OVENS MURRAY AREA

Community needs assessment 2024

Ovens Murray
Child and Family Services Alliance
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OVENS MURRAY MENTAL HEALTH, ALCOHOL AND DRUG ALLIANCE

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VICTORIA State Government

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The University acknowledges Aboriginal people's ongoing connection to the land upon which its campuses are located and values the contributions Indigenous Australians make to its activities.

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EXECUTIVE SUMMARY.

This report was commissioned by a conglomerate of service alliances operating within the Ovens Murray area. The project was initiated by Ovens Murray Child and Family Services Alliance (Upper Murray Family Care Lead agency) and Ovens and Murray Mental Health, Alcohol and Drug Alliance (Gateway Health Lead agency). Other sectors participating in the project include the Ovens Murray Family Violence Strategic Partnership and the Ovens Murray Homelessness Network. The project is supported by the Victorian Government.

Each agency and alliance represent providers of services targeted at, among other things, families with children. It is this aspect of service provision that the following report investigates.

The report addresses and prioritises critical social issues affecting families with children and young people in the Ovens Murray region. By focusing on the areas of alcohol and other drugs, mental health, homelessness, and family violence, the report provides a comprehensive analysis that will inform regional planning and guide action.

KEY FINDINGS

The analysis identifies significant areas of concern across the Ovens Murray region, with with the LGAs of Benalla, Wangaratta, and Wodonga emerging as localities with particularly high needs.

Benalla LGA is marked by severe socio-economic disadvantage, the highest rates of family violence, and alcohol-related incidents in the region. The high prevalence of mental health issues, the substantial proportion of single-parent families, and high levels of developmental vulnerability highlight the challenges faced in this LGA.

Wangaratta LGA faces escalating challenges with alcohol-related ambulance attendances, mental health conditions—especially among young women—and increasing family violence incidents. The LGA also struggles with housing stress and homelessness.

Wodonga LGA has the highest rate of homelessness in the region, coupled with significant mental health challenges among young women and a rising rate of family violence. The city's rapidly growing population exacerbates these issues, creating an urgent need for expanded services and infrastructure.

SERVICE LANDSCAPE AND CHALLENGES

The service landscape in Ovens Murray is varied, with notable gaps in Alcohol and Other Drug (AOD) services and homelessness support. Despite the high need in regions like Benalla, the availability of specialised services still needs to be improved.

- Clients often present with multiple interconnected issues, complicating the service delivery process. The lack of integration across services exacerbates these challenges, particularly in areas with limited resources.
- Strong collaborations between services in Ovens Murray have been shown to improve outcomes. However, a pressing need remains to enhance networking opportunities, raise awareness about available services, and address the barriers posed by strict eligibility criteria and time-limited programs.
- Geographical challenges and financial burdens further limit access to essential services. The inadequacy of public transportation and the divide created by the regional borders intensify these access issues.

METHODOLOGY

The findings in this report are based on a rigorous methodology that includes a comprehensive review of literature, analysis of national and regional datasets, service mapping, and qualitative insights from focus groups and interviews. The Modified Monash Model (MMM) was employed to assess the remoteness and service accessibility in the region.

RECOMMENDATIONS

Given the critical issues identified, the report recommends a multi-faceted approach to addressing these social challenges:

Enhancing Service Integration

Increase collaborations between service providers, particularly in areas with limited AOD and homelessness services. Strengthening these networks can improve the comprehensive care provided to clients with multiple issues.

Expanding Service Availability

Prioritise the expansion of mental health and family violence services in high-need areas like Wodonga and Wangaratta. Additionally, addressing the gaps in AOD services, particularly in Benalla, should be a key focus.

Improving Accessibility

Address geographical and financial barriers to service access by investing in transportation infrastructure and ensuring that outreach services have adequate facilities. Proactively planning for Wodonga's rapid population growth is crucial to meet future demand.

CONCLUSION

The Ovens Murray region faces significant social challenges that require immediate and coordinated action. By addressing service gaps, enhancing collaborations, and improving access, stakeholders can better support vulnerable families and contribute to the region's overall well-being.

This report is a crucial tool for service providers and funding bodies to make informed decisions that will shape the future of social services in Ovens Murray.

ACKNOWLEDGEMENT.

The Ovens Murray Community Needs Assessment is a collaboration between Ovens Murray Child and Family Services Alliance (Upper Murray Family Care Lead agency) and Ovens and Murray Mental Health, Alcohol and Drug Alliance (Gateway Health Lead agency).

Other sectors participating in the project include the Ovens Murray Family Violence Strategic Partnership and the Ovens Murray Homelessness Network. The project is supported by the Victorian Government. The Care Economy Research Institute (La Trobe University) undertook the research and writing of the report as consultants to the alliances.

We extend our deepest gratitude to the dedicated service providers and courageous clients who generously gave their time to share their stories with us. Our discussions showed how deeply the service providers care for their clients and their families. Your unwavering commitment to supporting those in need is inspiring, and your insights have enriched our understanding of the challenges and opportunities within our community.

To the clients who participated, your love and concern for your children and families were palpable in every conversation. Your resilience and willingness to share your experiences are invaluable, and your voices have played a crucial role in shaping our work.

We are profoundly grateful for your contributions, which have helped us better appreciate the complexities faced by individuals and families in our region. Your stories will guide efforts to make meaningful improvements in the services that support our community.

Thank you for your trust, honesty, and commitment to making a difference.

RESEARCH TEAM

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GLOSSARY OF TERMINOLOGY.

CHILD AND FAMILY SERVICES

Child and Family Services in Australia encompass a range of programs and interventions designed to support the well-being of children and their families. These services aim to ensure children's safety, promote their development, and assist families in providing nurturing environments. They include child protection services, family support programs, early childhood education and care, and parenting support initiatives (Victoria State Government, ND) .

FAMILY VIOLENCE

Family violence in Australia is defined as any violent, threatening, or abusive behaviour by a family member that coerces, controls, or causes fear. It encompasses physical, emotional, psychological, sexual, financial, and social abuse. Family violence can occur in various familial relationships, including intimate partners, parents, children, and extended family members (Victoria State Government, 2022).

ALCOHOL AND OTHER DRUGS

Alcohol and Other Drugs (AOD) use encompasses the consumption of alcohol and other psychoactive substances, which may result in a range of health, social, and legal issues. This includes the use of substances such as alcohol, cannabis, opioids, stimulants, and hallucinogens (American Psychological Association, 2024).

HOMELESSNESS

Homelessness is the lack of stable, safe, and adequate housing. It encompasses a range of living situations, including sleeping rough, staying in crisis accommodation, living in temporary or overcrowded dwellings, and other forms of insecure housing.

MENTAL HEALTH

Mental health refers to a state of mind marked by emotional well-being, effective behavioural adjustment, relative freedom from anxiety and debilitating symptoms, and the ability to form positive relationships and manage the typical challenges and stresses of life (American Psychological Association, 2022).

ABBREVIATIONS.

AOD	ALCOHOL AND OTHER DRUGS
FV	FAMILY VIOLENCE
IPV	INTIMATE PARTNER VIOLENCE
OM	OVENS MURRAY
LGA	LOCAL GOVERNMENT AREA

INTRODUCTION.

Ensuring young children can reach their full developmental potential is a fundamental human right and crucial for sustainable development (World Health Organisation, 2020). For optimal development to occur, children and young people need access to a nurturing environment (World Health Organisation et al., 2018). Many families need support to provide such an environment, especially in the early years of development (World Health Organisation, 2020). Adverse environments, including chronic exposure to family violence, discrimination, disability, substance abuse, parental mental health issues, displacement and poverty, severely limit a child's developmental potential (World Health Organisation et al., 2018).

Recent findings from the Australian Child Maltreatment Study (ACMS: Haslam et al., 2023) highlight the long-lasting impact of childhood physical, sexual, and emotional abuse, neglect, and exposure to family violence (child maltreatment). Describing their findings as "deeply sobering", the authors report that 62.2% of the Australian population aged 16-65 years and older has experienced at least one form of maltreatment in childhood, with exposure to domestic violence being the highest (39.6%). Maltreatment was found to be chronic, occurring multiple times over a period of years, with multiple types of maltreatment commonly co-occurring (Haslam et al., 2023). The ACMS found that 48% of people who experienced child maltreatment met the criteria for mental health disorders compared to 21.6% of those who had not experienced maltreatment in childhood. Further, they were more likely to smoke, binge drink, be dependent on cannabis, have obesity, engage in self-harm and have attempted suicide within the last 12 months than those who had not experienced childhood maltreatment. Those who have experienced maltreatment were more likely to have been hospitalised, visited a general practitioner six or more times, and sought help from a mental health professional in the previous 12 months. Consultations with psychiatrists, mental health nurses, and psychologists demonstrated the most significant effects, indicating the impact of maltreatment on mental health. This effect is even stronger for those who have experienced multiple types of maltreatment (Haslam et al., 2023).

Similarly, children exposed to domestic and family violence experience a range of adverse outcomes that can include impaired cognitive functioning and behavioural issues, poorer academic outcomes, learning difficulties, and impaired mental and physical well-being (Campo, 2015). Further compounding this issue, FV is a leading cause of homelessness for Australian children (Campo, 2015, Haslam et al., 2023).

Alcohol and other substance use within families affects children across the life course and begins in the prenatal stage (Straussner & Fewell, 2018). Although some children of parents with alcohol and drug use disorders are relatively well-adjusted, growing up with a parent who has a substance use disorder is often negative and increases the risk of emotional, behavioural, physical, cognitive, academic, and social problems (Straussner & Fewell, 2018). The interconnectedness of AOD use disorders, mental health, homelessness and family violence make it difficult to unpick causal relationships between outcomes, and those working with families with children in any one of the four areas are likely to be working at the intersection of multiple issues (Healey et al., 2020; Heward-Belle et al., 2022).

The Intersection of Alcohol and Other Drug Abuse, Family Violence, Mental Health, and Homelessness in Families with Children

Family dynamics are complex, and various factors intersect to create challenging situations. In this section, we explore the interplay between alcohol and other drug (AOD) abuse, family violence, mental health, and homelessness, particularly within families that include children.

Alcohol and other drug use frequently intersect with domestic and family violence, with both perpetrators and victims affected (Australian Institute of Health and Welfare, 2016a; Miller et al., 2016). Substance abuse can exacerbate aggression, impair judgment, and escalate conflict within families. It often coexists with family violence, leading to a vicious cycle of harm (Australian Institute of Health and Welfare, 2016b). Experiencing family violence leaves women and their children vulnerable to homelessness as the safety of the home is compromised, and leaving the violent situation often involves exiting the family home (Australian Institute of Health and Welfare, 2016a).

Mental health issues, such as depression, anxiety, and post-traumatic stress disorder, are prevalent among individuals experiencing family violence. The stress and trauma associated with violence can significantly impact mental well-being. Children growing up in violent households are also at risk of developing mental health problems due to exposure to such environments. Young people (aged 16-24 years) who experienced child maltreatment are 5.8 times more likely to have been diagnosed with post-traumatic stress disorder (PTSD), and 4.1 times more likely to have a severe alcohol use disorder than those who have not (Haslam et al., 2023). Given the established links between alcohol and other drug (AOD) use and family violence and the recognition of exposure to family violence as a form of child maltreatment, it is conceivable that the patterns of child maltreatment experienced by these young people may be perpetuated within their own families.

Homelessness is a critical issue affecting families. Isolation, poverty, and housing instability contribute to the vulnerability of parents and children. AOD misuse often leads to homelessness, as individuals struggle to maintain stable living conditions. The breakdown of extended family relationships or personal tragedies can isolate families further, exacerbating substance abuse and homelessness (Bower et al., 2018).

For this report, alcohol and other drugs, family violence, mental health and homelessness will be referred to collectively as "the four factors".

Supportive services are an integral part of ensuring environments for optimal child development (World Health Organisation et al., 2018). The Australian Child Maltreatment Study (Haslam et al., 2023) recommends intensified support for parents in prenatal, postnatal and early childhood periods to combat the harmful effects of child maltreatment, with additional support for parents experiencing mental ill-health and substance use issues. However, services are not always available. In the Australian context, issues with service access, gaps in service types, workforce retention problems, and the integration or flexibility of models

remain barriers to accessing services for many (Hanley et al., 2023; Oostermeijer et al., 2021). In non-urban areas (i.e., rural, regional and remote areas), the gaps in service provision are more pronounced, compounded by travel requirements and high demand (Hanley et al., 2023), limited resourcing and insufficient culturally sensitive practices (Kavanagh et al., 2023). Further, rural and regional areas appear to have less diversity in service offerings, particularly within the AOD sector (Calabria et al., 2021).

The Ovens Murray Region, located in North East Victoria, is a mixture of inner and outer regional areas and small rural towns. The region consists of seven local government areas (LGAs) and is unique in its makeup, with a range of population densities, socio-economic classifications and terrain. Ovens Murray is situated on the border of New South Wales, with residents living close to the border accessing services in both states, creating a complex and nuanced set of access issues. Further, within the OM area, residents are often required to move between LGAs to access services not available in their home LGA. The region also has higher rates of mental health issues per 1000 people than the rest of Victoria, higher disengagement with schooling (Infrastructure Victoria, 2021), and LGA-specific worsening time trends in unemployment, family violence and bullying, among other factors (McCoy, 2023). These social issues, coupled with the service access and delivery issues associated with non-urban areas, make the Ovens Murray region an area of high demand and service delivery complexity.

AIM

The purpose of the report is to examine social needs and issues in the Ovens Murray area related to alcohol and other drugs, mental health, homelessness, and family violence for families with children and young people. This investigation aims to assist in regional priority planning and to identify which issues should be given priority for action.

METHODOLOGY.

This exploratory needs assessment utilised a mixed methods approach to investigate social needs or issues across the Ovens Murray area for families with children and young people to support regional priority planning and to determine which issues should be prioritised for action. The project commenced with a stakeholder meeting with the alliances to determine the focus and direction of the assessment. A literature review was then undertaken to establish the social determinants of the four factors being investigated. Secondary data was utilised to profile LGAs and understand the prevalence of the social determinants of the four factors. Data sources are listed in Table 1.

Focus group interviews were undertaken with service providers to understand the barriers and facilitators of service provision within Ovens Murray. Individual interviews were conducted with service users to glean information from the perspective of clients. The assessment received ethical approval from La Trobe University's Human Ethics Committee (HEC24902).

LITERATURE AND DATA SEARCHING

A three-step search strategy was utilised in the search for social determinants. An initial limited search of PsycINFO using terms "social determinants" and combinations of "alcohol and other drugs", or "family violence", or "mental health", or "homelessness" was followed by analysis of the text words contained in the title and abstract, and of the index terms used to describe the articles. A second search using all identified keywords and index terms was undertaken across all OVID databases and CINAHL. Third, the reference lists of all identified reports and articles were searched for additional studies. A Google search was also undertaken to identify grey literature not indexed in traditional academic sources.

National data repositories such as the Australian Bureau of Statistics were searched for relevant raw census, admin, and survey data (Table 1). Data was extracted and cleaned using a combination of Australian Bureau of Statistics Tablebuilder, Microsoft Excel, Python and Tableau. Where sample sizes were insufficient to make statistically sound inferences, the data was aggregated. Data on

families whose place of enumeration was in one of the Ovens Murray LGAs (defined using 2022 boundaries) was taken from the 2021 Census using ABS Tablebuilder. The Census provides, among many other indicators, data on household income, housing costs and housing suitability, and the health status of individuals; data on individuals was also taken from the National Study of Mental Health and Wellbeing, which provides indicators of a variety of health conditions and mental health disorders, again using ABS Tablebuilder. However, the geographic location of these individuals is only defined at the primary health network (PHN) (in this case, Murray) or by remoteness areas (ARIA). Some information was also obtained from the National Health Survey for 2020-21, which includes information on various risk factors and identifies geographic location by state and by ARIA, although not by LGA or PHN. Although NHS 2022 has been released recently, it does not include the questions on stressors that were a key feature of NHS 2020-21.

The Modified Monash Model (MMM) was used to describe the remoteness ranking of LGAs. The MMM (Australian Government Department of Health and Aged Care, 2023) is a classification system used in Australia to rank geographical areas based on their remoteness and population size. It categorises regions from MM 1 (metropolitan areas) to MM 7 (very remote areas), facilitating a more nuanced understanding of service accessibility across the country. The MMM incorporates factors such as road distance to the nearest urban centre, population size, and population density to provide a detailed and practical approach to defining remoteness.

For privacy reasons, not all data is available at the LGA level. Where data is unavailable at an LGA or Ovens Murray level, regions or areas with similar populations or conditions have been used as proxies.

Table 01. Secondary data sources.

SOURCE	DATASET(S)
Australian Bureau of Statistics (ABS), Australian Government	Census of Population and Housing (2007–2021)
	National Study of Mental Health and Wellbeing (2020 – 2022)
	National Health Survey (2014–2022)
	Estimated Resident population (2001-2023)
	Socio-Economic Indexes for Areas (SEIFA), 2021
	Births, Australia (2022)
Australian Early Development Census, Australian Government	Australian Early Development Census data explorer
Victorian Government	Department of Families, Fairness, and Housing Rental Report
	Department of Transport and Planning 'Victoria in Future' Dataset
Reserve Bank of Australia	Reserve Bank of Australia Housing and Mortgages Dataset
Turning Point / AOD Stats	Ambulance attendances, Hospital Admittances, Family Violence, Liquor licenses
Crime Statistics Agency	Police Victoria (Family Violence), Ambulance Victoria (Domestic, family and sexual violence), Victorian Emergency Department National Minimum Dataset (Family Violence)

SERVICE MAPPING

A database was created to understand the current landscape of Ovens Murray services. First, a comprehensive list of known service providers was compiled across the 7 LGAs using existing websites and directories. Then, a web scraping tool was developed to automatically extract relevant information about the unique services each provider offers. Information was manually added when this was more time-efficient.

Service information was then aggregated and categorised into nominal (fixed-term) tables as follows:

1. Service Name
2. Brief description of (types of care) service provided
3. Services users (including any restrictions)
4. Broad sector/s the service operates within (children and families, family violence, mental health, alcohol and other drugs, housing and homelessness).
5. Service provider
6. Service provider alliance memberships
7. Headquarters location/s (of the service provider)
8. Service location (where the actual service is being offered)
9. How often the service is offered
10. Outreach locations

This approach allows for complex and varying information about service offerings to be aggregated, analysed and compared for a broad overview of service coverage and gaps.

FORECASTING

Detailed data from the 'Victoria in Future' set of population forecasts was used to estimate the likely numbers of individuals in the Ovens Murray LGAs in five-year bands out to 2036. For analysis using Census data, it is possible to relate families to the individuals who are enumerated and, hence, to project forward the number of people and families using particular assumptions. For the NHS and the Study of Mental Health and Wellbeing, data is less well-stratified, and sample size constraints mean that only general trends may be identified.

FOCUS GROUPS AND INTERVIEWS

Focus group interviews were conducted with 14 staff representing nine organisations operating across the 7 LGAs. Interviews were conducted with three service recipients. Interview questions focused on barriers and challenges to, and gaps in, service provision and access in Ovens Murray. Questions also covered perceptions of the service landscape in OM and the positive aspects of service provision in OM.

The qualitative analysis for this study employed thematic analysis (Braun & Clarke, 2022) to uncover patterns and themes. Thematic analysis was conducted in several iterative stages, including familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and finally producing the report. This method allowed for a comprehensive data exploration while ensuring rigour and reliability in the analysis process (Nowell et al., 2017). The qualitative phase's conceptual framework was based on a constructivist perspective, which acknowledges that reality is socially constructed and subjective (Charmaz, 2006). This approach recognises the importance of context, culture, and individual interpretations in shaping the data and subsequent analysis (Creswell, 2018).

FINDINGS.

SOCIAL DETERMINANTS

Social determinants are the “non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. As defined by the World Health Organization, these forces (e.g., racism, climate) and systems include economic policies and systems, development agendas, social norms, social policies, and political systems”(Centers for Disease Control and Prevention, 2022). The four factors under investigation each contain their own determinants, with intersections between factors. Further, each of the four factors are recognised determinants of each other.

While social determinants may trigger or impact outcomes, it is important to note that the presence of those determinants does not necessarily lead to the outcomes associated with them.

Family Violence

Rurality impacts family violence. Women in regional, rural and remote areas are more likely to experience family and domestic violence than their counterparts in urban areas (Campo & Tayton, 2015). Perpetrators can exploit physical isolation in rural and remote areas. Further, Social norms and structures in regional, rural and remote areas may deter disclosure and minimise the experience of domestic violence. Rural ideals of masculinity that normalise male dominance and control may also contribute to this determinant of family violence (Campo & Tayton, 2015).

Aboriginal and Torres Strait Islander women are 2.5 times more likely to experience intimate partner violence than their non-indigenous counterparts (Respect Victoria, 2023). Women with a disability are at heightened risk of experiencing intimate partner violence. Women in the 25–34-year age bracket are slightly more likely to report experiencing IPV in the last two years. While data is limited, at least one study suggests that 1 in 3 migrant or refugee women have experienced IPV (Handerer et al., 2022).

Alcohol and other drug use also contribute to family and intimate partner violence. One study suggests alcohol is related to 34% of intimate partner violence incidents and 29% of family violence incidents. More than half the alcohol consumed during such incidents was purchased close to home (between 500m and 10km), with supermarkets being the most likely place of purchase (Miller et al., 2016). The same study found that 13% of IPV and 12% of FV incidents were drug-related.

Concerning family violence against children and neglect, multiple known determinants can be broadly grouped into three categories related to the child, family/parent and social/environmental factors (Smart, 2017). These include child temperament and behaviour, parental AOD abuse, parental mental health issues, teenage/young parental age, history of child abuse, as well as socio-economic disadvantage and parental unemployment.

Alcohol and Other Drug Use and Abuse

Rurality plays an important role in AOD use, with people aged 14 years and over living in regional and remote areas being more likely to consume alcohol at harmful levels than their urban counterparts (Australian Institute of Health and Welfare, 2019). Drug use levels are similar between regional and metropolitan areas. However, the type of drugs used differs (Australian Institute of Health and Welfare, 2019).

Alcohol and other drug use in youth is impacted by multiple factors, including history of childhood abuse, family history of AOD abuse, stress, social isolation, lack of parental support, male gender, parent’s education level, comorbid mental disorders and general mental health issues (Alhammad et al., 2022).

Several social factors exacerbate AOD use in adults, including the availability of alcohol and outlet density, socio-economic disadvantage, stress, previous incarceration, homelessness (Institute of Alcohol Studies, 2020), mental health issues (Baginski et al., 2022) and childhood maltreatment or adversity (Evans et al., 2020; Henry, 2020).

Homelessness

Underlying homelessness is a complex combination of determinants that are social, economic and environmental. These factors interact to form direct and indirect chains to homelessness (Mago et al., 2013). Determinants include involvement in the criminal justice system, AOD use disorders, mental ill health, unemployment, poverty and financial issues, education level, housing costs, family breakdown, childhood homelessness, lack of social support (Mago et al., 2013), family violence (Australian Institute of Health and Welfare, 2016a; Pawson et al., 2018) and availability of housing (Australian Institute of Health and Welfare, 2016a).

Mental Health

The social determinants of mental health encompass a range of structural conditions influencing mental health outcomes. These include socioeconomic disadvantage, discrimination, social isolation, early life adversities, neighbourhood disadvantage, physical environment, climate change, and access to healthcare (Kirkbride et al., 2024). Rurality also plays a role in a higher burden of mental disorders experienced in rural Australia compared to metropolitan areas (Kavanagh et al., 2023). Adverse childhood experiences also negatively affect mental health, while strong social networks and safe living conditions promote well-being. Environmental factors, including housing quality and pollution, further influence outcomes (Kirkbride et al., 2024). The complex, multidirectional and intersectional experience of family violence, homelessness (Lund et al., 2018) and AOD use (Sullivan, 2022) also negatively impacts mental health outcomes.

It is evident from the literature that all four factors share fundamental social determinants and are determinants of each other (intersectionality). The most prominent of these shared determinants were utilised to profile the Ovens Murray and its LGAs to understand possible service needs in the region better.

In the following section, the unique characteristics of the Ovens Murray Region are described before a detailed profile of the individual LGAs is provided.

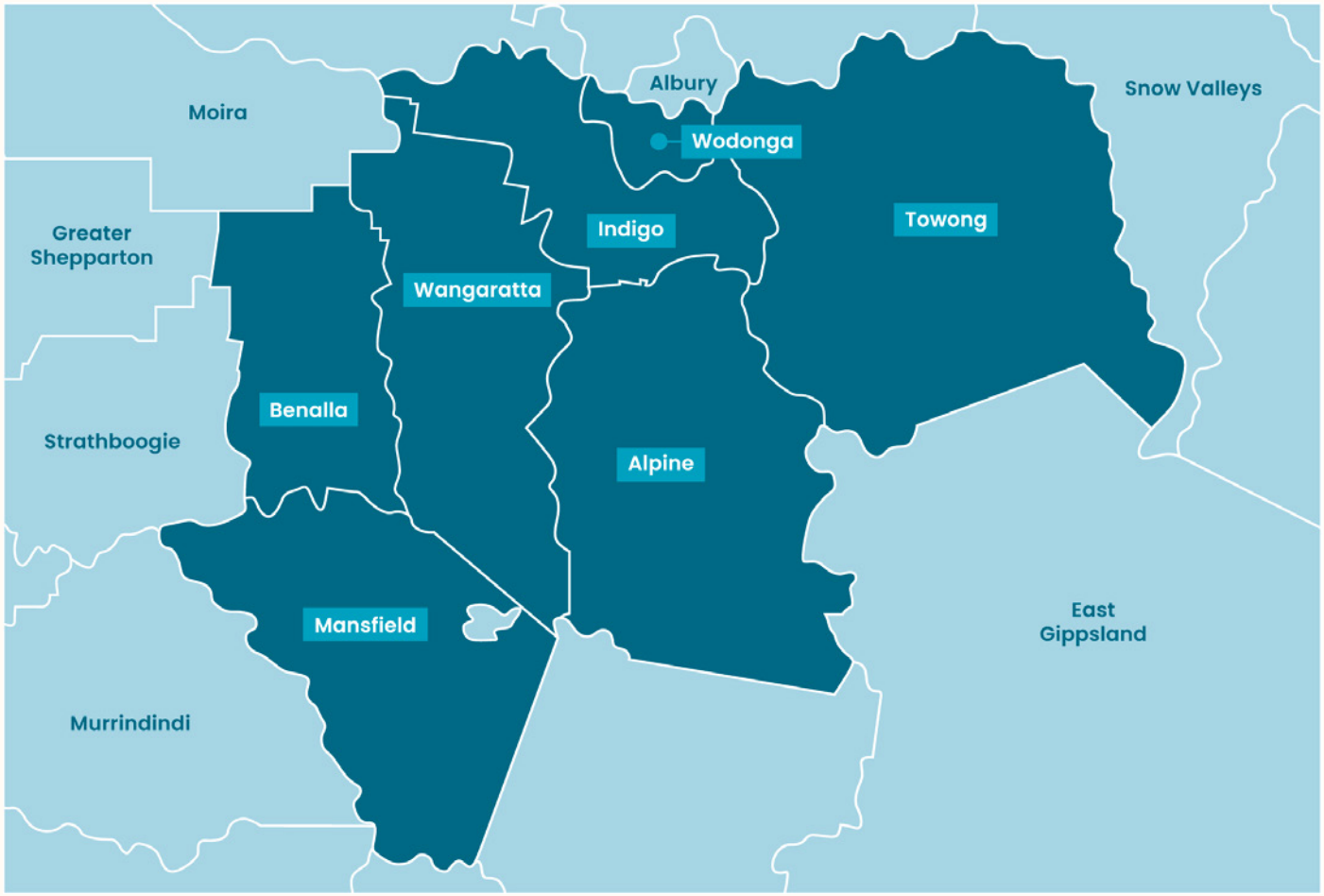


Figure 01. The Ovens Murray Region and constituent LGAs.

THE OVENS MURRAY REGION

The Ovens Murray region is large and diverse, stretching from the Murray River on its Northern border to the Victorian Alps in its Southeastern corner. It comprises seven local government areas: Alpine Shire, Benalla Rural City, Indigo Shire, Mansfield Shire, Towong Shire, Rural City of Wangaratta, and Wodonga City.

Ovens Murray has strong manufacturing and tourism sectors and is renowned for producing quality food and wine. Most of the 135,000 residents live in the two regional centres: Wangaratta and Wodonga.

Ovens Murray is characterised by rurality and regionality. It has an average population density of 5.66 persons per kilometre squared, slightly sparser than the average population density in regional Victoria. However, the population throughout the region is clustered, with much of the population living in relatively dense and well-connected areas and others in much more remote locations. This challenges service provision, as many social issues for families are exacerbated by rurality; resource allocation needs to balance proportional need in hard-to-reach areas with the often-higher actual need in more densely populated areas. Challenges of service provision are heightened by Ovens Murray's profile as a border region, as funding realities can lead to gaps and other service inefficiencies. The following section highlights the unique profiles of the seven LGAs in Ovens Murray.

LGA PROFILES.

Table 2 describes the geographic and demographic profiles of the seven LGAs in Ovens Murray. The region, with a total population of approximately 134,587, has a predominantly older population, with a median age of 49 years, compared to 38 years across Victoria. This aging demographic is most pronounced in Towong, where the median age is 52, and least in Wodonga, where it is 38.

The region is characterised by a lower population density, with Alpine and Towong having fewer than three persons per square kilometre, highlighting the rural nature of these areas. Despite this, Wodonga stands out with a much higher population density of nearly 100 persons per square kilometre, reflecting its status as a more urban setting within the region (Table 2).

The economic indicators described in Table 2 show that a significant portion of the population owns their homes outright, particularly in Towong (49.9%) and Mansfield (47%), which is considerably higher than the state average of 32.2%. Conversely, Wodonga has the highest percentage of rented dwellings at 32.6%, reflecting different housing market dynamics across the region.

The region also faces challenges related to educational attainment and employment. The percentage of residents holding a Bachelor's degree or above is notably lower than the state average of 29%, with Benalla and Towong at the lowest (14%). Employment rates are relatively high, with most areas reporting over 80% of working-age persons employed, but Benalla and Wodonga slightly lag at 77%.

Liquor licensing is another area of interest, with a particularly high concentration in Alpine, where there is one liquor license for every 57.5 residents, significantly above the regional average of one per 148.4 residents. This finding should be interpreted with caution. The Alpine Shire contains multiple ski resorts and tourist towns; as a result, a number of these licenses may operate on a seasonal basis.

Table 02. Comparison table of the profiles of the seven LGAs with Ovens Murray, Regional Victoria and Victoria as comparators.

	ALPINE	BENALLA	INDIGO	MANSFIELD	TOWONG	WANGARATTA	WODONGA	OVENS MURRAY	REGIONAL VICTORIA	VICTORIA
Population	13,235	14,528	17,368	10,178	6,223	29,808	43,253	134,587	1,472,641	6,503,491
Remoteness Ranking	5	4	5	5	5	3	2	-	-	-
Population density (persons per km2)	2.8	6.2	8.5	2.7	0.9	8.2	99.9	5.66	7.28	-
Median age (years)	49	51	47	49	52	45	38	49	45	38
Children and youth (0-17 years)	19%	17%	21%	21%	18%	21%	24%	21%	21%	21%
Young adults (18-25 years)	6%	7%	6%	5%	5%	8%	10%	8%	8%	10%
Working age population (15-64 years)	59%	56%	59%	57%	56%	58%	62%	59%	60%	65%
Identify as Aboriginal and/or Torres Strait Islander	1%	2%	2%	1%	2%	2%	3%	2%	2%	1%
Born overseas	14%	9%	9%	11%	8%	9%	11%	10%	11%	30%
Speaks language other than English	7%	4%	2%	4%	3%	5%	7%	5%	6%	28%
Index of Socioeconomic Disadvantage (IRSD) decile*	9	5	9	9	7	6	5	-	-	-
Number of liquor licenses	230	60	157	135	43	169	113	907	7,362	23,789
Number of people per liquor license	57.5	242.2	110.6	75.4	144.7	176.4	382.8	148.4	200.3	273.4
Number of km2 for each liquor license	20.8	39.2	13	28.5	155.2	26.2	3.8	26.2	27.48	9.6
Number of families with children	1,689	1,815	2,455	1,203	732	4,297	6,847	19,018	212,559	1,044,361
Single parent families as percentage of families	25%	34%	23%	26%	23%	30%	32%	29%	29%	25%
Percentage of dwellings owned outright	46.3%	44.1%	43.5%	47%	49.9%	41.1%	29.1%	43%	42%	32.2%
Percentage of dwellings owned with a mortgage	29.8%	29%	37.3%	31.7%	30.1%	32%	34.8%	32.1%	31.9%	36.1%
Percentage of dwellings rented	19.1%	21.8%	15.1%	15.8%	14.5%	22.2%	32.6%	20.2%	21.6%	28.5%
Number jobs per working-age person	1.4	1.3	1.4	1.3	1.45	1.35	1.2	1.3	-	-
Percentage working-age persons employed	82%	77%	82%	80%	82%	81%	77%	79%	79%	79%
Percentage residents aged 15 and above educated at Cert III or above	51%	43%	53%	50%	45%	48%	49%	49%	47%	53%
Percentage residents holding a Bachelor's degree or above	21%	14%	22%	18%	14%	17%	16%	17%	17%	29%

*Wherein 1 is the most disadvantaged and 10 is the least disadvantaged
Data sources: (Australian Bureau of Statistics, 2021, 2023b, 2023c, 2023d, 2023e, 2023f, 2023g, 2023h; Turning Point, 2023)

CHILDREN AND YOUNG PEOPLE IN OVENS MURRAY.

In 2021, 38,130 children and young people (0-24 year-olds) lived in Ovens Murray (refer Table 5), with the largest portion (37.4%) living in Wodonga LGA. Children aged 0-14 represent more than half of the population under 24 years of age in Ovens Murray (58.5%).

Trends in fertility rates, defined as the number of registered births per woman (Australian Bureau of Statistics, 2022a), differ across the LGAs (refer Figure 2). While Wodonga has experienced a gradual decline in fertility rates over time, Alpine and Towong LGAs experienced an upswing from 2020 to 2022. Fertility rates across all LGAs in 2022 were on par with or above the Victorian fertility rate (1.51), which has also seen a decrease over time (from 1.88 in 2012, Australian Bureau of Statistics, 2022a). While fertility rate projections at LGA or Ovens Murray level were not located, the projected populations for each LGA, by age bands, can be found at Table 5.

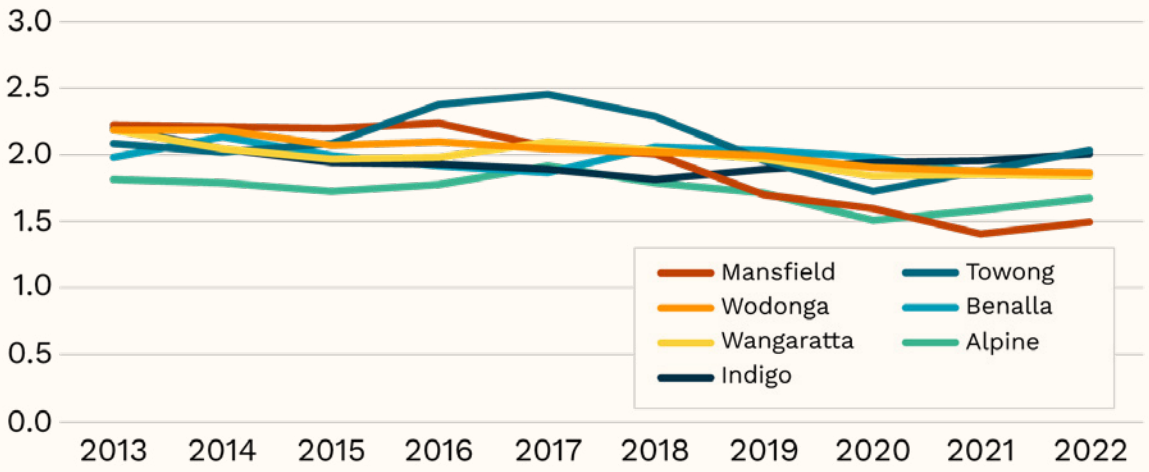


Figure 02. Changes in fertility rates across LGAs, 2013-2022

Young maternal age (under 20 years) affects the health, development, and well-being of both mother and child (Marino et al., 2016; Mollborn & Dennis, 2012) and is linked to increased risks of child abuse and neglect (Smart, 2017). Although specific data on maternal age for the Ovens Murray region and its individual LGAs is not publicly available, Statistical Area Level 4 (SA4) data from the Australian Bureau of Statistics (2022a) provides useful insights into regional trends. The Hume SA4 region is comprised largely of the seven Ovens Murray LGAs: all seven LGAs are within Hume, and in total make up 73% of Hume. Please see Appendix Table 4 for a detailed breakdown of the population between Ovens Murray and Hume. This SA4 data allows for the identification of broader patterns when localised data is inaccessible, offering insights on regional issues such as maternal age and fertility rates. Figure 3 illustrates changes in the fertility rate for mothers aged 15-19 (including those younger than 15) in the Hume region compared to Victoria. While the fertility rate in this age group has nearly halved since 2013, it remains consistently and significantly higher than the Victorian average (Australian Bureau of Statistics, 2022a)

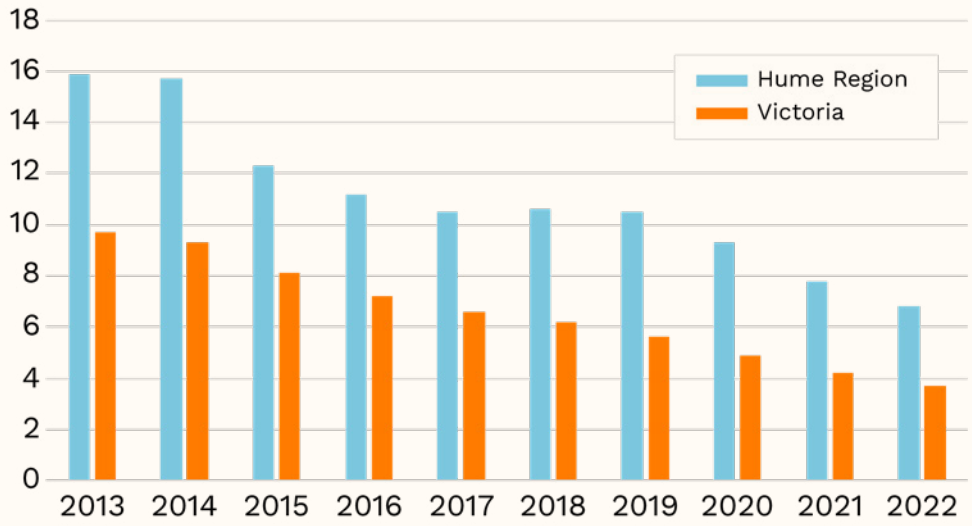


Figure 03. Changes in fertility rate for the 15-19 year old maternal age bracket for the Hume Region in comparison to Victoria. Age-specific fertility rate is number of live births per 1,000 women.

EARLY DEVELOPMENT IN OVENS MURRAY

The Australian Early Development Census (AEDC) is a national survey that assesses early childhood development. It provides insights into how young children have developed as they begin their first year of full-time schooling. The AEDC identifies areas of success and areas that need improvement to better support children and their families. Upon entering full-time school, a child's development is captured through a "snapshot" assessment, completed by their teacher using the Australian version of the Early Development Instrument (Australian Early Development Census, 2024).

Table 3 describes the percentage of children in each LGA that were identified as developmentally vulnerable in each of the AEDC domains in their first year of schooling (Australian Early Development Census, 2022). Vulnerability is defined as a child experiencing a number of challenges across each domain (for more information, see Australian Early Development Census, 2024) . Regarding developmental vulnerability, the Ovens Murray region closely aligns with the Victorian average (refer to Table 3). However, when viewed at an LGA level, there are significant differences in developmental vulnerabilities between the LGAs (Table 3). In 2021, Benalla had a higher percentage of children in their first year of school experiencing vulnerability in two or more domains compared to other LGAs in Ovens Murray and Victoria as a whole. This trend has been consistent over time (see Figure 2).

Further, Benalla consistently had higher numbers of developmentally vulnerable children across all domains, with the social competence domain representing the highest percentage of children experiencing vulnerability (15%) across all domains and geographical comparators. Conversely, Alpine, Indigo, and Mansfield had significantly lower percentages of children experiencing developmental vulnerability across domains. Almost a quarter of children in the first year of schooling in Towong and Wangaratta were considered developmentally vulnerable in at least one domain (23.8% and 23.5%, respectively).

	ALPINE	BENALLA	INDIGO	MANSFIELD	TOWONG	WANGARATTA	WODONGA	OVENS MURRAY	VICTORIA
Number of children	120	122	194	75	44	345	605	1505	73,492
Physical health and wellbeing	3.5%	8.8%	3.3%	1.3%	9.5%	9.5%	7.5%	6.5%	8.1%
Social competence	1.7%	15.0%	5.4%	1.3%	4.8%	10.1%	10.1%	8.0%	9.0%
Emotional maturity	4.3%	12.4%	3.8%	0.0%	7.1%	11.7%	9.4%	7.9%	7.7%
Language and cognitive skills (school-based)	1.7%	8.8%	2.7%	2.7%	7.1%	7.6%	8.3%	6.2%	7.2%
Communication skills and general knowledge	2.6%	9.7%	3.8%	2.7%	9.5%	8.3%	5.4%	5.6%	7.4%
Vulnerable on **one** or more domains of the AEDC	8.7%	21.2%	9.8%	6.7%	23.8%	23.5%	21.4%	17.5%	19.9%
Vulnerable on **two** or more domains of the AEDC	4.3%	17.7%	4.3%	1.3%	14.3%	12.5%	9.4%	8.8%	10.2%

Table 03. LGA level comparison of percentages of children in their first year of schooling who are considered developmentally vulnerable across the five AEDC domains.

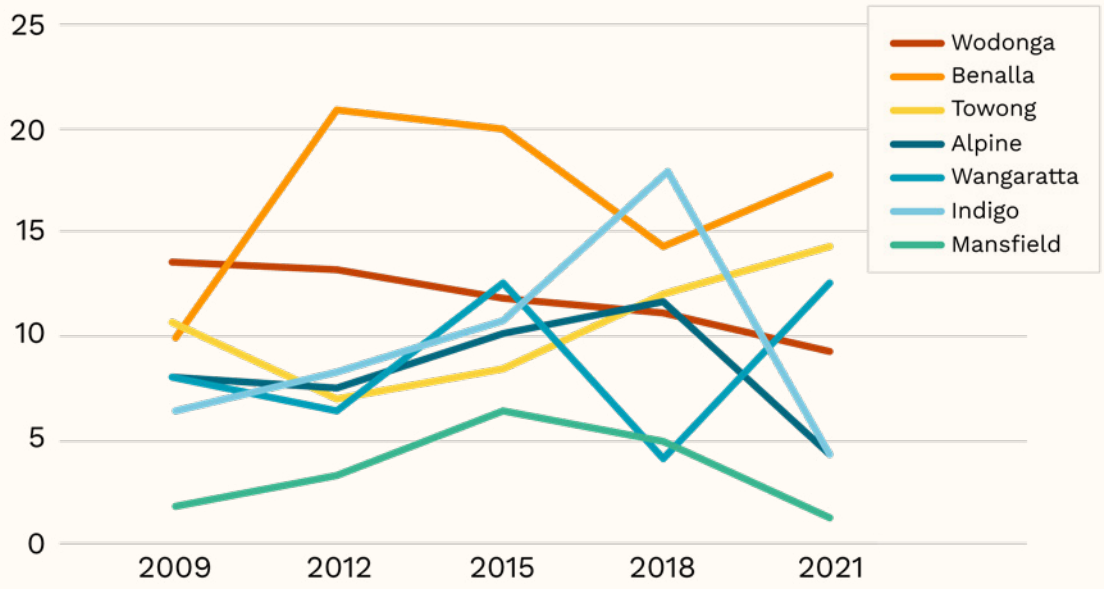


Figure 04. Changes in percentages of children experiencing vulnerability in two or more domains across LGAs, 2009-2021.

OVENS MURRAY POPULATION PROJECTION.

The following section projects the population of Ovens Murray up to 2036. These projections help to establish a possible picture of the prevalence of the four factors over time.

For this work, the State Government's Victoria in Future projections were used (State of Victoria Department of Transport and Planning, 2023). Victoria in Future is the official Victorian state government projection of population and households, projecting populations for all Victorian LGAs from 2023 to 2036[1].

Overall, 134,080 people resided in the seven LGAs that comprise Ovens Murray in 2021, expected to grow to 153,440 by 2036, as shown in Table 4.

Table 04. Ovens Murray resident population, growth to 2036.

LGAS	2021	2026	2031	2036
Alpine	13,150	13,400	13,670	13,970
Benalla	14,450	14,660	14,910	15,110
Indigo	17,240	18,010	18,780	19,520
Mansfield	10,100	10,970	11,820	12,560
Towong	6,210	6,210	6,260	6,310
Wangaratta	29,740	30,650	31,490	32,270
Wodonga	43,190	46,230	50,210	53,700
Ovens Murray Total	**134,080**	**140,130**	**147,140**	**153,440**

The resident populations in the Ovens Murray LGAs are expected to grow at very different rates, as shown in Figure 5. Mansfield and Wodonga are projected to grow the fastest, at an average of 1.6% per annum, while Alpine, Benalla, and Towong will grow the slowest, at 0.4%, 0.3%, and 0.1%, respectively.

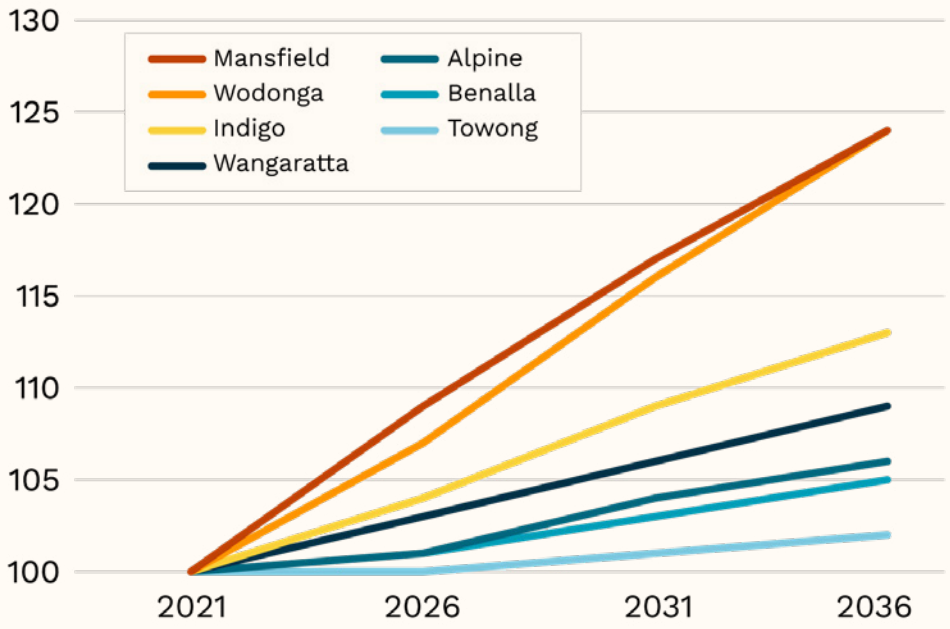


Figure 05. Growth of resident population in Ovens Murray, 2021 - 2036.

[1]Assumptions underpinning Victoria in Future can be found at **here**.

The age distribution in Ovens Murray is projected to change considerably over the 15 years 2021 to 2036, as shown in Figure 6. The number of persons aged 65 and over is expected to grow by around 40% to 2036. In contrast, the number aged 10 to 19, and 50-64, is expected to fall. Those aged 20 to 49 are expected to grow in number by around 10%.

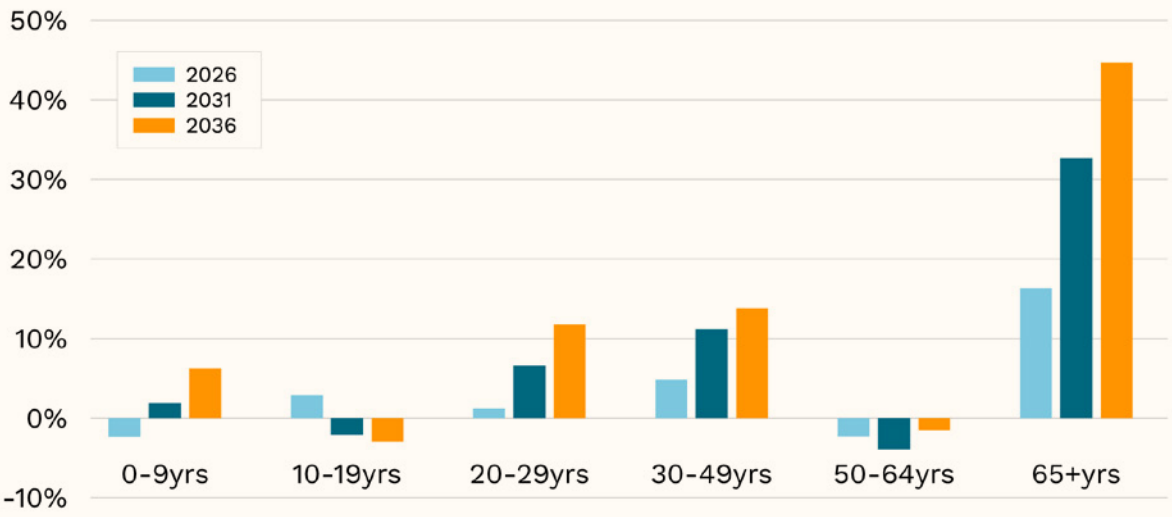


Figure 06. Change in population at different ages between 2021 and 2036.

These projections are utilised in calculating future prevalence in the following sections.

Across Ovens Murray, the expected decline in younger persons varies by LGA and age band (Table 5). While there is significant growth expected in the 0-4 and 20-24 age groups in Mansfield LGA by 2036, Benalla will experience a decrease in both age groups; most significantly in the 20-24 age group. Wodonga is expected to see increases across all age groups.

[1]Assumptions underpinning Victoria in Future can be found at **here**.

Table 05. Expected population growth by age group in LGAs from 2021 to 2036.

		LOCAL GOVERNMENT AREA							
	YEAR	ALPINE	BENALLA	INDIGO	MANSFIELD	TOWONG	WANGARATTA	WODONGA	GRAND TOTAL
0-4-year age group	2021	540	670	850	410	290	1570	2760	7090
	2026	580	670	830	490	270	1490	2920	7250
	2031	610	670	880	520	270	1550	3130	7630
	2036	630	650	920	570	280	1560	3290	7900
15-year change		**16.67%**	**-2.99%**	**8.24%**	**39.02%**	**-3.45%**	**-0.64%**	**19.20%**	**11.42%**
5-9-year age group	2021	680	680	1030	580	330	1730	3020	8050
	2026	610	640	1040	470	320	1710	2740	7530
	2031	660	650	1020	560	310	1650	2970	7820
	2036	690	660	1080	580	310	1720	3150	8190
15-year change		**1.47%**	**-2.94%**	**4.85%**	**0.00%**	**-6.06%**	**-0.58%**	**4.30%**	**1.74%**
10-14-year age group	2021	800	750	1190	770	380	1980	3040	8910
	2026	730	660	1070	750	330	1770	3070	8380
	2031	670	630	1090	640	330	1760	2840	7960
	2036	720	660	1070	730	320	1710	3050	8260
15-year change		**-10.00%**	**-12.00%**	**-10.08%**	**-5.19%**	**-15.79%**	**-13.64%**	**0.33%**	**-7.30%**
15-19-year age group	2021	650	740	980	540	290	1780	2820	7800
	2026	730	720	1110	730	280	1940	3260	8770
	2031	670	650	1010	720	240	1740	3360	8390
	2036	610	630	1030	610	240	1750	3120	7990
15-year change		**-6.15%**	**-14.86%**	**5.10%**	**12.96%**	**-17.24%**	**-1.69%**	**10.64%**	**2.44%**
20-24-year age group	2021	610	610	590	360	200	1300	2610	6280
	2026	500	480	550	360	190	1380	2960	6420
	2031	570	450	670	550	190	1510	3410	7350
	2036	510	380	570	540	150	1330	3500	6980
15-year change		**-16.39%**	**-37.70%**	**-3.39%**	**50.00%**	**-25.00%**	**2.31%**	**34.10%**	**11.15%**

PREVALENCE OF THE FOUR FACTORS.

Following the in-depth overview of the profiles of the seven LGAs in the Ovens Murray region, it is crucial to understand the broader social challenges faced by these communities. This section delves into the prevalence of mental health issues, alcohol and other drug use, family violence, and homelessness within the region, and provides some projections where possible. Understanding these issues is essential for developing targeted interventions and policies to support the health and resilience of these communities.

MENTAL HEALTH

This section summarises key data on mental health issues in the Ovens Murray area, along with determinants of mental ill-health and co-occurring issues often associated with mental ill-health.

Mental Health in Ovens Murray matches regional and socioeconomic patterns of mental health determinants

Mental health conditions are more prevalent in regional areas of Victoria (11%) than in the state as a whole (9%). The proportion of Ovens Murray's population who have been told by a doctor or nurse they have a mental health condition is on par with the regional Victorian average (also 11%) (Australian Bureau of Statistics, 2021).

At the LGA level, the incidence rate of a diagnosed mental health condition correlates with general socio-economic disadvantage, as described by the IRSD index[2] as a combination of low income, no qualifications, and low-skilled employment (Australian Bureau of Statistics, 2021). As Figure 7 shows, Wodonga has a significantly elevated rate of diagnosed mental health conditions compared with the Ovens Murray and regional Victorian averages, and the highest rate in Ovens Murray, followed by Benalla. The populations in Wodonga and Benalla are classified as the most socioeconomically disadvantaged populations within Ovens Murray, with both LGAs falling in decile 5, making them the most socioeconomically disadvantaged LGAs in Ovens Murray.

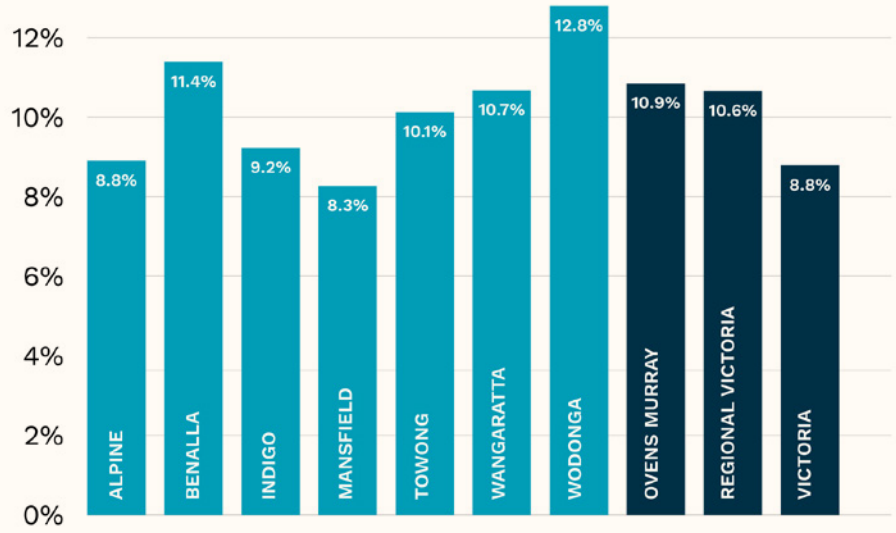


Figure 07. Proportion of the population told by a doctor or nurse that they have a mental health condition (including depression or anxiety) (ABS,2021-census).

[2]IRSD index deciles are population based, and analysed in this case is based on geographic location (LGA). This does not necessarily mean that mental health diagnoses and relative socio economic disadvantage correlates at an individual level. For information on SEIFA Index of Relative Socioeconomic Disadvantage (IRSD), see Appendix.

Table 06. Comparison of prevalence of DSM-IV mental health disorders in the last 12 months.

TYPE OF DSM-IV 12 MONTH MENTAL HEALTH DISORDER*	OVENS MURRAY	REGIONAL VICTORIA	MAJOR CITIES	TOTAL VICTORIA
Panic Disorder	4.31%	4.12%	2.69%	2.93%
Agoraphobia	4.57%	2.49%	2.00%	2.16%
Social Phobia	11.01%	8.84%	7.80%	7.92%
Generalised Anxiety Disorder	4.63%	4.66%	3.21%	3.55%
Obsessive Compulsive Disorder	1.30%	3.82%	3.51%	3.54%
Post Traumatic Stress Disorder	2.36%	5.18%	3.94%	4.16%
Major Depressive Disorder	9.08%	7.60%	6.35%	6.64%
Dysthymia	5.98%	2.34%	1.53%	1.61%
Bipolar Affective Disorder	0.49%	0.37%	0.82%	0.71%
Alcohol Abuse	2.60%	1.73%	1.29%	1.40%
Alcohol Dependence	N/A	0.48%	0.98%	0.90%
Drug Abuse Disorder	N/A	0.37%	0.34%	0.43%
Drug Dependence Disorder	N/A	N/A	0.78%	0.62%
No reported mental health disorder	79.75%	80.57%	80.07%	80.14%
With any mental health disorder	20.00%	19.43%	19.93%	19.86%
Base (n=)	431.5	1046.3	4079.8	5128.4

*Multiple response. Respondents who indicate they have any mental health disorder may have indicated they have more than one mental health disorder.
**N/A: Cells are supressed due to low result.
*** 16-85 year olds were surveyed
****12-month mental health disorders refers to individuals who not only only met the diagnostic criteria for the disorder categorised in the DSM IV at some point in their life but also exhibited sufficient symptoms of the disorder in the 12 months preceding the survey

Anxiety and depressive disorders are most prevalent

As highlighted in Table 6, disorders of depression and social phobia, which are especially prevalent in regional Victoria compared to metropolitan areas, are even more elevated in Ovens Murray (Australian Bureau of Statistics, 2020-2022). While the type of mental health disorders in Ovens Murray is comparable to regional Victoria in most cases, the rates of social phobia and major depressive disorder in Ovens Murray are especially elevated compared to regional Victoria (Table 6) (Australian Bureau of Statistics, 2020-2022).

The prevalence of respondents who identify having problems with alcohol abuse is slightly elevated in regional Victoria compared to the Victorian total (1.73% v 1.40%) and the number of respondents who identify as having alcohol dependence is lower (0.48% v 0.90%). In addition, fewer in regional Victoria identify an issue with drug abuse. It should be noted that despite rates of self-reported alcohol abuse being lower in regional Victoria, actual rates of alcohol and drug-related crime and health incidents are higher in regional areas compared with metropolitan areas of Victoria. Refer to the Alcohol and Other Drugs section that follows for a more detailed discussion of this.

Women and girls in all LGAs far more likely to have a mental health condition

Women across all LGAs are consistently more likely to receive a mental health diagnosis. The gender disparity is particularly striking in Wodonga, where 15% of women report receiving a mental health diagnoses, compared with just over 10% of men (Figure 8).

Young women, and women around childbearing age, are particularly affected.

As described in Figure 8, young people, especially young women, are particularly affected by mental ill health. Sixteen percent of 20-29-year-olds and 30-39-year-olds in Ovens Murray report a mental health diagnosis, significantly above the regional average of 11%. This disparity is largely driven by women in these age groups. In Ovens Murray, 20% of women aged 20-29 and 19% of women aged 30-39 have been diagnosed with a mental health condition, compared to 11% and 12% of men, respectively (Australian Bureau of Statistics, 2021).

Wodonga and Benalla consistently report above-average mental health diagnoses across both age and gender categories. Younger women in these LGAs have significantly elevated rates of diagnosed mental health conditions. Additionally, the proportion of mental ill health among 20–29-year-old women is high in Indigo and Wangaratta, especially compared to their male counterparts.

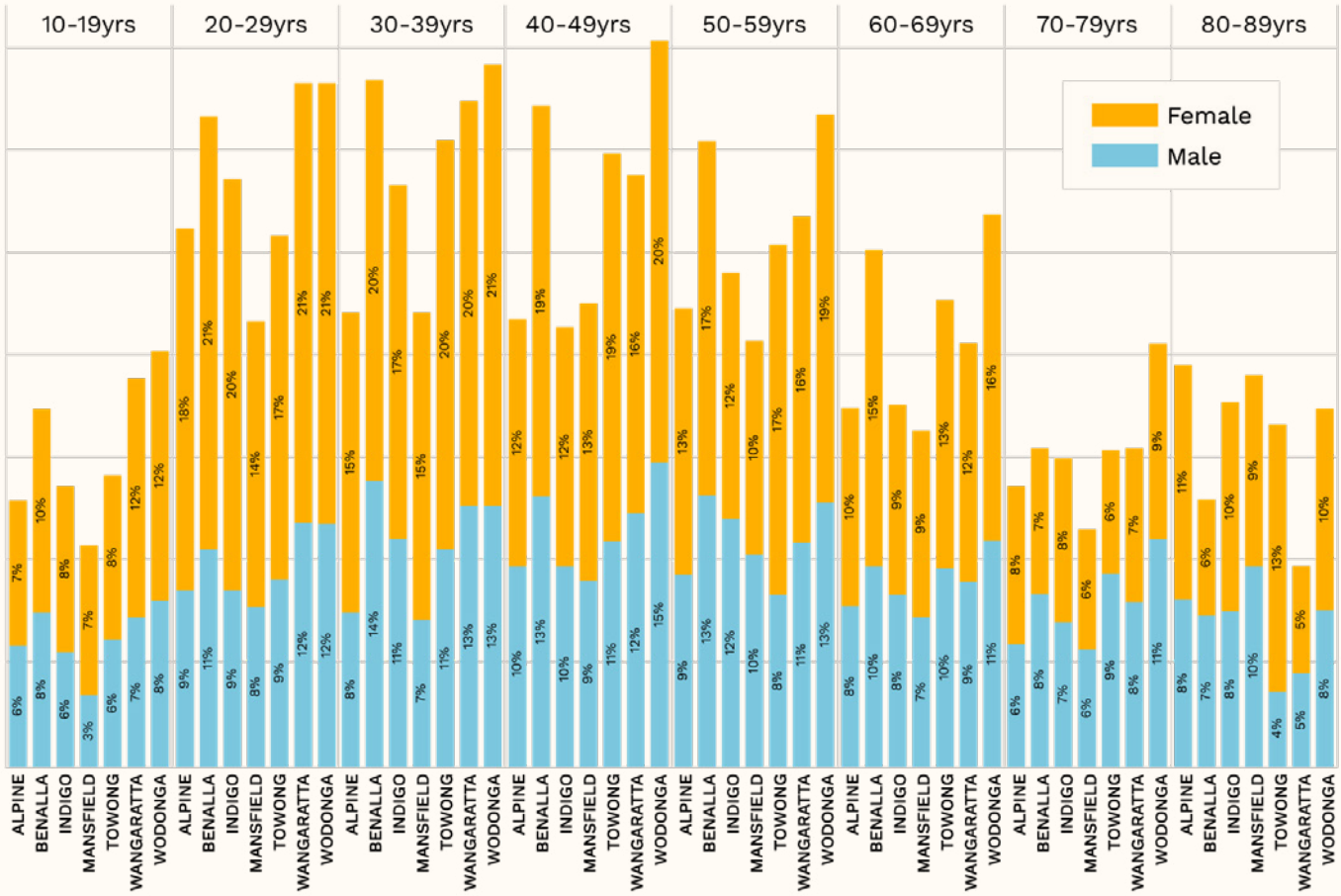


Figure 08. Age and gender distribution of mental health conditions across LGAs. The proportion of the population told by a doctor or nurse that they have a mental health condition (including depression or anxiety) by Age and Gender.

COVID ERA HAD A DRAMATIC EFFECT ON DISTRESS IN REGIONAL VICTORIA

A look at scores on the Kessler Psychological Distress Scale-10 (K10)[3], collected during the more recent 2022 National Health Survey reveals a significant spike in psychological distress during the Covid era (there was an 8 and 10 points increase in self-reports of high or very high distress amongst women and men, respectively), self-reported psychological distress appears to have returned to the pre-Covid-era range.

While both women and men reported the sharp spike in psychological distress at a similar rate, women continue to report comparatively greater psychological distress than men. This remained unchanged even throughout the disruptive Covid era.

Household financial pressures correlate with 12-month mental health disorders

Household financial pressures are more prevalent in households where individuals report at least one mental health disorder. The percentage of respondents in inner and outer Regional areas of Victoria who reported no mental disorders (81% of 1046.3 respondents asked this question in regional Victoria) who experienced at least one of the identified household cash flow issues in the last 12 months was 12% (Table 7). Conversely, more than one quarter (27%) of the 203.3 respondents who identified at least one mental health condition in the last 12 months also reported experiencing at least one of the cash flow problems in the last 12 months (Australian Bureau of Statistics, 2020-2022)

Table 07. Prevalence of household cashflow problems for people with and without a reported mental health disorder.

Type of household cash flow problems	No Mental Health Disorder	At least one Mental Health Disorder	Total
Could not pay electricity, gas, or telephone bills on time	4.6%	7.1%	5.1%
Could not pay mortgage or rent payments on time	1.7%	2.0%	1.7%
Could not pay for car registration or insurance on time	2.8%	6.8%	3.6%
Could not pay for home and/or contents insurance on time	1.0%	3.6%	1.5%
Could not make minimum payment on credit card on time	1.4%	6.1%	2.3%
Pawned or sold something	1.8%	4.3%	2.3%
Went without meals	1.4%	1.0%	1.4%
Went without dental treatment when needed	4.3%	13.2%	6.0%
Was unable to heat or cool home	1.0%	2.8%	1.4%
Sought financial help from friends or family	2.8%	10.7%	4.3%
Sought assistance from welfare or community organisations	1.5%	5.5%	2.3%
None of these cash flow problems	88.3%	72.7%	85.2%
At least one of these cash flow problems	11.7%	27.3%	14.8%
Base (n=)*	843	203.3	1046.3

*Bases have been adjusted to remove respondents who did not answer this question.

[3]The Kessler Psychological Distress Scale-10 (K10) is a scale of non-specific psychological distress. It was developed by Professors Ron Kessler and Dan Mroczek, as a short dimensional measure of non-specific psychological distress in the anxiety-depression spectrum, for use in the US National Health Interview Survey.

Families with children are more vulnerable to simultaneous financial distress and experience a 12-month mental health disorder.

Projecting mental health and financial stress into the future

The National Study of Mental Health and Wellbeing 2020-2022 provides data on both financial stress and mental health disorders. However, it does not offer analysis at the LGA level due to small sample sizes, which could compromise privacy. Instead, it specifies the remoteness area (ARIA). This allows for the grouping of families with children based on whether they live in inner/outer regional areas or major cities. By using the incidence of various mental health issues as an indicator, we can estimate the number of families in the Ovens-Murray LGAs who may have someone experiencing these problems.

In what follows, we identify families that report at least one of the financial stressors referred to in Table 7.

Financial stress is felt more by households where a member reported having a mental health disorder in the past 12 months. This is especially true for family households with children. The combination of financial stress and a 12-month mental health disorder is more common in households with children compared to those without.

Table 8 shows the proportion of families with children where at least one person experiences a DSM-IV 12-month mental health disorder. In most categories, the incidence of these disorders is higher in inner and outer regional areas and on par for the remaining categories.

While this might seem intuitive (a combination of complex, interlinked stressors creates heightened vulnerability amongst already disadvantaged community groups), this analysis shows that there are specific socio-environmental stressors that contribute to both mental ill-health and financial vulnerability and that families with children, particularly in regional areas, are most vulnerable.

Table 08. Families with Children in Australia with financial stress and mental health disorders.

	Inner Outer Regional		Major Cities of Australia	
Type of DSM-IV 12 month Mental Health Disorder - multiple response	Proportion with disorder, with FS*	Proportion with disorder, no FS	Proportion with disorder, with FS	Proportion with disorder, no FS
Panic Disorder	7.5%	2.9%	6.8%	1.7%
Agoraphobia	4.9%	1.9%	3.8%	1.5%
Social Phobia	16.9%	6.7%	12.0%	6.3%
Generalised Anxiety Disorder	11.3%	2.7%	8.1%	2.8%
Obsessive Compulsive Disorder	7.0%	3.1%	6.3%	3.2%
Post-Traumatic Stress Disorder	6.3%	3.8%	6.2%	3.3%
Major Depressive Disorder	9.1%	4.5%	9.0%	4.7%
Dysthymia	3.2%	1.0%	2.9%	0.8%
Bipolar Affective Disorder	11.7%	0.0%	1.6%	0.4%
Alcohol Abuse	4.7%	1.3%	1.6%	1.0%
Alcohol Dependence	2.6%	0.9%	1.4%	0.7%

*FS = financial stress.

On the assumption that Ovens-Murray families experience similar problems to their counterparts in inner/outer regional areas in the rest of Australia, we can use these incidence estimates to predict the likely number of families in Ovens-Murray LGAs that will experience these problems in the future.

Table 9 shows that, if Ovens-Murray families exhibit similar patterns to those found in inner/outer regional areas in Australia, we can expect 445 families to include someone, for example, with bipolar affective disorder and also some form of financial stress. This is likely to rise to 504 families by 2036.

Table 09. Estimated numbers of families in Ovens-Murray experiencing mental health disorders with financial stress.

	Families with financial stress			
DSM-IV 12 month Mental Health Disorder (with hierarchy) - multiple response	**2021**	**2026**	**2031**	**2036**
Panic Disorder	285	295.2	312.5	322.2
Agoraphobia	185	192.3	203.5	209.8
Social Phobia	642	666.2	705.2	727.1
Generalised Anxiety Disorder	430	445.7	471.7	486.3
Obsessive Compulsive Disorder	267	277.1	293.3	302.4
Post Traumatic Stress Disorder	238	246.6	261.0	269.1
Major Depressive Disorder	347	359.7	380.7	392.5
Dysthymia	123	127.8	135.3	139.5
Bipolar Affective Disorder	445	461.5	488.5	503.6
Alcohol Abuse	179	185.5	196.4	202.4
Alcohol Dependence	97	100.7	106.6	109.9
Number of families in Ovens-Murray	**3,802**	**3,943**	**4,174**	**4,303**

ALCOHOL AND OTHER DRUGS

This section summarises key data relating to alcohol and drug use, and incidents of crime and service involvement where alcohol and drug use was a contributing factor.

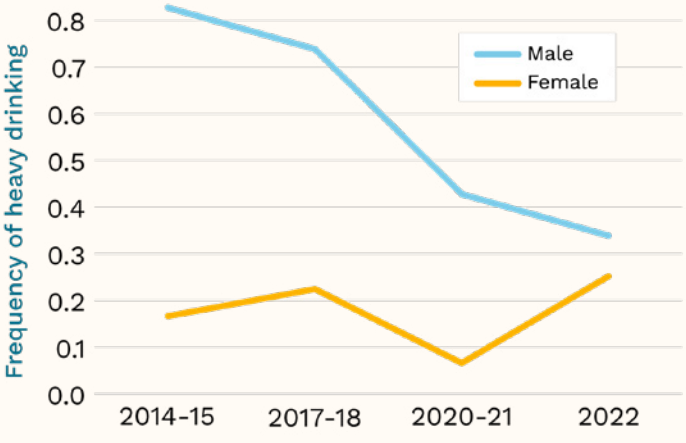
Men, overall, drink more; Women more likely to report daily heavy drinking

According to the 2022 National Health Survey (Australian Bureau of Statistics, 2022b), 1.3% of Regional Victorians (n=1372) reported drinking five or more drinks per day, every day (0.9% of women and 0.6% of men). 4.1% of men in regional Victoria reported drinking five drinks or more in a 24-hour period once per week, and 1.4% reported doing so two days per week. In comparison, 1.5% of women reported drinking that amount once per week, and none reported drinking that amount two days per week. 43.7% said they have not had five or more drinks in one day over the last 12 months. This result was higher for women (26.6%) than for men (17.7%).

Heavy drinking over time

As highlighted in Figure 9, heavy alcohol consumption among men is decreasing, while among women it has remained relatively stable, with a slight increase between 2014/15 and 2022. Alcohol score is derived from the frequency with which respondents self-report drinking five or more drinks per day. A higher score equals heavier drinking.[4]

Figure 09. Frequency of heavy drinking in regional Victoria by sex, 2014-15–2022.



*Data source (Australian Bureau of Statistics, 2014-2015, 2017-2018, 2020-2021, 2022b)

Alcohol and drug-related ambulance attendances have increased

The rate (per 100,000 residents) of drug and alcohol-related alcohol ambulance attendances in Ovens Murray has steadily increased by 123.7% since the 2014/15 financial year, from 204.1 in 2014/15 to 456.6 in 2022/23 (Turning Point, 2024). This increase is sharper than the average rate increase for regional Victoria during the same period, from 268.4 in 2014/15 to 479.5 in 2022/23, a 78.6% increase. The average rate in Regional Victoria is, moreover, higher than metropolitan Victoria, which experienced a 36.4% rate increase during the same period, from 266.5 in 2014/15 to 363.6 in 2022/23 (Turning Point, 2024).

However, some LGAs within Ovens Murray have experienced a significantly sharper rate increase of alcohol and drug-related ambulance attendances during the same period. Wangaratta has experienced the sharpest rate increase of alcohol and drug-related ambulance attendances in Ovens Murray during this period, from 247.7 to 712.3 per 100,000 residents in 2014/15 to 2022/23, a rate increase of 187.5%. Benalla's rate of alcohol and drug-related ambulance attendances increased from 367 to 781.6 per 100,000 residents from 2014/15 to 2022/23, an increase of 112.9% (Turning Point, 2024).

[3]See appendix 3 for a detailed breakdown of the alcohol score, as derived from the survey respondents.

Benalla has the highest rate of alcohol-related ambulance attendances and hospital admittances

Focusing on alcohol-related care incidents, the 5-year average (Figure 10) shows again that by population (per 100,000), Benalla (733.8) and Wangaratta (651.4) have the highest average rates of ambulance attendances (per 100,000 residents) in Ovens Murray. However, while Wangaratta's rate of ambulance attendances is below Benalla, it has by far the highest count of ambulance attendances for reason of intoxication (Table 10): 213 in 2022/23, more than double the number in 2024/15 (106).

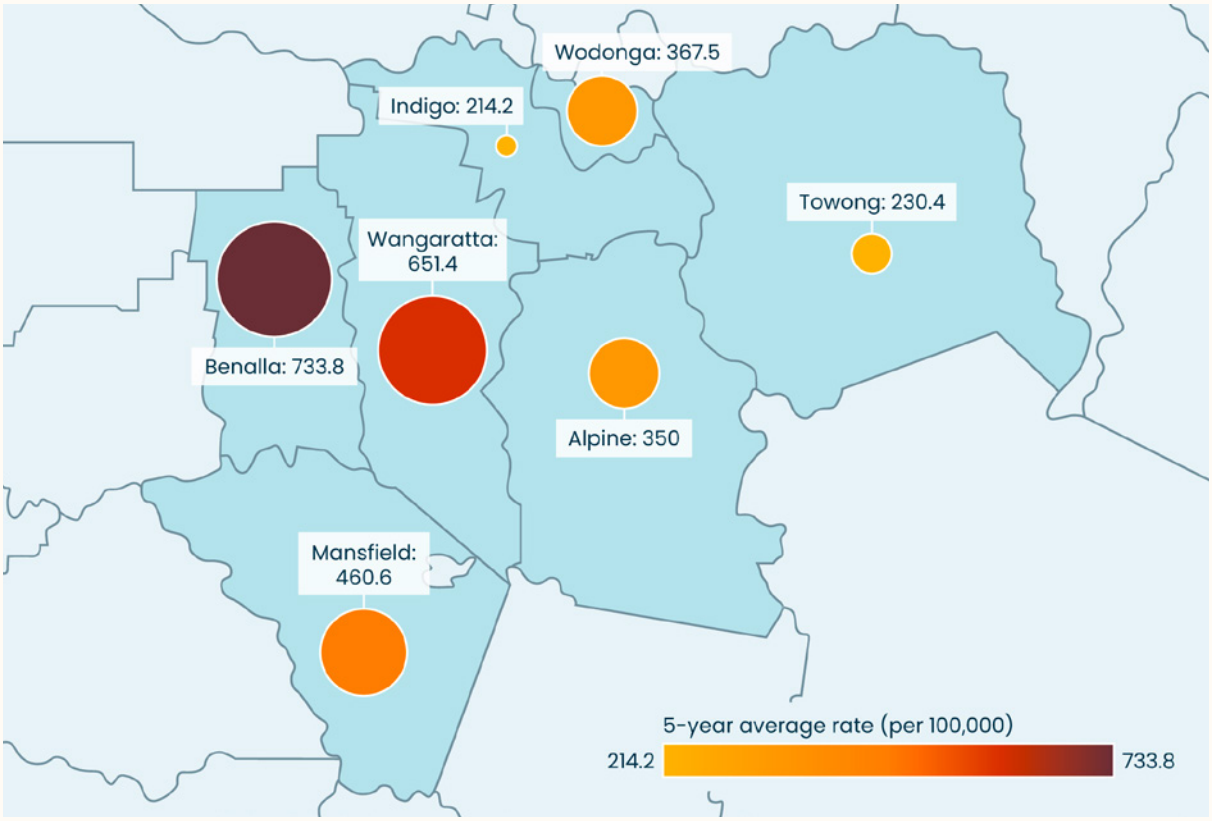


Figure 10. Average (5 year) Rate (per 100,000 residents) of ambulance attendances due to alcohol intoxication (with or without other substances), by LGA. 2018/19–2022/23.

Table 10. Number of Ambulance Admittances in Ovens Murray LGAs, 2013/14–2022/23.

Financial Year	Alpine	Benalla	Indigo	Mansfield	Towong	Wangaratta	Wodonga
2022/23	47	113	40	55	12	213	143
2021/22	43	108	45	26	16	209	168
2020/21	49	99	38	45	18	214	200
2019/20	47	102	28	53	15	180	141
2018/19	42	104	32	45	10	148	132
2017/18	33	69	26	36	15	146	137
2016/17	29	63	31	31	14	148	114
2015/16	31	49	31	34	8	118	126
2014/15	17	51	14	10	2.5	69	90
2013/14	18	82	16	15	13	106	104

The average rate of hospital admissions over four years[5] tells a similar story. Benalla had the highest relative average rate of hospital admissions related to alcohol from 2018/19 to 2021/22, with 759.8 admissions per 100,000 residents (Figure 11). However, considering the size of the population, Wangaratta still has the highest actual need, with a four-year average rate of 468.8, translating to 134 actual admissions in 2021/22 (Table 11).

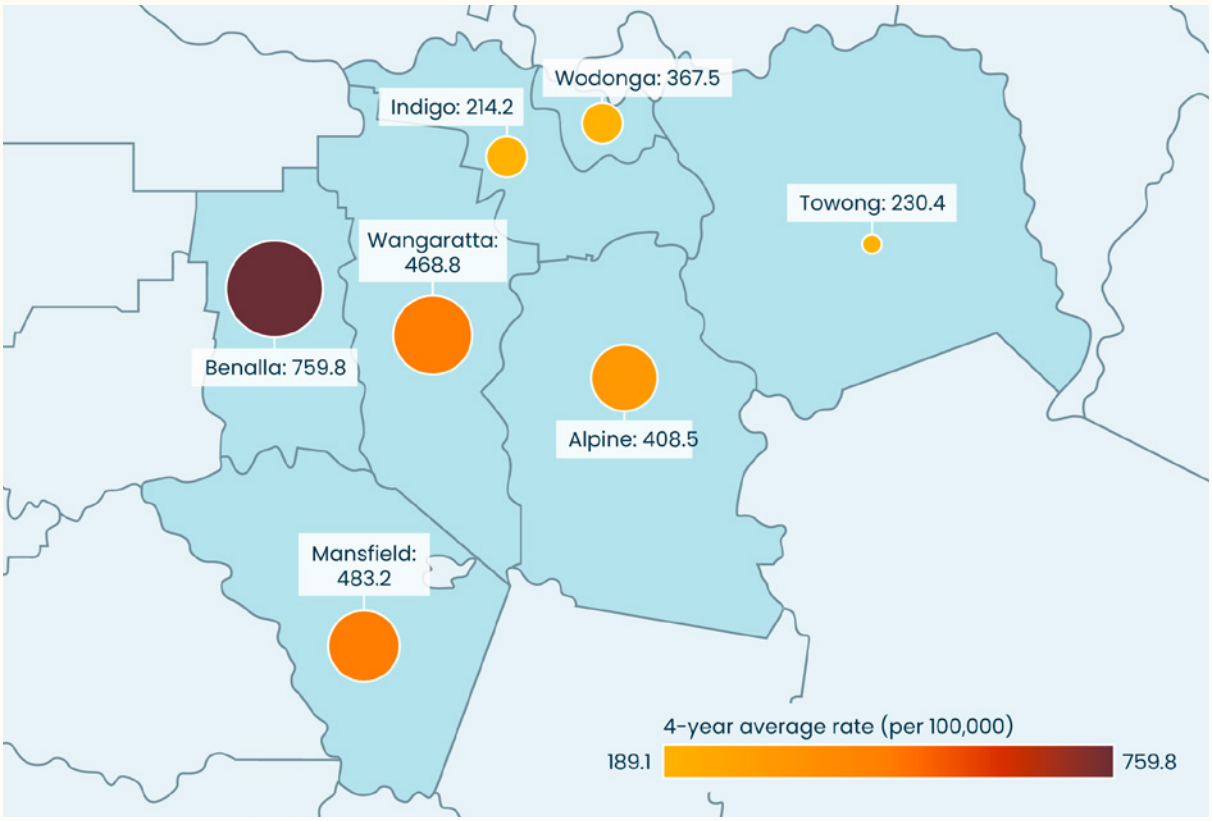


Figure 11. Average (4 year) Rate (per 100,000 residents) of hospital admittances due to alcohol intoxication by LGA. 2018/19–2021/22.

Table 11. Number of Hospital Admittances due to Alcohol intoxication in Ovens Murray LGAs (place of residence), 2013/14–2021/22

Financial Year	Alpine	Benalla	Indigo	Mansfield	Towong	Wangaratta	Wodonga
2021/22	60	106	32	53	6	134	94
2020/21	58	120	38	35	13	117	106
2019/20	47	104	59	50	18	130	114
2018/19	64	76	56	59	7	105	97
2017/18	58	70	52	50	14	136	95
2016/17	48	72	67	60	10	147	121
2015/16	37	85	44	32	12	185	103
2014/15	61	81	44	27	26	131	122
2013/14	46	100	37	44	9	169	107

[5]Data about hospital admittances due to alcohol use was not available for 2022/23.

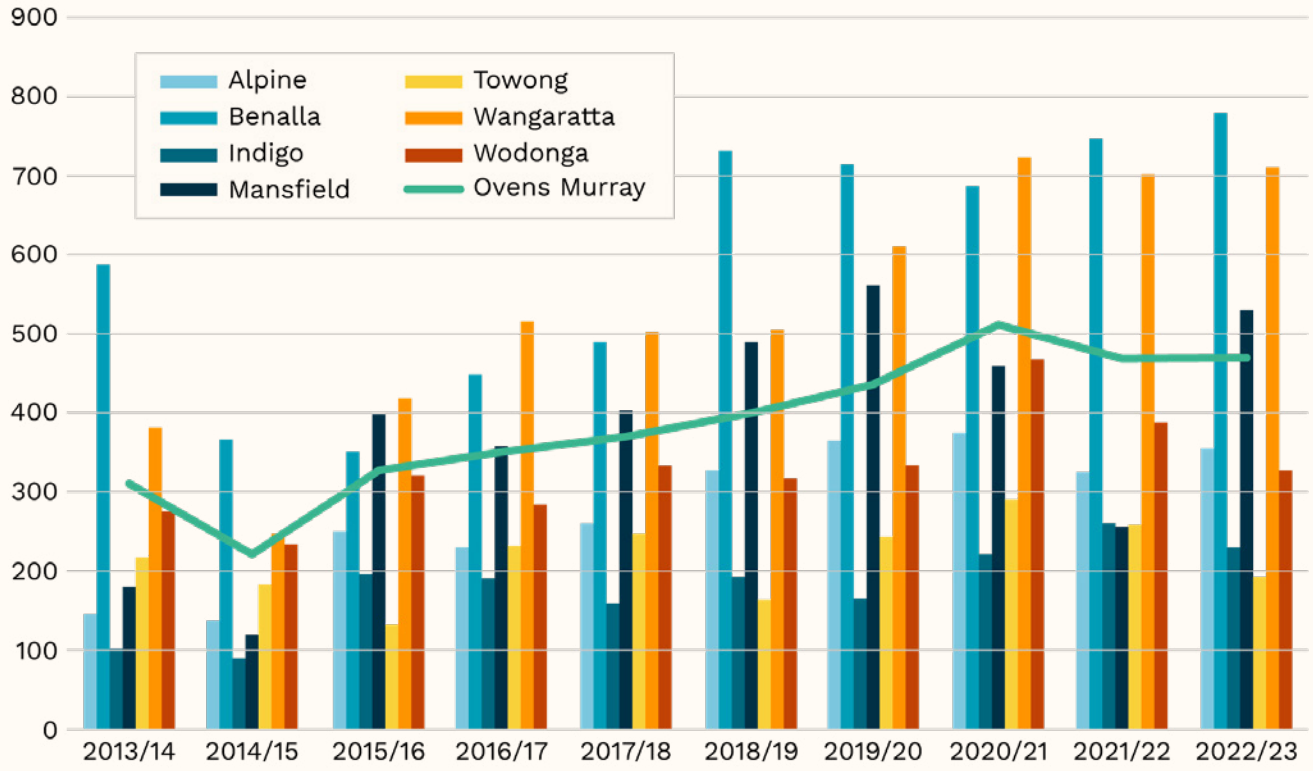


Figure 12. LGA trends in ambulance attendance for alcohol with or without drugs (per 100,000 population) with total Ovens Murray trend line.

Utilising the Ovens Murray overall trend data for alcohol-related ambulance attendances (Figure 12) and the expected population growth (Table 4) from 134,080 in 2021 rising to 153,440 in 2036, we can imply an ambulance attendance of 670 in 2021 and 767 in 2036, if attendances stabilise at 500 per 100,000 population.

FAMILY VIOLENCE

The section summarises key data relating to family violence as recorded by government services in Victoria, the Ovens Murray area and seven LGAs that make up ovens Murray.

Family Violence in Victoria

In Victoria, family violence reports have steadily increased since 2018. However, the number of victims presenting to hospitals and those attended by ambulances remained stable. Following broader trends, women were three times more likely to be victims in Victoria. Alcohol and drug use were significant contributing factors. Alcohol was identified in 10% of affected family members and 21% of perpetrators, while drug use was present in 15% of incidents. Mental health issues, including depression, were significant in 26% of victims and 39% of perpetrators (Victoria Police, 2023; Crime Statistics Agency, 2023).

There were 93,115 police recorded incidences of family violence recorded during the 2022-23 financial year, a steady increase of just over 10,000 since 2018-19. However, the same number of victims presenting to hospitals and the number attended by a Victorian ambulance during the same period remained stable. During the 2022-23 financial year, incidents of family violence recorded by police involved additional risk factors including pregnancy or new birth in 5% of cases, financial difficulties in 24% of cases, presence of a disability in 4% and recent or planned separation in 32% of cases (Crime Statistics Agency, 2023a).

Family violence rates have increased in Ovens Murray over the last five years

Rates of family violence in Ovens Murray increased by 18.5% from 2018-19 to 2022-23. The region also experienced a 12.8% increase between 2021-2022 and 2022-23, from 1,385 to 1,699 recorded incidents per 100,000 residents (Figure 13). In the same period, family violence rates in Indigo increased by 57.6%, in Towong by 38.6%, in Benalla by 35.4%, and in Wangaratta by 32.7%. In contrast, presentation to emergency departments and attendance by ambulances to family violence incidences decreased slightly in Ovens Murray between 2018/19 and 2022/23 (Figure 14). The notable exception to this region-wide trend is Wangaratta, where the rate of ambulance attendances to family violence incidents increased 95% between 2018/19 and 2023, from 20.4 to 39.8.

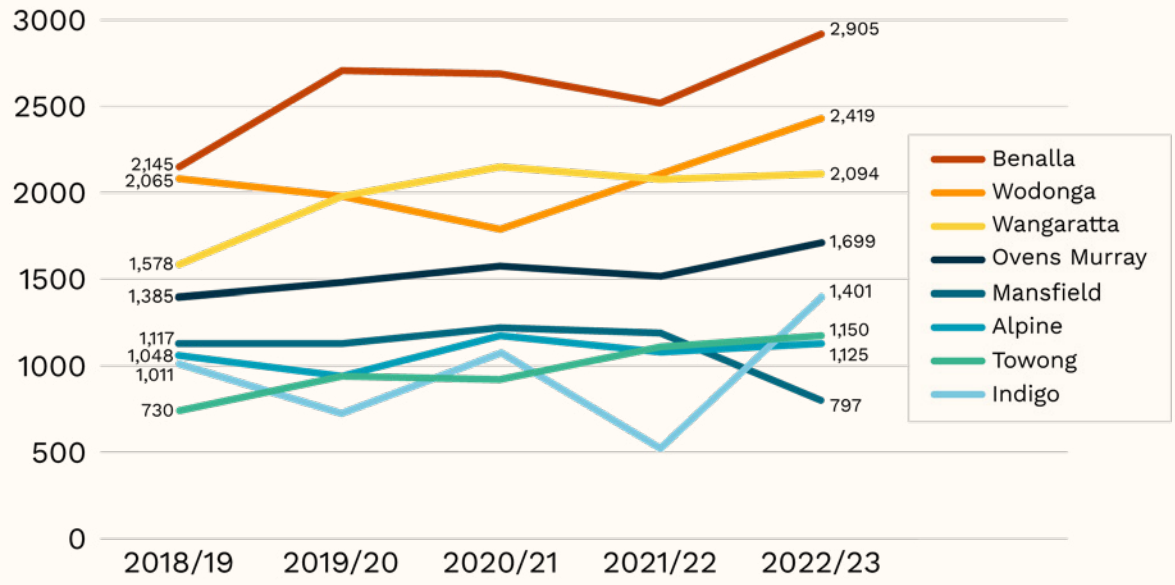


Figure 13. Rate (per 100,000) of Police-recorded family violence incidents in Ovens Murray LGAs (Crime Statistics Agency, 2023a).

[7]Ambulance Victoria data on attendance to family violence incidents includes family and domestic violence and sexual violence.

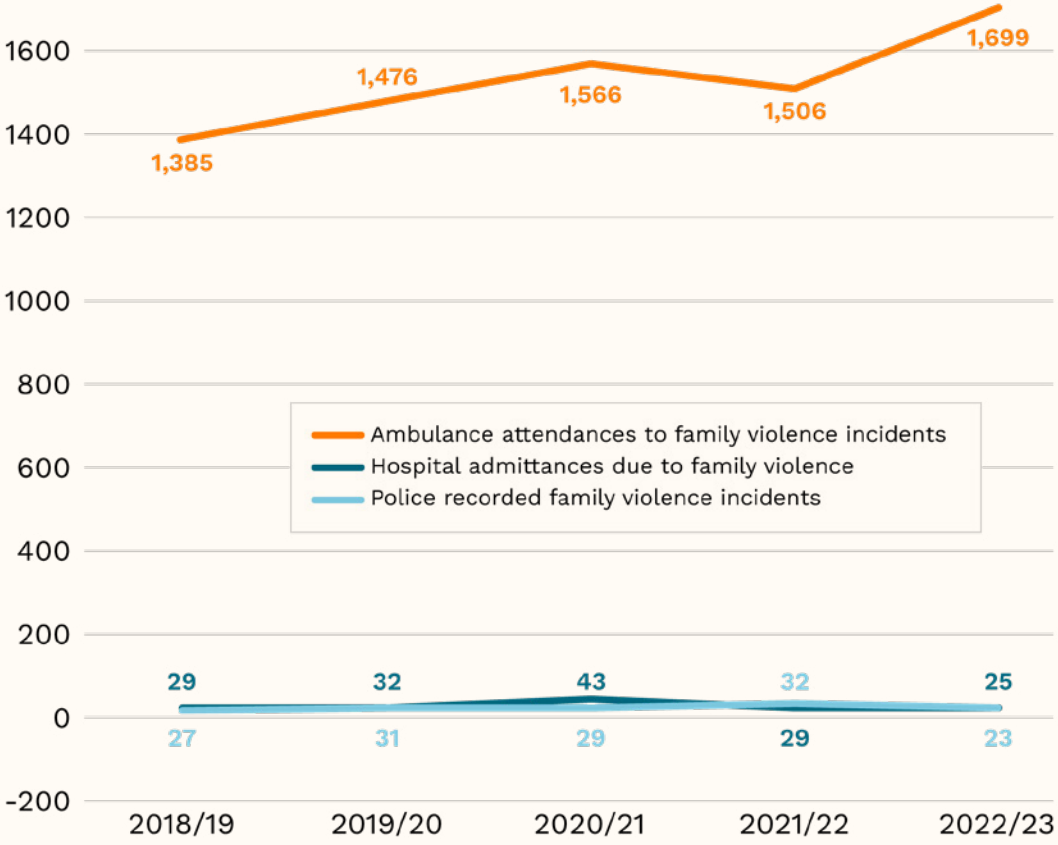


Figure 14. Rate (per 100,000) of family violence incidents, hospital admittances due to family violence, and ambulance attendances for reasons of family violence in Ovens Murray (Crime Statistics Agency, 2023a).

Alcohol is consistently a contributing factor in 10-20% of police-recorded family violence incidents in Ovens Murray, which is in line with Victoria-wide police statistics on alcohol involvement in family violence incidents. However, as not all incidents of family violence are reported, some estimates of alcohol involvement in family violence incidents put the rate much higher (Crime Statistics Agency, 2023a; Turning Point, 2024).

In the Ovens Murray region, the involvement of alcohol in police-recorded family violence has slightly decreased since 2018/19, despite an overall increase in the rate of family violence. In 2018/19, alcohol was identified as definitely or possibly involved in 20.7% of police-recorded family violence incidents, compared to 13.1% in 2021/22 (Turning Point, 2024).

Alcohol plays a more significant role in LGAs with comparatively lower rates of family violence

The Crime Statistics Agency (2023b) data shows that LGAs with lower levels of family violence incidents tend to have a higher proportion of those incidents linked to alcohol use, compared to areas with higher family violence rates (refer Figure 15). For instance, between 2018/19 and 2021/22, Alpine, Indigo, and Towong recorded the lowest rates of family violence. In 2021/22, Towong LGA had the lowest family violence rate in Ovens Murray (517 per 100,000), with 24.9% of incidents attributed to alcohol use (129 per 100,000). Similarly, Alpine LGA, with the second lowest family violence rate (1070 per 100,000), had 24.8% of incidents linked to alcohol (266 per 100,000). Alpine LGA also has the highest liquor license density per person (one liquor license per 58 residents).

[7]Ambulance Victoria data on attendance to family violence incidents includes family and domestic violence and sexual violence.

On the other hand, LGAs with the highest family violence rates in 2021/22, Benalla and Wodonga (2505 and 2104 per 100,000, respectively), had lower percentages of incidents related to alcohol (9% and 8.1% respectively). This suggests that alcohol has a complex and significant impact on family violence rates, especially in areas with lower overall socio-economic risk factors and relatively lower family violence rates.

Alongside having the highest rate of assaults and alcohol and drug-related hospital admittances, Benalla had the highest rate of family violence incidents in 2022/23, followed by Wodonga and Wangaratta (Figure 15).

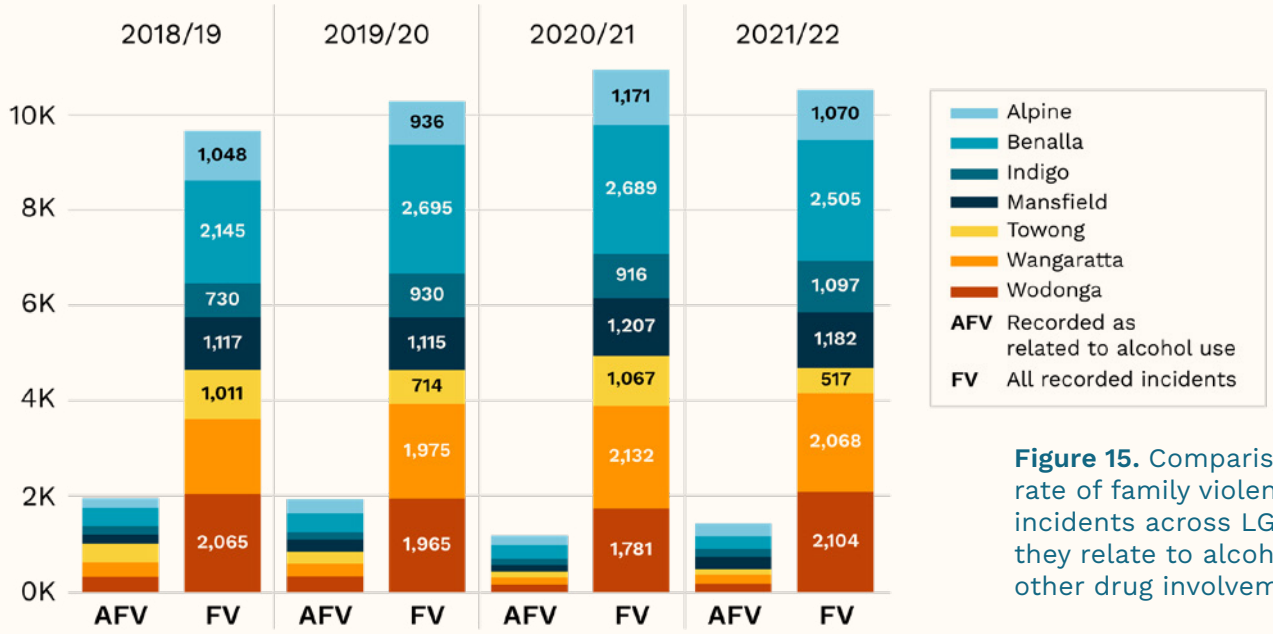


Figure 15. Comparison of rate of family violence incidents across LGAs as they relate to alcohol and other drug involvement.

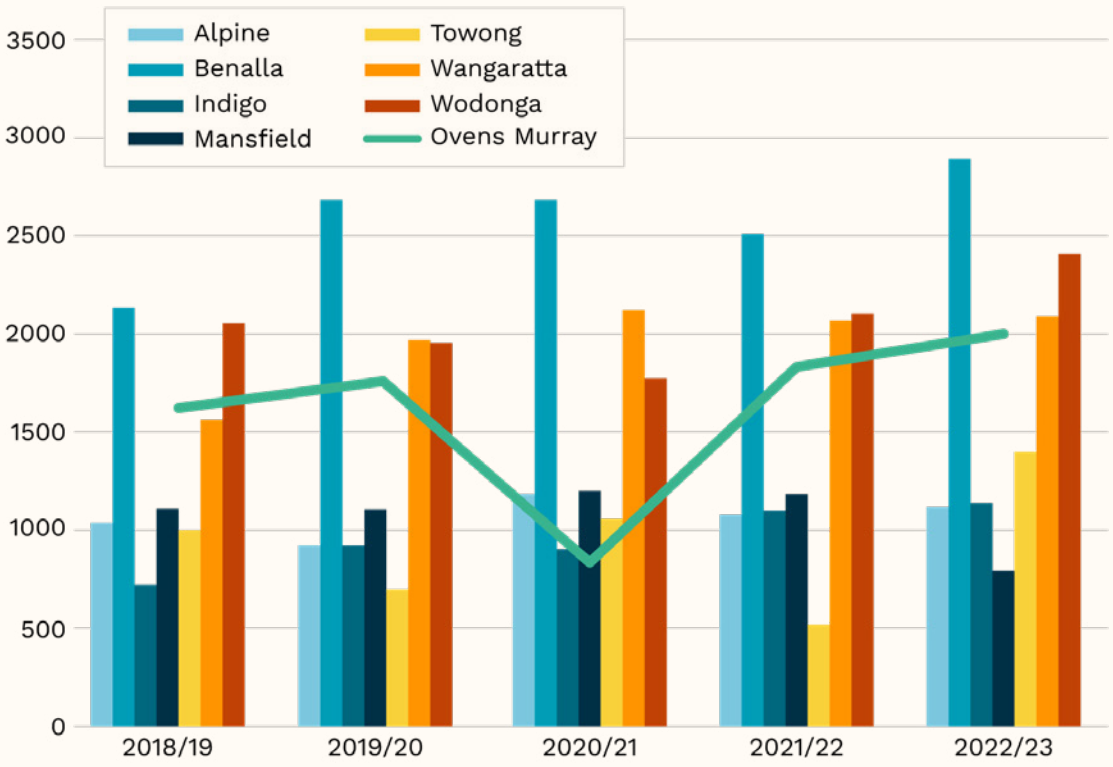


Figure 16. LGA trends in police-reported family violence incidents (per 100,000 population) with total Ovens Murray trend line.

Utilising the Ovens Murray overall trend data for police-reported family violence (Figure 16) and the expected population growth (Table 4) from 134,080 in 2021 rising to 153,440 in 2036, we can imply an incidence of family violence of 670 in 2021 and 767 in 2036, if reports of FV stabilise at 500 per 100,000 population.

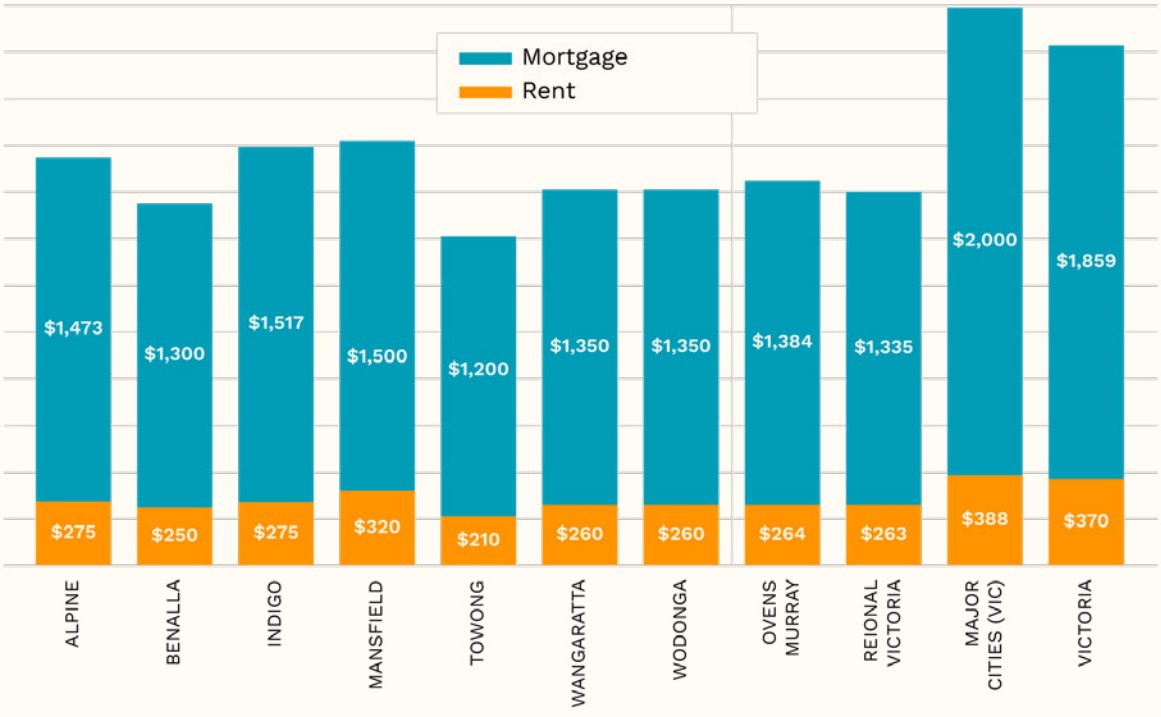
HOUSING AND HOMELESSNESS

This section summarises key data relating to home ownership, issues of inadequate housing, an estimate of current and future housing stress, and homelessness in the Ovens Murray region.

As described in Figure 17, the picture of renting, ownership, and housing affordability in Ovens Murray is typical for regional Victoria. Housing tends to be more affordable in regional Victoria than in metropolitan areas, and residents in regional Victoria are much more likely to own their home outright. In Ovens Murray, 43% own their home outright (similar to Regional Victoria, 42%), much higher than average in Victoria, where 32% own their home outright. Conversely, private dwellings paid off with a mortgage make up 31% in Ovens Murray and 32% in regional Victoria – significantly below the average for total Victoria at 36%. Renting is relatively less common in Ovens Murray, where 20% of dwellings are rented, compared to 21.6% in regional Victoria and 28.5% in Victoria (Australian Bureau of Statistics, 2021).

While housing affordability is a key variable affecting housing stress and insecure housing, the housing crisis is both complex and interdependent on other factors of vulnerability. Although data may indicate high occupancy and homeownership rates, it does not reveal the quality or adequacy of the premises. For example, a relatively high number of low-income households are owner-occupied (Liu et al., 2019). Due to financial constraints, however, lower-income households may live in inadequately sized, poorly maintained, inadequately heated or cooled, or structurally unsafe premises (Liu et al., 2019) . A significant percentage of Australia's poor-quality housing is located in the regions (Beer et al., 2024).

Figure 17. Comparison of housing affordability across LGAs, OM, regional Victoria and Victoria.



Mortgage: Median monthly mortgage repayments for dwellings in the area
Rent: Median weekly rent payments for dwellings in the area
Regional Victoria: Average of Inner Regional Australia (VIC) and Outer Regional Australia (VIC)
All data from ABS (Census 2021)

The concept of housing quality was raised in the service provider focus group interviews. As one participant framed it: "People think it's about homelessness, and it is, and affordability. But we have people in old share farmhouses so far out of town that they can't afford the fuel in, that are staying in unsafe – unsafe because they've got black mould and they've got no heating and there could be a perpetrator there... it's really making our clients vulnerable".

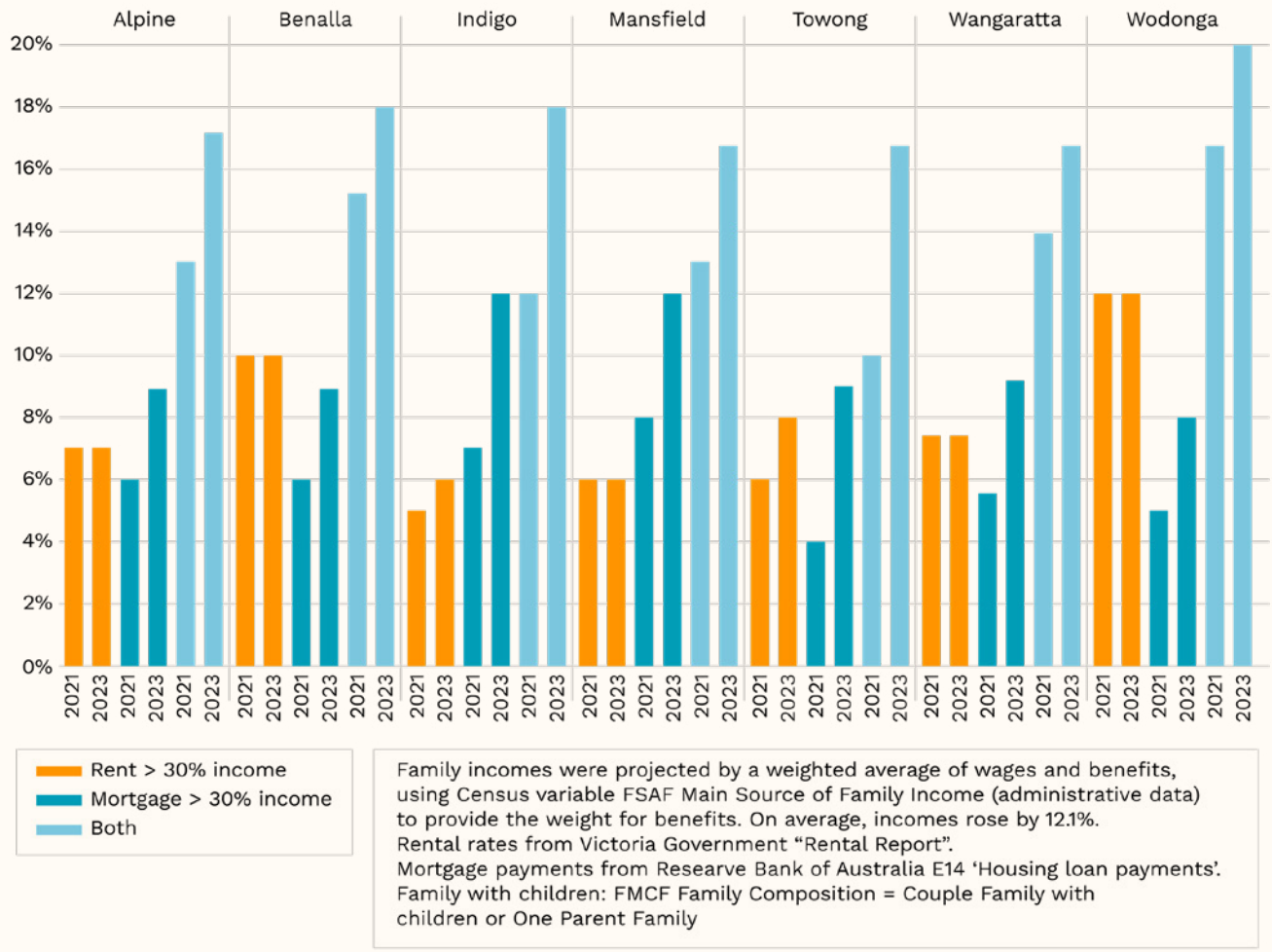
Housing stress is increasing; 19% of families affected by the end of 2023

Housing stress is defined as either having to pay a mortgage or rent that exceeds 30% of the family income or not having sufficient bedrooms for the family's size (Australian Bureau of Statistics, 2022a). It is a broadly used measure of economic vulnerability that suggests a precarious financial situation and a higher likelihood of insecure housing in the future. Housing insecurity often co-occurs with other social issues that elevate risk for individuals and families, increasing the likelihood of support needs and service involvement.

The following analysis looks at the balance of income per family and housing costs (rent and mortgage payments) during 2021 and projects the calculation forward until the end of 2023. Despite housing in regional Victoria being comparatively cheaper compared with metropolitan areas, there have been substantial rises in rental rates and mortgage repayments from 2021 to 2023.

By the end of 2023, there were an estimated 3,160 families (19% of all families) facing either rental or mortgage stress, a sharp increase from 2021 (15.3% of all families: Figure 18). By the end of 2023, there were also 910 families (4.7% of all families) with inadequate accommodation, a slight real number increase from 2021 (897 families or 4.8% of all families) (Australian Bureau of Statistics, 2021, 2023a; Homes Victoria, 2024; Reserve Bank of Australia, 2024).[8,9]

Figure 18. Percentage changes in housing stress amongst families with children in Ovens Murray LGAs from 2021 to 2023.



[8]We cross-tabulated mortgage, or rental, by family income, and computed the ratio of mortgage or rental costs to income, using the mid-point of each range as an average. Where this ratio exceeded 30%, we included the number of families in that cell in our totals.

[9]Re. FINF. Note that this estimate of income has been adjusted by ABS (a) to separate out families within multi-family households and (b) to adjust stated income (FINASF) where necessary.

In 2023, Wodonga had the highest proportion of families facing housing stress (20%) in Ovens Murray and, due to its larger population size, the most families under stress in real numbers (1,266 families). Wangaratta had the second highest number of families facing housing stress (673 families or 17.4%), followed by Indigo (393 families or 18.3%).

Underlining the complexity of housing stress in rural areas, wherein housing affordability is often too simple a measure to describe housing inadequacy for families, Benalla had the highest proportion of families with inadequate accommodation (5.8% or 106 families), followed by Towong (5.2% or 38 families) and Wangaratta (5.1% or 222 families).

Assuming that these proportions stay constant from now on and applying population projections estimated by the Victorian government's 'Victoria in Future' database, Figure 19 shows that some 3,534 families are expected to have rental or mortgage costs over 30% of income, and Figure 17 shows that 1,008 families will have inadequate accommodation, in Ovens Murray by 2036.

Figure 19. Number of families where rental payments or mortgage repayments are greater than 30% of household income, projected to 2036.

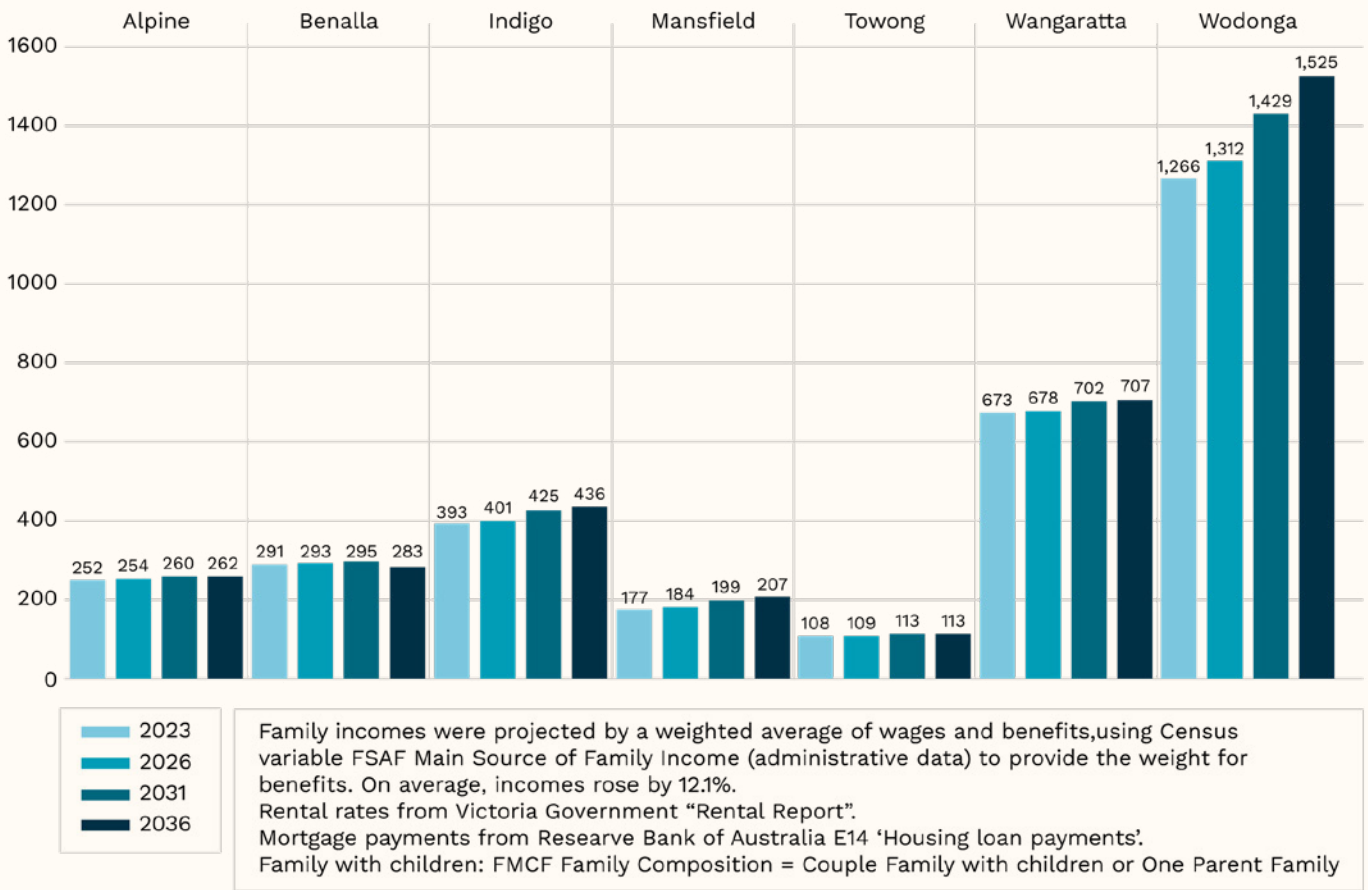


Figure 20. Number of families who have inadequate housing (number of bedrooms), projected to 2036.

Homelessness in Ovens Murray

The Australian Bureau of Statistics uses six operational groups to estimate homelessness on census night. These are people living in improvised dwellings, tents or sleeping out; people living in supported accommodation for the homeless; people staying temporarily with other households; people living in boarding houses; people living in 'severely' crowded dwellings. Any person fitting into one of these categories is counted as homeless throughout Australia. Three additional categories: people living in other crowded dwellings, people in other improvised dwellings, and 'people marginally housed in caravan parks' are classified by the ABS as "marginally housed"(Australian Bureau of Statistics, 2021).

Regional Victoria, in general, has a lower rate of homelessness and marginally housed population in comparison to Melbourne (Major cities, Vic; refer Figure 21), where 50.71 persons per 10,000 are homeless, and an additional 34.72 are marginally housed. However, the average rate of homelessness in regional Victoria (36.09 per 10,000) and marginally housed persons in regional Victoria (27.01 per 10,000) is still slightly higher than the average rate in Ovens Murray (31.33 homeless and 25.35 marginally housed). In addition, the rate is elevated in the comparatively more populated regional centres of Wodonga and Wangaratta (Australian Bureau of Statistics, 2021).

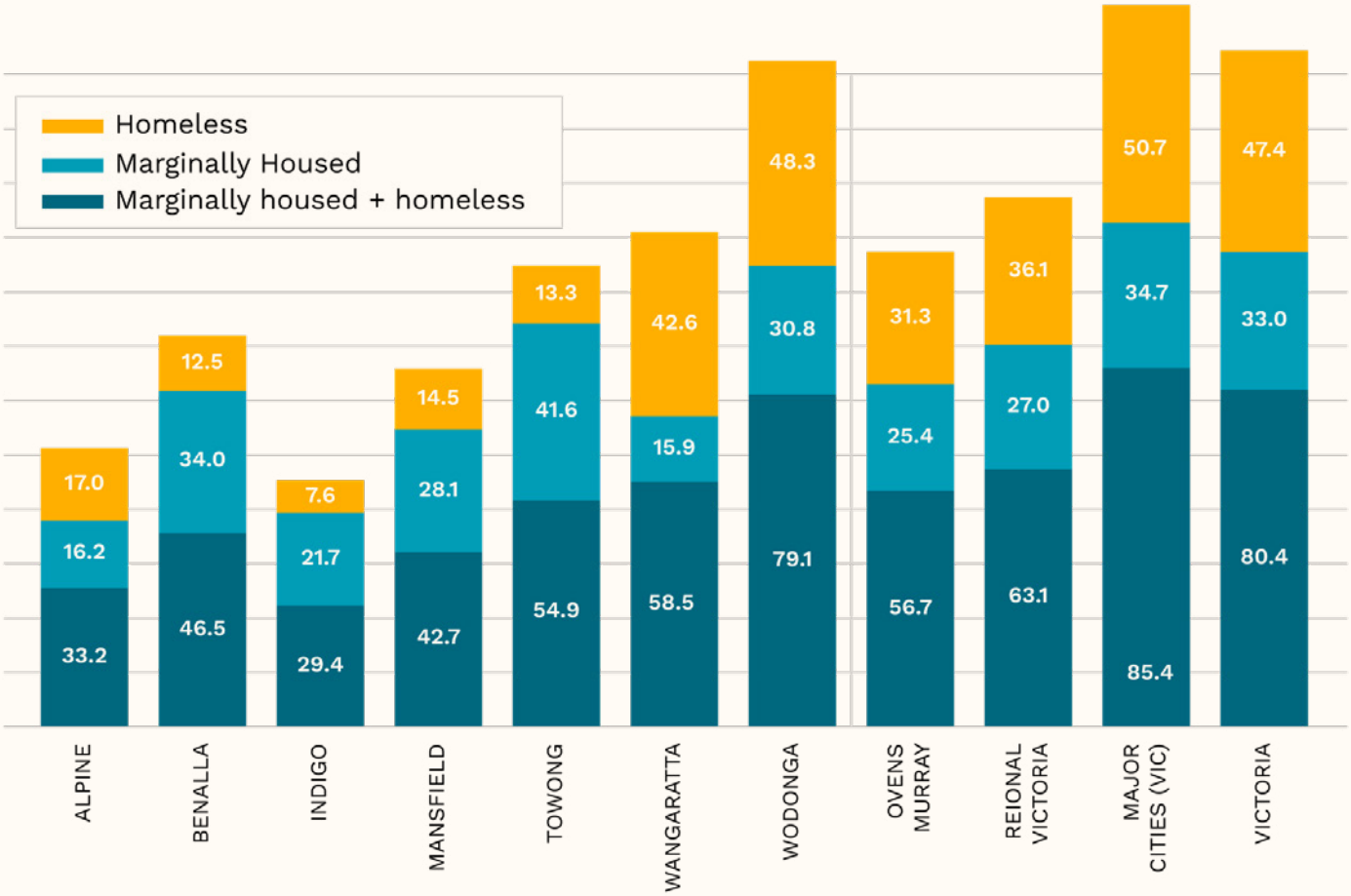


Figure 21. Rate (per 10,000) of homelessness in Ovens Murray and Victoria.

Service providers in the Ovens Murray region see housing and homelessness as a fundamental factor that compounds other issues for the families they work with. Focus group participants reported waitlist time changes from less than 12 months pre-COVID to two years more recently. While much of this can be attributed to housing pressure more broadly, participants believed that a system-level change may have contributed to the issue. Participants reported that previously, AOD and mental health workers could complete housing applications, resulting in a larger workforce supporting housing. Policy changes meant that only staff with an External Party Register Identification Number (EPRIN) could lodge applications for housing support on behalf of clients. One participant described the knock-on effects of housing waitlists "The time that people are getting case managed in housing has gone up... so it's that vicious cycle of they're having to be supported longer... which then impacts somebody else getting supported for housing".

A SNAPSHOT OF SERVICES IN OVENS MURRAY.

This section of the report provides a snapshot of the current service offerings in alcohol and other drugs, family violence, mental health, homelessness, and child and family services in the Ovens Murray region. It is important to note that service provision in these areas is dynamic and subject to frequent changes due to variations in funding and the implementation of short-term programs. Therefore, the information presented here reflects the status at a specific point in time and may not capture subsequent changes. Further, analysing the service landscape at the service level offers a one-dimensional view of actual coverage. The quantity of services may not accurately measure whether they are sufficient to address the need (see Perspectives on current services and gaps for a more nuanced discussion).

Taking a high-level view of service offerings, there is a broad spread of services available in Ovens Murray. More than 200 'on-the-ground' services are provided across the region, with headquarters in at least one of the seven LGAs surveyed at the time of service mapping. More than 30 service providers offered these services. Some providers offer services encompassing all four factors, with 19 providers offering mental health services, four providers offering housing and homelessness services, five providers offering AOD services, 22 providers offering child and family services, and nine providers offering family violence services.

The service mapping for Ovens Murray reveals a wide range of support options across various areas. For instance, there are 65 services related to mental health, 17 related to alcohol and other drugs, 17 related to housing and homelessness, 107 related to children and families, and 39 related to family violence. Many agencies offer services that span across multiple categories. For example, an agency might offer both housing support referrals and parenting programs, showcasing the integrated nature of their services. This approach enables agencies to address the interconnected needs of individuals and families in the region.

SERVICE DISTRIBUTION ACROSS LGAS

ALPINE	3	72*	16^	14	3	9	53	17
BENALLA	5	70*	14^	12	1	10	52	18
INDIGO	2	68*	15^	13	2	14	50	21
MANSFIELD	2	69*	14^	12	3	9	52	18
TOWONG	4	66*	17^	11	2	13	48	23
WANGARATTA	13	137*	22^	44	15	10	78	24
WODONGA	19	150*	19^	44	14	14	90	37

LEGEND

- Unique service providers are headquartered in the LGA.
- Unique services are offered in the LGA.
- Unique services are offered in the LGA.
- Mental Health Support
- Alcohol and Other Drugs Support
- Homelessness and Housing Support
- Support for Children and Families
- Family Violence Support

*These services are further divided in the subcategories: Mental Health Support, AOD support, Homelessness and Housing Support, Support for Children and Families, and FV support.
^The number of service providers that offer to total unique services.

PERSPECTIVES ON CURRENT SERVICES AND GAPS.

With an understanding of the current service offering in Ovens Murray, it is important to understand the service provider and client perceptions of those services. To do this, focus groups and interviews were conducted. During focus groups and interviews, service providers and clients reflected on barriers and challenges to service provision in Ovens Murray and the positive aspects of service provision in the region. These aspects were apparent at the client, service, geographical, and systems levels. The core themes reported by service providers and clients were client complexity, collaboration, community, awareness, lack of services, and place and space.

CLIENT COMPLEXITY (INTERSECTIONALITY)

As highlighted in the introduction, the intersectional nature of the four factors being investigated was at the forefront of discussions. Service providers indicated that clients presenting with multiple issues are common, making navigating services challenging and deciding which issues should be prioritised for action. Services are not always equipped to deal with multiple issues simultaneously, creating a stalemate regarding which issues should be dealt with first. As one service provider describes it, ***"... then we sometimes end up in a situation where you have one service say, well, we can help with mental health but not until AOD's dealt with. AOD is saying we need mental health to be dealt with..."***. Working at the intersection of issues is further complicated by clients not wanting to disclose other problems they are experiencing for fear of judgement, involvement of police or other protective services, not wanting to use resources they believe others are more deserving of or thinking they should only discuss the issues relevant to the service they are engaged with. For Child and Family service practitioners particularly, they ***"need to really be able to talk about everything to get to what needs to be done in the home around parenting, around the functioning of the family, because there is all this other stuff going on"***.

Service providers report that client complexity appears to be increasing. When client complexity is left unaddressed or undetected, and clients are not referred to relevant services, issues can become more acute. As one provider puts it: ***"Well if they're not recognised - if it's not unpacked in that space, they're not referred to us... it's become much more complex..."***

Client complexity often prevents service providers from undertaking the therapeutic work they are trained in and engaged for. For example, ***"...we sometimes don't get into a routine or parenting until, like, 100 hours in because we are just keeping families safe with working with other services around the violence, the mental health, the drugs"***. There was a perception amongst service providers that policymakers or funding bodies do not always recognise client complexity. Service providers spoke of the investment in time required to untangle the complex web of issues a client is experiencing before getting to the work that a particular provider is engaged for. One participant encapsulated this sentiment: ***"I guess it's just the expectation of getting through an amount of work that doesn't see clients as individuals that have complexities and need extra time to get them from point A to point B, I think, yeah. The government sees clients as numbers that should take this amount of time to do this amount of work without considering barriers..."***.

COLLABORATION

The strong collaborations between services in the OM region are a protective factor when client complexity is detected. This was highlighted by one service provider who explained, ***"When care teams are in sync with each other and the families and being very transparent around all the issues, it just works"***. Service providers spoke of the significant influence collaboration had on outcomes for families and services noting the success of care teams often hinges on their ability to work cohesively. When teams are cooperative, they can achieve meaningful progress. Those effective collaborations were often underpinned by strong relationships between different services. This is evident in the rural context where services have established strong connections, with one participant agreeing that: ***"in rural***

communities there is that - there is really strong partnerships and really good udnerstanding in the main between all sorts of services."

The process of coming together to decide the best course of action for families was a recurring theme for service providers. This collaborative decision-making ensures that the most appropriate services are involved and that resources are used efficiently ***"that helps where you're able to come together and work out what is best for the family and which service needs to be in there."***. By joining forces, different services can provide a wraparound model of care that addresses multiple aspects of a family's needs. This also helps prevent duplication of services and ensures no gaps in service provision.

Collaboration across LGAs and organisations often requires flexibility, with services sometimes working outside their usual scope to meet the needs of families. This adaptability is seen as a strength, allowing for more tailored and responsive service delivery. This is reflected by one service provider who states ***"I think with relationships comes the flexibility to work outside of scope to promote clients' best interests, and that comes a lot with conflicts of interest. So, for example, we see often that [LGA1] family services will say, we can't work with this family because it's a conflict, and so [LGA2] family services say, yep, we're happy to pick this family up, even though it's outside of their (geographical) scope."***

Smaller communities with fewer service providers create an environment where building connections and working together is more feasible and often necessary. Local organisations are an important aspect of this with sporting mentors, GPs, childcare workers, teachers, and maternal and child health nurses playing a critical role in supporting families and raising awareness of the professional services available in the area. In Benalla, the Tomorrow Today Foundation exemplifies how philanthropic organisations can create positive opportunities for families through programs that promote engagement and community cohesion. The close-knit dynamics of the community foster mutual respect and a collective attitude toward helping each other, enhancing service effectiveness. This is, however, a double-edged sword with smaller communities also presenting a challenge to perceptions of privacy for clients accessing services.

AWARENESS

Participants spoke of awareness as a key barrier to understanding and perception of services within the community and among professionals. There is a notable lack of awareness about the available services and their purpose. Intake workers and other practitioners may not fully understand what different organisations offer, which can lead to inappropriate referrals or missed opportunities for support. While this runs counter to the findings that collaboration between services allows for a better understanding of service offerings, high staff turnover and vacant positions in the industry contribute to a lack of networking and continuity and loss of knowledge. Without established relationships and consistent networking, professionals may lack the necessary knowledge about available services and how to connect families to them effectively. Service providers report that important opportunities to network outside of the professional setting have ceased since the COVID-19 pandemic.

Awareness is also tied to misconceptions within the community. Families often harbour misconceptions about the involvement of services, fearing police or child protection involvement. This fear can prevent clients

from seeking help, as they worry it implies wrongdoing rather than seeing engagement as a source of support. There also appears to be a community perception that support services are only for those in crisis. People often believe they must be in dire need to seek help, missing out on early intervention opportunities that could prevent situations from worsening.

In some areas there is confusion about where to access services. Residents may not realise that local services are available and instead think they need to travel to other towns for support. ***"So we feel like sometimes people don't know what our service does and what we can provide. They think they need to go to Wangaratta for something whereas we are here, and we can support clients in the area."***

Service providers believe that more community outreach and development is required to raise awareness of services and assist with early intervention. Current efforts are fragmented and not part of a coordinated approach, limiting their effectiveness. Increasing community engagement and education through public speaking, community events, and partnerships with local organisations may assist with overcoming these obstacles and improve service awareness: ***"There's a community development part to this as well where we're not - you can only do so much public speaking, and so there aren't hours allocated for community development around this with the programs that we're with at the moment. I think that that's impacting on things, too. I mean, I try and do as much as I can, but it gets to a point where it's outside of the scope, or it's not main core business for me"***.

In the case of family violence, community development activities would help to highlight non-physical forms of abuse as family violence.

Awareness was discussed as being foundational to early intervention, thus preventing crisis. Crisis interweaves significantly with discussions on early intervention, underscoring the systemic challenges faced by support services. A pervasive issue is the shift in service focus from early intervention to crisis management. Service providers report that this shift has led to the neglect of lower-level risk cases, with services like family support becoming overwhelmed by crisis situations. As a result, cases are only addressed when they have reached a critical point, leaving little room for preventative measures. The increasing complexity and crisis-driven nature of cases further exacerbate the problem, highlighting the need for a more balanced approach that includes crisis intervention and robust early intervention programs. Effective early intervention could prevent many situations from escalating to a crisis, but current resource constraints and systemic priorities hinder this proactive approach. ***"I think another difference in what we see is that in terms of a landscape or a scope, everybody's in crisis. We've completely lost sight of early intervention, lower-level risk cases, everything we're getting - we have our crisis services, we have CAV, and we have immediate responses through hospital for mental health, but services like family services that are that longer-term in-home supporting the family, that's become about crisis as well."***

CRITERIA

Service delivery is often time-limited and tied to strict criteria. Clients often face delays in accessing services due to eligibility criteria that exclude them at the time of need. This issue is highlighted by comments from clients who express frustration over not being eligible for programs due to age restrictions or their child's issues or diagnoses not fitting criteria: ***"It did take us a long time to get into there, though, because the school tried, like about two years ago, the psychologist at my son's school referred us, and she tried everything. She even - we did a report to child protection saying that I was the one at risk. And yeah, tried so many different things and yeah, just***

knockbacks from everybody saying, no, I didn't really fit what they did and stuff like that. But finally, yeah, we have our foot in the door now". These sentiments were echoed by service providers who described age restrictions that present substantial barriers, with some programs limiting eligibility to individuals 26 and above. This exclusion prevents younger clients from accessing necessary services and creates challenges in providing holistic family support. Agencies can work with parents but not their children, leading to fragmented care and unmet needs within families. Agencies receive frequent requests to serve individuals who do not meet current eligibility criteria, highlighting a demand for more inclusive eligibility standards that can accommodate a broader range of clients.

The housing crisis significantly impacts eligibility and service delivery. Due to limited housing options, services must prioritise who gets help first, often based on immediate risk. This prioritisation process can exclude individuals who do not meet the urgent criteria but still need assistance, underscoring how external factors like housing availability can complicate eligibility and service provision: ***"There's a massive housing crisis here and I think that impacts all our clients, plus it impacts our service delivery and sometimes, because of this, we have victims of family violence that can't leave and services are prioritising who's going to get hurt first. That sounds very simple, but they're very big issues"***. This sentiment was echoed by one client on a waiting list for housing after her child was witness to a violent assault near their home: ***"So I don't think (I) fit that criteria of actual – threats to physical harm and violence because it's not within my home, so I'm not looked at number one, right? Just because I don't have a boyfriend that bashes me, why don't I fit that criteria?"***

There is a tension between honouring client self-determination and adhering to criteria such as program targets or funding requirements. This balance is particularly challenging regarding engagement, where program criteria may not align with clients' needs. Eligibility issues can arise when programs prioritise certain targets over clients' individualised needs. This includes program length. Practitioners express a strong desire to extend their engagement with families beyond the initial intensive phase. They observe that current programs, while beneficial, often end too soon, leaving families without continued support that could significantly improve their outcomes. Service providers agreed that providing sustained, less intensive support over an additional year or two could bridge existing gaps and offer more meaningful assistance to families. There is a consensus that many existing services are short-term and only scratch the surface of the families' needs. This suggests that a long-term approach could be much more effective in fostering stability and positive change. Clients echoed the sentiment of service providers, reporting that programs often ended too soon because specific goals were met while ignoring other issues.

LACK OF SERVICES

The lack of services in the Ovens Murray region also presents a barrier to client access. Families often face the burden of travelling long distances to access essential services, with clients reporting that advertised local services are frequently unavailable when needed most. This is compounded by substantial referral challenges to specialist services, such as paediatricians and mental health professionals, especially in smaller communities. The scarcity of GPs accepting new patients exacerbates these issues, often necessitating travel to other towns for urgent care. Post-COVID school absenteeism has worsened, and a lack of childcare affects both service users and potential agency staff, making recruitment and retention difficult for agencies. For the more isolated areas within Ovens Murray, geographic barriers further limit outreach services.

Possible solutions such as telehealth are often not viable due to internet and mobile

phone connectivity issues (blackspots) in some locations and families living in poverty lacking the financial resources to pay for connectivity. Specific localities like Benalla and Mansfield initially lacked significant mental health services, leading to surges in demand when introduced, while dependency on referrals and long waitlists hindered timely assistance. Additionally, the absence of a dedicated drug squad in the Ovens Murray region exacerbates drug-related issues, impacting community safety and well-being. Collectively, these service deficiencies underscore the urgent need for improved access, better resource allocation, and innovative solutions to effectively meet the community's diverse needs.

PLACE AND SPACE

Clients often face disadvantages when it comes to their geographical location. Many services are located outside the immediate vicinity of clients, requiring extensive travel, which imposes financial and logistical burdens. For instance, a participant highlighted the need to travel to Wodonga for therapy due to the unavailability of local accredited psychologists, exacerbating the victim's stress and adding out-of-pocket expenses. Similarly, the large geographical area and sparse population of a portion of the Ovens Murray region necessitate long travel times for critical care, particularly for children, and routine face-to-face services. Transport issues are compounded by inadequate public transportation, making it difficult for families living between towns to engage with services. While some programs offer financial assistance for travel, such as petrol vouchers, these solutions are often insufficient or delayed, failing to address the immediate needs of clients adequately: ***"But we had to travel to Wodonga, which was putting me out-of-pocket... I was meant to be sent fuel vouchers every week – I never accessed those fuel vouchers until the last session. They gave me all of the fuel vouchers, all in one – that's not going to – like it didn't help me."***

The burden of travel also extends to service providers with a full day of travel for outreach services, often only resulting in a small number of clients being seen. ***"Sometimes that makes our workload a little more. It's - does take a fair bit to drive out to Mansfield and bring somebody into here if they're needing to meet, and it just chews up hours quickly."***

The unique positioning of the Ovens Murray area on the border between states is a significant barrier to accessing services due to administrative divides between New South Wales and Victoria, which hinder consistent care. However, there is some flexibility in managing these issues on a case-by-case basis, prioritising the best outcomes for families. Additionally, the border can be strategically advantageous, as seen during the COVID-19 pandemic when it was used to separate victim-survivors from perpetrators for safety.

Significant financial barriers exist to accessing services for families with children in the Ovens Murray area. Travel expenses to access essential services impose a substantial financial strain, particularly for single parents. Additionally, the lack of bulk billing for medical services creates further barriers as families struggle to afford basic medical care. This sometimes results in Child Protection involvement simply because parents cannot afford transportation to a doctor. While some organisations have the means to offer financial assistance, these resources are limited and not widely available. The cumulative impact of these financial barriers severely limits access to necessary early intervention and other supportive services.

While outreach services are available in the LGAs, the need for dedicated meeting spaces forces practitioners to meet clients in public places when meeting in the home is inappropriate, which can compromise confidentiality and safety. For instance, meeting in a park can expose clients to recognition by perpetrators, as well as discomfort due to weather conditions. While some offices are equipped with client and family rooms, this is not universally available, resulting in inconsistencies in service delivery. The idea raised in the focus groups of a mobile service bus equipped with the necessary facilities highlights the desire for innovative solutions to address these spatial challenges.

Client interviews largely supported the points raised during the focus groups with service providers. Further, the findings highlighted in this qualitative phase support those of the literature review, LGA profiling, quantitative prevalence data, and service mapping.

KEY OBSERVATIONS.

Benalla LGA emerges as a region of significant concern within Ovens Murray, characterised by multiple indicators of high need. The LGA experiences the second-highest rate of mental health diagnoses, underscoring the substantial mental health burden within the community. This is compounded by the LGA having the highest 5-year average for alcohol-related care incidents, highlighting the prevalent issue of alcohol and other drug (AOD) misuse. Furthermore, Benalla LGA records the highest rate of family violence in the region. This critical issue intertwines with social determinants such as socio-economic disadvantage and limited service availability. The LGA also has the highest proportion of single-parent families, which often correlates with increased vulnerability to economic hardship and social isolation. Moreover, Benalla LGA is identified as one of the most socio-economically disadvantaged LGAsin Ovens Murray, further exacerbating the challenges faced by its residents.

Early childhood development indicators suggest a high level of developmental vulnerability for children in **Benalla LGA**. While there has been a decrease in vulnerability over time, Benalla has primarily remained the LGA with the highest level of developmental vulnerability.

Wangaratta LGA is identified as a locality of considerable need within the Ovens Murray region, marked by significant and escalating social and health challenges. The LGA has seen a sharp increase in alcohol-related ambulance attendances, leading to it having the highest rate of such incidents in the region. This concerning trend is exacerbated by the high density of liquor licenses, with few square kilometres separating them and a notably high number of licenses per person. This may contribute to the accessibility and prevalence of alcohol consumption in the area.

Wangaratta LGA also ranks third in the region for the rate of diagnosed mental health conditions, with a particular concentration of affected individuals among women aged 20-29 years. This demographic trend points to the need for targeted mental health services for young women, who may be particularly vulnerable to the pressures contributing to mental health issues. Additionally, the LGA has experienced the sharpest increase in ambulance attendances due to family violence and now holds the third-highest rate of family violence incidents in Ovens Murray. These statistics underscore the critical need for enhanced interventions and support systems to address the rising incidents of family violence and its impact on the community.

Further compounding the challenges in **Wangaratta LGA** are the issues of housing stress and homelessness. The LGA has the second-highest percentage of people experiencing housing stress and the second-highest rate of homeless or marginally housed persons in the region. These conditions highlight the socio-economic pressures faced by residents, which are likely exacerbated by the intersection of mental health issues, family violence, and alcohol-related harm.

In 2021, almost a quarter of children in their first year of schooling in **Wangaratta LGA** were considered developmentally vulnerable on one or more AEDC domains.

Wodonga LGA is identified as a locality of significant concern within the Ovens Murray region, with several indicators highlighting its high level of need. The LGA has a notably higher rate of mental health issues, particularly among young women, signalling a critical area for targeted mental health services and interventions. Wodonga also has the second-highest rate of family violence in the region, reflecting the complex interplay of social determinants that exacerbate these conditions.

Wodonga LGA faces severe challenges related to housing stability, as evidenced by its position as the locality with the highest rate of homeless and marginally housed individuals in Ovens Murray. This alarming statistic indicates significant socio-economic pressures and a potential shortfall in available housing and support services.

Wodonga LGA's population is projected to grow at the fastest rate in the region, at 1.6% per annum, compounding existing challenges. This rapid growth is likely to place additional strain on the LGA's infrastructure and social services, particularly in areas related to mental health, family violence, and housing. The projected increase in population underscores the need for proactive planning and resource allocation to meet the future demands of the community.

SERVICE LANDSCAPE

- Alcohol and Other Drug services are comparatively fewer, with a noticeable lack of partnerships between these services and other providers. This contrasts with family violence and children and family services, which are highly integrated and often offer services in conjunction with other providers.
- There is a comparative lack of homelessness services. Only Junction Support Services, North East Support and Action for Youth (NESAY), Outreach Connections, Salvo Care and Mungabareena Aboriginal Corporation (in collaboration with the Orange Door and DFFH), and Beyond Housing offer specific housing and homelessness services.
- There is only one identified service offering drug and alcohol support in Benalla despite it having the worst rate of drug and alcohol-related care and service incidents in the area.

PERSPECTIVES ON SERVICES

- Clients often present with multiple issues, complicating prioritisation and navigation of services, with services frequently unequipped to handle all issues simultaneously.
- Strong collaborations between services in the OM region improve outcomes by ensuring cohesive and comprehensive support, leveraging relationships to work flexibly across scopes. There is a need to provide networking opportunities.
- Lack of awareness about available services among professionals and the community leads to missed support opportunities, exacerbated by high staff turnover and COVID-19 disruptions to networking.
- Strict eligibility criteria and time-limited programs hinder access to services, often excluding those in need and creating fragmented care.
- Service shortages in the OM region necessitate long-distance travel, complicate referrals, and hinder timely assistance, particularly in isolated areas with connectivity issues.
- Geographical challenges and financial burdens limit access to essential services, with inadequate public transportation and the border divide adding further barriers.
- Outreach services require adequate and appropriate spaces to operate from.

RECOMMENDATIONS.

Based on the comprehensive analysis of the social issues in the Ovens Murray region, this report presents the following recommendations to address the identified challenges:

ENHANCING SERVICE INTEGRATION

- **Strengthen Collaborative Networks:** Establish and enhance partnerships between service providers, particularly in regions where Alcohol and Other Drug (AOD) services and homelessness support are limited. Developing integrated service networks can ensure a more cohesive approach to addressing clients' complex needs who often present with multiple issues.
- **Facilitate Inter-Agency Communication:** Increase opportunities for networking and collaboration among service providers through regular forums, workshops, and joint initiatives. This will help to share best practices, reduce service duplication, and promote a holistic approach to client care.

EXPANDING SERVICE AVAILABILITY

- **Increase Mental Health and Family Violence Services:** Prioritize the expansion of mental health services, particularly those targeted at young women, in high-need areas such as Wodonga and Wangaratta. Additionally, there is an urgent need to enhance family violence services in these regions to address the rising incidents.
- **Address Gaps in AOD Services:** Given the high rates of alcohol and drug-related incidents in Benalla LGA, there is a critical need to increase the availability of specialised AOD services. This should include treatment and prevention programs that are easily accessible to the community.
- **Enhance Housing Support Services:** Expand homelessness support services, particularly in Wodonga, which has the highest rate of homelessness in the region. This includes increasing the availability of emergency housing, transitional accommodations, and long-term support to help residents achieve stable housing.

IMPROVING ACCESSIBILITY

- **Invest in Transportation Infrastructure:** Address geographical barriers by improving public transportation options in the Ovens Murray region. This will help residents in isolated areas access essential services more easily, reducing the need for long-distance travel.
- **Provide Adequate Facilities for Outreach Services:** Ensure that outreach services have suitable and sufficient spaces from which to operate. This will enable them to reach and support vulnerable populations across the region effectively.
- **Plan for Population Growth:** In anticipation of Wodonga's rapid population growth, proactively plan and allocate resources to expand social services and infrastructure. This will ensure that the growing population can access necessary support without overburdening existing services.

INCREASING AWARENESS AND ACCESSIBILITY

- **Raise Awareness of Available Services:** Implement community outreach and education programs to increase awareness of available services among professionals and the general public. This should include information dissemination strategies that overcome the challenges of high staff turnover and disruptions caused by the COVID-19 pandemic.
- **Review and Adjust Eligibility Criteria:** Assess and, where necessary, modify the eligibility criteria and time-limited nature of current programs. The goal is to reduce barriers to access and ensure that services reach those who need them most, particularly in areas with high levels of socio-economic disadvantage.

These recommendations aim to guide stakeholders in addressing the social issues within the Ovens Murray region, ensuring that vulnerable families with children and young people receive the comprehensive support they need to thrive.

LIMITATIONS.

This report offers a snapshot in time, with limited forecasting of the prevalence of the four factors. If the population increases while the incidence rates of AOD, family violence, and homelessness remain constant, one might expect the number of affected individuals to rise. However, this assumption is fraught with uncertainties. The reasons behind population growth are crucial. For instance, if wealthier individuals move into the area for a 'tree change,' their incidence rates may be lower due to better access to resources.

Additionally, the demographic makeup of new residents might differ significantly from the current population, further complicating predictions. Given our limited time and resources, a detailed analysis was not feasible. Therefore, any projections should be approached with caution, as they are based on broad assumptions that may not fully reflect the complexities involved.

Service mapping utilised publicly available information. There is a possibility that services exist that are not openly advertised in the public domain and were missed using this method. However, the technique used to identify the information mimics that of a potential service user.

Despite extensive efforts to identify data sources that could stratify variables specific to families with children, this was only feasible in a limited number of cases. Further, in some cases where family-level data was available, sample sizes were too small at LGA levels, and data obscured for privacy reasons. However, by being in environments where issues such as those investigated here are prevalent, children are at risk of poor outcomes. Further, the lack of publicly available data on child outcomes, such as that from the Victorian Child and Adolescent Monitoring System (VCAMS) and maternal fertility rates at the Ovens Murray or LGA level, presents a significant challenge for a comprehensive understanding of the region. While the lack of openly available data may be due to privacy concerns, it restricts the nuanced understanding of the region's specific needs and trends. Without access to localised data, it is difficult to develop targeted strategies to address developmental vulnerabilities and other key indicators affecting children and families in the region.

REFERENCES.

Alhammad, M., Aljedani, R., Alsaleh, M., Atyia, N., Alsmakh, M., Alfaraj, A., Alkhunaizi, A., Alwabari, J., & Alzaidi, M. (2022). Family, Individual, and Other Risk Factors Contributing to Risk of Substance Abuse in Young Adults: A Narrative Review. Cureus, 14(12), e32316. https://doi.org/10.7759/cureus.32316

American Psychological Association. (2022). Mental health. https://www.apa.org/topics/mental-health

American Psychological Association. (2024). Alcohol and other drug use. https://www.apa.org/topics/substance-use-abuse-addiction

Australian Bureau of Statistics. (2014-2015). National Health Survey. https://doi.org/https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0.55.001Main+Features12014-15?OpenDocument=

Australian Bureau of Statistics. (2017-2018). National Health Survey. https://doi.org/https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/2017-18

Australian Bureau of Statistics. (2020-2021). National Health Survey. https://doi.org/https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/latest-release

Australian Bureau of Statistics. (2020-2022). National Study of Mental Health and Wellbeing. https://doi.org/https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release.

Australian Bureau of Statistics. (2021). Census of Population and Housing. https://doi.org/https://www.abs.gov.au/census

Australian Bureau of Statistics. (2022a). Housing: survey of income and housing, user guide, Australia. Australian Bureau of Statistics,. Retrieved 1/8/24 from https://www.abs.gov.au/statistics/detailed-methodology-information/concepts-sources-methods/survey-income-and-housing-user-guide-australia/2019-20/housing

Australian Bureau of Statistics. (2022b). National Health Survey, 2022. https://doi.org/https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/latest-release

Australian Bureau of Statistics. (2023a). Average Weekly Earnings, Australia. https://doi.org/https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/average-weekly-earnings-australia/latest-release

Australian Bureau of Statistics. (2023b). Region Summary: Alpine. https://doi.org/https://dbr.abs.gov.au/region.html?lyr=lga&rgn=20110

Australian Bureau of Statistics. (2023c). Region Summary: Benalla. https://doi.org/https://dbr.abs.gov.au/region.html?lyr=lga&rgn=21010

Australian Bureau of Statistics. (2023d). Region Summary: Indigo. https://doi.org/https://dbr.abs.gov.au/region.html?lyr=lga&rgn=23350

Australian Bureau of Statistics. (2023e). Region Summary: Mansfield. https://doi.org/https://dbr.abs.gov.au/region.html?lyr=lga&rgn=24250

Australian Bureau of Statistics. (2023f). Region Summary: Towong. https://doi.org/https://dbr.abs.gov.au/region.html?lyr=lga&rgn=26670

Australian Bureau of Statistics. (2023g). Region Summary: Wangaratta. https://doi.org/https://dbr.abs.gov.au/region.html?lyr=lga&rgn=26700

Australian Bureau of Statistics. (2023h). Region Summary: Wodonga. https://doi.org/https://dbr.abs.gov.au/region.html?lyr=lga&rgn=27170

Australian Government Department of Health and Aged Care. (2023, 12 December 2023). Modified Monash Model. Retrieved 20/06/2024 from https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

Australian Institute of Health and Welfare. (2016a). Domestic & family violence & homelessness 2011–12 to 2013–14. Retrieved 28/05/2024 from https://www.aihw.gov.au/reports/family-domestic-and-sexual-violence/domestic-family-violence-homelessness-2011-12-to/contents/the-intersection-of-domestic-violence-and-homeless

Australian Institute of Health and Welfare. (2016b, 07 Jun 2022). Specialist homelessness services client pathways: Clients with problematic drug or alcohol use in 2015–16. Retrieved 28/05/2024 from

Australian Institute of Health and Welfare. (2019). Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment, 2016–17. https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-use-regional-remote-2016-17/contents/summary

Baginski, B. N., Byrne, K. A., Demosthenes, L., & Roth, P. J. (2022). Examining internalizing mental health correlates of addiction severity in patients hospitalized with medical complications from substance use disorder [Substance Abuse & Addiction 3233

Drug & Alcohol Rehabilitation 3383]. Substance Abuse: Research and Treatment, 16. https://doi.org/https://dx.doi.org/10.1177/11782218221115583 (Substance Use: Research and Treatment)

Beer, A., Vij, A., Baker, E., Crommelin, L., Didson, J., Gharaie, E., Li, T., & Horne, S. (2024). Disruption in regional

housing: Policy responses for more resilient markets (AHURI Final Report No. 424, Issue. http://www.ahuri.edu.au/research/final-reports/424

Bower, M., Conroy, E., & Perz, J. (2018). Australian homeless persons' experiences of social connectedness, isolation and loneliness. Health & social care in the community, 26(2), e241-e248. https://doi.org/https://doi.org/10.1111/hsc.12505

Braun, V., & Clarke, V. (2022). Thematic Analysis: A Practical Guide. QMiP Bulletin(33), 46-50.

Calabria, B., Salinas-Perez, J. A., Tabatabaei-Jafari, H., Mendoza, J., Bell, T., Hopkins, J., Furst, M., Teesson, M., Gillespie, J., Bagheri, N., & Salvador-Carulla, L. (2021). Alcohol and other drug service availability, capacity, and diversity in urban and rural Australia: An integrated atlas. Journal of studies on alcohol and drugs, 82(3), 401-413. https://doi.org/10.15288/jsad.2021.82.401

Campo, M. (2015). Children's exposure to domestic and family violence: Key issues and responses. Journal of the Home Economics Institute of Australia, 22(3), 33.

Campo, M., & Tayton, S. (2015). Domestic and family violence in regional, rural and remote communities: an Overview of key issues. A. I. o. F. Studies. https://aifs.gov.au/resources/policy-and-practice-papers/domestic-and-family-violence-regional-rural-and-remote

Centers for Disease Control and Prevention. (2022). NCHHSTP Social Determinants of Health. Retrieved 19/2/2024 from https://www.cdc.gov/health-disparities-hiv-std-tb-hepatitis/about/social-determinants-of-health.html?CDC_AAref_Val=https://www.cdc.gov/nchhstp/socialdeterminants/index.html

Charmaz, K. (2006). Constructing Grounded Theory A Practical Guide Through Qualitative Analysis. London : Sage Publications Ltd.

Creswell, J. W. (2018). Qualitative inquiry & research design : choosing among five approaches (Fourth edition.. ed.). Los Angeles SAGE.

Crime Statistics Agency. (2023a). Victoria Police: L17 risk assessment and risk management report. https://www.crimestatistics.vic.gov.au/crime-statistics/latest-victorian-crime-data/family-incidents-2

Crime Statistics Agency. (2023b). Victorian Emergency Minimum Dataset (VEMD) - 1 July 2018 to 30 June 2023.

Evans, E. A., Goff, S. L., Upchurch, D. M., & Grella, C. E. (2020). Childhood adversity and mental health comorbidity in men and women with opioid use disorders [Substance Abuse & Addiction 3233]. Addictive Behaviors, 102. https://doi.org/https://dx.doi.org/10.1016/j.addbeh.2019.106149

Handerer, F., Kinderman, P., Shafti, M., & Tai, S. (2022). A scoping review and narrative synthesis comparing the constructs of social determinants of health and social determinants of mental health: Matryoshka or two independent constructs? [Health Psychology & Medicine 3360]. Frontiers in Psychiatry, 13. https://doi.org/https://dx.doi.org/10.3389/fpsyt.2022.848556

Hanley, N., MacPhail, C., Simpson, H., & Stevenson, S. (2023). 'You are up against it down here'. Providing domestic and family violence services in regional Australia. International journal for crime, justice and social democracy, 12(2), 124-136. https://doi.org/10.5204/ijcjsd.2437

Healey, L., Heward-Belle, S., Humphreys, C., Isobe, J., Tsantefski, M., & Young, A. (2020). Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues. Research report of the STACY Project: Safe & Together Addressing ComplexitY. https://vawc.com.au/wp-content/uploads/2020/10/STACY-working-with-complexity-Final-Report.pdf

Henry, B. F. (2020). Typologies of adversity in childhood & adulthood as determinants of mental health & substance use disorders of adults incarcerated in US prisons. Child Abuse & Neglect, 99. https://doi.org/https://dx.doi.org/10.1016/j.chiabu.2019.104251

Heward-Belle, S. L., Kertesz, M., Humphreys, C., Tsantefski, M., & Isobe, J. (2022). Participatory practice guideline development at the intersections of domestic and family violence, mental distress and/or parental substance use. Advances in dual diagnosis, 15(1), 51-65. https://doi.org/10.1108/ADD-12-2021-0017

Homes Victoria. (2024). Rental Report - Quarterly: Median Rents by LGA Mar 2024 Victorian Government. https://doi.org/https://discover.data.vic.gov.au/dataset/rental-report-quarterly-quarterly-median-rents-by-lga

Infrastructure Victoria. (2021). Regional priorities: Victoria's infrastructure strategy 2021-2051 Ovens Murray Summary. https://assets.infrastructurevictoria.com.au/assets/Resources/Regional-Brochure_Ovens-Murray-1.pdf

Institute of Alcohol Studies. (2020). Alcohol and health inequalities (Alcohol Knowledge Centre Briefing, Issue. https://www.ias.org.uk/wp-content/uploads/2020/12/Alcohol-and-health-inequalities.pdf

Kavanagh, B. E., Corney, K. B., Beks, H., Williams, L. J., Quirk, S. E., & Versace, V. L. (2023). A scoping review of the barriers and facilitators to accessing and utilising mental health services across regional, rural, and remote Australia. BMC Health Serv Res, 23(1), 1060. https://doi.org/10.1186/s12913-023-10034-4

Kirkbride, J. B., Anglin, D. M., Colman, I., Dykxhoorn, J., Jones, P. B., Patalay, P., Pitman, A., Soneson, E., Steare, T., Wright, T., & Griffiths, S. L. (2024). The social determinants of mental health and disorder: Evidence, prevention and recommendations [Health & Mental Health Treatment & Prevention 3300]. World Psychiatry, 23(1), 58-90. https://doi.org/https://dx.doi.org/10.1002/wps.21160

Liu, E., Martin, C., & Easthope, H. (2019). Poor-quality housing and low-income households. Review of evidence and options for reform. Shelter Brief No. 63. University of New South Wales. https://cityfutures.ada.unsw.edu.au/documents/544/poor_quality_housing_report_2019.pdf

Lund, C., Brooke-Sumner, C., Baingana, F., Baron, E. C., Breuer, E., Chandra, P., Haushofer, J., Herrman, H., Jordans, M., Kieling, C., Medina-Mora, M. E., Morgan, E., Omigbodun, O., Tol, W., Patel, V., & Saxena, S. (2018). Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. The Lancet. Psychiatry, 5(4), 357-369. https://doi.org/10.1016/S2215-0366(18)30060-9

Mago, V. K., Morden, H. K., Fritz, C., Wu, T., Namazi, S., Geranmayeh, P., Chattopadhyay, R., & Dabbaghian, V. (2013). Analyzing the impact of social factors on homelessness: a Fuzzy Cognitive Map approach. BMC Medical Informatics and Decision Making, 13(1), 94. https://doi.org/10.1186/1472-6947-13-94

McCoy, L. (2023). Benalla Rural City Social Inclusion Action Group (SIAG) Community needs analysis.

Miller, P., Cox, E., Costa, B., Mayshak, R., Walker, A., Hyder, S., Tonner, L., & Day, A. (2016). Alcohol/Drug-Involved Family Violence in Australia (ADIVA). https://www.aic.gov.au/sites/default/files/2020-09/monograph68-key-findings.pdf

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. International Journal of Qualitative Methods, 16(1), 1-13. https://doi.org/10.1177/1609406917733847

Oostermeijer, S., Bassilios, B., Nicholas, A., Williamson, M., Machlin, A., Harris, M., Burgess, P., & Pirkis, J. (2021). Implementing child and youth mental health services: early lessons from the Australian Primary Health Network Lead Site Project. International Journal of Mental Health Systems, 15(1), 16. https://doi.org/10.1186/s13033-021-00440-8

Pawson, H., Parsell, C., Saunders, P., Hill, T., & Liu, E. (2018). Australian Homelessness Monitor 2018. L. Housing.

Reserve Bank of Australia. (2024). E13 Housing Loan Payments. https://doi.org/https://www.rba.gov.au/statistics/tables/xls/e13hist.xlsx

Respect Victoria. (2023). Intimate partner violence perpetrated against women by men. https://www.respectvictoria.vic.gov.au/what-we-know-about-drivers-of-violence

Smart, J. (2017). Risk and Protective Factors for Child Abuse and Neglect. Australian Institute of Family Studies. Retrieved 10/2/2042 from https://aifs.gov.au/resources/policy-and-practice-papers/risk-and-protective-factors-child-abuse-and-neglect

State of Victoria Department of Transport and Planning. (2023). Victoria in Future 2023: population and household projections to 2051. https://www.planning.vic.gov.au/__data/assets/pdf_file/0022/703453/DTP0552-Victori-in-Future-2023-report.PDF

Straussner, S., & Fewell, C. (2018). A review of recent literature on the impact of parental substance use disorders on children and the provision of effective services. Curr Opin Psychiatry, 31(4), 363-367. https://doi.org/10.1097/YCO.0000000000000421

Sullivan, M. A. (2022). Drug use and mental health: Comorbidity between substance use and psychiatric disorders [Psychological & Physical Disorders 3200]. Substance and non-substance related addictions: A global approach., 3-17. https://doi.org/https://dx.doi.org/10.1007/978-3-030-84834-7_1

Turning Point. (2023). Liquor Licences in Victoria. https://aodstats.org.au/explore-data/liquor/

Turning Point. (2024). Alcohol and drug-related ambulance attendances in Victoria. https://doi.org/https://aodstats.org.au/explore-data/ambulance-attendances/

Victoria State Government. (2022). What is family violence? https://www.vic.gov.au/what-family-violence

Victoria State Government. (ND). Child and Family Services. Victoria State Government,. https://www.vic.gov.au/family-services

World Health Organisation. (2020). Improving early childhood development: WHO guideline. https://www.who.int/publications/i/item/97892400020986

World Health Organisation, United Nations Children's Fund, & World Bank Group. (2018). Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/child-health/nurturing-care

APPENDIX.

LIST OF TABLES

LIST OF FIGURES

1. MODIFIED MONASH MODEL

The model classifies whether a location is Metropolitan, rural or remote using a combination of population size, and distance to population settlements and roads.

Modified Monash category	Inclusions
MM 1	Metropolitan areas: Major cities accounting for 70% of Australia's population. All areas categorised ASGS-RA1.
MM 2	Regional centres: Areas categorised ASGS-RA 2 and ASGS-RA 3 that are in, or within 20km road distance, of a town with a population greater than 50,000.
MM 3	Large rural towns: Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 and are in, or within 15km road distance, of a town with a population between 15,000 and 50,000.
MM 4	Medium rural towns: Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 or MM 3 and are in, or within 10km road distance, of a town with a popula-tion between 5,000 and 15,000.
MM 5	Small rural towns: All other areas in ASGS-RA 2 and 3.
MM 6	Remote communities: All areas categorised ASGS-RA 4 and islands that are separat-ed from the mainland in the ABS geography and are less than 5km offshore. Islands that have an MM 5 classification with a population of less than 1,000 with-out bridges to the mainland (2019 Modified Monash Model classification only).
MM 7	Very remote communities: All other areas that are categorised ASGS-RA 5 and populated islands separated from the mainland in the ABS geography that are more than 5km offshore.

Source: The Department of Health and Aged Care. https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm. Accessed 05/06/2024.

2. POPULATION OF OVENS MURRAY RESIDING IN AREAS AUSTRALIAN BUREAU OF STATISTICS' REMOTENESS STRUCTURE

According to the Australian Bureau of Statistics' Remoteness Structure, which divides Australia into five classes of remoteness characterised by relative geographic access to services, all LGAs in Ovens Murray are Inner Regional or Outer Regional Areas. For the purposes of comparability, therefore, when referring to regional Victoria throughout the report, we are referring to the collapsed Remoteness Area categories of Inner Regional (Vic.) and Outer Regional (Vic.).

All LGAs in Ovens Murray are classified as either small, medium, or large rural towns, with the exception of Wodonga (large rural city) breakdown of Rural and most of the region is classified as inner and outer regional (ABS), or small rural towns (MMM).

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LGA (UR)	Major Cities (VIC)	Inner Regional (VIC)	Outer Regional (VIC)	Remote (VIC)	Migratory, Offshore, Shipping (VIC)	No usual address (VIC)	Total
Alpine	0	7720	5513	0	0	0	13235
Benalla	0	14181	347	0	0	0	14528
Indigo	0	17368	0	0	0	0	17368
Mansfield	0	0	10178	0	0	0	10178
Towong	0	1318	4906	0	0	0	6223
Wangaratta	0	28839	969	0	0	0	29808
Wodonga	0	43253	0	0	0	0	43253

3. ALCOHOL SCORE

The following was derived from the responses gathered from four years of responses to the national health survey. A simple score to compile the responses was used, as follows:

Frequency	Score
Everyday	7
6 days a week	6
5 days a week	5
4 days a week	4
3 days a week	3
2 days a week	2
1 day a week	1
25 to 51 times in a year	0.730769
13 to 24 times in a year	0.355769
1 to 12 times in a year	0.115385
Nil in the last 12 months	0
Never consumed alcohol	0
Not applicable	0
Not stated	0

4. OVENS MURRAY POPULATION LOCATED IN ABS GEOGRAPHICAL AREAS:

- **SA4:** Hume
- **SA3:** Upper Goulburn Valley, Wangaratta- Benalla, and Wodonga-Alpine
- **SA2:** Mansfield, Benalla, Benalla Surrounds, Rutherglen, Wangaratta, Wangaratta Surrounds, Beechworth, Bright-Mount Beauty, Chiltern-Indigo Valley, Myrtleford, Towong, West Wodonga, Yackandandah, Baranduda-Leneva, Wodonga.

		SA4 - HUME | TOTAL POPULATION: 184,935																				
		SA3 | UPPER GOULBURN VALLEY: 60,001									SA3 | WANGARATTA - BENALLA: 48,457					WODONGA - ALPINE: 76,491								
	SA2	Alexandra	Euroa	Kilmore - Broadford	Mansfield	Nagambie	Seymour	Seymour Surrounds	Upper Yarra Valley	Yea	Benalla	Benalla Surrounds	Rutherglen	Wangaratta	Wangaratta Surrounds	Beechworth	Bright - Mount Beauty	Chiltern - Indigo Valley	Myrtleford	Towong	West Wodonga	Yackandandah	Baranduda - Leneva	Wodonga
		6828	6922	15563	10157	4537	6569	4645	238	4182	10822	3781	4047	19882	9925	4986	8903	3184	4745	6196	15396	5221	12778	15082
LGAS IN HUME	**LGA POP**																							
Greater Shepparton	42											42												
Mitchell	26830			15563		27	6569	4645		33														
Murrindindi	10996	6828	10		9					4148														
Strathbogie	11455		6915			4514						29												
Yarra Ranges	238								238															
Unincorporated VIC	785				333												450							
OVENS MURRAY Alpine	13235																8450		4745			40		
OVENS MURRAY Benalla	14528										10822	3706												
OVENS MURRAY Indigo	17368												4047			4986		3184				5150		
OVENS MURRAY Mansfield	10178				10178																			
OVENS MURRAY Towong	6223																			6196		31		
OVENS MURRAY Wangaratta	29808													19882	9925									
OVENS MURRAY Wodonga	43253																				15396		12778	15082
Ovens Murray Population	134593	% of Ovens Murray in Upper Goulburn Valley: 8%									% of Ovens Murray in Wangaratta - Benalla: 36.9%					% of Ovens Murray in Wodonga -Alpine: 56.5%								
Ovens Murray % of Hume	73%	% of Upper Goulburn Vallery in Ovens Murray: 17%									% of Wangaratta - Benalla in Ovens Murray: 99.8%					% of Wodonga Alpine in Ovens Murray: 99.4%								

5. EXPLANATION OF IRSD DECILES OF SOCIOECONOMIC DISADVANTAGE

Decile 1	**Most Disadvantaged**
Decile 2	
Decile 3	
Decile 4	
Decile 5	
Decile 6	
Decile 7	
Decile 8	
Decile 9	
Decile 10	**Least Disadvantaged**

6. IRSD INDICATORS OF SOCIOECONOMIC DISADVANTAGE, CONSTRUCTED USING THE FOLLOWING ABS CENSUS VARIABLES.

Indicator	Description
INC_LOW	Per cent of people with stated household equivalised income between $1 and $25,999 per year
CHILDJOBLESS	Per cent of families with children under 15 years of age who live with jobless parents
NOYEAR12ORHIGHER	Per cent of people aged 15 years and over whose highest level of education is Year 11 or lower (Includes Certificate I and II)
LOWRENT	Per cent of occupied private dwellings paying rent less than $250 per week (excluding $0 per week)
UNEMPLOYED	Per cent of people (in the labour force) who are unemployed
OCC_LABOUR	Per cent of employed people classified as Labourers
DISABILITYU70	Per cent of people aged under 70 who need assistance with core activities due to a long–term health condition, disability, or old age
ONEPARENT	Per cent of one parent families with dependent offspring only
OVERCROWD	Per cent of occupied private dwellings requiring one or more extra bedrooms.
OCC_DRIVERS	Per cent of employed people classified as Machinery Operators and Drivers
SEPDIVORCED	Per cent of people aged 15 years and over who are separated or divorced
NOEDU	Per cent of people aged 15 years and over who have no educational attain-ment
OCC_SERVICE_L	Per cent of employed people classified as low skill (skill level 4 and 5) Community and Personal Service workers
NOCAR	Per cent of occupied private dwellings with no cars
ENGLISHPOOR	Per cent of people who do not speak English well

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