Part VII

HOW SAFE AND SECURE ARE AUSTRALIA'S CHILDREN?

Part VI discussed the importance of family and community factors for the health, development and wellbeing of Australian children. The family and community environment also has a vital role to play in protecting children from physical and emotional harm, which can have a significant impact on the health and wellbeing of children in both the short term and throughout life.

Part VII focuses on the safety and security of Australian children, and discusses key indicators that place children at immediate and long-term risk of physical and/or emotional harm and associated adverse outcomes:

- injuries
- school relationships and bullying
- child abuse and neglect
- children as victims of violence
- homelessness
- children and crime.

The following table shows how children fare across the various indicators presented in *Part VII*, and whether there has been any improvement over time.

Indicator		Value	Trend
Injuries	Age-specific death rates from all injuries for children aged 0–14 years	6 per 100,000	✓
	Road transport accident death rate for children aged 0–14 years	1.6 per 100,000	✓
	Accidental drowning death rate for children aged 0–14 years	1.0 per 100,000	✓
	Assault (homicide) death rate for children aged 0–14 years	0.7 per 100,000	. .
	Injury hospitalisation rate for children aged 0–14 years	1,462 per 100,000	✓
	Assault hospitalisation rate for children aged 0–14 years	20 per 100,000	✓
	Intentional self-harm hospitalisation rate for children aged 10–14 years	41 per 100,000	×
School relationships and bullying	Under development	Data not available	. .
Child abuse and neglect	Children aged 0–12 years who were the subject of a substantiation of a child protection notification received in 2007–08	7.4 per 1,000	✓
	Children aged 0–12 years who are the subject of care and protection orders (2008)	7.1 per 1,000	×
Children as victims of violence	Children aged 0–14 years who have been the victims of (2003):		
	physical assault	309 per 100,000	. .
	sexual assault	187 per 100,000	. .
Homelessness	Accompanying children aged 0–14 years attending agencies funded under the Supported Accommodation Assistance Program (2006–07)	16 per 1,000	. .
Children and crime	Number of children aged 10–14 years who are under juvenile justice supervision (2006–07)	1.7 per 1,000	. .

Key: n.a = not available; ✓ = favourable trend; × = unfavourable trend; . . = no trend data presented.

32 Injuries

Injuries are largely preventable through public health interventions, and yet they remain a leading cause of death and hospitalisation among children.

In 2006, there were 6 deaths due to injuries per 100,000 children and, in 2006–07, children were hospitalised for injury at a rate of 1,462 per 100,000 children.

Injury is the leading cause of death of children aged 1–14 years in every industrialised country, including Australia (Mercy et al. 2006), and is also a major cause of hospitalisation. For each death and hospitalisation due to injury, there are many more visits to emergency departments and health professionals outside hospital settings. Injuries sustained during childhood can have profound and lifelong effects on health and development, by causing permanent physical disabilities or long-term cognitive or psychological damage (for example, traumatic brain injury) (Mercy et al. 2006).

Children are particularly vulnerable to certain types of injury according to their stage of development. Infants and young children (0–4 years) explore their physical environment before they understand and have the skills to respond to hazards. Initiatives to prevent injuries among children of this age therefore focus on creating safer products and environments and raising the awareness of children's carers (NPHP 2004). Successful steps in this area have included child-resistant packaging to prevent poisoning, and legislation requiring the fencing of swimming pools and the use of car seats.

Older children (5–14 years) are exposed to a broader range of settings, such as schools, sporting environments, streets and neighbourhoods. At the same time, their ability to make decisions about their safety increases. Injuries sustained among older children are increasingly influenced by behaviour in addition to their physical and social environment. As children enter adolescence, they may be exposed to alcohol and other drugs, and are on the verge of developing new skills, such as driving and job skills. Behaviour patterns established during this stage can influence risk of injury in later life. For older children, the compulsory use of helmets and seat belts, safe playgrounds, and reduced speed limits and traffic-calming devices in school zones are examples of injury prevention initiatives relating to individual behaviour and physical and social environments.

Because of its major impact on the health of Australians and the largely preventable nature of injury, injury prevention and control was made a National Health Priority Area in 1986. This led to the development of national injury prevention plans (NPHP 2004). The *National injury prevention and safety promotion plan: 2004–2014* identifies children as a major priority area for injury prevention.

Injury has been endorsed by the AHMC, CDSMC and the AESOC as a Children's Headline Indicator priority area (see *Part X* for further information and state and territory data).

This chapter examines the leading causes of injury death and hospitalisation for children. Refer to *Appendix 1 Methods* for technical notes regarding the analysis of injury data.

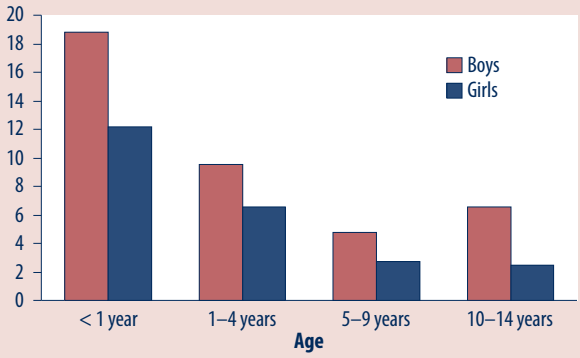
DEATHS FROM INJURY

Headline Indicator: Age-specific death rates from all injuries for children aged 0–4, 5–9 and 10–14 years

In 2006, injuries contributed to 241 deaths of children aged 0–14 years—a rate of 6 per 100,000 children:

- Injury was the underlying cause in 94% of these deaths and was a contributing factor in the remainder.
- Boys were overall 80% more likely to die from injury than girls, although there was some variation by age group (Figure 32.1). The greatest disparity was among 10–14 year olds, where the rate among boys was around 2.5 times the rate for girls.

- Infants (< 1 year) had the highest rate of injury death (16 per 100,000 infants), although injuries accounted for only 3% of all infant deaths. This is due to the higher overall death rate of infants compared with children aged 1–14 years, and the high rates of death due to other causes in the first year of life, such as conditions relating to pregnancy and birth and congenital anomalies (see *Chapter 4*).
- Injury deaths comprised a substantial proportion of all deaths among 1–14 year olds (40%). Rates were 8, 4 and 5 per 100,000 children aged 1–4, 5–9 and 10–14 years, respectively.



Source: AIHW National Mortality Database.

Figure 32.1: Injury deaths for children aged 0–14 years, 2006

Injury death rates among children have been decreasing over time—by almost 40% between 1997 and 2006, from 10 to 6 deaths per 100,000 children.

- The decrease is largely due to a reduction in deaths from land transport accidents, and accidental drowning and submersion.
- The rate for boys has been consistently higher than for girls over this period, although there have been fluctuations in the size of this gap.

Road transport accidents, accidental drowning and assault were leading causes of injury death among children in 2006.

Road transport accidents

The most accurate information on road transport accident deaths is from the Australian Transport Safety Bureau (ATSB) Fatal Crash Database (see Henley et al. 2007:19 for further information). Data from this source are presented here.

The ATSB Fatal Crash Database collects information on fatal traffic accidents, which are accidents occurring on a public highway or street involving a moving vehicle, which can be a motor or non-motor vehicle. Information on non-traffic accidents, that is, those that do not occur on public highways or streets, is not available from this database.

Key national indicator: Road transport accident death rate for children aged 0–14 years

In 2007, among children aged 0–14 years:

- There were 66 deaths due to road transport accidents, a rate of 1.6 per 100,000 children and a decline from 5.5 per 100,000 in 1989. The rate of decline over this period was greater for boys (79%) than for girls (57%), resulting in no significant difference between the sexes in 2007.
- Death rates among 0–4 and 10–14 year olds were more than twice those of 5–9 year olds.
- Almost three-quarters of children who died as a result of a road transport accident were passengers, and a further 20% were pedestrians. The remaining 5% were cyclists or drivers.

Accidental drowning

Key national indicator: Accidental drowning death rate for children aged 0–14 years

In 2006, among children aged 0–14 years:

- There were 46 accidental drowning deaths—a rate of 1 per 100,000 children and accounting for almost one-fifth of accidental drowning deaths for all ages.
- The death rate due to accidental drowning has almost halved between 1997 and 2006—from a rate of 2 per 100,000 deaths in 1997 (80 deaths).
- Infants and young children (1–4 years) had the highest accidental drowning death rates (2.7 and 2.3 per 100,000 children, respectively). Rates were lower among older children, with rates of 0.5 and 0.3 per 100,000 children for 5–9 and 10–14 year olds, respectively.

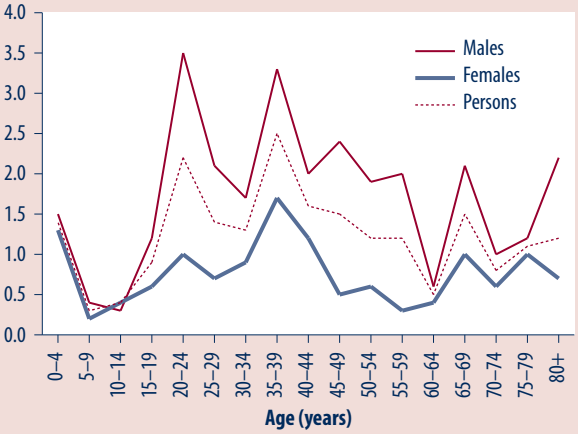
Assault and homicide

The most accurate information on assault (homicide) deaths is from the Australian Institute of Criminology National Homicide Monitoring Program (see Henley et al. 2007:80 for further information). Data from this source are presented here.

Key national indicator: Assault (homicide) death rate for children aged 0–14 years

In 2006–07, among children aged 0–14 years:

- There were 27 deaths due to homicide, a rate of 0.7 per 100,000 children (Dearden & Jones 2008).
- Among children, the rate of homicide was highest among 0–4 year olds (1.9 per 100,000 children) and declined to 0.6 among 5–9 year olds and 0.2 among 10–14 year olds. The rate among children aged 0–4 years was the fifth highest of all age groups, while the lowest rate was among 10–14 year olds (Figure 32.2).



Source: Dearden & Jones 2008.

Figure 32.2: Age-specific assault death rates, 2006–07

INJURY HOSPITALISATIONS

Key national indicator: Injury hospitalisation rate for children aged 0–14 years

In 2006–07, among children aged 0–14 years:

- There were around 59,000 hospital separations for injury—a rate of 1,462 per 100,000 children, representing 11% of all hospitalisations for children. The hospital separation rate was 4% lower in 2006–07 than in 1998–99.
- Boys were overall 60% more likely to be hospitalised for injury than girls, but this varied by age—from 10–40% among infants, 1–4 year olds and 5–9 year olds, to more than twice as high among 10–14 year olds (Table 32.1).
- Injury hospital separation rates were lowest among infants, although injury death rates were highest in this age group.

The cause of an injury provides important information for developing preventive strategies to reduce the risk of serious injury to children.

In 2006–07, among children aged 0–14 years:

- Falls were the most common reason for injury hospitalisation of children, accounting for around 40% of all injury separations. Falls were the leading cause of hospitalised injury for each age group.

Table 32.1: Injury hospital separation rate for children aged 0–14 years, leading specific causes of injury, 2006–07 (per 100,000)

	Age group	Falls	Land transport accidents	Accidental poisoning	Burns and scalds	Assault	All injuries
Boys	< 1 year	338.9	18.7	43.9	96.4	68.4	807.4
	1–4 years	737.9	94.8	173.8	113.2	16.9	1,857.9
	5–9 years	771.6	227.1	15.1	19.5	8.1	1,554.3
	10–14 years	755.1	514.3	10.6	13.8	40.9	2,156.4
	0–14 years	*728.3*	*278.1*	*56.5*	*46.9*	*25.7*	*1,790.7*
Girls	< 1 year	349.3	14.4	34.0	59.0	43.9	727.3
	1–4 years	556.7	55.6	144.7	85.0	11.4	1,398.0
	5–9 years	622.4	137.9	10.3	16.4	5.8	1,122.4
	10–14 years	348.4	177.7	14.1	11.3	17.0	971.5
	0–14 years	*492.8*	*122.1*	*47.9*	*35.2*	*13.7*	*1,115.1*
All children	**0–14 years**	**613.7**	**202.2**	**52.3**	**41.2**	**19.8**	**1,461.8**

Notes
1. Refer to Table A1.3 for ICD-10-AM codes.
2. Exposure to inanimate mechanical forces, accidental exposure to other and unspecified factors, and exposure to animate mechanical forces were also leading causes of injury hospitalisation for children. These categories are diverse and are not useful for reporting purposes.

Source: AIHW National Hospital Morbidity Database.

- Land transport accidents (including both traffic and non-traffic) accounted for 8,200, or around one in seven (14%), injury hospitalisations of children. Rates differed considerably with age, accounting for 2.2% of injury hospitalisations among infants and increasing to more than one-fifth (22%) among 10–14 year olds. Of all children hospitalised for land transport accidents, pedal cyclists were most likely to be hospitalised (45%), followed by motorcyclists (22%).
- There were distinct differences in age patterns of hospital separations for different causes of injury. For example, hospital separations for assault were more common among infants than children aged 1–14 years, and hospital separations for burns and scalds were highest among infants and young children (1–4 years). Hospital separation rates for accidental poisoning were highest among young children (1–4 years).

Assault

Key national indicator: Assault hospitalisation rate for children aged 0–14 years

In 2006–07, among children aged 0–14 years:

- There were around 800 hospital separations due to assault—a rate of 20 per 100,000 children (Table 32.1).
- Hospital separations for assault were more common among infants than children aged 1–14 years, and were almost twice as common among boys as girls.
- In 45% of hospitalised cases for assault, the perpetrator was either a parent, carer or other family member.
- The most common form of assault leading to hospitalisation was assault by bodily force (43% of assault hospital separations among children).
- The assault hospital separation rate decreased by 14% between 1998–99 and 2006–07, with the rate of decline for girls greater than for boys over this period (20% and 11% decline, respectively).

Intentional self-harm

Key national indicator: Intentional self-harm hospitalisation rate for children aged 10–14 years

In 2006–07, among children aged 10–14 years:

- There were around 570 hospital separations for intentional self-harm—a rate of 41 per 100,000 children, a 35% increase since 1998–99 (30 per 100,000 children). This has been driven by an increase of almost 50% in the rate for girls, from 47 to 70 per 100,000 children. By contrast, the rate for boys was the same in 2006–07 as in 1998–99 (13 per 100,000 children).
- The majority (84%) of intentional self-harm hospital separations were for girls (a rate of 70 per 100,000 children compared with 13 for boys).

How does injury mortality and hospitalisation vary across population groups?

The rate of injury mortality and morbidity is higher among certain population groups, such as Aboriginal and Torres Strait Islander children, and children living in remote areas.

Aboriginal and Torres Strait Islander children

Among children aged 0–14 years:

- The injury death rate for Indigenous children was more than 3 times that for non-Indigenous children in 2002–2006 (data from Queensland, Western Australia, South Australia and the Northern Territory only).
- The injury hospital separation rate among Indigenous children was 40% higher than for other children in 2006–07—1,941 per 100,000 children compared with 1,378 (excludes data from Tasmania, the Australian Capital Territory and private hospitals in the Northern Territory). The leading causes of injury hospital separation for Indigenous children were the same as for other Australian children—falls, land transport accidents, accidental poisoning, burns and scalds, and assault—although the rates of each of these were much higher for Indigenous children (see also *Part IX*).

Remoteness

Among children aged 0–14 years:

- Children in *Remote and very remote* areas experienced the highest injury death rate, at more than 4 times the rate in *Major cities* in 2004–2006 (20 per 100,000 children compared with 4). The higher injury death rate in *Remote and very remote* areas may be partly explained by the high proportion of Indigenous children living in these areas and the higher injury death rate occurring in this group. Indigenous children accounted for less than 5% of the Australian child population in 2006, yet comprised more than one-third of all children living in *Remote and very remote* areas.
- In *Remote and very remote* areas, the injury hospital separation rate for children was 60% higher than in *Major cities* in 2006–07—2,136 per 100,000 children compared with 1,325. For assault, the hospital separation rate was 6 times as high among children in *Remote and very remote* areas than among children in *Major cities* (74 and 13 per 100,000 children, respectively).

33 School relationships and bullying

Children who are bullied may have higher absenteeism, lower academic achievement, physical and somatic symptoms, anxiety and depression, social dysfunction, and alcohol and substance use.

No national data are currently available on bullying due to definition and measurement difficulties.

An essential function of all Australian schools is to promote and provide a supportive learning environment in which all students can expect to feel safe (MCEETYA 2005). School connectedness and supportive social relationships have been associated with positive child outcomes such as lower levels of absenteeism, aggression, substance use and sexual risk behaviour, and higher levels of academic achievement and self-esteem among children (Hopkins et al. 2007; Springer et al. 2006). School bullying removes that safe environment.

In Australia, there is currently no agreed definition for bullying; however, the most commonly cited definition is the 'repeated oppression, psychological or physical harm, of a less powerful person by a more powerful person or group of persons' (DEST 2006). Bullying typically involves a power imbalance and deliberate acts that cause physical, psychological and emotional harm (Lodge 2008). It can either be direct (for example, hitting and teasing) or indirect/covert (for example, spreading gossip, deliberately excluding or enforcing social isolation, and sending malicious text messages) (DEST 2007). Bullying often occurs because of differences between the bullies and the victims, such as culture, ethnicity, age, ability or disability, religion, body size and physical appearance, personality, sexual orientation, and economic status (Rigby 2009).

Bullying in Australian schools is widely recognised as a problem, with over 20% of males and 15% of females aged 8 to 18 years reporting being bullied at least once a week (Rigby & Slee 1999).

The negative consequences of school bullying include higher absenteeism in children who are bullied, lower academic achievement and consequent lower vocational and social achievement, physical and somatic symptoms, anxiety, social dysfunction, depression, school failure, and alcohol and substance use (Lodge 2008; Spector & Kelly 2006).

ANTI-BULLYING PROGRAMS

Concern about bullying in schools has resulted in numerous schools in Australia and overseas developing and implementing anti-bullying programs (Rigby & Thomas 2002). An evaluation of the effectiveness of anti-bullying programs in reducing bullying among children aged 5 and 12 years, between 1985 and 2001, found reductions in overall bullying behaviour for the majority of schools with anti-bullying programs (Rigby 2002a, 2002b). The largest reported reduction in bullying was found by Olweus (1991) in Norway in the 1980s, with reductions of 50% or more in bully or victim problems, reductions in antisocial behaviour, and improved student satisfaction with school life and the social climate of the classroom. The Friendly Schools and Families Program, an evidence-based program in Australia, has also shown a very significant reduction in bullying behaviour (Edith Cowan University 2008).

In Australia, the House of Representatives Standing Committee on Employment, Education and Training responded to the issue of bullying in Australian schools in a 1994 inquiry on violence in schools. The inquiry found that bullying was a major problem in schools and recommended the development of intervention programs to reduce school bullying (House of Representatives Standing Committee on Employment, Education and Training 1994).

The Ministerial Council on Education, Employment, Training and Youth Affairs, through its Taskforce on Student Learning and Support Services, has developed a National Safe Schools Framework to help schools and their communities tackle bullying and violence, among other issues. Jurisdictions report on their strategies and efforts to provide safe, supportive learning environments through the annual *National report on schooling in Australia* (MCEETYA 2008c, and earlier years).

HOW TO MEASURE BULLYING IN SCHOOLS

There are a number of important aspects to consider when measuring bullying, including the severity (type of bullying and frequency) and the effect that bullying has on the child, which may vary depending on children's resilience.

A widely used instrument to measure bullying behaviours in school-aged children is the Olweus Bully/Victim Questionnaire. This questionnaire measures bully and victim problems such as exposure to various physical, verbal, indirect, racial or sexual forms of bullying; various forms of bullying other students; where the bullying occurs; pro-bully and pro-victim attitudes; the extent to which the social environment (teachers, peers, parents) is informed about and reacts to the bullying; victims' experiences and feelings of acceptance by classmates, negative self-evaluations and depressive tendencies (Jimerson & Furlong 2006; Olweus 1996).

Rigby and Slee (1993) used the Peer Relations Questionnaire to estimate the prevalence of bullying in schools and to determine how children feel about bullying, how they typically react towards bullying in terms of the frequency or intensity of the bullying, and what they are prepared to do about it. Information was also collected on how children are affected by bullying depending on the child's resilience.

The Strengths and Difficulties Questionnaire collects information about children's risk of developing a clinically significant behavioural problem (Goodman 2001). This questionnaire has been widely used within Australia and has good reliability and validity. The questionnaire collects information from parents on whether their child (aged 4–12 years) was 'picked on' or bullied by other children or young people. However, it does not incorporate questions on the severity, regularity or effects of bullying.

HOW MANY CHILDREN ARE BULLIED IN AUSTRALIAN SCHOOLS?

Key national indicator: Under development

There is currently no indicator or national data source available for school relationships and bullying, due to definition and measurement difficulties. Further consultation and research are required in order to identify the most appropriate tool to use in measuring and collecting information on relationships and bullying in the Australian school context.

Victorian data from the Strengths and Difficulties Questionnaire are presented here in the interim. According to the 2006 Victorian Child Health and Wellbeing Survey, around 24% of parents reported that it was either certainly or somewhat true that their child was bullied (Vic DHS 2006).

34 Child abuse and neglect

Abuse and neglect victims may experience lower social competence, poor school performance, impaired language ability, and are at increased risk of criminal offending and mental health problems.

In 2007–08, there were 7.4 child protection substantiations per 1,000 children aged 0–12 years. Indigenous children were over-represented at 8 times the rate of other children.

There is a demonstrated relationship between the health and wellbeing of children and the environment in which they grow up. Children who are raised in supportive, nurturing environments are more likely to have better social, behavioural and health outcomes (McCain & Mustard 2002; Stanley et al. 2003). The reverse is also true: children who have been abused or neglected emotionally or physically often have poor social, behavioural and health outcomes immediately and later in life. Abuse and neglect victims may experience lower social competence, poor school performance and impaired language ability, a higher likelihood of criminal offending, and mental health issues such as eating disorders, substance abuse and depression (Chartier et al. 2007; Gardner 2008; Zolotor et al. 1999). The short- and long-term consequences of abuse may be related to the type, severity and duration of abuse, and the context in which it occurs.

The interrelationship of multiple risk factors can create complex situations that place children at higher risk of abuse and neglect. Family stressors such as financial difficulties, limited social support, domestic violence, mental or physical disability, alcohol and substance abuse and problems with unsafe, unsanitary or uninhabitable housing all contribute to the level of risk of abuse and neglect (Layton 2003; Tennant et al. 2003; Vic DHS 2002). Many of these factors are interrelated and therefore exacerbate the problems faced by some families.

Child abuse and neglect has been endorsed by the AHMC, CDSMC and the AESOC as a Children's Headline Indicator priority area (see *Part X* for further information and state and territory data). Child abuse and neglect is also being tackled by the Australian Government through the *National framework for protecting Australia's children*. This aims to increase coordination between governments and non-government organisations, with a focus on improving child protection through prevention, early intervention and best practice strategies (FaHCSIA 2008a).

MEASURING CHILD ABUSE AND NEGLECT

There are no reliable data on the prevalence of child abuse and neglect in Australia, mainly due to the difficulties in defining measures and collecting data. Available data relate to situations where children have come to the attention of child protection authorities, but these cases are an unknown proportion of all abuse and neglect cases in the community.

In Australia, child protection is the responsibility of the state and territory governments. The AIHW collects and reports national data on child protection notifications, investigations and substantiations; children on care and protection orders; and children in out-of-home care, for children aged 0–17 years (Box 34.1). Child protection data are reported annually (see AIHW 2009c and earlier issues).

While the broad processes in state and territory child protection systems are similar, child protection legislation, policies and practices vary. Variations between jurisdictions in recorded cases of abuse or neglect may reflect these differences in each jurisdiction, rather than a true variation in the levels of child abuse and neglect (see Bromfield & Higgins 2005). Trend data must also be interpreted with caution, as increases over time may reflect more children requiring a child protection response, but are more likely to be the result of increased community awareness or changes to policies, practices and data reporting methods. These differences should be noted when interpreting child protection data across jurisdictions and over time.

Box 34.1: Definitions of notification, investigation and substantiation

*A child protection **notification** is an allegation of child abuse or neglect, child maltreatment or harm to a child that is made to an authorised department. Notifications can be made by persons or organisations, for example, a concerned relative, friend or neighbour, teacher or school, police, or health professional.*

***Investigation** is the process of obtaining more detailed information about a child who is the subject of a notification, and the assessment of the degree of harm or risk of harm to the child. A finalised investigation refers to an investigation where an outcome has been reached; that is, the notification is substantiated or not substantiated.*

***Substantiation** refers to the conclusion, after investigation, that a child has been, is being or is likely to be abused or neglected or otherwise harmed. An appropriate level of continued involvement by the state or territory child protection and support services would then be made. This generally includes the provision of support services to the child and family. In situations where further intervention is required the child may be placed on a **care and protection order** or in **out-of-home care**.*

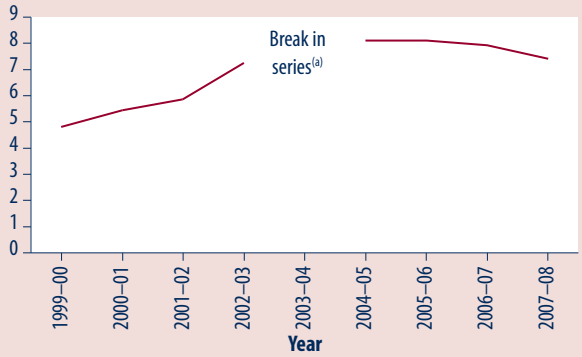
Source: AIHW 2009c.

CHILD PROTECTION SUBSTANTIATIONS

Headline Indicator: Children aged 0–12 years who were the subject of a substantiation of a notification received in 2007–08

Nationally, among children aged 0–12 years:

- Around 26,200 children were the subject of one or more substantiations of a notification received in 2007–08—a rate of 7.4 per 1,000 children.
- Between 1999–00 and 2004–05 the substantiation rate increased by 59% (Figure 34.1), before levelling off and then declining from 2005–06 to 2007–08.
- Substantiation rates were highest for infants (16 per 1,000 children)—at least twice the rate recorded for older children (7.5 per 1,000 for 1–4 year olds, 6.5 and 5.8 per 1,000 for 5–9 and 10–12 year olds, respectively). This is partly due to an increased focus on early intervention for infants, as infants are recognised as requiring extra care and protection.
- The main type of abuse reported was emotional abuse, reported in 39% of substantiations, followed by neglect (28%), physical abuse (24%) and sexual abuse (9%).



(a) In 2003–04, New South Wales was unable to provide data due to the implementation of a new data system. Because New South Wales accounts for the largest number of substantiations, a national rate cannot be calculated for this year.

Note: Trend data must be interpreted with caution as changes over time may reflect changes in community awareness regarding abuse and neglect and/or changes to jurisdictional policies, practices and reporting methods.

Source: AIHW National Child Protection Data Collection.

Figure 34.1: Children aged 0–12 years who were the subject of a substantiation of a child protection notification received in a given year, 1999–2000 to 2007–08

CARE AND PROTECTION ORDERS

If a child has been the subject of a child protection substantiation, there is often a need for state and territory child protection and support services to have continued involvement with the family. The relevant department generally attempts to protect the child through the provision of appropriate support services to the child and family. In situations where further intervention is required, the department may apply to the relevant court to place the child on a care and protection order. Recourse to the court is usually a last resort—for example, where supervision and counselling are resisted by the family, where other avenues for resolution of the situation have been exhausted, or where removal of the child to out-of-home care needs legal authorisation. Not all applications for an order will be granted. Data on care and protection orders may also include legal processes other than formal legal orders, such as administrative arrangements or care applications, which relate to the care and protection of

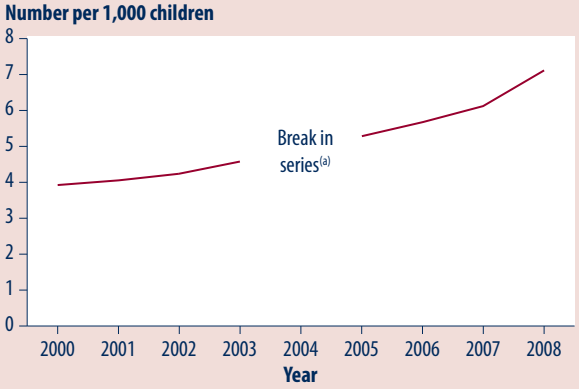
children. Children may be placed on care and protection orders for reasons other than abuse and neglect—for example, in situations where the parents are deceased, ill or otherwise unable to care for the child, or where there is an irreversible breakdown in the child–parent relationship.

Key national indicator: Rate of children aged 0–12 years who are the subject of care and protection orders

Among children aged 0–12 years in 2008:

- Around 25,000 children were on care and protection orders (7.1 orders per 1,000 children), an 88% increase since 2000, when the rate was 3.9 per 1,000 children (Figure 34.2).
- Infants were less likely to be on a care and protection order than older children (4.2 orders per 1,000 infants compared with 7 for older children).

The increase in the number of children on care and protection orders partly reflects the increasing number of families that are considered unable to adequately care for children, but may also be due to changing community standards in relation to child safety. Some of the increase may also be a flow-on effect from the greater number of cases substantiated over the last 5 years and the accumulation of children in the system as children remain on orders for longer periods of time. The increased duration of care and protection orders reflects the increasing complexity of family situations faced by these children (Layton 2003; Tennant et al. 2003; Vic DHS 2002).



(a) In 2004 New South Wales was unable to provide data due to the implementation of a new data system. Because NSW accounts for the largest number of care and protection orders, a national rate cannot be calculated for this year.

Source: AIHW National Child Protection Data Collection.

Figure 34.2: Children aged 0–12 years on care and protection orders at 30 June, 2000–2008

Are rates of child abuse and neglect different for Aboriginal and Torres Strait Island children?

Aboriginal and Torres Strait Islander children are over-represented in the child protection system. Indigenous 0–12 year olds were the subject of a substantiation of a notification received in 2007–08 at 8 times the rate of other children, and were also on care and protection orders at 8 times the rate of other children. See *Part IX* for further information.

35 Children as victims of violence

Physical and sexual assault can have a range of short- and long-term negative effects on the physical and psychological health of children, and increases the risk of later victimising others.

In 2003, there were 12,400 reported victims of physical assault and 7,500 reported victims of sexual assault among children, with three-quarters of sexual assault victims being girls.

Being a victim of violence can be detrimental to a child's health, sense of safety and security, and their feelings about the future. For some children, being victimised may lead to diminished educational attainment and social participation in early adulthood, or result in physical injury, suicidal ideation and behaviour, depression, disability and even death (Arboleda-Florez & Wade 2001; Macmillan & Hagan 2004; Simon et al. 2002). Experience of violence is central to issues of community safety in general, and even more so for children—the most vulnerable members of society.

For many children, their personal experience of violence is as victims of child abuse. Physical and sexual assault can have complex short- and long-term negative effects on the physical and psychological health of children. In particular, a history of child sexual abuse has been associated with psychopathology, depression, anxiety disorder, phobias, panic disorder, post-traumatic stress disorder, substance abuse, and violent and sexual offending later in life (Lee & Hoaken 2007; Molnar et al. 2001; Rick & Douglas 2007). Of major concern is that children who are victimised are at greater risk of perpetrating violence, and international approaches to crime prevention are increasingly recognising the strong links between youth victimisation and offending (see *Chapter 37 Children and crime*). Young victims of violent crime are also more likely than other young people to become victims of violent crime in adulthood (AIC: Johnson 2005).

Australian data show that children are sometimes victims of extreme violence and are particularly vulnerable to certain types of violence. In 2006–07, 27 children aged under 15 years died as the result of homicide (Dearden & Jones 2008, see also *Chapter 32 Injuries*) and in 2003, 41% of all reported sexual assault victims were aged 0–14 years (ABS 2004d).

Obtaining an accurate count of the number of children who are victims of violence is difficult. Many victims are reluctant to report crimes to the police and therefore the actual level of crime experienced by children is likely to be underestimated. Children, in particular, may feel intimidated and reluctant to report personal crimes if the perpetrator is known to them or is in a position of power (for example, they may be older or an authority figure).

CHILDREN AS VICTIMS OF PHYSICAL AND SEXUAL ASSAULT

The two main sources of information on the criminal victimisation of children are administrative data sets: recorded crime statistics and substantiations of child abuse (see *Chapter 34 Child abuse and neglect*). Since 1993, the ABS has published recorded crime statistics reported to police in each state and territory, according to standard offence categories, and the data for this chapter are based on this data collection. Note that alleged offences may be later withdrawn or not be substantiated, and that many incidents are not reported to the police. Data are from 2003—more recent data are not available.

Victimisation rates from administrative data sources tend to be significantly lower than those based on survey data, as many people do not report crimes to the police. There is currently no national source of information on crimes against children under 15 years of age that are not reported to police or child protection services.

Key national indicator: Rate of children 0–14 years who have been the victim of physical or sexual assault

In 2003, physical assault was the most commonly reported crime against children:

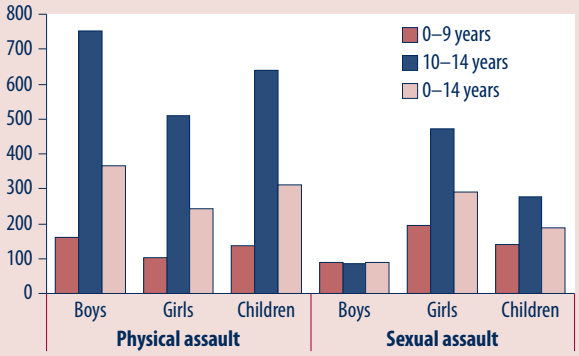
- A reported 12,400 children aged 0–14 years were victims of physical assault—a rate of 309 victims per 100,000 children.
- Children aged 10–14 years were physically assaulted at more than 4 times the rate of children aged 0–9 years.
- Rates were 50% higher among boys than girls (367 per 100,000 compared with 244) (Figure 35.1).

In the same year, around 7,500 children aged 0–14 years, or 187 in every 100,000 children, were the reported victims of sexual assault:

- Sexual assault rates were higher for children aged 10–14 years than for children aged 0–9 years (277 and 142 per 100,000 children, respectively), and three-quarters of reported victims were girls. Rates of reported sexual assault were higher for older girls (aged 10–14 years) than for 0–9 year old girls (more than twice as high), but rates for boys were similar for both age groups (Figure 35.1).

For boys, reported rates of physical assault were much higher than for sexual assault (367 per 100,000 boys and 89, respectively); however, for girls this pattern was reversed (244 per 100,000 girls and 291, respectively).

Children aged 0–14 years were less likely to have been reported victims of physical assault than those aged 15 years and over (309 in every 100,000 compared with 920). However, they were more likely to have been the reported victim of sexual assault (187 in every 100,000 compared with 68) (ABS 2004c).



Source: ABS 2004c.

Figure 35.1: Victims of physical and sexual assault by age and sex, 2003

Do rates of reported physical and sexual assault vary across population groups?

There are no national data on how rates of reported physical and sexual assault vary across population groups. There is limited evidence suggesting that child sexual assault is more prevalent in rural and remote areas than in urban areas (Neame & Heenan 2004) and is associated with social disadvantage (Fleming et al. 1999). Information available from New South Wales and the AIHW National Child Protection Data Collection indicate that Aboriginal and Torres Strait Islander children are over-represented among victims of physical and sexual assault. See *Part IX* for further information.

36 Homelessness

Children who are homeless experience high rates of mental health and behavioural disorders and are socially isolated.

Around 64,800 children, or 16 out of every 1,000 Australian children, accompanied a parent or guardian to a SAAP agency in 2006–07. These children were either homeless or at risk of becoming homeless.

Children who are homeless, whether as part of a family unit or on their own, experience significant negative social and health consequences. Homelessness affects children in a variety of ways. Babies and toddlers may experience delays in physical and mental development (Horn & Jordan 2007), while older children experience high levels of stress, anxiety, loss and grief; have difficulties attending school and making friends; and are socially isolated (Moore et al. 2007). Children who are homeless experience high rates of mental health problems and behavioural disorders during periods of homelessness (Karim et al. 2006; Yu et al. 2008), and the instability and insecurity of temporary housing further contributes to fear and distress (Moore et al. 2007). The effects of homelessness often persist beyond the period of homelessness (Karim et al. 2006; Moore et al. 2007). Parents in homeless families are also likely to be suffering from depression or stress, which may mean they are unable to give their children adequate attention or affection.

The causes of homelessness are complex and may include economic factors such as poverty, unemployment or increased housing costs. Other circumstances, such as an unstable home environment caused by domestic violence, can also lead an individual to experience homelessness (Toro 2007). Factors that may lead to homelessness among children include family problems such as neglect, abuse and conflict, as well as drug and alcohol problems (Martijn & Sharpe 2006; Thrane et al. 2006). Reducing homelessness is a priority for the Australian government, and in 2008 the Australian, state and territory governments set the goal of halving overall homelessness by 2020 (FaHCSIA 2008b).

The largest government response to homelessness in Australia is the Supported Accommodation Assistance Program (SAAP), which is a joint Commonwealth and state/territory government initiative designed to help people who are homeless or at risk of becoming homeless. The Program funds non-government, community and local government agencies to provide accommodation and support services to a range of groups, including families and children (AIHW 2008h). Children and young people may access SAAP services individually or they may accompany a parent or guardian to a SAAP agency. Information on people seeking assistance from SAAP and the services provided by SAAP agencies are collected and collated by the AIHW. See *Appendix 2* for further information on the SAAP Data Collection.

HOW MANY CHILDREN ARE HOMELESS?

There are two main data sources that provide a national picture of the number of homeless children in Australia: the Counting the Homeless project and the SAAP data collection. However, obtaining an accurate count of the homeless population is difficult as some people move in and out of homelessness and may never be counted in official statistics, while some may never seek SAAP assistance or are turned away from SAAP services.

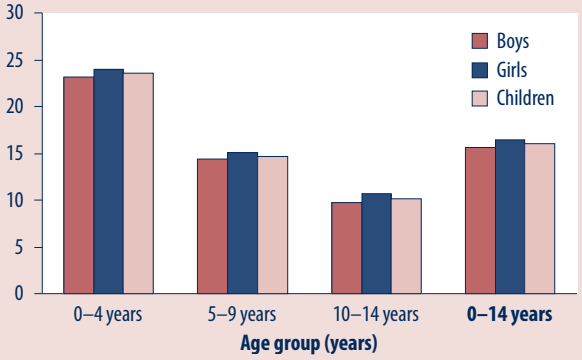
The Counting the Homeless project uses data primarily from the ABS Census of Population and Housing to estimate the number of homeless people in Australia on Census night (ABS 2008c). In 2006, an estimated 105,000 Australians were homeless, equating to 75,000 homeless households. Of these, one in ten, or 7,500 families, were homeless families with children, equating to 16,000 children. Homeless families with children accounted for one-quarter (26%) of the homeless population. In 2006, there were around 12,000 homeless children under 12, accounting for 12% of the homeless population (up from 10% in 2001).

More detailed information is available on those who accessed SAAP services, including why they sought assistance, the types of support required, how long they were supported and their circumstances before and after support. However, the number of SAAP clients and accompanying children is not equivalent to the number of homeless people as the count from the SAAP data collection excludes those who did not approach or were turned away from a SAAP service, and includes some people who were at risk of homelessness (that is, they were not homeless at the time a SAAP agency initially provided support).

Key national indicator: Rate of accompanying children aged 0–14 years attending agencies funded under the Supported Accommodation Assistance Program

In 2006–07, among children aged 0–14 years:

- Around 64,800 children, or 16 out of every 1,000 Australian children, accompanied a parent or guardian to a SAAP agency (Figure 36.1).
- Younger children were more likely to have accompanied their parent or guardian to a SAAP agency; there were 24 accompanying children per 1,000 children aged 0–4 years, declining to 15 and 10 for 5–9 year olds and 10–14 year olds, respectively.
- The majority of children accompanied their mother or a female guardian to a SAAP agency (in 86% of accompanying child support periods), in 10% they accompanied a couple and in 4% they accompanied their father or a male guardian.



Source: AIHW 2008h.

Figure 36.1: SAAP accompanying children, by age and sex, 2006–07

Clients with accompanying children aged 0–14 years most often gave domestic or family violence as the main reason for seeking SAAP assistance (in 48% of their support periods). Eviction or being asked to leave was the next most frequently reported main reason (in 9%), followed by relationship or family breakdown (8%) and time out from family or other situation (5%).

Unmet demand for SAAP accommodation

Families (couples or individuals with children) who required immediate SAAP accommodation were more likely to have been turned away from a SAAP agency than people presenting alone during the 2006–07 Demand for SAAP Accommodation collection. Around 69% of couples with children (29 people per day), and 64% of individuals with children (185 people per day) who required immediate accommodation were unable to get it. The comparable turn away rate was 49% for individuals without children (146 people per day) (AIHW 2008d).

Families may have had higher turn away rates than individuals because, once accommodated, family groups tended to stay longer in SAAP accommodation. In 2006–07, couples with children and individuals with children had average stays in SAAP accommodation of 144 days and 68 days, respectively, while individuals without children had a relatively short average stay of 40 days. As families typically stayed longer in SAAP accommodation, fewer places would become available in agencies targeting family groups on any given day, and fewer families requiring new accommodation would gain access.

Do rates of homelessness vary across population groups?

Aboriginal and Torres Strait Islander children

Indigenous Australians were over-represented in the Counting the Homeless project. Although the number of homeless Indigenous children was not presented, 9% of the homeless population were Indigenous, considerably higher than the 2% of the Australian population (ABS 2008e).

Indigenous accompanying children aged 0–14 years were over-represented in SAAP relative to their proportion in the Australian population in 2006–07:

- Around 27% of accompanying children were Indigenous, which was greater than the 5% of the Australian population aged 0–14 years who were Indigenous.
- The rate of Indigenous children accompanying their parent or guardian to a SAAP agency was 7 times that for non-Indigenous children (87 per 1,000 children compared with 12).

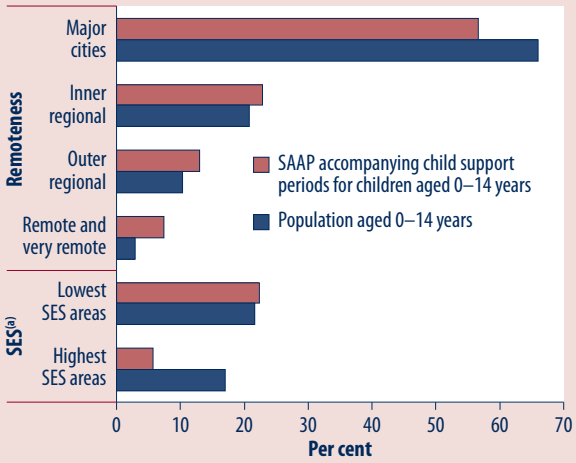
See *Part IX* for further information on Indigenous children experiencing homelessness.

Remoteness and socioeconomic status

SAAP agencies can be assigned to a remoteness and socioeconomic status category based on the mailing address of the agency. However, it is important to note that this may not match the actual location of the agency or be in the area where the client usually lives.

In 2006–07, among children aged 0–14 years:

- The majority of accompanying child support periods were provided by SAAP agencies located in *Major cities* (57%). Agencies located in the more remote regions provided smaller proportions, ranging from 23% in *Inner regional* areas to 7% in *Remote and very remote* areas (Figure 36.2).
- While 57% of accompanying child support periods were provided in *Major cities*, 66% of children lived there. The reverse was seen for the other regions, where the proportion of accompanying child support periods provided was greater than the proportion of children who lived there.
- Almost one-quarter (22%) of accompanying child support periods were provided by SAAP agencies located in the lowest socioeconomic status (SES) areas, which was in line with the proportion of children who were living in these areas in 2006 (22%). A much smaller proportion of accompanying child support periods were provided by SAAP agencies located in the highest SES areas (6%); lower than the 17% of children in the general population who lived in these areas.



(a) See *Appendix 1 Methods* for explanation of socioeconomic status (SES).

Note: SAAP agencies are assigned to a remoteness and socioeconomic status category based on the mailing address of the agency, and this may not match the actual location of the agency.

Source: AIHW National SAAP Data Collection.

Figure 36.2: SAAP accompanying child support periods and the child population, by remoteness and socioeconomic status, 2006–07

37 Children and crime

Children in the criminal justice system represent a particularly disadvantaged population and are vulnerable to continued and more serious offending later in life.

In 2006–07, there were 2,337, or 1.7 in every 1,000, children aged 10–14 years were under juvenile justice supervision at some time during the year. Indigenous children were over-represented at 24 times the rate of other children.

During childhood, some children will have an encounter with the juvenile justice system. For most children engaged in criminal activities, the nature of the offence is relatively minor and the behaviour is short-lived. However, for a small number of children this becomes more serious or persistent and results in a juvenile justice supervision order, such as probation or sentenced detention. It is these children who are most vulnerable to continued and more serious offending later in life (Makkai & Payne 2003). Children whose first juvenile justice supervision order occurs before the age of 15 comprise around 40% of all young people under juvenile justice supervision (AIHW 2008i). They represent a particularly disadvantaged and high-risk group of the Australian population, characterised by high levels of socioeconomic stress, low levels of educational attainment, significant physical and mental health needs, and a history of drug and alcohol abuse, physical abuse and childhood neglect (Kenny et al. 2006; NSW Department of Juvenile Justice 2003; Prichard & Payne 2005; Stewart et al. 2002). Childhood neglect is considered one of the strongest predictors of later youth offending.

The juvenile justice system is responsible for children and young people who have committed or allegedly committed a crime. In all states and territories of Australia, 10 years is the youngest age at which a child may enter the juvenile justice system, as children under the age of 10 cannot be charged with a criminal offence. Juvenile justice involves several organisations, each having different roles and responsibilities in dealing with young offenders: the police, who apprehend children who have allegedly committed an offence; the courts, where matters regarding the charges are heard; and the juvenile justice departments, which are responsible for supervising children on community-based and detention orders. A major feature of the juvenile justice system is the diversion of children from the formal system. This diversion may occur at the level of police or at the courts. If the young person is not diverted and is found guilty of the offence, the court may order the young person to serve an unsupervised sentence, a community-based supervised sentence (such as suspended detention, community service order, probation or good behaviour bond) or a detention sentence.

Children and young people under supervision, both in the community and detention, have poorer physical and mental health and a higher death rate than other young people in the population (Coffey et al. 2004; Kenny et al. 2006; NSW Department of Juvenile Justice 2003).

CHILDREN UNDER JUVENILE JUSTICE SUPERVISION

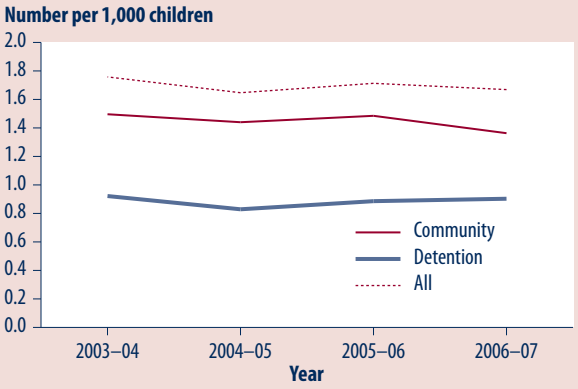
This chapter reports on children aged 10–14 years who are under juvenile justice supervision and includes both children who have been found guilty of an offence and are serving supervised sentences and children who are being supervised while awaiting trial or sentencing. Children may be supervised either in the community or in detention. Children who are supervised by other agencies, such as the police, are not included here.

Key national indicator: Rate of children aged 10–14 years who are under juvenile justice supervision

In 2006–07:

- A total of 2,337 children aged 10–14 years were under juvenile justice supervision at some time during the year—a rate of 1.7 per 1,000 children. This rate remained relatively stable between 2003–04 and 2006–07 (Figure 37.1).

- Four-fifths (80%) of children who were under supervision had community-based supervision and over half were in detention during the year—that is, over one-third experienced both community-based supervision and detention at some time during the year.
- The majority of children under supervision were boys—only one in five (20%) supervisions were girls.
- Most (60%) children under supervision were aged 14 years and only 5% were aged 10 or 11 years.



Source: AIHW Juvenile Justice National Minimum Data Set.

Figure 37.1: Children aged 10–14 years under juvenile justice supervision by type of supervision, 2003–04 to 2006–07

Currently there are no national data on the types of offences for which children are under supervision. National data on the cases finalised in the Children's Courts during 2006–07 (ABS 2008f) showed that the most common principal offence types for those who were given a principal sentence of detention or community-based supervision (such as home detention, suspended detention, community service orders or probation) were:

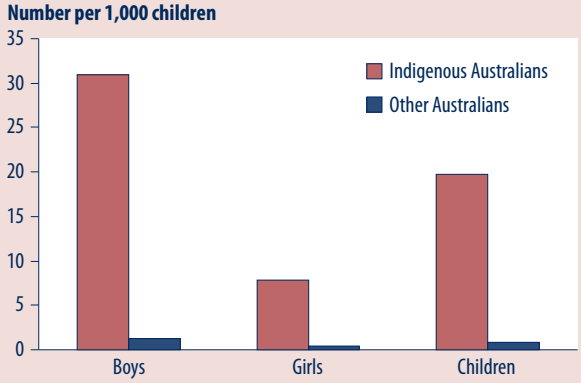
- unlawful entry with intent (32% and 24% of finalised cases resulting in detention or community-based supervision sentences, respectively)
- acts intended to cause injury (26% and 23%, respectively)
- theft and related offences (13% and 16%, respectively)
- robbery, extortion and related offences (14% of finalised cases resulting in detention sentences) and property damage and environmental pollution (8% of finalised cases resulting in community-based supervision sentences).

These data are only an indication of the types of offences for which children may be under juvenile justice supervision. Firstly, children may have been found guilty for other offences in addition to the principal offence reported above; secondly, the cases for some children in supervision may have been finalised before 2006–07; and thirdly, some children may not yet have had their case finalised.

Are rates of juvenile justice supervision different for Aboriginal and Torres Strait Island children?

Indigenous children aged 10–14 years were over-represented in juvenile justice supervision, accounting for more than half of all children under supervision in 2006–07. Indigenous children were 24 times as likely to have been under juvenile supervision at some time during the year as other Australian children (24 and 21 times for Indigenous boys and girls, respectively) (Figure 37.2).

See *Part IX* for further information on Indigenous children under juvenile justice supervision.



Note: Other Australians includes children with unknown Indigenous status.
Source: AIHW Juvenile Justice National Minimum Data Set.

Figure 37.2: Children aged 10–14 years in juvenile justice supervision, by sex and Indigenous status, 2006–07

Risk factors for youth offending

National data on the risk factors that may lead to youth offending are not available. However, surveys of young people in detention and under community-based supervision in New South Wales (Kenny et al. 2006; Weatherburn et al. 1997) have found that:

- Nearly half of those in detention and one-quarter of those under community-based supervision had parents who had been imprisoned.

- Eleven per cent of those in detention and 5% of those under community-based supervision had a parent currently incarcerated.
- Between 30% and 40% of those in detention or under community-based supervision had experienced physical abuse, 11–14% had experienced sexual abuse and between one-third and one-half had experienced neglect.
- There were low levels of intellectual performance and educational attainment.
- Levels of mental illness were very high.

Social and economic stress, such as poverty, unemployment, one-parent families, residential instability and crowded dwellings, has also been linked with juvenile participation in crime (Weatherburn et al. 1997).

How does Australia perform internationally on crime indicators?

Limited data are available on the number of young people under juvenile justice supervision internationally. Available data for the number of children aged 10–14 years in juvenile detention on an average day during 2006–07 show that:

- Children in Australia were around twice as likely to be detained as children in England and Wales (Table 37.1).
- Children in the United States were 5 times as likely to be detained as children in Australia.

Table 37.1: Children aged 10–14 years in juvenile detention on an average day, selected countries, 2006–07

	Australia	England and Wales	United States
Number	181[a]	196[b]	13,758[c]
Number per 100,000	12.9	5.9	66.8

(a) Average daily number in juvenile detention during July 2006 and June 2007.
(b) Average daily number in juvenile detention between April 2006 and March 2007.
(c) Number in juvenile detention on 22 February 2006.

Sources: AIHW 2008i; Office for National Statistics 2008; Sickmund et al. 2008; US Census Bureau Population Division 2008; Youth Justice Board 2008.