td>Serious illness of sibling(s)</td>
<td>754</td>
</tr>
<tr>
<td>Parent was witness to violence</td>
<td>736</td>
</tr>
<tr>
<td>History of abuse to children</td>
<td>501</td>
</tr>
<tr>
<td>Gambling problem in the family</td>
<td>313</td>
</tr>
</tbody>
</table>

The SEHQ further asks parents to assess the overall level of their family stress over the previous month.

A five-point scale is used, with the end points being ‘little or no stress/pressure’ and ‘almost more than I can bear’. For the purpose of analysis, the responses are aggregated into ‘low or no’, ‘moderate’ and ‘high’ levels of stress. Statewide, parent responses are 38.3 per cent, 51.6 per cent and 9.9 per cent respectively.

**Parenting**

Parents were asked if they had any concerns they wished to discuss with the school nurse. Across the state, 4.2 per cent of parents expressed concern about parenting, with metropolitan region parents (4.4 per cent) expressing a slightly higher level of concern than rural region parents (3.6 per cent). Parents in the Eastern Region expressed the highest level of concern (4.9 per cent) with parents in Loddon Mallee Region expressing the lowest level of concern (3.2 per cent). Single parent families (mother only – 8.0 per cent, and father only – 10.5 per
cent) and families with ATSI children (5.3 per cent) identified the greatest levels of concern about parenting.

**Parent requests to consult with school nurse**

Parents were asked if they had any concerns about their child’s health that were not raised in the SEHQ and that they wished to discuss with the school nurse. Across the state, 8.1 per cent of parents responded ‘yes’ to this item.

The number of parents indicating that they wished to consult with the school nurse about their child’s health varied regionally. The results show that there is generally a higher proportion of parents in the metropolitan regions (8.6 per cent) than in the rural regions (7.2 per cent) wanting additional consultations. This is particularly the case in Western Metropolitan Region (8.8 per cent) and Southern Metropolitan Region (8.6 per cent), which contrasts sharply with Hume (6.4 per cent) and Gippsland (6.8 per cent) regions.

Higher proportions of parents who wished to speak with the school nurse were identified in the following subgroups:

- male children (8.4 per cent)
- ATSI children (10.4 per cent)
- children who do not speak English (9.6 per cent)
- children who come from CALD backgrounds (10.1 per cent)
- children from single parent families (mothers only – 9.4 per cent and fathers only – 11.4 per cent).

These respondent categories are persistently identified throughout the data as being associated with health concerns and now with the desire to speak to the school nurse.
Conclusions and future directions

Analysis of the year 2000 SEHQ data has provided a rich and detailed source of information about parental perceptions of the health and wellbeing of year 2000 preparatory grade children in Victoria. It creates one of the largest databases in Australia in relation to parent perceptions about the health and wellbeing of school entrant age children.

The SEHQ data provides an opportunity to better inform both planning and practice of new and existing programs and initiatives. A summary of the key findings was presented in the section 'What parents tell us – key findings'.

In this section, conclusions about the broad use of the SEHQ data, some examples of implications of the current analysis for specific programs, and a discussion of future directions for the SEHQ are presented.

Use of the SEHQ data

As this report illustrates, the information collected from the SEHQ gives key decision makers valuable information from parents about the main health issues that may have an impact on children’s capacity to learn at school. The information has the capacity to inform not only the Victorian School Nursing Program, but also to provide significant insight into future directions in child health, early intervention, parenting support and education programs, and services that could benefit Victorian children during their early developmental years.

Analysis of SEHQ data highlights issues that are of most concern to parents about their child’s health and wellbeing, and identifies the health services accessed by children in the 5–7 year old age cohort.

The SEHQ data can be analysed at local, regional and state levels, with further identification of needs by particular population subgroups which will assist in planning and targeting of prevention, support, enhancement and early intervention strategies.

At a local level, the data provides a unique resource for service providers such as those involved in the Primary Care Partnerships (PCP) Strategy. PCPs are alliances of primary care providers in a local area. The partnerships aim to improve the health and wellbeing of their catchment’s population by better coordination of planning and service delivery in response to identified needs. The work of PCPs involves the development of community health plans to identify priority needs and how services will work together to respond to these needs. The local SEHQ data could assist in the review of community health plans and contribute to informing the direction of local health promotion, illness prevention and disease management programs for young children in each of the PCP sites.

The data also has the capacity to inform planning and resource allocation decisions across a range programs within each of the nine Department of Human Services regions. The significant variations between regions that are identified in relation to some of the variables discussed in this report, highlight the importance of information such as the SEHQ data to inform regional service delivery.
The SEHQ data can further be used to support relevant research in relation to child and family health and wellbeing. Examples may include:

- Fitting Fathers into Families: Men and the Fatherhood Role in Contemporary Australia
- National Investment for the Early Years (NIFTEY)
- Literacy, Numeracy and Social Outcomes in Early Childhood Education and Care
- National Indigenous English Literacy and Numeracy Strategy
- Solid Foundations: Health and Education Partnership for Indigenous Children Aged 0–8 years

**Findings of relevance to particular programs**

The current analysis of SEHQ 2000 data provides insights relevant to a number of Department of Human Services programs.

**Dental health services**

Good oral health is integral to a child’s health and wellbeing and oral health promotion has been identified as a priority for the Department of Human Services. The department’s publication, Promoting oral health 2000-2004: strategic directions and framework for action outlines a framework for oral health promotion across Victoria over five years.

The SEHQ findings support the need, as identified in the framework, for targeted information on dental health. The findings of this report suggest that more accessible information may be particularly important for parents from ATSI and CALD groups. The findings also provide some data that may help to meet an identified need for further research into the oral health status of Victorians.

**Victorian Maternal and Child Health Service**

The Maternal and Child Health (MCH) Service is a universal primary health service for all 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. In addition, the Enhanced MCH Service provides a more intensive level of support for vulnerable families experiencing significant early parenting difficulties and children identified as being at risk of harm.

Data available through the SEHQ providing parents’ perception of health issues in older children may provide valuable insight to inform the MCH Service Improvement project currently being undertaken by the department and the Municipal Association of Victoria.
In considering the implications of the SEHQ 2000 data for the MCH Service, it is important to note that, of the families who completed the SEHQ in this year and participated in the MCH Service as infants, many would not have benefited from the numerous quality improvement projects and enhancement initiatives introduced since 1995. Most of these families’ contact with the MCH Service preceded these enhancements. Future years of SEHQ data may, therefore, provide a comparison with 2000 as a baseline against which to assess some service improvements.

Speech therapy services

Gaps in existing community health speech therapy services have been identified. These findings are supported by the SEHQ results showing that, of the parents who identified their child as having a speech or language problem, only 45.8 per cent have visited a speech therapist. Enhancements to community health services in 2001–2002 included addressing gaps in speech therapy services. Analysis of later years’ SEHQ data may provide some indication of the outcomes of these enhancements.

Child and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) are specialist tertiary public mental health assessment and treatment services provided for children and adolescents up to the age of 18 years who display complex and serious emotional, behavioural and psychological disturbance, and their families. CAMHS are community-based multidisciplinary services that have some capacity to provide intensive outreach to those clients with complex needs as well as limited inpatient admission. CAMHS also provide a secondary consultation and support role to other service providers working with children who display more moderate emotional and/or behavioural difficulties.

The Victorian Government has recently allocated funding for two pilot projects aimed at improving early intervention with children aged 5–8 years with emerging or existing conduct disorders. These pilots are to take place in both a rural and metropolitan setting and involve the development of collaborative partnerships between CAMHS and schools. As many children with conduct disorders are also identified as having attention deficit and/or hyperactivity difficulties, these pilots will provide significant learnings about this group of children.

Information gained through the SEHQ could be used to inform CAMHS activities through the provision of a cross-section of parent’s concerns about a range of behavioural and emotional indicators at a relevant point for early intervention. The data also provides further information to build on the Child and Adolescent National Survey of Mental Health and Wellbeing (Sawyer et al, 2000).

The SEHQ 2000 data suggests particular needs amongst children from ATSI families and children from single parent families. These two groups have the highest levels of parental concern about behaviour and emotional wellbeing.
Victoria’s Best Start Program

Best Start is a prevention and early intervention project that aims to improve the health, development, learning and wellbeing of Victorian children from pregnancy through to transition to school (taken to be 0–8 years of age). Best Start is underpinned by an extensive body of research that tells us that a child’s brain development is intimately linked with a child’s environment and that a child’s early experiences have an impact on long-term outcomes.

Eleven demonstration projects are trying new approaches to the delivery of universal early years services. Demonstration sites are located in metropolitan, regional and rural Victoria. Best Start partnerships have been developed in each demonstration area. These partnerships bring together local parents, health, education and community services. Partnerships are undertaking a comprehensive planning process, including service mapping, consultations with parents and service providers and analysis of local needs. They are developing action plans that will explore ways that community resources and local services can be better used to support all families, especially those that have not been using services.

The SEHQ data may provide important and timely information for Best Start by providing an outline of parents’ perspectives of the health and wellbeing of Victorian children at school entry. The data can be used to target particular population groups whose specific health issues are identified to assist planning and set priorities in Best Start activities across the state.

Preschool support services

Preschool Inclusion Support Services consist of the Special Education Program (SEP), which assists children with severe disabilities and high support needs to access preschool; and the Preschool Field Officer Program, which supports the inclusion of children with a broad range of additional needs in preschool.

Enhancement of the Inclusion Support Program in 2003 has enabled more flexible models of support for children with severe disabilities in preschool and fostered more innovative and integrated approaches to inclusion support for children with a broad range of additional needs to participate in preschool programs.

A review of the Koori Early Childhood Education Program was completed in March 2003 and will guide directions to increase Indigenous preschool participation.

The SEHQ data provides information highlighting areas of parental concern which can inform planning of preschool program content to meet the identified issues for parents in the transition of their children from preschool to school enrolment.
SEHQ developments

Data repository

Work is currently underway to develop a service planning data repository, including SEHQ data, for use as a general planning and evaluation resource to support Department of Human Services staff with a broad range of service planning, resource allocation and service evaluation activities. It is envisaged that the repository will provide consistent information and support an integrated planning approach across a range of department program areas.

The data repository will draw together SEHQ data over consecutive years. To date this includes a total of 246,066 records spanning 1997–2001. The data will be accessible through a range of reports both within single calendar years and showing trends over a number of years. It is also intended that queries will be able to be run at the LGA level. This will assist in more accurate targeting of programs and identification of local needs.

SEHQ review

The current SEHQ has been in use since 1997. Over time it will become important to review the instrument to take advantage of emerging research in child health surveillance and screening and to improve the design of the parent questionnaire. Any such review should take into account the role of the SEHQ within the broader aims of the Primary School Nursing Program and should consider what can be learned from the data collected to date. For example, the emergence of cultural and linguistic diversity as an important variable influencing a number of health dimensions assessed through the SEHQ may highlight the need to consider translation of the SEHQ into other languages to ensure the accuracy of data collected from parents of diverse backgrounds.
References


Department of Human Services 2000a, *Primary School Nursing Program—Year 2000 report*, Community Health Unit, Department of Human Services, Melbourne, Victoria.

Department of Human Services 2000b, *Primary School Nursing Program data collection*, Department of Human Services, Melbourne, Victoria.


Sawyer et al. 2000, *The mental health of young people in Australia*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.
A child health questionnaire has been used since 1991 as part of the Victorian School Nursing Program (SNP). In addition to acting on information gained through the questionnaire, primary school nurses conduct (with parental consent) health assessments of all children at English Language Centre schools and those children who have newly arrived from overseas. Children in other grades are also seen by school nurses when referred by parents or teachers, with parental consent.

A systematic and streamlined approach to health surveillance and screening activities was recommended by the Department of Human Services in 1995, following the National Health and Medical Research Council's (NHMRC, 1993) review of child health surveillance and screening. A research team at the RMIT University and the University of Melbourne was commissioned by the department to revise the child health questionnaire and to develop the School Entrant Health Questionnaire (SEHQ).

The aims of the SEHQ are to:

- develop a partnership between children, parents and the School Nursing Program
- enable parents to participate in identifying the health needs of their children
- provide cues for parents to review the health status of their child
- contribute to prioritising workloads for school nurses (Department of Human Services, 1996).

An advisory committee was established to guide the development of the SEHQ. This committee consisted of key stakeholders concerned with the health assessment of preparatory grade children, including representatives from the Department of Human Services and the Directorate of School Education, primary school principals, a senior school nurse, two school nurses (one rural and one metropolitan), and representatives from the Victorian Council of School Organisations Inc., Centre for Community Child Health and Ambulatory Paediatrics, and the Australian Education Union.

The first process in the development of the SEHQ consisted of identifying a series of relevant domains. Within these domains, items which were likely to discriminate between healthy children and children having health concerns were generated. The basic criteria used for including an item in the SEHQ was that it could assist in identifying conditions that may interfere with a child’s ability to learn. The items were then trialled and reviewed by the advisory committee and parents (Edgecombe, Avant, Griffin and Corneille, 1997). Eleven domains and 52 items were eventually selected for inclusion in the SEHQ.
The 11 domains include:

- general health
- medication
- immunisation
- dental health
- speech/language
- hearing
- vision
- disabilities
- general development
- behaviour and emotional wellbeing
- family stress.

The SEHQ endeavours to obtain a comprehensive and informed profile of parents’ perceptions of their child’s health. Viewed as a critical component of the redevelopment of the School Nursing Program (Department of Human Services, 1996), the SEHQ took on a primary role in school entry health assessment processes by helping with identification of health concerns related to children’s general health and development, social and emotional wellbeing, vision and hearing.
Appendix 2: Administration of the SEHQ

Distribution and collection of the SEHQ occurs through partnership between the nurse and the school. All parents of preparatory aged children are given the opportunity to complete the SEHQ and have their child assessed by a school nurse. Privacy of the child and family and confidentiality of any information collected is respected at all stages of the process. Figure 16 outlines the distribution, collection and analysis of the SEHQ through Victorian primary schools and the Department of Human Services.

Figure 16: How the SEHQ is administered
Appendix 3: School nursing program information and questionnaire for parents/guardians of the school entrant child
The School Nursing Program offers Victorian families a free health assessment for children in their first year at school. This program gives parents/guardians, teachers and nurses an opportunity to work together for the wellbeing and educational progress of children.

It is important that the school nurse has an understanding of any concerns you have related to your child’s health. The information provided through the questionnaire will assist the school nurse in providing a service to your family. Your cooperation in completing the questionnaire as fully as possible is appreciated. Following the initial assessment, the school nurse may contact you to discuss any matters of concern regarding your child’s health.

The health assessment is not intended to replace your normal source of health care.

The health assessment of your child will consist of:

- Information provided by you on the questionnaire.
- Vision screening.
- Information provided by your child’s teacher if they believe there are health concerns.
- A hearing test, where indicated by the information provided by you on the questionnaire or by the teacher’s concerns. This may include inspection of the ear canal.
- Brief assessment of any health related problem, where indicated by the information provided by you on the questionnaire or by the teacher’s concerns.

If you agree to have your child’s health assessed by the school nurse, please complete the consent form below (part A), the family details section (part B) and the questionnaire.

---

**Part A**

I consent to a health assessment of my child by the school nurse. If during this assessment there are concerns identified requiring a more detailed examination, I understand that the nurse will contact me before this is carried out.

Signature: ___________________________ Date: / /

( Parent/Guardian )

Name: (Please Print) ___________________________

( Parent/Guardian )

If consent is not given, it may help us to improve our service if you told us your reason. Please return this questionnaire to your child’s school in the supplied envelope.

Reason: ___________________________

---

**Please note:**

- Identifying details provided by you will be treated in strictest confidence.
- If you require assistance to complete this form, or an interpreter, please contact your school nurse during their visit to your child’s school or at your regional office at the address listed on the back of the enclosed brochure.
- You are encouraged to consult your school nurse at the time of their visit to your child’s school to discuss any concerns you may have.
This Section to be Completed by the School Nurse

School Entrant Health Assessment Results

Child’s Name: ____________________________

Eyesight
Within normal screening limits at date of test. Yes [ ] No [ ]

School Nurse Comments:

Nurse’s Name: ____________________________ Date: __/__/____

Telephone: ________________________________

This section will be returned to you on completion of the health assessment to keep with your child’s health record.

This Section and Following Pages to be Completed by Parent/Guardian

Part B

Child’s Family Name: ____________________________

First Name: ____________________________

Date of Birth: ____________________________ Age of Child: yrs mths

Home Address: ____________________________

Postcode: ____________________________ Home Phone No: ____________________________

Mother’s/Guardian’s Name: ____________________________ Work Phone No: ____________________________

Father’s/Guardian’s Name: ____________________________ Work Phone No: ____________________________

Name Of School Your Child Attends: ____________________________

Names & Ages of Brothers & Sisters

Name: ____________________________ Age: ________

Name: ____________________________ Age: ________

Name: ____________________________ Age: ________

Name: ____________________________ Age: ________

---

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HA3
School Entrant Health Questionnaire

INSTRUCTIONS for PARENT/GUARDIAN

Please use a BLACK lead pencil to answer questions.
Please DO NOT fold or crease the questionnaire.
Colour in the bubbles like this:

An example of how to answer a question is as follows:

Is your child in prep?  Yes No

NAME OF SCHOOL

BOY ☐ GIRL ☐

1. Does your child live at home with:
   1.1 both parents ☐
   1.2 mother only ☐
   1.3 mother & partner ☐
   1.4 father only ☐
   1.5 father & partner ☐
   1.6 guardian(s) ☐
   1.7 other ☐
   (please specify)

2. Does your child speak English?  Yes No
   ☐ ☐

3. Is English the main language spoken at home?  Yes No
   ☐ ☐

4. Is the child of Australian Aboriginal or Torres Strait Islander origin?
   4.1 No, not Aboriginal or Torres Strait Islander ☐
   4.2 Yes, Aboriginal ☐
   4.3 Yes, Torres Strait Islander ☐
   4.4 Yes, Aboriginal and Torres Strait Islander ☐

5. Did your child go to kindergarten/daycare?

6. How healthy is your child? (Mark the one that applies)
   6.1 generally healthy ☐
   6.2 frequent minor illnesses (6 or more per year) ☐
   6.3 major illness ☐

7. Compared to other children of the same age is your child very small?  Yes No
   ☐ ☐

8. Does your child have allergies that may require attention at school?
   8.1 If yes, what to? ________________
   8.2 How does it affect your child? ________________

9. Does your child have asthma?  Often ☐ Sometimes ☐ Never ☐
   9.1 If often/sometimes, does s/he have a written asthma plan? ☐ ☐
   9.2 Would you like to talk to the nurse about your child's asthma? ☐ ☐

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10. Has your child had any of the following health conditions?

10.1 low birth weight (less than 1500g) ...........................................
10.2 birth abnormality ..............................................................
10.3 intraventricular shunt (or hydrocephalus) ..............................
10.7 If yes to any of the above, please give details: (eg. bacterial meningitis, tuberculosis) ....
10.8 Do you think that the condition(s) might affect your child’s school performance? ........................

11. Does your child have any of the following health problems?

11.1 diabetes .................................................................
11.2 arthritis .................................................................
11.3 epilepsy (seizure disorder) ...........................................
11.4 cystic fibrosis ............................................................
11.5 cerebral palsy ...........................................................
11.6 spina bifida ............................................................
11.7 chronic joint or bone problems (other than arthritis) ..........
11.8 chronic lung or respiratory problems (other than asthma) ....
11.9 stomach, intestinal, or absorption problems (other than cystic fibrosis) ....
11.10 other (please specify) ..............................................

12. If your child has any of the above health problems or conditions, has the problem been attended to by a health professional? .........................

13. In the past year, has your child been seen by any of the following health professionals?

13.1 general practitioner (GP) .............................................
13.2 paediatrician ...........................................................
13.3 ear, nose & throat doctor ..........................................
13.4 optometrist/eye doctor ..............................................
13.5 general surgeon ........................................................
13.6 bone & joint doctor ...................................................
13.7 psychologist/psychiatrist ...........................................
13.8 speech therapist ........................................................
13.9 physiotherapist ........................................................
13.10 occupational therapist ............................................
13.11 hearing services ......................................................
13.12 dietician .................................................................
13.13 maternal & child health nurse ................................
13.14 school nurse ...........................................................
13.15 Specialist Children’s Services .....................................
13.16 other (please specify) ...............................................

14. If your child is a boy, are both testes (balls) down in the scrotum? ........................... 

15. Is your child currently on regular medication(s)? ......................................................

15.1 If yes, please give details: ...............................
### IMMUNISATION

16. Has your child had all the immunisations recommended prior to starting school?  
   *(If unsure look at your child health record book or Certificate of Immunisation Status for Primary School Enrolment)*

### DENTAL HEALTH

17. Have you any concerns about your child's teeth?  
18. Has your child been to the dentist in the last 1-2 years?

### SPEECH-LANGUAGE

19. Does your child have any difficulties with speech or language?  
   *(If yes, in which areas? (mark all that apply)*

   - 19.1 reluctant to speak
   - 19.2 speech not clear to the family
   - 19.3 speech not clear to others
   - 19.4 difficulty finding words
   - 19.5 difficulty putting words together
   - 19.6 doesn't understand you when you speak
   - 19.7 doesn't understand others when they speak
   - 19.8 voice sounds unusual
   - 19.9 stutters or stammers
   - 19.10 other

   *(specify)*

19.11 If yes to any of the above, is the problem being attended to by a speech therapist?

### HEARING

20. Is there a history of children born deaf or nerve deafness during childhood on either side of your family?  

21. How many ear infections has your child had in the last year?  

22. Has your child ever been referred to an ear, nose and throat specialist?  
   *(If yes, when, and what was the outcome)*

23. Has your child ever had a hearing test conducted by an audiologist?  
   *(If yes, when, and what was the outcome)*

24. Does your child wear a hearing aid?

25. Do you have to repeat simple instructions before your child responds?  

26. Does your child seem to hear better if watching your face?

27. Are you concerned about your child's hearing?  
   *(If yes, is it being attended to)*
VISION

28. Has anyone on either side of the family (including brothers/sisters) had childhood eye problems for which they needed treatment? .......................................................... ○ ○

29. Does your child have, or has s/he ever had, one or both eyes that turn in towards the nose or outwards towards the ear? (sometimes called a squint or strabismus or lazy eye). ○ ○ ○ ○

30. Does your child tilt his/her head in one direction when looking at things like books or pictures? ○ ○ ○ ○

31. Has your child ever seen an eye doctor or optometrist? ........................................ ○ ○

32. Has your child ever had any treatment for eyesight problems? ................................. ○ ○

33. When was the last time your child had his/her eyesight checked?

<table>
<thead>
<tr>
<th>33.1 within the last year</th>
<th>33.2 1-2 yrs ago</th>
<th>33.3 more than 2 yrs ago</th>
<th>33.4 never had eyesight checked</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

34. Are you concerned about your child’s eyesight? ................................................ ○ ○

35. Does your child have any disabilities? .................................................................. ○ ○

36. Has your child ever been diagnosed as having Attention Deficit Disorder or Hyperactivity Disorder? .......................................................... ○ ○

37. If yes to any of the above, are your child’s extra needs being taken care of? ........ ○ ○

GENERAL DEVELOPMENT

38. Have you been told that your child has intellectual impairment, developmental delay or learning disability? .......................................................... ○ ○

39. Is your child having, or do you think your child might have learning difficulties? ○ ○

40. Are you concerned about your child’s toileting? .................................................. ○ ○

41. Can your child easily and without help, go up and down stairs? ............ ○ ○

42. Can your child cut along a straight line with scissors? ...................................... ○ ○

43. Can your child easily draw a circle with a pencil? .............................................. ○ ○

44. Compared to other children of the same age is your child well coordinated? ...... ○ ○

45. Are you concerned about your child’s ability to participate in school activities? ○ ○

45.1 If yes, please give details (include whether you have discussed with teacher):
46. Do you have any concerns about your child’s behaviour and/or emotional wellbeing?  
46.1 If yes, please specify

47. How would you describe your child’s behaviour and emotional wellbeing in the following areas? 

47.1 Does your child have trouble paying attention or completing an activity?  
47.2 Does your child have temper tantrums?  
47.3 Does your child display aggressive behaviour (e.g. kick/bite/scratch)?  
47.4 Does your child play well with other children?  
47.5 Does your child look forward to going to school?  
47.6 Is your child generally happy?  
47.7 Does your child sleep well throughout the night?

48. Do you have any other concerns about your child’s behaviour that you wish to discuss with the school nurse?  
48.1 If yes, please specify

49. Has your child been affected by any of the following?  If yes, mark all that apply

49.1 recent divorce/separation of parents  
49.2 death of relative or friend  
49.3 move to new house  
49.4 move to new school  
49.5 parent’s change of job  
49.6 parent’s loss of job  
49.7 new baby in the house  
49.8 remarriage of parent(s)  
49.9 serious illness of parent(s)  
49.10 serious illness of sibling(s)  
49.11 history of abuse to parent  
49.12 history of abuse to child(ren)  
49.13 alcohol or drug related problems in family  
49.14 history of mental illness of parent  
49.15 child was witness to violence  
49.16 parent was witness to violence  
49.17 gambling problem in the family  
49.18 other (please specify)  
49.19 other (please specify)  
49.20 other (please specify)

50. Sometimes, families have times when there is more stress/pressure than usual.  
Overall, how would you rate your own family’s stress level over the last month?  
Almost more than I can bear  
(middle)  
Little or no stress/pressure

51. Do you have any concerns about the parenting of your child that you wish to discuss with the school nurse?  
51.1 If yes, please specify

52. Do you have any other concerns about your child’s health that you wish to discuss with the school nurse?  
52.1 If yes, please specify

Thank you for your time and effort in completing this questionnaire.