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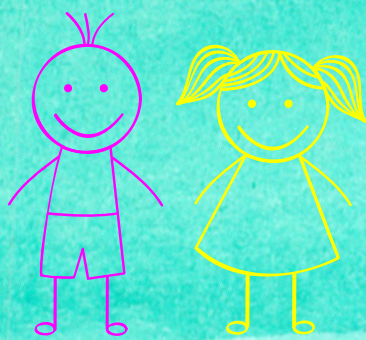
Australia's Children




welcome



Australia's children



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Summary

Summary

Childhood is an important time for healthy development and learning, and for establishing the foundation blocks of future wellbeing, but it is also a time of vulnerability. While a positive start in life helps children to reach their full potential, a poor start increases the chances of adverse outcomes for the individual, society and possibly future generations.

Australia's children examines the most recent data on children and their families across the 7 domains of the Australian Institute of Health and Welfare people-centred data model—health, education, social support, household income and finance, parental employment, housing, and justice and safety.

The report shows that most Australian children are healthy, safe and doing well, but there is scope for further gains in some areas. It also includes some data collected directly from children giving them a voice on their wellbeing.

How are Australia's children faring on national indicators?

Doing well

- Death rates among Australia's infants and children have dropped substantially. Between 1998 and 2017, infant deaths dropped from 5.0 to 3.3 deaths per 1,000 live births. Child deaths halved from 20 to 10 deaths per 100,000 children.
- Less mothers are smoking during the first 20 weeks of pregnancy. Between 2011 and 2017, the proportion of mothers smoking fell from 13% to 9.5%.
- The proportion of Year 5 students achieving at or above the national minimum standard for reading and numeracy increased between 2008 and 2018. Reading increased from 91% to 95% and numeracy from 93% to 96%.
- The rate of children aged 10–14 under youth justice supervision decreased between 2008–09 and 2017–18, from 95 to 73 per 100,000 children.

Could be better

- Around 1 in 4 children aged 5–14 are overweight or obese, with the proportion remaining relatively stable between 2007–08 (23%) and 2017–18 (24%).
- Most children (96%) aged 5–14 do not eat enough vegetables, with the proportion meeting the guidelines for vegetable consumption only increasing slightly between 2014–15 (2.9%) and 2017–18 (4.4%).
- In 2016–17, there were around 66,500 hospitalised injury cases for children aged 0–14, slightly higher than 10 years earlier. The rate was relatively stable between 2007–08 and 2016–17 (1,419 and 1,445 per 100,000, respectively).
- Around 19,400 (0.4%) of children aged 0–14 were homeless on Census night in 2016, similar to the proportion in 2006 (0.5%).

What do Australia's children say?

- Most children (91%) aged 12–13 felt safe in their neighbourhood in 2015–16.
- 1 in 5 Year 4 students experienced bullying on a weekly basis in 2015.
- Most children (94%) in years 4, 6 and 8 spent quality time doing at least one of talking, having fun or learning with their family most days in the week in 2014.
- 97% of children aged 12–13 had someone to talk to if they have a problem in 2016.
- Almost 9 in 10 children aged 12–13 would talk to their mum and/or dad if they had a problem in 2016.
- For children in years 4, 6 and 8, health ranked as the second most important domain, after family, for having a good life in 2014.



Background

Introduction

Australia's children gives a comprehensive overview of the wellbeing of children living in Australia. It brings together the latest available data on a wide range of topics and builds on previous Australian Institute for Health and Welfare (AIHW) reporting about children.

Childhood is an important time for healthy development, learning and establishing the foundation blocks of future wellbeing. It is also a time of vulnerability, during which children have the right to live in safety and be protected from harmful influences and abuse. While a positive start in life helps children to reach their full potential, a poor start increases the chances of adverse outcomes with wide and long-reaching consequences for the individual, society and potentially future generations.

Australia's children includes information on a range of topics, relevant to each of the 7 domains of the AIHW people-centred data model—health, education, social support, household income and finance, parental employment, housing and justice and safety.

The key national indicators for child health, development and wellbeing, which underpinned the report series, *A picture of Australia's children* form the basis of *Australia's children*. The [Children's Headline Indicators](#) are a subset of the key national indicators for child health, development and wellbeing. In 2006, the 19 priority areas of the Children's Headline Indicators were endorsed by 3 ministerial councils. One ministerial council focused on health, another on education, and another on community and disability services. There is scope for a comprehensive review of these areas and the indicators to ensure they reflect contemporary information needs. Established child indicators have been supplemented by emerging topics identified in the course of data gaps analyses.

Each topic area in this report outlines the importance of the subject to child wellbeing, and present data on established measures over time, and for particular priority population groups, wherever possible. International comparisons are given where available. Limitations in current national reporting, and opportunities for development, are discussed, and sources for more information are given. For topics that do not have established measures, available national data sources or sub-national data sources have been used to give some insight on the topic.

Australia's children will be updated as more recent data becomes available. A companion pdf report ([in brief](#)), gives a high-level summary of key statistics and findings from the report.

Report structure

There are 8 major parts to this report: Background, Health, Education, Social Support, Income, finance and employment, Housing, Justice and safety, and Data gaps.

Technical notes relating to each specific section of the report can be found in the online version of [Australia's children](#) at the end of the relevant section.

The online version of [Australia's children](#) also includes standalone sections on:

- [Aboriginal and Torres Strait Islander children](#)
- [Technical notes](#)
- [Data sources](#).

The importance of national reporting

Reporting on national data informs an understanding of how Australian children are faring over time, supports comparisons across different groups and internationally, and compares to support more local level reporting.

The purpose of *Australia's children* is to:

- bring together and contextualise key national statistics on child wellbeing in 1 place
- give updated data on 38 measures, not elsewhere published under other AIHW child reporting frameworks
- support a more comprehensive understanding of related data gaps.

The report's online version supports regular data updates and could, in future, present data at finer levels of disaggregation; for example, at small geographical area levels, to complement other reporting.

About this report

Children in scope for this report

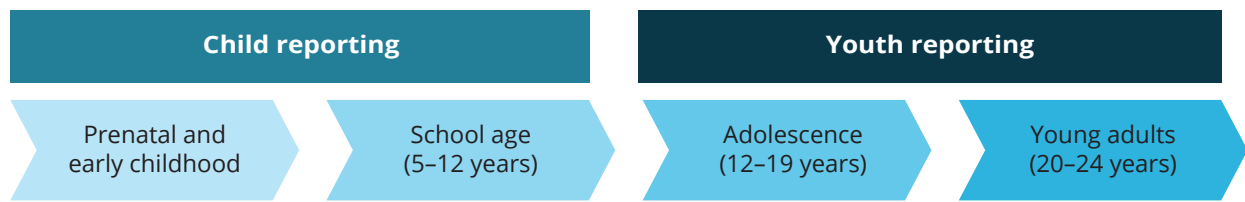
Definitions for what constitutes the age range for children vary across Australian and international data collections and reporting. Definitions can be based on theories of child development and/or levels of dependency at different stages from birth to youth, or legal definitions.

For this report, children are defined as aged 0–12, covering infancy through to the end of primary school.

The importance of the antenatal period to childhood is acknowledged and included. This age range aligns with the [Children's Headline Indicators](#), and complements the age range in the [National Youth Information Framework](#) of 12–24 year olds (noting an overlap of children and young people aged 12). Where data for 0–12 year olds are not available or the numbers are too small for robust reporting, a different age range (most commonly 0–14 years) is reported. This is especially the case for health-related data from the Australian Bureau of Statistics (ABS) and for this reason summary demographic information is also given for 0–14 years in the section [Australian children and their families](#). It is recognised that the age span covered in this report may include early adolescence. For ease of reference the term 'children' will be used.

While childhood influences adolescence and young adulthood, specific subjects relating to youth wellbeing are beyond the scope of this report. The AIHW reports separately on youth to enable more thorough reporting on those factors influencing youth development and wellbeing (Figure 1). Data on youth reporting is currently included in the data portal [National Youth Information Framework](#) and the report [Young Australians: their health and wellbeing](#). Regardless of the scope for each measure, AIHW reporting on children and youth also present data by specific 5-year age groups wherever possible.

Figure 1: Relationship between AIHW reporting on children and youth



An ecological approach to reporting about children

This report takes an ecological approach to child reporting, derived from existing frameworks used in Australia, which place child development at the centre (Victoria Department of Education and Training 2018; Tasmanian DHHS 2018). This approach recognises that positive child development occurs within dynamic concentric circles of influence exerted by different settings:

- immediate influences on the child of a confident and capable family
- direct and indirect influences of strong and supportive communities
- broader influences of the wider society in which the child lives.

The many influences on the child of these spheres can be organised into a information domains. The structure of this report draws on the 7 domains of the AIHW's people-centred data model. This model is based on social-ecological models of the determinants of health and wellbeing and was developed to measure and report on health and welfare of the general population. It has been modified for child reporting and includes 7 information domains across the health and welfare sectors: individual health, education, family social support, household income and finance, parental employment, housing, and justice and safety. The impact of the interrelationship of the domains in the context of children's development and wellbeing is highlighted in Figure 2.

Figure 2: AIHW people-centred data model and an ecological approach to child development



Priority population groups

The AIHW's people-centred data model approach supports reporting on population groups that are especially vulnerable and often in greater need of health and welfare services and support. Many inequities that start early in childhood, persist into adulthood and can be passed on to the next generation (RACGP 2018).

For children, a number of priority population groups have been identified. These include children:

- from Aboriginal and Torres Strait Islander backgrounds
- from culturally and linguistically diverse backgrounds, including children of refugee and asylum seeker families
- with disability
- who identify as lesbian, gay, bisexual, trans and gender diverse, or children who have intersex variations
- living in out of home care
- who are incarcerated
- with parents in the youth justice system
- born into poverty
- experiencing socioeconomic disadvantage
- living in rural and remote communities (AHRC 2017; RACGP 2018).

To assist in identifying inequity, the report aims to present data for each domain disaggregated by children described in these priority population groups, wherever possible. However, due to current data availability, reporting has generally been limited to children:

- from Aboriginal and Torres Strait Islander backgrounds
- from culturally and linguistically diverse backgrounds or born overseas
- living in different geographical areas (remoteness)
- living in areas with different socioeconomic characteristics.

While some Indigenous Australians experience little or no disadvantage, other Indigenous Australians are highly disadvantaged (SCRGSP 2016). A significant amount of evidence suggests that disadvantage among Indigenous Australians has deeper underlying causes, including 'intergenerational trauma' resulting from the effects of:

- colonisation
- loss of land, language and culture
- forced removal of children
- racism
- discrimination (SCRGSP 2016; AIHW 2018).

Members of the Stolen Generations (people forcibly removed from their families as a result of government policies across Australian jurisdictions) are recognised as experiencing worse outcomes in a range of areas, including health, socioeconomic, justice and housing, compared with Indigenous people not removed from their families (AIHW 2018). Indigenous children living in households with members of the Stolen Generations are also more likely to experience adverse outcomes than other

Indigenous children (AIHW 2019a). These historical factors are important for interpreting the data given about Indigenous children throughout this report.

While disadvantage among Indigenous children can vary by geography and other socioeconomic factors, reporting on these additional dimensions is beyond the scope of this report.

Data are included on children living in areas of low socioeconomic status for each section, using the Index of Relative Socio-Economic Disadvantage (see [Technical notes](#) in the online report). It should be noted that children experiencing economic disadvantage may also experience social exclusion.

This report includes some overarching information on children with disability, children living in out-of-home care, and children involved with the justice system; however, additional data on these groups from other sources is limited.

Reporting data for different groups is important for high-level national reporting; however, as each sub-group is reported separately, insight on the multiple disadvantage that children may experience is not given. For example, children living in out-of-home care can also experience relatively high social and economic disadvantage (Royal Commission into Institutional Responses to Child Sexual Abuse 2017). A wide range of other factors, such as biological, developmental and environmental, can impact a child's vulnerability and potential need for services and support.

National reporting on child wellbeing

Responsibility at the national level for services and/or policies to support core elements of child wellbeing—health, development, learning and safety—cuts across different sectors. It also cuts across different government departments:

- Health
- Social Services
- Education and Training
- Prime Minister and Cabinet, which since January 2019 includes the National Office for Child Safety.

As a result of the shared responsibility for child health and wellbeing, national reporting frameworks have been developed by different government departments as well as non-government agencies to support decision making. Some reporting frameworks are child-specific and broad in scope while others focus on an aspect of child wellbeing (for example, child safety). Others cover whole-of-population, or specific population groups (for example, Indigenous children) and include indicators relevant to children and/or disaggregate for children.

Figure 3 categorises the reporting frameworks as:

- general child frameworks (holistic in nature)
- subject-specific child frameworks
- whole-of-population frameworks
- Indigenous frameworks.

For information on policies and/or strategies, and national royal commissions on specific subject areas, see the introduction of the relevant domain:

- Health
- Education
- Social support
- Income, finance and employment
- Housing
- Justice and safety

Figure 3: National frameworks that report on children

<p>General child frameworks</p> <p>Government</p> <p>Key national indicators for child health, development and wellbeing (A picture of Australia’s children and Australia’s children) Children’s Headline Indicators</p> <p>Non-government</p> <p>ARACY’s Report Card: the wellbeing of young Australians</p>	<p>Whole population and sector specific</p> <p>Health</p> <p>Australian Health Performance Framework^(a) National Healthcare Agreement National Strategic Framework for Chronic Conditions^(b)</p> <p>Welfare</p> <p>The Australia’s Welfare Indicator Framework National Disability Agreement National Housing and Homelessness Agreement^(c)</p>
<p>National Child Reporting</p>	
<p>Child and sector specific</p> <p>Health</p> <p>National Action Plan for Health of Children and Young People 2020–2030: Healthy, Safe and Thriving Framework (<i>currently no reporting</i>) Core maternity indicators</p> <p>Safety</p> <p>National Framework for Protecting Australia’s Children National Standards for Out-Of-Home Care</p> <p>Education</p> <p>National Schools Reform Agreement</p>	<p>Aboriginal and Torres Strait Islander People</p> <p>Aboriginal and Torres Strait Islander Health Performance Framework Aboriginal and Torres Strait Islander Health Plan: Implementation Plan goals National Indigenous Reform Agreement National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families</p>

(a) The Australian Health Performance Framework subsumes The National Health Performance Framework and the Performance and Accountability Framework. A core set of indicators has been agreed.

(b) Indicators for the National Strategic Framework for Chronic Conditions are being finalised.

(c) Indicators for the National Housing and Homelessness Agreement and any disaggregation for children are being finalised.

Some variation exists across the frameworks in relation to the:

- breadth and depth of domain subjects covered
- age range reported
- disaggregation of data for specific populations
- frequency of reporting (Table 1).

Table 1: Domain commonalities across national reporting frameworks

Framework	Age in years	Disaggregations	Reporting frequency
Key national indicators of child health, development and wellbeing (Australia's children)	0-12	Age, gender, Indigenous, CALD, Remoteness, SES, some international	4-yearly to 2012
Children's Headline Indicators	0-12	State/territory AND age, gender, Indigenous, CALD, Remoteness, SES	Annual to 2017
Key national indicators of youth health, and wellbeing (National Youth Information Framework indicators)	12-24	Age, gender, Indigenous status, CALD, Remoteness, SES, some international	4-yearly to 2015
ARACY Report Card	0-24	Indigenous, International	5-yearly
National Framework for Protecting Australia's children	0-17	Age, gender, Indigenous, CALD (for some indicators)	Annual
National Standards for Out-of-Home Care	0-17	TBC	Annual
National core maternity indicators	Mothers and babies	Indigenous, CALD, SES, Remoteness	Annual
Australian Health Performance Framework	Whole population	TBA	2-yearly
Australia's Welfare Indicator Framework	Whole population	Varying child ages	2-yearly
National intergovernmental agreements	Whole population/ students	Varying child ages	Annual
Aboriginal and Torres Strait Islander Health Performance Framework	Whole population	Varying child ages	2-yearly
Aboriginal and Torres Strait Islander Health Plan: Implementation Plan goals	Whole population	Varying child ages	Annual

Abbreviations: ARACY (Australian Research Alliance for Children and Youth); CALD (Culturally and linguistically diverse); SES (Socio-economic status).

Variation also exists in the topics covered in each domain of the frameworks (not included here) which reflects their different purposes.

Of the 7 domains in the AIHW people-centred data model, the Health domain has the highest number of established measures across the various frameworks while the Household income and finance, and Parental employment domains have the fewest (Table 2).

The maturity of indicators available for reporting also impacts the breadth of topics covered in each domain in this report. Well-established indicators are used to describe most existing topics in the domains of Health, Education, and Household income and finance. Relatively less-established indicators are used to describe several topics in Family social support, and Justice and safety, especially for children outside the child protection population.

While there is growing interest in Australia and internationally in developing positive indicators for child wellbeing, some national well-established indicators presented in this report have a deficit, rather than strengths-based focus.



Table 2: Established measures under national reporting frameworks

Framework	Domain						
	Health	Family social support	Justice and safety	Housing	Education and skills	Income and finance	Parental employment
Key national indicators of child health, development and wellbeing (Australia's children)	✓	✓	✓	✓	✓	✓	
Children's Headline Indicators	✓	✓	✓	✓	✓	✓	
Key national indicators of youth health, and wellbeing (National Youth Information Framework indicators)	✓	✓	✓	✓	✓	✓	✓
ARACY Report Card	✓	✓	✓	✓	✓	✓	✓
National Framework for Protecting Australia's children	✓	✓	✓	✓	✓	✓	
National Standards for Out-of-Home Care		✓	✓		✓		
National core maternity indicators	✓						
Australian Health Performance Framework	✓						
Australia's Welfare Indicator Framework	✓	✓	✓	✓	✓	✓	✓
National intergovernmental agreements	NHA NDA NIRA			NHHA	NSRA NIRA		
Aboriginal and Torres Strait Islander Health Performance Framework	✓	✓	✓	✓	✓		
Aboriginal and Torres Strait Islander Health Plan: Implementation Plan goals	✓						

Abbreviations: ARACY (Australian Research Alliance for Children and Youth); NHHA (National Housing and Homelessness Agreement); NSRA (National Schools Reform Agreement); NYIF (National Youth Information Framework).

Children's perspective of wellbeing

How children view their own wellbeing (subjective, or self-reported wellbeing) is important (Box 1).

Box 1: Measuring wellbeing

Wellbeing is defined as a state of health, happiness and contentment (AIHW 2018). What this actually includes has been widely contested over the years; however, recent years have seen growing support for a comprehensive view of wellbeing that includes components of both objective and subjective wellbeing (Wallace et al. 2011).

Objective wellbeing includes indicators of how well people are, or are doing, measured by national health statistics (physical and mental) and socio-economic indicators; for example household income or unemployment level (AIHW 2018; Pollard & Lee 2003).

Subjective wellbeing, on the other hand, uses self-report instruments to gather information about how well people think they are doing in all health and socio-economic aspects of their life (AIHW 2018; Deci & Ryan 2008; Pollard & Lee 2003). Subjective wellbeing is usually measured with surveys that can target 1 specific aspect of life (for example, mental health or education) or, more broadly, a person's overall life satisfaction and/or happiness (Dolan & Metcalfe 2012; Wallace et al. 2011; Stiglitz et al. 2009).

Currently, national data related to the wellbeing of children are primarily administrative and based on service delivery by-product information (that is, not self-reported by the child), or surveys administered only to adults (for example, the National Health Survey). However, several published reports give data on wellbeing from the child's perspective. These include reports published by the:

- national and jurisdictional children's commissioners and guardians
- Australian Child Wellbeing project
- AIHW—survey on children's experiences of out-of-home care experiences (AIHW 2019b)
- Longitudinal Study of Australian Children—data has recently been used to measure child deprivation and opportunity across a number of domains relevant to child wellbeing (Sollis 2019).

In recent years, Behind the News has also run 2 large-scale self-selected Kids' Happiness surveys looking at the subjective mental health and wellbeing of Australian children aged 6–18 (Box 2).

Box 2: How do Australian children rate their own wellbeing?

Approximately 47,000 Australian children aged 6–18 self-selected and completed the 2nd Behind the News Kids' Happiness Survey—93% (approximately 43,700) were aged 6–12. Some key findings for children aged 6–12 include:

- 3 out of 5 (63%) felt happy lots of the time. The things most likely to make them happy include friends (64%), family (60%), playing sport (53%) and music (50%).
- 3 out of 4 (76%) felt scared or worried at least some of the time. The things most likely to cause worry, include the future (73%), issues with friends (68%), issues with family (69%) and their health (69%).
- 71% said they talk to their parents if they have a problem and 50% said they talk to their friends.
- 1 in 4 (25%) children reported they did not talk to anyone if they have a problem.
- some children reported they did not feel safe at home (9%), at school (14%) or in their neighbourhood (24%) a lot of the time.
- 1 out of 4 (28%) reported that their device (phone, tablet, computer or video console) was stopping them from getting the right amount of sleep at least some of the time.

Source: University of Melbourne analysis of the second Australian Broadcasting Corporation Behind the News Happiness survey data.

Indigenous people define their personal health and wellbeing beyond physical health and social and emotional aspects to include spiritual and/or cultural aspects and the need for a connection to environment, community and family (Bourke et al. 2018; Boddington & Räisänen 2009; Brady et al. 1997). Culture and cultural identity are crucial components (Box 3). A number of historical factors can also impact the wellbeing of Indigenous children, including intergenerational disadvantage, the impact of the Stolen Generation and Indigenous community functioning (AIHW 2019a; AHMAC 2017).

Limited national data sources are available on the subjective wellbeing of Aboriginal and Torres Strait Islander children in Australia. The Longitudinal Study of Indigenous Children has collected some data on subjective wellbeing, including their feelings, social supports and the activities they enjoy (DSS 2015).

Box 3: Cultural identity

Children are not born with a sense of cultural identity but rather develop it through exposure to traditional and cultural knowledge, language, practices and activities (Kickett-Tucker et al. 2015; PM&C 2017; DoCA Arts 2019). In most instances, families and broader kinship groups are likely the primary source for providing and supporting these exposures for Indigenous children in Australia (Lohoar et al. 2014).

The 2014–15 National Aboriginal and Torres Strait Islander Social Survey captured information relevant to aspects of cultural identity for Indigenous children aged 0–14 in selected households by way of a proxy interview with a parent or other adult household member (ABS 2016). The 2014–15 survey results estimated that of the approximately 173,000 Indigenous children aged 4–14 years:

- 50% (approximately 86,900) identified with a clan, tribal or language group. This increased to 71% when only looking at children living remotely.
- Just less than 8% (approximately 13,000) spoke an Australian Indigenous language as their primary language at home. This increased to 31% for children living remotely.
- 34% (approximately 58,400) spoke at least a few Australian Indigenous words. This increased to 66% for children living remotely.
- 75% (approximately 129,800) were involved in selected events, ceremonies or organisations in the last 12 months. This increased to 80% for children living remotely.
- 44% (approximately 75,900) spent at least some time with a leader or elder each week. This increased to 66% for children living remotely.

Data supporting national indicator reporting

As *Australia's children* aims to give a national overview of how Australian children are faring at a particular point, which can be regularly updated and progress tracked, the report focuses on data which are nationally representative, collected periodically, and which support population-level comparisons.

The report draws predominantly on:

- cross-sectional administrative datasets held by the AIHW
- national surveys by the ABS
- specific national collections such as the Australian Early Development Census and National Assessment Program – Literacy and Numeracy.

See the [Data sources](#) for a full listing of data sources used. However, for some topics of interest, other national data sources that may not meet the above criteria, or sub-national data-sources, have been used for insight on a topic (also Box 4).

In future, data integration could provide opportunities for improved national indicator reporting; for example, by bringing together data from multiple sources relating to select population groups (such as children in out-of-home care) to better understand their use of services across multiple sectors (such as education, health and justice) and their transitions over time (such as from school to work).

Box 4: Additional studies and data sources on children

The rich national data sources described briefly here can demonstrate how children respond to different situations over time, and assist in identifying pathways for children, or paint a very rich picture of child wellbeing.

Longitudinal Study of Australian Children and Longitudinal Study of Indigenous Children

These studies each follow 2 cohorts of children as they grow up. Data from these studies can show why children have taken particular pathways and what factors have made a difference to their outcomes over time, especially when linked to administrative data sources such as Medicare, National Assessment Program – Literacy and Numeracy and Australian Early Development Census:

- The Longitudinal Study of Australian Children collects information on physical and mental health, education, and social, cognitive and emotional development of 2 large cohorts of children (totalling >10,000 children at the outset of the study in 2004). The 2 cohorts are made up of children born March 1999 to February 2000 and March 2003 to February 2004. The data are sourced from parents, child carers, pre-school and school teachers, and the children themselves.
- The Longitudinal Study of Indigenous Children collects information on physical and mental health, education and social, cognitive and emotional development, as well as families, communities and services of 2 cohorts of Indigenous children (totalling around 1,700 children at the outset of the study in 2008). The 2 cohorts are made up of children born December 2003 to November 2004 and December 2006 to November 2007. The data are sourced from parents, child carers, pre-school and school teachers, and the children themselves.

Australian Child Wellbeing Project

Published in 2016, this project focused on children in the middle years (aged 8–14). It used the perspectives of young people to conceptualise and measure wellbeing. Marginalised groups were a particular focus and included: young people with disability, young carers, materially disadvantaged, CALD, Indigenous, rural and remote, young people in out-of-home care.

Royal Children’s Hospital National Child Health Poll

This Poll is a quarterly, national survey of Australian households providing information on important issues in contemporary child and adolescent health, as told by the Australian public (specifically from the point of view of the parent). Each quarter, the poll focuses on a different topic or theme. The process for selecting poll topics responds to and is informed by the national political and social agenda. For more information, see [poll survey methods](#).

International reporting on child wellbeing

Australia is a signatory to the United Nations (UN) Convention on the Rights of the Child which underpins the work of the National Children's Commissioner, a role established in 2012.

The Commissioner produces an annual Statutory Report to Parliament focusing on recurrent child wellbeing themes in contemporary Australia, including safety, social support and health issues ([Children's Rights Report](#)).

Every 5 years, the Children's Commissioner reports to the UN Committee on the Rights of the Child about Australia's progress in implementing the UN Convention on the Rights of the Child. In January 2018, the Australian Government submitted Australia's combined 5th and 6th periodic reports on progress under the Committee on the Rights of the Child and its Optional Protocols to the UN.

In February 2019, the National Children's Commissioner addressed the UN Committee and assisted them in looking at the major issues facing children living in Australia. Following this, the UN Committee gave the Australian Government a list of issues to be addressed in writing and provided Australia with its Concluding observations and recommendations.

Where do I go for more information?

For more information on:

- children's rights and reporting to the UN, see: [Children's rights](#)
- technical notes relating to this section, refer to [Introduction](#) in the online report.

References

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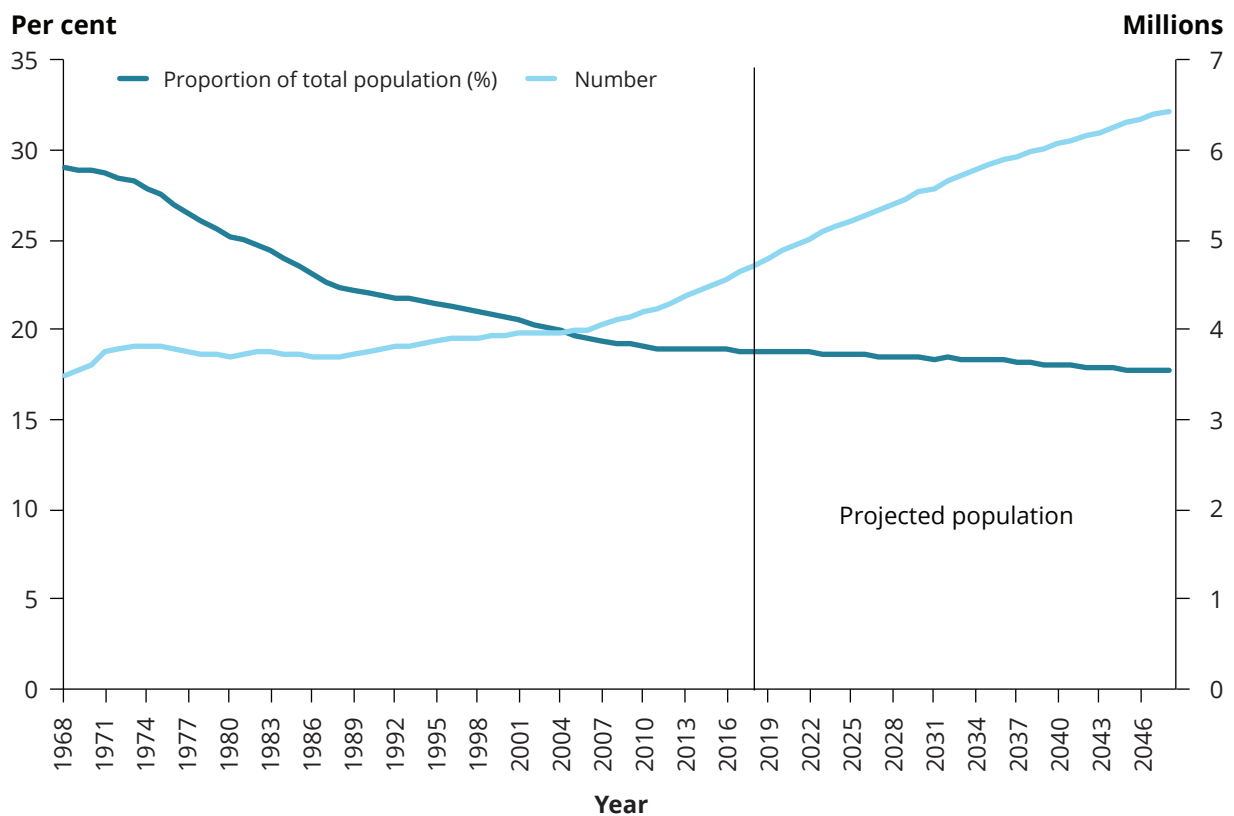
Australian children and their families

How many children live in Australia?

As at 30 June 2018, an estimated 4.7 million children aged 0–14 lived in Australia. Boys made up a slightly higher proportion of the population than girls (51% compared with 49%) (ABS 2018a).

The number of children in Australia has increased over the past 5 decades and is projected to increase to 6.4 million by 2048 (ABS 2018e). However, due to sustained low fertility rates and increasing life expectancy, the number of children as a proportion of the entire population steadily fell from 29% in 1968 to 19% in 2018. It is projected to fall to 18% by 2048 (Figure 1) (ABS 2014; ABS 2018e).

Figure 1: Number of children and children as a proportion of the total Australian population, 1968–2048



Note: Population projections (2019 onwards) are based on ABS Projection Series B. See ABS 2018e for the assumptions on which Projection Series B is based.

Sources: ABS 2014; ABS 2018a; ABS 2018e.

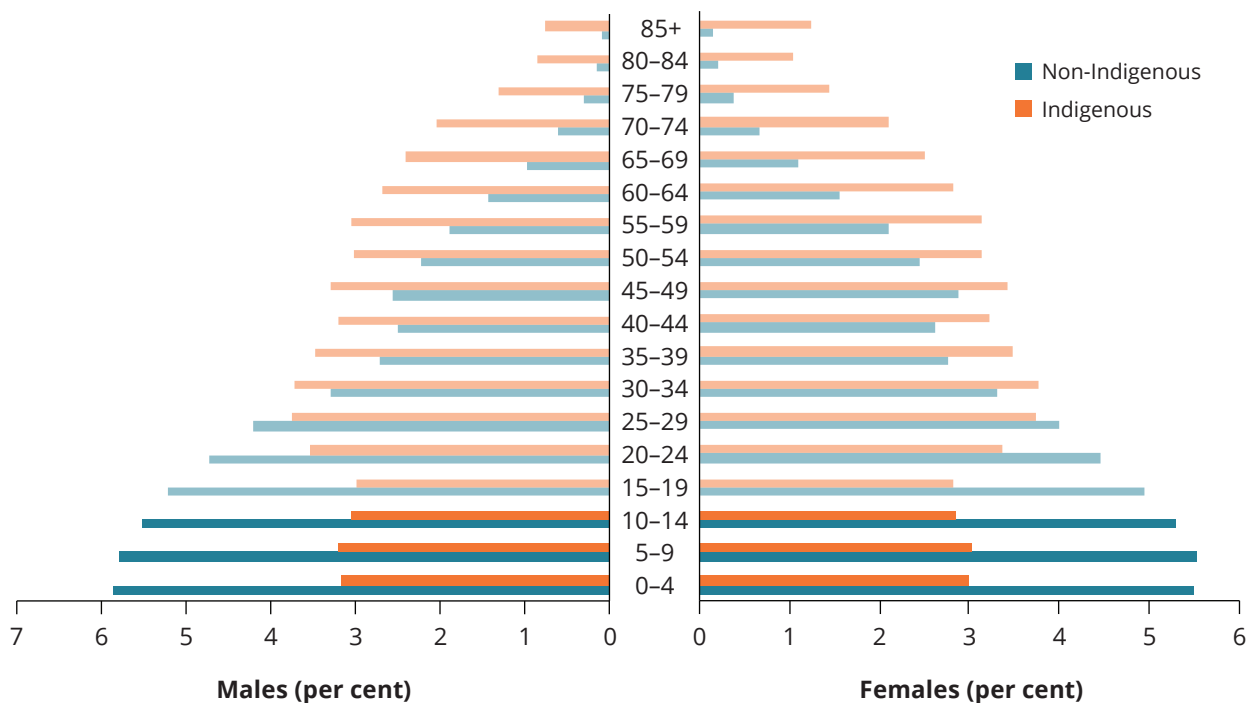
Aboriginal and Torres Strait Islander children

In 2018, Aboriginal and Torres Strait Islander children made up 5.9% (an estimated 278,000) of the total child population in Australia. The gender distribution of Indigenous children was the same as for all Australian children (51% boys and 49% girls) (ABS 2018c).

Although Indigenous children comprise a relatively small proportion of the Australian child population, they represent more than one-third of the Indigenous population (34%) (ABS 2018c) (Figure 2).

The Indigenous population has a much younger age structure than the non-Indigenous population (Figure 2). This reflects the higher fertility rate among Indigenous women compared with non-Indigenous women in Australia (2.3 births compared with 1.8 in 2017), as well as the shorter life expectancy among Indigenous Australians (ABS 2018b).

Figure 2: Age and sex distribution of Indigenous and non-Indigenous populations, 2018



Source: ABS 2018c.

Overseas-born children

In Australia, just under 1 in 11 (8.9% or around 411,000) children aged 0–14 were born overseas. This is considerably lower than the total overseas-born Australian population, with nearly one-third (29%) of the population in June 2017 born overseas (ABS 2018e).

About one-third (34%) of overseas-born children were from other mainly English-speaking countries, with the largest populations from:

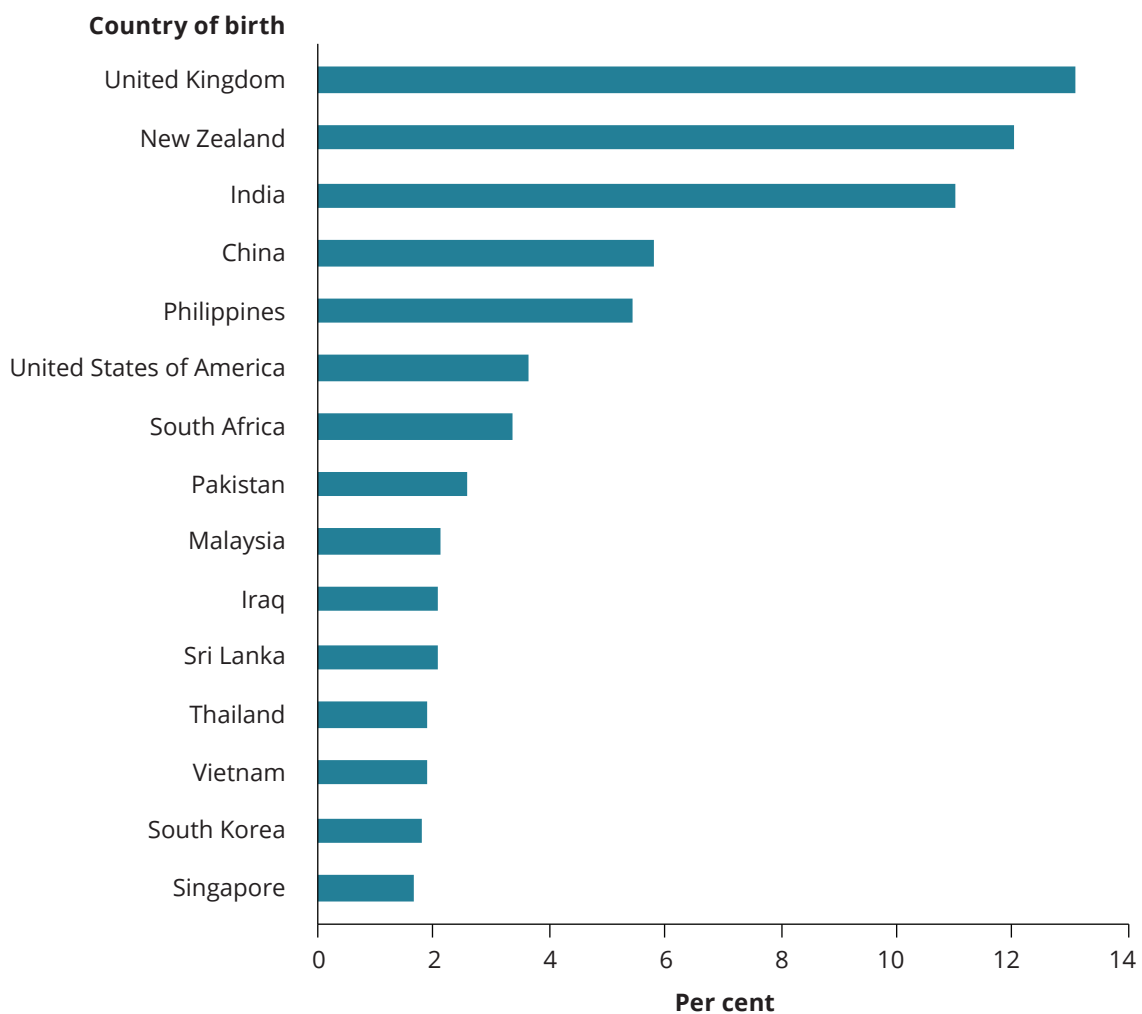
- United Kingdom (13%)
- New Zealand (12%)
- United States of America (4%) (Figure 3).

Of the remaining two-thirds (66%) born in mainly non-English-speaking countries, the largest groups were from:

- India (11%)
- China (6%)
- the Philippines (5%).

More than one-fifth of children (23% or around 995,700) aged 0-14 had both parents born overseas, while another 16% (around 701,500) had 1 parent born overseas (8.6% or around 373,200 with overseas-born fathers and 7.5% or around 328,300 with overseas-born mothers) (ABS 2016b).

Figure 3: Leading countries of birth for children aged 0-14 born overseas, June 2017



Note: Data for China exclude Special Administrative Regions and Taiwan Province.

Source: ABS 2018d.

Refugee children

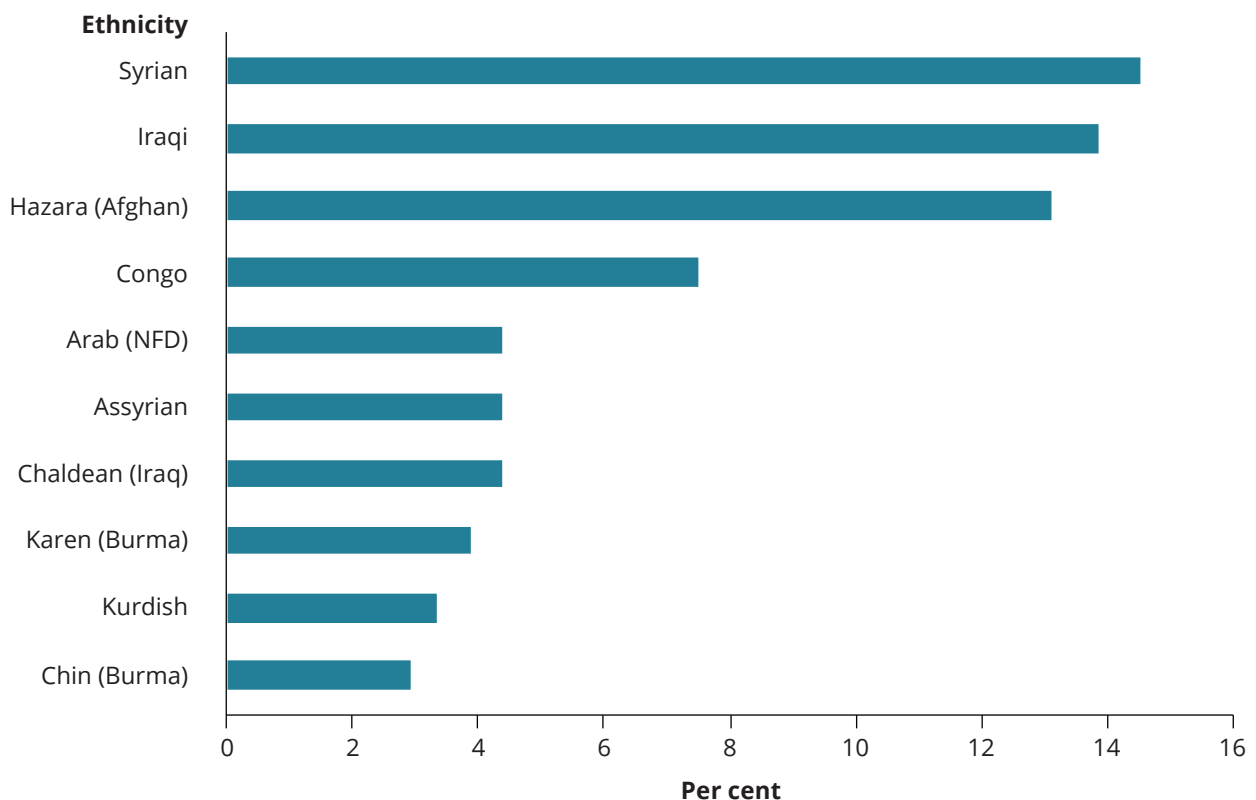
In 2017-18, around 4,100 children aged 0-14 arrived in Australia under the Humanitarian Program for refugees and others in refugee-like situations. Most of these children were:

- Syrian (15%)
- Iraqi (14%)
- Hazara (Afghan) (13%)
- Congolese (8%).

These 4 ethnic groups made up almost half (49%) of all refugee children arriving in 2017–18 (Figure 4).

The number of children aged 0–14 arriving in Australia under the Humanitarian Program in 2017–18 was slightly lower than the number in 2008–09 (around 4,600). Numbers varied moderately between 2008–19 and 2015–16, ranging from around 3,700 to 5,000, before peaking at around 7,900 children in 2016–17 (DSS 2019).

Figure 4: Leading ethnicities for refugee children aged 0–14 arriving in Australia, 2017–18



Abbreviations: NFD (Not further defined)

Source: AIHW analysis of DSS customised report.

Children with disability

In 2015, around 7.4% of children aged 0–14 had some level of disability.

For information on these children, see [disability](#).

Children in non-parental care

While the vast majority of children in Australia live with 1 or both of their biological parents, some parents are unable to care adequately for their children and these children are placed in non-parental care.

For information on these children, see [non-parental care](#).

Where do children live?

States and territories

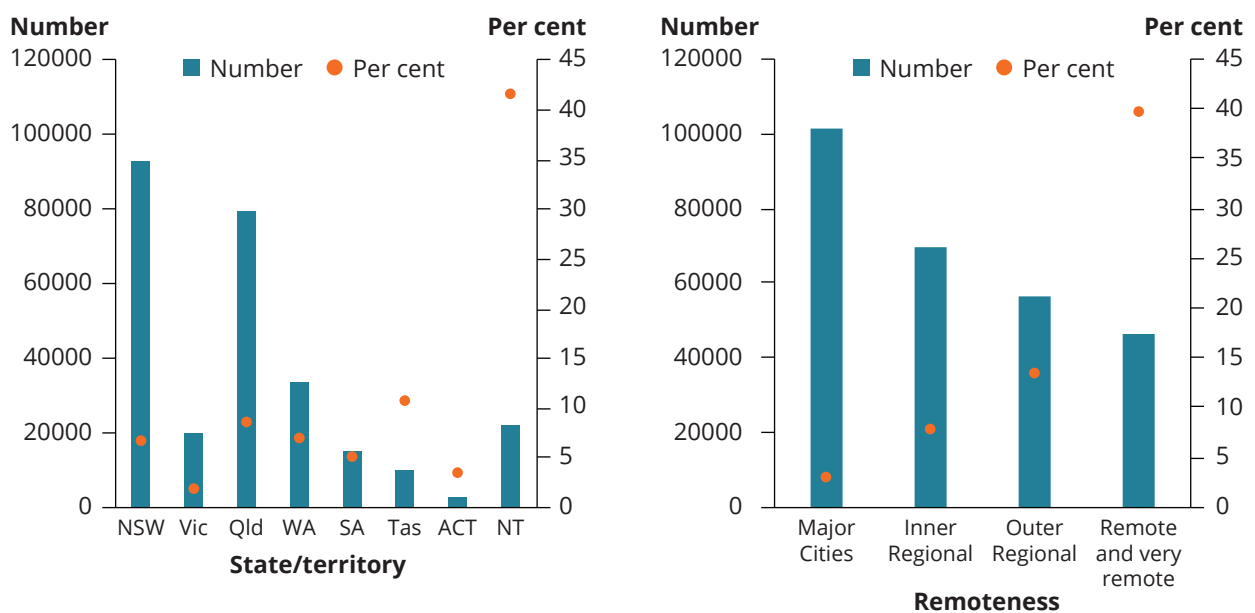
The population distribution of children across the states and territories is similar to that for all Australians. In 2018, nearly:

- one-third (32%) of Australian children lived in New South Wales
- one-quarter (25%) in Victoria
- one-fifth (21%) in Queensland (Figure 5) (ABS 2018a).

In 2018, the largest proportion of children in a state or territory was in the Northern Territory, where children made up more than one-fifth of the population (22%). In other states and territories, children made up between 18% (South Australia and Tasmania) and 20% (Queensland) of the respective population (ABS 2018a).

The higher proportion of children in the Northern Territory is largely due to the high number of Indigenous Australians, and the younger age structure of this population group. In 2016, Indigenous children made up 9% of the Territory's total population, and 41% of the territory's population of children aged 0–14. In most other states, Indigenous children made up between 2% (Victoria) and 10% (Tasmania) of the child population (Figure 5) (ABS 2018c).

Figure 5: Distribution of Indigenous children aged 0-14 across the states and territories and remoteness areas, June 2016



Note: Number refers to the number of Indigenous children aged 0-14 within each state, territory or remoteness area. Per cent refers to the proportion of all children aged 0–14 within each state, territory or remoteness area.

Source: AIHW analysis of ABS 2018c.

The population distribution of refugee children was similar to that of Australian children overall. Of refugee children arriving in 2017–18:

- 31% were living in New South Wales
- 31% in Victoria
- 19% in Queensland
- 8% in South Australia
- 6% in Western Australia (DSS unpublished data).

Remoteness

In 2016, more than two-thirds (70% or 3.2 million) of Australian children aged 0–14 lived in *Major cities*, while:

- about one-fifth (18% or 841,700) lived in *Inner regional areas*
- 9% (404,000) lived in *Outer regional areas*
- 2% (109,400) lived in *Remote and very remote areas* (ABS 2017).

The majority of Indigenous children lived in *Major cities*, *Inner regional* and *Outer regional areas* in 2016 (83%, or around 227,800 children). Indigenous children:

- were more than 7 times as likely to live in *Remote and very remote areas* (17%) as all Australian children (2.4%)
- accounted for 43% of all children in *Remote and very remote areas*, despite accounting for 6% of all children in Australia in 2016 (ABS 2018c).

Socioeconomic status

In 2017, similar numbers of children aged 0–14 lived in high, medium and low socioeconomic areas:

- 21% (around 953,700) children lived in the lowest socioeconomic areas
- 20% (around 921,900) lived in the highest socioeconomic areas.

How many Australian families have children aged 0-14?

This section presents data according to a national definition of a family (Box 1) used for official statistical purposes. This definition may not always align with how a child defines their family, and it may not align with the concept of a family for Indigenous Australians (AIHW & AIFS 2016).

From 2006 to 2016, the types of families that children were living in have changed very little.

In 2006 and 2011, 81% of children aged 0–14 years lived in couple families; this rose to 82% in 2016 (ABS 2006; ABS 2011; ABS 2016a). In 2016, the rest (around 18%) lived in 1-parent families (18%).

Of these children, the majority (86%) lived with their mother (ABS 2016b).

The majority of children living in couple families in 2016 lived with their natural or adopted parents (90%):

- 6% lived in blended families—a family with at least 1 child of both partners (natural or adopted) and at least 1 step child
- 3% lived in step families—a family with at least 1 step child and no natural or adopted children.

Children living in 1-parent families, blended or step families may live according to shared-care arrangements agreed between their original parents; however, no nationally consistent data are available on these arrangements. Less than 1% of children in couple families lived in other arrangements, such as grandparent families and families with foster children only.

For more information on children living in grandparent families, see [Children in non-parental care](#).

A higher proportion of infants and young children (aged 0–4) lived in couple families in 2016 (86%), compared with 81% of those aged 5–9 and 78% of those aged 10–14. Conversely, in 1-parent families a considerably higher proportion of children were aged 10–14 than 0–4 (22% compared with 14%) (ABS 2016b).

A small number of children live in adoptive families. In 2017–18, there were 263 adoptions of children aged 0–14 in Australia (this includes known, local and intercountry adoptions) (AIHW 2018).

Box 1: Definition of family

The ABS defines a family as 2 or more persons, 1 of whom is at least 15 years of age, who are related by blood, marriage (registered or de facto), adoption, step or fostering, and who usually live in the same household (ABS 2016c).

Recognising the changing nature and understanding of family formation—including who makes up a family and the relationships existing within that family—the ABS is exploring definitions of family across its full suite of surveys and data sources.

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Health

The health of Australia's children

In a national study of Australian young people's perspectives, health ranked as the second most important domain for having a good life (Redmond et al. 2016). In addition to their own health, young people also reported that the health of family members (for example, a parent or grandparent) was important for their wellbeing (Redmond et al. 2016).

Health is influenced by factors such as individual and psychological make-up, lifestyle, environmental and cultural influences, socioeconomic conditions and access to quality health care programs and services (AIHW 2018a). The World Health Organization (WHO) defines health as a multidimensional construct that incorporates physical, mental and social wellbeing and so is more than just the absence of disease or infirmity (WHO 1946).

While the WHO's definition of health is widely accepted, there can be variation across cultures. Aboriginal and Torres Strait Islander people take a broader perspective of health and view it not just as the physical wellbeing of the individual, but the social, emotional and cultural wellbeing of the whole community (AIHW 2016).

Why is child health important?

Good health influences how children feel and go about their everyday lives because health can affect participation in family life, schooling, social and sporting activities. This chapter includes information on a number of topics considered important to children's health, development and/or overall wellbeing.

The foundations for good health start during the antenatal period, and the first years of life. Maintaining a healthy lifestyle during pregnancy contributes to better outcomes for the baby and the mother. Smoking during pregnancy is associated with poorer perinatal outcomes such as low birthweight, perinatal death and sudden infant death syndrome (SIDS). Teenage mothers are also more likely to have low birthweight babies and are themselves a vulnerable population who may experience a greater risk of socioeconomic disadvantage.

The health of a baby at birth is a key determinant of subsequent health and wellbeing. Low birthweight has been associated with increased risk of coronary heart disease, diabetes, hypertension and stroke in adulthood. Following birth, breastfeeding is a protective factor by reducing infant mortality, protecting against illnesses, and helping develop the baby's microbiome (COAG Health Council 2019). As children grow, immunisation protects them from harmful, and potentially fatal diseases.

Chronic conditions that particularly affect children, such as asthma and diabetes, cancer, mental illness, and disability have a substantial impact on a child's overall quality of life. They can require considerable disease management and affect physical, social and emotional development, schooling attendance and education outcomes. There may also be an impact on family life, parental health and employment if time off work is needed for caring responsibilities, with a potential flow-on effect for household finance. This illustrates the inter-relationship of health with other domains of wellbeing.

Poor oral health is also associated with increased risk of chronic disease later in life, including stroke and cardiovascular disease (AIHW 2019). Children with poor oral health are also more likely to miss school and perform poorly in school (Jackson et al. 2011).

Children's social and emotional wellbeing—how they think and feel about themselves and others, and deal with daily challenges—is 1 component of mental health and wellbeing. Socially and emotionally competent children:

- are confident
- have good relationships
- communicate well
- do better at school
- take on and persist with challenging tasks
- develop the necessary relationships to succeed in life.

While rates of infant and child deaths are decreasing, and survival rates for certain cancers are increasing, perinatal conditions, injuries and cancer remain leading causes of death for children.

Good health in childhood also has a long-term impact, as problems that become more apparent in old age can have their origins in childhood. Children who smoke and drink at risky levels often continue to do so into adolescence and adulthood, putting them at risk of chronic conditions and premature death. Poor nutrition and sedentary lifestyles have been linked with obesity, and children who are overweight or obese are also more likely to become obese adults, putting them at risk of chronic conditions such as type 2 diabetes and cardiovascular disease at younger ages (Sahoo et al. 2015).

Many topics included in this health domain also reflect what Australian adults see as the key health issues for children. A survey of Australian adults on how much of a problem they considered 29 child and adolescent health issues, identified these top 10 child health problems:

- excessive screen time
- obesity
- not enough physical activity
- unhealthy diet
- bullying
- illegal drug use
- family and domestic violence
- internet safety
- child abuse and neglect
- suicide (Rhodes 2015).

Some of these topics are included in other domains (for example, bullying, family and domestic violence and child abuse) reinforcing the interrelation between health and other domains.



The governance supporting children's health

While parents have the primary caring role for their children, ensuring that children get the best possible start in life is a responsibility shared with the wider community and governments.

From a governance perspective, responsibility for supporting children's health is shared by the Australian and state and territory governments, as they are for the population as a whole

Australian Government responsibilities

The Australian Government is responsible for:

- leading the development of national health policy
- administering Medicare
- funding state and territory public hospital services
- funding and providing oversight of Primary Health Networks
- funding medicines (through the Pharmaceutical Benefits Scheme)
- regulating private health insurance
- funding community-controlled Indigenous primary health care and some prevention programs (for example, cancer screening)
- health and medical research.

The Australian Government also funds a range of mental health-related services through the Medicare Benefits Schedule (MBS), and the Pharmaceutical Benefits Scheme (PBS)/Repatriation Pharmaceutical Benefits Scheme (RPBS).

The Australian Government also funds a range of mainstream programs and services including:

- income support
- social and community support
- disability services
- workforce participation programs
- housing assistance.

State and territory government responsibilities

State and territory governments are responsible for:

- funding and managing public hospitals
- regulating and licensing private hospitals
- providing oversight of local health networks
- delivering public community-based and primary health care services
- delivering preventive services, such as cancer screening and immunisation programs
- delivering ambulance services
- managing health complaints services.

State and territory governments also fund and deliver public sector mental health services. These provide specialist care for people with severe mental illness in public acute and psychiatric hospital settings, state and territory specialised community mental health care services, and state and territory specialised residential mental health care services. In addition, states and territories provide other mental health-specific services in community settings such as supported accommodation and social housing programs.

Local governments, in some jurisdictions, are responsible for:

- environmental health-related services such as waste disposal and water fluoridation
- community and home-based health and support services
- delivery of health promotion activities.

All Australian health ministers are members of the Council of Australian Governments (COAG) Health Council—the forum for cooperation on health issues and the health system (COAG Health Council 2014).

National health strategies for children

A key objective of the COAG National Healthcare Agreement is that Australians are born healthy and remain healthy. This is also the vision of the [Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health](#) (the framework).

The framework was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in 2015 and provides a 10-year overarching vision and set of priorities for child and youth health, which other targeted health policies at the national and/or state and territory level can build on. The framework's priorities are to:

- equip children and young people with the foundations for a healthy life
- support children and young people to become strong and resilient adults
- support children and young people to live in healthy and safe homes, communities and environments
- ensure children and young people have equitable access to health care services and equitable health outcomes
- improve systems to optimise the health outcomes of children and young people.

Improvement of child health and wellbeing outcomes is also the goal of the Australian Government's [National Action Plan for the Health of Children and Young People: 2020–2030](#) (the action plan).

This plan builds on the framework. It has these 5 key priority areas:

- improve health equity across populations
- empower parents and caregivers to maximise healthy development
- tackle mental health and risky behaviours
- address chronic conditions and preventive health
- strengthen the workforce.

A number of national whole-of-population health policies are also relevant to children and to particular sections of Australia’s children. An overview is in Table 1 and a more detailed listing can be found in the [Healthy, Safe and Thriving National Framework for Child and Youth Health](#) and the COAG Health Council website: <http://www.coaghealthcouncil.gov.au/>

While the Department of Health has responsibility for most health areas, some fall under the remit of other Australian government organisations. Disability, for example, falls under the remit of the Department of Social Services, and Indigenous health under the Department of Prime Minister and Cabinet.

People with disability, including children, are a focus of The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. The Royal Commission was announced on 5 April 2019 and is expected to run over 3 years. It will cover all forms of violence, abuse, neglect and exploitation, in all settings where they occur. As such, its recommendations will have implications for children with disability (see [Justice and safety](#)).

Table 1: National strategies relevant to health sections

Topic area	Strategy
Health	National Healthcare Agreement
Antenatal period	National Fetal Alcohol Spectrum Disorder Action Plan 2018–2028
	National Strategic Approach to Maternity Services—emerging strategy
Breastfeeding	Australian National Breastfeeding Strategy: 2019 and beyond
Chronic conditions	National Strategic Framework for Chronic Conditions
Asthma	National Asthma Strategy (2018)
Diabetes	Australian National Diabetes Strategy 2016–2020
Mental health	Fifth National Mental Health and Suicide Prevention Plan (2017)
	Australia’s Long Term National Health Plan
	National Children’s Mental Health Strategy—announced in Australia’s Long Term National Health Plan, and under development as at 15 August 2019
Disability	National Disability Strategy 2010–2020
Oral health	Healthy Mouths, Healthy Lives: Australia’s national Oral Health Plan 2015–2024
Injuries	National Injury Prevention Strategy—emerging strategy
Physical activity	Sport 2030
Drugs and alcohol	National Drug Strategy 2017–2026
	National Alcohol Strategy 2018–2026 (draft)
Preventive healthcare	National Preventive Health Strategy—announced in Australia’s Long Term National Health Plan, and under development as at 15 August 2019
	National Aboriginal and Torres Strait Islander Health Plan 2013–2023
Indigenous	Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023
	National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families
Immunisation	National Immunisation Strategy for Australia 2019 to 2024



What is missing?

The sections in this domain include a number of established national indicators; however, consistent national reporting is not available in some areas due to lack of a suitable data source and/or indicator. For more information on national data gaps, see [Data gaps](#).

A number of topics were not included for other reasons but could be considered for future updates.

Children's subjective view of health

National data on how children view their own health are limited. Of particular interest are the views of children living with disability and areas of social and emotional wellbeing. The Social-Emotional Wellbeing (SEW) Survey and Rumbles Quest, could offer opportunities.

Priority populations

Health data for a number of priority population groups are limited, including children:

- who are refugees
- with disability
- living in out-of-home-care
- involved in youth justice.

Data on some priority groups, for example children receiving child protection and care services, would be particularly valuable for further examination of topics, such as [teenage mothers](#) (AHRC 2017).

The Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory (Royal Commission) reported a lack of comprehensive data on the health of children and young people in detention in the Northern Territory (Royal Commission 2017a, 2017b).

A recent feasibility study by the Australian Institute of Health and Welfare (AIHW) identified significant gaps in the available national data and current knowledge about the health and risk behaviours of young people involved in youth justice and health services provided to them (AIHW 2018b).

In the future, data linkage between youth justice and health data, such as hospitalisations data, has the potential to improve the information available about this group of children.

More routine linkage of mortality data with other data collections, such as disability services, could also provide opportunities to examine variation in death rates across particular population groups.

Sleep

Sleep is essential to healthy brain development. Sleep, or a sleep deficit, has been associated with the development and severity of a range of physical, behavioural and other mental health issues.

Young children who do not get enough sleep are at increased risk of becoming overweight, even after adjustment for initial weight status and multiple confounding factors (AHMAC 2015). A study among Indigenous children, for example, confirmed that short sleep duration is associated with unhealthy body mass index, with sleep duration decreasing with the number of adults in the household increasing (Deacon-Crouch et al. 2017).

Research based on the Longitudinal Study of Australian Children (LSAC) found that sleep problems were associated with externalising and internalising difficulties in children (Quach et al. 2018). Difficulty sleeping was also reported as the most frequent health complaint, occurring almost every day for 12% to 16% of participants in years 4, 6, and 8 in the Australian Child Wellbeing Project (Redmond et al. 2016). National, regular, population-level reporting on children's sleep is not available; however future updates could include a focus on available data.

Hearing

For children, hearing is critical to learning to speak, and subsequently performing academically, and engaging socially (WHO 2016). Early detection of profound permanent childhood hearing impairment, together with access to appropriate intervention, can minimise the impact of children with this condition. National neonatal hearing screening data are not currently available for reporting. However, a working group was established in 2013 to review the National Framework for Neonatal Hearing Screening and National Performance Indicators to Support Neonatal Hearing Screening in Australia. The review is expected to be completed in 2020.

Health service use

Future updates to this domain could include information on children's health service use, for example use of hospitals, alcohol and other drug services mental health services, and prescription use.

While service use data are readily available for a number of health services see [Australia's Health](#), national data are not available for community health services, and medical technology and devices used by children with health conditions. There are also limited comprehensive and nationally representative data on allied health services and primary health care consultations. Developments are underway to establish a National Primary Health Care Data Asset to improve the completeness and use of primary care data, as should the use of My Health Record data for research and public health purposes once available.



The emergence of new national data assets, such as the National Integrated Health Services Information Analysis Asset, which contains de-identified data from hospitals, the MBS, PBS and the National Death Index, will provide opportunities for examine the service use patterns of children. Work is also underway to develop enduring linked assets related to cancer and diabetes data.

Specific areas related to domain topics

- While [physical activity](#) includes some data on children's physical activity, trend data are not currently available. Under the Intergenerational Health and Mental Health Study, the ABS National Nutrition and Physical Activity Survey is scheduled to be conducted again in 2023. National data on the variety of physical activity children undertake, beyond organised sport, are also not available. Information on screen time that promotes physical activity, such as active video games, is also not available.
- Routine national data on children's consumption of food, other than fruit and vegetables, is also limited. For example, the most recent data on children's intake of grains, meat (and alternatives), dairy and discretionary foods comes from the 2011–12 Australian Health Survey (AIHW 2018c).

- This domain includes some data on [mental illness](#) and [social and emotional wellbeing](#); however regular, national data and reporting on children's overall mental health and wellbeing are not currently available. This reporting could include measurement of concepts such as overall life satisfaction or happiness, engagement in life and optimism.
- National data on the health of young fathers are limited. For example, there are limited data about the role of young fathers in parenting and the impact the birth of a child has on them (AHRC 2017).

Where do I find more information?

For information on technical notes relating to this section, refer to [The health of Australia's children](#) in the online report. See also [Methods](#).

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Smoking and drinking in pregnancy

Key findings

- In 2017 about 1 in 10 (9.5% or about 28,600) women who gave birth reported smoking during the first 20 weeks of their pregnancy.
- The rate of smoking during the first 20 weeks decreased with increasing maternal age up to 35–39 years.
- In 2016, of women who reported they were unaware of being pregnant for a part of their pregnancy, 1 in 2 (49%) drank alcohol before they knew they were pregnant and 1 in 4 (25%) drank after they knew.

Smoking and drinking during pregnancy can increase the risk of poorer outcomes for both mother and baby. These behaviours are known as modifiable risk factors, which means that measures can be made to change them.

Smoking is associated with poorer perinatal outcomes, such as low birthweight, babies who are small for their gestational age at birth, pre-term birth and perinatal death (AIHW 2019a). The risk of SIDS is higher for babies of mothers who smoked during or after pregnancy (WHO 2013). Smoking during pregnancy has also been associated with an increased body mass index (BMI) score among Indigenous children (Thurber et al. 2015).

Mothers who stop smoking during pregnancy reduce the risk of complications during pregnancy and birth, and adverse health outcomes for their baby (AIHW 2019a).

Alcohol use during pregnancy can cause Fetal Alcohol Spectrum Disorder—birth defects and growth and developmental problems—that can persist into adulthood (NHMRC 2009). The risk of harm to the baby is greatest with high, frequent alcohol consumption during the first trimester (12 weeks). The National Health and Medical Research Council (NHMRC) advises that the safest option for women who are pregnant, planning a pregnancy or breastfeeding is to abstain from drinking (NHMRC 2009).

For more information on data used throughout this section, see Box 1.

Box 1: Data sources on smoking and drinking during pregnancy

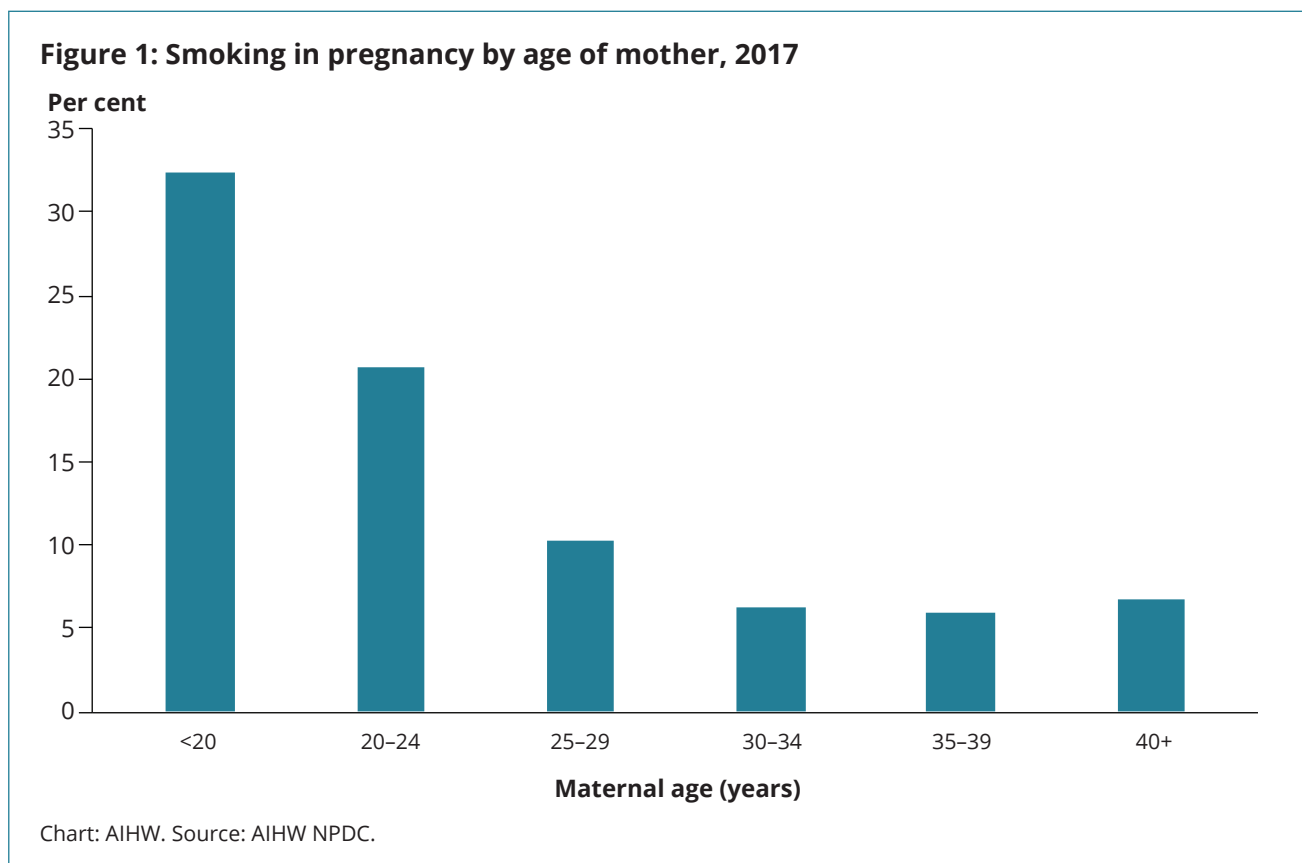
Data on smoking during pregnancy is sourced from the National Perinatal Data Collection (NPDC). The NPDC is a national population-based, cross-sectional collection of data on pregnancy and childbirth. The data are based on births reported to the perinatal data collection in each state and territory.

Data on drinking during pregnancy are sourced from the National Drug Strategy Household Survey (NDSHS) which collects information on alcohol and tobacco consumption, and illicit drug use among the general population in Australia aged 12 or older. It also surveys people's attitudes and perceptions relating to tobacco, alcohol and other drug use. The survey has been conducted every 2 to 3 years since 1985.

How many women smoke during the first 20 weeks of pregnancy?

In 2017, about 1 in 10 (9.5% or about 28,600) women who gave birth reported smoking during the first 20 weeks of their pregnancy, according to data from the AIHW NPDC.

Teenage mothers were the most likely to smoke during the first 20 weeks (1 in 3 or about 32%), and this rate generally decreased with increasing maternal age. Mothers aged 35–39 were the least likely to smoke during the first 20 weeks of pregnancy (1 in 17 or 5.7%) (Figure 1).



As pregnancy progressed, women were less likely to smoke. In 2017, 7.3% of mothers smoked after the first 20 weeks (AIHW 2019a).

Babies whose mothers smoked at any time during pregnancy were twice as likely to be of low birthweight (less than 2,500 grams) as babies of mothers who did not smoke during pregnancy (13% compared with 6.0%, respectively) (AIHW 2019b).

How many women drink during pregnancy?

In 2016, just over 1 in 3 (about 35%) women aged 14–49 drank during pregnancy. The majority (81%) did so once a month or less frequently—about 1 in 6 (16%) drank 2–4 times a month. The vast majority of women who drank (97%) usually consumed 1–2 standard drinks (AIHW 2017b).

Some women reported they were unaware of being pregnant for a part of their pregnancy. Of these women, 1 in 2 (49%) drank alcohol before they knew they were pregnant and 1 in 4 (25%) drank after they knew.

Have these behaviours changed over time?

Between 2011 and 2017, the proportion of women who smoked during the first 20 weeks of pregnancy fell from 13% to 9.5% (AIHW 2019b).

Overall, fewer women aged 14–49 drank during pregnancy in 2016 (35%) than in 2013 (42%). The proportion of women who drank before they knew they were pregnant fell between 2013 (56%) and 2016 (49%), but the result was not statistically significant. The proportion who drank after they knew was similar (26% in 2013 and 25% in 2016) (Figure 2).

Figure 2: Drinking before and after knowing about their pregnancy, women aged 14–49, 2013 and 2016

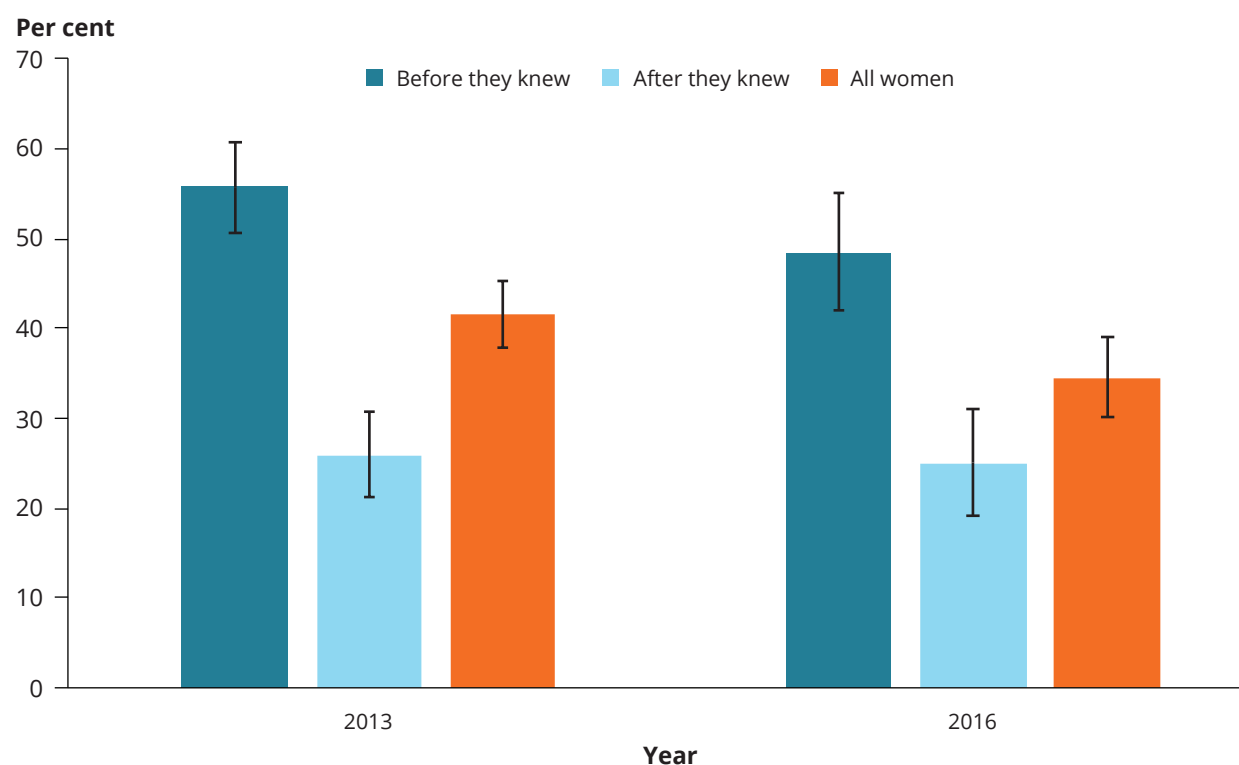


Chart: AIHW. Source: NDSHS.

How many women use illicit drugs during pregnancy?

In 2016, according to the NDSHS, 2.3% of women used an illicit drug, such as marijuana, ecstasy, cocaine, while pregnant. A slightly lower proportion (1.9%) had used prescription analgesics for non-medical purposes during pregnancy. However, these estimates have high relative standard errors and should be interpreted with caution (AIHW 2017b).

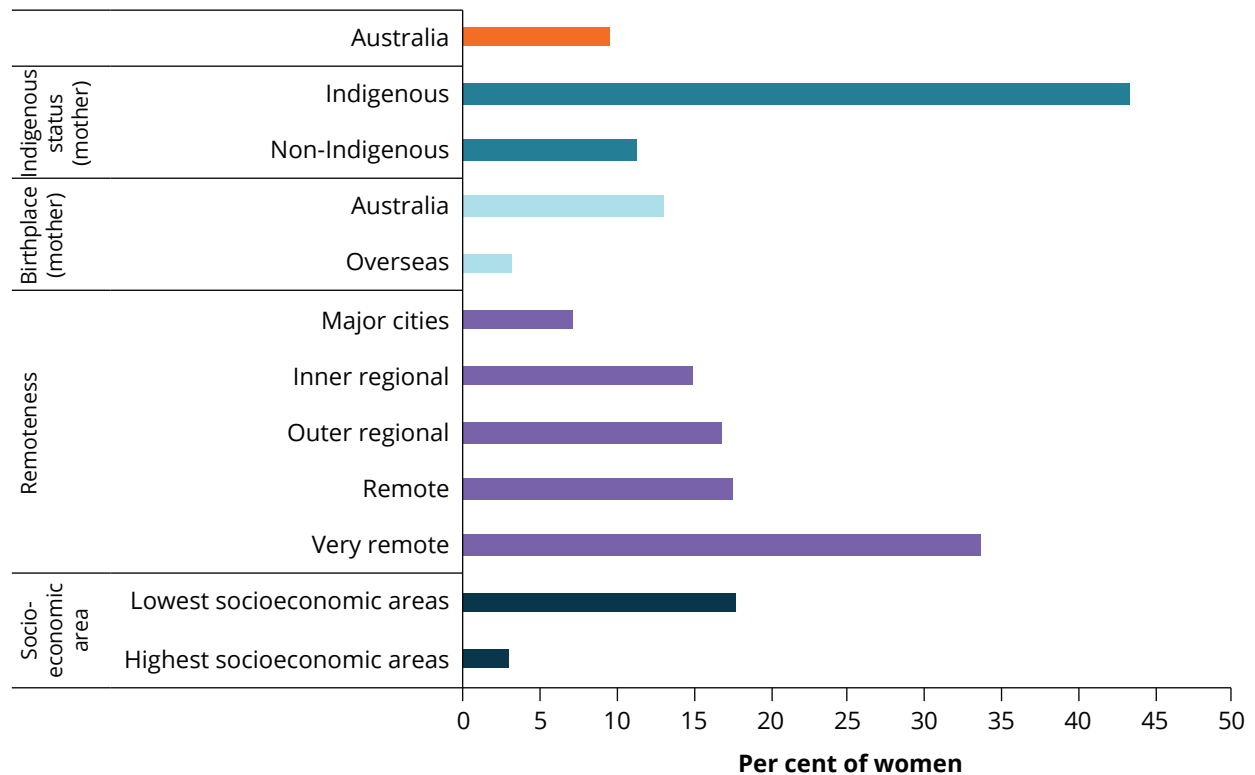
In 2014–15, according to AIHW and Australian Bureau of Statistics (ABS) analysis of the National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 4.1% of Indigenous women reported that they used illicit substances during pregnancy. However, this estimate has a high relative standard error and should be interpreted with caution (AIHW 2017a). Note: this rate for Indigenous women is from a different source and so data are not comparable with the NDSHS data cited.

Are these risk factors the same for everyone?

In 2017, the likelihood of a mother smoking during pregnancy differed depending on population group:

- mothers living in *Remote* (18%) and *Very remote* (34%) areas had considerably higher rates than mothers living in *Major cities* (7.2%)
- women living in areas of greater socioeconomic disadvantage were more likely than those living in areas of least disadvantage to smoke (18% and 2.9%, respectively)
- Australian-born mothers had higher rates than mothers born overseas (13% and 3.2%, respectively)
- Indigenous and non-Indigenous mothers varied (age-standardised rates of 43% and 11%, respectively). However, smoking rates during pregnancy among Indigenous women showed a positive change between 2011 and 2016, decreasing by 4 percentage points. See also [Indigenous children](#) (Figure 3).

Figure 3: Smoking in pregnancy by selected population groups, 2017



Note: Rates by Indigenous status are age standardised.

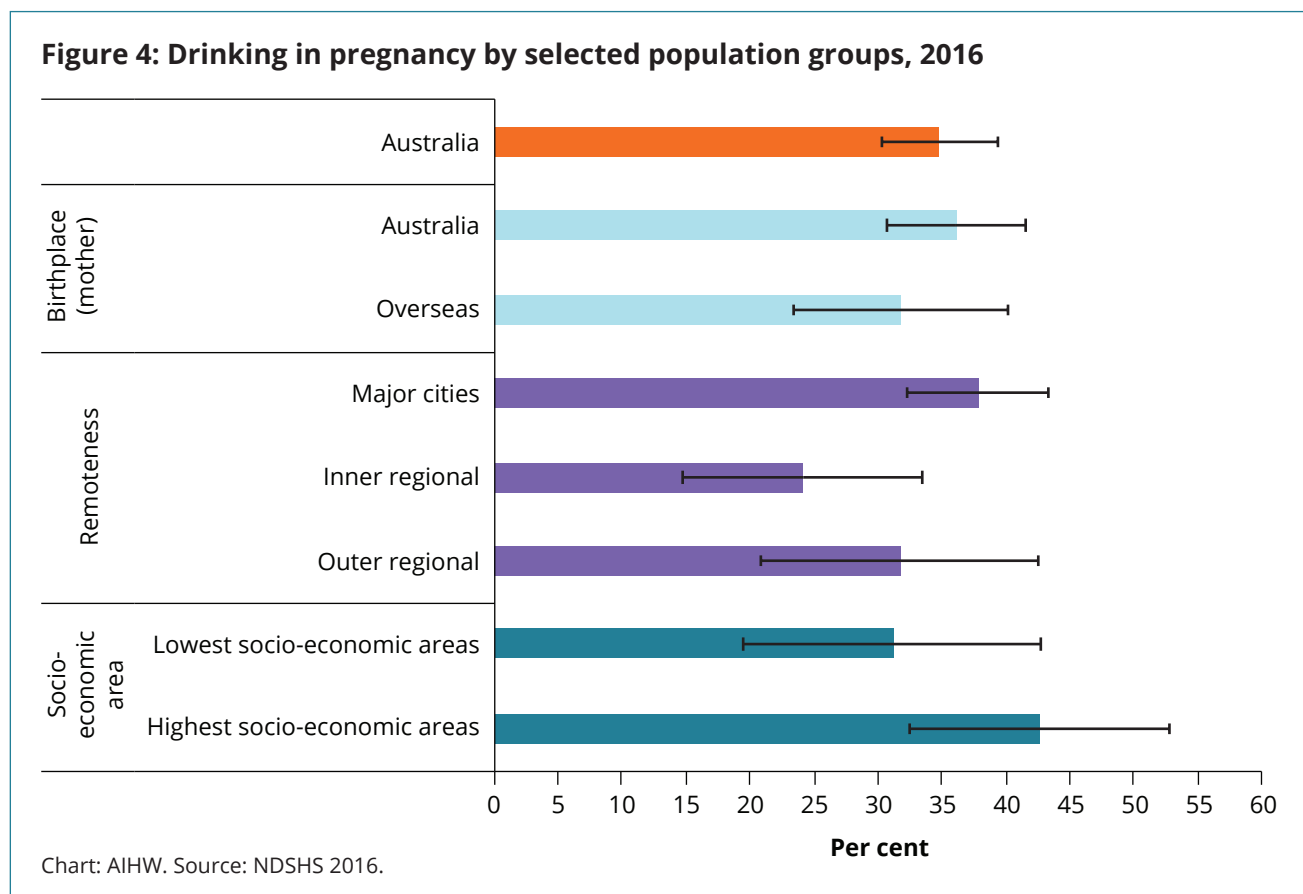
Chart: AIHW. Source: AIHW NPDC.

Patterns of drinking were different from those of smoking (Figure 4). Mothers living in *Major cities* were more likely to drink during pregnancy than those in *Inner regional* areas (38% compared with 24%, respectively). Note that data are unreliable for *Remote* and *Very remote* areas.

There was no statistically significant difference in the likelihood of drinking during pregnancy between mothers living in the highest socioeconomic areas (43%) and those in the lowest (31%).

There was also no statistically significant difference between mothers born in Australia (36%) and mothers born overseas (32%).

Data on Indigenous mothers were available from the NDSHS. However, 2014–15 NATSISS data found that of mothers of children aged 0–3, 10% reported drinking alcohol after finding out they were pregnant (AIHW 2017a). It should be noted that these data are not directly comparable.



Data limitations and development opportunities

The data on smoking and drinking during pregnancy come from 2 data sources (Box 1) so are not directly comparable. The NPDC is adding alcohol to its collection in 2019–20, with data expected to be available around mid-2022.

Fetal Alcohol Spectrum Disorder (FASD) describes conditions considered to be the result of exposure of an unborn baby to alcohol during pregnancy. These conditions affect the structural and functional development of the brain, structural development of the face, and growth and development generally (AIHW: Bonello et al. 2014). Regular data on FASD are not available for reporting, but surveillance and monitoring have been identified as priorities for determining how many children have FASD, and the rate of new cases occurring.

One option is to enhance the scope of jurisdictional congenital anomalies collections to include FASD, which could then be included in a national congenital anomalies surveillance system, if developed (AIHW: Bonello et al. 2014).

The Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory (Royal Commission) identified FASD as a major problem among young people in the youth justice sector in the Northern Territory (Royal Commission 2017). The Royal Commission also reported a lack of accurate data on the prevalence of FASD in children and young people (Royal Commission 2017).

Some prevalence data are available for Western Australia, where a study of young people in the only youth detention centre in the state identified a high prevalence of FASD (36% of 99 participants) and 88% of participants had at least 1 domain of severe neurodevelopmental impairment (Bower et al. 2018).

Data are available for a range of other antenatal risk and protective factors, as outlined later in this domain. In addition, the AIHW is working with the National Perinatal Data Development Committee to capture family violence in the antenatal period, with the initial focus on recording when screening for family and domestic violence occurred.

Where do I find more information?

For information on:

- smoking during the first 20 weeks of pregnancy for Indigenous mothers, see: [Indigenous children](#)
- smoking in pregnancy, see: [smoking during pregnancy in Children's Headline Indicators, Australia's mothers and babies 2017—in brief Data tables](#) and [Healthy community indicators](#)
- drinking and other drug taking during pregnancy, see: Data tables: Chapter 8 specific population groups in [National Drug Strategy Household Survey 2016: detailed findings](#)
- antenatal risk and protective factors, such as maternal overweight and obesity, physical activity during pregnancy and antenatal visits, or birth outcomes, see: [Australia's mothers and babies data visualisations](#), [National Core Maternity Indicators data visualisations](#) and [Physical activity during pregnancy 2011–12](#)
- technical notes relating to this section, refer to [Smoking and drinking in pregnancy](#) in the online report. See also [Methods](#).

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Teenage mothers

Key findings

- In 2017, births to teenage mothers made up 2.2% of all live births.
- Births to teenage mothers decreased by more than 40% between 2006 and 2017 from 17.6 to 9.2 live births per 1,000 females aged 15–19.

Motherhood for women under the age of 20 can be a positive and maturing experience. For many young people, becoming a parent can have a transformative impact, particularly with changing unhealthy behaviours and relationships (AHRC 2017; Rhys Price-Robertson 2010).

Recent findings also show some positive birth outcomes for teenage mothers compared with mothers aged 20–24 with teenage mothers:

- more likely to have a spontaneous labour (and less likely to have a caesarean section)
- less likely to have diabetes
- less likely to have gestational diabetes (AIHW 2018).

However, mothers who give birth under the age of 20 are also a vulnerable population group, who may experience lower education and reduced employment. This may increase the risk of socioeconomic disadvantage for both child and mother (Marino et al. 2016). Children of vulnerable young parents are also at risk of becoming teenage parents themselves (Gaudie et al. 2010; Marino et al. 2016).

Teenage motherhood is associated with a number of poorer health and wellbeing outcomes for both mother and baby. In the short-term, babies born to teenage mothers are at greater risk of being born pre-term, with a low birthweight, stillbirth and neonatal death (AIHW 2018; Marino et al. 2016). Children of teenage mothers may go on to have behavioural, emotional and cognitive disadvantages (Marino et al. 2016). Depression is more prevalent among pregnant teenagers than adult pregnant women or teenagers in general, and teenage motherhood can have a long-lasting effect on mental health (Marino et al. 2016).



Box 1: Data source on teenage mothers

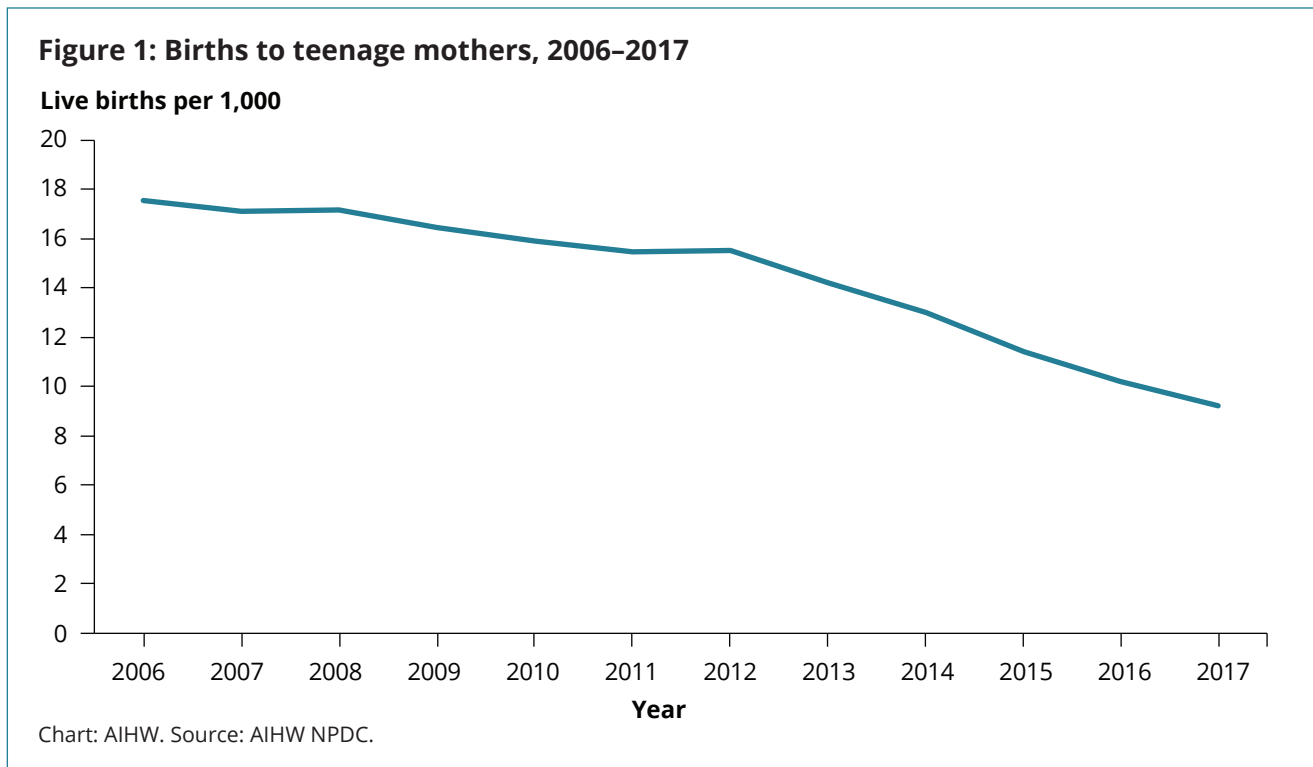
Data on teenage mothers is sourced from the National Perinatal Data Collection (NPDC). The NPDC is a national population-based cross-sectional collection of data on pregnancy and childbirth. The data are based on births reported to the perinatal data collection in each state and territory. Rates are calculated using denominators based on the ABS estimated resident population of females aged 15–19.

How many children are born to teenage mothers?

In 2017, around 6,600 babies were live-born to teenage mothers—a rate of 9.2 live births per 1,000 females aged 15–19. Births to teenage mothers made up 2.2% of all live births.

Have birth rates to teenage mothers changed over time?

Births to teenage mothers decreased by more than 40% between 2006 and 2017 from 17.6 to 9.2 per 1,000 females aged 15–19 (Figure 1).



In Australia, this decrease has been attributed to greater personal control over fertility rather than an increase in terminations (Marino et al. 2016).

In the 10 years to 2015, there was also been a change in the age distribution of teenage mothers. The proportion of mothers aged 16 decreased from 8.7% to 6.9% while the proportion of mothers aged 19 increased from 42% to 46% (AIHW 2018).

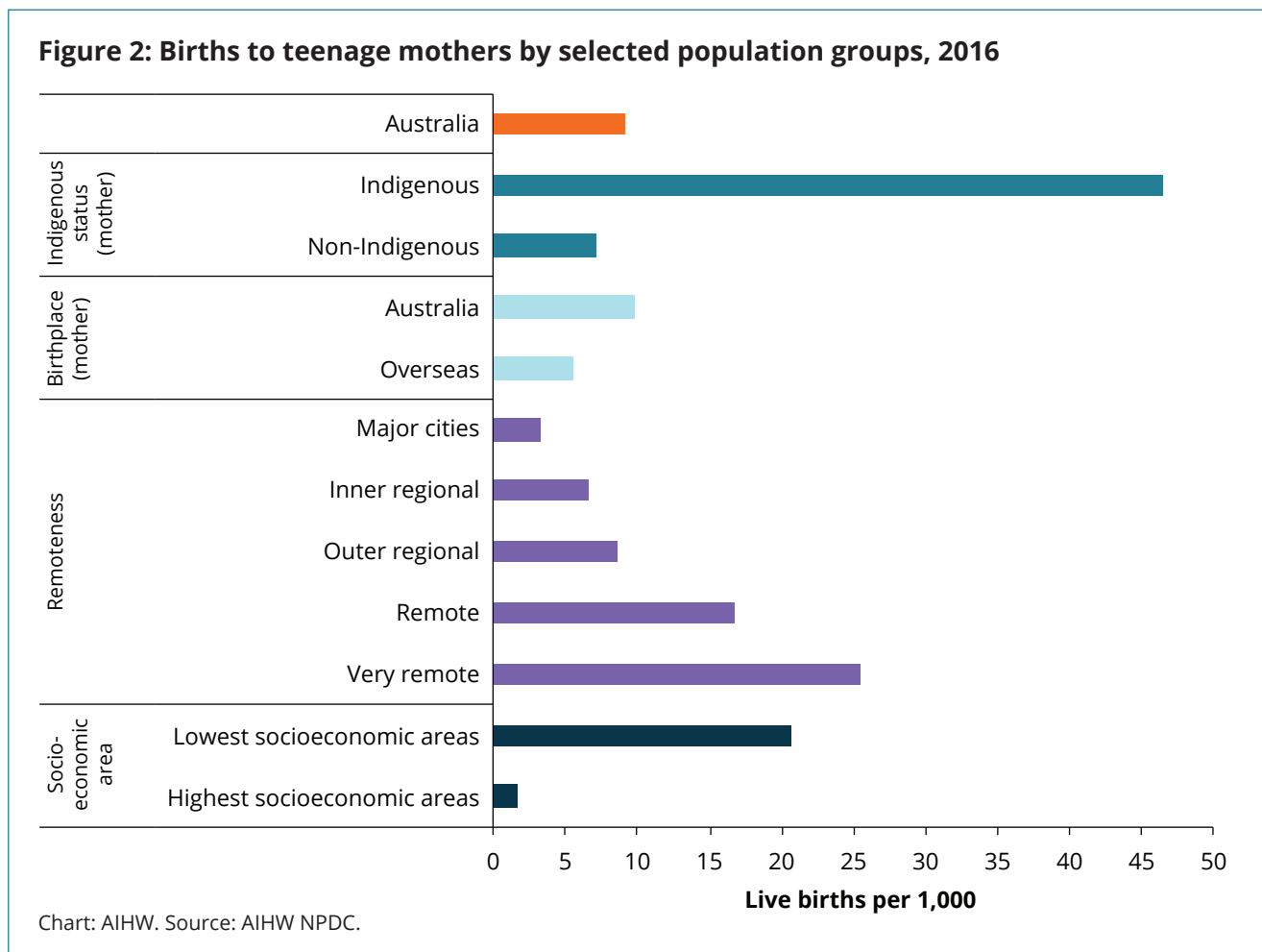
Are teenage births rates the same for everyone?

Teenage birth rates differ across population groups (Figure 2). In 2017, teenage mothers aged 15–19 were more likely to:

- live in *Remote and very remote* areas (21 births per 1,000) than in *Major cities* (3.2 births per 1,000)
- live in areas of greater socioeconomic disadvantage (21 births per 1,000 compared with 1.7 births per 1,000 in areas of least disadvantage).
- be born in Australia (9.9 births per 1,000) than overseas (5.6 births per 1,000).

Differences were also evident between Indigenous teenage mothers (46.4 births per 1,000) and non-Indigenous women (7.1 per 1,000). However, Indigenous teenage birth rates decreased considerably from 70 births per 1,000 Indigenous women aged 15–19 in 2006, to 46 births per 1,000 in 2017. See also [Indigenous children](#).

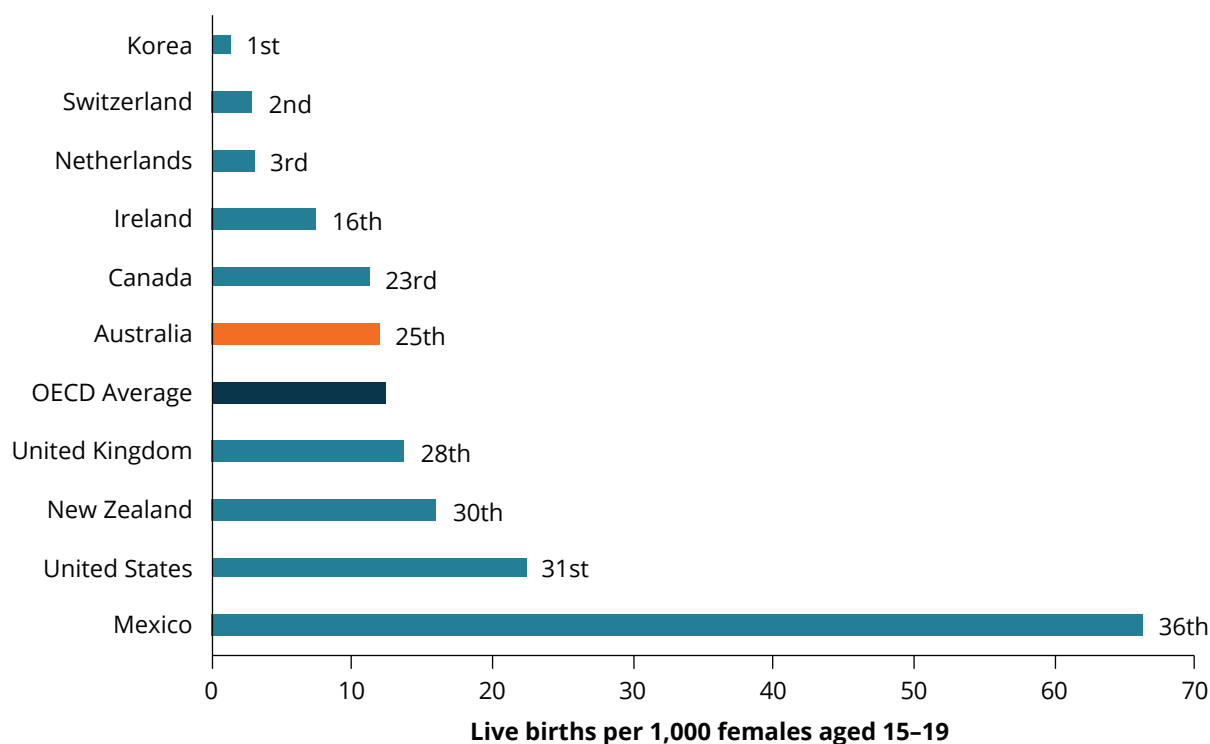
Note that not all these categories are mutually exclusive. It is likely that some of these associated factors overlap.



How does Australia compare internationally?

Internationally, Australia's birth rate for mothers aged 15–19 was lower than the national Organisation for Economic Co-operation and Development (OECD) average, according to the most recent OECD report on births to teenage mothers (Figure 3). Australia's birth rate for these mothers (11.9 births per 1,000) was lower than the OECD average of 36 countries (12.4 births per 1,000). Korea had the lowest teenage birth rate (1.3 births per 1,000) while Mexico had the highest (66 per 1,000) (OECD 2018).

Figure 3: Births to teenage mothers by selected OECD countries and rankings, 2016



Notes: Data for Canada refer to 2013, for Australia and the United States to 2015. Data in this graph are for OECD member states only. Graph reflects top 3 countries, English-speaking background countries, and bottom-ranked country.

Chart: AIHW. Source: OECD Family Database.

Data limitations and development opportunities

The teenage birth rate includes only live births to teenage mothers, and is therefore lower than the pregnancy rate, which would include stillbirths, miscarriages and terminations.

National data are not currently available on termination, with South Australia and Western Australia the only states to have data publicly available. Pregnancy termination rates in these states have declined since the late 1990s (Hutchinson & Ballestas 2018, SA Health 2018). In South Australia, the rate decreased from 23.6 to 8.3 per 1,000 women aged 15–19 between 2001 and 2016, respectively. While in Western Australia, the rate decreased from 23.1 to 9.1 for the same age group between 2002 and 2015, respectively.

Where do I find more information?

For more information on:

- teenage mothers for Indigenous children, see: [Indigenous children](#).
- births to teenage mothers, see: [Teenage births in Children’s Headline Indicators](#).
- selected indicators disaggregated by maternal age, including teenage mothers, see: [National Core Maternity Indicators data visualisations](#), [Demographics of mothers and babies: Maternal age in Australia’s mothers and babies data visualisations](#) and [Australia’s mothers and babies 2017—in brief](#).

- teenage motherhood, see: [Teenage mothers in Australia 2015](#) and [Australia's mothers and babies 2017—in brief](#).
- technical notes relating to this section, refer to [Teenage mothers](#) in the online report. See also [Methods](#).

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Birthweight

Key findings

- In 2017, around 20,300 (6.7%) live-born babies were of low birthweight (less than 2,500 grams).
- Around 15% of low birthweight babies weighed less than 1,500 grams.
- Low birthweight was higher among mothers who smoked during pregnancy (12.9%) than mothers who did not (6%).

Low birthweight is a key indicator of a baby's immediate health and a determinant of their future health. Low birthweight babies—whose weight at birth is less than 2,500 grams—are more likely to die in infancy or to be at increased risk of illness in infancy.

Long-term health effects can include poor cognitive development and increased risk of developing chronic diseases, such as diabetes and cardiovascular disease later in life (WHO 2014). Children born with very low birthweight are especially at high risk of developmental difficulties, poor cognitive and motor skills (Scharf et al. 2016). The risk of dying is greater for babies of very low birthweight (Mayor 2016).

Evidence has found that factors influencing low birthweight include:

- extremes of maternal age (younger than 16 or older than 40)
- multiple pregnancy
- obstetric complications
- chronic maternal conditions (for example, hypertensive disorders of pregnancy)
- infections (such as, malaria)
- nutritional status
- exposure to indoor air pollution
- tobacco
- drug use (Blencowe et al. 2019).

Research from the Maternal Health Study conducted in Victoria found that women who experienced family violence were twice as likely to give birth to babies of low birthweight as women who did not experience violence (Brown et al. 2015).

Low birthweight is closely associated with pre-term birth—almost 3 in 4 low birthweight babies were pre-term, and more than half of pre-term babies were of low birthweight in 2017 (AIHW 2019a).

Babies may also be low birthweight because they are small for gestational age, while some low-birthweight babies may be both pre-term and small for gestational age. Babies who are small for gestational age indicates a possible growth restriction within the uterus (see, [Where do I find more information?](#)).

While this section focuses on low birthweight, high birthweight is also of concern. Evidence based on data from 12 high, middle and low-income countries indicates that higher birthweight was associated with increased odds of obesity among children aged 9–11 (Qiao et al. 2015).

Box 1: Data source on low birthweight babies

Data on birthweight is sourced from the National Perinatal Data Collection (NPDC). The NPDC is a national population-based cross-sectional collection of data on pregnancy and childbirth. The data are based on births reported to the perinatal data collection in each state and territory in Australia.

How many babies are of low birthweight?

In 2017, around 20,300 (6.7% of around 303,000) liveborn babies were of low birthweight. Girls were slightly more likely to be of low birthweight than boys (7.3% compared with 6.1%, respectively). Around 15% of low birthweight babies weighed less than 1,500 grams (AIHW 2019a).

In 2017, the proportion of low birthweight babies was higher among twins (55%) and other multiple birth babies (99%) compared with singletons (5.2%). It was also higher among mothers who smoked during pregnancy (13%) than mothers who did not (6.0%) (AIHW 2019a).

In 2017, the proportion of pre-term babies of low birthweight was considerably higher than that of full-term babies (57% and 2.2%, respectively).

Have low birthweight rates changed over time?

The proportion of liveborn low birthweight babies was fairly stable in the 11 years to 2017 ranging between 6.1% and 6.7% (Figure 1). The proportion of pre-term babies of low birthweight ranged between 56% and 58% during this time, while for full-term babies the rate ranged between 1.9% and 2.2%.

Figure 1: Low birthweight liveborn babies, 2006 to 2017

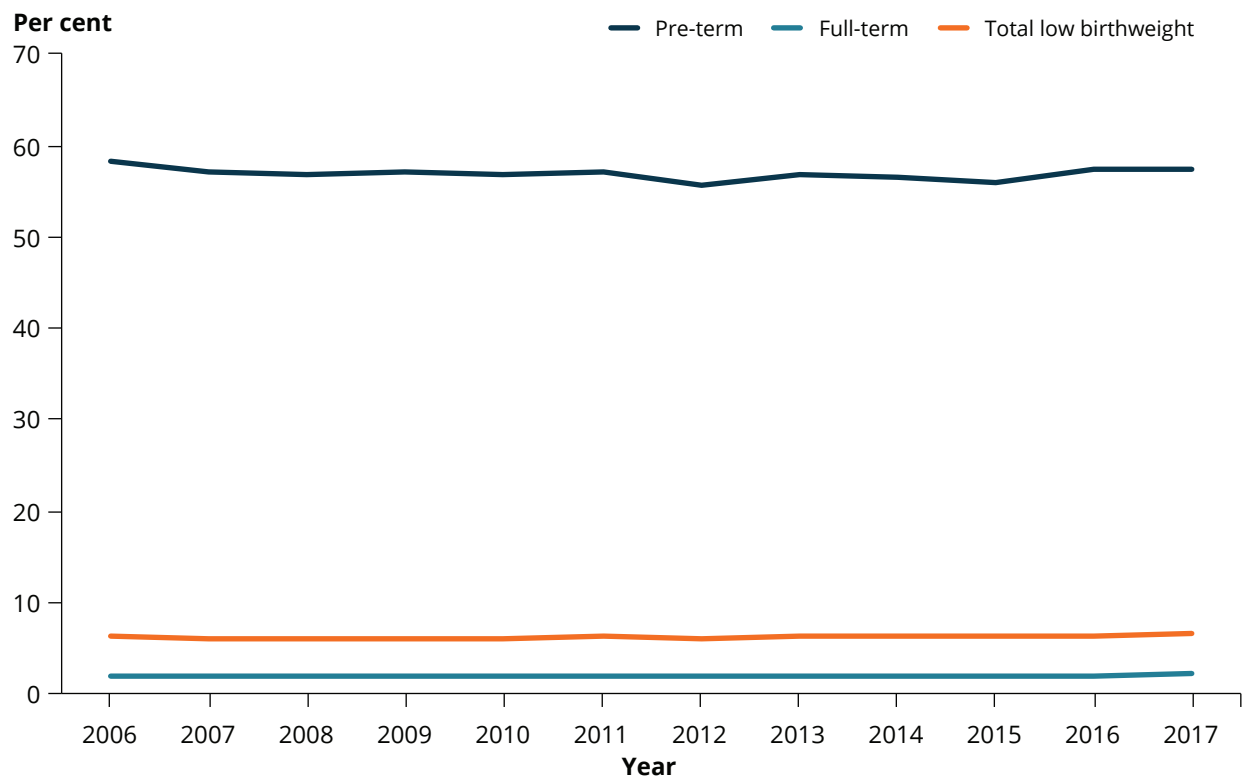


Chart: AIHW. Source: AIHW NPDC.

Are low birthweight rates the same for everyone?

Low birthweight rates vary across some population groups. In 2017, babies born in:

- *Very remote* areas (11%) were more likely to be of low birthweight than those born in *Major cities* (6.5%).
- areas of greatest socioeconomic disadvantage were also more likely to be of low birthweight (7.8%) than those born in areas of least disadvantage (5.7%) (Figure 2).

Differences were also evident between babies of Indigenous mothers and those of non-Indigenous mothers (13% and 6.4% born of low birthweight, respectively). The proportion of low-birthweight babies born to Indigenous mothers remained relatively stable between 2006 (12.4%) and 2017 (12.5%). See also [Indigenous children](#).

Not all these categories are mutually exclusive. It is likely that some of these influencing factors overlap.

Figure 2: Low birthweight babies by selected population groups, 2016

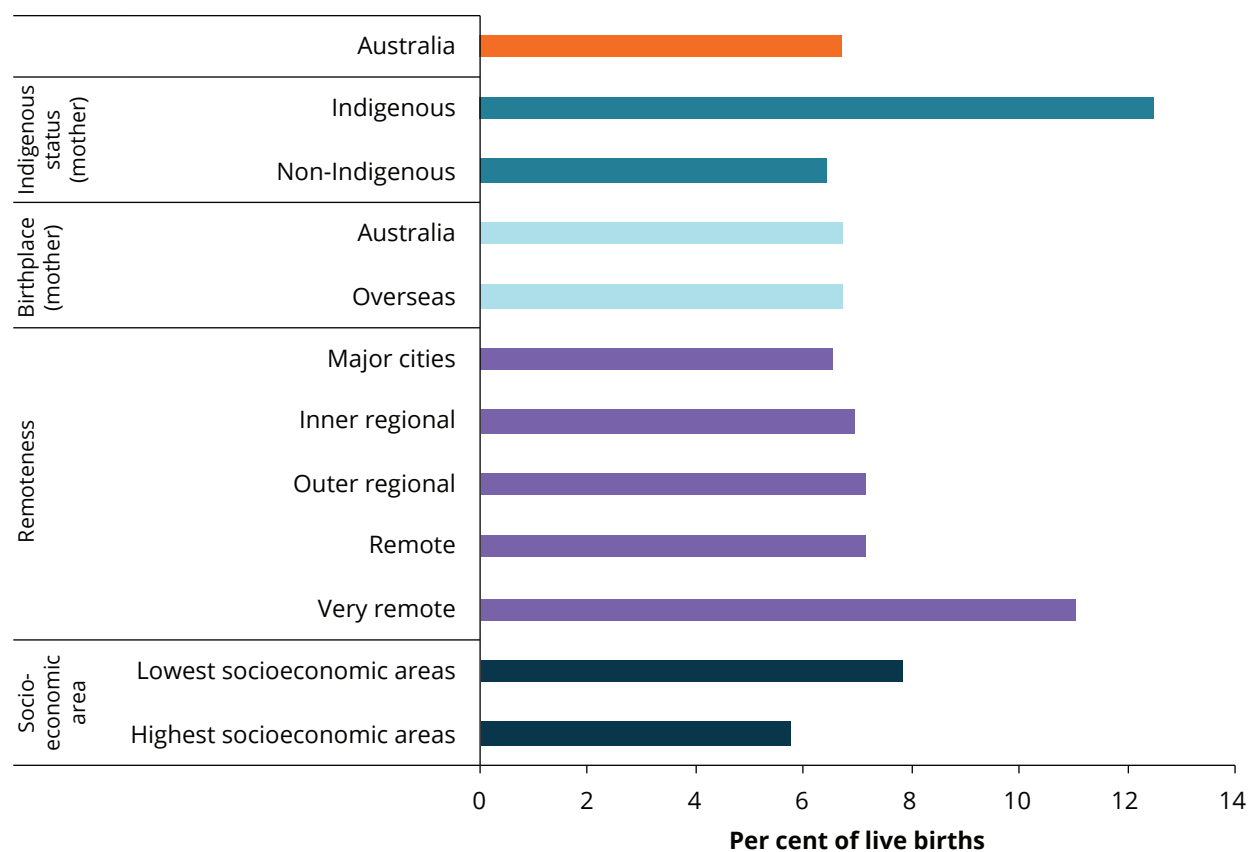
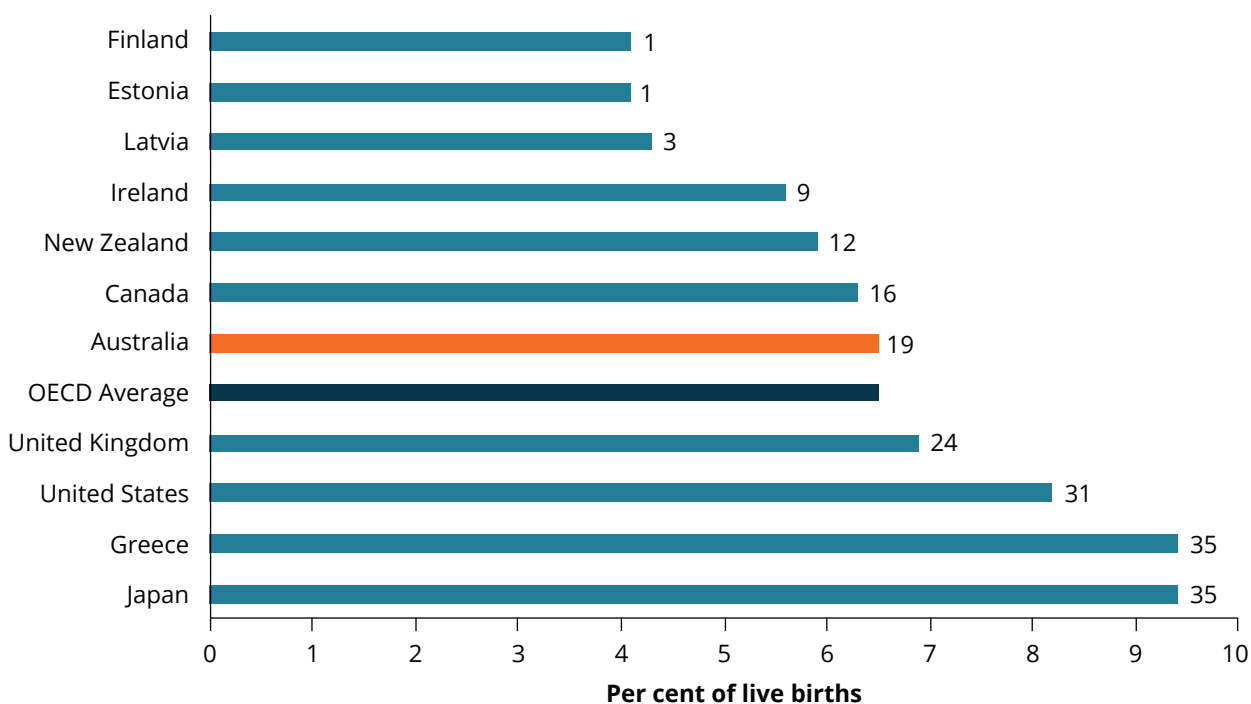


Chart: AIHW. Source: AIHW NPDC.

How does Australia compare internationally?

Internationally, Australia's proportion of low birthweight babies was equal to the Organisation for Economic Co-operation and Development (OECD) average (6.5%). The proportion of low birthweight babies was lowest in Finland and Estonia (4.1% each), and highest in Greece and Japan (9.4% each) (OECD 2018).

Figure 3: Low birthweight babies by selected OECD countries and rankings, 2016 or latest available



Notes: Data for Canada refer to 2014, and for Australia, to 2015. Exact definitions of low birthweight and of live births may differ slightly across countries. Data in this graph are for OECD member states only. Graph reflects top 3 countries, English-speaking background countries, and bottom ranked countries.

Chart: AIHW. Source: OECD Family Database.

Data limitations and development opportunities

While low birthweight is both a national and international indicator of infant health, it does have limitations as birthweight alone does not account for differentiation in growth status and maturity. Pre-term babies are inherently of low birthweight but may be of normal birthweight for their gestational age (AIHW 2019b).

Where do I find more information?

For more information on:

- low birthweight for Indigenous children, see: [Indigenous children](#).
 - birthweight data, see: [Australia's mothers and babies 2017—in brief. Data tables and Healthy community indicators](#).
 - low birthweight, see: [Low birthweight in Children's Headline Indicators](#).
 - birthweight including adjusted for gestational age, see: [Baby outcomes in Australia's mothers and babies data visualisations](#).
 - birthweight of stillborn babies, see: [Australia's mothers and babies 2017—in brief](#).
 - small babies among births at or after 40 weeks gestation, see: [National Core Maternity Indicators](#).
 - technical notes relating to this section, refer to [Birthweight](#) in the online report.
- See also [Methods](#).

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Immunisation

Key findings

- The number of children who are fully immunised remained high in 2018. More than 9 in 10 (91%) children aged 2 were fully immunised.

Vaccination initiates the body's natural defence mechanism—the immune response—to build resistance to specific infections (immunise). It is a safe and effective way to protect against harmful communicable diseases.

Vaccines are a powerful and cost-effective public health intervention, significantly reducing the risk of disease, disability and death, particularly in childhood (McGovern & Canning 2015; Orenstein & Ahmed 2017; WHO 2016). Successful immunisation interventions include the worldwide eradication of smallpox and the widespread elimination of poliomyelitis (polio).

Children who do not receive complete and timely vaccinations are at risk of contracting vaccine-preventable diseases and the short and long-term health consequences associated with these.

Immunisation also helps to protect people who are not immunised through a process called 'herd immunity', where enough people are immunised against a disease to stop the infection from spreading. Herd immunity helps to protect those more at risk of getting the disease, as well as those who are unvaccinated, so that those who are too young or too sick to be vaccinated can be protected. Outbreaks can occur where there is low immunisation coverage.

Measuring childhood immunisation coverage helps track how protected the community is against vaccine-preventable diseases and reflects the capacity of the health-care system to effectively target and provide vaccinations to children. Due to a higher level of immunisation coverage needed to protect the community against measles, Australia's aspirational childhood coverage target has been set at 95% to achieve herd immunity against all vaccine-preventable diseases (DoH 2016).

To increase childhood immunisation rates, to be eligible for the full rate of Family Tax Benefit Part A, children need to be immunised in accordance with the National Immunisation Program childhood vaccination Schedule, on an approved catch-up schedule or have an approved exemption (DSS 2019). Incentive payments are made to vaccination providers and general practitioners who follow up and vaccinate children more than 2 months overdue for their childhood vaccinations (DoH 2019a).



Box 1: Data sources on immunisation

Australian Immunisation Register

Data on rates of immunisation come from the Australian Immunisation Register (AIR), administered by the Australian Government Department of Human Services.

Children are registered on the AIR if they have Medicare, or when they first receive a vaccination. The AIR is a nearly complete population register, as approximately 99% of children are enrolled in Medicare by 12 months of age (Hull et al. 2019).

Children identified as Aboriginal and/or Torres Strait Islander in this report reflect the Indigenous status recorded on the AIR, which is based on Medicare enrolment records (AIHW 2018b). Indigenous status in Medicare records is based on the Medicare Voluntary Indigenous Identifier introduced in 2002 (AIHW 2010).

The AIR includes vaccines funded under the National Immunisation Program (NIP). A series of vaccinations are given at specific times throughout a person's life. The NIP provides free vaccines to eligible people (including babies, young children, teenagers and older Australians) to help reduce diseases that can be prevented by vaccination.

Childhood immunisation coverage is the percentage of children registered on the AIR who have had all the vaccines recommended for their age in the NIP Schedule. For children aged 2, these are:

- diphtheria, tetanus, pertussis (DTP or whooping cough) (4 doses)
- polio (3 doses)
- hepatitis B (3 doses)
- haemophilus influenza Type b (4 doses)
- pneumococcal (3 doses)
- meningococcal (1 dose)
- measles, mumps, rubella (2 doses)
- varicella (chickenpox) (1 dose).

Additional vaccines are required for Indigenous children in Queensland, Western Australia, South Australia and Northern Territory, as well as some medically at-risk children.

The NIP schedule is subject to change. For the most recent schedule, see: [National Immunisation Program Schedule](#).

National Notifiable Diseases Surveillance System

Data on rates of notifiable vaccine-preventable diseases come from the National Notifiable Diseases Surveillance System (NNDSS), which coordinates the national surveillance of more than 50 communicable diseases or disease groups. Under the NNDSS, doctors, diagnostic laboratories and hospitals are required by law to notify their state or territory health authority when cases of particular communicable diseases are identified. This data are collated, analysed and published on the internet by the Department of Health every day.

How many children are immunised at age 2?

More than 9 in 10 (91%) children aged 2 were fully immunised in 2018. This was slightly lower than coverage rates for children aged 1 (94%) and 5 (95%) due to changes to the NIP Schedule in 2016 (DoH 2019b).

Have immunisation rates changed over time?

The proportion of children fully immunised at age 2 remained relatively stable at around 91% to 93% between 2009 and 2018, dropping slightly to 89% in 2015 and 90% in 2017 (Figure 1).

These drops in the coverage rate are due to the inclusion of additional vaccinations to the NIP Schedule in December 2014 and March 2017. The more vaccinations included in the criteria to be fully immunised, the higher the likelihood of reduced coverage rates. However, historical data indicates this usually resolves over time as the changes become more routine (DoH 2019b).

Figure 1: Proportion of children aged 2 who were fully immunised, 2009 to 2018

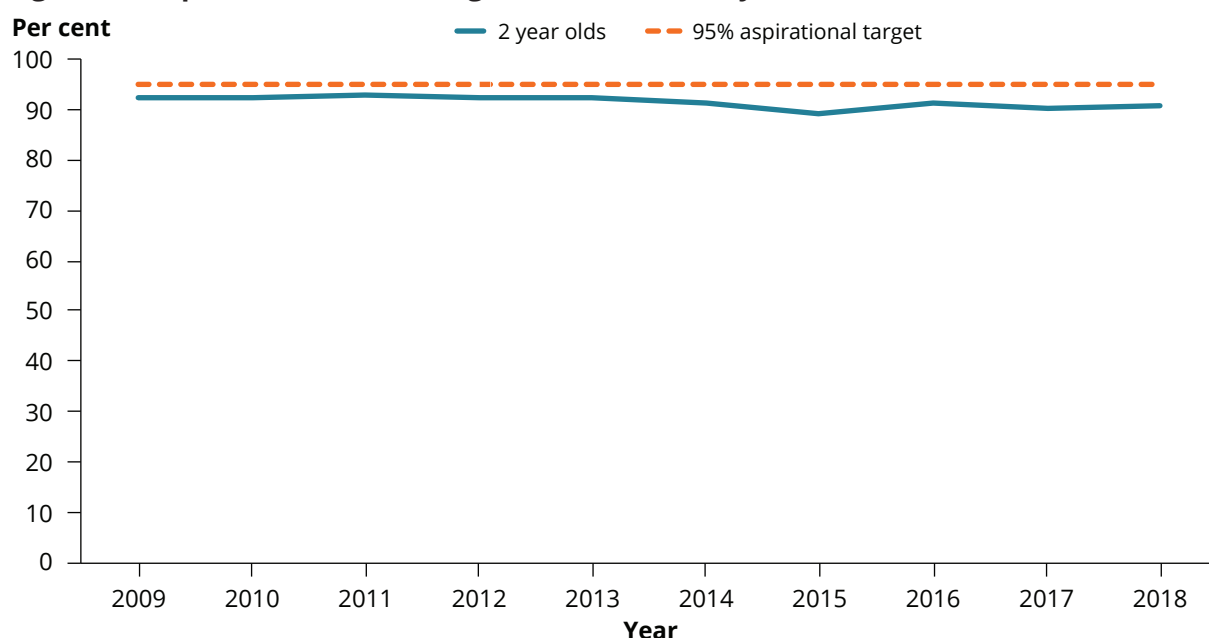


Chart: AIHW. Source: AIR, unpublished data.

Do rates of immunisation vary across population groups?

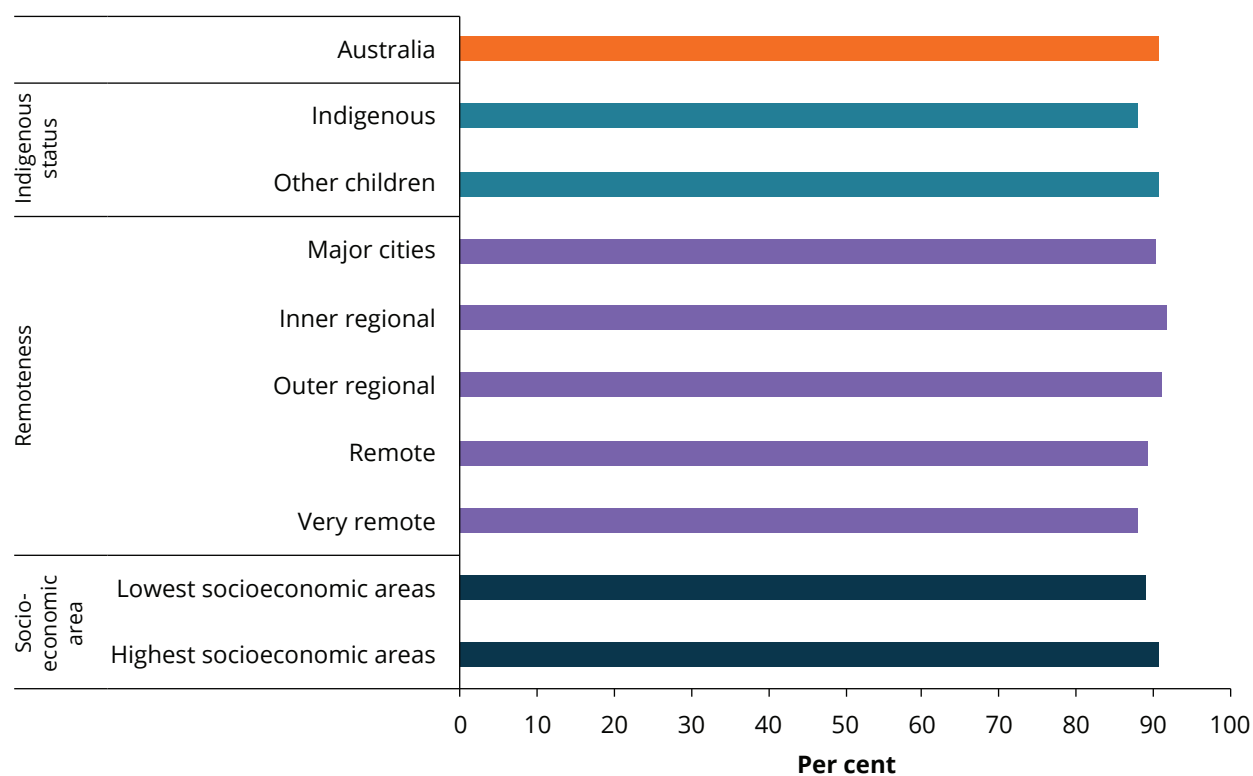
In 2018, children living in *Inner regional* areas had the highest rate of complete immunisation at age 2 (92%), followed by:

- *Outer regional* areas (91%)
- *Major cities* (91%)
- *Remote* areas (90%)
- *Very remote* areas (88%).

Children living in areas of least socioeconomic disadvantage were slightly more likely than those living in areas of greatest disadvantage to be fully immunised at age 2 (91% compared with 89%).

Differences were also evident between Indigenous children (88%) and non-Indigenous children (91%) (Figure 2). Indigenous childhood immunisation rates fluctuated between 2009 and 2018, decreasing from 90% in 2009 to 86% in 2015, before increasing to 88% in 2018. See also [Indigenous children](#).

Figure 2: Proportion of children aged 2 who were fully immunised, by priority population group, 2018



How does Australia compare internationally?

The percentage of children receiving diphtheria, tetanus and pertussis (DTP) is often used as an indicator of how well countries are providing routine immunisation services (UNICEF 2019). Internationally comparable data for immunisation coverage are only available for children aged 1.

Overall, OECD member countries have high DTP immunisation coverage for children aged around 1, ranging from 82% to 99% in 2018. The Australian rate was equal to the OECD average of 95%.

Notifications of childhood diseases

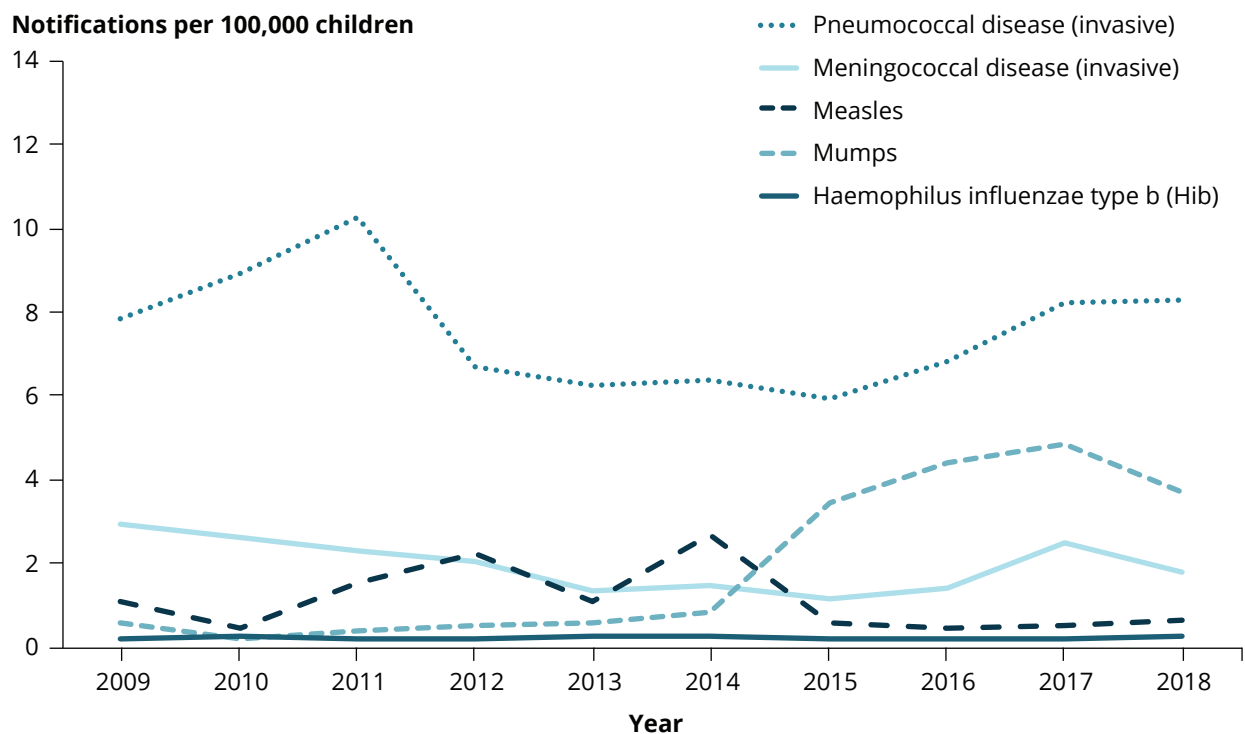
Factors influencing notification rates for vaccine-preventable diseases include:

- natural history of a disease
- length of time that an immunisation program has been in place
- particulars of the immunisation program (for example, receiving all injections at the required age)
- immunisation coverage.

Notification rates for some vaccine-preventable diseases fluctuated between 2009 and 2018 (Figure 3). According to the National Notifiable Diseases Surveillance System, for children aged 0–14:

- There were no notifications of diphtheria or poliomyelitis (polio), and only 3 notifications of tetanus (2 in 2017 and 1 in 2018) between 2009 and 2018.
- Notification rates of mumps increased from 0.6 notifications per 100,000 children in 2009 to 3.4 in 2015 when an outbreak occurred (AIHW 2018a). The rate peaked at 4.9 in 2017 before dropping slightly to 3.7 in 2018 (Figure 3).
- Haemophilus influenzae type b remained stable at around 0.2–0.3 notifications per 100,000 children between 2009 and 2018.
- Rates of invasive meningococcal disease decreased from 2.9 per 100,000 children in 2009 to 1.2 in 2015, before increasing to 2.5 in 2017.
- Notification rates of invasive pneumococcal disease peaked at 10.3 per 100,000 children in 2011 before declining to 5.9 in 2015, following the introduction of a more comprehensive pneumococcal vaccine in July 2011. The rate increased to 8.2 in 2017 and 2018.
- There were 18 notifications of rubella between 2009 and 2018, with the notification rate ranging from 0 and 0.1 per 100,000 children over this period.
- There were outbreaks of measles in 2012 and 2014, with notification reaching 2.2 per 100,000 children in 2012 and 2.7 in 2014. Notifications of measles then dropped, with 0.7 cases per 100,000 children reported in 2018.

Figure 3: Trend in notifications of selected communicable diseases among children aged 0–14, 2009–2018



Data limitations and development opportunities

The integration of AIR data with other national data sets, for example hospitals or education, will enhance understanding of the outcomes of children who are vaccinated.

For more information on how data linkage can fill data gaps, see [Data gaps](#).



Where do I find more information?

For more information on:

- immunisation for Indigenous children, see: [Indigenous children](#).
- Immunisation rates for children aged 1, 2 and 5 by Primary Health Network (PHN), see: [Immunisation rates for children in 2016–17](#)
- a range of vaccine-preventable diseases in Australia, including information on the number of cases reported, hospitalisations and deaths, see: [Vaccine-preventable diseases](#)
- technical notes relating to this section, refer to [Immunisation](#) in the online report. See also [Methods](#).

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Chronic conditions and burden of disease

Key findings

- For 2017–18, asthma, hayfever and allergic rhinitis, anxiety-related problems and psychological development problems were the 4 leading chronic conditions for children aged 0–14, based on self-reported proxy data from the ABS National Health Survey.
- Among all children aged 5–14, asthma was the leading cause of disease burden followed by mental health disorders.

Chronic conditions, also known as long-term conditions or non-communicable diseases, refers to a wide range of conditions, illnesses and diseases that tend to be long lasting with persistent effects.

Chronic conditions can interrupt a child's normal development and can increase their risk of being developmentally vulnerable at school entry (Bell et al. 2016). Because chronic conditions often persist throughout a person's life, there is generally a need for long-term management by individuals and health professionals (AIHW 2018a).

Managing chronic conditions can be complex, expensive and take a psychological, social and economic toll on the children affected and their families. Early intervention and joined-up support services can minimise the negative effects and support families (AHMAC 2015).

Burden of disease analysis measures the impact of different diseases or injuries on a population. This is done by measuring how many years of life Australia loses to diseases either due to people:

- dying early (fatal burden)
- living with ill health (non-fatal burden) (AIHW 2018b).

This section provides an overview of chronic conditions among children and the leading causes of the total burden of disease. Separate sections of this report focus on 4 specific chronic conditions that can have a major impact: asthma, diabetes, cancer and mental health conditions. These conditions significantly impact children's lives and are leading causes of disease burden (asthma, mental health conditions) (Figure 2), particularly common among children (Type 1 diabetes) (see [Children with diabetes](#)), or a leading cause of death (cancer) (see [Cancer incidence and survival](#)).

In 2017–18, around 43% of children had at least 1 long-term condition, while 20% had 2 or more long-term conditions. Boys were more likely to have at least 1 long-term condition than girls (46% compared with 39%) (ABS 2019b).

There are socioeconomic differences in the prevalence of some conditions, but this varies depending on if the disease risk factors/etiology are related to socioeconomic drivers. However, ensuring there is equity with service use and access is important for the treatment and/or management of chronic conditions.

What are the most common chronic conditions?

Based on self-reported data from the ABS National Health Survey 2017–18, the 2 leading chronic conditions for children aged 0–14 were diseases of the respiratory system:

- asthma
- hayfever and allergic rhinitis, both 10% (Figure 1).

Both these diseases are more common among people with hypersensitivity to allergens. For more information on asthma, see [Asthma prevalence among children](#).

The third and fourth leading conditions relate to mental and behavioural disorders:

- anxiety-related problems
- psychological development problems—5.7% for each).

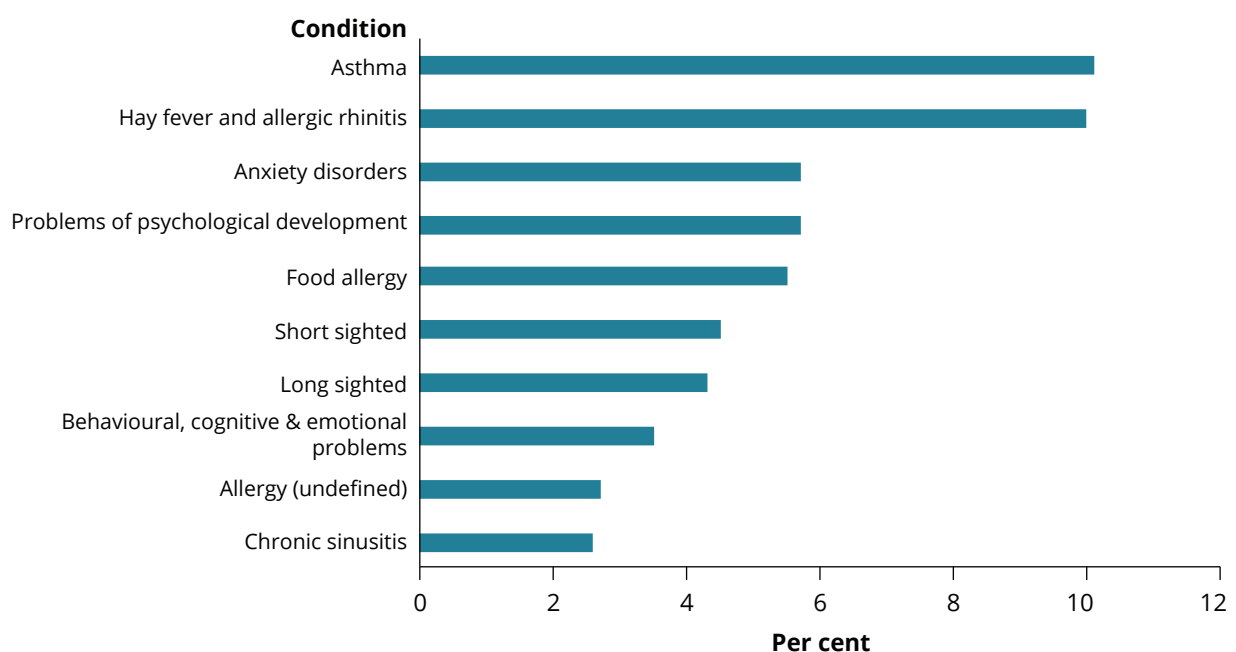
For more information on mental health, see [Children with mental illness](#) and [Social and emotional wellbeing](#).

The fifth most commonly reported chronic condition was food allergies (5.5%). In Australia, a 350% increase in hospital admissions for anaphylaxis and food allergies was reported in 1994–95 to 2004–05 (AHMAC 2015).

The number of children with a food allergy or food-related immune disorder has increased in the last 10 years. A study of more 2,000 Melbourne infants (the Healthnuts study) found that more than 10% of 1 year olds have a food allergy. Common food allergies, such as egg and milk allergies, which were previously limited to early childhood, are becoming increasingly persistent (Osborne et al. 2011).

Vision disorders are also common among children, with around 12% of children experiencing a vision disorder (diseases of the eye and adnexa) (ABS 2019a). The most common long-term vision disorders were short-sightedness (4.5% of children) and long-sightedness (4.3%) (Figure 1). Recent research on short-sightedness showed that increasing the time that children spend outside can slow the onset of short-sightedness (Morgan & Rose 2019).

Figure 1: Most commonly reported long-term conditions in children aged 0–14, 2017–18



Note: Long-term condition is defined here as a condition which has lasted, or is expected to last, for 6 months or more.

Source: ABS 2019a.

A study based on data from the Longitudinal Study of Australian Children (LSAC) looked at the prevalence and persistence of 19 paediatric conditions among the same group of children from infancy to mid-adolescence (aged 14–15). The paediatric conditions discussed in this study are defined differently to the chronic conditions discussed earlier in this section. Most children (60%) were found to have at least 1 ongoing health condition at any given time, although many of the conditions discussed resolved within 2 years.

The prevalence of 8 paediatric conditions rose steadily with age:

- overweight/obesity
- obesity
- injury
- anxiety/depression
- frequent headaches
- abdominal pain
- autism spectrum disorder
- attention-deficit hyperactivity disorder.

The prevalence of 6 conditions fell with age:

- eczema
- sleep problems
- day-wetting
- soiling
- constipation
- recurrent tonsillitis.

Three conditions remained stable (asthma, diabetes, epilepsy) and 2 peaked in mid-childhood (dental decay, recurrent ear infections).

Conditions were more likely to persist through childhood if present for 2 years; persistence was especially high for obesity beyond those aged 6–7 (91%–95%) persisting to the ages of 14–15. (Liu et al. 2018).

What are the leading causes of the burden of disease?

In 2015, findings from the Australian Burden of Disease Study 2015, reported that for children under the age of 5, 4 of the 5 leading causes of the total burden of disease were infant and congenital conditions, mostly due to pre-term birth and low birthweight complications (see [Infant and child deaths](#)) (Figure 2).

Among all children aged 5–14, asthma was the leading cause of burden followed by mental health disorders and dental caries (Figure 2).

Figure 2: Leading causes of total burden among children aged 0–14, by age group, 2015

Age group	1	2	3	4	5
Under 5	Pre-term birth and low birthweight complications	Birth trauma and asphyxia	Sudden infant death syndrome	Cardiovascular defects	Asthma
5–14	Asthma	Anxiety disorders	Depressive disorders	Conduct disorders	Dental caries

■ Infant/congenital ■ Mental ■ Respiratory ■ Oral

Note: Excludes 'other' residual conditions.

Source: AIHW Burden of Disease database.

In 2015, asthma and anxiety disorders were the 2 leading causes of burden among boys and girls aged 5–14. For boys the third leading cause of burden was conduct disorders, while for girls it was depressive disorders (AIHW 2019).

In 2011, findings from the Australian Burden of Disease Study 2011 (which included estimates for the Indigenous population) showed that among Indigenous children aged 5–14, 4 of the 5 leading causes of the disease burden were the same as those for all children in 2015 although the order differed. Conduct disorder was the first leading cause followed by asthma (Figure 3).

Figure 3: Leading causes of total burden among Indigenous children aged 0–14, by age group, 2011

Age group	1	2	3	4	5
Under 5	Pre-term birth and low birthweight complications	Sudden infant death syndrome	Other disorders of infancy	Birth trauma and asphyxia	Other gastrointestinal infections
5–14	Conduct disorders	Asthma	Anxiety disorders	Depressive disorders	Dental caries

■ Infant/congenital ■ Mental ■ Respiratory ■ Oral

Source: AIHW Burden of Disease database.

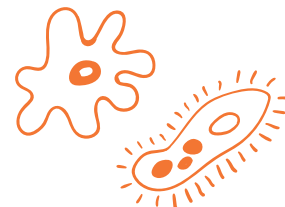
Conduct disorder and asthma were the 2 leading causes of burden among Indigenous boys aged 5–14. For Indigenous girls, the 2 leading causes of burden were asthma and anxiety disorders (AIHW 2016).

Data limitations and development opportunities

Future reporting of priority populations may be possible with linkage. For more information, see [Data gaps](#).

Where do I find more information?

For information on technical notes relating to this section, refer to [chronic conditions and burden of disease](#) in the online report. See also [Methods](#).



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Asthma prevalence among children

Key findings

- In 2017–18, an estimated 10% (around 460,000) of Australian children aged 0–14 were reported to have asthma as a long-term condition.
- Asthma prevalence was twice as high among children with disability (18%) compared with children with no reported disability (8.9%).
- Between 2007–2008 and 2017–18, prevalence of child asthma remained similar (between 9.3% and 11%).

Asthma is a common respiratory condition characterised by chronic inflammation of the airways. It causes episodes of wheezing, shortness of breath, coughing and chest tightness due to widespread narrowing of the airways.

The severity of the symptoms varies between individuals (National Asthma Council Australia 2019b). Asthma was the leading cause of disease burden for children in Australia in 2011; however, child deaths from asthma are relatively low (23 deaths of children 2014–2016) (AIHW 2011, 2018).

While the underlying causes of asthma are still not well understood, a wide range of factors have been identified as triggers for asthma, prompting or exacerbating asthma symptoms. Triggers differ between individuals, and can include viral infections, exposure to specific allergens, irritants, exercise, some chemical or food additives and genetic factors (National Asthma Council Australia 2019a).

Tobacco smoke is a common irritant that exacerbates asthma symptoms. Children can be exposed to second-hand tobacco smoke in the household, or through maternal smoking (passive or active) during pregnancy. The prevalence of asthma has been found to be greater among children living in households with smokers, with the risk of developing asthma reported to increase in proportion with the number of smokers in the home (Campbell et al. 2017). See also [Smoking and drinking during pregnancy](#) and [Smoking and drinking behaviour](#).

Most factors contributing to asthma can be controlled with the appropriate use of preventative and relief medication, in addition to avoiding or controlling trigger factors. For some people, however, asthma can place considerable restrictions on their physical, social and emotional lives. Experiences such as going back to school can cause an asthma flare-up for a child who may be impacted by the stress of returning to school, allergic triggers at school or being in close proximity to new classmates with viruses (National Asthma Council Australia 2019c).

Box 1: Sources and definitions

Data on asthma is from the ABS National Health Survey, conducted in 1989–90, 1995, 2001, 2004–05, 2007–08, 2011–12, 2014–15 and, most recently, in the 2017–18.

The survey collects information on the health status of the population, including long-term conditions; health risks; demographic and socioeconomic characteristics.

An adult was nominated to respond on behalf of each child included in the survey. The nominated respondent was asked if the child had ever been told by a doctor or nurse that they have asthma. Children with asthma is defined as those with a response of having been diagnosed by a doctor or nurse as having asthma and it is considered current and long-term (that is, had lasted, or was expected to last, for 6 months or more).

The 2017–18 survey was conducted from a sample of approximately 21,300 people from 16,400 private dwellings across Australia.

While urban and rural areas in all states and territories were included, very remote areas of Australia and discrete Indigenous communities were excluded.

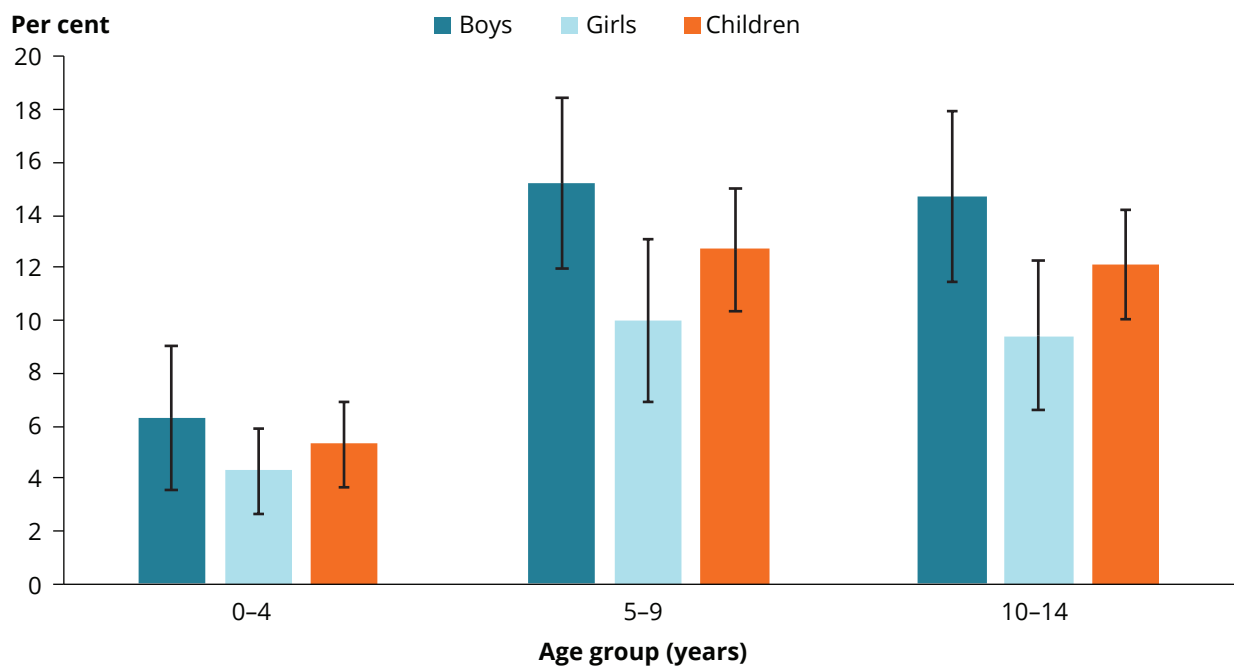
Data on asthma prevalence in the Indigenous population is from the ABS Australian Aboriginal and Torres Strait Islander Health Survey, 2012–13. The survey included approximately 5,900 non-remote and 3,400 remote participants across Australia, and collected information on a range of demographic and health characteristics of Indigenous people.

How many children have asthma?

In 2017–18, an estimated 10% (around 460,000) of Australian children aged 0–14 had asthma as a long-term condition. Asthma was more common among boys aged 0–14 years (12%) compared with girls (7.9%). This pattern has been consistent since 2001 (ABS 2018).

Asthma prevalence was highest among children aged 5–9 for boys (15%) and girls (10%). The prevalence of asthma among children aged 0–14 was similar to the general population (11%) (Figure 1).

Figure 1: Prevalence of asthma among children aged 0–14, 2017–18



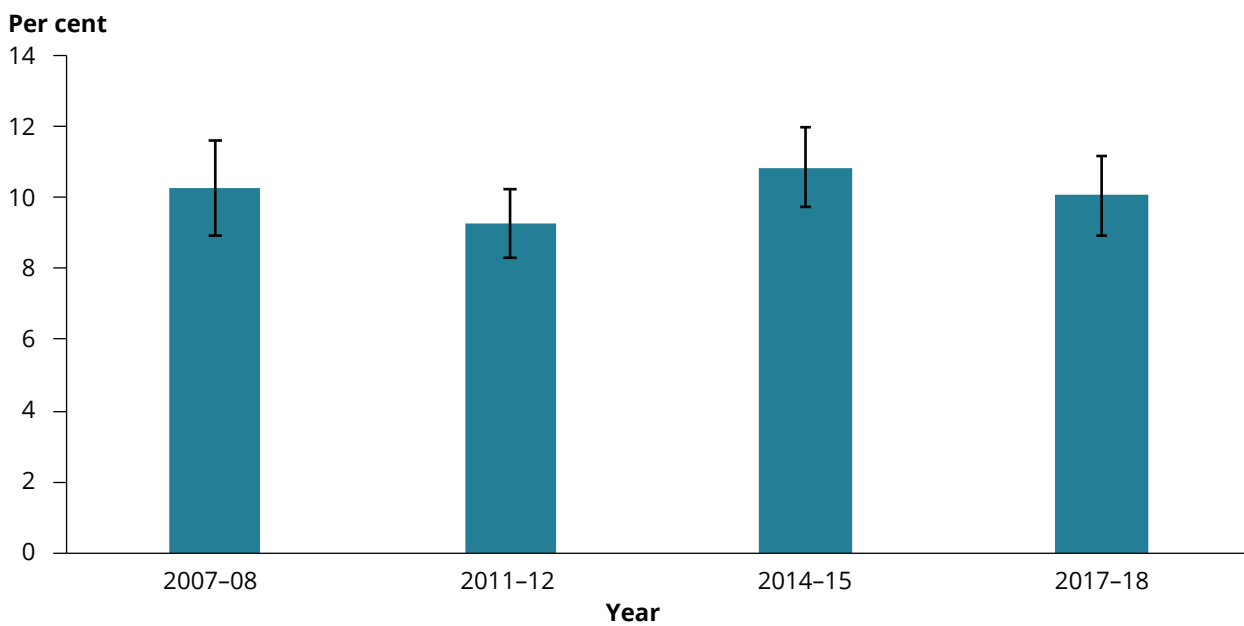
Note: Asthma prevalence is based on having been diagnosed by a doctor or nurse as having asthma (current and long term).
Source: AIHW analysis of ABS 2018.

Have asthma rates changed over time?

While the prevalence of current asthma among children increased during the 1980s and early 1990s, between 2001 and 2007–08 the prevalence among children aged 0–15 decreased from 13.5% to 9.9% (age standardised rates). This trend is based on the older National Health Survey definition of ‘Do you still get asthma?’ from the 2001, 2004–05 and 2007–08 National Health Surveys. See [Australian Centre for Asthma Monitoring 2011](#) for more details.

Between 2007–08 and 2017–18, prevalence of child asthma remained similar (between 9.3% and 11%) (Figure 2). These data are based on the revised definition of current asthma as defined in Box 1.

Figure 2: Prevalence of asthma over time among children aged 0–14, 2007–08 to 2017–18

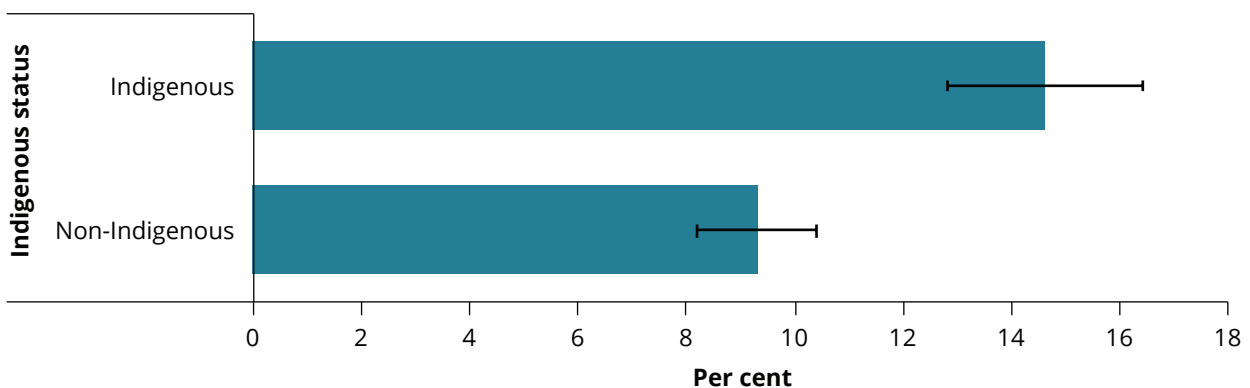


Sources: ABS 2010; ABS 2012; ABS 2015; ABS 2018.

Is asthma prevalence the same for everyone?

According to self-reported data in the 2012–13 Australian Aboriginal and Torres Strait Islander survey, asthma prevalence for Indigenous children (15%) was significantly higher than in non-Indigenous children (9.3%) (ABS 2014) (Figure 3).

Figure 3: Prevalence of children aged 0–14 with asthma, by Indigenous status, 2012–13

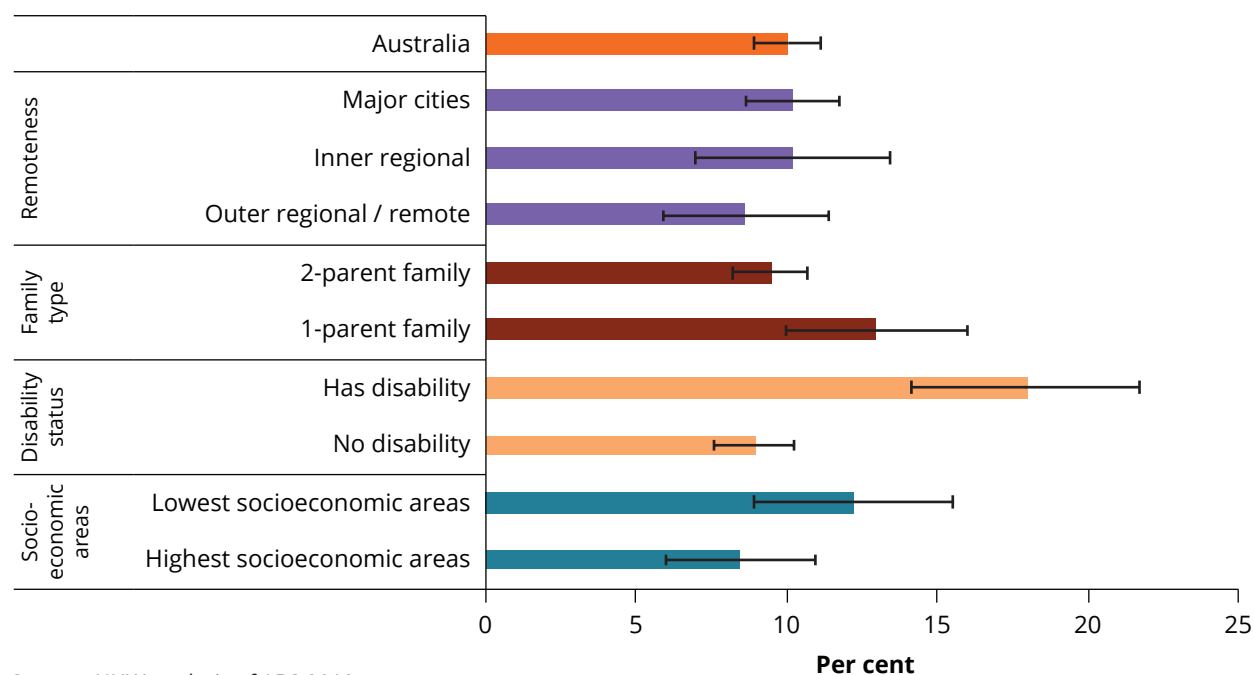


Source: ABS 2014.

In 2017, Asthma prevalence was twice as high among children with disability (18%) compared with children with no reported disability (8.9%) (ABS 2019) (Figure 4).

Differences were also evident between children living in the lowest socioeconomic areas (12%) and the highest (8.4%), and between children living in a 1-parent family compared with children living in a 2-parent family (13% compared with 9.4%, respectively) (ABS 2019).

Figure 4: Prevalence of asthma among children aged 0–14, by populations group, 2017–18



Source: AIHW analysis of ABS 2019.

Data limitations and development opportunities

Asthma symptoms, triggers and treatment vary between individuals. Currently, limited data are available about asthma treatment by general practitioners. Understanding the experiences of patients with asthma may provide greater insight into the physical, social and financial burden of the condition.

Where do I find more information?

For more information on topics related to asthma in Australia’s children, see:

- [Smoking and drinking during pregnancy](#)
- [Smoking and drinking behaviour.](#)

For more information on:

- asthma, see: [Asthma snapshot](#) in AIHW’s [Chronic respiratory conditions](#) and [Australian Asthma Handbook](#).
- technical notes, see [Methods](#).

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Children with diabetes

Key findings

- In 2017, around 6,500 children aged 0–14 had type 1 diabetes, a rate of 141 per 100,000 children.
- The prevalence of type 1 diabetes among children remained stable between 2013 and 2017.
- Aboriginal and Torres Strait Islander children were less likely than non-Indigenous children to have type 1 diabetes (89 compared with 137 cases per 100,000).

Diabetes is a chronic condition in which the body cannot properly use its main energy source—the sugar glucose. This is due to a deficiency in insulin (a hormone made by the pancreas to control blood glucose levels), or the inability to use the insulin available.

Diabetes is marked by an abnormal build-up of glucose in the blood and can have serious short and long-term effects, including:

- ketoacidosis
- kidney failure
- loss of eyesight and limbs
- disability
- premature death.

People with diabetes can control and reduce their risk of complications by ensuring that blood glucose levels remain within the normal range. Death due to diabetes is extremely rare among children aged 0–14. In 2014–16, there were fewer than 5 deaths from diabetes (AIHW 2018).

There are 2 main types of diabetes that occur in children—type 1 and type 2 (Box 1). Type 1 diabetes is the most common form of diabetes among children.

Box 1: Types of diabetes affecting children aged 0–14

Type 1 diabetes

This is a lifelong autoimmune disease that develops when the immune system destroys the insulin-producing cells of the pancreas, and usually has onset in childhood and adolescence (AIHW 2015). A person with type 1 diabetes needs insulin replacement to survive and, except in cases where a pancreatic transplant occurs, insulin will be required every day for the rest of their life. They must also maintain a careful balance of diet, exercise and insulin intake (AIHW 2015).

Type 2 diabetes

This is the most common form of diabetes among the Australian adult population and it occurs when the body becomes resistant to the insulin being produced by the pancreas and/or the amount produced is inadequate to meet the body's needs (AIHW 2017). While involving a genetic component, type 2 diabetes is largely preventable by maintaining a healthy lifestyle. Modifiable risk factors that can lead to type 2 diabetes include insufficient physical activity, saturated fat intake, obesity, and tobacco smoking (AIHW 2017).

Difficulties with determining the number of people with type 2 diabetes, including undiagnosed cases, misdiagnosis and misreporting mean there are currently no reliable national estimates of type 2 diabetes among children (AIHW 2014).

Type 1 diabetes It is the focus of this report, with data drawn from the National (insulin-treated) Diabetes Register (NDR) (Box 2).

Box 2: Data sources on type 1 diabetes

Data for this report come from the National (insulin-treated) Diabetes Register (NDR), a database of Australians who use insulin to treat diabetes. It was established in 1999 to monitor the incidence of insulin-treated diabetes in Australia, and aims to record all cases of people who begin to use insulin to treat their diabetes.

The NDR includes people with type 1 diabetes, insulin-treated type 2 and gestational and other types of diabetes. Data for the NDR are sourced from the National Diabetes Services Scheme and the Australasian Paediatric Endocrine Group’s state and territory registers.

For those with type 1 diabetes, age at first insulin use is used as a proxy for age of diagnosis.

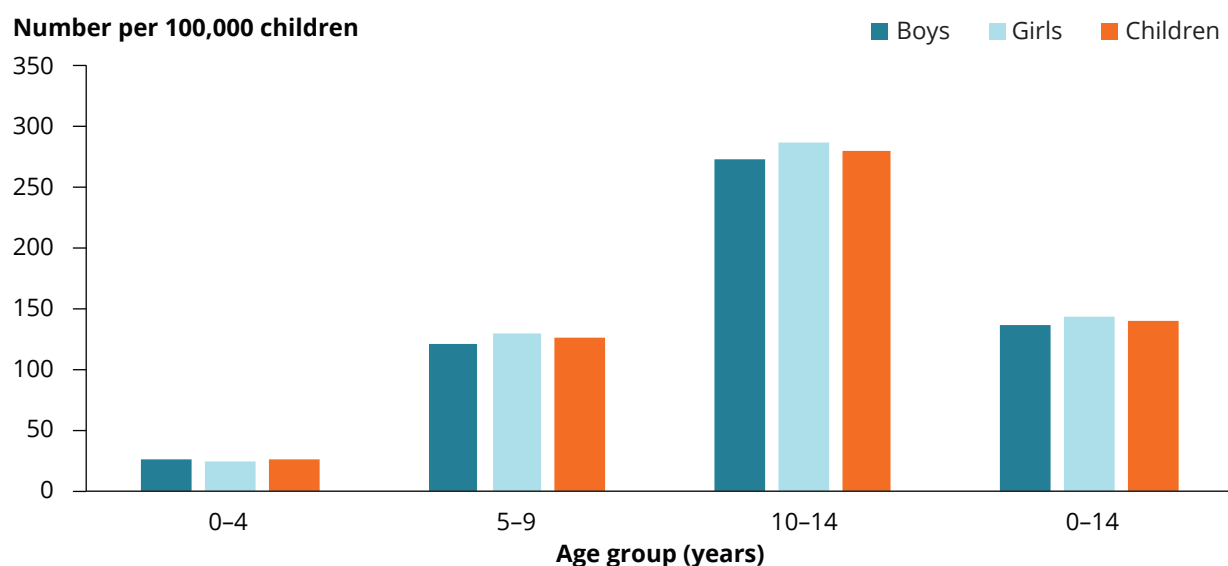
How many children have diabetes?

Overall, 6,527 children had type 1 diabetes in 2017, a rate of 141 per 100,000 children.

Girls were slightly more likely than boys to have diabetes (144 compared with 138 per 100,000, respectively). This difference was greatest in children aged 10–14, with 288 per 100,000 girls and 273 per 100,000 boys.

In 2017, the prevalence of diabetes increased with age, with rates among 10–14 year olds 11 times as high as 0–4 year olds (280 compared with 26 per 100,000) (Figure 1).

Figure 1: Prevalence of type 1 diabetes among children aged 0–14, by age group and sex, 2017



Source: AIHW analysis of 2017 NDR.

Has the rate of diabetes improved over time?

The prevalence of type 1 diabetes among children aged 0–14 remained stable between 2013 and 2017, at around 142 cases per 100,000 children (ranging between 140 to 143 cases per 100,000).

Is the rate of diabetes the same for everyone?

In 2017, the prevalence of type 1 diabetes was highest among children aged 0–14 living in Inner regional areas (169 per 100,000). This was followed by children living in:

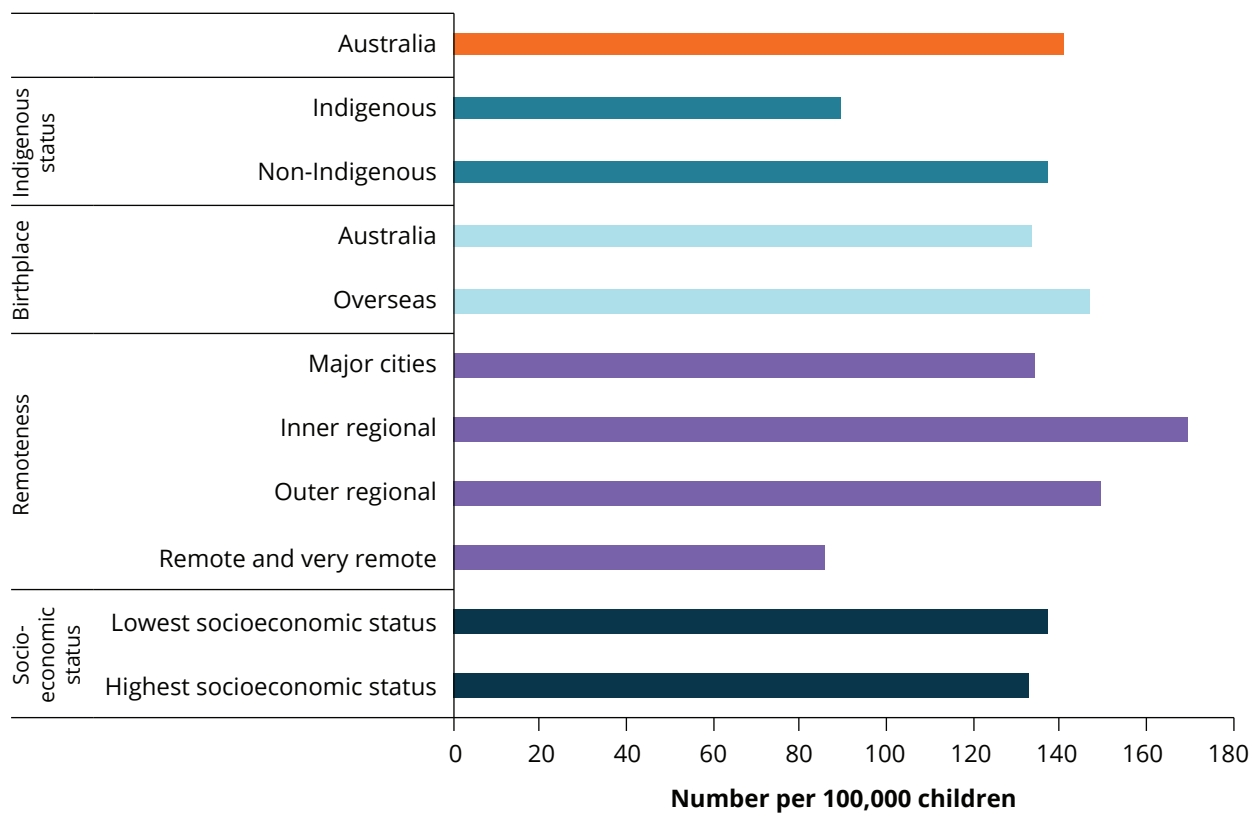
- *Outer regional areas* (149 cases)
- *Major cities* (134 cases)
- *Remote and very remote areas* (86 cases per 100,000).

Non-Indigenous children were also more likely than Indigenous children to have type 1 diabetes (137 compared with 89 cases per 100,000).

Children born overseas were slightly more likely to have type 1 diabetes than children born in Australia (147 compared with 133 cases per 100,000).

The rate of type 1 diabetes among children aged 0–14 was similar across low and high socioeconomic areas (137 compared with 133 cases per 100,000) (Figure 2).

Figure 2: Prevalence of type 1 diabetes in children aged 0–14 by selected population groups, 2017



Data limitations and development opportunities

Australian research suggests that the diagnosis rate of type 2 diabetes in children is increasing, likely due to the increase of childhood obesity (NDSS 2019). Data development is being undertaken to enable reporting of accurate estimates of type 2 diabetes among children; however national data are not reliable enough for reporting on the very young at this time.

The number of Indigenous children with type 1 diabetes may be underestimated by the NDR, as identifying as an Indigenous person on both data sources of the NDR (Box 2) is voluntary (AIHW 2019).

Rates of type 1 diabetes may also be influenced by the lower capture of people living in *Remote and very remote* areas in the NDR data.



Where do I find more information?

For information on:

- type 1 diabetes in children, see: [Incidence of insulin-treated diabetes in Australia and Prevalence of type 1 diabetes among children aged 0–14 in Australia, 2013](#)
- complications associated with diabetes in childhood, see: [Diabetic ketoacidosis among children and young people with type 1 diabetes](#)
- technical notes relating to this section, refer to [Children with diabetes](#) in the online report. See also [Methods](#).

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Cancer incidence and survival

Key findings

- During 2011–2015, an average of 714 new cases of cancer were diagnosed annually among children aged 0–14—a rate of 16 per 100,000 children.
- The most common cancer groups were leukaemia, cancer of the central nervous system (including the brain) and lymphoma

Cancer is a term used to describe diseases in which abnormal cells divide without control and can invade nearby tissues. Cancer can also spread to other parts of the body through the blood and lymph systems (AIHW 2019).

Cancers in children are often different from those observed in adults in appearance, site of origin and response to treatment (AIHW 2012). They can be caused by DNA (epigenetic) changes in cells that occur very early in life, sometimes even before birth (Cancer Australia 2019).

Leukaemia is the most common type of cancer among children. It refers to a group of cancers that affect the blood and blood-producing tissues of the body. Unlike many cancers in adults, childhood cancers are not strongly linked to lifestyle or environmental factors (Cancer Australia 2019).

Cancer causes significant illness for children. It was 1 of the leading causes of death for those aged 1–14 in 2015–2017 (see [Infant and child deaths](#)). Survival after a diagnosis of cancer provides an indication of cancer prognosis and the effectiveness of available treatments (AIHW 2019).

Box 1: Data sources and classifications for cancer

Data on **new cases** of cancer, and **5-year relative survival rates** are derived from the AIHW Australian Cancer Database. Reporting on types of new cases and survival rates uses the International Classification of Childhood Cancer, 3rd edition (ICCC-3), a classification scheme specifically developed for childhood cancer. Note that this differs from the International Classification of Diseases 10th edition (ICD-10) used in [Cancer in Australia](#) which reports on the whole population.

Deaths data are sourced from the AIHW National Mortality Database (NMD). Types of cancer deaths are reported using the International Classification of Diseases 10th edition (ICD-10), as it is not possible to report mortality using the ICC-3.

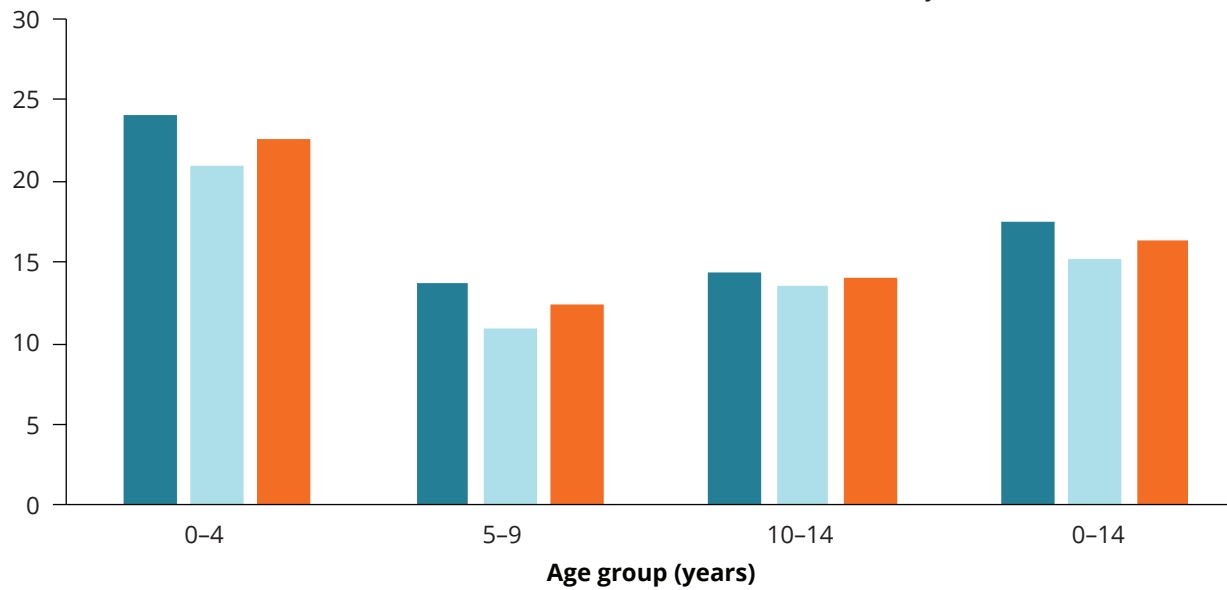
How many new cases of childhood cancers are there?

During 2011–2015, an average of 714 new cases of cancer were diagnosed annually among children aged 0–14 years—a rate of 16 per 100,000 children (18 and 15 per 100,000 boys and girls, respectively). More than half (55%) were diagnosed among boys.

The cancer incidence rate for very young children aged 0–4 (23 per 100,000) was almost twice that of children aged 5–9 (12 per 100,000) and 1.6 times as high as children aged 10–14 (14 per 100,000, respectively) (Figure 1).

Figure 1: New cases of cancer among children aged 0–14, by age and sex, 2011–2015

Incidence per 100,000 children



Source: AIHW Australian Cancer Database 2015.

What are the most common types of new cases of cancer?

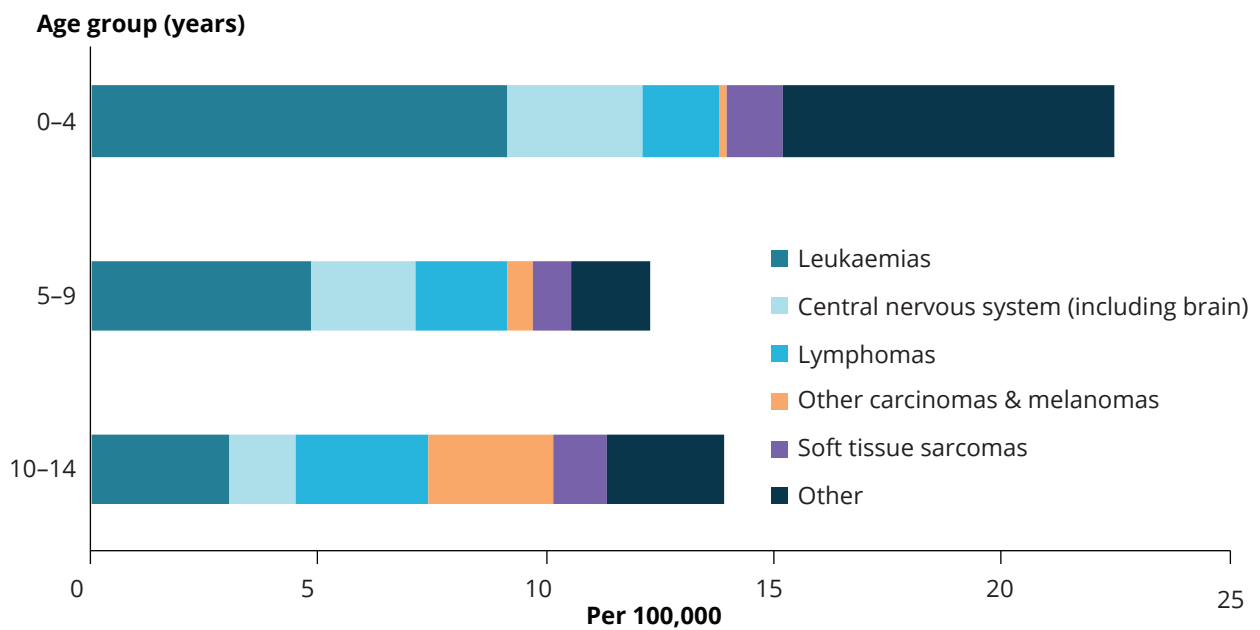
During 2011–2015, the most common cancers among children aged 0–14 fell into 3 broad cancer groups (ICCC-3):

- leukaemias (5.8 per 100,000 or 35% of all cases), including lymphoid leukaemias (27% of all cases)
- central nervous system (including brain) cancers (2.3 cases per 100,000 children aged 0–14 or 13.8%)
- lymphomas (2.2 cases per 100,000 children aged 0–14 or 13%), including:
 - Hodgkin lymphomas (3.8%)
 - Non-Hodgkin lymphomas (except Burkitt lymphoma) (3.5%).

There were more new cases of cancer for children aged 0–4 than for older children (Figure 2).



Figure 2: Most common types of new cancers among children aged 0-14, 2011–2015



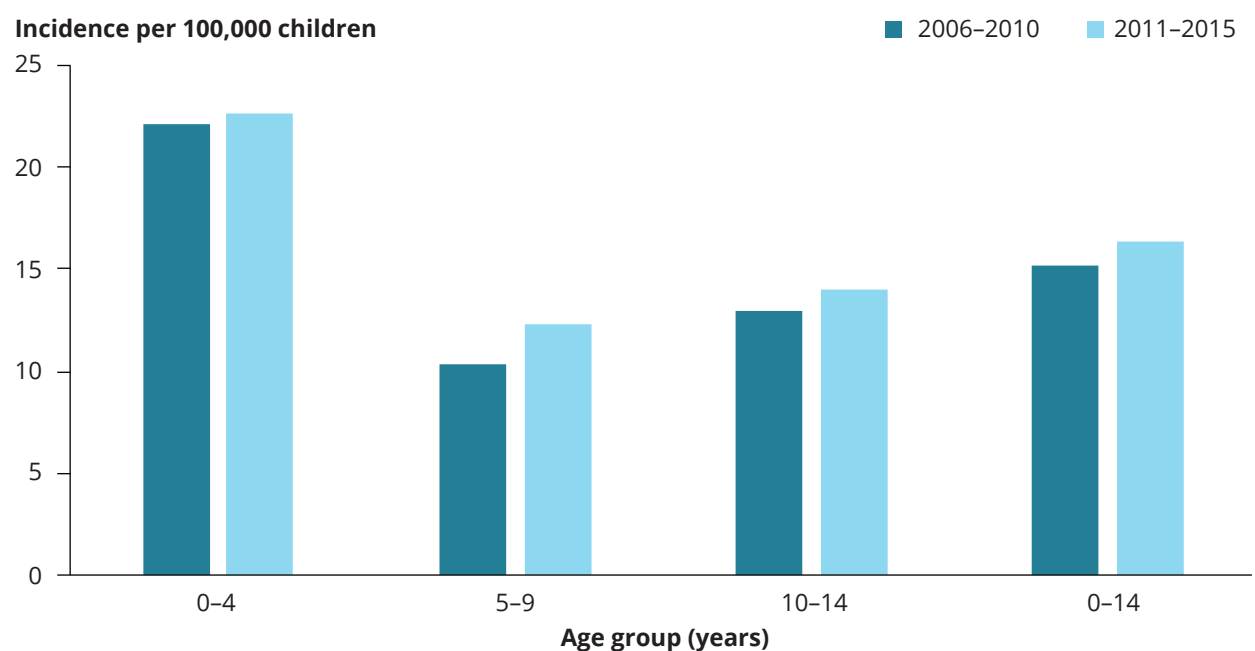
Note: For full names of the ICC-3 groups, see Technical notes in the section [Cancer incidence and survival](#) of the online report.
 Source: AIHW Australian Cancer Database 2015.

Have rates of new cases of cancer changed over time?

The rates for 2011–2015 for children aged 0–14 (16.3 per 100,000) were slightly higher than for 2006–2010 (15.1 per 100,000) (Figure 3).

While rates increased for all age groups, the largest increase was for children aged 5–9 (10.3 cases per 100,000 in 2006–2010 to 12.3 cases per 100,000 in 2011–2015).

Figure 3: New cases of cancer among children aged 0-14, in 2006–2010 and 2011–2015



Source: AIHW Australian Cancer Database 2015.

Have 5-year relative survival rates changed over time?

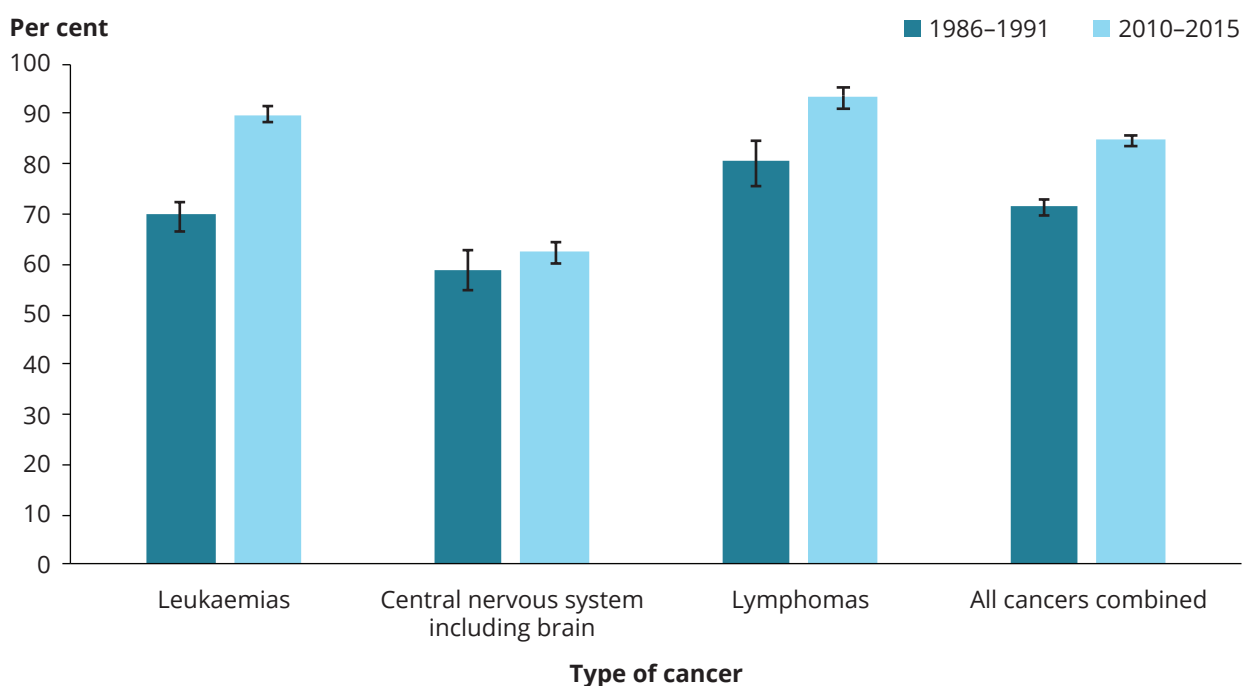
Five-year relative survival refers to the probability of being alive 5 years after diagnosis compared with the general population (see Technical notes in the section [Cancer incidence and survival](#) of the online report). During 2010–2015, the 5-year relative survival among children aged 0–14 was 84% for all cancers, with no statistically significant difference between boys (85%) and girls (84%).

All cancers

The 5-year relative survival rate for children aged 0–14 for all cancers steadily increased from 71% in 1986–1991 to 84% in 2010–2015 (Figure 4). However, gains were not consistent across all cancers:

- leukaemias—20 percentage point increase (rising from 70% to 90%)
- lymphomas—13 percentage point increase (rising from 80% to 93%)
- central nervous system cancers (including brain)—increase was small (4%) and not statistically significant.

Figure 4: Five-year relative survival for cancer among children aged 0–14, in 1986–1991 and 2011–2015



Source: AIHW Australian Cancer Database 2015.

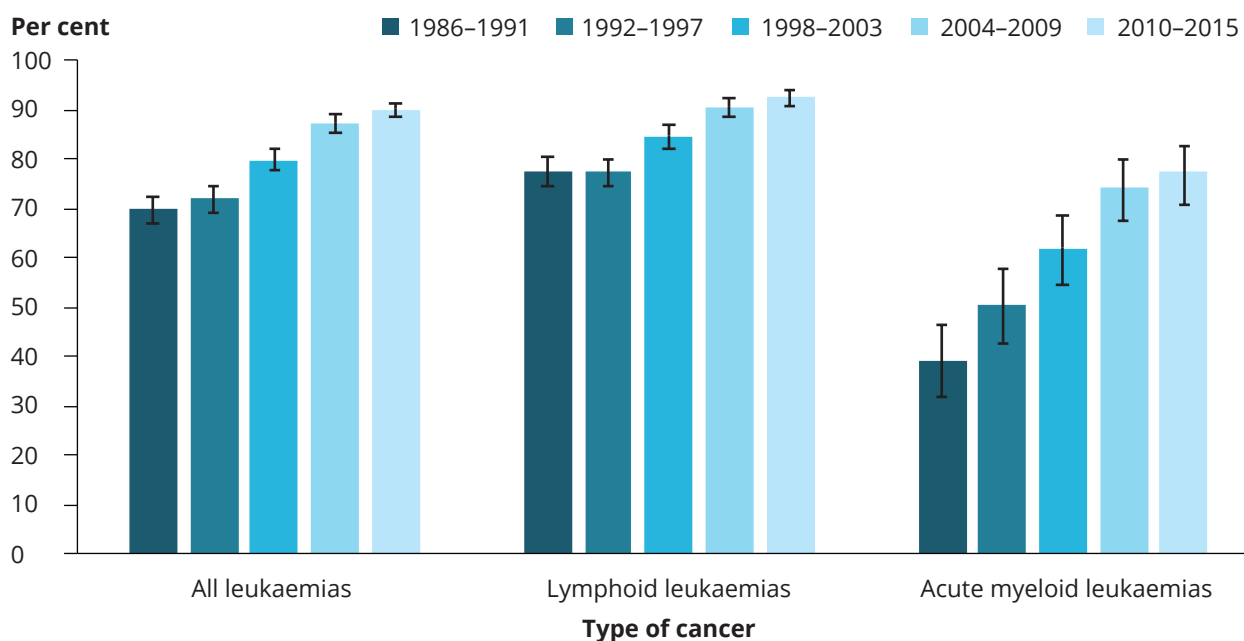
Leukaemia

Between 1986–1991 and 2010–2015, the 5-year relative survival for children aged 0–14 for all leukaemias increased from 70% to 90% (Figure 5).

Improvements were greatest for acute myeloid leukaemias, which almost doubled from 39% in 1986–1991 to 77% in 2010–2015.

In 2010–2015, the 5-year relative survival remained higher for lymphoid leukaemias (92%) than acute myeloid leukaemias (77%), a pattern that has remained consistent since 1986–1991 (Figure 5).

Figure 5: Five-year relative survival for leukaemia among children aged 0-14, from 1986-1991 to 2011-2015



Source: AIHW Australian Cancer Database 2015.

How many children die of cancer?

In this section, types of cancer deaths are reported using ICD-10 codes.

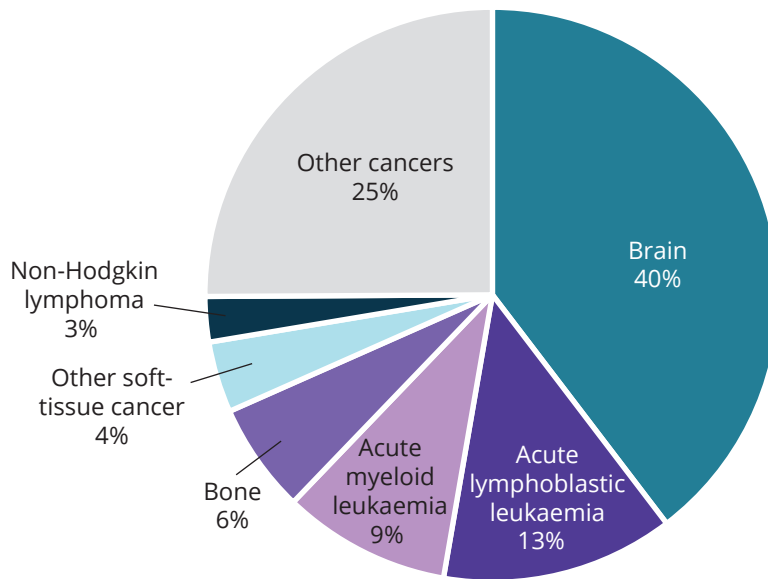
In 2015-2017, there were 275 cancer deaths among children aged 0-14. This is an average of 92 deaths a year or a rate of 2 deaths per 100,000 (Figure 6).

For children aged 1-14, cancer was the second leading cause of death, after injury deaths at 19% (see [Infant and child deaths](#)).

The most common cancers causing death among children in 2015-2017 were:

- brain cancer (0.8 deaths per 100,000 or 40% of all cancer deaths)
- acute lymphoblastic leukaemia (0.3 deaths or 13%)
- acute myeloid leukaemia (0.3 deaths or 9.5%).

Figure 6: Most common cancer deaths for children aged 0-14, 2015-2017



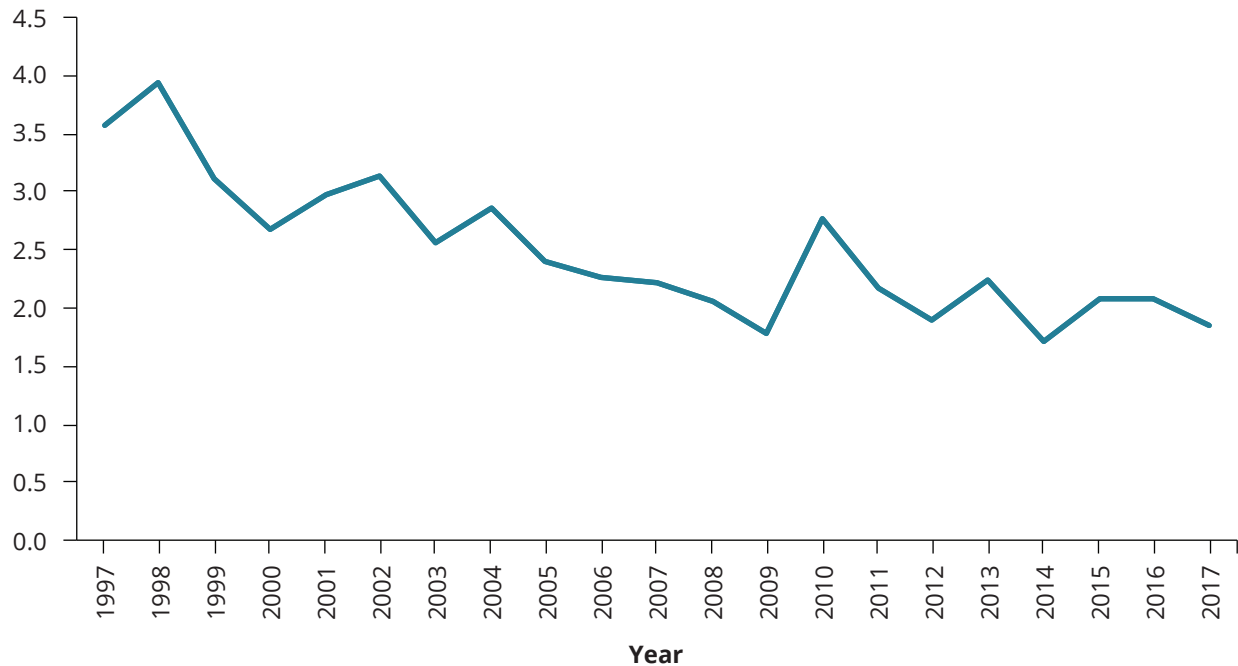
Source: Analysis of AIHW National Mortality Database.

Have cancer death rates changed over time?

Death rates from cancer almost halved between 1997 and 2017—from 3.6 deaths per 100,000 children aged 0-14 to 1.9 deaths per 100,000 (Figure 7).

Figure 7: Cancer deaths among children aged 0-14, 1997-2017

Deaths per 100,000 children



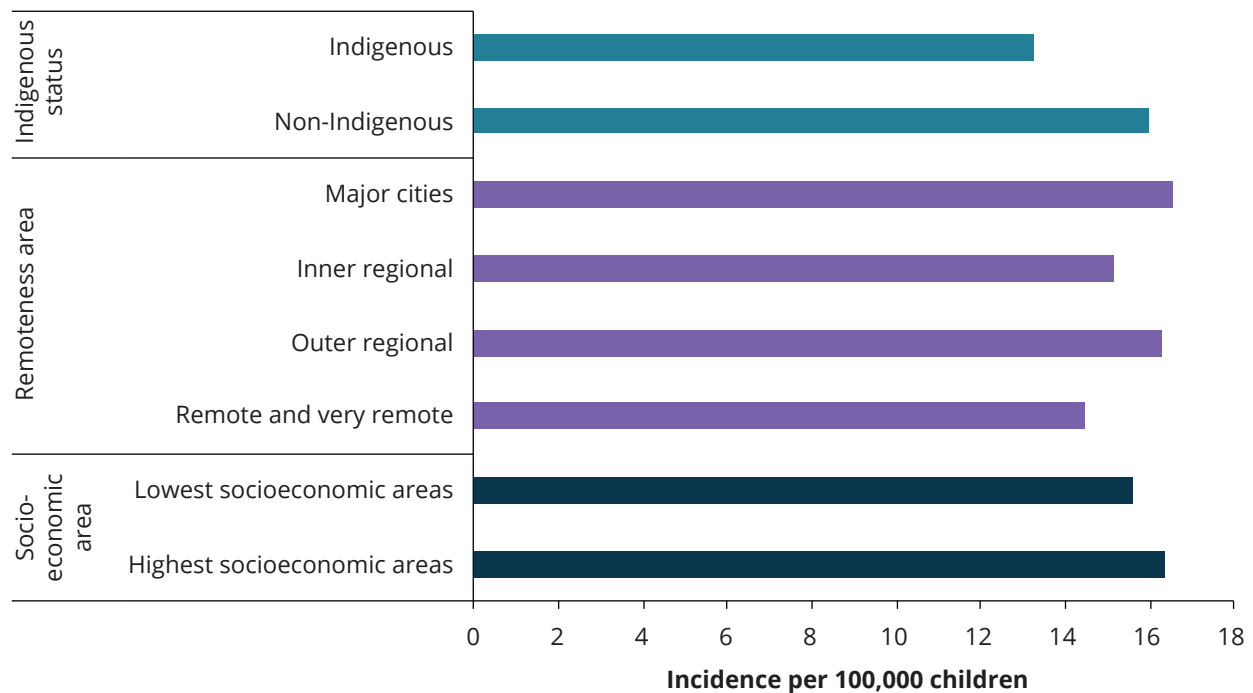
Source: AIHW Australian Cancer Database 2015.

Is the rate of new cancers the same for everyone?

During 2010–2014, there was little difference in the rate of new cases of cancers diagnosed in Indigenous children aged 0–14 and non-Indigenous children (13 and 16 cases per 100,000 children, respectively) (Figure 8).

Rates in areas of greater and least socioeconomic disadvantage and between different geographical areas were similar with the greatest difference between children in *Major cities* and *Remote and very remote* areas (17 and 15 per 100,000, respectively).

Figure 8: New cases of cancer among children aged 0–14, by selected population groups, 2010–2014



Note: 2015 data for New South Wales were not available and AIHW estimates of incidence for NSW in 2015 could not be stratified by Indigenous status, Remoteness Area or Socioeconomic Group.

Source: AIHW Australian Cancer Database 2015.

International comparisons

An international study of the incidence of cancer in 2001–10 for children aged 0–14 across 14 world regions found that the most common types of cancers in all regions combined among children aged 0–14 were:

- leukaemia
- central nervous system tumours
- lymphomas.

This ranking was observed in most world regions (Steliarova-Foucher et al. 2017). These were the same as those reported in this section for Australian children (See [What are the most common types of new cases of cancer?](#)).

The regions with the highest age-standardised rates of cancer incidence were in some predominantly white populations of North America, as well as in Europe, and Oceania (which includes Australia). From the 1980s to 2001–10, there was an increase in the world age-standardised rate for all cancer incidence in children aged 0–14. This increase was observed in all regions except sub-Saharan Africa (Steliarova-Foucher et al. 2017).

Reasons for the increase since the 1980s may include:

- improved diagnosis in high-income countries
- less under-diagnosis in some parts of world
- ongoing development of cancer registration
- more effective ascertainment techniques.

The highest incidence of all central nervous system tumours was noted in high-income countries, which is related to the wide availability of diagnostic facilities (Steliarova-Foucher et al. 2017).

Data limitations and development opportunities

Future national reporting of cancer is likely to be enhanced with the introduction of the Enduring Linked Cancer and Treatment Analysis Asset, which aims to bring together data from the Australian Cancer Database with health service, treatment and mortality data. This analysis asset is currently being developed by AIHW, in conjunction with the Australian Government and the states and territories. For more information data linkage, see [Data gaps](#).

Where do I find more information?

For more information on:

- Australian cancer incidence and mortality (classified using the ICD-10), see: [Cancer data in Australia](#) and [Cancer in Australia 2019](#).
- technical notes relating to this section, refer to [Cancer incidence and survival](#) in the online report. See also [Methods](#).

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Children with mental illness

Key findings

- In 2013–14, an estimated 314,000 children aged 4–11 (almost 14%) experienced a mental disorder. Boys were more commonly affected than girls (17% compared with 11%).
- Attention deficit hyperactivity disorder (ADHD) was the most common disorder for children (8.2%). It was also the most common disorder among boys (11%).
- Anxiety disorders were the second most common disorders among all children (6.9%), and the most common among girls (6.1%).

Mental health is a state of wellbeing in which an individual realises their own abilities, can cope with the normal stresses of life, can work productively and make a contribution to their community. Poor mental health can impact on the potential of young people to live fulfilling and productive lives (WHO 2014a). See 'Social and emotional wellbeing'.

Mental illness (also referred to as mental health disorders) are diagnosable health conditions and most can be successfully treated. They comprise a broad range of problems but are generally characterised by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are:

- schizophrenia
- depression
- disorders due to drug abuse.

Mental illness can vary in severity and duration. It may also be episodic (AIHW 2018).

Mental illness affects individuals, families and carers. It also has far-reaching influence on society, through issues such as poverty, unemployment and homelessness (AIHW 2018).

Mental health and many common mental illnesses are influenced by social, economic, and physical environments factors. For children, loving, responsive and stable relationships with a caring adult help build secure attachment between child and caregiver. This is essential for healthy social and emotional development. Secure attachment to the primary caregiver in the early years helps to protect against anxiety and boosts the ability to cope with stressors (WHO 2014b).

Mental health problems in childhood can have a substantial impact on wellbeing. In addition, there is strong evidence that mental disorders in childhood and adolescence predict mental illness in adulthood (WHO 2014b; Lahey 2015; NMHC 2019a).

At the same time, childhood presents the greatest opportunity for intervention. Investing in prevention and early intervention gives children the best opportunity for good mental health and wellbeing (NMHC 2019a). For high risk groups, such as children affected by violence, abuse, maltreatment or poverty, early intervention can help reduce disparities between the mental health of these children and children in psychologically healthy environments (NMHC 2019a).

To ensure that mental illnesses are diagnosed and treated early to prevent lifelong disability, a National Children’s Mental Health and Wellbeing Strategy is being developed. The strategy aims to provide a framework for preventing mental illness and reducing its impact on children, families and the community (NMHC 2019b).

A wide variety of support services are available to assist children with emotional and behavioural problems. These include:

- health services
- school services
- telephone counselling services
- online services (Lawrence et al. 2015).

The Be You program provides educators with knowledge, resources and strategies for helping children and young people achieve their best possible mental health (Be You 2019).

In 2015, for children aged 5–14, 3 of the 5 leading causes of the total burden of disease were mental disorders:

- anxiety disorders ranked second
- depressive disorders third
- conduct disorders fourth (AIHW Burden of Disease database).

For boys and girls aged 5–14, anxiety disorders were the second leading cause of total burden. Conduct disorders were the third leading cause of total burden for boys while depressive disorders were the third leading cause for girls (AIHW 2019).

Box 1: Data sources on mental illness

Data on mental illness are sourced from the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (also known as the Young Minds Matter Survey), and the Young Minds Matter Survey Results Query Tool. This household survey was conducted in 2013–14 by the Telethon Kids Institute at the University of Western Australia in partnership with Roy Morgan Research. Children aged 4–11 are reported in this section based on parent and/or carer reported data.

Children with mental health disorders are children who meet the criteria for a medical diagnosis of a mental disorder within the 12 months before the survey. Diagnoses were based on the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition). The DSM-IV includes all currently recognised mental health disorders.

How many children have mental illness?

In 2013–14, an estimated 314,000 children aged 4–11 (almost 14%) experienced a mental disorder in the 12 months before the survey (Lawrence et al. 2015). Boys were more commonly affected than girls (17% compared with 11%).

ADHD was the most common disorder for children (8.2%), and the most common among boys (11%).

Anxiety disorders were the second most common disorders among all children (6.9%), and the most common among girls (6.1%) (Figure 1).

Figure 1: Mental illness among children aged 4–11, by gender, 2013–14

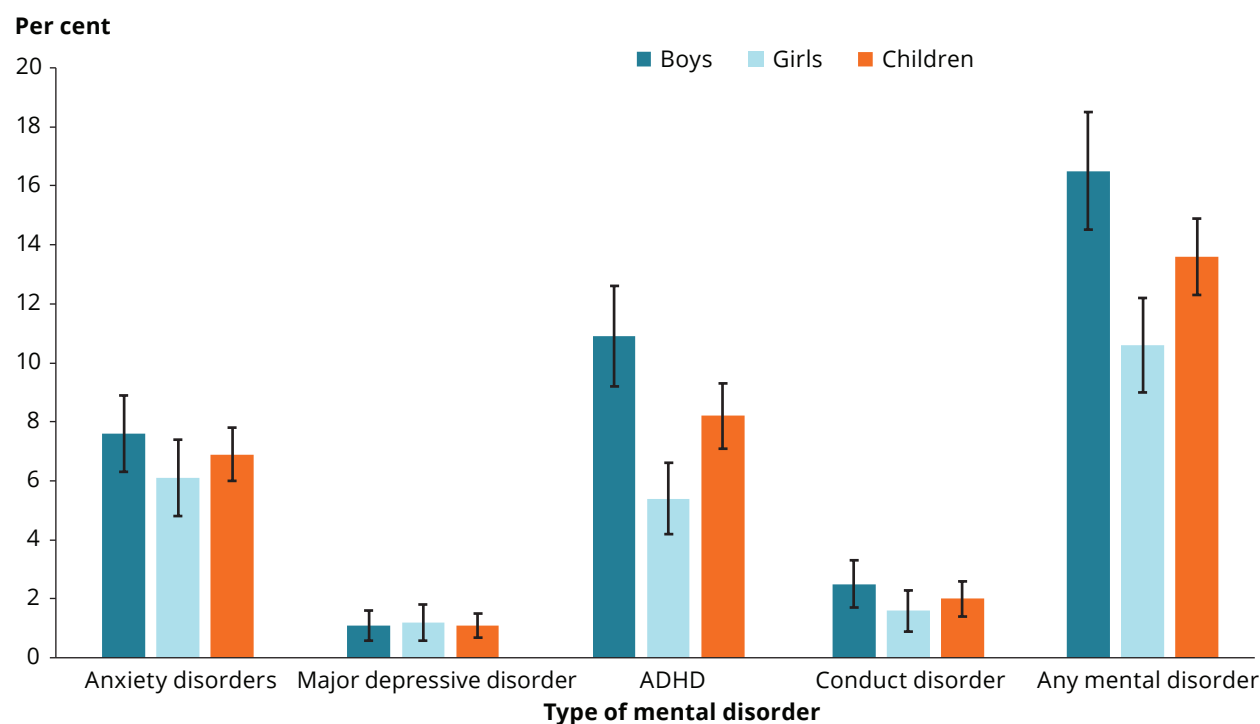


Chart: AIHW. Source: AIHW analysis of the Young Minds Matter Survey Results Query Tool.

Overall almost:

- 3 in 4 (72%) had mild disorders
- 1 in 5 (20%) had moderate disorders
- less than 1 in 10 (8.2%) had severe disorders
- Severe disorders were more common among boys (9.9%) than girls (5.6%).

Children with mental illness use a range of services (Box 2).

Box 2: How many children use services?

A wide variety of services are available to support children with emotional and behavioural problems. The 2013–14 Young Minds Matter survey collected information on 4 key types of services:

- health services
- school services
- telephone counselling service
- online services.

For children aged 4–11, very few were reported to have used telephone or online services. However, parents and carers often reported not knowing which services children had used (Lawrence et al. 2015).

Data from the survey indicated that in the previous 12 months:

- Around 49% of children with mental disorders had used services for emotional or behavioural issues (50% boys and 48% girls).
- Service use was highest among children with a major depressive disorder (73%) followed by children with conduct disorders (66%), children with anxiety disorders (54%) and children with ADHD (49%).
- Service use varied with severity of mental disorder—40% of children with mild disorder, 68% with moderate disorders and 83% with severe disorders.
- The 3 most common types of health service providers were general practitioner (30%), paediatrician (23%) and psychologist (20%).
- The 3 most common types of school services were individual counselling (20%), special class or school (13%) and group counselling or support program (6.5%).

Survey data suggests service use by children with mental disorders in Australia increased significantly between 1998 and 2013–14 (Lawrence et al. 2015).

For more information of mental health service use in Australia, see [Mental health services in Australia](#).

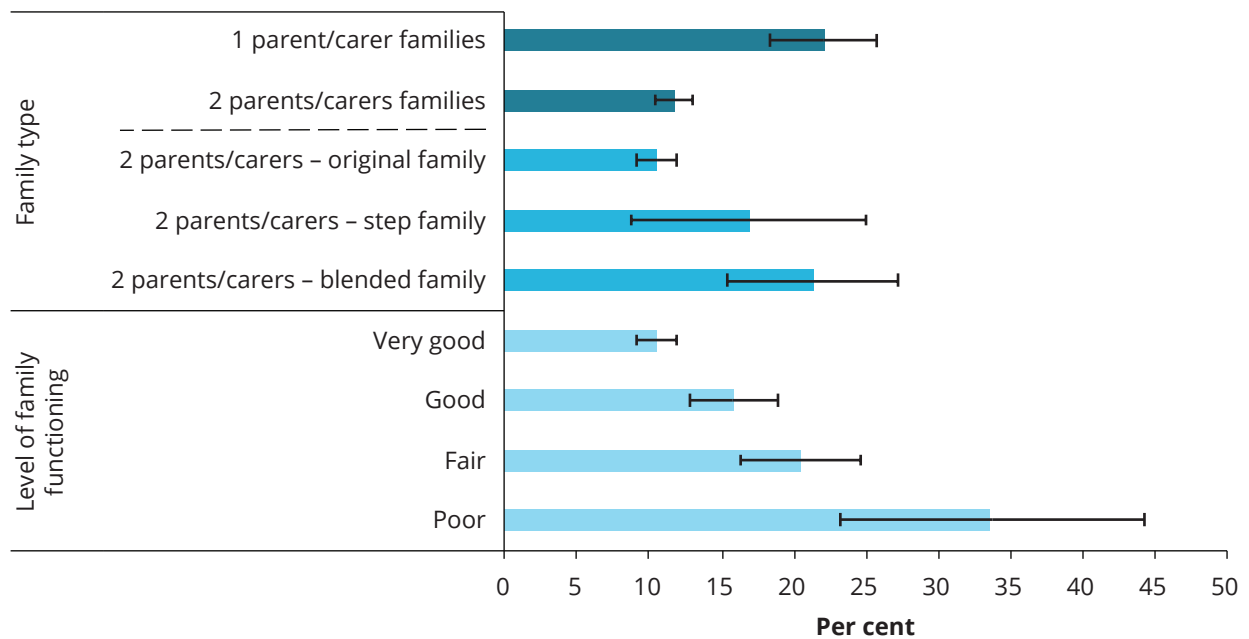
How does mental illness relate to family type and family functioning?

In 2013–14, children living:

- in families with 2 parents or carers were less likely to have mental health disorders than children living in families with 1 parent or carer (12% compared with 22%) (Figure 2)
- with their original families (with 2 parents or carers) were less likely to have mental health disorders than children living with blended families (11% compared with 21%).

Mental disorders were also more common among children living in families with poor family functioning (34%) compared with those in families with very good family functioning (11%) (Figure 2).

Figure 2: Mental illness among children aged 4–11, by family type and functioning



Note: Stepfamilies have at least 1 resident stepchild, but no child who is the natural or adopted child of both partners. Blended families have 2 or more children where at least 1 is the natural or adopted child of both parents, and at least 1 is the stepchild of 1 of them.

Chart: AIHW. Source: AIHW analysis of the Young Minds Matter Survey Results Query Tool.

How does mental illness impact on schooling?

Of all children aged 4–11 with a mental disorder, children with a major depressive disorder on average missed the most days of school due to their symptoms (14 days in the previous 12 months). This was more than twice as high as for children with anxiety disorders (6 days) and more than 3 times as high as for children with ADHD (4 days) (Lawrence et al. 2015).

While separation anxiety had the highest prevalence among children, generalised anxiety disorder was on average associated with more days off school (10 days compared with 6 for separation anxiety) (Lawrence et al. 2015).

The level of impact on functioning at school varied with the type of mental disorder. The greatest impact was due to symptoms of major depressive disorder. This disorder had a severe impact on school function for close to half (45%) of students with this disorder. The symptoms of ADHD and anxiety disorders had a mild impact on schooling for 42% and 37% of students respectively. Almost half (46%) of those with conduct disorder and 27% with anxiety disorders experienced no impact on schooling according to parents and carers (Lawrence et al. 2015).

Average NAPLAN test scores were lower for students with mental disorders, compared to those with no mental disorder (Goodsell et al. 2017).

Has mental illness prevalence changed over time?

Between 1998 and 2013–14, the prevalence of major depressive disorder among children aged 6–11 remained the same (1.4%), while the prevalence of conduct disorder and ADHD decreased (3.2% to 2.2% and 13% to 9.2%, respectively). The proportion of those aged 6–17 who had any of these disorders decreased slightly from 12% to 11%.

Is it the same for everyone?

Mental illness was more common among children born in Australia (14%) compared with children born overseas (8.1%) (Figure 3). It was also more common among children with both carers born in Australia (15%) compared with both carers born overseas (5.6%).

Other studies involving young immigrants have also found fewer mental health problems reported by immigrant adolescents compared with non-immigrant adolescents (Minas et al. 2013). However, some studies on the prevalence of mental illness of the children of immigrants have found similar rates between children of immigrants and those of Australian-born parents (Minas et al. 2013).

Mental illness was also more common among children living in areas with the lowest socioeconomic areas (19%) compared with those living in the highest (12%) (Figure 3).

Children in households where parents had lower levels of education, lower household income, or were living in public housing also had higher proportions of mental disorders. However, there may be overlapping issues here, for example some children living in households with lower incomes may also live in public housing (AIHW analysis of the Young Minds Matter Survey Results Query Tool).

Figure 3: Mental illness among children aged 4–11, by selected population groups, 2013–14

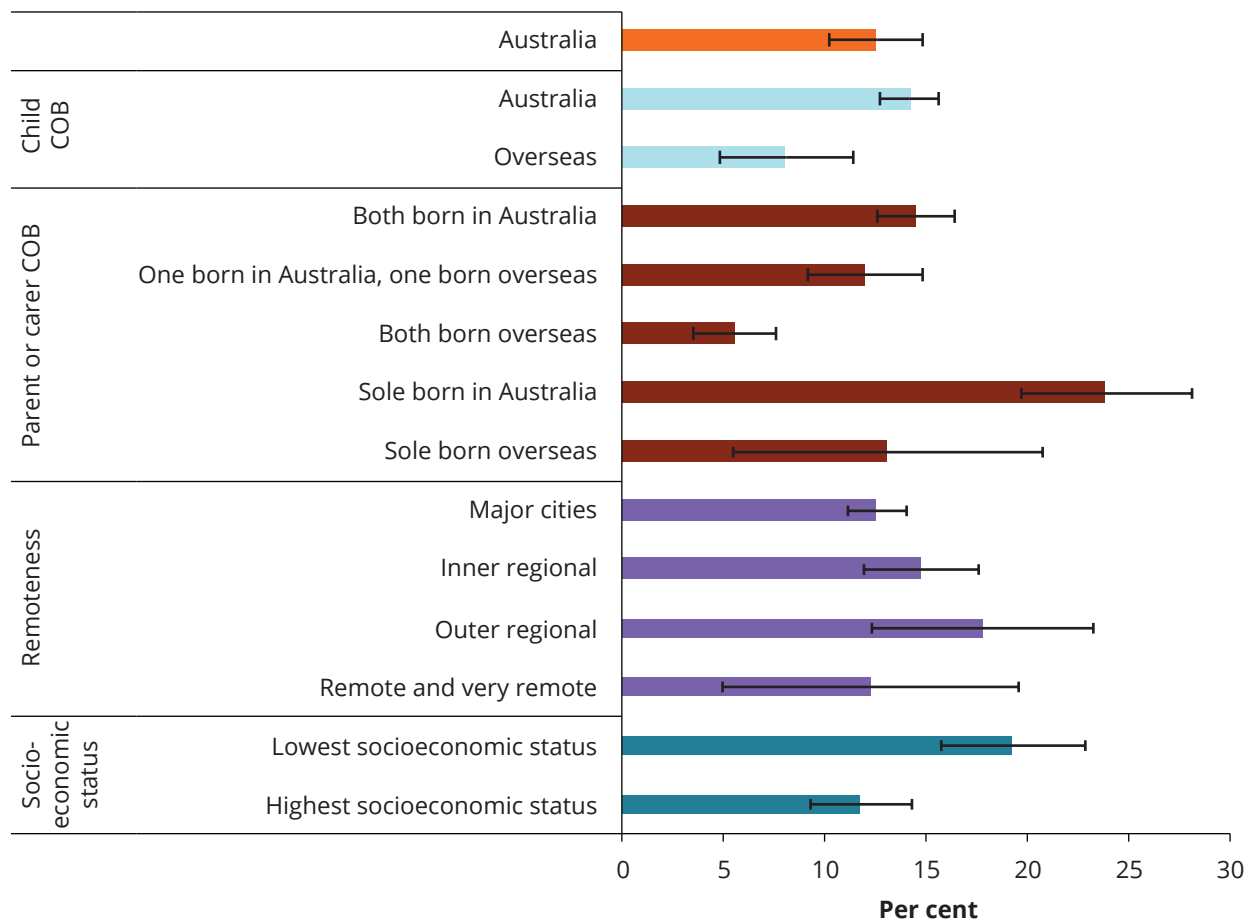


Chart: AIHW. Source: AIHW analysis of the Young Minds Matter Survey Results Query Tool.

Data limitations and development opportunities

While there are no plans to repeat the Australian Child and Adolescent Survey of Mental Health and Wellbeing, the Intergenerational Health and Mental Health Study announced in [Australia's Long Term National Health Plan](#) will provide a detailed information base for mental health planning at local level over the next decade (Department of Health 2019).

Where do I find more information?

For information on topics related to mental health in Australia's children, see:

- [Social and emotional wellbeing](#) (Strengths and Difficulties Questionnaire results and mental health competence)
- [Injuries](#) (information on suicide and self-harm)
- [Bullying](#).

For more information on:

- mental disorders of young people aged 12–17, see: [AIHW's National Youth Information Framework](#).
- mental health disorders, see: [The Mental Health of Children and Adolescents: Report on the second Australian child and adolescent survey of mental health and wellbeing](#) and [The Young Minds Matter Survey Results Query Tool](#)
- mental health care services and support, including presentations to emergency departments, hospitalisations and mental health-related prescriptions, see: [Mental health services in Australia](#)
- technical notes relating to this section, refer to [Children with mental illness](#) in the online report. See also [Methods](#).

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If you or someone you know needs help please call:

Lifeline 13 11 14

beyondblue 1300 22 4636

Kids Helpline 1800 55 1800

Children with disability

Key findings

- In 2015, 7.4% of children aged 0–14 had some level of disability and 4.0% had a severe or profound level of disability.
- Disability was more common among boys (9.4%) than girls (5.4%).
- The most common disability types were intellectual and sensory/speech.

Disability is more than the presence or absence of mental and physical health conditions; it relates to a person's ability to participate in a range of activities (AIHW 2017a).

Disability may limit what a person can do in their daily life. It is typically measured in terms of the level of difficulty (also expressed as a need for assistance) a person experiences when performing the core activities of daily living: self-care, mobility and communication, as well as difficulties in other activities such as schooling and work.

Schooling is an integral part of life for most children and a child's disability can be described in terms of core activity limitation and schooling restriction. Schooling restriction is often associated with a need for special assistance or equipment to participate in a mainstream class or attend a special school or special classes (ABS 2013).

Children with disability are an especially vulnerable population. Australian research suggests that children with intellectual disability, and mental and behavioural problems have a greater risk of experiencing maltreatment than children without disability (Maclean et al. 2017).

For more information, see [Child abuse and neglect](#).

Box 1: Data sources on disability

Data on rates of disability for this snapshot are sourced from the ABS 2015 Survey of Disability, Ageing and Carers (SDAC), which collected information about people with disability, older people, and carers who assist people with disability and older people.

How many children have a disability?

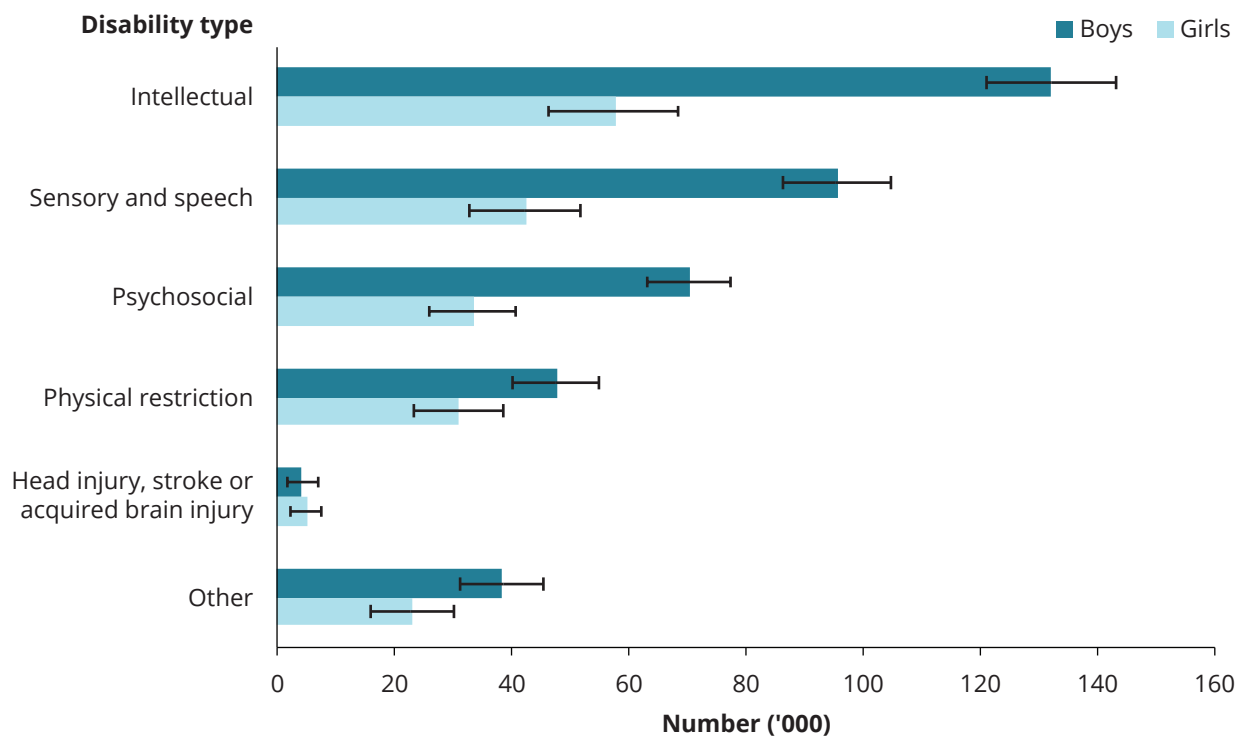
It is estimated using data from the 2015 SDAC that, around 7.4% (or 329,000) of Australian children aged 0–14 had some level of disability. The proportion was slightly higher among boys than girls (9.4% compared with 5.4%).

The most common disability types among children were:

- intellectual, reported for an estimated 190,000 children (4.3%)
- sensory/speech, 140,000 children (3.2%) (Figure 1).

Of children aged 5–14, 219,000 (7.6%) had schooling restrictions. This includes children who have core activity limitations and schooling restrictions (ABS 2015).

Figure 1: Children aged 0–14 with disability, by disability group, 2015



Note: Figure is based on all reported conditions and so children with multiple conditions will be counted more than once.
 Chart: AIHW. Source: ABS 2015.

How many children have a severe disability?

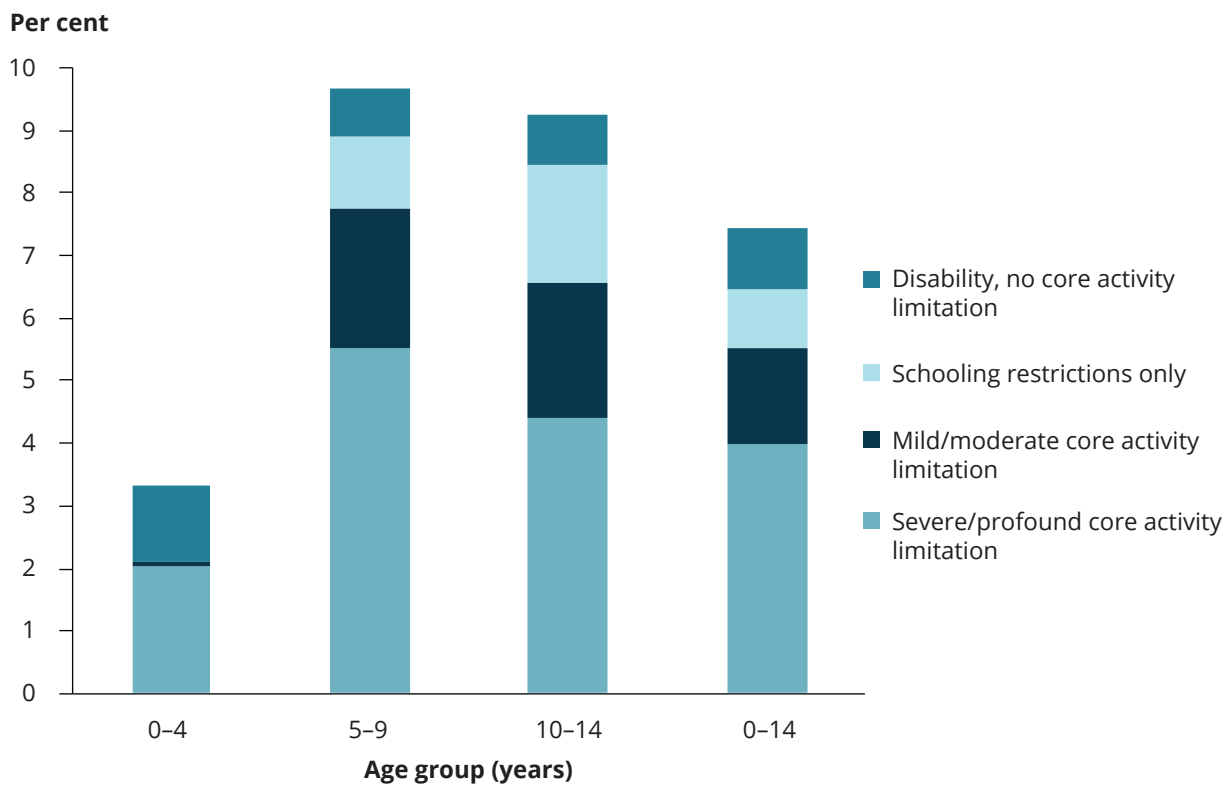
Around 177,000 children aged 0–14 (4.0%), had a severe disability in 2015 (Figure 2).

Boys (5.2%) were twice as likely as girls (2.6%) to have a severe disability, and the prevalence of severe disability was higher among children aged 5–9 (5.5%) than among those aged 10–14 (4.4%) or 0–4 (2%) (ABS 2015).

The higher rate among children aged 5–9 may:

- relate to increased identification of activity restrictions upon starting school
- relate to the availability of assistance
- suggest that some issues resolve or become less prominent in the minds of parents, children and/or teachers as children get older
- relate to the complexity of asking and answering questions about activity limitations among children aged 0–4, who, regardless of disability, are likely to need assistance in many activity areas due to their age (AIHW 2004).

Figure 2: Disability status of children aged 0–14, 2015



Note: The category 'schooling restriction' above does not include children who have a core activity limitation and a schooling restriction.

Chart: AIHW. Source: ABS 2015.

Has the prevalence of disability changed over time?

The prevalence of disability in children has remained stable with the proportion of those aged 0–14 with any type of disability decreasing slightly from 8.3% in 2003 to 7.4% in 2015. Over the same period, the proportion of children with severe disability remained stable at around 4% (Figure 3).

Figure 3: Prevalence of disability in children aged 0–14, 2003–2015

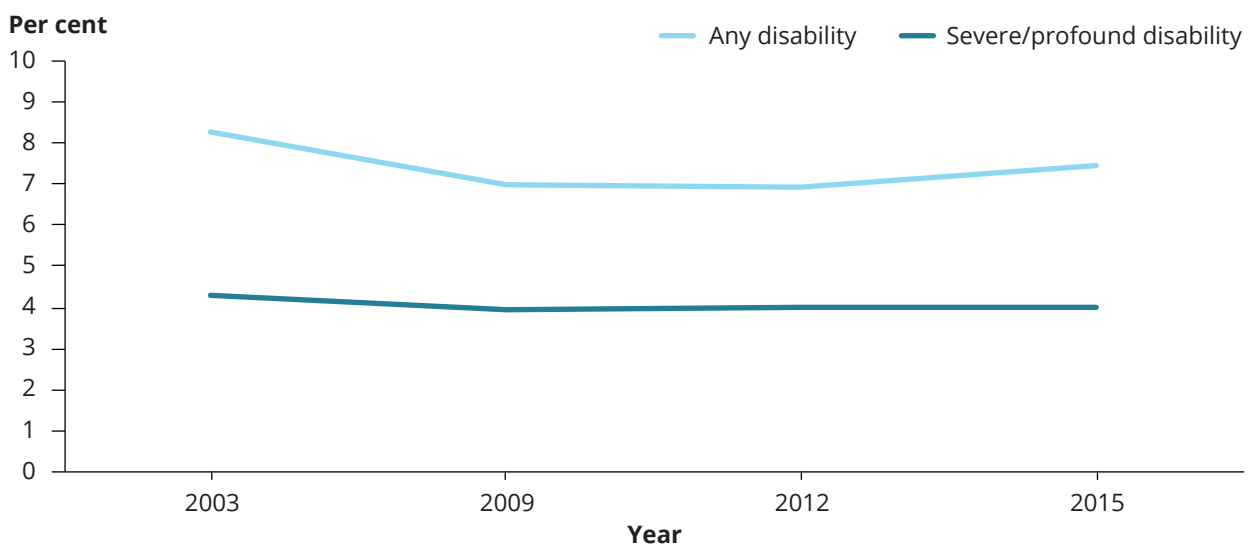


Chart: AIHW. Sources: ABS 2003, 2009, 2012, 2015.

Box 2: 2018 SDAC results

According to the 2018 SDAC, an estimated 7.7% (or around 357,000) children aged 0–14 had some level of disability. These results were similar to those for 2015. Rates of disability varied according to age and sex. The largest difference between males and females was for children aged 5–14 (12% of boys with disability compared with 7.1% of girls) (ABS 2019a).

In 2018, an estimated 4.5% (or around 211,200) children aged 0–14 had a profound or severe disability. Generally, this was more likely among boys than girls—3.3% of boys aged 0–4 had a profound or severe disability compared with 1.5% of girls aged 0–4. Similarly, 7.5% of boys aged 5–14 had a profound or severe disability compared with 3.7% of girls of the same age (ABS 2019a).

Do rates of disability vary across population groups?

In 2015, the proportion of children aged 0–14 with severe disability was highest:

- in *Inner regional areas* (5.4%) and lowest in *Major cities* (3.6%)
- among low-income households (5.2%) and lowest among high-income households (3.1%) (ABS 2015) (Figure 4).

The higher representation of children with severe disability among low-income households may be a result of decreased household earnings due to parental caring responsibilities.

Information about the prevalence and type of disability among Indigenous children nationally is limited (ABS 2019b). According to the 2015 Survey of Disability, Ageing and Carers, rates of severe disability were similar among Indigenous and non-Indigenous children aged 0–14 (5.9% and 3.9%, respectively) (ABS 2017).

Figure 4: Proportion of children aged 0–14 with severe disability by priority population group, 2015

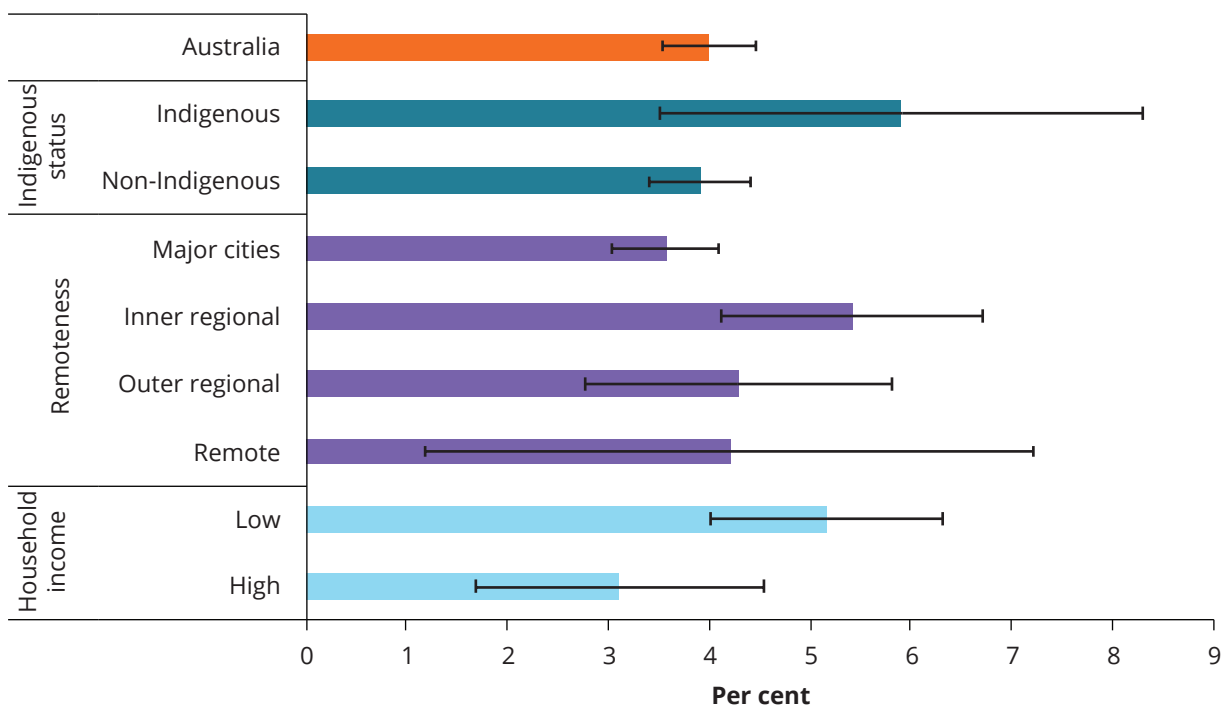


Chart: AIHW. Sources: ABS 2015, 2017.

Data limitations and development opportunities

While the SDAC provides information on the number of children with disability, including disability type, health conditions and some household and family characteristics, disability status is not commonly captured in other routinely collected data sources. This makes it difficult to compare outcomes for children with disability with other children across a wide range of topics.

This report includes data for children with disability in other snapshots, wherever possible.

Where do I find more information?

For more information on:

- children with disability, see: [Children with disabilities in Australia](#) and [Disability updates: children with disabilities](#).
- children with disability and education (primary and secondary school-age children), see: [Engagement in education](#) and [Education participation needs and challenges](#)
- people with disability, including disability-free life expectancy at birth, see: [People with disability in Australia](#), [Life expectancy and disability in Australia](#) and [Australia's Welfare 2017](#)
- technical notes relating to this section, refer to [Children with disability](#) in the online report. See also [Methods](#).

Box 3: Defining and measuring disability

The ABS SDAC defines a person as having a disability if they report having a limitation, restriction or impairment, which has lasted, or is likely to last, for at least 6 months and restricts everyday activities (ABS 2019a).

A person with a very high level of disability will sometimes or always need help with self-care, mobility or communication. The SDAC defines this level of disability as 'severe or profound core activity limitation'. For ease of reference in this report, this has been shortened to severe disability.

Estimates of the number of children with disability vary across data sources due to differences in the definition of disability and the age groupings used for reporting purposes. For example, the Nationally Consistent Collection of Data on School Students with Disability, which collects information about Australian students who receive a government-funded educational adjustment to address disability, reports that 18.8% of all Australian primary and secondary students received an adjustment in 2017 (Productivity Commission 2019).

Indigenous peoples

The Census of Population and Housing also collects data on disability using 4 questions about a person's need for assistance with a core activity of self-care, mobility and communication. These questions are based on the measure of 'severe or profound core activity limitation' in the SDAC.

The 2016 Census estimated that Indigenous children aged 0–14 were 1.7 times as likely as non-Indigenous children to require assistance, higher than the 2015 SDAC estimates. However, Census estimates of Indigenous disability should be interpreted with caution as a significant number of people do not respond to the 'need for assistance' questions, and it is estimated that the Census significantly undercounts Indigenous people (ABS 2019b).

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Dental health

Key findings

- In 2012-14, around 2 in 5 (42%) children had experienced decay in their primary (baby) teeth, and 1 in 4 (24%) children had experienced decay in their permanent (adult) teeth.
- Children in low-income households were twice as likely to have untreated decay in their primary (36%) and permanent teeth (15%) as children in high-income households (18% and 7%, respectively).
- More than two-thirds (69%) of children aged 5–14 brushed their teeth with toothpaste at least twice a day.

Good oral health is central to a person's overall health and wellbeing, positively affecting their quality of life, social interactions and self-esteem (COAG 2015). Without it, a person's quality of life can be compromised, with pain, discomfort and embarrassment affecting the ability to eat, speak, sleep and socialise confidently. Good oral health in children can also indicate good oral health in adults (AIHW 2016a).

Dental caries, commonly known as dental decay, refers to the development of cavities (small holes) in the teeth that compromise the health and structure of the tooth. It is the most prevalent oral disease among Australian children (AIHW 2016b, 2019).

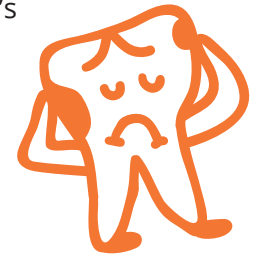
In 2011, dental decay was the 7th leading cause of total disease burden among boys aged 5–14, and the 4th among girls, accounting for 4.3% and 5.1% of the total burden of disease, respectively (AIHW 2016b).

A complex interaction of factors contribute to a person's oral health and their risk of developing dental decay, including:

- personal
- social
- economic
- environmental
- cultural.

Some factors include:

- consumption of sugar-sweetened beverages (for example, soft drinks, energy drinks, cordials and sweetened fruit juices) (WHO 2017)
- consumption of snacks containing sugar (for example, sweetened dairy, biscuits, cake, confectionary, sweet preserves and muesli bars) (WHO 2017)
- lack of good oral hygiene and regular dental check-ups (NACDH 2012)
- lack of access or exposure to fluoridated water (NHMRC 2017)
- affordability of private dental care (NACDH 2012)
- long waiting periods for public dental care (NACDH 2012).



If left untreated, dental decay can cause infection and the systemic spread of disease (NACDH 2012).

Most dental diseases are largely preventable. Early preventive strategies include:

- parental counselling about diet
- establishing sound oral hygiene practice, including the appropriate use of fluorides
- regular oral health check-ups (COAG 2015).

Box 1: Data sources on child dental health

The most recent data available on child dental health is from the National Child Oral Health Study 2012–14, a cross-sectional study of children aged 5–14 that included a clinical examination component and a parental questionnaire.

How many children have experienced dental decay?

Younger children normally have a combination of primary (baby) teeth and permanent teeth. As such, data for both sets of teeth are reported here separately.

By age 12, most children have lost all their primary teeth and gained their permanent teeth, therefore data for children over age 10 only relates to permanent teeth. Both sets of teeth are important for a child's health and development.

In 2012–14:

- around 2 in 5 (42%) children aged 5–10 had experienced decay in their primary teeth
- over 1 in 4 (27%) had untreated decay in these teeth, according to the National Child Oral Health Study (Ha et al. 2016).

The study also found that with children aged 6–14:

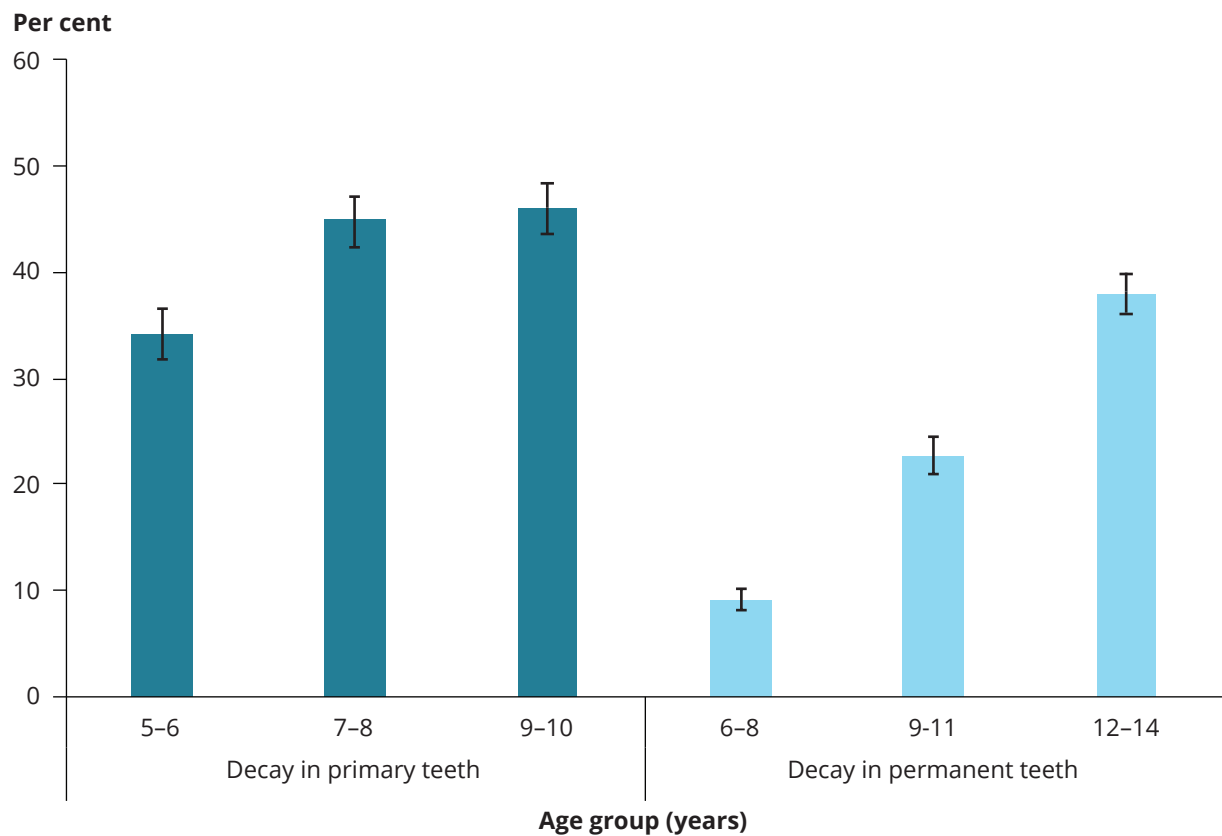
- almost 1 in 4 (24%) had experienced decay in their permanent teeth
- more than 1 in 9 (11%) had untreated decay.

The prevalence of tooth decay increased with age. Children aged 7–8 and 9–10 were more likely to have experienced decay in their primary teeth (45% and 46%, respectively) than younger children aged 5–6 (34%). Older children aged 12–14 were also more likely to have experienced decay in their permanent teeth (38%) than younger children aged 6–8 and 9–11 (9% and 23%, respectively) (Figure 1).

Across all age groups, a similar proportion of boys and girls had experienced decay in their primary and permanent teeth.



Figure 1: Proportion of children who have experienced decay in their primary or permanent teeth, by age group, 2012–14



Source: National Child Oral Health Study 2012–14, published in Ha et al. 2016.

How many decayed teeth do children have?

The number of teeth decayed, missing or extracted due to decay, or teeth with fillings, is an important indicator of dental health (Box 2).

Box 2: The dmft and DMFT score

A score that counts the number of teeth (t) that are decayed (d), missing due to caries (m) or filled because of caries (f):

- dmft refers to deciduous (primary) teeth
- DMFT refers to permanent teeth.

Children aged 5–10 had an average of 1.5 decayed, missing or filled primary teeth (dmft). The average number of dmft was higher in children aged 7–8 (1.7) than those aged 5–6 (1.3) and 9–10 (1.5).

Children aged 6–14 had an average of 0.5 decayed, missing or filled permanent teeth (DMFT). The rate of DMFT increased with child’s age, from 0.1 in children aged 6–8 to 0.9 in children aged 12–14 (Ha et al. 2016).

Has dental decay in children improved over time?

Between 1990 and 2000, the mean number of dmft among children aged 5–6 declined, followed by an increase until 2010 (AIHW 2016c). However, by 2012–14, the number of dmft had decreased to a similar level to the year 2000 (Do et al. 2016b).

Similarly, during the 1990s, the mean number of DMFT among children aged 12 decreased, followed by a fluctuating increase until 2010 (AIHW 2016c). In 2012–14, the number of DMFT had decreased and was comparable to the lowest level reported in the late 1990s (Do et al. 2016b).

Is dental decay experience the same for everyone?

Some population groups face greater challenges in accessing oral health care and experience the greatest burden of poor oral health (AIHW 2019).

Children living in *Remote and very remote* areas (53%) were more likely to have had decay in their primary teeth than children in *Major cities* (39%). They were also more likely to have untreated decay in:

- at least 1 primary tooth (38%; 25% in *Major cities*) or
- 1 permanent tooth (22%; 10% in *Major cities*).

The prevalence of primary and permanent tooth decay was highest among children living in households with low income:

- half (50%) had experienced decay in their primary teeth
- nearly one-third (28%) had experienced decay in their permanent teeth.

In comparison:

- one-third (33%) of children in high-income households had experienced decay in their primary teeth
- around one-fifth (19%) in their permanent teeth (Figure 2).

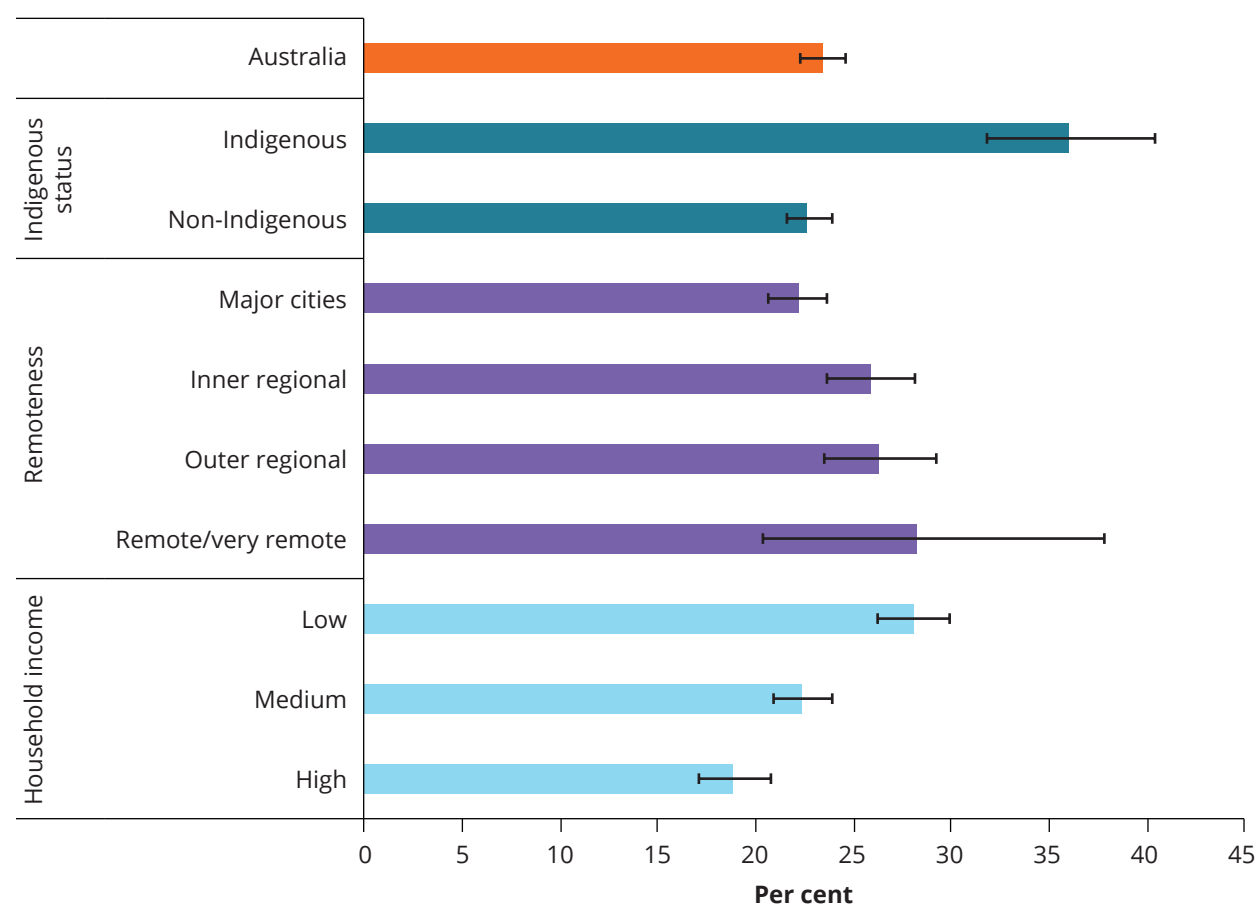
Children in low-income households were also more likely to have untreated decay in at least 1 primary tooth (36%) or 1 permanent tooth (15%) than children in high-income households (18% and 7%, respectively).

Differences were also evident between Indigenous children and non-Indigenous children. Around:

- 6 in 10 (61%) Indigenous children and 4 in 10 (41%) non-Indigenous children had experienced decay in their primary teeth
- 1 in 3 (36%) Indigenous children and 1 in 4 (23%) non-Indigenous children had experienced decay in their permanent teeth.

Indigenous children were also more likely to have untreated decay in at least 1 primary tooth (44%) or 1 permanent tooth (23%) than non-Indigenous children (26% and 10%, respectively).

Figure 2: Proportion of children aged 6–14 who have experienced decay in permanent teeth by selected population groups, 2012–14



Source: National Child Oral Health Study 2012–14, published in Ha et al. 2016.

Dental health behaviours and risk factors for dental decay

Teeth brushing

Regular teeth brushing is critical to maintaining good oral health and reducing the risk of dental decay. It is recommended that children’s teeth be wiped or gently brushed as soon as they erupt, and that brushing with fluoridated toothpaste be introduced from 18 months of age. Australia’s fluoride guidelines recommend brushing teeth twice a day from 18 months, and at least twice a day from the age of 6 (Armfeld et al. 2016). Sugar consumption and water fluoridation are both related to dental decay (Box 3).

In 2012–14, just over two-thirds (69%) of children aged 5–14 were brushing their teeth at least twice a day with toothpaste, with girls more likely than boys to do so (71% compared with 66%) (Armfeld et al. 2016). This difference was largest between boys and girls aged 13–14, with 78% of girls brushing their teeth twice a day compared with 65% of boys.

A smaller and more recent national survey found similar overall patterns of teeth brushing for primary school children aged 6 to 12, with 73% children brushing twice a day and 24% once a day (Rhodes 2018).

Differences in teeth brushing behaviours were observed across population groups:

- 54% of Indigenous children and 70% non-Indigenous children brushed their teeth at least twice a day
- 78% of children in high-income households and 59% of children in low-income households did so.

Box 3: Sugar consumption and water fluoridation

Sugar consumption

High sugar consumption is associated with tooth decay and other associated oral health issues. WHO recommends adults and children reduce consumption of free sugars to less than 10% of total energy intake, and that reducing intake to less than 5% would provide additional health benefits (WHO 2015). This translates to 2–6 teaspoons of free sugars a day, depending on the age and energy requirements of the child.

For more information on children’s consumption of sugar, see [Breastfeeding and nutrition](#).

Water fluoridation

Consumption of fluoridated water helps prevent tooth decay in children by protecting their teeth against damage, and helping to repair damaged teeth (NHMRC 2017). While all Australian states and territories provide fluoridated tap/public water, coverage varies across each jurisdiction. The proportion of the population with access to fluoridated water ranges from 76% in Queensland to 100% in the Australian Capital Territory.

The National Child Oral Health Study 2012–14 estimates that 71% of Australian children aged 5–14 had almost all tap/public water as their daily drinking water from age 5 (Do et al. 2016a). Reflecting patterns in public water supply, as some people get their drinking water from other sources such as water tanks and private bores:

- 77% of children in *Major cities* were more likely to drink mostly tap water as their daily drinking water
- 58% in *Inner regional*
- 56% in *Outer regional*
- 55% in *Remote and very remote*.

Children in high-income households were also more likely to frequently drink tap water (79%) than children in low-income households (65%).

Patterns of water consumption from age 5 did not vary significantly by sex, Indigenous status or parents’ country of birth (Do et al. 2016a).

Data limitations and development opportunities

National surveys of the oral health status of children have been conducted infrequently since the AIHW’s Child Dental Health Survey series finished in 2010. As such, monitoring changes in children’s dental health since 2012–14 is not possible.

Some national data development work related to public dental services may result in some data on children's dental health being available in the future; however this would be limited to children accessing public dental care. Data on services provided in the private dental care sector are also limited.

Where do I find more information?

For more information on:

- the oral health of Australian children and information on access to dental health services and patterns of dental visiting, see: [Oral health and dental care in Australia](#) and [Healthy teeth](#).
- toothbrushing, see [Preventative strategies](#).
- the number of DMFT among primary school children aged 12, see: [Dental health in Children's Headline Indicators](#).
- technical notes relating to this section, refer to [Dental health](#) in the online report. See also [Methods](#).

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Injuries

Key findings

- During 2015–2017, injuries contributed to 563 deaths of children aged 0–14—a rate of 4.1 per 100,000 children.
- The most common causes of injury death were land transport accidents, accidental drowning and assault.
- In 2016–17, among children aged 0–14, there were around 66,500 hospitalised injury cases—a rate of 1,445 per 100,000 children.
- Overall, boys were 1.5 times as likely to be hospitalised for injury than girls.
- Falls accounted for close to half (45.9% or around 30,500) of hospitalised injury cases and were the most common reason for injury hospitalisation of children across all age groups.

Injury is a leading cause of child deaths (see [Infant and child deaths](#)) and a major cause of hospitalisation (AIHW: Pointer 2014). Children are vulnerable to certain types of injuries depending on their age, reflecting their stage of development. Very young children are particularly vulnerable to injury as they are not yet able to adequately assess the risks involved in new activities and avoid potential dangers. Injuries sustained among older children are increasingly influenced by risk-taking behaviour in addition to their physical and social environment (AIHW: Pointer 2014).

Injury death and disability can be prevented by identifying and removing the causes or reducing children's exposure to them. Recognising the impact of injury on children, a new National Injury Prevention Strategy is being developed to reduce the risk of injury for children (DoH 2018).

This section includes injury deaths and hospitalised injury cases.

Box 1: Data sources on injuries

This section draws on a range of data sources:

Deaths data are sourced from the AIHW National Mortality Database (NMD) and the Australian Bureau of Statistics (ABS) Causes of Death (Suicide data).

Road traffic accidents data are sourced from the Australian Road Deaths Database which includes basic details of road transport crash fatalities in Australia as reported each month to the state and territory road safety authorities. The database is published by the Bureau of Infrastructure, Transport and Regional Economics (BITRE). For differences between BITRE data and the AIHW National Mortality Database, see Technical notes in the [Injuries](#) section of the online report.

Data on **assault deaths** are sourced from the Australian Institute of Criminology National Homicide Monitoring Program.

Data on **hospitalised injury cases** are sourced from the AIHW National Hospital Morbidity Database (NHMD).

How many children die from injuries?

During 2015–2017, injuries contributed to 563 deaths of children aged 0–14—a rate of 4.1 per 100,000 children.

The rate of injury deaths for boys (4.9 per 100,000) was 1.5 times as high as that for girls (3.2 per 100,000) (Figure 1).

The youngest children (aged 0–4) had the highest rate of injury death (6.1 per 100,000 infants), compared with children aged 5–9 (2.1 per 100,000) and 10–14 (4.1 per 100,000).

Injury deaths comprised a substantial proportion of all deaths among those aged 1–14 (33%) (see [Infant and child deaths](#)).

Figure 1: Injury deaths among children aged 0–14, 2015–2017

Injury deaths per 100,000

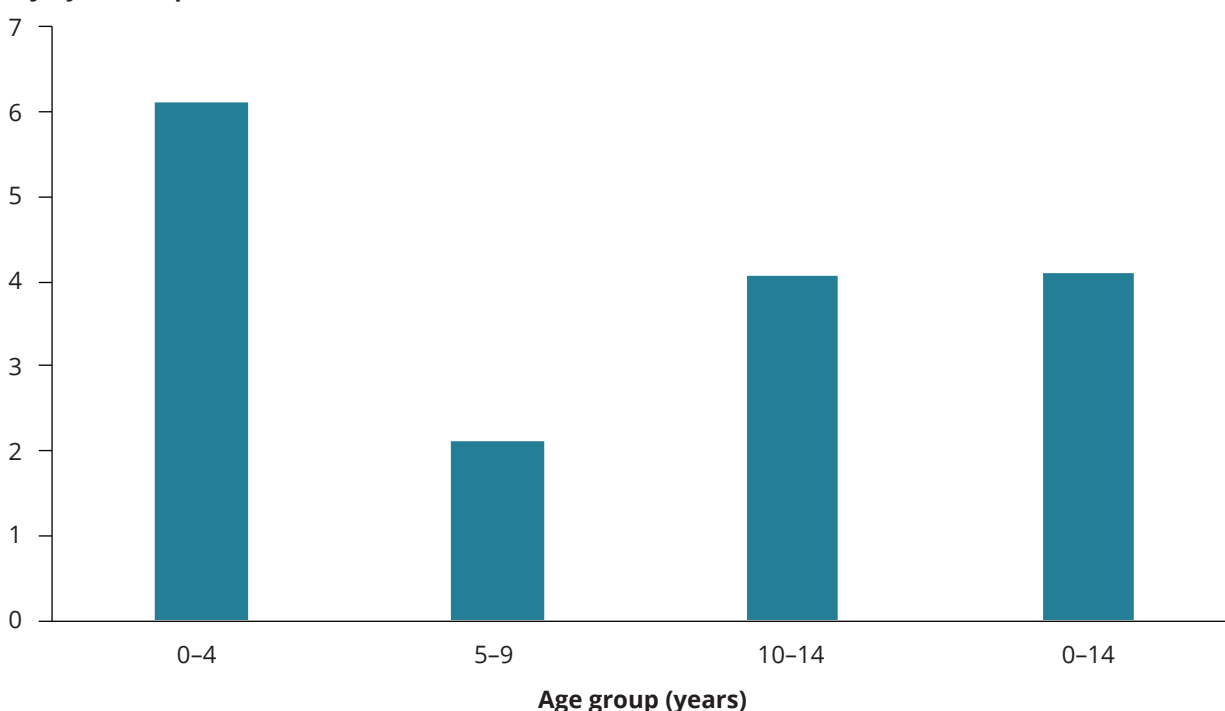


Chart: AIHW. Source: Analysis of AIHW National Mortality Database.

Have child injury deaths changed over time?

Injury death rates among children decreased between 2004–2006 and 2015–2017, from 6.2 to 4.1 deaths per 100,000 children. The rate for boys was consistently higher than for girls, fluctuating between 1.2 and 1.6 times as high (Figure 2).

Figure 2: Injury deaths among children aged 0–14, 2004–2006 to 2015–2017

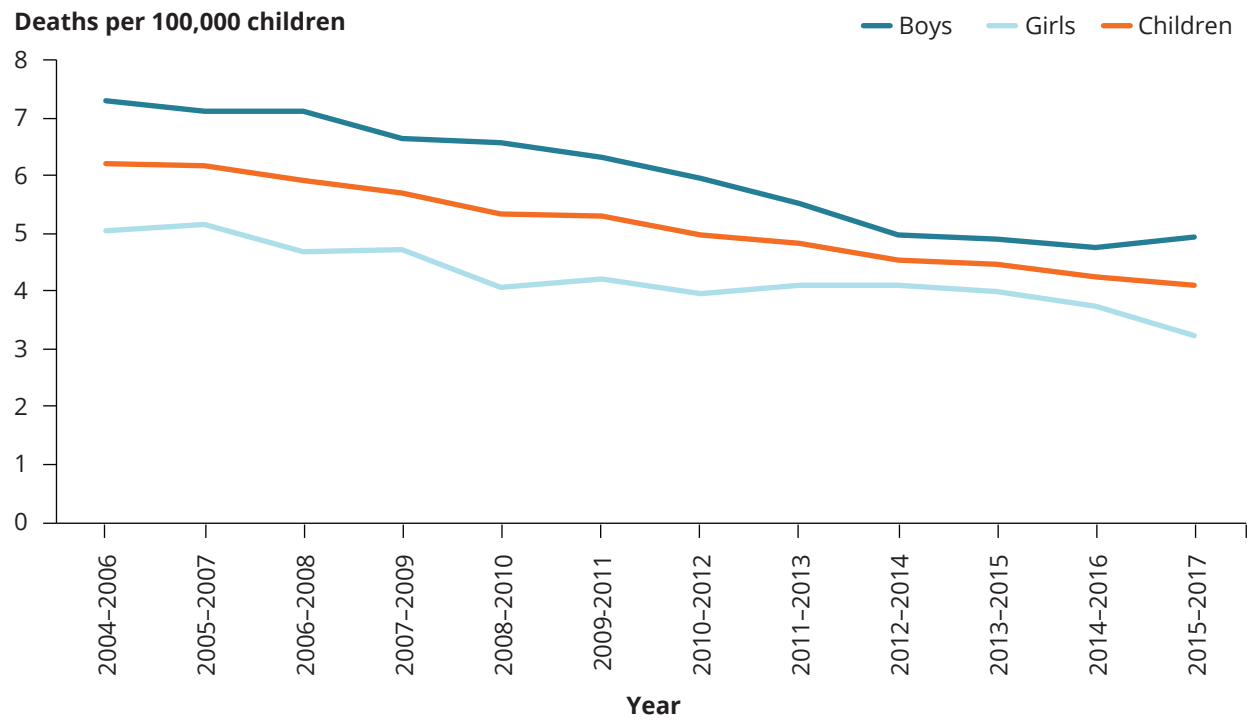


Chart: AIHW. Source: AIHW analysis of AIHW National Mortality Database; Children’s Headline Indicators 2018.

What are the leading injury causes of death?

In 2015–2017, among children aged 0–14, the 3 leading causes of injury deaths among children were:

- land transport accidents (29%), which includes road traffic fatalities
- accidental drowning (18%)
- assault (11%) (Figure 3).

Figure 3: Leading causes of injury deaths among children aged 0–14, 2015–2017

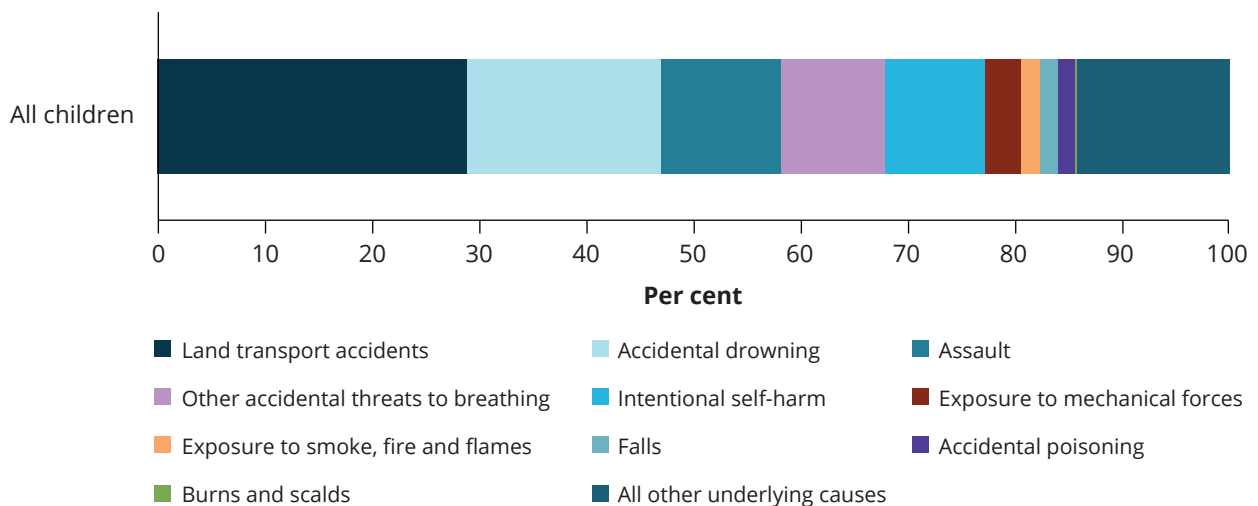


Chart: AIHW. Source: AIHW analysis of AIHW National Mortality Database.

How many children died on Australian roads?

According to the Australian Road Deaths Database, in 2018 among children aged 0–14:

- 34 deaths were due to road transport accidents, a rate of 0.7 per 100,000 children.
- Boys were slightly more likely to be killed in a road transport accident than girls—rates of 0.8 and 0.6 per 100,000, respectively.
- Children aged 10–14 had the highest death rate (0.9 per 100,000), followed by children aged 0–4 (0.7). Children aged 5–9 had the lowest rate (0.6).

The death rate more than halved between 2009 and 2018 (1.7 per 100,000 to 0.7). The decline in road accident deaths is most noticeable among children aged 0–4, which has decreased by 68% since 2009 (2.2 to 0.7).

Of children who died because of a road transport accident:

- 59% were passengers
- 29% were pedestrians
- 5.9% pedal cyclists
- 5.9% were drivers or other.

Accidental drowning

During 2015–2017, 111 children aged 0–14 died because of accidental drowning—an average of 37 deaths a year (rate of 0.8 per 100,000 children). Boys made up 58.6% of accidental drowning deaths (65 compared with 46 girls).

During 2015–2017:

- infants and young children (aged 1–4) had the highest accidental drowning death rates (0.9 and 1.8 per 100,000 children, respectively).
- rates were lower among older children (0.5 for children aged 5–9 and 0.3 aged 10–14).

The death rate due to accidental drowning decreased by around 27% between 2008–2010 and 2015–2017—from a rate of 1.1 per 100,000 deaths (139) to 0.8 (111).

Assault deaths (homicide)

During 2012–14, there were 35 homicide deaths among children aged 0–14, a rate of 0.4 per 100,000 children (Figure 4).

Among infants under 1 year, the rate of homicide was almost 8 times as high (2.3 per 100,000 infants or 14 deaths) compared with children aged 1–9 (0.3 or 16 deaths) or aged 10–14 (0.2 or 5 deaths).

While there was a small difference in the overall rates of homicide among boys and girls (0.42 and 0.38 per 100,000, respectively, or 19 and 16 deaths, respectively), homicides were 1.7 times as likely to happen to infant boys as infant girls (2.9 and 1.7, respectively).

For more information on assault, see [Children and crime](#).

Figure 4: Assault deaths (homicides) among children aged 0–14, 2012–14

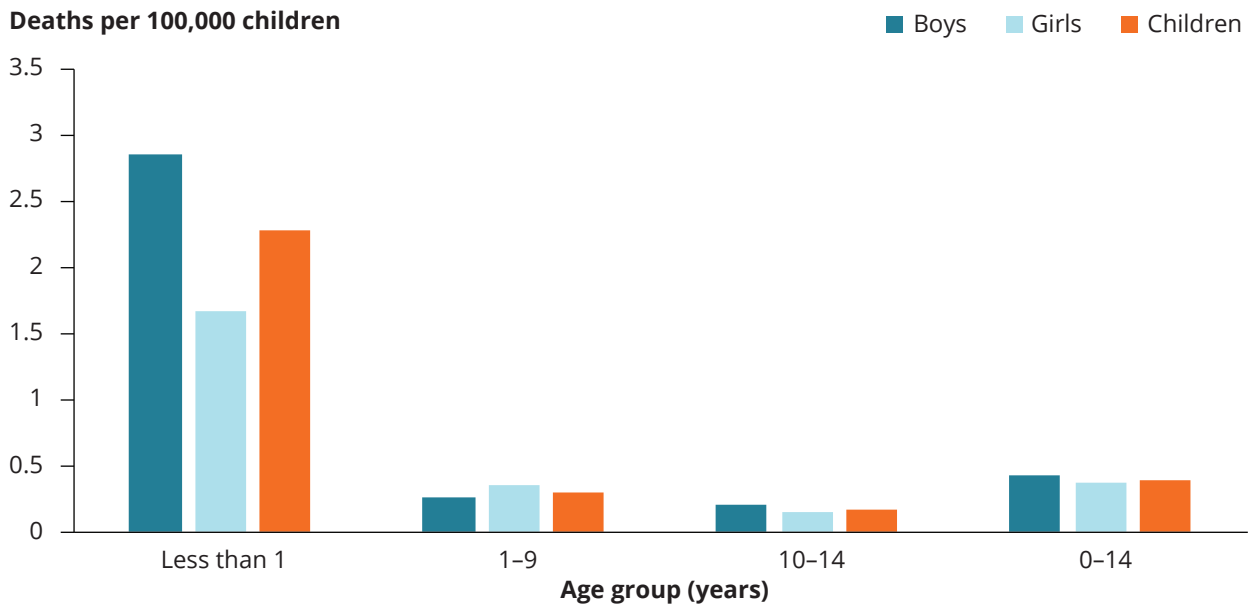


Chart: AIHW. Source: AIHW analysis of Bryant & Bricknell 2017.

The rate of deaths due to homicides among children aged 0–14 was slightly lower in 2012–2014 (0.4 per 100,000) compared with the 2 previous reporting periods (0.5 in 2008–2010 and 2010–12).

Suicide deaths

In 2015–2017, the suicide rate for children aged 0–14, was 0.4 per 100,000, with little difference between boys and girls (0.4 and 0.3, respectively) (Figure 5).

Between 2010–2012 and 2015–2017, the child suicide rate showed little change. It should be noted that deaths of children attributed to suicide can be influenced by reporting practices, and so care needs to be taken in interpreting results (Box 2).

Figure 5: Suicides among children aged 0–14, 2010–2012 to 2015–2017

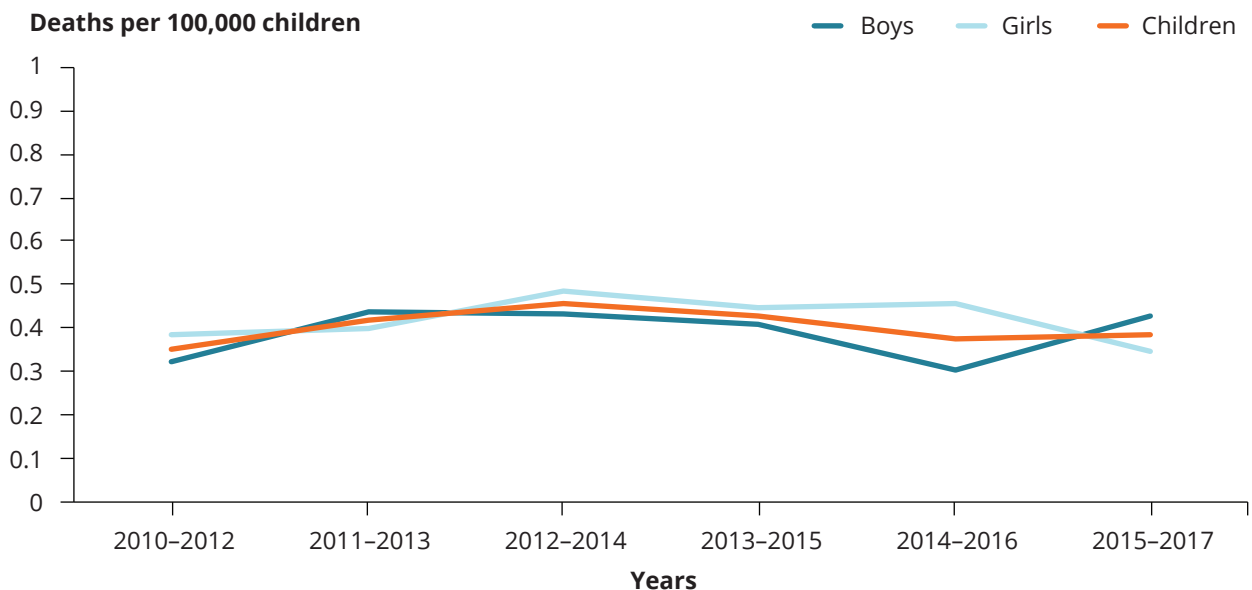


Chart: AIHW. Source: AIHW analysis of ABS Causes of death, Australia, 2017.

Box 2: Suicide deaths of children under the age of 15

Deaths of children by suicide are an extremely sensitive issue. The number of deaths can be influenced by coronial reporting practices. Reporting practices may lead to differences in counts across jurisdictions and this should be taken into account when interpreting these data. For more information on issues associated with the compilation and interpretation of suicide data, see [ABS 3303.0—Causes of Death, Australia, 2011 explanatory notes 92–95](#).

For information on changes to coding guidelines from 2007 and their impact on suicide deaths, see [ABS Causes of Death, Australia, 2014 \(Cat. no. 3303.0\) Explanatory Notes 85–92](#) and Technical notes in the [Injuries](#) section of the online report.

How many hospitalised injury cases for children are there?

In 2016–17, among children aged 0–14 there were around 66,500 hospitalised injury cases—a rate of 1,445 per 100,000 children.

Overall, boys were 1.5 times as likely to be hospitalised for injury than girls (1,708 and 1,168 per 100,000, respectively), but this varied by age—from 1.3 times for those aged 0–4 and 5–9, to 1.8 times among those aged 10–14 (Figure 6).

Figure 6: Hospitalised injury cases among children aged 0–14, 2016–17

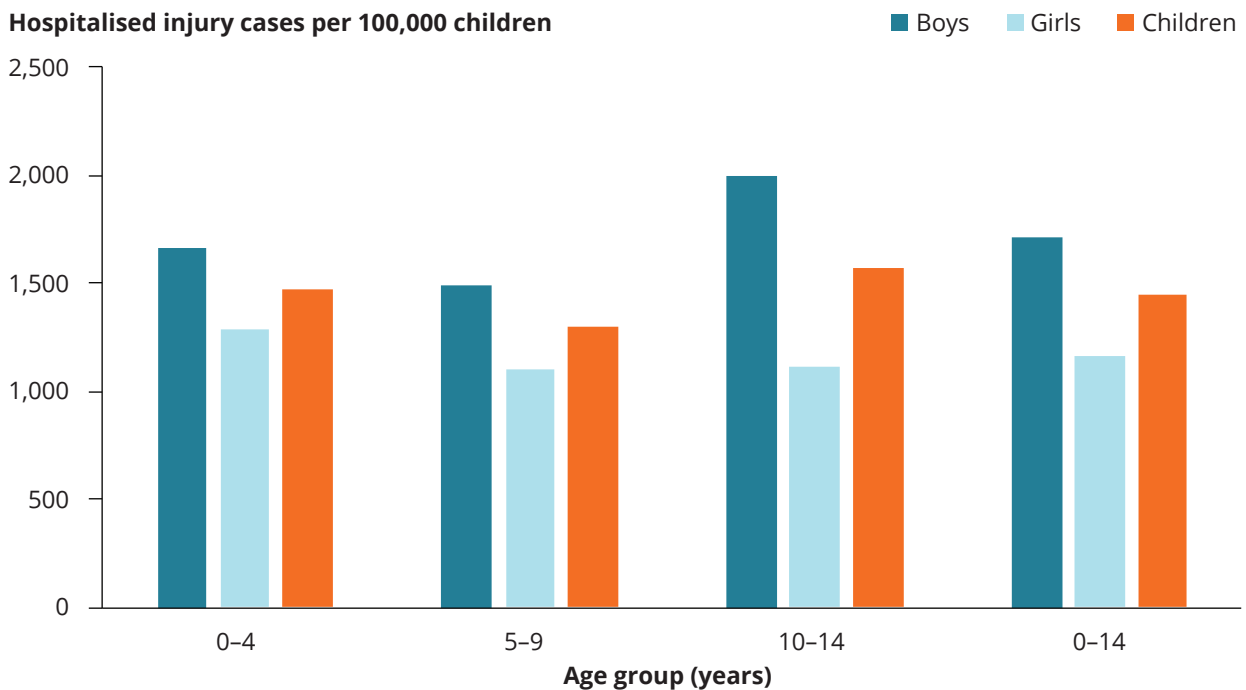


Chart: AIHW. Source: AIHW NHMD.

Has the rate of hospitalised injury cases changed over time?

The number of hospitalised injury cases for children aged 0–14 in 2016–17 was slightly higher (66,500) than in 2007–08 (57,800). However, overall, the rate of hospitalised injury cases for children aged 0–14 was relatively stable between 2007–08 and 2016–17 (Figure 7). The rate for girls was 9% higher in 2016–17 compared with 2006–07 (1,168 and 1,071 per 100,000 respectively). However, boys consistently had higher rates than girls over the 10 years.

Figure 7: Hospitalised injury cases among children aged 0–14, by gender 2007–08 to 2016–17

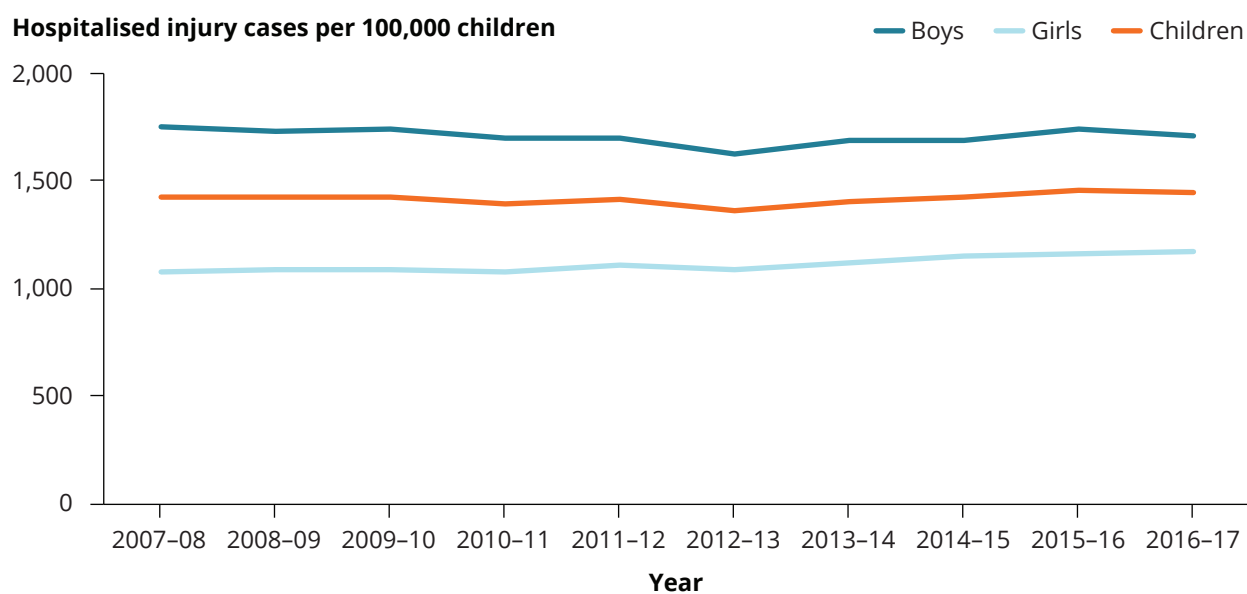


Chart: AIHW. Source: AIHW NHMD.

What are the leading injury causes of hospitalisations?

In 2016–17, among children aged 0–14, falls accounted for close to half (46% or around 30,600) of hospitalised injury cases and were the most common reason for injury hospitalisation of children across all age groups (Figure 8).

For subsequent leading causes of injury cases, there were differences across age groups. Land transport accidents (including both traffic and non-traffic) were the second leading cause of injuries for all children (9% or 6,100 cases) and for older age groups (5–9 year olds—10% or 2,000 cases; 10–14 year olds—15% or 3,400 cases) (AIHW analysis of NMHD).

Accidental poisoning was the third leading cause of injuries for all children (3% or 2,000 cases), but the second leading cause for children aged 1–4 years (7% or 1,500 cases) (AIHW analysis of NMHD).

In 2016–17, over half (53%) of accidental drowning and submersion injury cases in Australia occurred in children. The largest proportion was for children aged 0–4 (40%), with 13% occurring in children aged 5–14 (AIHW: Pointer SC 2019).

Figure 8: Hospitalised injury cases for children aged 0–14, by leading specific causes of injury, 2016–17 (per 100,000)

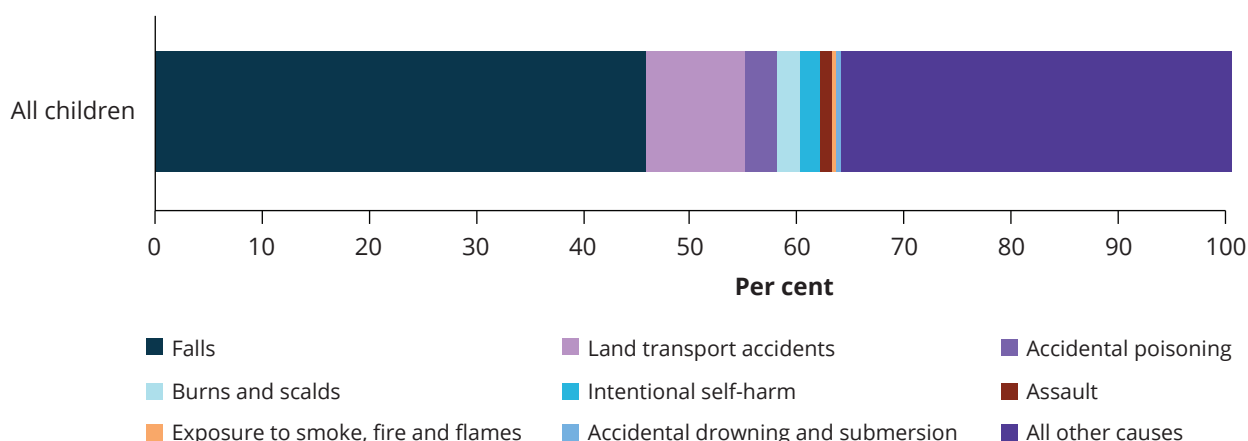


Chart: AIHW. Source: AIHW NHMD.

Hospitalised assault cases

In 2016–17, among children aged 0–14 there were 612 hospitalised assault cases—a rate of 13.3 per 100,000 children.

Hospitalised assault cases were 1.6 times more common among boys than girls (16.2 and 10.3 per 100,000 children, respectively). Hospitalisation was also most common among older children aged 10–14 followed by infants (23.8 and 12.8, respectively). Almost half of hospitalised assault cases (48%) were from assault by bodily force.

In almost half (48.1%) of hospitalised assault cases (294 cases), the perpetrator was a parent, carer or other family member. The perpetrator was unspecified or 'other' in 30.4% of cases (186) and identified as an acquaintance or friend in 13.7% of cases (84). See [Children exposed to family violence](#). For information on data quality relating to perpetrator identification, see Technical notes in the [Injuries](#) section of the online report.

Between 2007–08 and 2012–13, the rate for hospitalised assault cases decreased by one-quarter (25.1%). Since 2012–13, the rate has ranged between 12.2 and 13.3 per 100,000. The rate for boys has fluctuated over time while the rate for girls has been more stable. However, the rate for boys has been consistently higher than that for girls.

Figure 9: Hospitalised assault cases for children aged 0-14, by gender, 2016-17

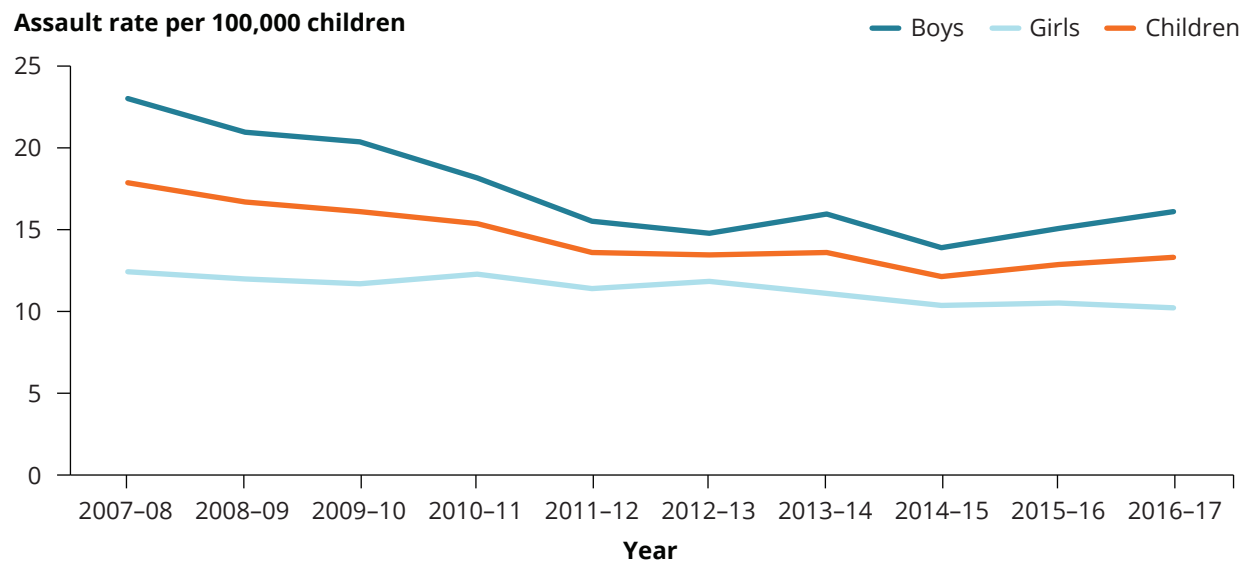


Chart: AIHW. Source: AIHW NHMD.

Intentional self-harm cases

In 2016-17, among children aged 0-14, there were 1,300 hospital separations for intentional self-harm—a rate of 87 per 100,000 children. The vast majority of these cases (86.1%) were for girls (153.9 per 100,000; 23.6 for boys).

Between 2007-08 and 2012-13, cases of self-harm more than doubled, increasing from 32.6 per 100,000 to 77.3.

Following a small decrease in 2013-14 (to 68.7 per 100,000) the rate rose again to 87.0 2016-17. This increase was driven by an increase in the rate for girls.

Figure 10: Hospitalised cases of self-harm for children aged 0-14, 2016-17

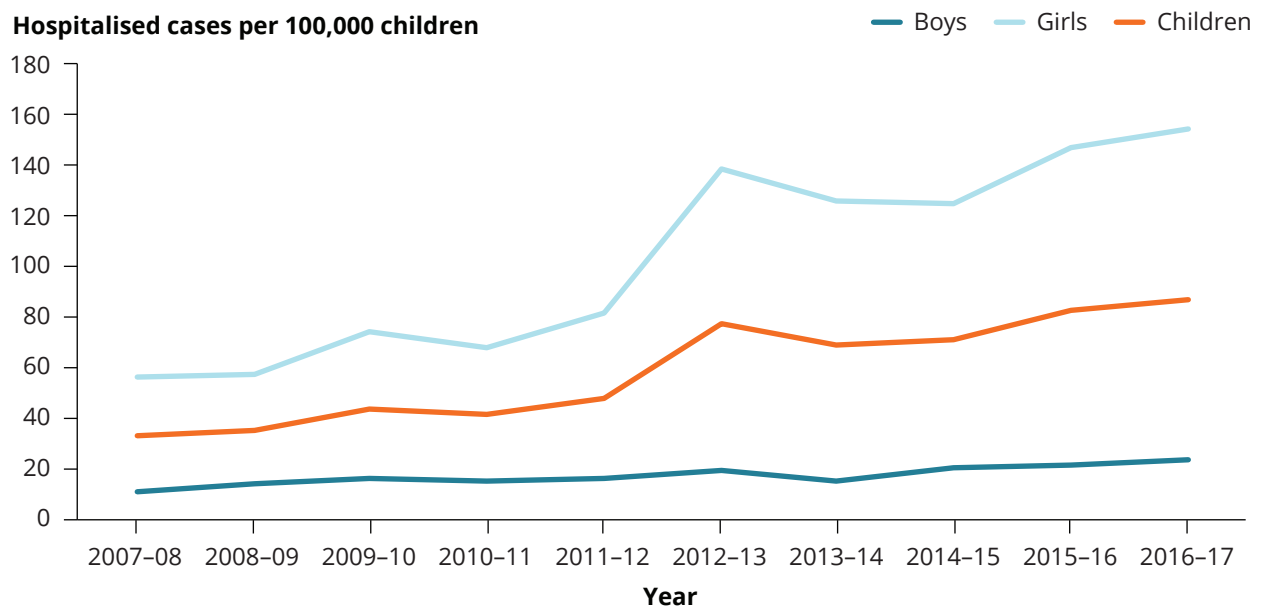


Chart: AIHW. Source: AIHW NHMD.

Box 3: Self-harm, suicide and mental health

By definition, hospitalised cases of intentional self-harm can include cases where the intent is self-injurious or suicidal in nature. However, as hospital data only include cases where admitted hospital care was provided, the data do not capture the total number of children who have self-harmed.

The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (also known as Young Minds Matters) collected data on self-harm and suicidal behaviour directly from young people aged 12–17. Self-harm is defined as a child deliberately hurting or injuring themselves without trying to end their life. Suicidal behaviours refer to suicidal ideation (serious thoughts about taking one's own life), making suicide plans and suicide attempts where the self-injury is intended to end in death.

Based on self-report, the survey found that in 2013–14 for those aged 12–15:

- 8.2% reported having ever self-harmed
- 3.8% reported self-harming 4 or more times
- 6.2% had self-harmed in the previous 12 months (Lawrence et al. 2015).

Over the same period and for the same age group:

- 5.6% had seriously considered attempting suicide (suicidal ideation) in the previous 12 months
- 1.7% had attempted suicide.

Girls aged 12–15 were more likely than boys to have self-harmed, had suicide ideation and to have attempted suicide (Lawrence et al. 2015).

Self-harm and suicide can be associated with mental health disorder. The highest rates of self-harm and suicidal behaviours among young people aged 12–17 were among those with major depressive orders, particularly for females. For information on the prevalence of mental health disorders, see [Children with mental illness](#).

Survey participants who answered 'prefer not to say' to questions on self-harm or suicidal ideation were not asked subsequent questions. As such the proportion of young people who have ever self-harmed may be higher than indicated in these estimates (Lawrence et al. 2015).

Are injury rates the same for everyone?

Injury deaths

During 2013–2017, the injury death rate for children increased with remoteness. In *Outer regional, remote and very remote* areas the rate was 3 times as high as for *Major cities* (10 per 100,000 children compared with 2.9, respectively) (Figure 11).

The injury death rate for children living in the lowest socioeconomic areas was also higher than for those the highest (7.3 per 100,000 children compared with 2.1, respectively).

Differences were also evident between Indigenous and non-Indigenous children (15 per 100,000 children compared with 4.0, respectively). The Indigenous injury death rate remained relatively stable between 2006–2010 and 2013–2017. See also [Indigenous Children](#).

Figure 11: Injury deaths for children aged 0–14, by priority groups 2016–17

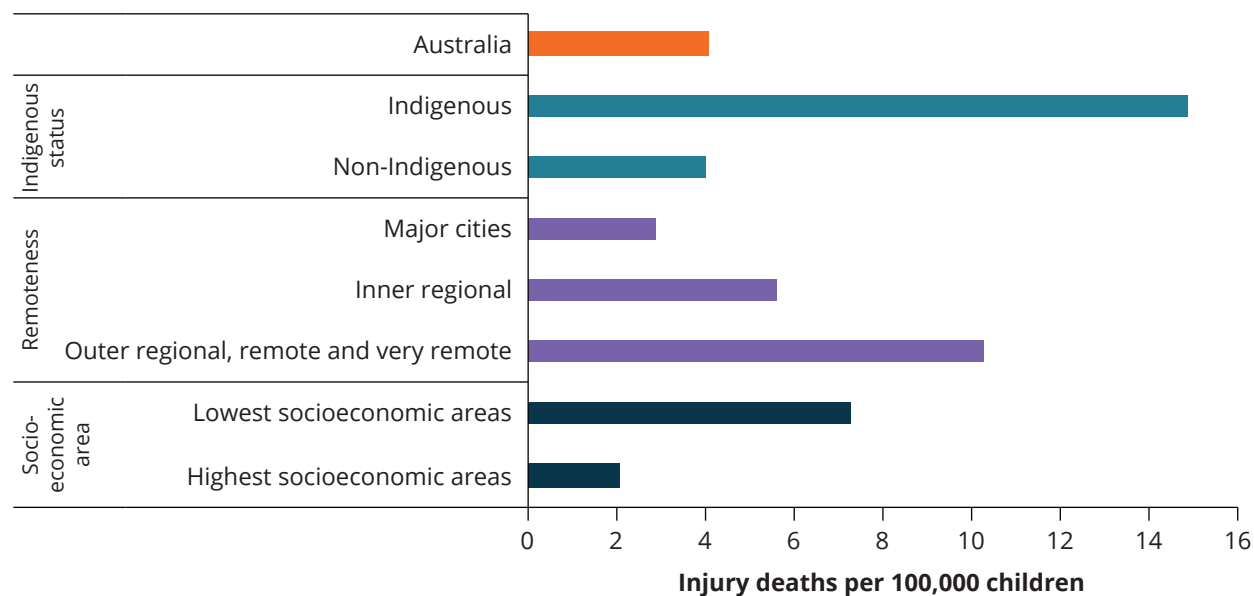


Chart: AIHW. Source: Analysis of AIHW National Mortality Database.

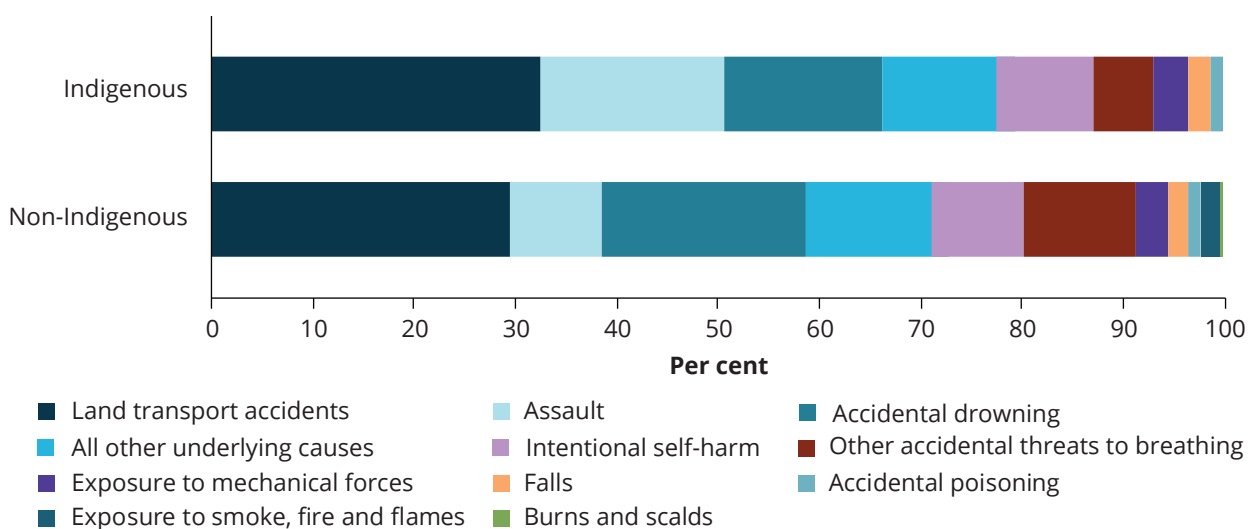
During 2015–2017, land transport accidents (including road traffic fatalities) were the leading cause of injury deaths for Indigenous children aged 0–14 (31%) and non-Indigenous children (29%).

For Indigenous children, assault (18%) and accidental drowning (15%) were the second and third leading causes of death.

For non-Indigenous children, accidental drowning (20%) and accidental threats to breathing (11%) were the second and third leading causes of death.

Intentional self-harm was the fourth leading cause for both Indigenous and non-Indigenous children (Figure 12).

Figure 12: Leading causes of injury deaths among children aged 0–14, by Indigenous status, 2015–2017



Note: Mortality data by Indigenous status are restricted to New South Wales, Queensland, Western Australia, South Australia and the Northern Territory due to data quality.

Chart: AIHW. Source: Analysis of AIHW National Mortality Database.

Suicide data for Indigenous children aged 5–14 is not readily available. However, data for a broader age group (5–17 years) for 2013–2017 shows that the rate for Indigenous young people was considerably higher than that for non-Indigenous young people (10.1 and 2.0 per 100,000, respectively) (ABS 2018).

A recent inquest into the deaths of 13 children and young persons, including 5 children aged 10–13, in Western Australia’s Kimberley Region found that 12 of the 13 deaths were suicides and that the individual events were shaped by the effects of intergenerational trauma and poverty upon entire communities (Coroner’s Court of Western Australia 2019).

Hospitalised injury cases

In 2016–17, among children aged 0–14, the rate of hospitalised injury cases was:

- almost twice as high for children in *Very remote* areas as for *Major cities* (2,617 per 100,000 children compared with 1,342)
- 1.1 times as high for children living in the lowest socioeconomic areas as for those in the highest areas (1,525 and 1,365 per 100,000, respectively)
- higher among Indigenous and non-Indigenous children aged 0–14 (2,087 and 1,397 per 100,000 children, respectively) (Figure 13).

The rate of hospitalised cases for assault was:

- considerably higher in *Remote* and *Very remote* areas (87 and 50 per 100,000 children, respectively) than in *Major cities* (10)
- 4.6 times higher in the lowest socioeconomic areas than in the highest areas (23 and 5.0 per 100,000, respectively)

- considerably higher for Indigenous children than for non-Indigenous children (61.9 and 10.3 per 100,000, respectively). The difference was greater between Indigenous girls (62) and non-Indigenous girls (7.1) than between Indigenous boys (62) and non-Indigenous boys (13) (Analysis of AIHW NHMD).

The rate of self-harm hospitalised cases was:

- higher in *Inner regional* and *Outer regional* areas (113 and 116 per 100,000 children, respectively) than in *Major cities* (75.8).
- 1.6 times higher in the lowest socioeconomic areas than in the highest areas (34 compared with 22 per 100,000, respectively)
- higher among Indigenous children than non-Indigenous children (220 compared with 79 per 100,000 children). It was also higher for Indigenous girls than for Indigenous boys (398 compared with 49 per 100,000) (Analysis of AIHW NHMD). For information on the quality of Indigenous status data, see Technical notes in the [Injuries](#) section of the online report.

Figure 13: Hospitalised injury cases for children aged 10–14, by priority groups 2016–17

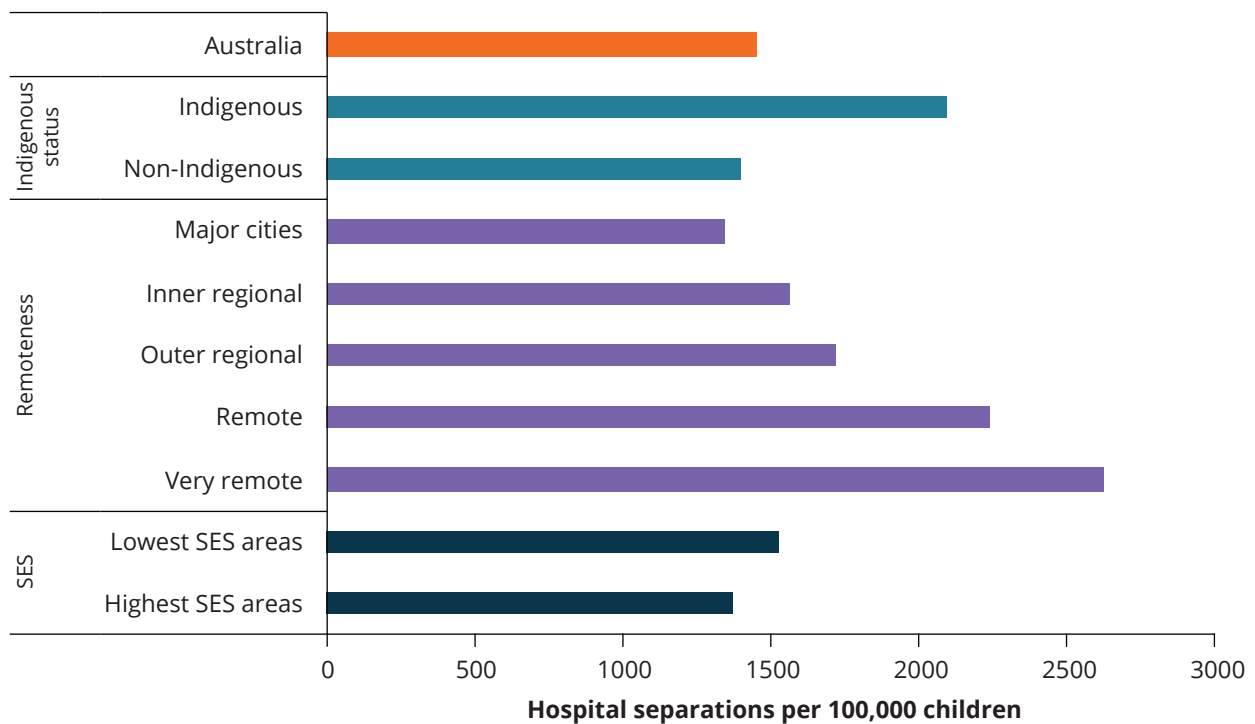


Chart: AIHW. Source: AIHW NHMD.

Data limitations and development opportunities

Hospitalised cases of self-harm

In very young children, ascertaining if a hospitalised injury was due to intentional self-harm can be difficult and may involve a parent’s or caregiver’s perception of the intent. Ability to form an intention to inflict self-harm, and to understand the implications of doing so, requires a degree of maturation that is absent in infancy and early childhood (AIHW: Pointer 2014).

It is not possible to differentiate between acts of self-injury and self-harm with suicidal intent within the NHMD, but it is likely that an unknown proportion of cases of intentional self-harm presented here are self-injurious in nature rather than suicidal in intent.

Such sources of uncertainty about intent limit the certainty of estimates of intentional self-harm based on routine hospital data, particularly for children. For these reasons, this report presents cases of intentional self-harm in aggregate for ages up to and including 14.

The hospitalised injury data presented is likely an underestimate of total prevalence of self-harm. Presentations for self-harm to emergency departments or outpatients are not included, nor are data from other services, such as ambulance and general practitioners.

Data linkage work may help to better understand the relationship between self-harm and suicide. There is a possibility that a small number of self-harm cases could end in death and therefore ultimately be included in hospital and suicide (deaths) data. However, without data linkage, it is not clear what the overlap is. Linking deaths and hospital data could possibly reveal repeated self-harm attempts. Linked deaths data to Medicare Benefits Schedule and Pharmaceutical Benefits Scheme data could also reveal service use patterns before suicide.

The 2019–20 Australian Government Budget includes a new measure to provide \$15 million over 3 years for a new national system for the improvement of data on self-harm and suicide to assist governments, communities, and mental health and suicide prevention bodies to better respond to incidences.

The AIHW will work with the National Mental Health Commission and the Department of Health to deliver a national view of the prevalence of suicide and self-harm.

Where do I find more information?

For information on:

- the rate of injury deaths for Indigenous children, see: [Indigenous children](#)
- child injury deaths breakdowns by states and territories, see: [Injury deaths in Children's Headline Indicators](#).
- child hospitalised injury for children, see: [Hospitalised injury in children and young people 2011–12](#).
- whole-of-population injury deaths (including disaggregations for children aged 0–14), see: [Trends in injury deaths, Australia, 1999–00 to 2014–15](#).
- whole-of-population hospitalised injury cases (including disaggregations for children aged 0–14), see: [Trends in hospitalised injury, Australia 1999–00 to 2014–15](#).
- land transport crashes, see: [Hospitalised injury due to land transport crashes](#)
- eye injuries, see: [Tovell A & McKenna K 2018. Eye injuries in Australia, 2010–11 to 2014–15](#).
- Hospitalised assault injuries among men and boys, see: <https://www.aihw.gov.au/getmedia/695ba12d-b0c6-4639-9b9a-db63b92890e1/aihw-injcat-196.pdf.aspx?inline=true>
- injuries among Indigenous peoples, see: [Indigenous child safety report](#) and [Hospitalised injury among Aboriginal and Torres Strait Islander people, 2011–12 to 2015–16](#).
- technical notes relating to this section, refer to [Injuries](#) in the online report. See also [Methods](#).

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Social and emotional wellbeing

Key findings

- In 2013–14, 1 in 10 children scored in the 'of concern' range of the Strengths and Difficulties Questionnaire (SDQ) total difficulties score.
- The proportion of children who scored in the range 'of concern' increased with age, from 7.3% for those aged 4–6 to 11.7% for those aged 7–9 and 12% for those aged 10–12.
- Boys were more likely to score in the range 'of concern' than girls (12.7% and 7.7%, respectively) (Figure 1).

Good mental health and wellbeing is important to enable children to thrive across the early years and into adolescence and young adulthood. Investing in prevention and early intervention gives children the best opportunity for achieving this (NMHC 2019).

Children's social and emotional wellbeing (SEWB) is a key component of mental health and wellbeing. It is a complex construct that is sometimes referred to as social and emotional competence, development, learning or literacy.

The emphasis is on behavioural and emotional strengths and ability to adapt and deal with daily challenges (resilience and coping skills) and respond positively to adversity while leading a fulfilling life (AIHW 2012).

An ecological conceptualisation of SEWB recognises that while children's individual internal characteristics contribute to their social and emotional wellbeing, relationships and interactions with their family, school and community environments have a significant influence (AIHW 2012). A meta-analysis of school-based interventions found that social and emotional skills can be taught at school, and have a positive impact on attitudes, behaviours and academic outcomes (Durklak et al. 2011).

Socially and emotionally competent children:

- are confident
- have good relationships
- communicate well
- do better at school
- take on and persist with challenging tasks
- develop the necessary relationships to succeed in life.

Strong social and emotional competence may also provide resilience against stressors (AIHW 2012).

Cultural background is an important consideration in measurement due to differences in social norms and values between cultural groups (Hamilton & Redmond 2010). For Indigenous children, for example, key elements of SEWB include:

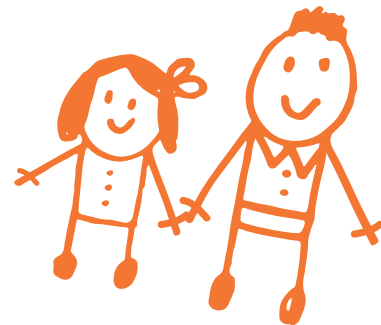
- family and community wellbeing
- connection to ancestry, culture, spirituality and country (Marmor & Harley 2018).

Measuring social and emotional wellbeing

Theories of SEWB development are diverse, and there is little agreement on how best to measure it (Bernard and Stephanou 2017). Positive constructs that measure how well children are thriving in terms of SEWB include the construct of mental health competence, which measures healthy psychosocial functioning (Goldfeld et al. 2014).

How children view their own wellbeing (subjective or self-reported wellbeing), is also important for measuring SEWB. Survey instruments giving children a voice include the South Australian Wellbeing and Engagement collection which measures SEWB for:

- happiness
- optimism
- satisfaction with life
- perseverance
- emotion regulation
- sadness
- worries (SA Department for Education 2018).



Other SEWB instruments include:

- ACER SEW Survey, which includes the domains of feelings and behaviour, internal strengths and values, and external strengths
- [Rumble's Quest](#), an interactive game allowing primary school children (aged 6–12) to report on their own wellbeing (See below Alternate measures for social and emotional wellbeing)
- Behind the News (BtN) which runs 2 large scale Kids' Happiness surveys for children aged 6–18 and includes data on how often children felt happy, worried and safe (Box 2: How do Australian children rate their own wellbeing? in [Introduction](#)).

Currently, these instruments are not being used to collect nationally representative population-level data.

For national reporting in the Children's Headline Indicators, SEWB is measured as the proportion of children (4–12 years) who scored in the 'of concern' range (also referred to as 'abnormal') using the SDQ (Box 1).

Box 1: National data on the Strengths and Difficulties Questionnaire

Data reported on the SDQ in this section is sourced from the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015), also known as the Young Minds Matter survey.

This household survey was conducted in 2013–2014 by the Telethon Kids Institute at the University of Western Australia in partnership with Roy Morgan Research. The survey collected information about the mental health and wellbeing of children and adolescents in Australia, and the extent to which they use health and education services to get help with problems.

The SDQ was originally designed as a screening tool for behavioural problems and mental illness. It incorporates positive and negative attributes through its 5 scales, each of which are relevant to conceptualising SEWB:

- emotional symptoms
- conduct problems
- peer problems
- hyperactivity
- pro-social (AIHW 2012).

While the SDQ has a bias in terms of negative constructs, it has been used extensively as an indicator of SEWB (Hamilton & Redmond 2010). For the purposes of reporting in the Children's Headline Indicators, it was found to have a sufficiently strong conceptual basis for SEWB, as it assesses individual internal and relational aspects (AIHW 2012).

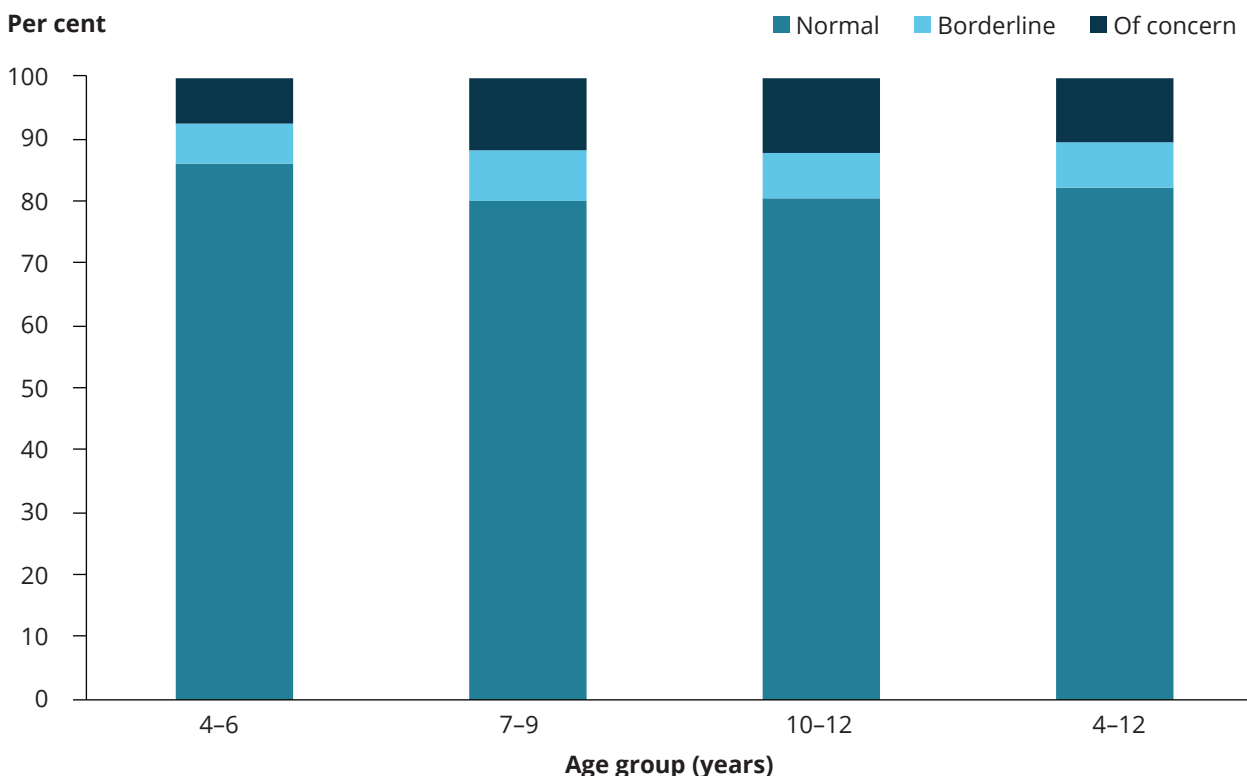
How many children scored 'of concern' on the SDQ?

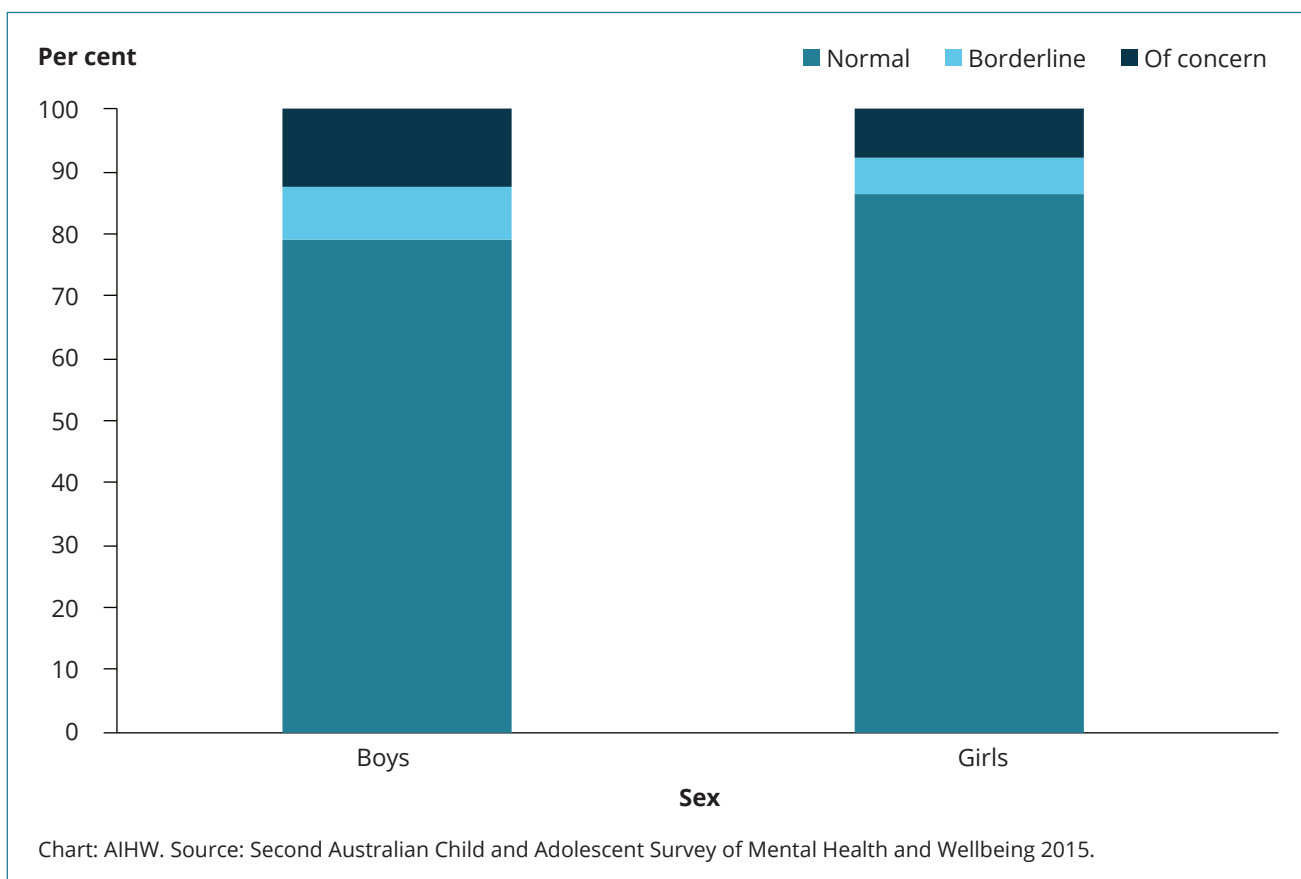
In 2013–14, 1 in 10 children reported on in the Young Minds Matter survey scored in the 'of concern' range of the SDQ total difficulties score. The proportion who scored in the 'of concern' range increased with age.

While 7.3% of 4–6 year olds were classified as 'abnormal' this increased to 12% of 7–9 year olds and 12% of 10–12 year olds.

Boys (13%) were more likely to score in the range 'of concern' than girls (7.7%) (Figure 1).

Figure 1: Children's scores on the SDQ, by age, gender, 2013–2014





Is social and emotional wellbeing the same for everyone?

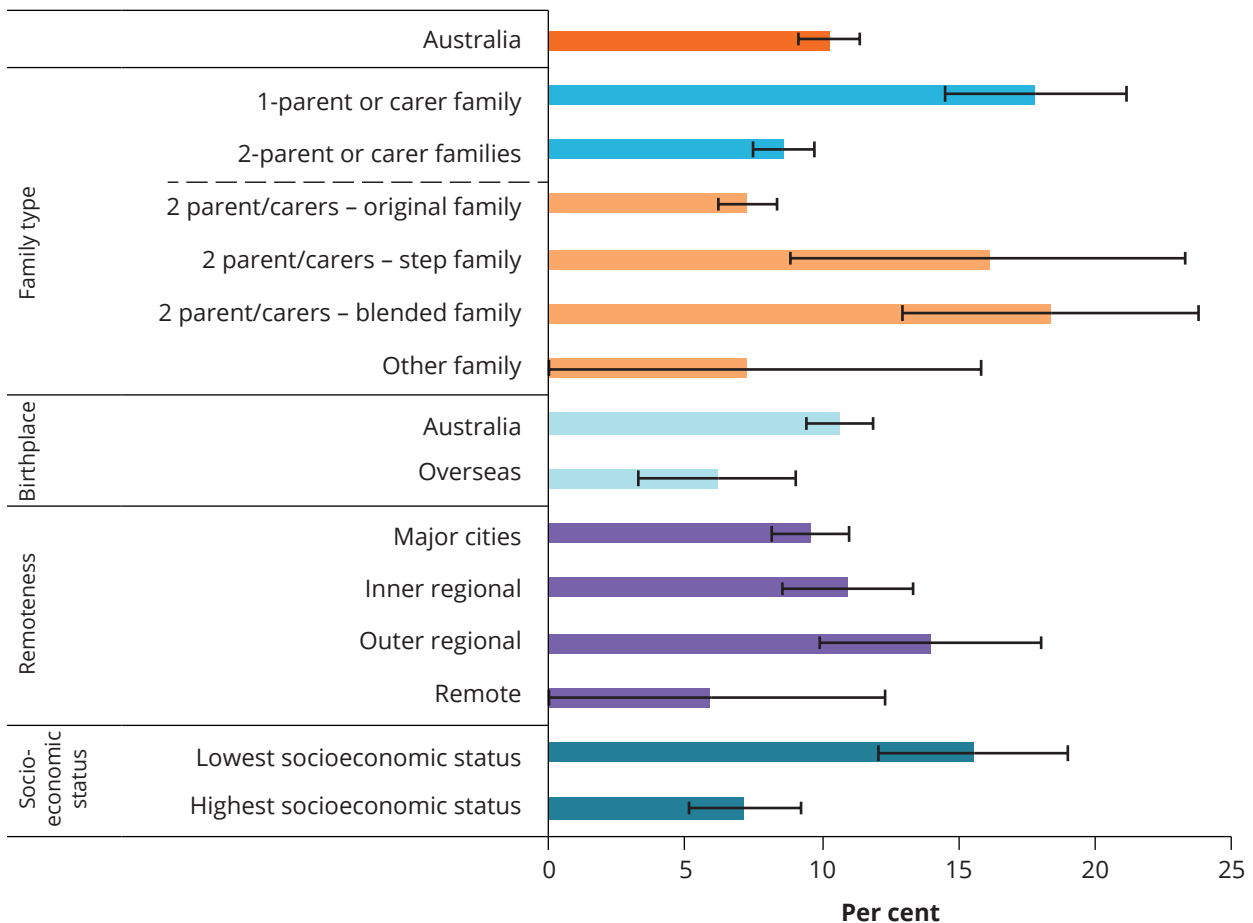
In 2013–14, children living in original 2-parent or 2-carer families were less likely to score ‘of concern’ (8.6%) compared with blended (18%) and 1-parent families (18%). Overseas-born children were also less likely to score ‘of concern’ (6.2%) compared to Australian-born children (11%).

Living in the lowest socioeconomic areas was strongly associated with a score ‘of concern’ and double the rate of that for children living in the highest socioeconomic areas (16% and 7.2%, respectively) (Figure 2).

Reliable data are not available on Indigenous children in the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing. The 2000–2002 Western Australian Aboriginal Child Health Survey found that among children aged 4–17, Indigenous children were 1.6 times as likely than non-Indigenous children to be at risk of social and emotional difficulties based on the SDQ (24% and 15%, respectively) (De Maio et al. 2005).

A comparison of Indigenous and non-Indigenous children aged 6–7 (based on the Longitudinal Survey of Indigenous Children (LSIC), and the Longitudinal Survey of Australian Children (LSAC), respectively) found that Indigenous children tended to have greater levels of social and emotional difficulties using the SDQ (DSS 2015). However, using the SDQ showed that on average Indigenous children in LSIC had higher prosocial scores (a strengths-based measure which includes being considerate, sharing and being helpful and kind) than non-Indigenous children (DSS 2015).

Figure 2: Children scoring 'of concern' on the SDQ by selected population groups, 2013–2014



Note: Step family have at least 1 resident stepchild, but no child who is the natural or adopted child of both partners. Blended families have 2 or more children with at least 1 the natural or adopted child of both parents, and at least 1 the stepchild of 1 of them.

Chart: AIHW. Source: Second Australian Child and Adolescent Survey of Mental Health and Wellbeing 2015.

Alternate measures for social and emotional wellbeing

Since the SEWB indicator for the Children’s Headline Indicators was developed, there has been growing interest in positive measures of social and emotional wellbeing. Several alternatives have emerged and could potentially inform future national information development and reporting in this area.

Positive mental health

An alternative to the SEWB measure using the SDQ is the construct of positive mental health, known as mental health competence. This measures healthy psychosocial functioning. It was developed as a population measure within the framework of the Australian Early Development Census (AEDC) (Goldfeld et al. 2014). The measure is strengths-based and includes 5 positive mental health constructs from the AEDC:

- overall social competence
- responsibility and respect

- approaches to learning
- readiness to explore new things
- prosocial behaviour (Goldfeld et al. 2014).

As the AEDC is conducted every 3 years, there is the opportunity for comparisons over time. One limitation is that it is limited to children age 4–5.

Results from an epidemiological study of positive mental health of children entering school (aged 4–5) and included in the 2012 AEDC cohort, found that mental health competence varied across child population groups (Goldfeld et al. 2017). The study found that:

- Children with good oral communication in the classroom were 19 times as likely to have high mental health competence than children with poor communication skills.
- Children who attended preschool were almost 40% more likely to have high mental health competence than children who had not.
- Boys were more than 50% less likely to have high mental health competence than girls.
- Overall, bilingual children were 16% less likely to have high mental health competence than monolingual children. However, bilingual children with good oral communication were slightly more likely (7%) to have high mental health competence than monolingual children.
- Children living in the highest socioeconomic areas were 60% more likely to have high mental health competence compared with children in the lowest socioeconomic areas (Goldfeld et al. 2017).

For information on the Multiple Strength Indicator, a measure of children’s developmental strengths based on the AEDC, see Box 2 in [The transition to primary school](#).

The Wellbeing and Engagement Collection, South Australia

Another approach to measuring SEWB comes from the Wellbeing and Engagement Collection in South Australia. This collection includes survey data from South Australian middle year students (years 4, 5, 6, 7—aged 9–12) and secondary school (years 8, 9—aged 13–14). Social and emotional wellbeing is defined in terms of 7 constructs:

- happiness
- optimism
- satisfaction with life
- perseverance
- emotion regulation
- sadness
- worries (SA Department for Education 2018).

The 2017 study found that among primary school children:

- Most reported high or medium levels of optimism (86%) and happiness (84%) and low or medium levels of sadness (86%).
- Fewer primary school children reported high or medium levels of perseverance (76%) and low or medium levels of worrying about life (77%) (SA Department for Education 2018).

ACER's Social-Emotional Wellbeing Survey

The ACER SEW Survey is a strengths-based survey based on an ecological conception of social and emotional wellbeing organised into 3 domains:

- feelings and behaviour, both positive and negative
- internal strengths, including social, emotional and learning skills, and values
- external strengths, which includes 3 aspects: community, home and school.

The survey distinguishes between 5 levels of social and emotional wellbeing of young people:

- very highly developed
- highly developed
- developed
- emerging
- low (Bernard & Stephanou 2017).

The survey provides schools with information about their student population (whole school, specific year levels or targeted groups) that can be used to direct planning and problem-solving efforts.

Currently, nationally representative results are not available; however, its feasibility could be explored.

Rumble's Quest

Rumble's Quest is a recent development in the area of SEWB. It is an interactive game allowing primary school children (aged 6–12) to report on their own wellbeing. Its 4 dimensions of child wellbeing are:

- attachment to school
- self-regulation
- social confidence and positive relationships
- supportive home relationships.

Although there is currently no national data collection based on Rumble's Quest, its feasibility could be further explored. This would involve looking at:

- expanding uptake
- establishing a nationally representative sample methodology
- developing the required data governance arrangements.

Data limitations and development opportunities?

Currently it is not possible to look at changes over time in Australian children's SEWB based on the SDQ. The SDQ was not included in the first Australian Child and Adolescent Survey of Mental Health and Wellbeing, and there are currently no plans for it to be repeated.

In recognition that the construct of SEWB has a different meaning for Indigenous children, an additional construct is needed covering relational health of community, culture and country (Marmor & Harley 2018).

Work being undertaken by the National Mental Health Commission on developing the National Children's Mental Health and Wellbeing Strategy will also help inform reporting in this area (NMHC 2019).

Where do I find more information?

For more information on related topics in Australia's children, see:

- Children's perspective of wellbeing in [Introduction](#)
- [Children with mental illness](#).

For information on:

- social and emotional wellbeing as defined using the SDQ, see: [Social & emotional wellbeing in Children's Headline Indicators](#) and [Social and emotional wellbeing: development of a Children's Headline Indicator](#).
- SDQ results from the Young Minds Matter survey, see: [Young Minds Matter Survey Results Query Tool](#).
- technical notes relating to this section, refer to [Social and emotional wellbeing](#) in the online report. See also [Methods](#).

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Overweight and obesity

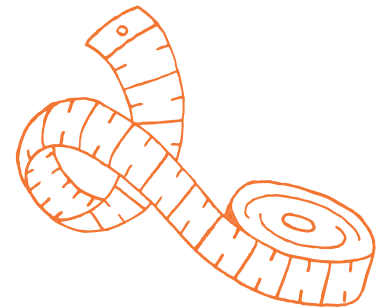
Key findings

- In 2017–18, around 1 in 4 (24%) children aged 5–14 were overweight (17%) or obese (7.7%).
- The proportion of children overweight or obese remained relatively stable between 2007–08 (23%) and 2017–18 (24%).
- Children living in a *Regional and remote* area were more likely to be overweight or obese (29%) than children living in *Major cities* (23%).

Overweight and obesity (the abnormal or excessive accumulation of fat in the body), increases a child's risk of poor physical health and is a risk factor for illness and mortality in adulthood. Overweight and obesity generally results from a sustained energy imbalance, where the amount of energy a child consumes through eating and drinking outweighs the energy they expend through physical activity and bodily functions (AIHW 2017).

Behaviours influencing the likelihood of this imbalance include:

- increased consumption of energy-dense, low-nutrient foods and sugar-sweetened beverages
- insufficient physical activity
- increased sedentary activity
- increased time spent in front of screens
- insufficient sleep (CDC 2016).



A complex interaction of biological, environmental and social factors also influences the likelihood of a child gaining excess weight, including:

- genetic differences in appetite and metabolism
- accessibility of fresh and healthy food,
- fewer options for safe outdoor play (NHMRC 2013; WHO 2014).

Children with obesity have a higher risk of experiencing breathing difficulties, bone fractures, hypertension, insulin resistance and early markers of cardiovascular disease (WHO 2018).

Children with overweight and obesity are also more likely to become obese adults, and to develop chronic conditions such as type 2 diabetes and cardiovascular disease at younger ages (Sahoo et al. 2015). Childhood obesity is also associated with an increased incidence of diabetes, coronary heart disease and some cancers in adulthood (Llewellyn et al. 2016).

In addition to physical health problems, children with overweight and obesity can often experience weight-based teasing and bullying which can have an impact on their:

- psychological wellbeing
- peer relationships
- school experiences
- self-confidence in being physically active (Pont et al. 2017).

Australian research also suggests that overweight and obesity in childhood is associated with depression, poorer health-related quality of life, and low self-esteem (Sanders et al. 2015).

Box 1: Defining and measuring overweight and obesity

Body mass index (BMI) is used to measure overweight and obesity in children. It is calculated as the ratio of weight in kilograms divided by height in metres squared (kg/m^2).

As children are constantly growing, BMI changes substantially with age and can differ between boys and girls. At population level, international cut-off points are used to determine the number of children either underweight, normal weight, overweight or obese based on their age and sex (Cole et al. 2000).

Box 2: Data sources on overweight and obesity in children

Data from the ABS 2017–18 National Health Survey are reported here. This survey collected physical measurements of the height and weight of children, excluding those living in *Very remote* areas.

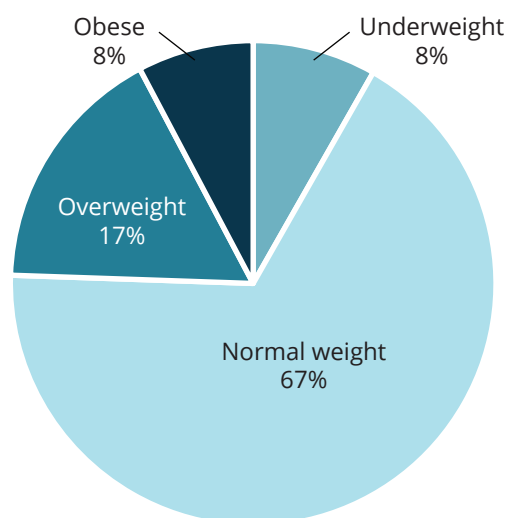
The most recent data on the prevalence of overweight and obesity among Indigenous children comes from the ABS 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey. To compare rates of overweight and obesity between Indigenous and non-Indigenous children, data for non-Indigenous children are taken from the ABS 2011–12 Australian Health Survey.

How many children are overweight or obese?

In 2017–18, while most children aged 5–14 (67% or just over 2 million) were a normal weight, an estimated 24% (746,000) of children were overweight (17%) or obese (7.7%) (Figure 1).

For children aged 5–9 and 10–14, similar proportions of boys and girls were overweight and obese (ABS 2019a).

Figure 1: Body mass index of children aged 5–14, by body mass index category, 2017–18



Source: ABS 2019a.

Have rates of overweight and obesity in children improved over time?

Over the 10 years before 2008, Australian research suggests that the prevalence of overweight and obesity in children plateaued, or only increased slightly, estimated at around 21%–25% (Garnett et al. 2011; Olds et al. 2010).

Data from the ABS National/Australian Health Survey series indicate no real change in the prevalence of overweight and obesity among children aged 5–14 between 2007–08 and 2017–18. Estimates of prevalence rose slightly from 23% to 26% between 2007–08 and 2014–15, before falling slightly to 24% in 2017–18; however these changes were not statistically significant (Figure 2).

Figure 2: Overweight or obese children aged 5–14, 2007–08 to 2017–18

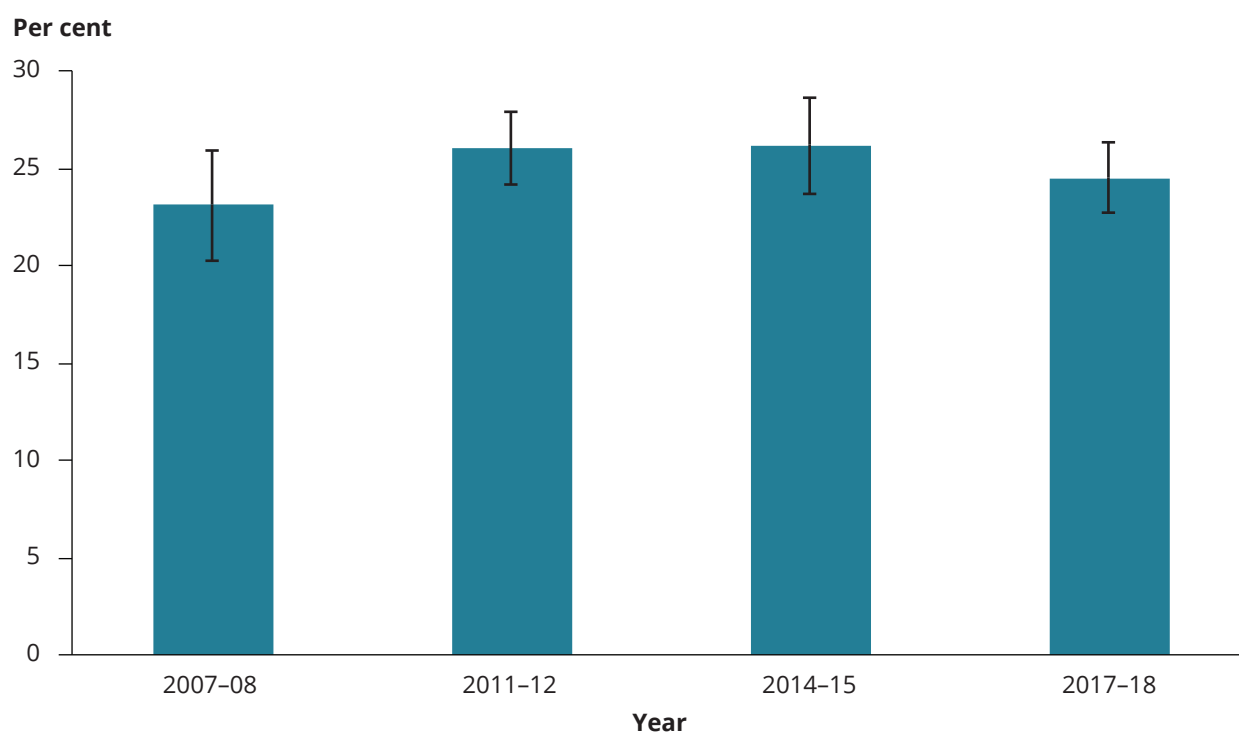


Chart: AIHW. Source: ABS 2019a; AIHW 2018.

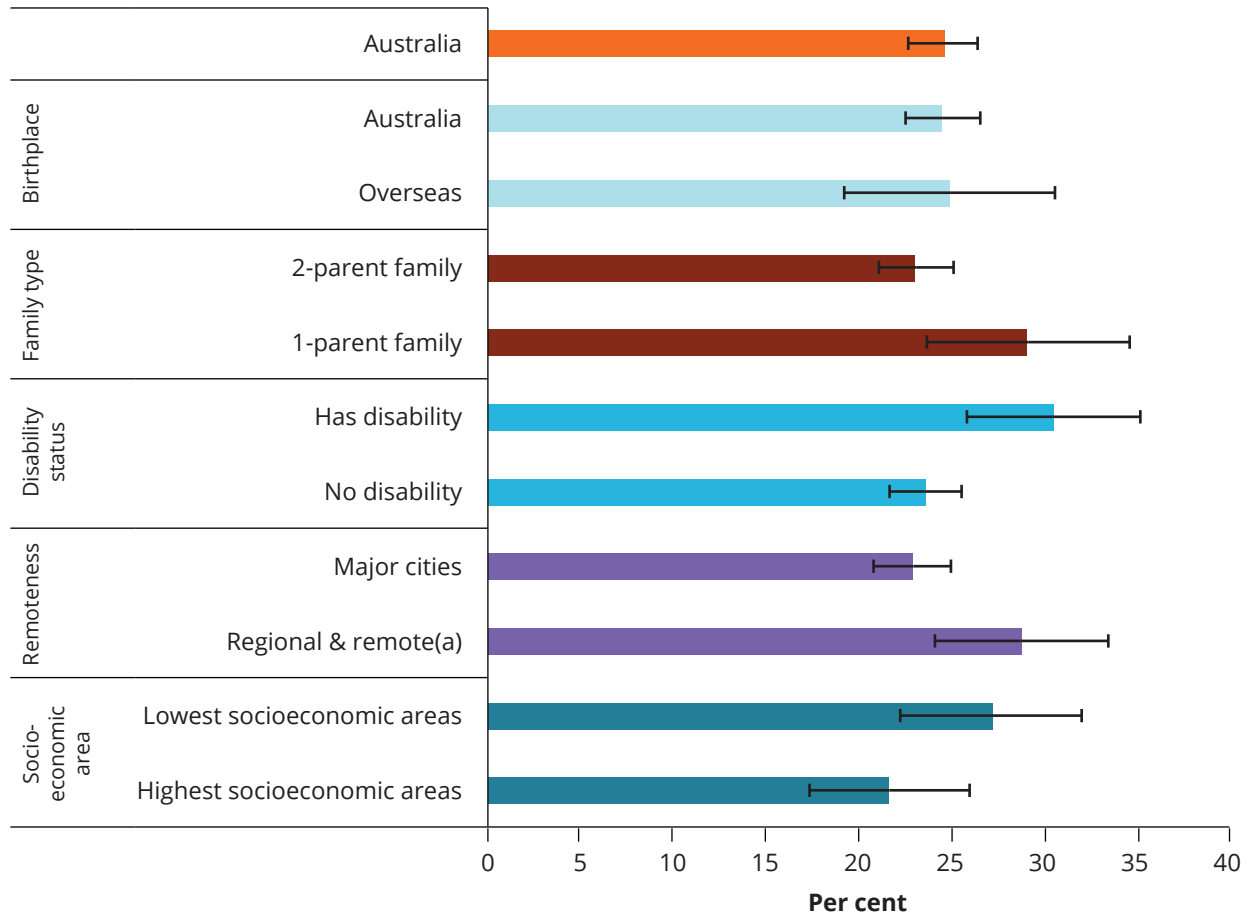
Is the prevalence of overweight and obesity the same for everyone?

In 2017–18, more children aged 5–14 were overweight or obese:

- in *Regional and remote* areas (29%) than in *Major cities* (23%). Data were not collected for children living in *Very remote* areas.
- in 1-parent families (29%) than children living in 2-parent families (23%)
- if they had disability (30%) than those with no disability (24%) to be overweight or obese (Figure 3).

The prevalence of overweight and obesity among children aged 5–14 was similar between those living in the lowest socioeconomic areas (27%) and those in the highest areas (22%). This may be due to the small sample size for these groups in the National Health Survey, as research suggests that children in disadvantaged families are typically at a higher risk of overweight and obesity than children from less disadvantaged families (Jansen et al. 2013).

Figure 3: Proportion (%) of children aged 5–14 who were overweight or obese, by priority population groups, 2017–18



(a) Regional & remote includes *Inner regional*, *Outer regional* and *Remote* areas. *Very remote* areas were excluded from the survey.

Chart: AIHW. Source: ABS 2019a.

Data from the 2012–13 ABS Australian Aboriginal and Torres Strait Islander Health Survey and 2011–12 Australian Health Survey shows differences in the proportion of Indigenous and non-Indigenous children aged 2–14 who were underweight (8.4% compared with 4.8%), as well as overweight or obese (30% compared with 25%). The difference in overweight and obesity was mainly due to higher obesity rates (10% compared with 6.5%), and higher rates of both overweight and obesity in Indigenous children aged 10–14 (37% compared with 27%) (Figure 4).

However, rates of overweight and obesity among Indigenous children varied by remoteness, with those aged 2–14 in *Very remote* areas being less likely to be overweight or obese (22%) than those in *Major cities* (36%). This pattern was consistent with other research that found lower rates of overweight and obesity among Indigenous children in remote areas compared to urban areas (Dyer et al. 2017).

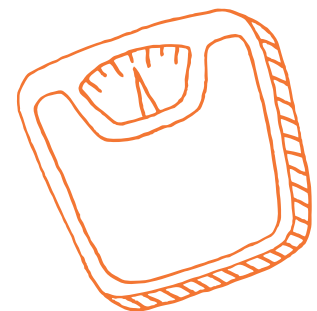
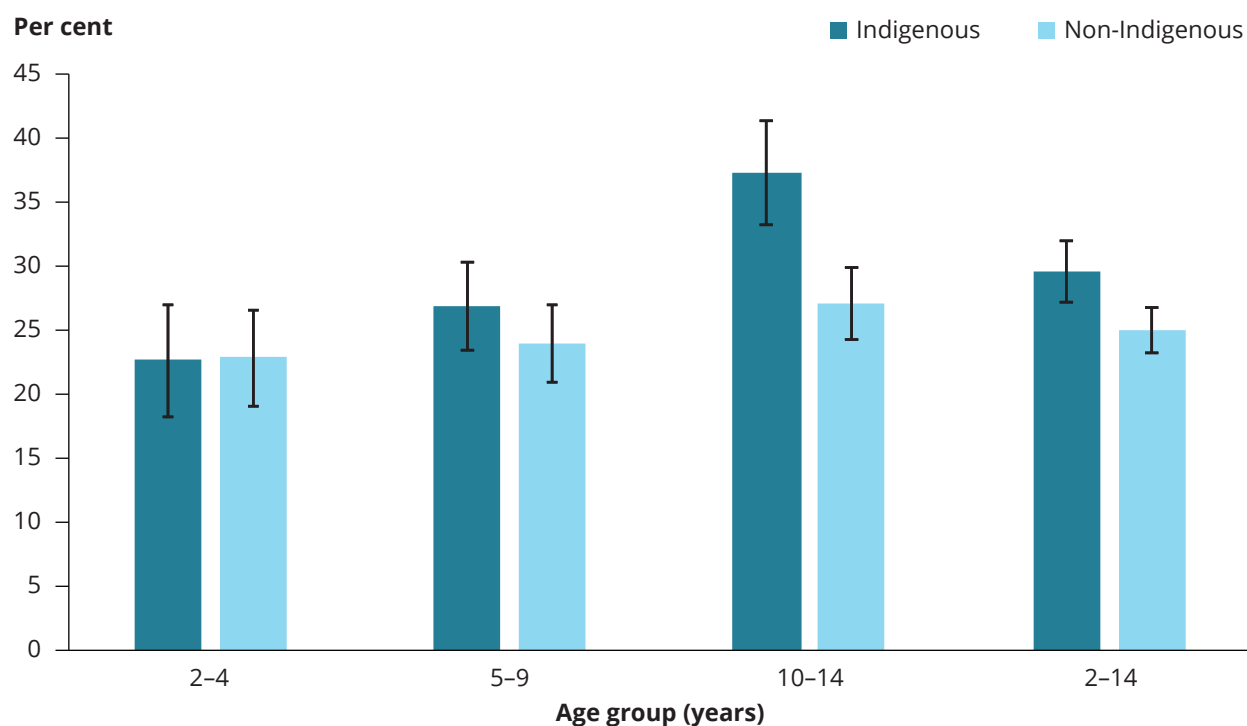


Figure 4: Overweight and obese children aged 2–14, by Indigenous status and age group, 2011–12 and 2012–13



Note: Data for Indigenous children was collected in 2012–13. Data for non-Indigenous children was collected in 2011–12.
Chart: AIHW. Source: ABS 2014.

Data limitations and development opportunities

While the ABS National Health Surveys provide estimates of the prevalence of overweight and obesity, participants can choose to opt-out of having their height and weight measured, which may affect the accuracy of these population estimates.

In 2017–18, 44% of respondents aged 2–17 years did not have their height, weight or both measured. For these respondents, imputation was used to obtain height, weight and BMI scores (ABS 2019b). The National Health Survey may also under-represent some groups as it does not cover *Very remote* areas or non-private dwellings such as hotels, motels, hostels, hospitals, and short-stay caravan parks.

Where do I find more information?

For more information on factors contributing to overweight and obesity in Australia’s children, see:

- [Physical activity](#)
- [Breastfeeding and nutrition](#)

For information on:

- overweight and obesity in children, see: [Overweight & Obesity in Children’s Headline Indicators](#) and [Overweight and obesity: an interactive insight 2019](#) .
- technical notes relating to this section, refer to [Overweight and obesity](#) in the online report. See also [Methods](#).

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Physical activity

Key findings

- In 2011–12, less than one-quarter (23%) of children aged 5–14 undertook the recommended 60 minutes of physical activity every day.
- On average, children aged 5–14 spent more than 2 hours (123 minutes) each day sitting or lying down for screen-based activities. Children aged 2–4 spent 83 minutes a day on average in front of screens.
- In 2018, two-thirds (67%) of children aged 0–14 participated in organised physical activities outside of school hours at least once a fortnight.

Participating in physical activity and limiting sedentary behaviour is central to a child's health, development and psychosocial wellbeing. Regular activity supports brain development, bone strength, muscle control, balance and coordination, and helps to achieve and maintain a healthy weight. Being active can positively affect sleep patterns, mental health, concentration, self-esteem and confidence (DoH 2009, 2017a).

Participation in sufficient levels of physical activity is also important for cardiovascular, metabolic and musculoskeletal health, and plays a critical role in the prevention and treatment of non-communicable diseases such as heart disease, type 2 diabetes and some cancers (WHO 2010). Australia has developed Physical Activity and Sedentary Behaviour Guidelines which outline the amount of physical activity necessary for children and young people to obtain health benefits, and recommendations for reducing time spent in front of screens (DoH 2017a) (Box 1).

Box 1: How much physical activity is recommended?

The Australian **Physical Activity and Sedentary Behaviour Guidelines** differ depending on the age of children.

For **children aged 2–4 who are not in school**, the guidelines recommend:

- at least 180 minutes a day of physical activity, including energetic play
- no more than 60 minutes a day engaged in screen-based activity.

For **children aged 5–12 and 13–17**, the guidelines recommend:

- at least 60 minutes a day of moderate to vigorous intensity physical activity
- no more than 2 hours a day of screen-based activity for entertainment (for example, television, seated electronic games and computer use).

Sedentary behaviour is defined as sitting or lying down for activities (ABS 2014).



The most recent data available on physical activity in children at the time of publication come from the ABS National Nutrition and Physical Activity Survey 2011–12 (NNPAS), and the ABS Australian Aboriginal and Torres Strait Islander Health Survey: Physical Activity (AATSIHS) 2012–13. Children are reported as meeting the guidelines each day if they achieved the recommended levels of physical activity and/or screen time every day in the 7 days before being surveyed, with the exception of Indigenous data which reflects the 3 days before being surveyed (Box 2).

Box 2: Data sources on physical activity

ABS National Nutrition and Physical Activity Survey 2011–12

The ABS NNPAS 2011–12 was conducted as part of the Australian Health Survey 2011–12. It collected detailed information on children through interviews with an adult nominated by the household. Children are reported as meeting the guidelines each day if they achieved the recommended levels of physical activity and/or screen time every day in the 7 days before interview, with the exception of data for Indigenous children.

Data are reported for children aged 5–14 to align with the Children’s Headline Indicators [Overweight and obesity indicator](#). Supplementary data are provided for children aged 2–4.

As the 2011–12 ABS National Nutrition and Physical Activity Survey data did not account for whether 5 year olds had started school, all 5 year olds were assessed using the guidelines for the 5–12 age group. In 2011, 82% of children aged 5 were in full-time schooling (ABS 2017).

ABS Australian Aboriginal and Torres Strait Islander Health Survey: Physical Activity 2012–13

Data for Indigenous children come from the ABS AATSIHS 2012–13. Comparison data for non-Indigenous children is from the NNPAS 2011–12.

Children are reported as meeting the guidelines each day if they achieved the recommended levels of physical activity and/or screen time every day in the 3 days before interview (ABS 2015).

Types of activities classified as physical activity in the AATSIHS and NNPAS include:

- outdoor activities such as individual or team sports, school physical education classes, brisk walking or running, helping in the garden, swimming, surfing, biking, rollerblading, and skateboarding.
- indoor activities such as dancing, ‘rough and tumble’ play, tidying up, helping to set the table and other active chores.

AusPlay survey

Data on children’s participation in organised sport and physical recreation come from the AusPlay survey, a national population tracking survey funded and led by the Australian Sports Commission. Data collection for AusPlay is continuous, with telephone interviews conducted every week and data aggregated over the year.

Multipurpose Household Survey

Data on children’s participation in cultural activities come from the ABS Multipurpose Household Survey. The survey is undertaken each financial year to collect statistics on a number of small, self-contained topics. In 2017–18, this included cultural participation.

How many children are doing enough physical activity?

According to self-reported data from the ABS NNPAS, in 2011–12:

- less than one-quarter (23%) of children aged 5–14 undertook the recommended 60 minutes of physical activity every day
- less than one-third (32%) met the screen-based activity guidelines
- only 1 in 10 (10%) children met both sets of guidelines each day (Figure 1).

Children aged 10–14 were less likely than those aged 5–9 to have met:

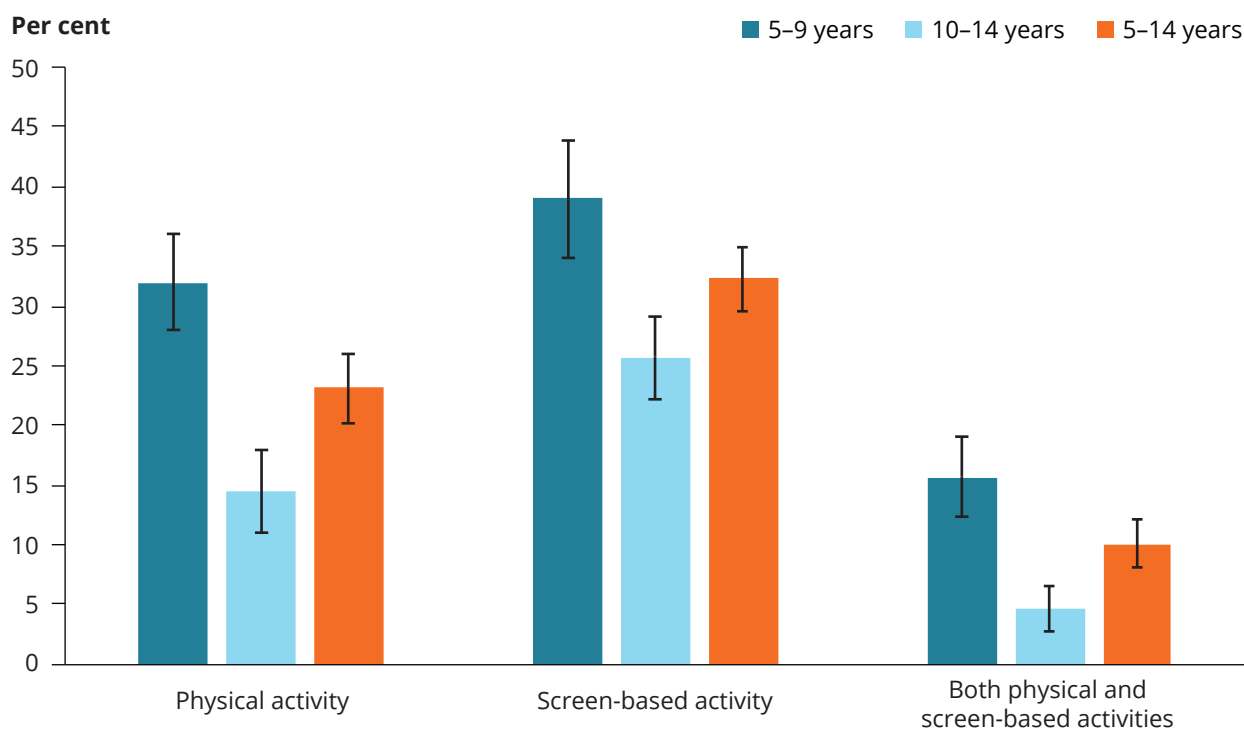
- physical activity guidelines (15% compared with 32%)
- screen-time guidelines (26% compared with 39%)
- both sets of guidelines (5% compared with 16%) (Figure 1).



On average, children aged 5–14 spent just over 2 hours (123 minutes) each day sitting or lying down for screen-based activities, with only 3.5 minutes of this being for homework (ABS 2013b).

Children aged 10–14 spent more time in front of screens (145 minutes a day, on average) than children aged 5–9 (102 minutes) (ABS 2013b).

Figure 1: Proportion of children aged 5–14 who met the physical and screen-based activity guidelines on all 7 days, by age group, 2011–12



Note: Met recommendations in the 7 days before interview.

Chart: AIHW. Source: ABS 2013a.

While there were no differences between the proportion of boys and girls aged 5–14 meeting the physical activity guidelines and both sets of guidelines, girls (38%) were more likely than boys (27%) to meet screen-time guidelines. On average, girls spent 115 minutes a day in front of screens, compared with 131 minutes for boys, with only 4 and 3 minutes of this being for homework (Figure 2) (ABS 2013b).

Nearly three-quarters (72%) of children aged 2–4 met the recommended 180 minutes of physical activity each day. However:

- just over one-quarter (26%) met the screen-based activity guideline
- only one-fifth (20%) met both physical and screen-based activity guidelines (ABS 2013b).

Boys and girls were equally as likely to meet each set of guidelines. On average, children aged 2–4 spent 83 minutes a day in front of screens (ABS 2013b).

Figure 2: Average minutes spent engaged in screen-based activities, children aged 5–14, by type of activity and sex, 2011–12

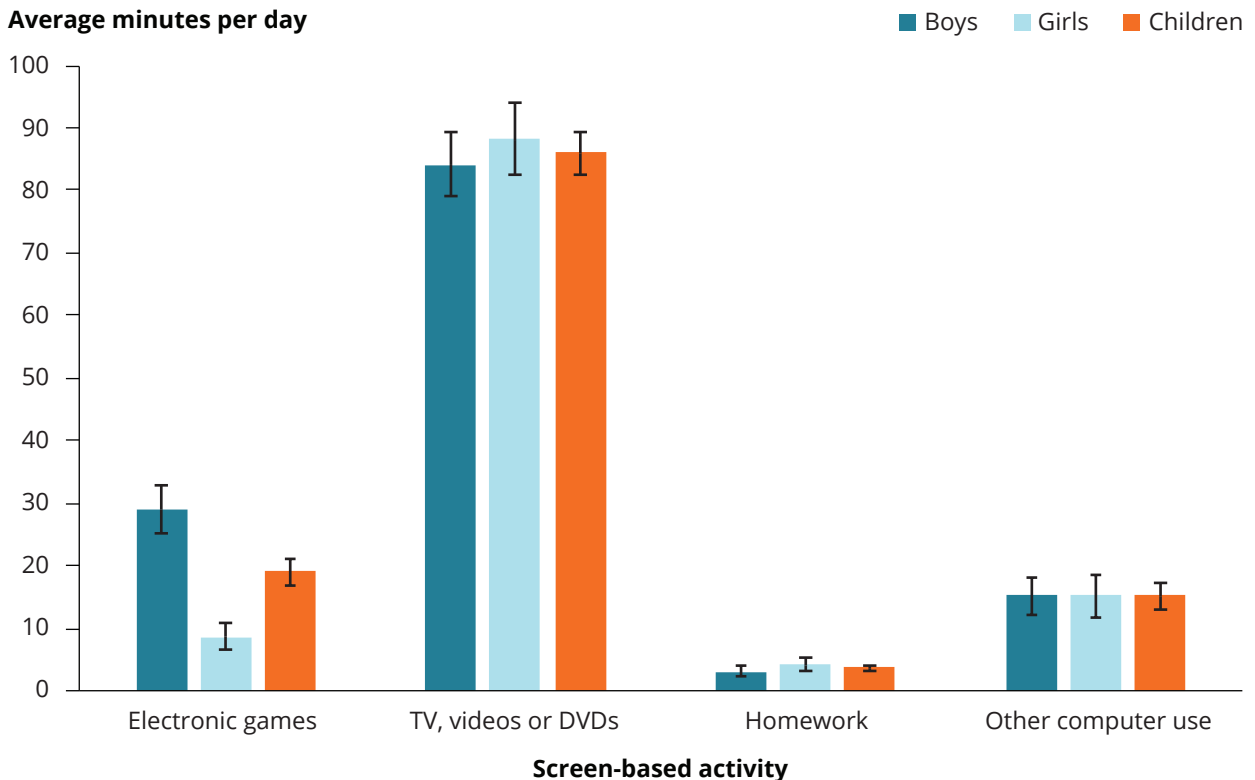


Chart: AIHW. Source: ABS 2013b.

Box 3: Screen time and children

Consistent with results from the NNPAS, a smaller, more recent national survey found 40% of primary school-aged children and 15% of teenagers met the screen-based activity guidelines in 2017 (Rhodes 2017).

The survey also found that nearly half (43%) of children regularly used screens at bedtime, and more than one-quarter (26%) reported having problems sleeping relating to their screen use (Rhodes 2017).

What types of physical activity are children doing?

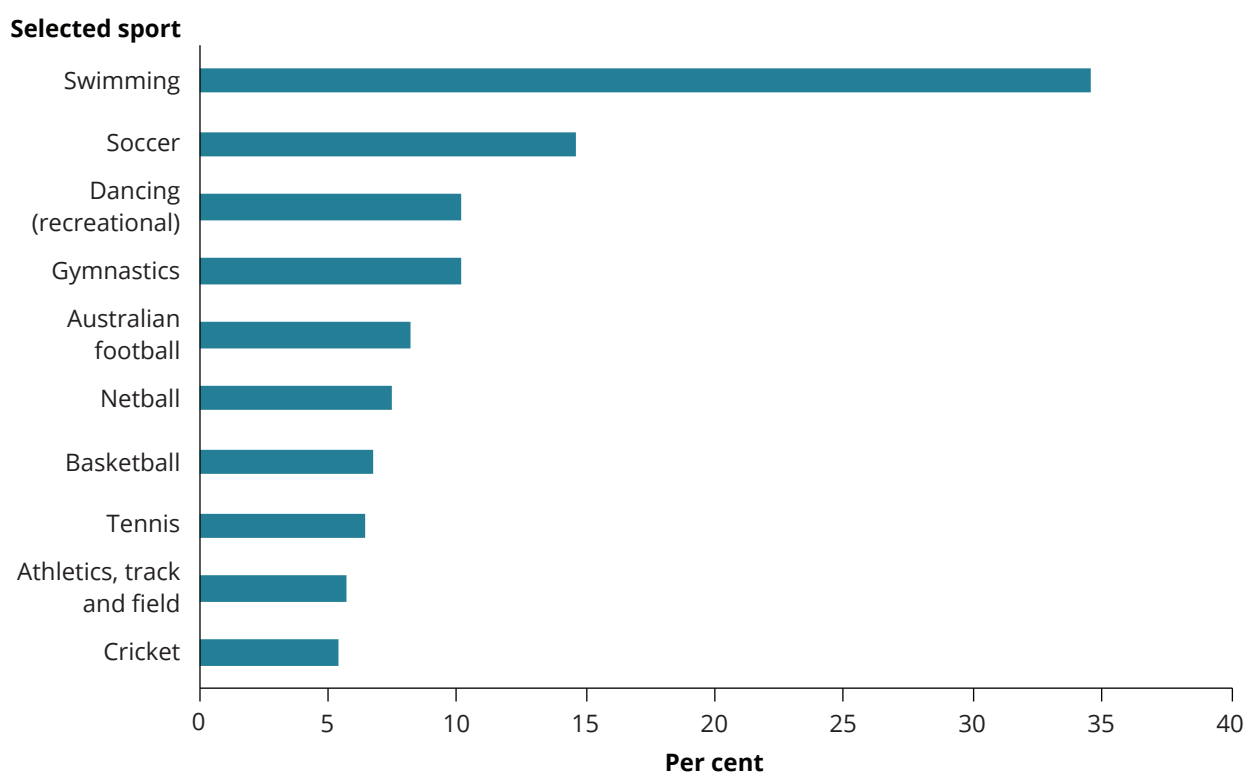
The 2018 AusPlay survey estimated participation in organised physical activities outside of school hours at least once a week for:

- 65% (956,000) of children aged 5–8
- 78% (740,000) of children aged 9–11
- 72% (652,000) of children aged 12–14 (ASC 2019).

The most popular activity for children was swimming, with just under 1.7 million children aged 0–14 (34%) participating in organised swimming activities at least once in 2018. After swimming, the most popular organised activities for children were:

- football/soccer (700,000, or 15%)
- recreational dancing, (485,000, or 10%)
- gymnastics (484,000, or 10%)
- Australian rules football (390,000, or 8.1%) (ASC 2019) (Figure 3).

Figure 3: Top 10 most popular organised sport and leisure physical activities for children aged 0–14, 2018



Notes

1. Data was collected through the child's parent or guardian and relate to organised out-of-school sports and activities. Athletics and track and field include jogging and running.
2. Data based on participation in activities at least once a year.

Chart: AIHW. Source: ASC 2019.

Box 4: Participation in cultural activities

Engaging in cultural activities, such as creative activities and reading for pleasure, are important for children's health and wellbeing.

Participation in creative activities can improve children's self-confidence, self-esteem, resilience, and pro-social behaviour, while recreational reading has been shown to improve imagination, focus, relaxation and mood regulation and increase social interactions (Bungay et al. 2013; Zarobe et al. 2017).

According to self-reported data from the 2017–18 ABS Multipurpose Household Survey, nearly two-thirds (63%) of children aged 5–14 participated in 1 or more creative activities outside of school hours, such as:

- drama
- singing
- playing a musical instrument
- dancing
- art and craft
- creative writing
- creating digital content.

Nearly 8 in 10 (79%) children aged 5–14 read for pleasure outside of school hours (ABS 2019).

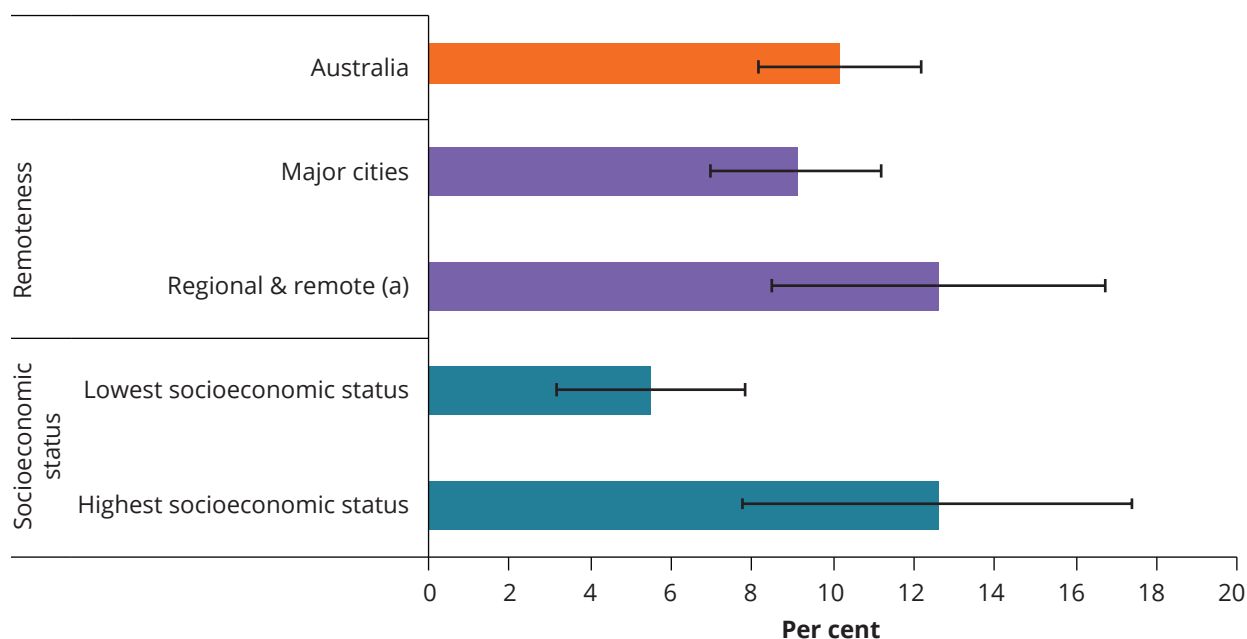
Do physical activity levels vary by population group?

In 2011–12, children living in *Major cities* (20%) were less likely to have met the physical activity guidelines than children living in other areas (30%). However, children in *Major cities* (32%) were similarly likely to have met the screen-based activity guidelines as those in other areas (33%), and to have met both sets of physical and screen-based activity guidelines (9.1% and 13%, respectively).

Children in the lowest and highest socioeconomic areas met the physical activity guidelines at similar rates (24% and 25%, respectively). However, children living in areas of lower socioeconomic disadvantage were more than twice as likely to have met both sets of guidelines as those living in areas of greater disadvantage (13% compared with 5.5%, respectively) (Figure 3).

In 2012–13, while Indigenous children and non-Indigenous children aged 5–14 were equally as likely to have met the screen-time guidelines, Indigenous children were more likely to have met the physical activity guidelines (54% compared with 41%, respectively) and both sets of guidelines (29% compared with 22%, respectively) (Box 2).

Figure 4: Children aged 5–14 who met both physical and screen-based activity recommendations, by selected population groups, 2011–12



(a) Regional & remote includes *Inner regional*, *Outer regional* and *Remote* areas.

Note: Met recommendations each day in the 7 days before interview.

Chart: AIHW. Source: ABS 2013a.

Data limitations and development opportunities

In 2017, the Australian Government reviewed the Australian physical activity guidelines for children aged 0–5 to incorporate a 24-hour movement approach following Canadian guidelines (DoH 2017b). This approach emphasises the integration of all movement behaviours during the day, including physical activity, sedentary behaviour and sleep. However, there is currently no national data to show how children aged 0–5 are faring in line with these guidelines.

There are no consistent data available to monitor long-term trends in physical activity in children, as surveys that collect comprehensive data on time spent engaging in physical and sedentary activity are conducted infrequently. The most recent physical activity data for children come from the ABS National Nutrition and Physical Activity Survey 2011–12 and no trend data are currently available. However, under the Intergenerational Health and Mental Health Study, the ABS National Nutrition and Physical Activity Survey is scheduled to be conducted again in 2023.

Where do I find more information?

For information on:

- physical activity levels among different age groups, see: [Physical activity across the life stages](#) and [Australia’s Health 2018, Insufficient physical activity](#).
- physical activity levels among young people aged 15–24, see: [Level of physical activity in the National Youth Information Framework indicators](#).
- technical notes relating to this section, refer to [Physical activity](#) in the online report. See also [Methods](#).

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Breastfeeding and nutrition

Good nutrition is essential for healthy growth and development across the life span—birth to childhood to adulthood. Australia has national guidelines that aim to support optimal nutrition and health for all Australians.

This section provides data relevant to 4 guidelines:

- breastfeeding
- fruit intake
- vegetable intake
- sweetened drinks intake.

Breastfeeding

Key findings

- In 2017–18, around 6 in 10 (61%) children aged 4–47 months had been exclusively breastfed to at least 4 months of age.
- Nearly two-thirds (64%) of infants in 2-parent families were exclusively breastfed to at least 4 months of age, compared with less than half of infants (46%) in 1-parent families.
- Around 7 in 10 (70%) of infants living in the highest socioeconomic areas were exclusively breastfed to at least 4 months of age, compared with around 5 in 10 (53%) infants in the lowest areas.

Breastfeeding promotes the healthy growth and development of infants and young children. In Australia, the National Health and Medical Research Council (NHMRC) publishes infant feeding guidelines recommending that infants be exclusively breastfed (Box 1) until around 6 months of age when solid foods are introduced. The guidelines also recommend that breastfeeding be continued until 12 months of age and beyond, 'for as long as the mother and child desire' (NHMRC 2012).

Breast milk contains all the requirements necessary for a baby's development for the first 6 months and remains the most important part of the baby's diet, with the addition of appropriate solid foods, until around 12 months. Breast milk continues to provide a valuable source of nutrition and immunological protection for 2 years and beyond (ABA 2013).

Box 1: What is exclusive breastfeeding?

Exclusive breastfeeding means the infant receives only breast milk (including expressed milk) and medicines (including oral rehydration solutions, vitamins and minerals), but no infant formula or non-human milk (WHO 2008).

One measurement difficulty in collecting breastfeeding information relates to the World Health Organization (WHO) (2003) recommendation of exclusive breastfeeding to around 6 months of age. Reporting exclusive breastfeeding to this age is not a stable indicator as solid foods are often introduced at this time. As such, exclusive breastfeeding to around 4 months of age is commonly reported in Australia.

Exclusive breastfeeding is recommended as evidence suggests it has health, nutritional and developmental benefits for infants, including:

- reduced risk of sudden infant death
- reduced risk of necrotising enterocolitis (a condition with high risk of fatality)
- protection against infectious diseases, including gastrointestinal illness, respiratory tract infections and middle ear infections
- protection against overweight and obesity
- reduced risk of type 1 and type 2 diabetes
- reduction in malocclusion (misalignment) in baby teeth
- improved cognitive development (Victora et al. 2016).

Breastfeeding also has health and reproductive benefits for the mother, including reduced risk of breast and ovarian cancer (Victora et al. 2016).

Nutrition as children grow

Key findings

- In 2017–18, around 7 in 10 (72%) children aged 5–14 met the recommended guidelines for fruit consumption.
- Only 1 in 25 children (4.4%) met the recommended guidelines for vegetable consumption.
- Almost half (45%) of children aged 5–14 usually consumed sugar sweetened drinks or diet drinks at least once a week.

As children are constantly growing, good nutrition is key to support their growth and development, and it gives them the energy they need to concentrate, learn and play (NHMRC 2013). A healthy diet also:

- supports children’s physical and cognitive development
- helps to prevent overweight and obesity
- helps to maintain a healthy weight
- increases quality of life
- protects against infection (AIHW 2018).

A balanced and varied diet in childhood also protects against the development of chronic disease and premature death in adulthood (WHO 2018).

Both the quality and quantity of children’s food consumption are important as insufficient or excess amounts of particular foods and nutrients can contribute to ill health.

The NHMRC’s dietary guidelines recommend children eat a wide variety of nutritious foods every day, with a focus on vegetables, fruit, wholegrains, lean meats, fish, legumes and dairy (NHMRC 2013) (Box 3). The guidelines also recommend children reduce their added sugar intake, as increased sugar consumption is associated with excess weight gain and increased risk of dental decay (see [Dental health](#)) (NHMRC 2013).

A number of economic, social, cultural, environmental and familial factors, as well as individual preferences, influence the type of diet a child consumes and the likelihood they will receive all the nutrients required for healthy development. Australian research shows that children living in high-income households and advantaged neighbourhoods are more likely to eat a healthy and balanced diet than those in socioeconomically disadvantaged areas, in large part due to the reduced availability and prohibitive cost of fresh and healthy foods (Friel et al. 2015).

Marketing of unhealthy food and drinks has also been found to impact the dietary patterns of children (Cairns et al. 2013).

Box 2: Data sources on breastfeeding and nutrition

Breastfeeding

Data on breastfeeding come from the **2017–18 ABS National Health Survey**.

Where there was a child aged 0–3 in the household selected for the survey who was currently receiving breast milk, an adult in the household was asked if the child had ever had any food or drink other than breast milk, and if so, the age the child first did so.

Where there was a child aged 0–3 in the household who was not currently receiving breast milk, an adult was asked when the child stopped and the age the child first had food or drink other than breast milk.

The response to these questions was used to determine the number of children breastfed exclusively to 4 months of age or older (Box 1).

Data in this snapshot are reported for children aged 4–47 months, with the exception of breastfeeding rates over time, where only children aged 4–24 months are analysed for comparability with 2014–15 data. Data for children aged 4–47 months are not available for 2014–15.

Due to changes in the sequencing of breastfeeding surveys, comparable data are not available before 2014–15.

Nutrition

Data on children's fruit, vegetable and sweetened drinks intake come from the **2017–18 National Health Survey** which collected information on children's diet through interviews with an adult nominated by the household.

Children are reported as meeting fruit and vegetable consumption guidelines if their usual daily number of serves meets the NHMRC recommendations for their age and sex (Box 3: How many serves of fruit and vegetables should children be eating?). The number of days per week children consume sugar sweetened, and artificially sweetened (diet) drinks is also included.

Data are reported for children aged 5–14 to align with the Children's Headline Indicators [Overweight and obesity indicator](#). Supplementary data are provided for children aged 2–4.

How many children are exclusively breastfed?

Data from the 2017–18 National Health Survey estimate that just under two-thirds (61%) of children aged 4–47 months were exclusively breastfed to at least 4 months of age (ABS 2019b).

Have rates of breastfeeding changed over time?

Due to changes in the age range of children for whom data was collected, time series data are only available for children aged 4–24 months. The rate of children aged 4–24 months who were exclusively breastfed to 4 months and over remained the same between 2014–15 (58%) and 2017–18 (58%) (ABS 2019b).

Due to differences in the age range of children for whom data was collected in different collections. The 2017–18 data in this section do not match data for children aged 4–47 months presented above (Box 2).

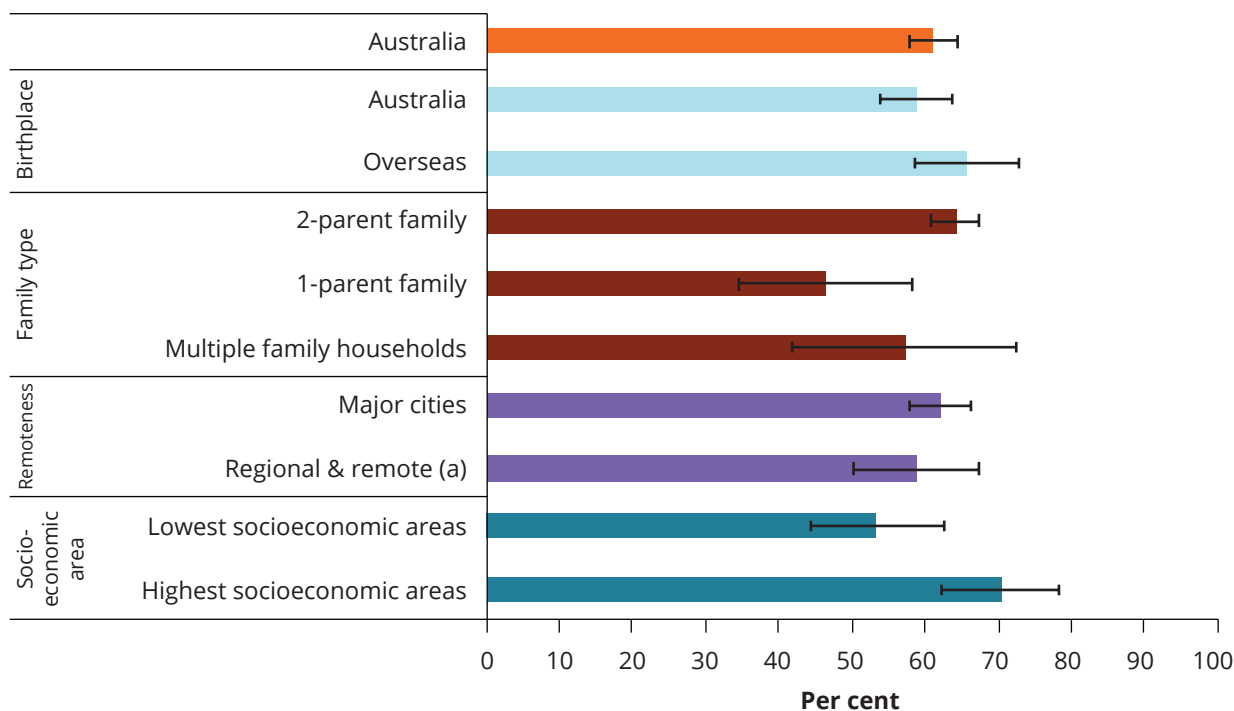
Is breastfeeding the same for everyone?

In 2017–18, of infants aged 4–47 months nearly two-thirds (64%) living in 2-parent families were exclusively breastfed to at least 4 months, compared with less than half of infants (46%) living in 1-parent families (Figure 1).

Around 7 in 10 (70%) infants aged 4–47 months living in the highest socioeconomic areas were exclusively breastfed to 4 months and over, compared with just over half (53%) in the lowest areas.

Rates of exclusive breastfeeding to at least 4 months were similar across other groups, regardless of the mother’s birthplace (Australia or overseas) and remoteness area.

Figure 1: Proportion of infants exclusively breastfed to at least 4 months, by priority population group, 2017–18



(a) Regional & remote includes *Inner regional*, *Outer regional* and *Remote* areas. Data are presented for children aged 4–47 months who were exclusively breastfed to at least 4 months.

Chart: AIHW. Source: AIHW analysis of ABS 2019b.

How much fruit and vegetables are children eating?

Fruit

Most children ate a sufficient amount of fruit in 2017–18, with around 7 in 10 aged 5–14 (72%) meeting the NHMRC guidelines for fruit consumption (Box 3—NHMRC guidelines). Children were most likely to consume 2 or 3 serves of fruit a day (36% and 24% of those aged 5–14, respectively) (Figure 2).



Figure 2: Proportion of children aged 5–14 consuming fruit and vegetables, by daily number of serves, 2017–18

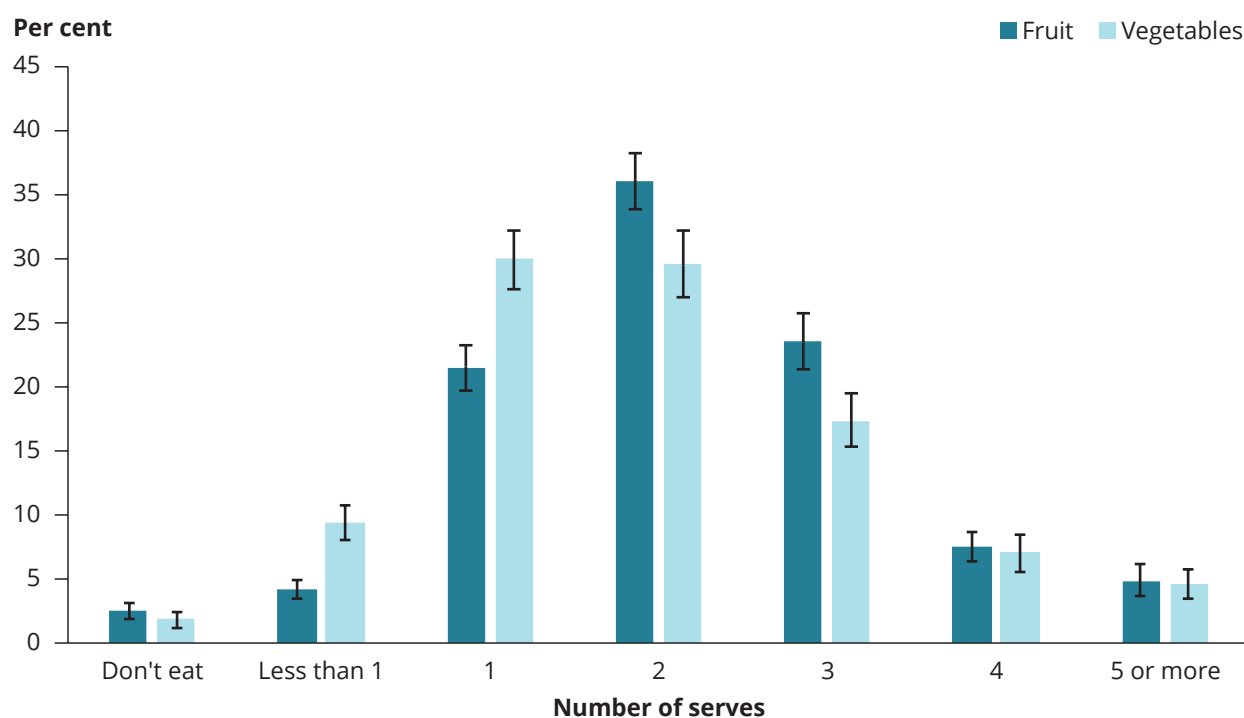


Chart: AIHW. Source: AIHW analysis of ABS 2019a.

In 2017–18, younger children (aged 5–9) were more likely than older children (aged 10–14) to meet the fruit consumption guidelines (78% compared with 66%, respectively). Girls aged 5–14 (75%) were more likely to do so than boys the same age (69%) (Figure 3).

Children aged 2–4 had the highest rate of adequate fruit consumption, with 91% meeting the NHMRC guidelines (ABS 2019a).

Figure 3: Proportion of children aged 5–14 meeting the NHMRC guidelines for fruit consumption, by age group and sex, 2017–18

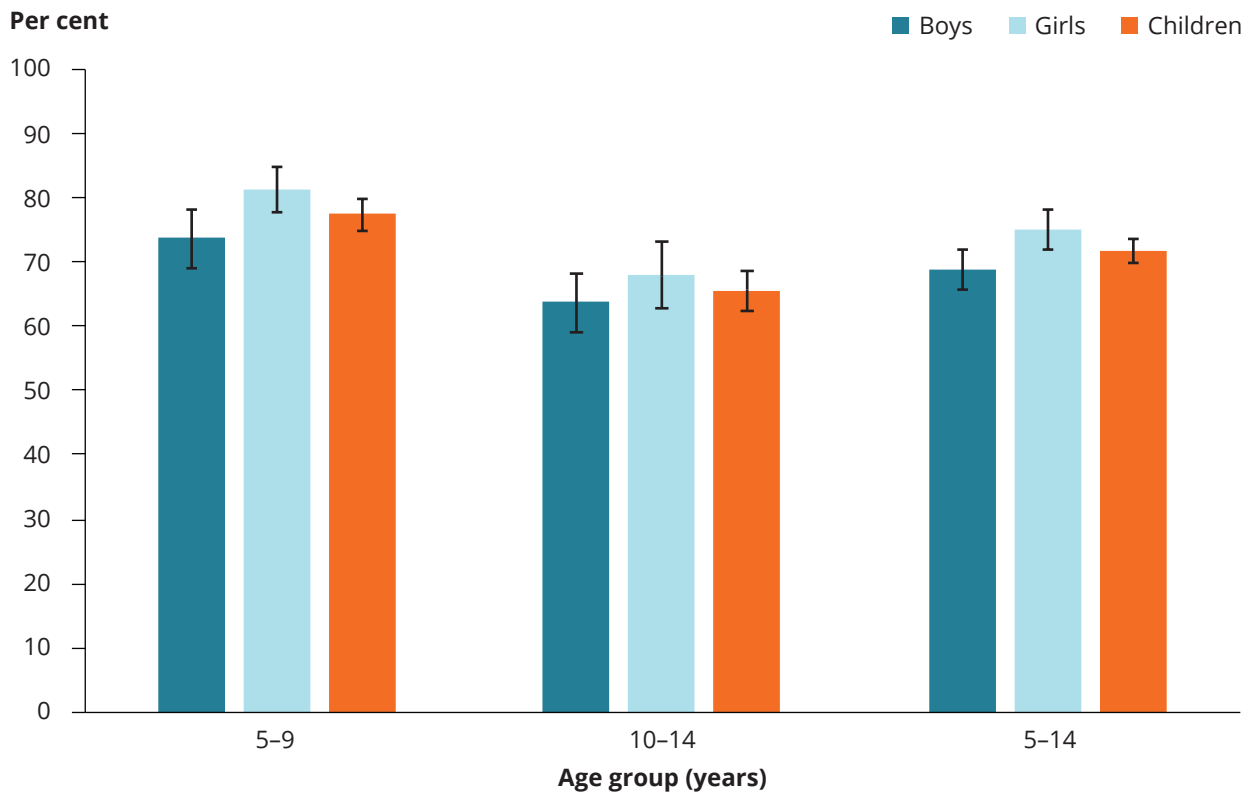


Chart: AIHW. Source: AIHW analysis of ABS 2019a.

Vegetables

In contrast to fruit consumption, the proportion of children aged 5–14 consuming an adequate amount of vegetables in 2017–18 was considerably lower. Only 1 in 25 children (4.4%) met these recommended guidelines (Box 3) (ABS 2019a). Children aged 5–14 were most likely to consume either 1 (30%) or 2 serves (30%) of vegetables a day (Figure 2).

Rates of adequate vegetable consumption were similar across age groups, with 4.7% of children aged 5–9 and 3.8% aged 10–14 meeting the vegetable consumption guidelines. There was little difference between how many boys (3.1%) and girls (5.2%) met the guidelines (ABS 2019a).

Younger children aged 2–4 had slightly higher rates of adequate vegetable consumption, with 13% meeting the guidelines (ABS 2019a).

Box 3: How many serves of fruit and vegetables should children be eating?

The amount of food children need for a diverse, balanced and healthy diet differs by age, sex and level of activity. The NHMRC publishes guidelines on how many serves of fruit and vegetables children need.

In the 2013 guidelines, the minimum recommended number of serves of **fruit** per day is:

- 1 for children aged 2–3
- 1½ for children aged 4–8
- 2 for people aged 9–18.

The minimum recommended number of serves of **vegetables and legumes** per day is:

- 2½ for children aged 2–3
- 4½ for children aged 4–8
- 5 for children aged 9–11
- 5 for females aged 12–18
- 5½ for males aged 12–18.

Consumption of sugar sweetened and diet drinks

Based on self-reported data from the 2017–18 ABS NHS, around 6 in 10 (57%) children aged 5–14 did not usually consume sugar sweetened drinks and more than 9 in 10 (93%) did not usually consume diet drinks (ABS 2019a).

Around 4 in 10 children (42%) consumed sugar sweetened drinks at least once a week, while less than 1 in 10 (7.0%) consumed diet drinks at least once a week (ABS 2019a). Almost half (45%) of children aged 5–14 usually consumed sugar sweetened drinks or diet drinks at least once a week (ABS 2019a).

One-third (34%) of children aged 5–14 consumed sugary drinks on 1–3 days a week, and 6.3% did so daily. In comparison, less than 1% of children consumed diet drinks daily and 5.4% on 1–3 days a week (ABS 2019a).

Older children were more likely to drink sugar sweetened beverages, with more than half (53%) of 10–14 year olds consuming these drinks at least once a week compared with one-third (33%) of 5–9 year olds (Figure 4). Similarly, older children were more likely than younger children to consume diet drinks at least once a week (9.7% of 10–14 year olds compared with 4.3% of 5–9 year olds) (ABS 2019a).

Daily consumption of sugar sweetened drinks was also higher in older children (8.1% of 10–14 year olds compared with 4.9% of 5–9 year olds); however daily consumption of diet drinks was low across both age groups (1.1% and 0.8%, respectively) (ABS 2019a).

Boys aged 5–14 were also more likely to consume sugar sweetened drinks than girls of the same age, with 48% of boys and 37% of girls consuming these drinks at least once a week (Figure 4). However, rates of consumption of diet drinks at least once a week was similar among boys and girls (7.7% and 8.8%, respectively) (ABS 2019a).

More than 1 in 5 (22%) children aged 2–4 consumed sugar sweetened drinks at least once a week, and around 3.3% consumed diet drinks at least once a week (ABS 2019a).



Figure 4: Proportion of children consuming sugar sweetened drinks at least once a week, by sex and age group, 2017–18

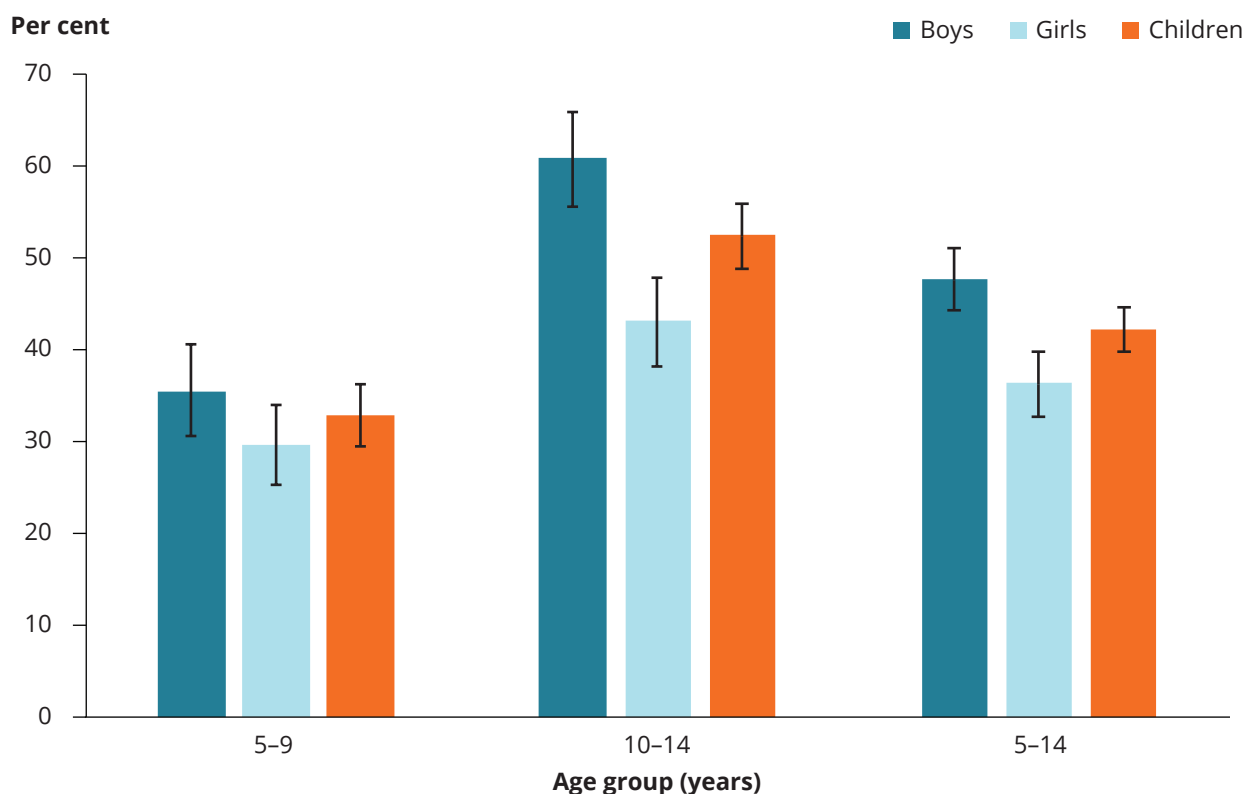


Chart: AIHW. Source: AIHW analysis of ABS 2019a.

Box 4: How much sugar should children be consuming?

The WHO recommends adults and children reduce their consumption of **free sugars** to less than 10% of total energy intake, and reducing intake to less than 5% of total energy intake would provide additional health benefits (WHO 2015). Five per cent of a child's total energy intake translates to 2–6 teaspoons of free sugars a day, depending on the age and energy requirements of the child. WHO recommends that intake of artificially sweetened (diet) drinks also be limited, as consumption of both sugar-sweetened and diet drinks increases the risk of dental decay (NHMRC 2013).

Free sugars include all sugars added to food by the manufacturer, cook or consumer, as well as sugars present in honey, syrups, fruit juices and fruit juice concentrates (WHO 2015).

How much sugar is in what we drink?

- fruit juice drink (250ml): more than 27g or 6.5 teaspoons
- small flavoured milk (300ml): more than 28g or 7 teaspoons
- energy drink (600ml): more than 36g or 8.5 teaspoons
- soft drink can (375ml): more than 38g or 9 teaspoons
- soft drink bottle (600ml): more than 64g or 15 teaspoons (DoH 2014).

Has diet improved over time?

The proportion of children aged 5–14 meeting the NHMRC guidelines for fruit consumption was similar between 2014–15 and 2017–18, with around 7 in 10 children meeting the guidelines over the 2 time periods (70% in 2014–15 and 72% in 2017–18) (AIHW analysis of ABS 2015, 2019a).

Although a small number of children consume sufficient serves of vegetables, the proportion meeting the guidelines for vegetable consumption increased between 2014–15 and 2017–18, from 2.9% to 4.4%.

The proportion of children meeting both sets of recommendations also increased slightly from 2.5% to 4.0% over the 2 time periods, driven by the increase in children meeting the vegetable recommendations (Figure 5).

Figure 5: Proportion of children aged 5–14 meeting the 2013 NHMRC guidelines for fruit and vegetable consumption, by year

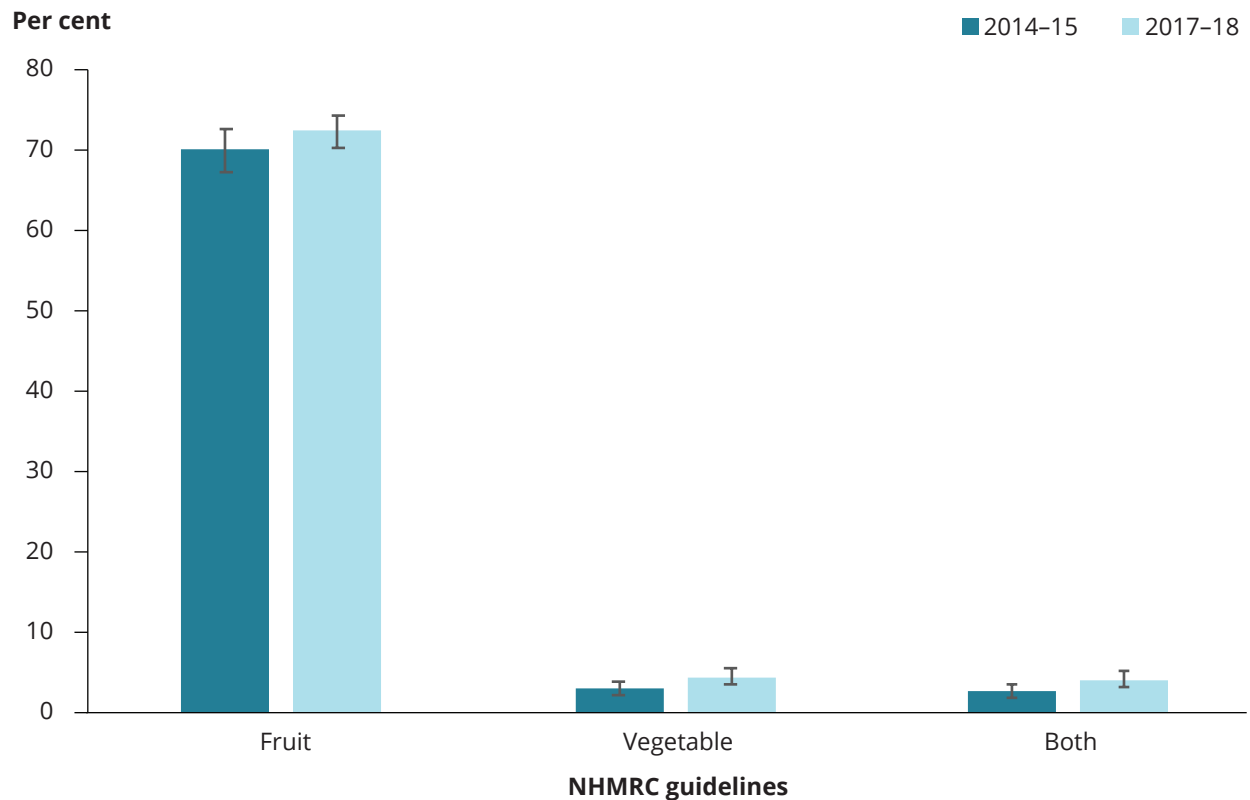


Chart: AIHW. Sources: ABS 2015, 2019a.

Is it the same for everyone?

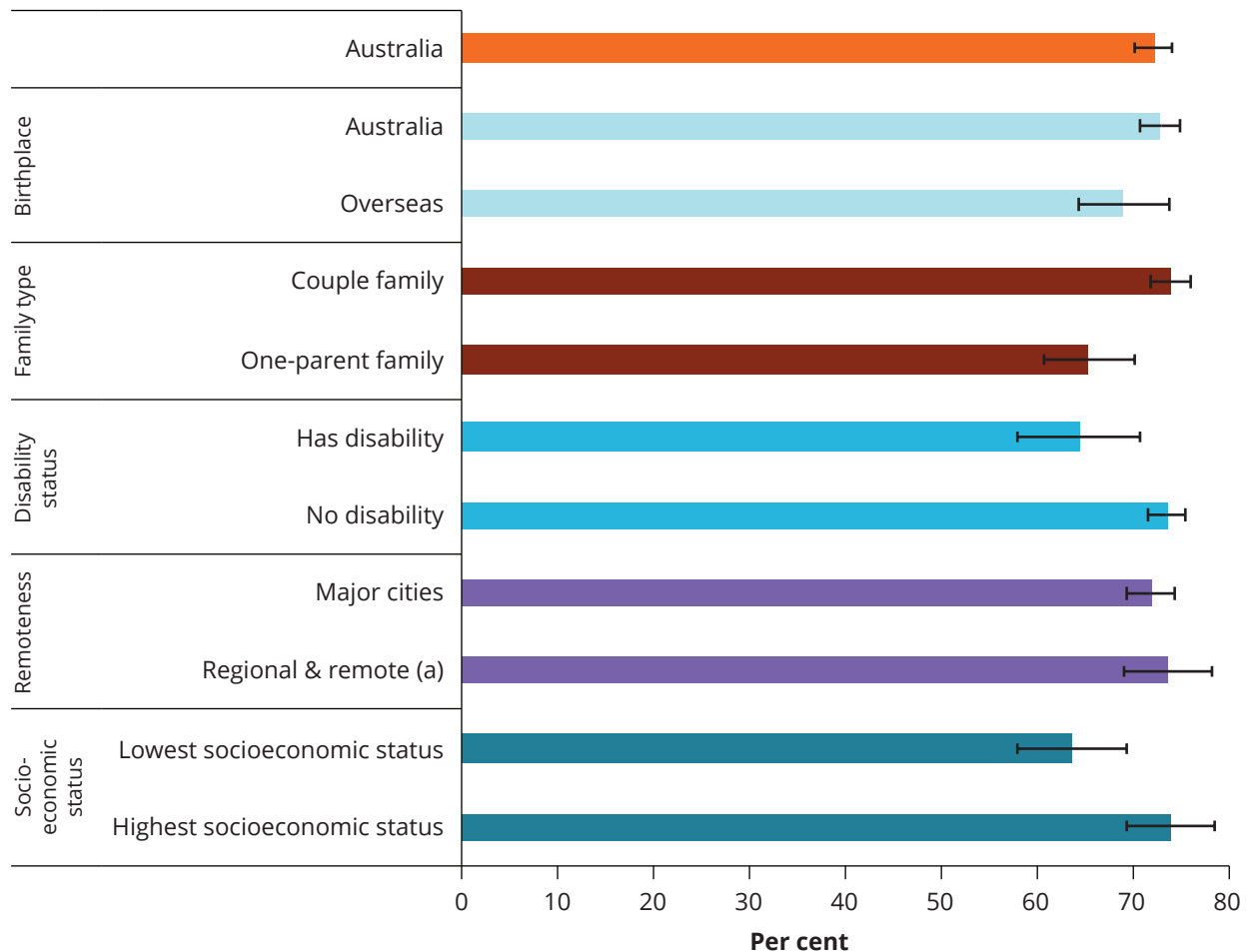
Fruit

In 2017–18, children living in 2-parent families were more likely to meet the fruit consumption guidelines than children living in families with 1 parent (74% compared with 65%, respectively).

Children with a disability (64%) were less likely than children with no disability (73%) to meet the fruit consumption guidelines.

Children living in areas of greatest socioeconomic disadvantage (63%) were also less likely to meet the fruit consumption guidelines than children living in areas of least disadvantage (74%) (Figure 6). In 2017–18, there were no differences between population groups in the proportion of children meeting the guidelines for vegetable consumption (ABS 2019a).

Figure 6: Proportion of children aged 5–14 meeting the recommended guidelines for fruit consumption, 2017–18



(a) Regional & remote includes *Inner regional*, *Outer regional* and *Remote* areas.

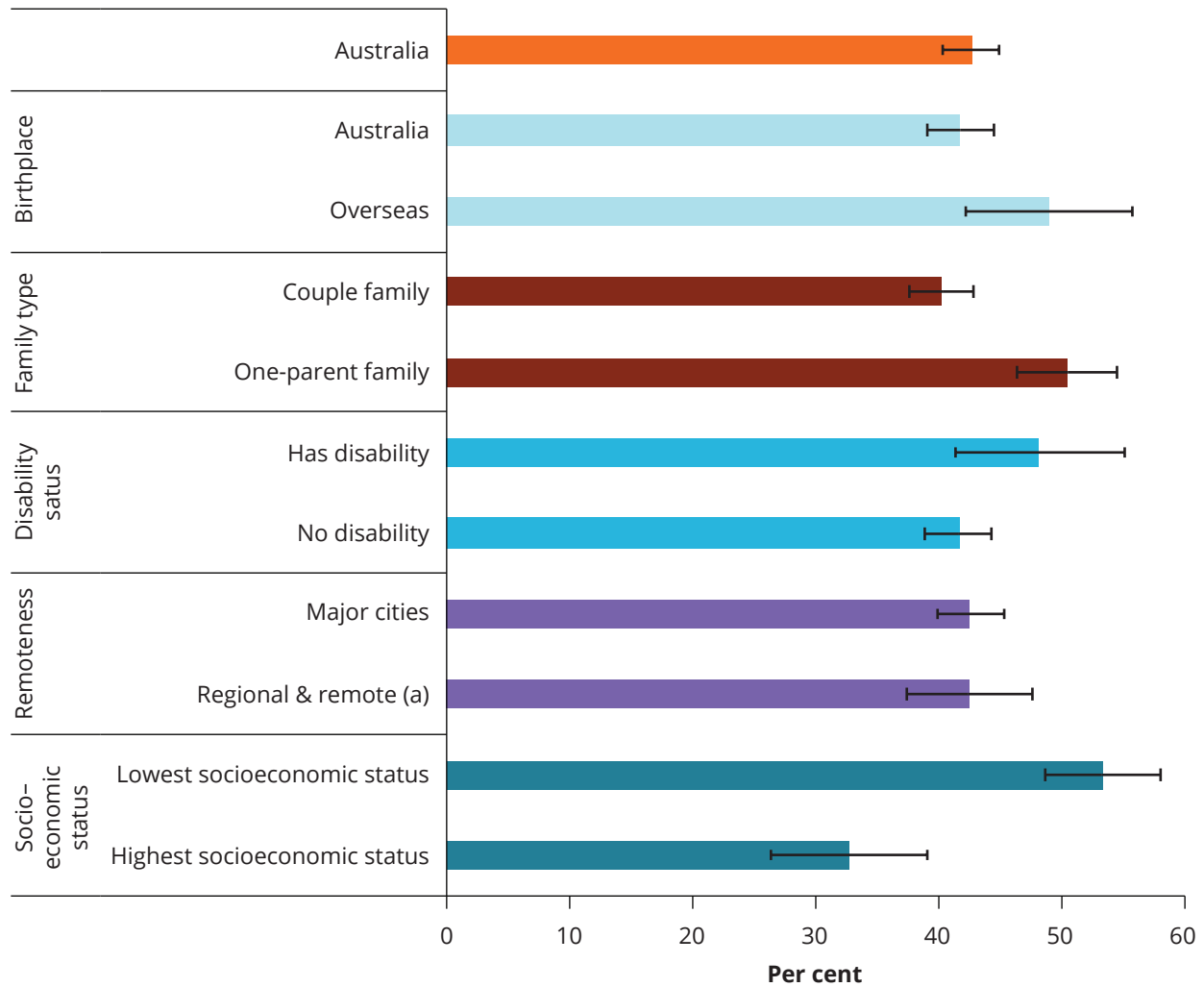
Chart: AIHW. Source: ABS 2019a.

Sugar sweetened drinks

Children living in 2-parent families (40%) were less likely to consume sugar sweetened drinks at least once a week compared with children in 1-parent families (50%). Children born in Australia (42%) were also less likely to consume sugar sweetened drinks at least once a week than children born overseas (49%).

Children living in the lowest socioeconomic areas were considerably more likely to consume sugar sweetened drinks at least once a week than those living in the highest socioeconomic areas (53% and 33%, respectively).

Figure 7: Proportion of children aged 5–14 consuming sugar sweetened drinks at least 1 day a week, by priority population group, 2017–18



(a) Regional & remote includes *Inner regional*, *Outer regional* and *Remote* areas.

Chart: AIHW. Source: ABS 2019a.

Indigenous children

Data from the National Child Oral Health Study 2012–14 estimates there are differences in the proportion of Indigenous and non-Indigenous children consuming 1 or more sugar-sweetened beverages in a usual day (73% and 50%, respectively) (Do et al. 2016).

Data limitations and development opportunities

Routine national data on breastfeeding are limited. A change in question sequencing prevents the comparison of 2014–15 and 2017–18 data with earlier surveys. In cases where an adult other than the child’s parent responded for the child, accuracy of breastfeeding data may be affected.

To address the absence of routine breastfeeding data, the Australian National Breastfeeding Strategy: 2019 and beyond outlines plans to commission a baseline infant feeding survey and to repeat the survey every 5 years (COAG Health Council 2019).

Changes to the recommended number of serves of fruit and vegetables also prevents the comparison of 2014–15 and 2017–18 data with earlier surveys. As the NHMRC's 2013 Australian dietary guidelines recommend a higher intake of fruit and vegetables than the preceding 2003 Dietary guidelines for children and adolescents, the proportion of children meeting the guidelines for fruit and vegetable consumption appears considerably lower than estimates from surveys before 2014–15.

Where do I find more information?

For more information on:

- breastfeeding, see: [Breastfeeding](#) in [Children's Headline Indicators](#).
- nutrition in childhood, see: [Nutrition across the life stages](#).
- technical notes relating to this section, refer to [Breastfeeding and nutrition](#) in the online report. See also [Methods](#).

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Smoking and drinking behaviour

Key findings

- In 2017, 2.2% of secondary school students aged 12–14 were current smokers.
- Between 2002 and 2017, the proportion of secondary school students who were current smokers declined significantly. While 9% of secondary school students were smoking in 2002, in 2017 this had decreased 4-fold to 2%.

Tobacco smoking is the leading preventable cause of death and disease in Australia and a leading risk factor for many chronic conditions such as cancer, respiratory diseases and cardiovascular disease (AIHW 2018).

People who start smoking during their early adolescent years are more likely to smoke daily later in life (AIHW 2017b). In 2015, tobacco use was responsible for 9% of the total burden of disease for the entire population when taking into account illness and deaths (AIHW 2019).

Exposure to second-hand smoke (also known as passive smoking) can increase the risk of adverse child health outcomes such as causing or exacerbating asthma, acute chest infections or middle ear disease. Second-hand smoke can affect a child's lung function, leading to greater vulnerability to other lung damage (Campbell et al. 2017).

Current Australian alcohol guidelines advise that children under 15 years of age are at the greatest risk of harm from drinking alcohol, making abstaining from drinking the safest option for this age group (NHMRC 2009). Drinkers under the age of 15 are much more likely than older drinkers to engage in hazardous behaviour or delinquency behaviour because of their drinking which puts them at risk of injury (NHMRC 2009).

As with smoking, starting to drink at an early age is related to more frequent and drinking more heavily in adolescence, which can then lead to a greater risk of alcohol-related harms in adolescence and adulthood (NHMRC 2009). Risky alcohol consumption can also increase the likelihood of developing a disease or health disorder (AIHW 2018). In 2015, alcohol use was responsible for 5% of the total burden of disease for the population when taking into account illness and deaths (AIHW 2019).

Box 1: Sources and definitions

Data on smoking and drinking by secondary school students comes from the Australian Secondary Schools' Alcohol and Drug Survey (ASSAD). This triennial secondary school-based survey has been monitoring the use of tobacco and alcohol among Australian adolescent students since 1984, and the use of other substances since 1996. Data on teenagers not enrolled at school were not included in the school-based sample. The latest findings are from 2017.

Data on exposure to second-hand smoke is from the National Drug Strategy Household Survey (NDSHS) which collects information on alcohol and tobacco consumption, and illicit drug use among those aged 12 or older in Australia. It also surveys people's attitudes and perceptions relating to tobacco, alcohol and other drug use. The survey has been conducted every 2–3 years since 1985. The latest survey findings are from 2016.

Data on exposure to second-hand smoke for Indigenous children is available from the 2014–15 National Aboriginal and Torres Strait Islander Social Survey which collects information on a range of demographic, social, environmental and economic characteristics across all states and territories, and in *Remote* and *Non-remote* areas.

Definitions

A **current smoker**, as defined in the ASSAD, is defined as having smoked tobacco at least once in the 7 days before the survey.

A **single occasion risky drinker**, for the purposes of this section, is an adolescent who has drunk 5 or more standard drinks on a single occasion. This is based on the NHMRC's Guideline 2 (single occasion risk): to reduce the risks of injury on a single occasion of drinking, a healthy adult should drink no more than 4 standard drinks on any 1 occasion (NHMRC 2009).

How many children smoke?

According to data from ASSAD, in 2017, 2.2% of secondary school students aged 12–14 were current smokers, and rates were similar for boys (2.6%) and girls (1.8%). Smoking was more common among 14 year olds (3.6%) than 12 year olds (1.5%).

How many children are exposed to second-hand smoke?

Data from the NDSHS indicates that in 2016, 2.8% of households with dependent children aged 14 and under had someone who smoked inside the house. Around one-quarter of these households (26%) had someone who only smoked outside the home, while the majority (almost three-quarters of households or 72%) had no-one at home who smoked regularly.

How many children aged 12–14 drink?

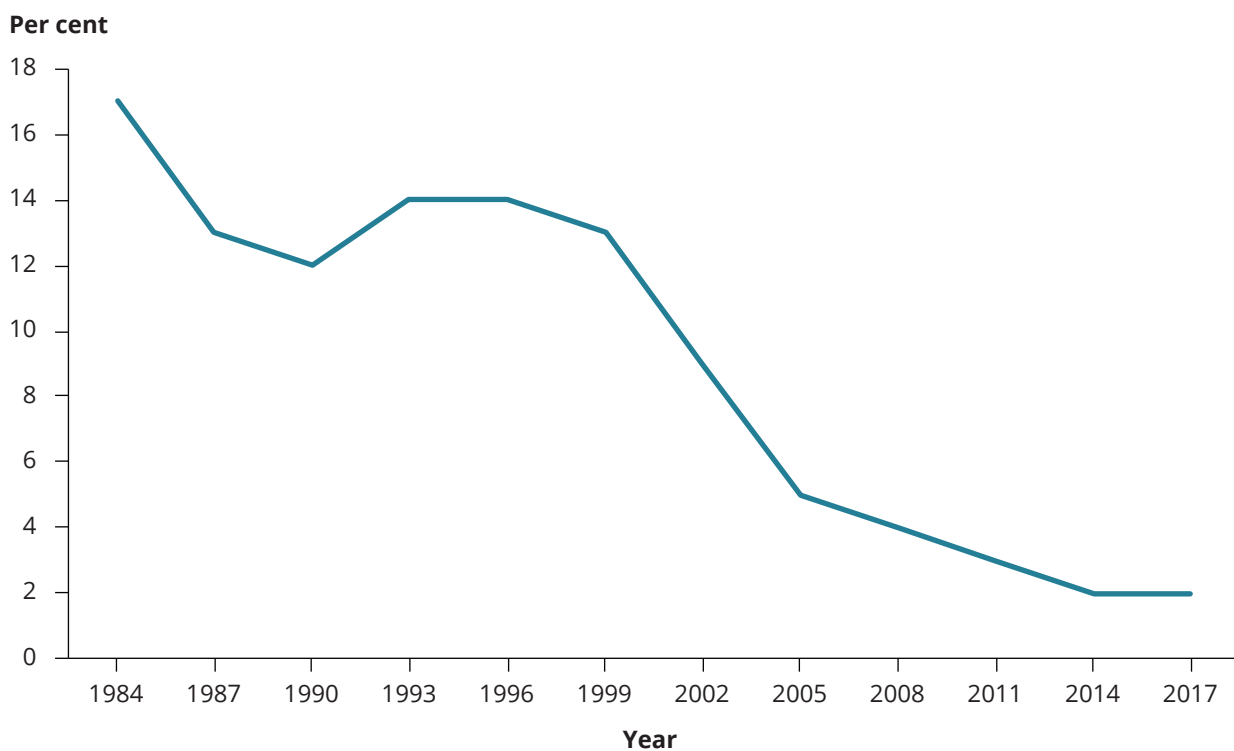
In 2017, 6.8% of secondary school students aged 12–14 had at least 1 drink on a single occasion in the last week and rates were similar for boys and girls (ASSAD data). Drinking was more common among 14 year olds (10.4%) compared with 12 year olds (4.2%).

In 2017, around 1% of secondary school students aged 12–14 engaged in single occasion risky drinking (that is, drank 5 or more standard drinks on 1 occasion in the past week), putting them at risk of injury. There was no statistically significant difference between rates of risky drinking in boys (1.2%) and girls (0.8%). Drinking at this level was again more common among 14 year olds (1.9%) compared with 12 year olds (0.2%).

Have risk behaviours improved over time?

Over 15 years (2002 to 2017), the proportion of secondary school students who smoked declined significantly (Figure 1). While 9% of secondary school students were smoking in 2002, in 2017 this had decreased 4-fold to 2%.

Figure 1: Students aged 12-14 who smoked, 1984-2017



Data from the NDSHS indicates that children's exposure to tobacco smoke at home significantly declined over the 21 years to 2016. The proportion of households with dependent children where someone smoked inside the home fell from 31% in 1995 to just 2.8% in 2016 (a significant decline from 3.7% in 2013) (Figure 2).

Figure 2: Exposure to second-hand smoke in the home, households with children aged 0–14, 1995–2016

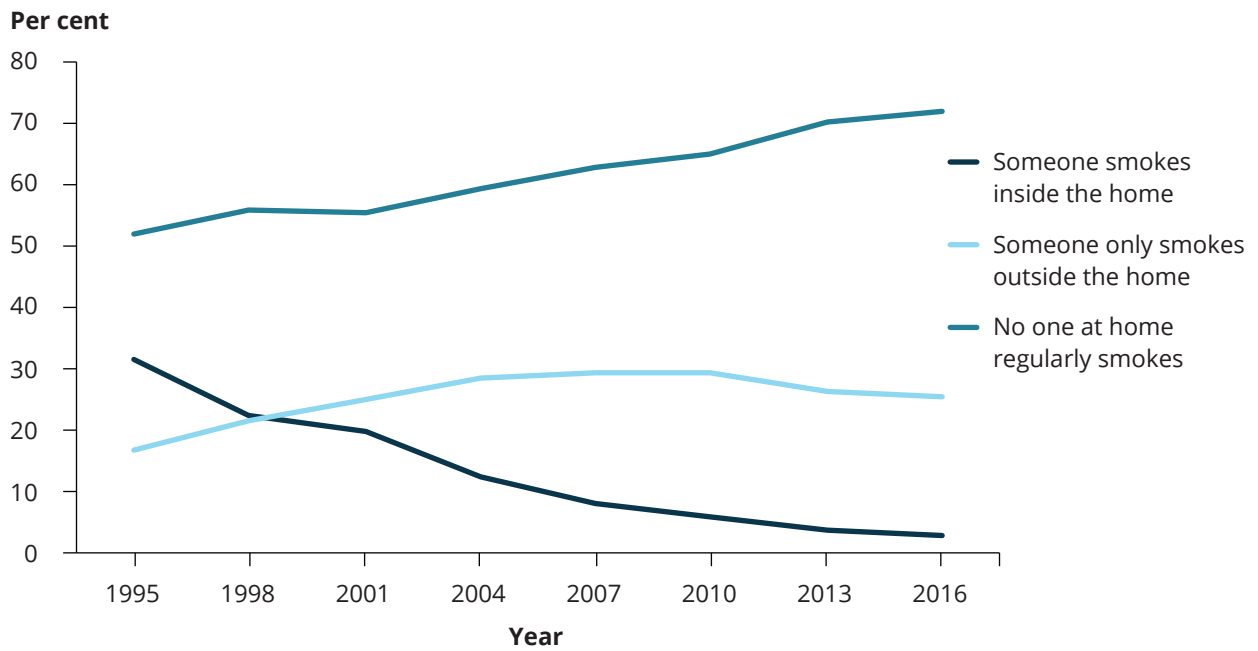


Chart: AIHW. Source: AIHW 2017b.

Over the 15 years between 2002 and 2017, the proportion of secondary school students drinking at all (at least 1 drink) or engaging in single occasion risky drinking decreased significantly.

The proportion of children drinking at all decreased more than 3-fold, from 24% in 2002 to 6.8% in 2017. The proportion of children drinking 5 or more drinks on 1 occasion in the past week also decreased, from 3.7% in 2002 to 1% in 2017.

Figure 3: Single occasion risky drinking behaviour of students aged 12–14, 2016

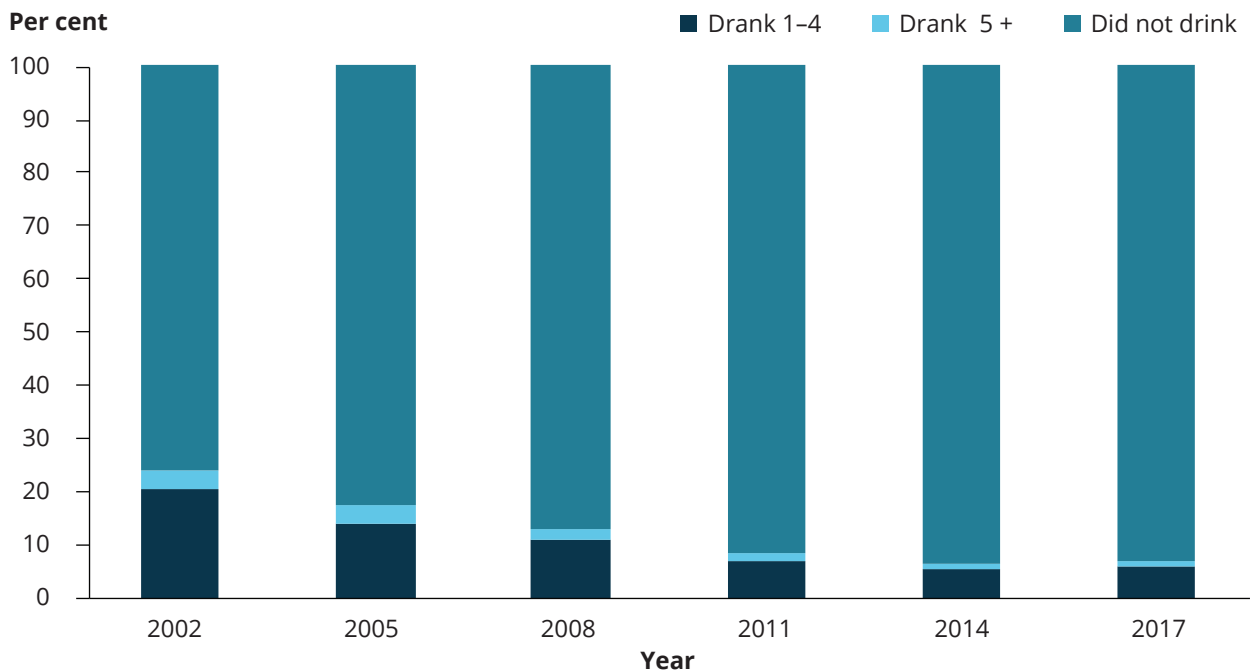
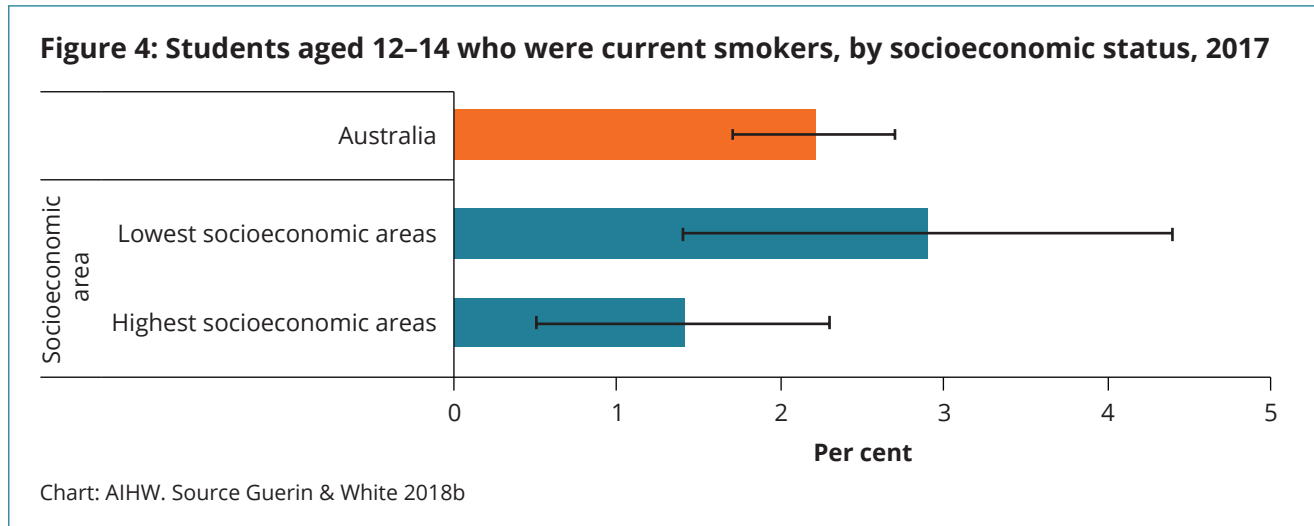


Chart: AIHW. Source: Guerin & White 2018b.

Are risk behaviours the same for everyone?

Smoking

The proportion of students aged 12–14 who were current smokers and lived in areas of greater socioeconomic disadvantage (lowest socioeconomic areas) was higher than the proportion who lived in areas of least disadvantage (highest areas) (2.9% and 1.4%, respectively). However, the difference was not statistically significant.



Exposure to second-hand smoke

Children living in areas of greatest socioeconomic disadvantage (4.4%) were more likely exposed to second-hand smoke than those in areas of least disadvantage (0.8%). There was no statistically significant difference across remoteness areas for exposure to second-hand smoke in the home (Figure 5).

Data from the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) 2014–15 shows that 13% (32,453) of Indigenous children aged 0–14 lived in households where someone smoked at home indoors. Note that NATSISS data are not directly comparable to NDSHS data (AIHW 2017a).

Figure 5: Exposure to second-hand smoke at home, by priority population groups 2016

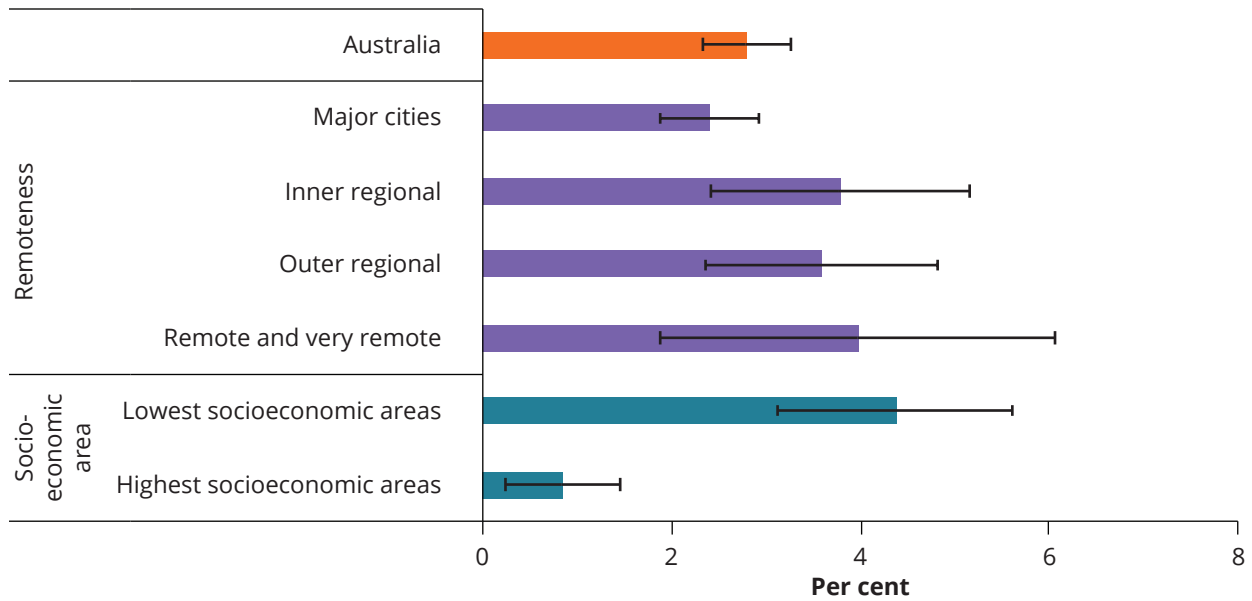


Chart: AIHW. Source: NDSHS 2016, unpublished data.

Engaging in single occasion risky drinking

Students aged 12–14 living in the lowest socioeconomic areas (2.2%) were more likely to drink at risky levels than those in the highest areas (0.1%) (Figure 6).

Figure 6: Students aged 12–14 who engaged in single occasion risky drinking, by socioeconomic status, 2017

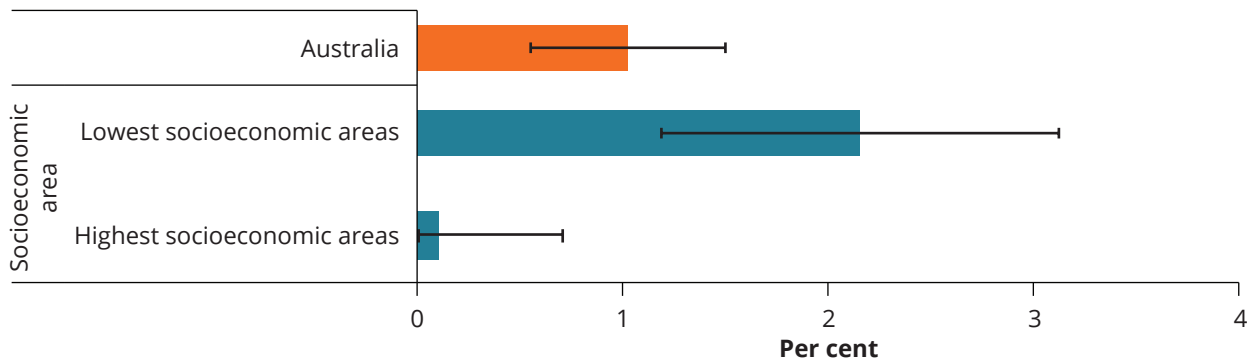


Chart: AIHW. Source: Guerin & White 2018b.

How many children aged 12–15 used illicit substances?

In 2017, around 14% of children aged 12–15 had ever used an illicit substance (Guerin & White 2018a). Boys (15%) were more likely than girls (13%) to have ever used an illicit substance.

The proportions of students that had used any illicit substance in their lifetime or in the past month (including or excluding cannabis) were similar in 2011, 2014, and 2017 (Guerin & White 2018a).

Data limitations and development opportunities

Currently there are no directly comparable national data on the smoking and drinking behaviour of Indigenous children, or children from culturally and linguistically diverse backgrounds.

For more information, see What's missing in [Health](#).

Where do I find more information?

For more information on:

- smoking and drinking behaviours, and illicit drug use of children and adolescents aged 10–17, see: [ASSAD 2017 Statistics & Trends: Australian Secondary Students' Use of Tobacco, Alcohol, Over-the-counter Drugs, and Illicit Substances](#) and [ASSAD 2017 Statistics and Trends: Trends in substance use among Australian secondary school students 1996–2017](#).
- comparisons of the smoking and drinking behaviour of young people aged 12–17, see: [Alcohol, tobacco & other drugs in Australia](#) and [National Drug Strategy Household Survey 2016: detailed findings](#)
- Indigenous children living in households with daily smokers, see: [Aboriginal and Torres Strait Islander Health Performance Framework \(HPF\) report 2017](#)
- technical notes relating to this section, refer to [Smoking and drinking behaviour](#) in the online report. See also [Methods](#).

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Infant and child deaths

Key findings

- The infant death rate decreased from a peak of 5.7 deaths per 1,000 babies in 1999 to 3.3 in 2017.
- The child death rate for children aged 1–14 halved between 1998 and 2017 (20 to 10 deaths per 100,000 children); however, since 2011, the death rate has stayed in the range of 10 to 12 deaths per 100,000.
- In 2015–17, the leading causes of child (aged 1–14) deaths were injuries, cancer and diseases of the nervous system.

Death rates and causes of death are key indicators of the health status of a population. Changes in the pattern of causes of death can result from:

- changes in behaviours
- exposures to disease or injury, and social and environmental circumstances
- data coding practices (AIHW 2018b).

Infant mortality provides insight into the effectiveness of the maternal and perinatal health system (AIHW 2018c).

This section focuses on infant deaths (under the age of 1) and child deaths (ages 1–14).

Halving the gap between Indigenous and non-Indigenous child deaths (ages 0–4) by 2018 was a key priority of the Closing the Gap framework established by the Council of Australian Governments (COAG) in 2008.

While Indigenous death rates have decreased, in 2017 the rate was not within the range to meet the target by 2018, and was, therefore, not on track (PM&C 2019) (see also Closing the Gap target in death rates below in this section). If the overall target will be met by 2018 will be determined when analysis of the final year of data (2018) has been completed.

Box 1: Data sources on deaths

Deaths data are sourced from the AIHW National Mortality Database (NMD).

This database includes information on factors that caused death, and other information about the deceased person such as:

- age at death
- place of death
- country of birth
- where applicable, circumstances of death.

These data are collected in Australia by the Registrars of Births, Deaths and Marriages in each state and territory. The data are then compiled nationally by the ABS and supplemented with information from the National Coroners Information Service.

The ABS codes the data according to the International Classification of Diseases (ICD) and provides the data for the AIHW National Mortality Database. See also Technical notes in the [Infant and child deaths](#) section of the online report.

How many infants die before turning one?

In 2017, around 1,000 deaths of infants under the age of 1—a rate of 3.3 per 1,000 live births (3.5 and 3.0 for boys and girls, respectively). Boys accounted for 55% of all infant deaths (ABS 2018).

Infant deaths comprised more than two-thirds (69%) of all deaths among children aged 0–14. Almost 3 in 4 (73%) infant deaths occurred within 4 weeks of birth and almost half (46%) on the day of birth.

What are the leading causes of infant deaths?

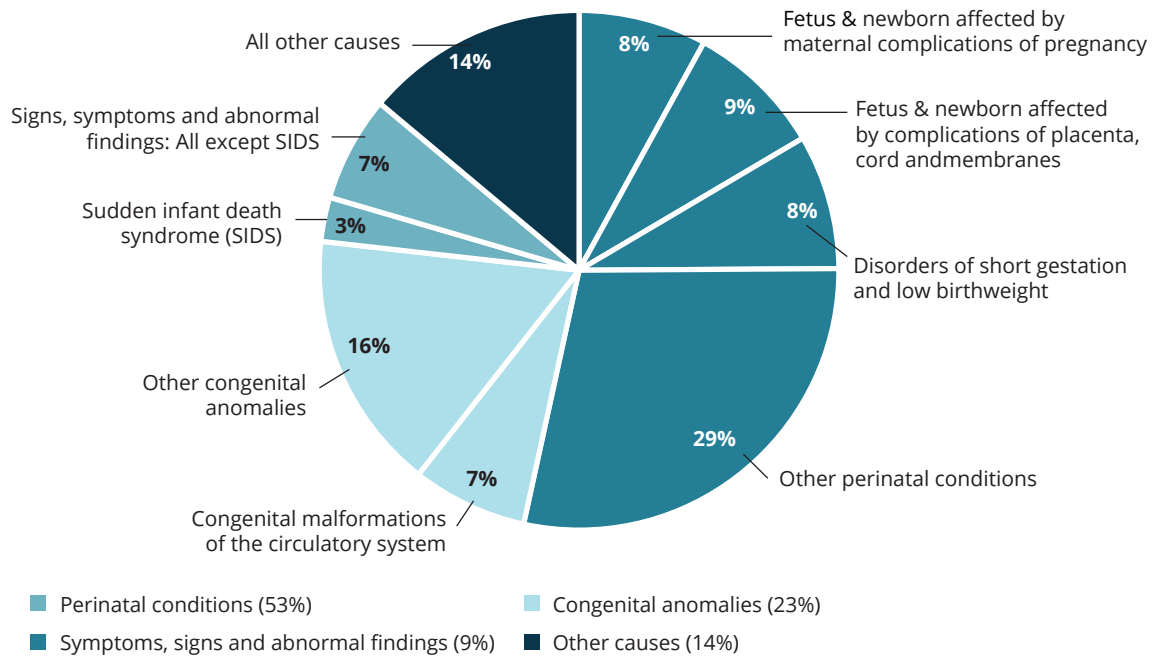
In 2015–17, 3 leading causes of infant deaths accounted for the majority (86%) of deaths:

- perinatal conditions (53%)
- congenital anomalies (23%)
- symptoms, signs and abnormal findings, including Sudden Infant Death Syndrome (SIDS) (9.3%) (Figure 1).

Of the perinatal conditions, complications of placenta, cord and membranes were the most common (9% of all infant deaths), followed by disorders of short gestation and low birthweight (8%) and maternal complications of pregnancy (8%).

SIDS accounted for 3% of all infant deaths. The rate of SIDS deaths per 100,000 live births has declined in Australia since the beginning of national public education campaigns about risk factors associated with SIDS in 1991 (AIHW 2012). Between 2007 and 2017 the rate declined from 28 per 100,000 to 6 in 2017, following a peak in 2009 of 32 per 100,000.

Figure 1: Leading causes of infant death, 2017



Note: Due to rounding the proportions do not sum to 100.

Chart: AIHW. Source: Analysis of AIHW National Mortality Database.

Has the infant death rate changed over time?

Between 1998 and 2017, the infant death rate peaked at 5.7 deaths per 1,000 babies before dropping to 3.3 deaths per 1,000 live births (Figure 2).

Boys consistently had higher death rates than girls, with their rates ranging between 1.1 and 1.3 as high as those for girls.

Figure 2: Infant death rates, 1998 to 2017

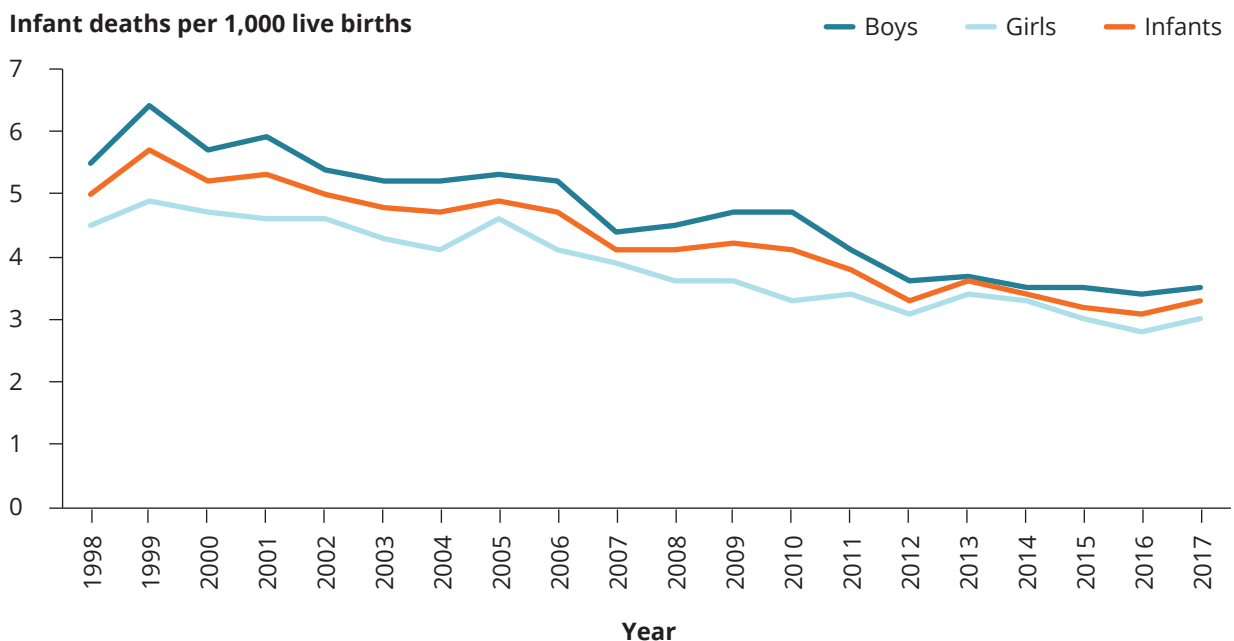


Chart: AIHW. Source: ABS 2018.

How many children (aged 1–14) die each year?

In 2017, 453 children aged 1–14 died—a rate of 10 per 100,000 children (12 per 100,000 for boys and 9.3 for girls). Boys accounted for 57% of child deaths.

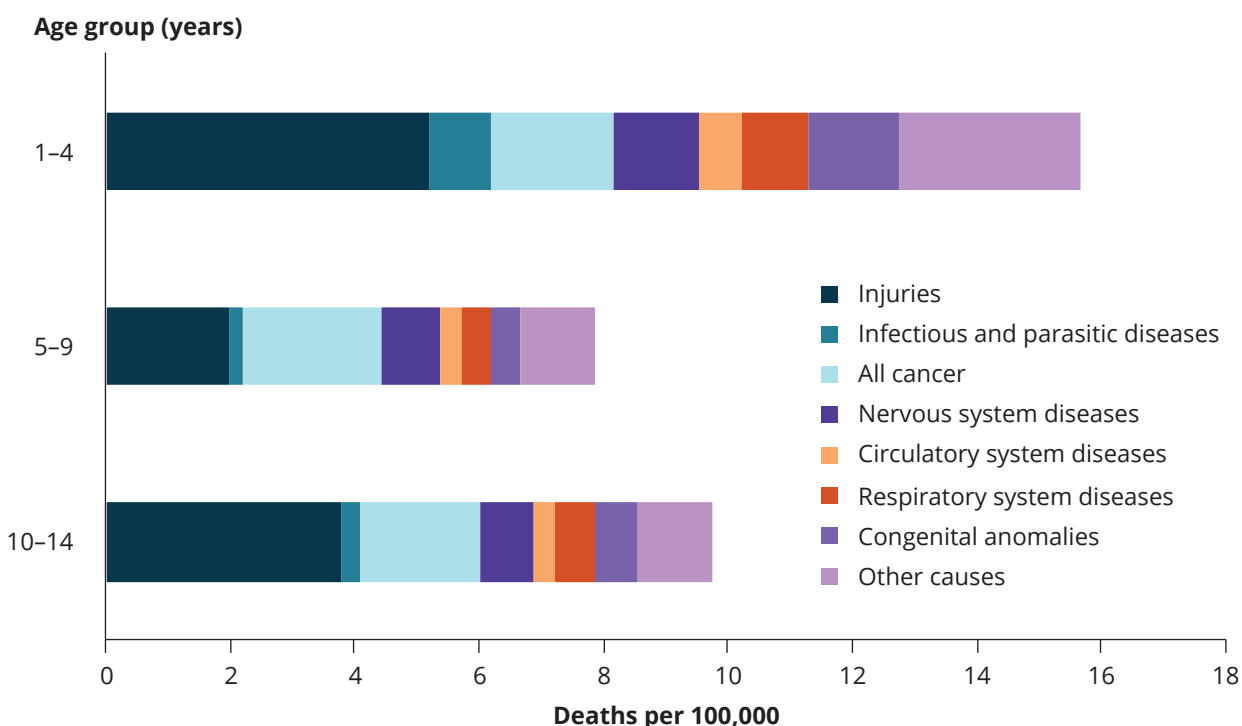
The death rate for children aged 1–4 (15 per 100,000 children) was almost twice the rate for children aged 5–9 (7.8) and 1.5 times as high as the rate for children aged 10–14 (9.5).

What are the leading causes of child deaths?

In 2015–17, the leading causes of child deaths were injuries (33%), cancer (19%) and diseases of the nervous system (10%)—rates of 3.5, 2.1 and 1.0 per 100,000 children, respectively.

Children aged 1–4 had the highest rates of death due to injury and diseases of the nervous system (Figure 3). Children aged 5–9 had the highest rates of cancer.

Figure 3: Leading causes of child deaths (aged 1–14), 2015–2017



Notes:

1. Injuries includes accidental drownings.
2. Congenital anomalies include congenital malformations, deformations and chromosomal abnormalities.

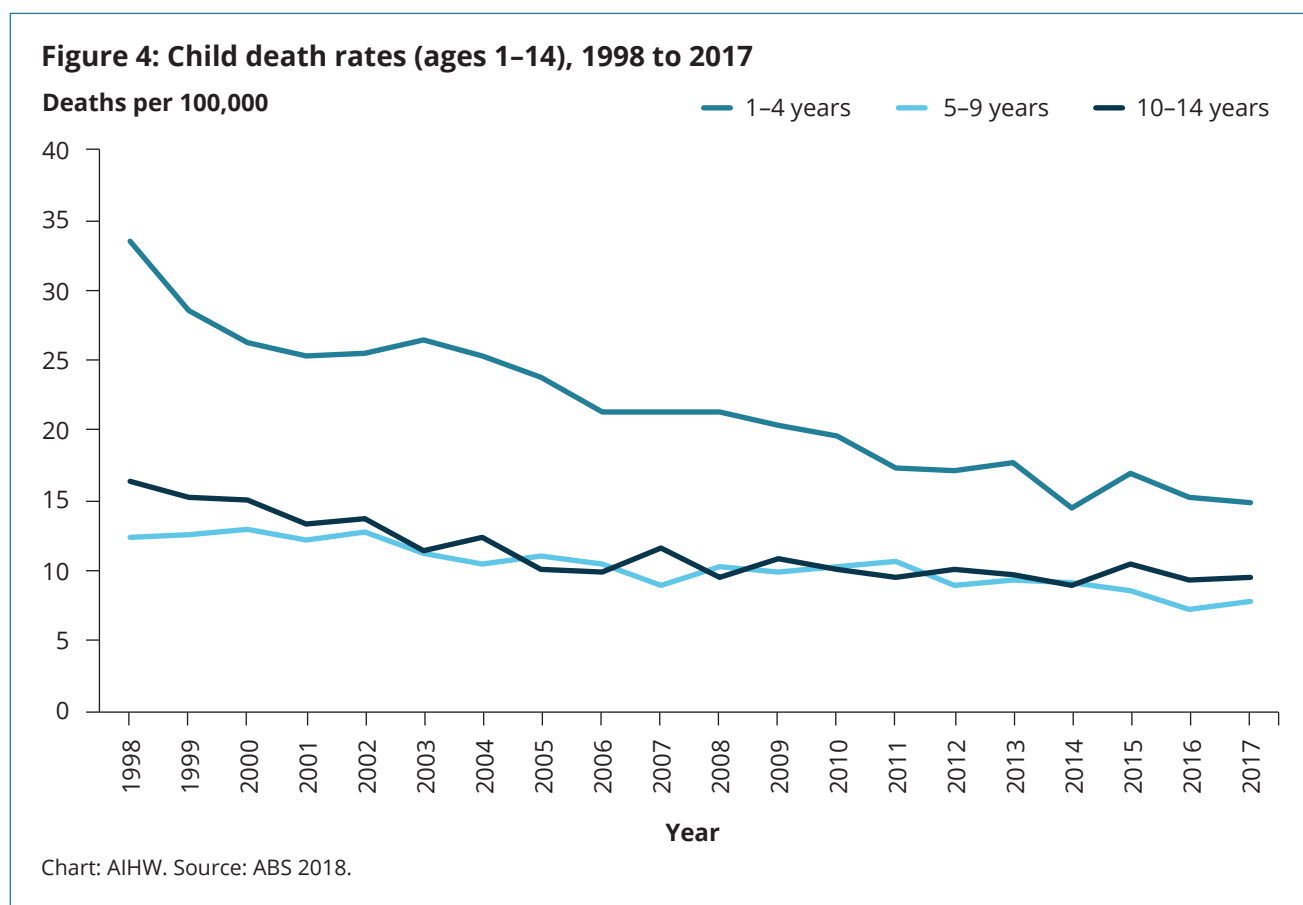
Chart: AIHW. Source: Analysis of AIHW National Mortality Database.

Has the child death rate changed over time?

The child death rate for children aged 1–14 halved between 1998 and 2017 (20 to 10 deaths per 100,000 children). Since 2011, the death rate has stayed in the range of 10 to 12 deaths per 100,000.

The decline in child deaths was observed for both boys and girls (23 to 12 deaths per 100,000 for boys and from 17 to 9.3 for girls). The rate for boys remained consistently higher than for girls over this period.

The decline in child death rates was evident across all 3 age groups, with the largest decrease among those aged 1–4 year (55%) compared with those aged 5–9 (37%) and 10–14 (42%) (Figure 4).



Is it the same for everyone?

Data on infant and child deaths by country of birth are not presented as the proportion of deaths for overseas-born children (age 0–14) are small (less than 3% of all child deaths) (AIHW analysis of AIHW National Mortality Database).

Infant deaths

In 2017, infant death rates were higher for different populations:

- 5.9 per 1,000 in *Remote and very remote* compared with 2.9 in *Major cities*
- 4.2 per 1,000 in lowest socioeconomic areas compared with 2.3 in highest areas.

Differences were also evident between Indigenous infant deaths and non-Indigenous (6.2 per 1,000 compared with 3.1 per 1,000). The Indigenous infant death rate decreased by almost 40% (10.2 per 1,000 to 6.2) between 2004–2006 and 2015–2017. See also [Indigenous children](#).

Child deaths

In 2015–2017, child death rates were higher for different populations:

- 25 per 100,000 in *Remote and very remote* areas compared with 9.4 in *Major cities*
- 16 per 100,000 in the lowest socioeconomic areas compared with 6.9 in the highest areas.

Differences were also evident between Indigenous and non-Indigenous children (22 compared with 11 per 100,000, respectively). The Indigenous child death rate decreased from 26 to 22 per 100,000 between 2005–2007 and 2015–2017. See also [Indigenous children](#).

As with infant deaths, not all of these categories are mutually exclusive. It is likely that some of these influencing factors overlap.

Figure 5: Infant and child deaths by selected population groups

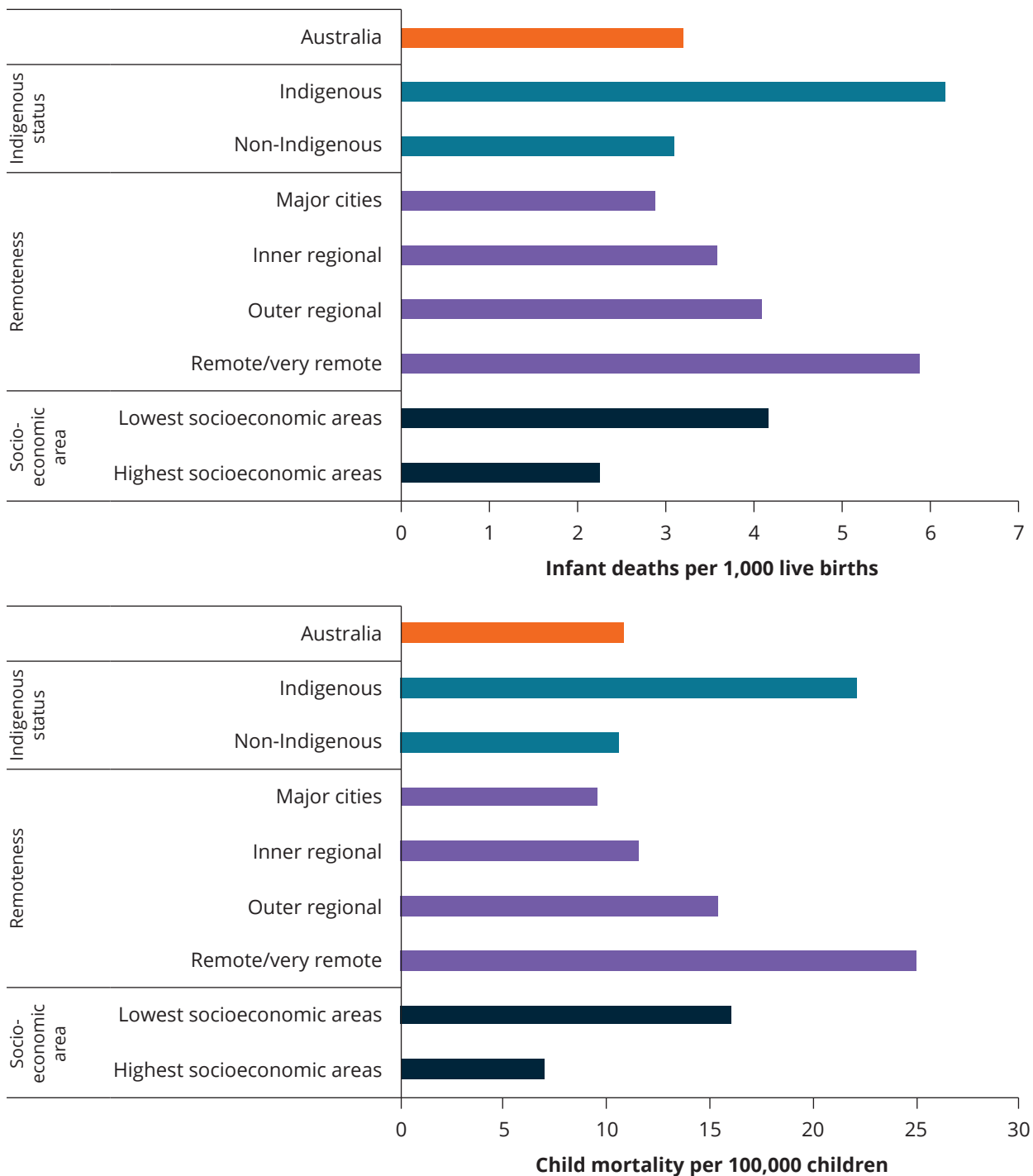


Chart: AIHW. Source: Analysis of AIHW National Mortality Database.

Closing the Gap target in death rates

In 2017, the COAG target of halving the gap in death rates for Indigenous children (aged 0–4) within a decade (by 2018) was not on track.

The rate for Indigenous children was 2.4 times the rate for non-Indigenous children (164 compared with 68 deaths per 100,000) (PM&C 2019). If the overall target will be met cannot be determined until analysis of the final year of data (2018) has been completed.

Since 2008, the Indigenous child death rate has declined by 10% (not statistically significant); however, the gap did not narrow as the non-Indigenous rate declined at a faster rate (PM&C 2019). Over the longer term, there was a 35% decline in the Indigenous child death rate between 1998 and 2017, with the gap narrowing by 29% (PM&C 2019).

In 2011–15, 4 causes of death were identified as responsible for most (90%) of the gap in child death rates between Indigenous and non-Indigenous children aged 0–4:

- pregnancy/birth-related conditions (40% of the gap)
- SIDS and other unknown causes (26%)
- accidents, injuries and other external causes (18%)
- respiratory diseases (5%) (AIHW 2018d).

Potentially avoidable deaths

Avoidable deaths are those resulting from conditions considered avoidable given timely and effective health care such as disease prevention and population health initiatives (AIHW 2018a). Deaths from most conditions are influenced by factors in addition to health system performance, including:

- underlying prevalence of conditions in the community
- environmental and social factors
- health behaviours (AHMAC 2017).

See [National Healthcare Agreement: P20-potentially avoidable deaths, 2010](#) for a list of avoidable death conditions.

Indigenous children are particularly vulnerable to avoidable deaths.

In 2011–15, avoidable Indigenous infant deaths were twice as high as avoidable non-Indigenous infant deaths (371 compared with 187 deaths per 100,000). For Indigenous children aged 1–14, the rate was 3.5 times as high as for non-Indigenous children (17.7 compared with 5.0 deaths per 100,000) (AIHW 2017).

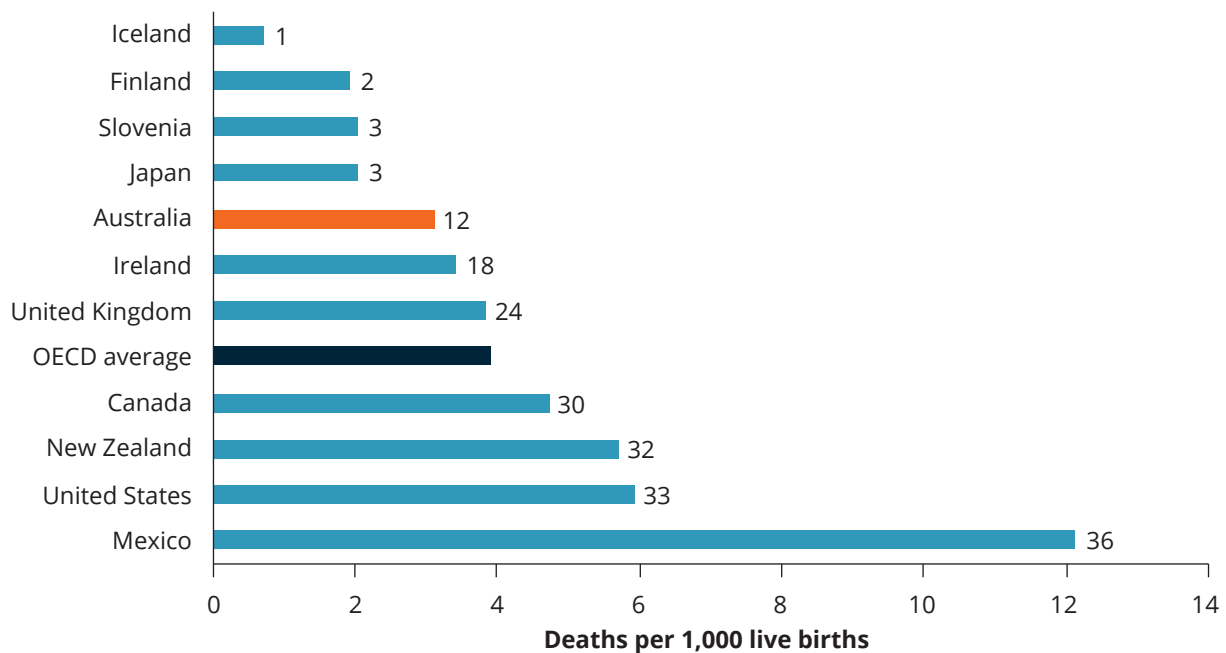
Injury deaths can also be considered preventable deaths. For information on injury deaths, see [Injuries](#).

How does Australia's infant death rate compare internationally?

In 2016, Australia's infant death rate (3.1 per 1,000) ranked equal 12th (alongside Israel, Denmark and Austria) out of 36 Organization for Economic Co-operation and Development (OECD) countries (Figure 6). This was ahead of the OECD average (3.9 per 1,000).

Iceland had the lowest rate (0.7 per 1,000) followed by Finland (1.9) and Slovenia and Japan (both with 2.0).

Figure 6: Infant deaths rates by selected OECD countries and rankings, 2016



Note: Data for Canada and New Zealand are for 2014. Date for Ireland and the United States are for 2015. Data in this graph are for OECD member states only. Graph reflects top 3 countries, English-speaking background countries, and bottom ranked country.

Chart: AIHW. Source: OECD Family Database.

Data gaps and opportunities?

Mortality data can support analysis of geographic variation at the Statistical area 3 (SA3) level. A study of child mortality rates in New South Wales from 2001 to 2015, showed a great deal of geographic variation in the number and rate of child deaths, with child mortality rates higher in more disadvantaged areas, such as those with:

- higher poverty rates
- lower school engagement
- overcrowded housing
- higher rates of developmental vulnerability (NSW CDRT 2018).

Indigenous deaths data are reported for only 5 jurisdictions (New South Wales, Queensland, Western Australia, South Australia and the Northern Territory) and may not reflect the national picture. The other jurisdictions have lower levels of identification and a small number of Indigenous deaths.

Where do I find more information?

For more information on topics related to infant and child deaths in Australia's children, see:

- Indigenous children [Indigenous children](#)
- How many children die for injuries? in [Injuries](#)
- How many children die of cancer? in [Cancer incidence and survival](#).

For information on:

- infant and child deaths, see: [Infant mortality in Children's Headline Indicators, Healthy Communities: child and maternal health in 2013–15](#) and [Deaths among children aged 1–14](#).
- Perinatal deaths, see: [Perinatal deaths in Australia 2013–14](#).
- deaths see: [AIHW's General Record of Incidence of Mortality \(GRIM\) books](#) includes historical and recent deaths data and [Mortality over Regions and Time \(MORT\) books](#)
- technical notes relating to this section, refer to [Infant and child deaths](#) in the online report. See also [Methods](#).

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Education

Child learning and development

Why is learning and development important?

Children's learning and development in the early years is integral to their wellbeing, and in the longer term impacts their job prospects, and participation in and connection with the wider community.

For most children, the home is the main influence on child language and cognitive development in the early years (Yu & Daraganova 2015). Starting to read regularly with children during this time stimulates brain development and strengthens parent-child relationships. This, in turn, builds language, literacy, and social-emotional skills (Council on Early Childhood 2014).

Preschool programs can help children prepare for starting school by developing learning-related skills, such as the ability to:

- express thoughts
- adapt appropriate behaviours
- control impulsivity
- show curiosity
- retain concentration
- develop social competence (Melhuish 2012).

Starting school is a key milestone in a child's life, requiring a significant adjustment to a new environment. Research has found that children developmentally vulnerable on school entry, were more likely to perform poorly on literacy and numeracy tests later in their schooling (AEDC 2014).

Schooling is important for children to develop the necessary skills for learning and educational attainment, as well as social skills such as friendship building, teamwork, communication and healthy self-esteem.

Attendance patterns have been found to be established early in school life, and differences in attendance tend to be carried into, and become greater in secondary school (Hancock et al. 2013).

Literacy and numeracy form part of the cornerstone of formal education for young Australians (MCEETYA 2008). They are fundamental building blocks for children's educational achievement, their lives outside school and engagement with society, and their future employment prospects.

Governance supporting child learning and development

All Australian education ministers are members of the Council of Australian Governments (COAG) Education Council—the principal forum for developing national priorities and strategies for the early childhood and education sector, schooling as well as higher education (Education Council 2014).

Early childhood, education and care

Early childhood, education and care (ECEC) services in Australia comprise child care and preschool services.

Child care services provide education and care services to children aged 0–12, and include:

- long day care
- family day care
- outside school hours' care
- occasional care
- other care, including services supporting children with additional needs or in particular situations, or 3-year-old preschool which does not meet the preschool service definition (as provided immediately below), mobile services, playschools and nannies.

Preschool services deliver a preschool program (also known as kindergarten in some jurisdictions). Preschool programs are:

- structured and play-based learning programs
- delivered by a qualified teacher
- aimed at children in the year or 2 before they start full-time schooling.

Responsibility for the ECEC is shared by the Australian Government, state and territory governments and, in some cases, local government (SCRGSP 2019a).

Australian Government responsibilities

The Australian Government is responsible for paying the Child Care Subsidy (formerly the Child Care Benefit and Child Care Rebate) to eligible families, and providing funding to:

- state and territory governments for early childhood education
- support the regulation, assessment and quality improvement for ECEC under the National Quality Framework (NQF).

The Australian Government also provides operational and capital funding to some ECEC providers (SCRGSP 2019a).

State and territory responsibilities

The roles and responsibilities of state and territory governments vary across jurisdictions but mainly include funding and/or providing preschool services and, in some cases, providing funding to child care services. They also provide funding to support activities under the NQF.

State and territory governments are responsible for regulating approved services and licensing and/or registering child care services not yet approved under the NQF.

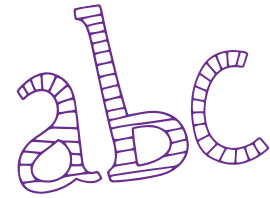
They also implement strategies to improve the quality of ECEC programs, and provide curriculum, information, support, advice, and training and development to ECEC providers (SCRGSP 2019a).

Local government responsibilities

Local governments also plan, fund and deliver ECEC (SCRGSP 2019a).

Schooling in Australia

School education is compulsory for all children across Australia, although the child age entry requirements vary by jurisdiction (SCRGSP 2019b). In Australia, there are 2 main types of schools—primary and secondary—differentiated by the level of education they provide.



Primary schools provide education from the first year of formal school—called Foundation in the Australian Curriculum. Primary school education extends to Year 6 (Year 7 in South Australia).

Secondary schools provide education from the end of primary school to Year 12 (SCRGSP 2019b). From Term 1, 2022, the South Australian public education system will change, and Year 7 public school students will be taught in high school (SA Department of Education 2019).

Schools can be broadly categorised into 3 sectors:

- government schools, owned and managed by state and territory governments
- Catholic schools
- independent schools.

The latter 2 are owned and managed by non-government establishments.

Responsibility for primary schooling is shared by the Australian Government, state and territory governments. The Australian Government provides funding for schools, government and non-government (Department of Education 2019a). These levels of government work together to progress and implement national education policy priorities, such as: a national curriculum; national statistics and reporting; national testing; and, teaching standards (PM&C 2014).

Responsibility for delivering and regulating schooling

Each state and territory government delivers and regulates schooling in its jurisdiction. They also provide most of the school education funding in their jurisdiction. They register schools, regulate school activities and are directly responsible for the administration of government schools.

Non-government schools operate under conditions determined by state and territory government registration authorities (SCRGSP 2019b).

Responsibility for delivering the Australian Curriculum

State, territory and non-government education authorities are responsible for delivering the Australian Curriculum, including decisions about implementation timeframes, classroom practices and resources that complement teaching of the curriculum (Department of Education 2018).

National education strategies and initiatives for children

Early Childhood, Education and Care

A key COAG objective under the National Partnership on Universal Access to Early Childhood Education is to ensure a quality preschool program (also referred to as kindergarten in some states) is available for all children in the year before full-time school (Department of Education 2019b).

Universal access to quality preschool is supported by the NQF. Under this framework, preschool services must have an early childhood teacher in attendance, with specific requirements varying depending on the size of the service (Department of Education 2019b). The Early Years Workforce Strategy provides an agreed vision and long-term framework for the early childhood education and child care workforce (Department of Education, 2017).

Schooling

In 2008, Australian education ministers agreed, within the Melbourne Declaration on Educational Goals for Young Australians, for Australian schools to promote equity and excellence, and for all young Australians to become successful learners, confident and creative individuals, and active and informed citizens (MCEETYA 2008).

These common goals underpin the strategic reforms outlined in the COAG National School Reform Agreement which are for Australian schooling to give a high quality and equitable education to all students. The agreement includes these outcomes:

- academic achievement improves for all students, including priority equity cohorts
- all students are engaged in their schooling
- students gain the skills they need to transition to further study and/or work and life success (COAG 2018).

The Measurement Framework for Schooling in Australia is the basis for reporting by Australian education ministers on performance in accordance with the Melbourne Declaration (ACARA 2015). It specifies the annual assessment and reporting cycle for the National Program, which includes the National Assessment Program—literacy and numeracy (NAPLAN) tests (Table 1).

Australia’s national curriculum gives schools, teachers, parents, students, and the community a clear understanding of what students should learn, regardless of where they live or what school system they are in (Department of Education 2018).

Table 1: National strategies and initiatives relevant to snapshots

Topic area	Strategy
Early years	<p>National Partnership on Universal Access to Early Childhood Education 2018–2019—This agreement is under review with a final report to the Education Council expected in 2020.</p> <p>National Quality Framework for Early Childhood Education and Care—This framework is under review during 2019–2020.</p> <p>Early Years Learning Framework</p> <p>My Time, Our Place: Framework for School Age Care in Australia</p> <p>Early Years Workforce Strategy</p>
Primary years	<p>Melbourne Declaration on Educational Goals for Young Australians—This declaration is under review—submissions closed 14 June 2019.</p> <p>National School Reform Agreement</p> <p>Australian Curriculum</p> <p>The Measurement Framework for Schooling in Australia</p> <p>National Assessment Program—This includes NAPLAN, Progress in International Reading Literacy Study (PIRLS), Trends in International Mathematics and Science Study (TIMSS) which are discussed in this domain. The National Assessment Program also includes civics and citizenship information and communication technology literacy, and science literacy which are conducted with Year 6 students.</p> <p>The Australian Student Wellbeing Framework</p> <p>National STEM [science, technology, engineering and mathematics] School Education Strategy</p> <p>National Aboriginal and Torres Strait Islander Education Strategy 2015</p>

What's missing?

The sections in this domain include a number of established national indicators; however, consistent national reporting is not available in some areas due to lack of a suitable data source and/or indicator. National work underway to improve the quality, consistency and collection of education data may lead to some improvements in these areas (COAG 2018). For more information on national data gaps, see [Data gaps](#).

A number of topics were not included for other reasons but could be considered for future updates.

Children's subjective view of school

There are currently limited national data on how children view their experience at school to support population-level monitoring. Some aspects, such as school belonging and bullying, are captured in data sources such as PIRLS, and the Longitudinal Study of Australian Children (LSAC). See also [Specific areas related to schooling](#) below.

Pathways, transitions and outcomes

Initiatives in national data integration work involving learning and development data will create a more complete picture of pathways through the Australian education system.

The National Education Evidence Base was established as a sub-project of the Data Integration Partnership for Australia, with work starting in 2017–18 (Department of Education and Training 2018). The National Education Evidence Base will draw together data on all aspects of education:

- early childhood education and care
- schools
- vocational education and training
- higher education (Department of Education and Training 2017).

This work could improve understanding of children's learning trajectories, including the impact of child care and/or preschool on these trajectories, and how trajectories may vary for some disadvantaged groups. Integration of education data with other data sources, such as health, will also give further insight into the relationship between health and educational outcomes; for example, the educational outcomes of children who received long-term intensive care at birth.

Priority populations

Currently, data are not available on school attendance for a number of priority groups, including attendance of children:

- from low socioeconomic groups
- with disability
- in out-of-home care.

There may be opportunities to enhance information through linkages; for example, NAPLAN and National Disability Insurance Scheme data, and regular linkage of literacy and numeracy data relating to children in out-of-home care.

National data on children who are home schooled are also limited.

Specific areas related to early learning

The [Early learning](#) section predominantly focused on how often children were read to. It was supplemented with data on the number of books in their households. This does not capture information on the actual quantity and quality of the early learning experienced.

National data on other types of learning, such as learning experiences at an early child care centre or exposure to other learning-based activities and materials, are also not available.

Specific areas related to schooling

The [Bullying](#) section in the [Justice and Safety domain](#) gives some overarching information on bullying at a national level but this does not paint a clear picture of bullying at school or other types of unfair treatment at school.

National data on school expulsions and suspensions are also limited.

Student engagement

Student engagement, comprising behavioural, emotional and cognitive engagement, is also an area of increasing interest where comprehensive national reporting is not available (SCRGSP 2019b).

School attendance is 1 measure of behavioural engagement (see [Attendance at primary school](#)), and students' attitudes towards school is 1 measure of emotional engagement.

Student attitudes are not reported here, but sense of school belonging is included as part of regular PIRLS reporting (see [Reporting Australia's results PIRLS 2016](#)) and could be considered for future updates.

Currently national data are not available to report against cognitive engagement (SCRGSP 2019b).

Box 1: Defining Language Background Other than English and Non-English Speaking Background

Different data collections use LBOTE (language background other than English) and NESB (non-English speaking background). While these terms have the same meaning, both are used in this report to remain consistent with the original data sources.

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Early learning: reading to children

Key findings

- In 2017, almost 4 in 5 children aged 0–2 (738,000 or 79%) were regularly read to or told stories by a parent (on 3 or more days in the previous week).
- In 2017, 44% of children age 0–2 had between 25 and under 100 children’s books in the home.

Language is central to human development and is especially important for reading development with long-term consequences for later social and academic functioning (Dickinson et al. 2012). Early home learning experiences in the first 3 years of life are important as for most children, the home is the main influence on child language and cognitive development (Yu & Daraganova 2015).



Reading regularly with children from a young age stimulates patterns of brain development and strengthens parent-child relationships. This, in turn, builds language, literacy, and social-emotional skills (Council on Early Childhood 2014). There is evidence that children begin to benefit from regular reading as early as 8 months (Dickinson et al. 2012). A review of the literature on shared reading found there were increases in the child’s:

- oral language
- vocabulary
- understanding of the conventions of print
- phonological awareness
- alphabet knowledge (Shoghi et al. 2013).

Quality, frequency and length of reading are also important.

Dialogic reading involves elaborating on a story by asking questions throughout the reading activity to create a conversation with the child about the story. This type of reading has stronger effects on children’s oral language skills than traditional shared reading where the child’s engagement in the reading activity is not as explicitly directed (Shoghi et al. 2013).

Frequency of reading to children has been associated with children’s greater vocabulary and higher cognitive ability at 14, 24 and 36 months of age (Raikes et al. 2006). Research using the LSAC found that children whose parents read to them every day when they were 2–3 year olds had higher Year 3 NAPLAN reading scores on average, than children whose parents read to them less frequently. The difference remained significant after accounting for socio-demographic factors (Yu & Daraganova 2015).

Having more than 30 children’s books at home when children were aged 2–3 was positively related to higher NAPLAN scores in reading and numeracy in Year 3. The difference remained significant after adjusting for socio-demographic factors (Yu & Daraganova 2015).

While the effects of shared reading on early literacy are well researched, other activities can also help develop emergent literary skills, including:

- singing
- nursery rhymes
- conversations
- oral storytelling
- environmental print (for example, written printed materials in the general environment such as street signs, food labels, billboards)
- use of digital media (for example mobile devices, smart phones, tablets) (Shoghi et al. 2013).

Box 1: Data sources for reading to children

Data on reading to children are sourced from the Australian Bureau of Statistics' (ABS) Childhood Education and Care Survey (CEaCS) which has been conducted every 3 years since 1969 and up until 2005 was known as the Child Care Survey. The latest data are for 2017.

The survey includes data on learning activities for children aged 0–8, as well as child care and early childhood education (see [Early childhood education and care](#)).

In each selected household, detailed information about child care arrangements and early childhood education was collected for a maximum of 2 children aged 0–12. Information was gathered through interviews with an adult who lived permanently in the selected household and was the child's parent, stepparent or guardian (ABS 2018a).

How many infants are read to by an adult?

In 2017, almost 4 in 5 children aged 0–2 (738,000 or 79%) were read to or told stories by a parent, on a regular basis in the previous week (that is, on 3 or more days). Around:

- 3 in 5 children (60%) were frequently read to or told stories (that is, on 6–7 days in the previous week)
- 1 in 6 children (16%) were not read to or told stories (Figure 1).

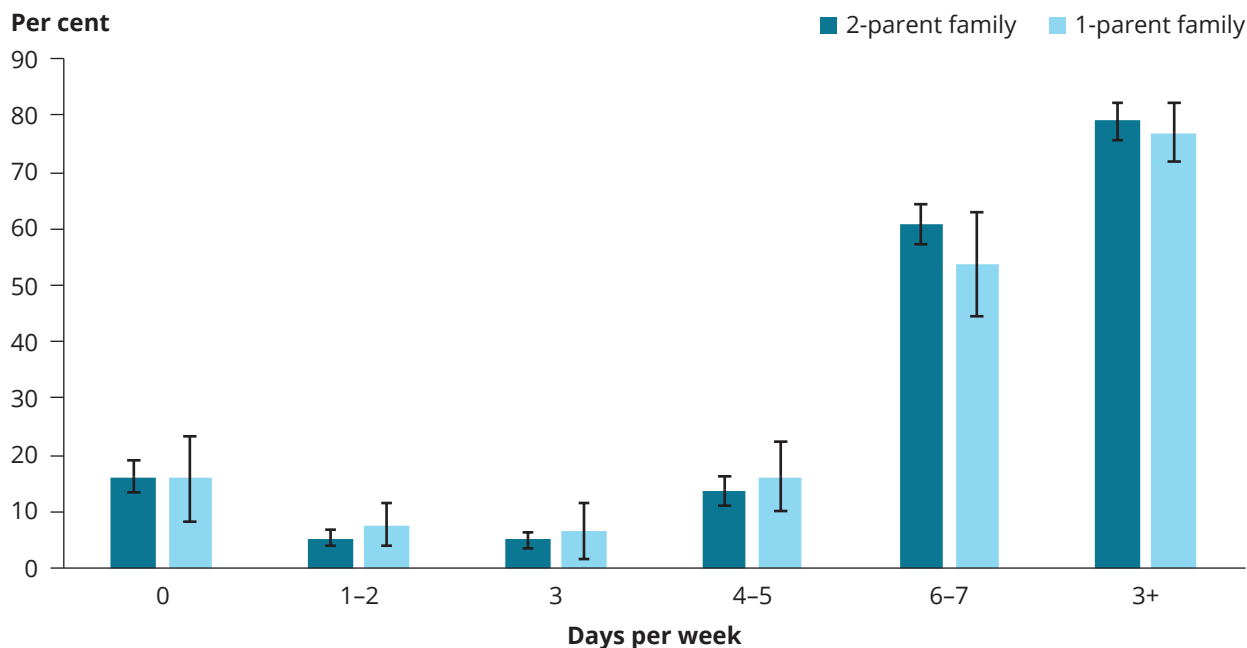
The extent to which parents read to or told stories did not differ depending on type of family:

- 79% of children in 2-parent families and 77% of children in 1-parent families were read to or told stories on a regular basis.
- 17% of children in 2-parent families and 15.7% of children in 1-parent families were not read to or told stories at all
- while children in 2-parent families were more likely to be frequently read to or told stories than children in 1-parent families (61% and 54%, respectively) the difference was not statistically significant.

However, an LSAC study of children aged 2–3 years found a statistically significant result for 2-parent families being more likely to read to their children frequently (61%) than 1-parent families (51%) (Yu & Daraganova 2015).

CEaCS data found that the parent predominantly involved in informal learning at home, which includes reading to children, was female (69%). For around 17% of families, the involvement was shared equally (ABS 2018a).

Figure 1: Number of days where a parent spent time with children aged 0–2 reading or telling stories in previous week, 2017



Note: Relative standard error for 1-parent families for 3 days per week is 39.3% and should be treated with caution.
 Chart: AIHW. Source: ABS 2018b.

Have rates changed over time?

Between 2008 and 2017, the proportion of children read to or told stories regularly in the previous week increased for both children in 2-parent and 1-parent families. The increase for children in 1-parent families was larger (15 percentage points, from 62% to 77%) than for 2-parent families (4 percentage points from 75% to 79%) (Figure 2).

Figure 2: Children aged 0–2 read to or told stories on 3 or more days in previous week, 2008 to 2017

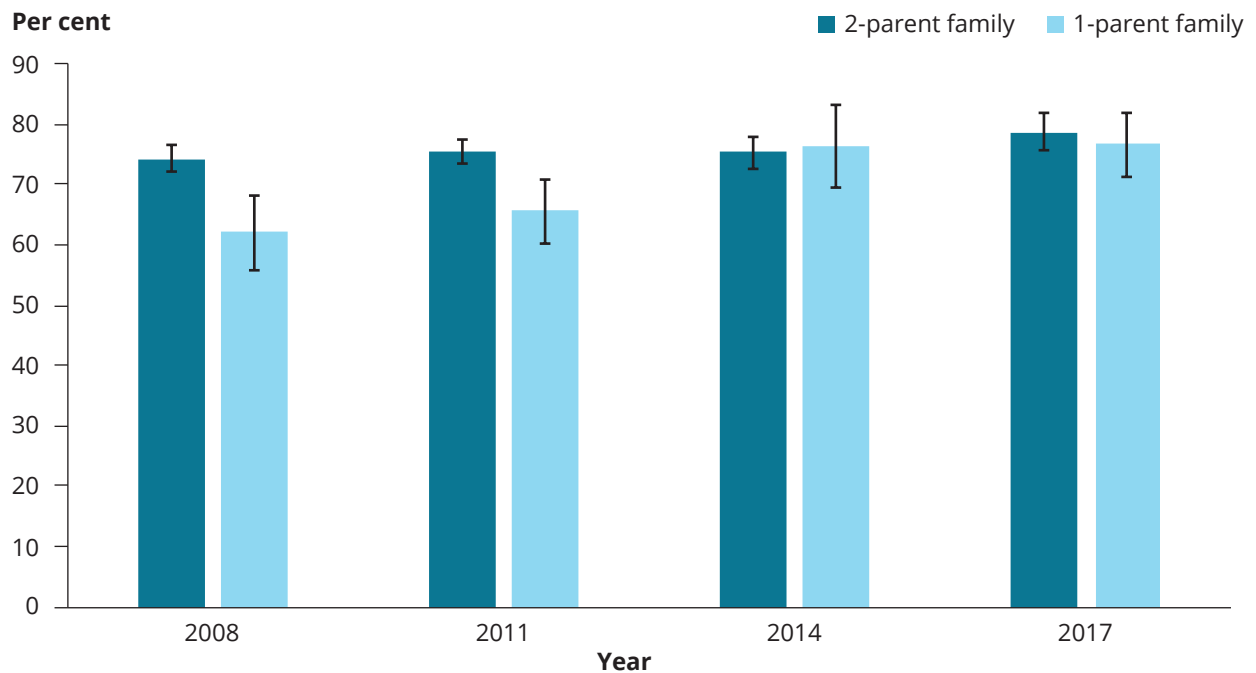


Chart: AIHW. Source: ABS 2018b.

Are rates of reading to children the same for everyone?

In 2017, the extent to which parents read to or told stories to their children varied by some population groups (Figure 3):

- More parents living in *Inner regional* (88%) read to children regularly than those in *Major cities* (78%) and *Outer regional and remote* combined (74%)
- More parents in the highest socioeconomic areas (85%) read to or told stories on a regular basis than those in the lowest socioeconomic areas (70%).
- The proportion of children in the lowest socioeconomic areas (25%) who were not read to or told stories was more than double that for children in the highest socioeconomic areas (9.8%).
- Fewer children in households where a language other than English was mainly used (62%) were read to or told stories on a regular basis compared to children in households where English was the main language to have been (81%).

Note: In households where English was not the main language spoken at home by the child, the survey does not ask which language was used for reading to child. This means that the language could be English, another language or both. It is possible, however, that respondents have interpreted the question as referring to English.

Figure 3: Children aged 0–2 read to or told stories on 3 or more days in previous week, by population group, 2017

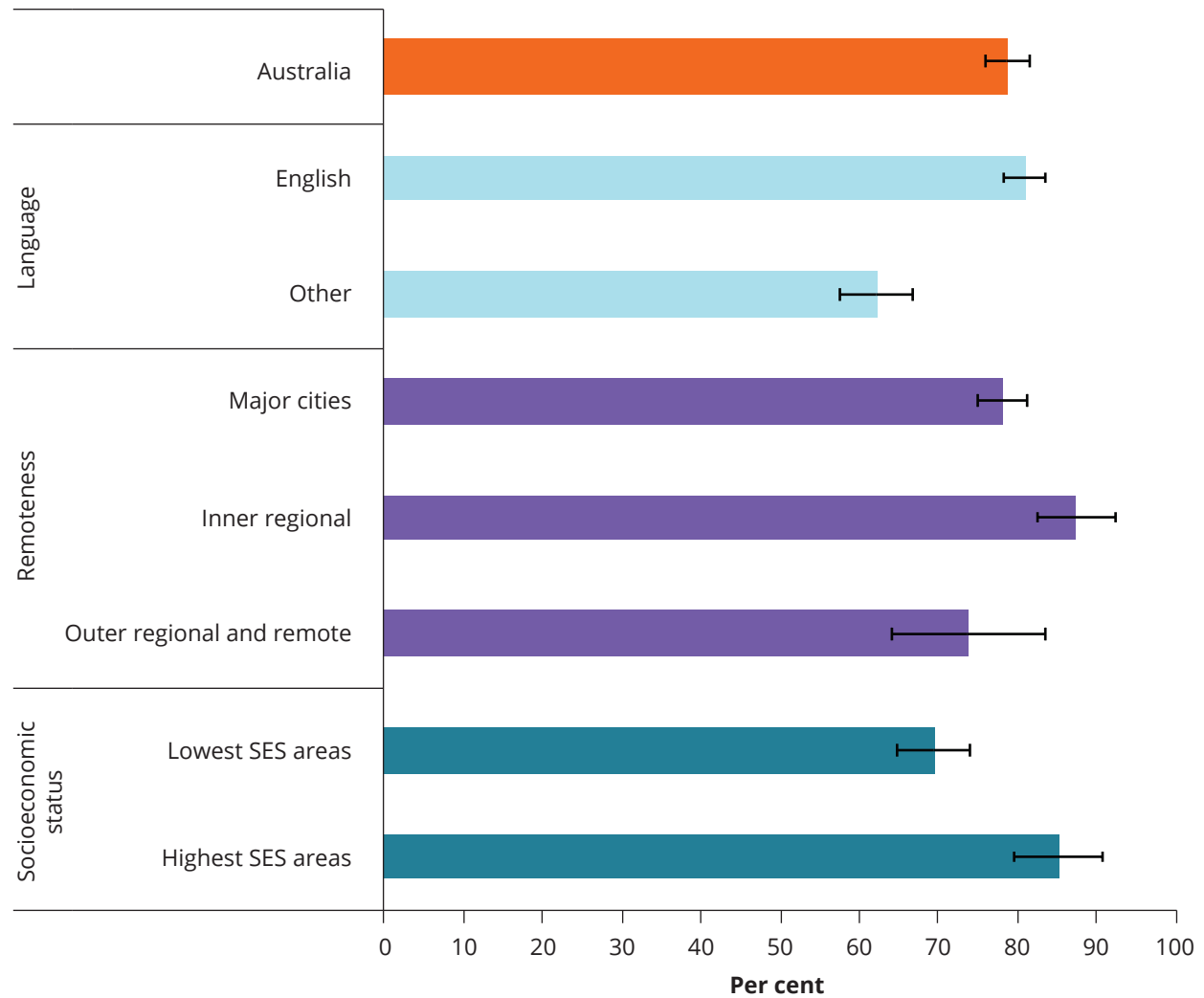


Chart: AIHW. Source: ABS 2018b.

How many books do children have in the home?

In 2017, 44% of children age 0–2 had between 25 and under 100 children’s books in the home. Children from 2-parent families were more likely to have between 25 and under 100 books (46%) than children in 1-parent families (35%).

A higher proportion of children from 1-parent families (28%) had 10 to less than 25 books compared with children from 2-parent families (19%) (Figure 4).

Figure 4: Number of books in the home for children aged 0–2 by family type, 2017

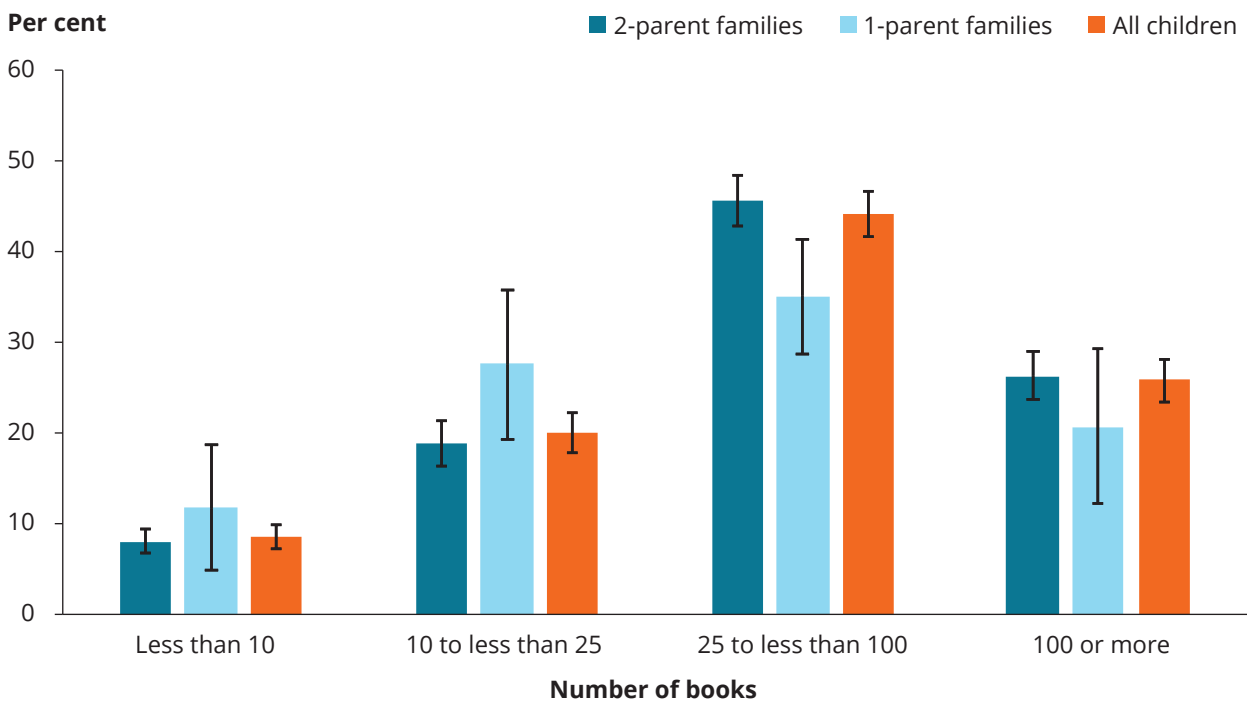


Chart: AIHW. Source: ABS 2018a.

Data limitations and development opportunities

The current measure of time spent reading or telling stories to children does not account for the time actually spent reading to the child. For example, a parent that spent 2 minutes every day would be classified along with those who spent 2 hours every day. It should also be noted that this measure does not capture children being read to or told stories by adults other than the parent, for example child care workers.

Where do I find more information?

For more information on:

- early learning, see [Childhood education and care](#)
- technical notes, see [Methods](#).

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Early childhood education and care

Key findings

- In 2017, around 3 in 5 children aged 0–4 (925,900 children) usually attended some form of child care.
- In 2017, nearly 296,000 (90%) of eligible children were enrolled in a preschool program in the year before full-time school.

Quality early childhood education and care assists with healthy early childhood development, while supporting workforce participation of parents/caregivers. Child care can be formal or informal. The formal early childhood education and care sector includes centre-based child care and preschool services (Productivity Commission 2016) (Box 1).

There is growing evidence that quality early childhood education and care gives children developmental opportunities and improves school readiness (Melhuish 2012; OECD 2017; Warren et al. 2018). Children who arrive at school 'ready' are more likely to do well in future years (see [Transition to primary school](#)).

Preschool programs can help children acquire school readiness by developing learning-related skills, such as the ability to:

- express thoughts
- adapt appropriate behaviours
- control impulsivity
- remain concentrated
- show curiosity, persistence and develop social competence (Melhuish 2012).

Matched data from the Australian Early Development Census (AEDC) showed a positive association between preschool experiences and children's development at school entry, especially for developmental domains related to learning (Warren et al. 2018). In 2015, children who received some Early Child Education and Care (ECEC) were less likely to be developmentally vulnerable on 1 or more domains (19.9 %), compared to children who did not receive any ECEC (38.5%) (SCRGSP 2019).

Research using data from LSAC found that, after controlling for socio-demographic characteristics, there was a significant positive association between attendance at preschool programs and Year 3 NAPLAN results (Warren & Haisken-DeNew 2013). The 2011 cycles of Trends in International Mathematics and Science Study (TIMSS) and Progress in International Reading Literacy Study (PIRLS) found that Year 4 students who had attended at least 1 year of pre-school had higher achievement than those who attended less than 1 year of pre-school (for reading achievement) or did not attend at all (for mathematics and science achievement) (Thomson et al. 2012).

Although beneficial for all children, preschool programs can help reduce the educational gap between children from vulnerable families and more affluent families (Melhuish 2012).

Box 1: Definitions of child care and preschool

Child care

Child care can be formal or informal:

- Formal child care is regulated care away from the child's home. The main types included in the CEaCS survey are long day care, before and/or after school care, family day care and occasional care (ABS 2018a). Before 2005, preschool was also considered a type of formal care (AIHW 2019).
- Informal paid or unpaid care is non-regulated care arranged by a child's parent or guardian, in the child's home or elsewhere. It includes care by grandparents, (step) brothers and sisters or other relatives (including a parent living elsewhere) and other people such as friends, neighbours, nannies or babysitters and other organisations (for example, crèche at gyms and health centres) (ABS 2018a).

Preschool

Preschool services deliver a preschool program. Preschool programs:

- are structured, play-based learning program, delivered by a qualified teacher, aimed at children in the year or 2 before they start full-time schooling (SCRGSP 2019).
- can be delivered within a long day care centre, or in a stand-alone facility.

The range of service types offered differs across states and territories and between service providers.

The age of entry to preschools varies slightly across jurisdictions but is generally around 4 years (Table 1).

Table 1: Preschool programs in Australia, 2017–18

State/territory	Program name	Age of entry—preschool program in year before full-time schooling	Age of entry—school
NSW	Preschool	Generally aged 4 and 5	5 by 31 July
Vic	Kindergarten	4 by 30 April	5 by 30 April
Qld	Kindergarten	4 by 30 June	5 by 30 June
WA	Kindergarten	4 by 30 June	5 by 30 June
SA	Preschool	4 by 1 May	5 by 1 May
Tas	Kindergarten	4 by 1 January	5 by 1 January
ACT	Preschool	4 by 30 April	5 by 30 April
NT	Preschool	4 by 30 June	5 by 30 June

Source: SCRGSP 2019.

In Australia, preschool attendance is not compulsory. However, in recognition of its benefits, the Australian Government and state and territory governments have, since 2008, committed to increase participation in high-quality education and care under a series of agreements on Universal Access to Early Childhood Education and Care in the year before full-time school (Department of Education 2019).

While the benefits of attending preschool in the year before full-time school are widely accepted, it has been suggested that attending high-quality preschool programs for longer may be even more beneficial (Warren et al. 2018). Australia does not currently have a national approach to this but some states and territories are introducing subsidised preschool programs for all 3 year olds.

Closing the gap in preschool enrolments for Aboriginal and Torres Strait Islander children was a key priority of the Closing the Gap framework established by the Council of Australian Governments (COAG) in 2008 (PM&C 2019). In 2017, the target to have 95% of Indigenous children aged 4 enrolled in early childhood education (by 2025) was on track (PM&C 2019) (See also 'Are preschool enrolment rates the same for everyone?').

Box 2: Data sources for early childhood education

Child care data are sourced from the ABS Childhood Education and Care Survey (CEaCS) which has been conducted every 3 years since 1969 (until 2005 it was known as the Child Care Survey). The latest data are for 2017. The survey also covers early childhood education, and learning activities for children aged under 13.

Preschool data are sourced from the SCRGSP's (Steering Committee for the Review of Government Service Provision) Report on government services. The SCRGSP's report uses ABS Preschool Education Australia, which is compiled from administrative data in the National Early Childhood Education and Care Collection. The collection includes data about services and children (enrolment and attendance). Data on child care workers were included in some previous cycles of the collection. They were sought for 2018 but were sometimes incomplete or not yet available.

Data on the quality of ECEC services are sourced from the Australian Children's Education & Care Quality Authority's (ACECQA) National Quality Framework (NQF) snapshots.

How many children aged 0–4 usually attend child care?

In 2017, around 3 in 5 children aged 0–4 (59% or 925,900 children) usually attended some form of child care:

- 30% (less than 1 in 3) for infants under the age of 1
- 62% (2 in 3) for 1 year olds
- 72% (almost 3 in 4) for 2 year olds (ABS 2018a).

Of the informal care types, grandparents were the most frequently used source across all ages 0–4. While almost 1 in 5 (20%) infants under the age of 1 were usually in the informal care of grandparents, this increased to 1 in 3 (33%) children aged 1, and around 30% of 2 year olds (ABS 2018a). The increase in the proportion of 4 year olds who did not usually attend care is likely due to the use of preschool at this age. Preschool is not included as formal care (Box 1).

Figure 1: Use of child care by age, 2017

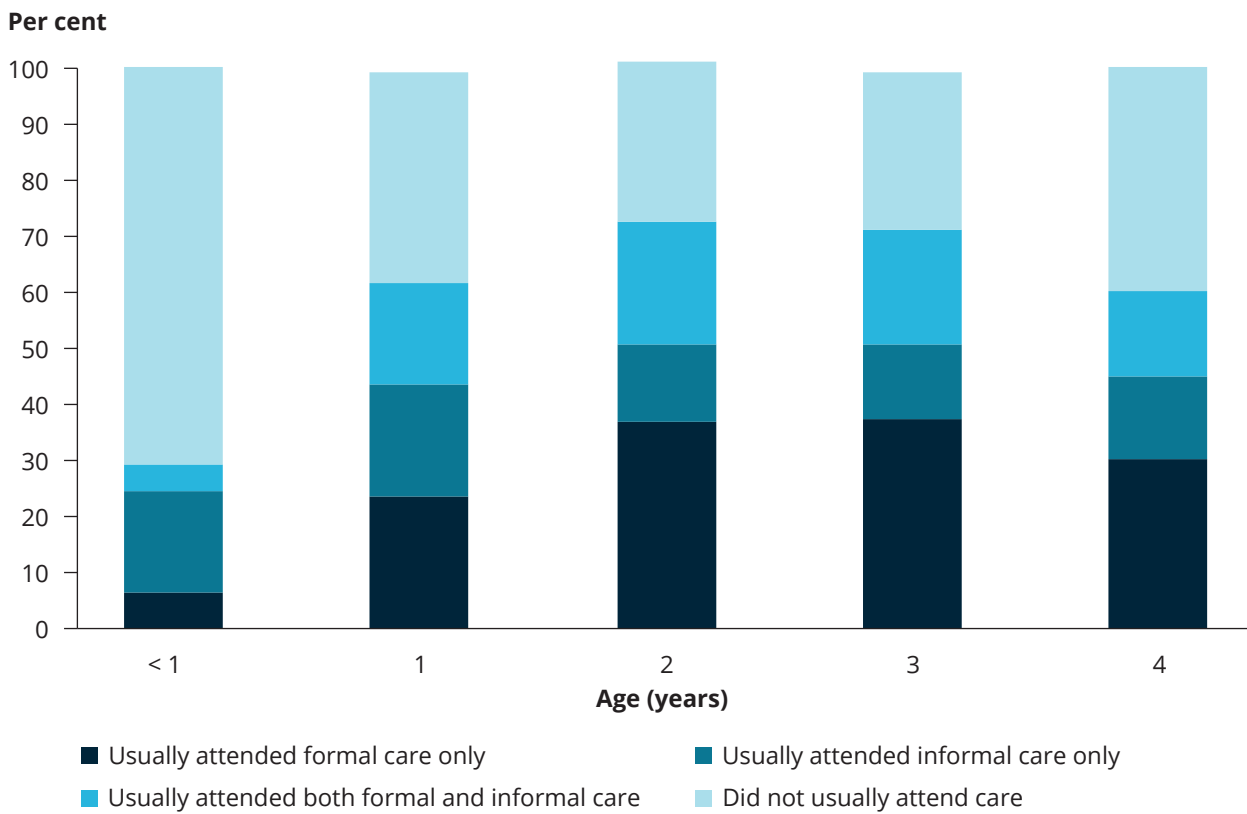


Chart: AIHW. Source: ABS 2018a.

Has the use of child care changed over time?

Between June 1999 and June 2017 there was little change in the proportion of children aged 0–4 attending some form of child care in the week before the survey:

- 55% in June 2011 and June 2014
- 60% in June 2005.

However, while informal care halved between 1999 and 2017 (32% to 15%), formal care increased by around 70% (16% in 1999 to 27% in 2017). Children who attended a mix of formal and informal care showed a small increase (11% in 1999 to 14% in 2017) (Figure 2).

Figure 2: Children aged 0–4 who attended formal and/or informal care in the previous week, 1999–2017

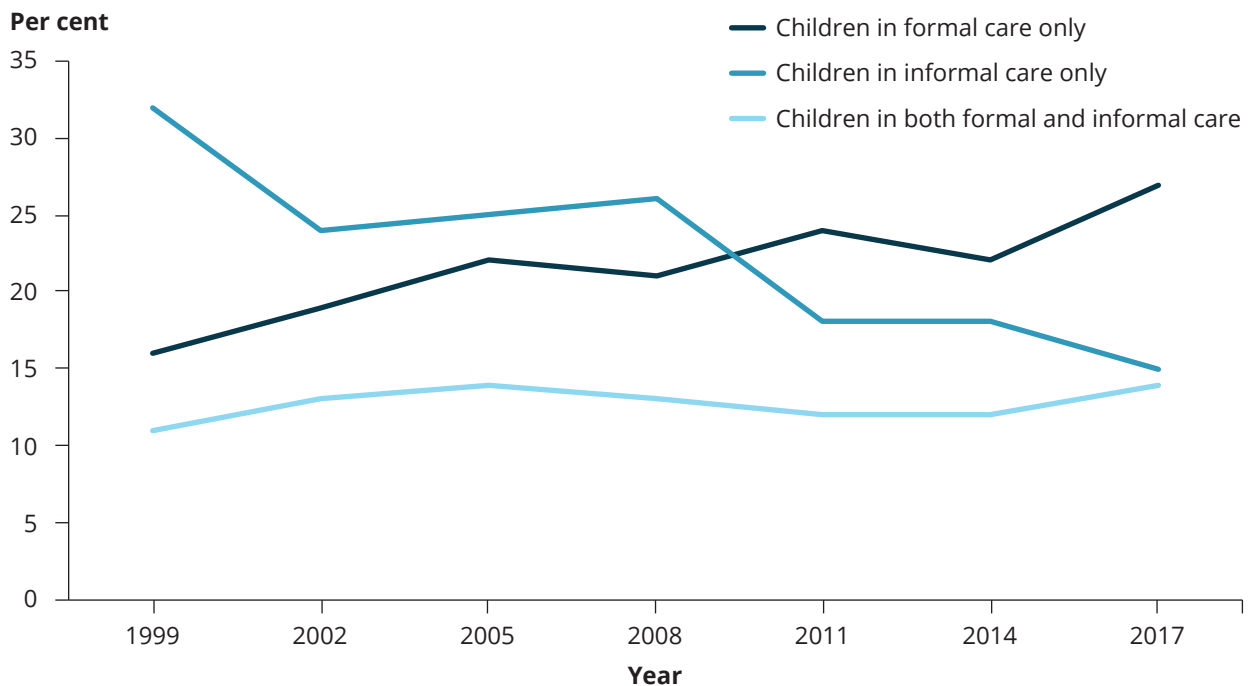


Chart: AIHW. Source: ABS 2018a.

How many children are enrolled in preschool?

In 2017, nearly 296,000 (90%) of eligible children were enrolled in a preschool program in the year before full-time school (YBFS) (SCGRSP 2019):

- 80% (236,000) were age 4
- 19% (56,000) were age 5
- 1.2% (3,500) were age 3
- more were boys (over 155,000 boys compared to around 140,000 girls) (ABS 2018b).
- 96% were enrolled for 15 hours per week or more (SCGRSP 2019).

Due to data availability, this section focuses on 2016 and 2017; however, some data on preschool enrolment in 2018 are included (Box 3).

Box 3: Preschool enrolment in 2018

In 2018, nearly 297,000 children were enrolled in a preschool program in the YBFS (ABS 2019), an increase from nearly 296,000 in 2017 and around 288,000 in 2016 (SCRGSP 2019).

As population estimates for the single year cohort for the population that will transition to full-time schooling in the following year was not available, the proportion of children enrolled in the state-specific YBFS cannot currently be calculated. For more information, see Technical notes in the [Early childhood education and care](#) section of the online report.

Have preschool enrolment rates changed over time?

While the number of children enrolled in a preschool program in the YBFS increased between 2016 and 2017 (from around 288,00 to around 296,000) the proportion decreased from 92% to 90% (SCGRSP 2019).

Are preschool enrolment rates the same for everyone?

In 2017, the proportions of children enrolled in a preschool program aged in the YBFS from priority group populations compared with the representation of these priority groups aged 4–5 in the community (that is the Australian child population) were as follows:

- In *Inner and outer regional* areas, the proportion was a little higher (27%) than the representation in the community (26%) (Figure 3).
- For children living in *Remote and very remote* areas, the proportion was almost the same (2.3%) as the representation in the community (2.4%).
- For children in the lowest socioeconomic areas (the most disadvantaged), the proportion was a little lower (17%) than the representation in the community (19%).

Figure 3: Proportion of children enrolled in a preschool program in the year before full-time school by priority population groups, compared with children aged 4–5 in the community, 2017

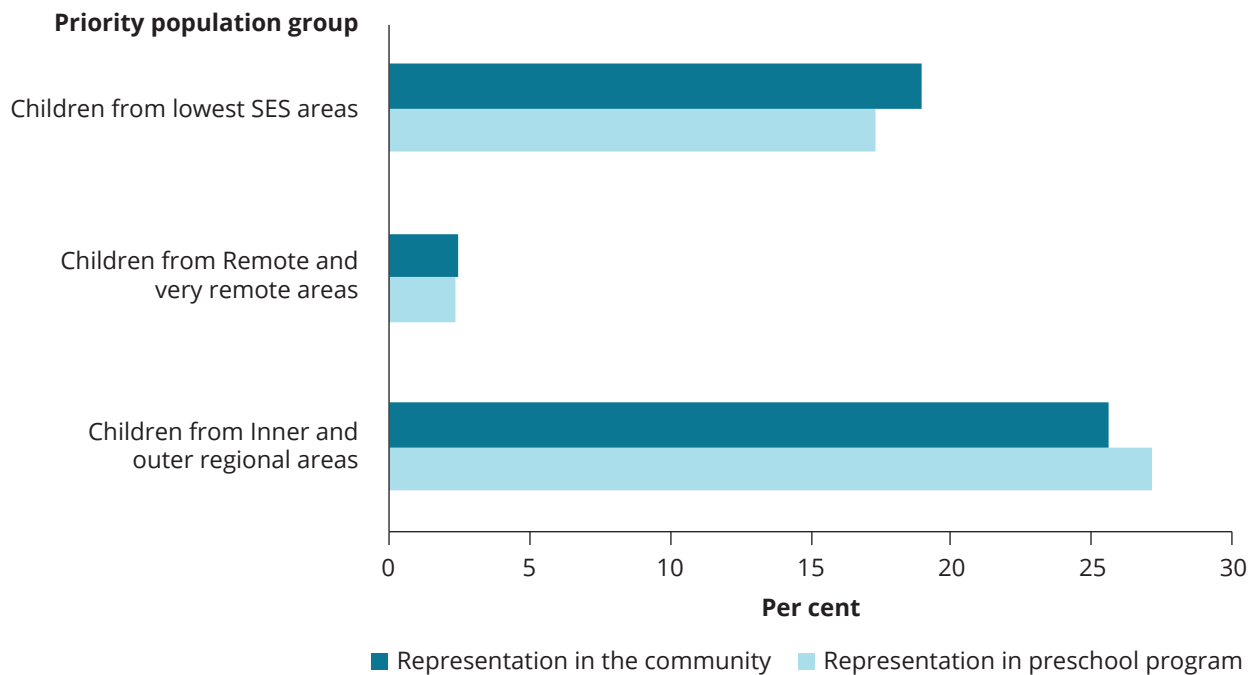


Chart: AIHW. Source: SCRGSP 2019.

Closing the Gap target for preschool enrolment

The COAG Closing the Gap target to have 95% of Indigenous 4 year olds enrolled in early childhood education (by 2025) was on track for 2017 (PM&C 2019). Progress against this target is measured by the proportion of children enrolled in early childhood education in the year before they start full-time school (PM&C 2019).

In 2017, the proportion of Indigenous children enrolled in a preschool program in the YBFS was higher than non-Indigenous children (95% or 15,700 Indigenous children compared with 90% or 280,000 non-Indigenous children) (SCRGSP 2018).

The proportion of Indigenous children enrolled in a preschool program in the YBFS increased between 2016 (91%) and 2017 (95%). In comparison, the proportion for non-Indigenous children declined slightly (92% to 90% (PM&C 2019)).

How many early childhood education services have a quality rating?

The NQF provides a national approach to regulation, assessment and quality improvement for ECEC and outside school hours care services. Services approved and regulated under the NQF, include child care services (long day care, family day care, and outside school hours' care) and preschool services.

The National Quality Standard comprises 7 quality areas:

- educational program and practice
- children's health and safety
- physical environment
- staffing arrangements
- relationships with children
- collaborative partnerships with families and communities
- governance and leadership.

As at 31 March 2019, there were 15,902 ECEC services were NQF approved, of which 94% (14,897) had received a quality rating. Around:

- 47% (7,049) met the NQS
- 31% (4,670) exceeded it
- 0.3% (47 services) received a rating of excellent (ACEQUA 2019).

Data limitations and development opportunities

Under the National Partnership on Universal Access to Early Childhood Education, the Australian Government has provided funding to support further data and analytical work to build the domestic evidence base, especially to:

- identify the children not enrolled or have low attendance
- better understand the factors contributing to low participation (Department of Education 2019).

Where do I find more information?

For more information on:

- preschool enrolment for Indigenous children, see: [Indigenous children](#)
- child care, see: [ABS 4402.0—Childhood Education and Care](#)
- preschool data by state and territory, see: [Early childhood education in Children's Headline Indicators](#) and [ABS 4240.0—Preschool education](#)

- children attending Australian Government Child Care Benefit-approved child care services, parental costs for ECEC services and ECEC staff qualifications. see: [Review of Government Services, Chapter 3: Early Childhood Education and Care](#)
- ratings of ECEC services, see: [ACEQUA's NQF snapshots](#)
- technical notes relating to this section, refer to [Early childhood education and care](#) in the online report. See also [Methods](#).

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The transition to primary school

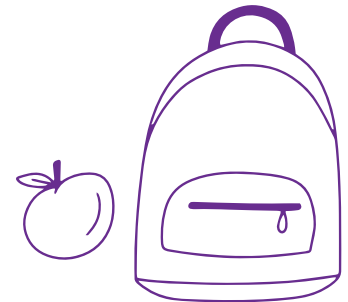
Key findings

- Between 2009 and 2018, the proportion of children developmentally vulnerable on 1 or more Australian Early Development Census (AEDC) domains decreased from 24% to 22%.
- The proportion of children developmentally vulnerable on 2 or more AEDC domains also decreased from 12% to 11%.

Starting school is a key milestone in a child's life, which can be exciting and challenging. The transition to primary school requires a significant adjustment to a new environment, with less personalised relationships, a different education and care model, and more children of many different ages (CCCH 2008).

A range of individual, family and community factors can affect a child's readiness for school (Edwards et al. 2009). Individual factors include early cognitive ability and temperament while family characteristics include parenting style, the home learning environment, maternal education and family income. Parenting and the home environment also mediate the relationship between financial disadvantage and school readiness. While community-level variables appear to have a smaller impact on children's school readiness, child care and preschool attendance have been found to affect early child development (Edwards et al. 2009).

The AEDC is a national measure of how children have developed by the time they start school (Box 1). A child's development when they start school is strongly associated with how well they continue through primary school.



Box 1: Data source on school readiness: The Australian Early Development Census

The AEDC is a population measure of children's development as they enter the first year of full-time school. It is considered a measure of how well children and families are supported from conception through to school age (AEDC 2019a).

Data are collected every 3 years using an Australian version of the Early Development Instrument (avEDI), a teacher-completed checklist developed in Canada.

The first Australian collection was in 2009 with subsequent collections in 2012, 2015, 2018. Participation is voluntary with data collected through the cooperation of parents and the active involvement of government, Catholic and independent school sectors across Australia (AEDC 2019a).

These 5 AEDC domains are considered crucial constructs that can affect a child's readiness to make a successful transition to primary school:

- physical health and wellbeing
- social competence
- emotional maturity
- language and cognitive skills (school-based)
- communication skills and general knowledge.

Results on AEDC domains group children into these categories:

- developmentally vulnerable (below 10th percentile)
- developmentally at-risk (between 10th and 25th percentile)
- on track (between 25th and the 50th percentile, and above 50th percentile)

Note that the cut-off scores were established in the first (2009) data collection cycle (AEDC 2019a).

Domain information about children with special needs is not included in AEDC results because of this group's already identified substantial developmental needs.

AEDC results also include summary measures of children developmentally vulnerable on 1 or more domains and on 2 or more domains. These children are considered at especially high risk developmentally.

In 2018, the AEDC collected data on almost 309,000 children in Australia, representing more than 96% of children in their first year of full-time school (AEDC 2019a).

In 2015, children who received some Early Childhood Education and Care (ECEC) were less likely developmentally vulnerable on 1 or more domains (19.9%), compared to children who did not receive ECEC (38.5%) (SCRGSP 2019).

Research has found that children vulnerable on 1 or more of the Early Development Instrument domains at age 5 were more likely in the bottom 20% of all student scores on the NAPLAN assessments in years 3, 5 and 7 than children not vulnerable on any Early Development Instrument domain (AEDC 2014).

The AEDC has also been used to construct the Multiple Strength Indicator (MSI) which focuses on children's strengths when they start school (see Box 2).

Box 2: The Multiple Strength Indicator

The Multiple Strength Indicator (MSI) is a positive measure of children's developmental strengths of what is going well for children when they start their first year of full-time school. It is constructed using data from the AEDC.

The key difference between the MSI and the AEDC summary indicators on children's vulnerability discussed in this section is that the MSI focuses on children's strengths when they start school whereas vulnerability indicators show if children are facing challenges in their development (AEDC 2019b). The MSI is a summary indicator that could be used to complement the current suite of deficit-based indicators reported from the AEDC (AEDC 2019b).

The MSI focuses on social and emotional developmental strengths such as:

- self-control
- pro-social skills
- respectful behaviour towards peers, teachers and property
- curiosity about the world.

The indicator also identifies children who have advanced literacy skills, a particular interest in reading, numeracy and memory, and very good communication skills (AEDC 2014).

Children can be classified into 3 groups as having:

- emerging strengths—children with scores falling below the 25th percentile.
- well-developed strengths—scores falling between the 25th and 50th percentile.
- highly developed strengths—scores above the 50th percentile (AEDC 2014).

Results found that the MSI provides complementary information for children who were developmentally vulnerable. In 2009, almost one-quarter of children (24%) who were developmental vulnerable on 1 or more AEDC domains had well developed (19.6%) or highly developed strengths (4.7%) based on the MSI (Gregory & Brinkman 2016).

A comparison of results from the 2009, 2012 and 2015 AEDC cycles showed at the national level, a decrease in the percentage of children with emerging strengths (24% to 22%) and well developed strengths (24% to 23%) and an increase in percentage of children with highly developed strengths (52% to 56%). However, if these differences are statistically significant has not been determined (Gregory & Brinkman 2016).

The MSI has good predictive validity for academic achievement. Children with strengths in more areas at school entry were found to be less likely to score at or below the national minimum standard in the Year 3 to Year 9 NAPLAN (AEDC 2014b).

Because of the broad range of skills, competencies and character strengths measured in the indicator (such as self-control, peer relationships, love of learning, and curiosity), the indicator would be expected to predict a wide range of (non-academic) life success measures (AEDC 2014b).

For more information on a positive measure of mental health competence that also draws on AEDC data, see the [Social and emotional wellbeing](#) section in the [Health domain](#).

How many children are developmentally vulnerable at school entry?

In 2018, the majority of Australian children were doing well, with almost 4 in 5 children (78%) on track across all AEDC domains; however:

- 22% of children (63,400 or 1 in 5) were developmentally vulnerable on 1 or more domains at school entry
- 11% (32,400) were vulnerable on 2 or more domains (Figure 1).

Boys were more likely developmentally vulnerable than girls on:

- 1 or more domains (28% compared with 15%) and
- 2 or more domains (15% compared with 6.7%).

Figure 1: Children developmentally vulnerable on 1 or more and 2 or more AEDC domains, by sex, 2018

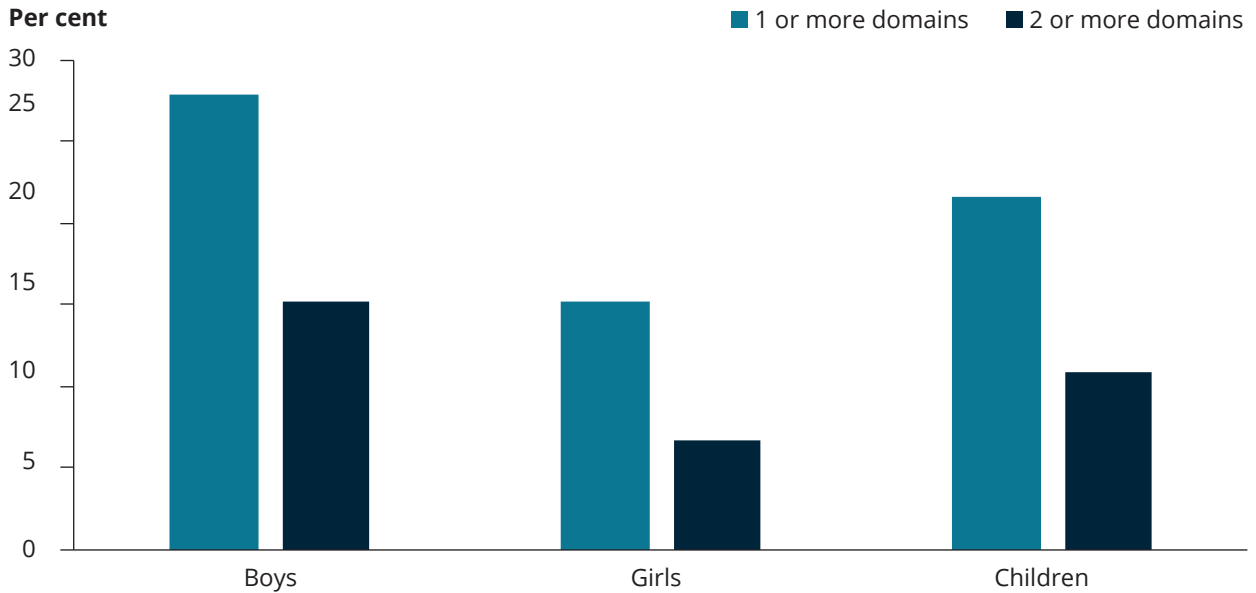


Chart: AIHW. Source: AEDC 2019a.

Looking at individual AEDC domains, boys were more likely than girls to be developmentally vulnerable on each. The difference was greatest for emotional maturity. On this domain, boys were more than 3 times as likely as girls to be developmentally vulnerable (13% compared with 3.8%).

Figure 2: Children developmentally vulnerable on each of the 5 AEDC domains, by sex, 2018

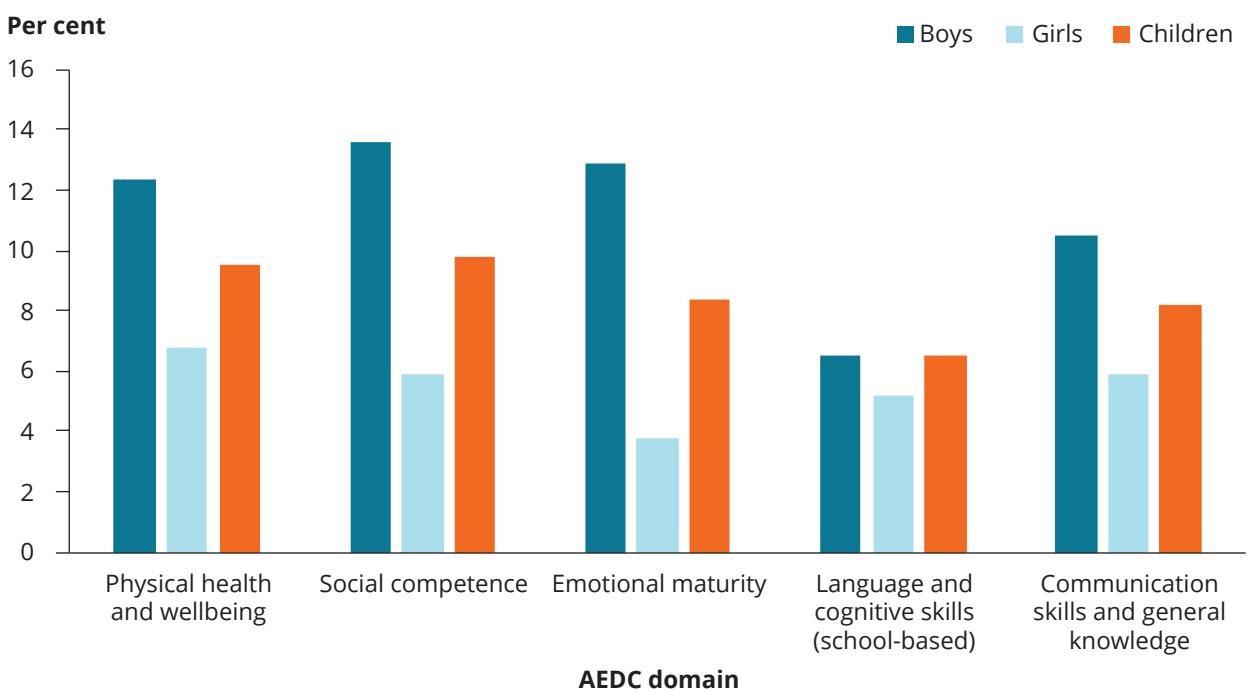
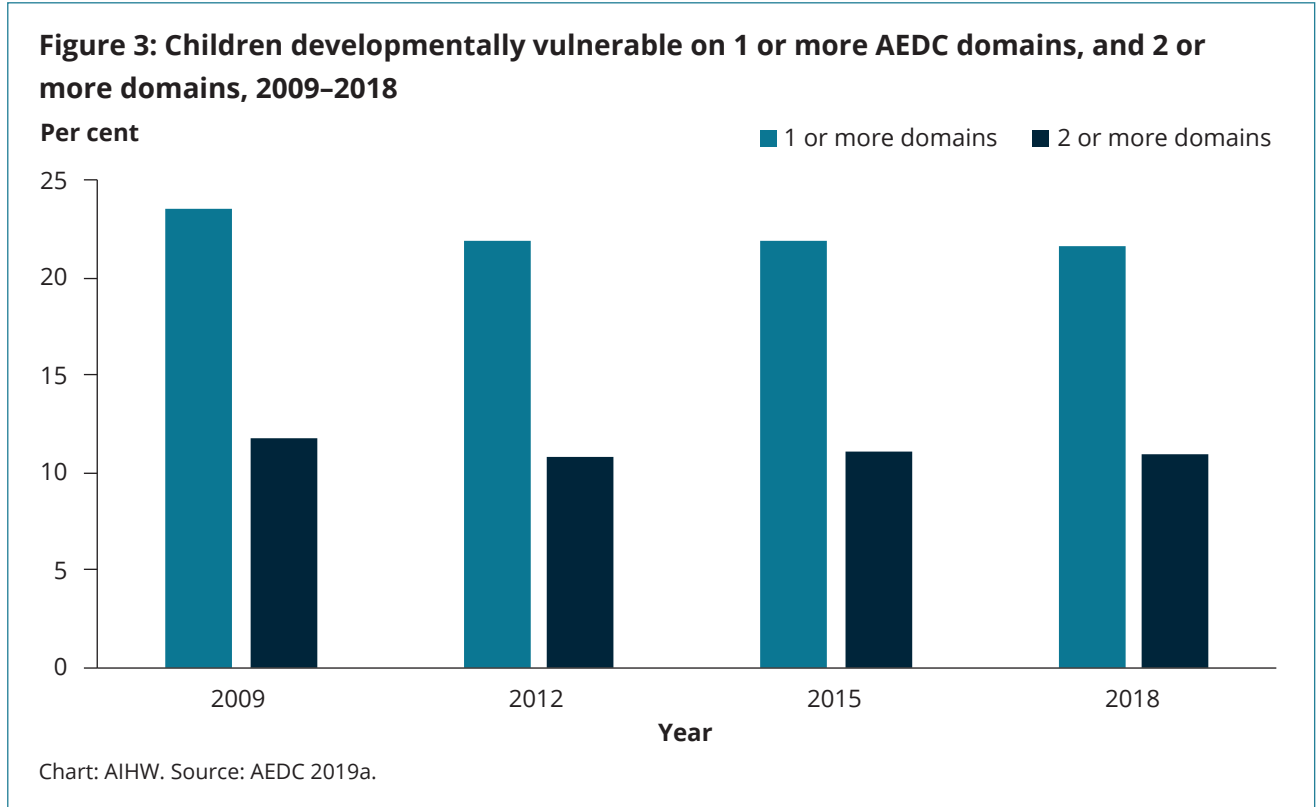


Chart: AIHW. Source: AEDC 2019a.

Has the rate of developmentally vulnerable children changed over time?

Between 2009 and 2018, the proportion of children developmentally vulnerable on 1 or more AEDC domains decreased from 24% to 22%. The proportion of children developmentally vulnerable on 2 or more also decreased, from 12% to 11%.



The largest change from 2009 to 2018 was in the language and cognitive skills (school-based) domain, with developmental vulnerability decreasing from 8.9% to 6.6%. However, most of this decline occurred between 2009 and 2012 (6.8%). Developmental vulnerability in the communication skills and general knowledge domain decreased from 9.2% in 2009, to 8.2% in 2018 and in the emotional maturity domain from 8.9% in 2009 to 8.4% in 2018.

The social competence and physical health and wellbeing domains had small fluctuations between 2009 and 2018. In both, the percentage of children developmentally vulnerable was higher in 2018 (9.8% and 9.6%) compared to the baseline (9.5% and 9.3%, respectively). In both, the percentage of children developmentally vulnerable was highest in 2015 (AEDC 2019a).

Physical health and wellbeing	Social competence	Emotional maturity	Language and cognition	Communication and general knowledge
↑	↑	↓	↓	↓

Are rates of developmental vulnerability the same for everyone?

The proportion of children with a language background other than English (LBOTE) who were developmentally vulnerable on 1 or more AEDC domains was 1.3 times as high as for children who spoke English only (26% compared with 20%) (Figure 4).

Children from LBOTE and English-only backgrounds can be proficient or not proficient in English. There was almost no difference between LBOTE children proficient in English and children who spoke English only (and were proficient in English)—18.1% and 18.2%, respectively.

For children with a LBOTE or English-only background, who were not proficient in English, the proportion developmentally vulnerable on 1 or more domains was above 90%. The vast majority of these children were developmentally vulnerable on the communication skills and general knowledge domain (AEDC 2019a).

Children living in *Very remote* areas (46%) were more than twice as likely to be developmentally vulnerable on 1 or more AEDC domains as children in *Major cities* (21%) (Figure 4). The domain with the greatest differences in vulnerability between children in *Very remote* areas and those in *Major cities* was the language and cognitive skills domain (29% compared with 5.8%).

The proportion of children living in the lowest socioeconomic areas who were developmentally vulnerable on 1 or more domains was twice that of those in the highest socioeconomic areas (32% compared with 15%) (Figure 4). The domain with the greatest differences was the language and cognitive skills domain (13% compared with 2.8%).

Differences were also evident between Indigenous and non-Indigenous children (41% compared with 20%), most notably in the language and cognitive skills domains (21% compared with 5.7%) (Figure 4). However, the proportion of Indigenous children vulnerable on 1 or more domains for Indigenous children decreased from 47% in 2009 to 41% in 2018 (AEDC 2019a).

Figure 4: Children developmentally vulnerable on 1 or more AEDC domains, by selected population groups, 2018

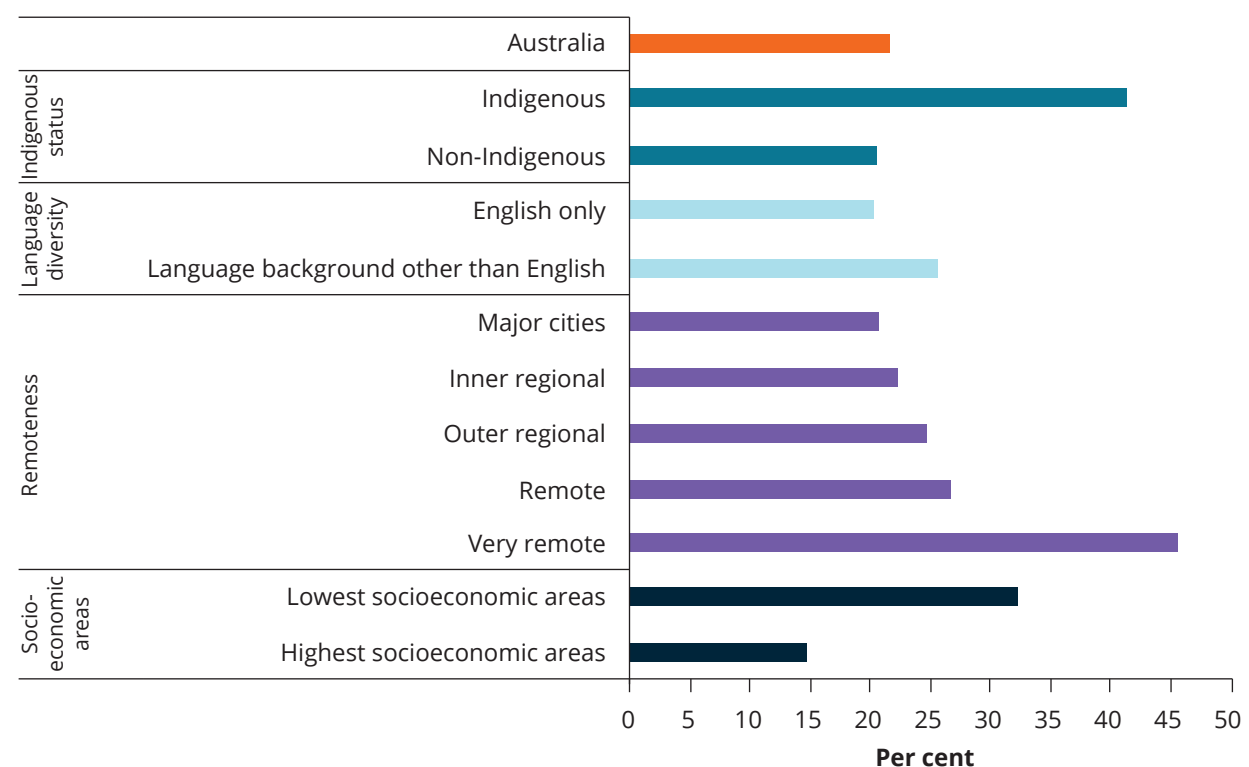


Chart: AIHW. Source: AEDC 2019a.

Children in contact with the child protection system

Data from the South Australian Early Childhood Data Project (SA ECDP) indicated that in South Australia, children who had contact with child protection agencies were more likely to be developmentally vulnerable on 1 or more domains at age 5 on school entry compared with children who did not have contact.

As the level of contact with the child protection system increases, so does the prevalence of developmental vulnerability on 1 or more domains at age 5 (Box 3). Children who had an episode of out-of-home care were almost 1.5 times as likely to have developmental vulnerabilities compared with those who had a notification only (Pilkington et al. 2019).

Data limitations and development opportunities

National integrated datasets can give insight on the risk and protective factors that influence a child's readiness and transition to school, and how these may vary for more vulnerable groups.

The Australian Institute of Health and Welfare (AIHW) has worked with states and territories to link child protection and AEDC data from selected jurisdictions. If regularly updated, this could facilitate routine reporting on the developmental outcomes of children in contact with child protection. Monitoring how this measure changes could inform planning, policy and services related to child protection.

Where do I find more information?

For information on:

- AEDC results for Indigenous children, see: [Indigenous children](#)
- AEDC results, see: [Transition to primary school](#) in [Children's Headline Indicators](#) and [AEDC Data Explorer](#)
- AEDC research projects in progress, see: [The AEDC website](#). For information on some state-based projects using AEDC data, see Box 3.
- technical notes relating to this section, refer to [Early childhood education and care](#) in the online report. See also [Methods](#).

Box 3: State-based linkage projects using AEDC data

Several states are linking data from the [AEDC](#) to government administrative data to facilitate research into the pathways leading to early developmental vulnerability as measured by the AEDC.

A number of risk factors associated with early developmental vulnerability have been identified including: parental mental illness and criminal offending, perinatal characteristics including parental smoking and occupation, child chronic illness and obesity, hospital admission for infection, exposure to disease, maltreatment and child protection involvement, gestational age, and maternal age.

For more information on state-based projects, see:

[New South Wales Childhood Development Study](#)

[South Australian Early Childhood Data Project](#)

[Western Australian Telethon Kids Institute's Developmental Pathways Project.](#)

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Attendance at primary school

Key findings

- In 2018, the national attendance rate for Year 5 students was 93%, with little difference between boys and girls.
- Between 2014 and 2018, attendance rates for Year 5 students remained steady (93.7% compared with 93%).

Primary school is the first compulsory educational experience for Australian children. Attendance at school, especially primary school, gives children opportunities to develop the basic building blocks for learning and educational attainment, as well as social and emotional skills such as good communication, resilience and teamwork (Vic Department of Education and Training 2019). Attendance patterns have been found to be established early in school life, and disparities in attendance tend to be carried into, and become greater in, secondary school (Hancock et al. 2013).

Regular school attendance is critical to successful student outcomes, which has implications for further educational and future employment opportunities. Data has shown that more days of school absenteeism is associated with increased impact on academic performance (Goodsell et al. 2017). A study drawing on the Longitudinal Study of Australian Children (LSAC) found that higher levels of school non-attendance were associated with lower levels of numeracy, especially in early primary school years (Daraganova et al. 2014).

School attendance can be affected by underlying issues including:

- housing
- physical health
- mental health issues
- family violence
- intergenerational unemployment (Mission Australia 2016).

The mobility of young people—moving home or school several times in a short period—has also been found to be associated with missing school (Redmond et al. 2016). For students aged 10–11, risk factors associated with high levels of school absenteeism included:

- lower levels of school readiness on school entry
- higher levels of emotional or behavioural problems
- higher levels of school absenteeism in previous years (Daraganova et al. 2014).

Among Indigenous children, available evidence suggests that key drivers of school attendance include family socioeconomic status, school environment, child health, history of being bullied, and structural/community factors (AIHW 2018).

Closing the gap between Indigenous and non-Indigenous children's school attendance for years 1–10 was a key priority of the Closing the Gap framework established by the Council of Australian Governments in 2018.

Attendance rates for Indigenous students did not improve between 2014 and 2018 and they remained below the rate for non-Indigenous students. However, the final assessment of the target will be considered when Semester 1, 2019 data are released as this is the agreed end point for the target. Targets for the Closing the Gap Refresh agenda are not yet finalised (PM&C 2019).

Box 1: Data sources for school attendance

School attendance data are sourced from the Australian Curriculum, Assessment and Reporting Authority (ACARA) Student Attendance Data Collection. National data has been collected annually for all compulsory school years (Foundation to Year 10) since 2014. ACARA developed the National Standards for Student Attendance Data Reporting (national standards) to standardise reporting across Australia for comparability purposes.

While data are available for all school years, the attendance rate of Year 5 students is the focus for this section, in line with indicator reporting Children's Headline Indicators and literacy and numeracy indicators (see [Literacy and numeracy](#) for an explanation of the choice of Year 5).

The nationally agreed student attendance measure is the number of actual full-time equivalent (FTE) student days attended as a percentage of the total number of possible student days attended over the period (ACARA 2019).

The FTE of a full-time student is 1.0. A full-time student is one who undertakes a workload equivalent to, or greater than, what is prescribed for a full-time student of that year level. This may vary between states and territories and from year to year. The prescribed minimum workload for a full-time student would ensure that a student could complete a given year level in a calendar year (ACARA 2019). FTE accounts for slightly different hours of school days and/or short (1–2 hour) absences of the child.

What is the school attendance rate for Year 5 students?

In 2018, the national attendance rate for Year 5 students was 93% with little difference between boys and girls (92.8% and 93.3%, respectively) (Figure 1). The national attendance rate across year levels also showed little difference:

- 93.2% for Year 3 students
- 93% for Year 5
- 92.7 for Year 7.



Figure 1: Student attendance rates for years 3, 5 and 7, by sex, 2018

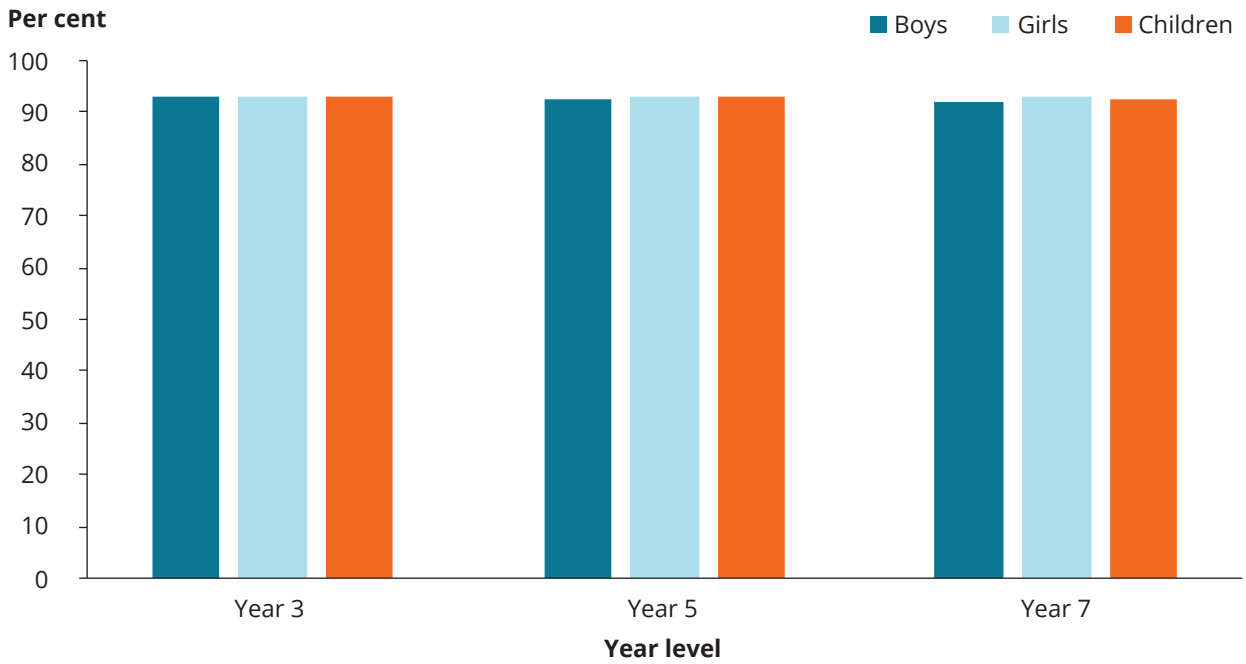


Chart: AIHW. Source: ACARA 2018.

Have attendance rates changed over time?

Between 2014 and 2018, the overall attendance rate for Year 5 students remained steady (93.7% in 2014 compared with 93% in 2018). Independent schools had a consistent pattern of having the highest attendance rates, followed by Catholic schools and government schools. (Figure 2).

Figure 2: Year 5 student attendance rates, by school sector, 2014–2018

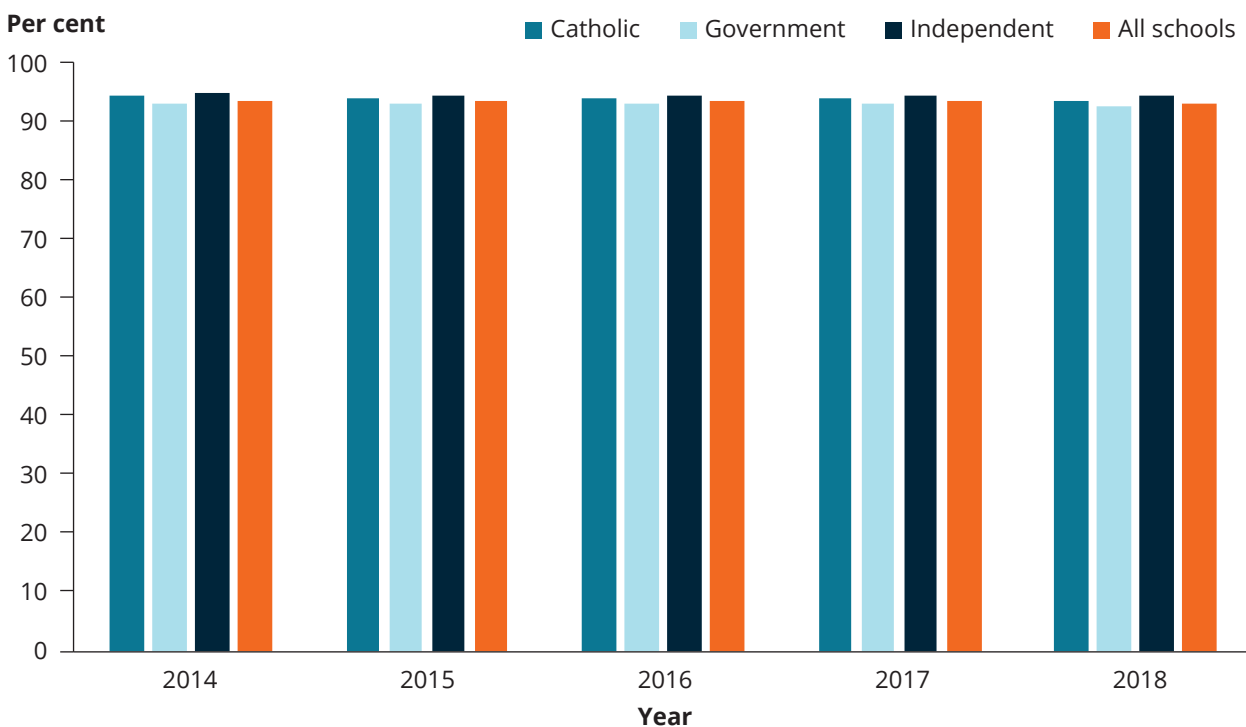


Chart: AIHW. Source: ACARA 2018.

Are attendance rates the same for everyone?

In 2018, Year 5 student attendance rates decreased as remoteness increased. It was considerably lower in *Very remote* areas (77%) than in *Major cities* (94%).

Differences were also evident between Indigenous and non-Indigenous Year 5 students (86% and 94%, respectively). Attendance rates for Indigenous students for this year level did not improve between 2014 (86.3%) and 2018 (85.7%).

Note: These categories are not mutually exclusive and it is likely that some of these influencing factors overlap. The data presented here does not show if poorer school attendance is restricted to particular schools.

Closing the Gap target for school attendance

Data for 2018 showed that the COAG target to close the gap between Indigenous and non-Indigenous school attendance for years 1–10 within 5 years (by 2018) was not on track as of Semester 1, 2018 (PM&C 2019).

The final assessment of the target will be considered when Semester 1, 2019 data are released as this is the closest data point to the end of 2018 and so is the agreed end point for the target (Productivity Commission 2019).

Figure 3: Year 5 student attendance rates, by priority populations, 2018

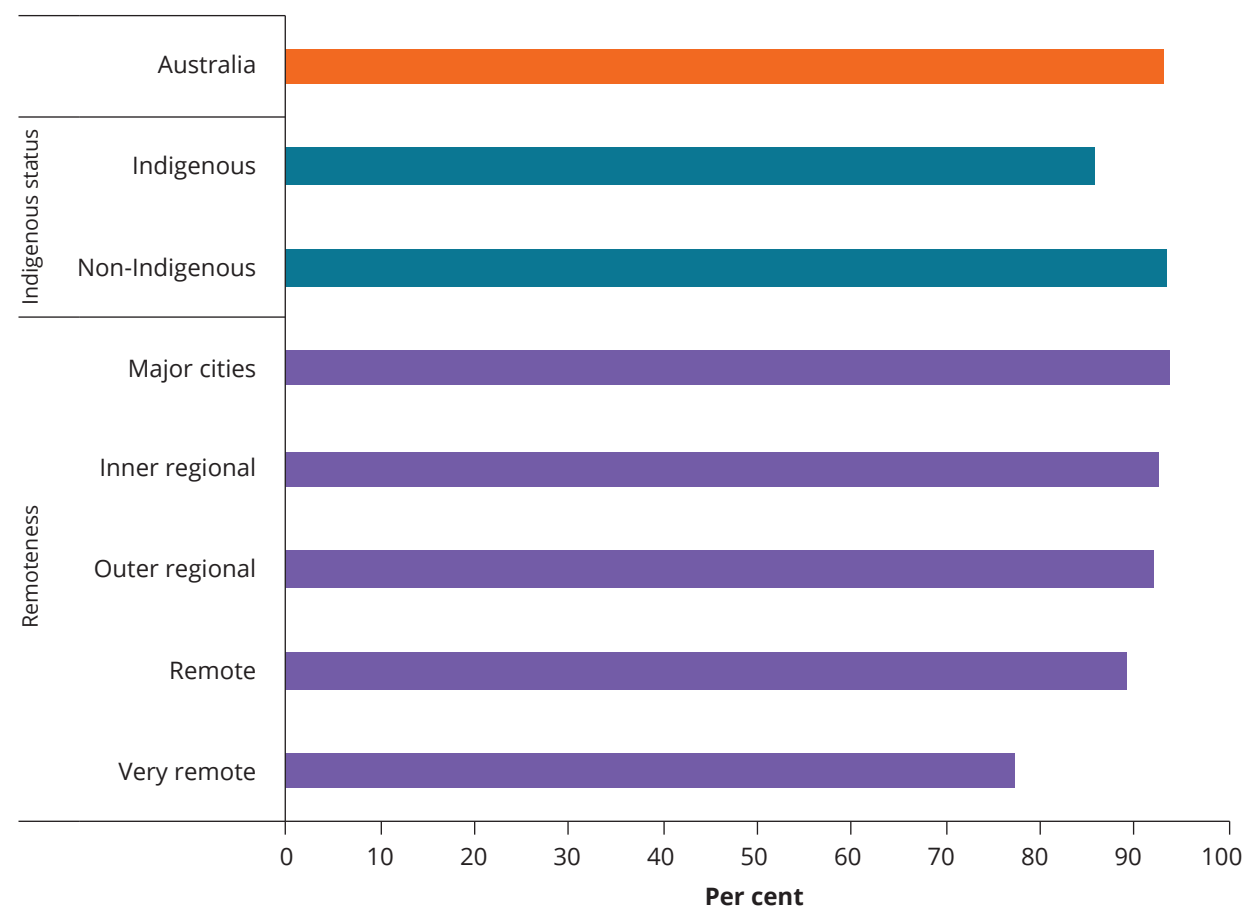


Chart: AIHW. Source: ACARA 2018.

Children with mental health disorders

The 2013–14 Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (also known as the Young Minds Matter survey) includes data on school attendance for children with mental health disorders.

Analysis of the survey data found that in 2013–14:

- students in primary school (years 1–6) with a mental disorder were absent on average 3.6 days more than students without a mental disorder (11.8 days compared with 8.2 days)
- boys had a slightly higher average number of absent days than girls (12.3 days compared with 11.1 days) (Goodsell et al. 2017).

In primary school, major depressive disorders (18.1 days) and anxiety disorders (15 days) were associated with higher absence rates than conduct disorders (12 days) and Attention deficit hyperactivity disorder (ADHD) (10.5 days) (Goodsell et al. 2017).

Box 2: Students with special needs

Low socio-educational advantage

In 2017, 25% of all enrolled students across all years (Year 1 to Year 12) and school sectors had low socio-educational advantage (for more information, see Technical notes in the [Attendance at primary school](#) section of the online report). The proportion was more than double in government schools compared with non-government schools (30% compared with 13%) (SCRGSP 2019).

Children with disability

In 2017, 19% (around 725,000) of all school students received an adjustment to participate in education because of disability. Independent schools had a higher proportion of students with disability (20%) than Catholic schools (17%) or government schools (19%) (SCRGSP 2019).

Disability types included:

- physical
- cognitive
- sensory
- social/emotional

The level of adjustment students were given to enable them to participate in education on the same basis as other students was:

- 1.5% with extensive disability
- 3% with substantial disability
- 8.2% with supplementary disability
- 6.2% required support within quality differentiated teaching practice (ACARA 2018).

Note: The definition of disability used here differs from that used in the ABS Survey of Disability, Ageing and Caring, which is used in [Disability](#) section in the [Health domain](#).

Attendance data are not currently available for children from a low socio-educational advantage background nor for children with disability.

Data limitations and development opportunities

The standardising of nationally consistent data on school attendance has been an important data development over the past years. An area where national data are currently limited is for school expulsions and suspensions.

Where do I find more information?

For more information on:

- school attendance for Indigenous children, see: [Indigenous children](#)
- school attendance, see [Attendance at primary school](#) in [Children's Headline Indicators](#) and [ACARA school attendance website](#).
- technical notes relating to this section, refer to [Attendance at primary school](#) in the online report. See also [Methods](#).

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Literacy and numeracy

Key findings

- Between 2008 and 2018, the proportion of Year 5 students who achieved at or above the national minimum standard for reading and numeracy increased.
- Reading increased 4 percentage points from 91% to 95%.
- Numeracy increased 3 percentage points from 93% in to 96%.

Literacy and numeracy are fundamental building blocks for children's educational achievement, their lives outside school and engagement with society, and their future employment prospects.

Literacy and numeracy skills have been positively associated with educational attainment in adulthood (Shuey & Kankaras 2018). Weak literacy and numeracy skills can lead to disadvantage in terms of limited access to desirable employment opportunities or unemployment (OECD 2017). Australia's performance in the 2011–12 Survey of Adult Skills was average to very good; however, 1 in 5 Australians had low literacy and/or numeracy skills, with numeracy a particular challenge (OECD 2017).

Literacy and numeracy and knowledge of key disciplines are the cornerstone of schooling for young Australians (MCEETYA 2008). They are 2 of the 7 general capabilities included in the Foundation to Year 10 Australian Curriculum (ACARA 2019a).

Literacy involves 'students listening to, reading, viewing, speaking, writing and creating oral, print, visual and digital texts, and using and modifying language for different purposes in a range of contexts' (ACARA 2019a).

Numeracy encompasses 'the knowledge, skills, behaviours and dispositions that students need to use mathematics in a wide range of situations' (ACARA 2019a).

While literacy and numeracy skills are explicit in English and Mathematics, all Australian Curriculum learning areas require discipline-specific literacy and numeracy knowledge and skills (ACARA 2017). The growth of new technologies and new industries has led to an increasing need for science, technology, engineering and mathematics (STEM) expertise in the workforce. Mathematical thinking is a fundamental skill that underpins all STEM learning (Education Council 2015).

A number of factors affect successful educational outcomes during the school years, including a child's home environment, such as if books are available at home and if parents read aloud to their children. Children whose parents read to them every day at 2–3 year olds had on average higher Year 3 NAPLAN reading scores, than children whose parents read to them less frequently (Yu & Daraganova 2015) (see [Early learning](#)). Attending preschool programs has also been found to be positively associated with year-3 NAPLAN results (Warren & Haisken-DeNew 2013) (see [Early learning](#)). School factors that affect outcomes can include:

- quality of schooling
- availability of interventions and support
- student commitment
- proximity of the school and other educational facilities to students' homes (ACARA 2015).

Closing the gap in literacy and numeracy national minimum standard achievement rates between Indigenous and non-Indigenous children was a key priority of the Closing the Gap framework established by the Council of Australian Governments (COAG) in 2018. In 2018, 77.2% of Indigenous Year 5 students achieved the national minimum standard for reading, and 81.4% for numeracy (ACARA 2018).

Although the target was not met, for Year 5 there were substantial improvements with the gap narrowing in reading and numeracy. Targets for the Closing the Gap Refresh agenda are not yet finalised (PM&C 2019).

Box 1: Data sources on literacy and numeracy

Australia's National Assessment Program has several components (see [Child learning and development](#)). The components discussed in this section are the:

- National Assessment Program – Literacy and Numeracy (NAPLAN)
- national sample assessments of civics and citizenship information, communication technology literacy, and science literacy
- international assessments, Progress in International Reading Literacy Study (PIRLS), Trends in International Mathematics and Science Study (TIMSS) and Programme for International Student Assessment.

National Assessment Program – Literacy and Numeracy

NAPLAN tests have been conducted annually for all students across Australia in years 3, 5, 7 and 9 since 2008. They give nationally comparable data. National minimum standards have been developed for reading, writing, spelling, language conventions (grammar and punctuation) and numeracy.

Data in this section are expressed in terms of the percentage of students who achieved at or above the national minimum standard (sometimes abbreviated in this section as the achievement rate). This is in line with national reporting for the Children's Headline Indicators. However, the indicator has limitations as more than 90% of students usually meet this and the standard can change.

In 2006, the 19 priority areas of the Children's Headline Indicators were endorsed by 3 ministerial councils, 1 focusing on health, 1 on education, and 1 on community and disability services. There is scope for a comprehensive review of these areas and the indicators to ensure they reflect contemporary information needs.

The focus in this section is on Year 5 students in line with indicator reporting for Children's Headline Indicators.

By Year 5, students have had an opportunity to build on the outcomes achieved in Year 3 and are able to demonstrate progress across several years of schooling. The national minimum standard is the agreed minimum acceptable standard of knowledge and skills without which a student will have difficulty making sufficient progress at school (ACARA 2018).

In 2018, NAPLAN participation rates for Year 5 students were 95.3% for reading and 94.8% for numeracy (ACARA 2018).

Progress in International Reading Literacy Study

PIRLS is an international comparative study of the reading literacy of students at Year 4, directed by the International Association for the Evaluation of Educational Achievement. The study has been conducted on a 5-year cycle since 2001. Australia has participated in the 2 most recent cycles—PIRLS 2011 and 2016 (Thomson et al. 2017a). Australia will also be participating in 2021.

In 2016, more than 580,000 Year 4 students in 50 countries from around the world took part. In Australia, 6,341 Year 4 students from 286 primary schools participated (Thomson et al. 2017a).

Trends in International Mathematics and Science Study

The TIMSS is an international comparative study of student achievement in maths and science at Year 4 and Year 8 directed by the International Association for the Evaluation of Educational Achievement. The study has been conducted on a 4-year cycle since 1995. Australia has participated since inception.

In 2015, more than 580,000 Year 4 and Year 8 students in 57 countries from around the world took part. In Australia, 6,057 Year 4 students from 287 primary schools participated and 10,338 Year 8 students from 285 secondary schools participated (Thomson et al. 2017b).

How many students achieve at or above the minimum standards for reading and numeracy?

In 2018, most Year 5 students achieved at or above the minimum standards for reading (95%) and numeracy (96%) (Figure 1). A higher proportion of girls (96%) than boys (94%) achieved at or above the minimum standard for reading. Similarly, a higher proportion of girls (96%) than boys (95%) in Year 5 achieved at or above the minimum standard for numeracy.

Most Year 3 (96%) and Year 7 (94%) students also achieved at or above the reading minimum standards. Similarly, 96% of both Year 3 and 7 students achieved at or above the numeracy minimum standards.

Girls were more likely to achieve at or above reading and numeracy standards for both years 3 and 7 (Figure 1).

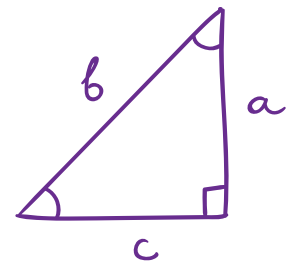


Figure 1: Students achieving at or above the national minimum standards for reading and numeracy, years 3, 5 and 7, 2018 (%)

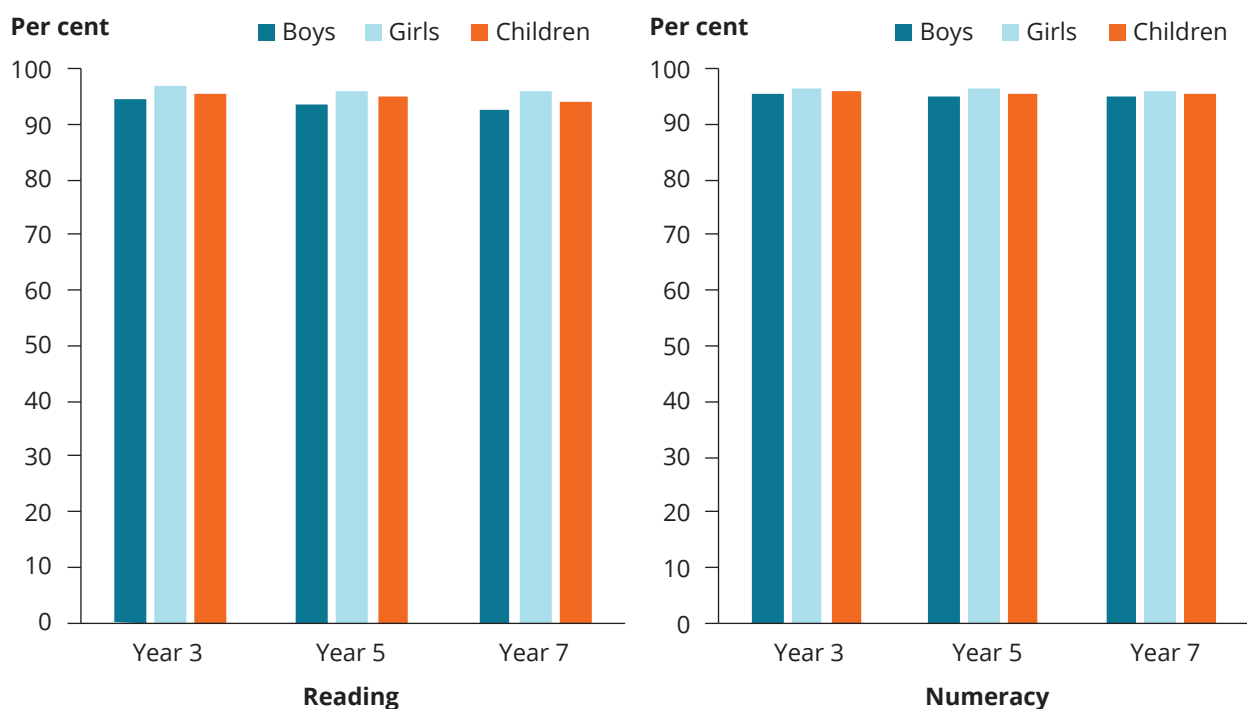


Chart: AIHW. Source: ACARA 2018.

Have literacy and numeracy rates changed over time?

Between 2008 and 2018, the proportion of Year 5 students who achieved at or above the national minimum standard for reading increased 4 percentage points (91% to 95%). This pattern was the same for boys and girls (Figure 2). The reading mean score for Year 5 students also increased significantly from 484.4 to 509.3:

- for boys it increased significantly from 478.4 to 505.1
- for girls it increased from 490.7 to 513.7 (ACARA 2018).

Similarly, the proportion of Year 5 students who achieved at or above the national minimum standard for numeracy increased from 93% in 2008 to 96% in 2018. The pattern was the same for boys and girls (Figure 2). The numeracy mean score for Year 5 students also increased significantly from 475.9 to 494.0:

- for boys it increased significantly from 481.6 to 498.7
- for girls it increased from 469.9 to 489.2 (ACARA 2018)

Over the same period, there was improvement in Year 3 reading achievement, but no change in numeracy achievement. There was no overall change for Year 7 students in reading or numeracy (ACARA 2018).

Box 2: Preliminary NAPLAN 2019 results

National 2019 preliminary results for Year 5 reading released in August 2019 indicate that 94.9% of students achieved at or above the national minimum standard. These results are the same as the 2018 final results.

For Year 5 numeracy, the national 2019 preliminary results showed almost no change from the 2018 final results (95.6% and 95.7%, respectively) (ACARA 2019b).

Figure 2: Students achieving at or above the national minimum standards for reading and numeracy, 2008 to 2018 (%)

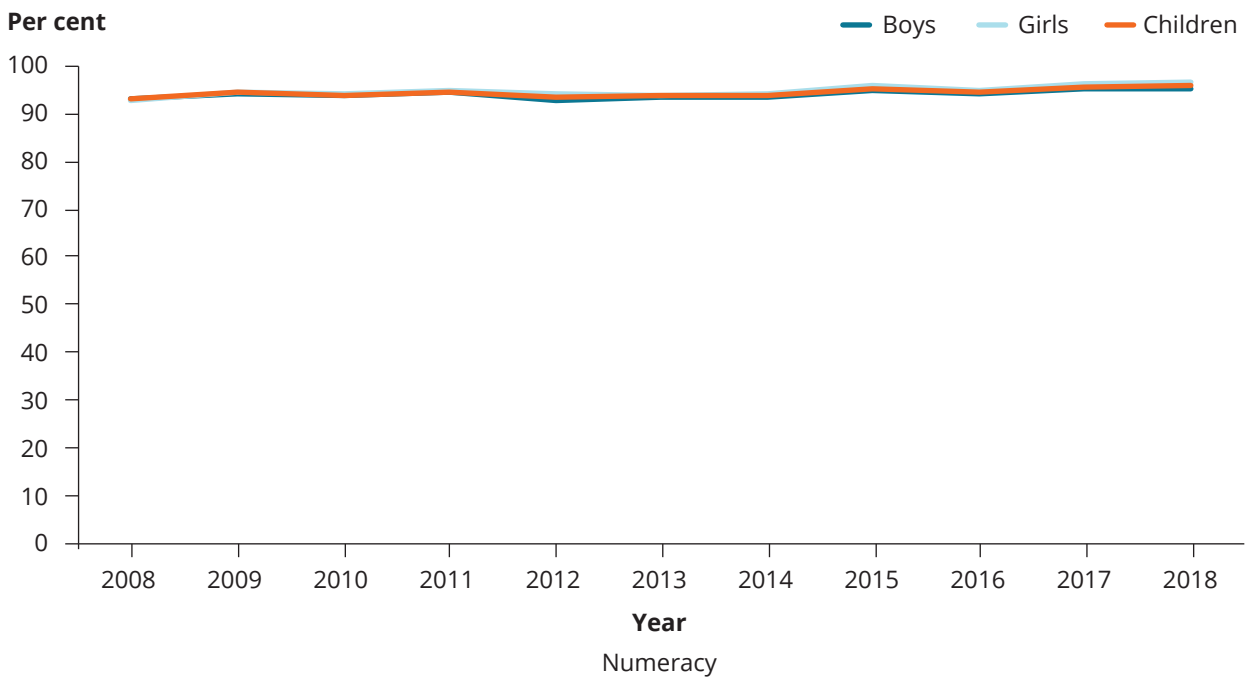
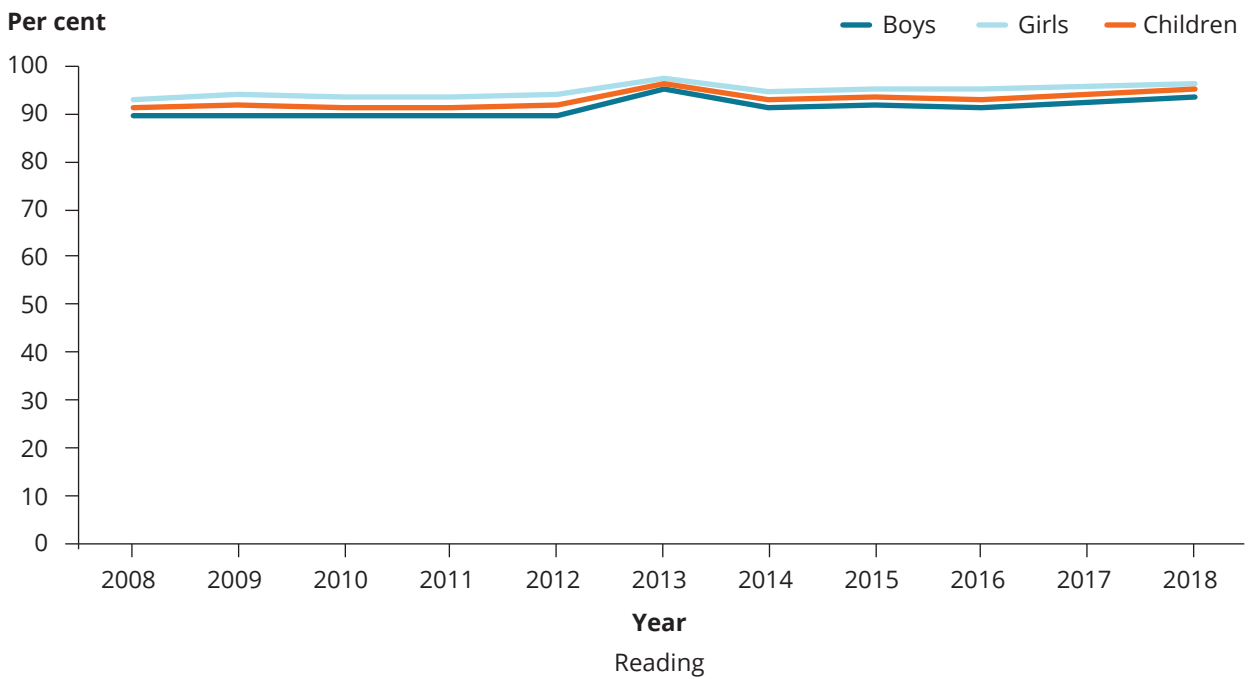


Chart: AIHW. Source: ACARA 2018.

Are literacy and numeracy rates the same for everyone?

In 2018, Year 5 students from schools in *Remote* (85%) and *Very remote* (54%) areas were less likely to achieve at or above the reading minimum standards than those from schools in *Major cities* (96%) (Figure 3). For numeracy, the corresponding proportions were 89% and 61%, compared with 96% (Figure 4).

Year 5 students with a language background other than English (LBOTE) were slightly less likely to achieve at or above the minimum standards in reading (93%) and numeracy (95%) than their non-LBOTE counterparts in 2018 (96% and 96%, respectively).

There were differences in achievement rates between Year 5 Indigenous and non-Indigenous students for reading (77% and 96%, respectively). The gap was slightly narrower for numeracy (81% and 97%, respectively).

Figure 3: Year 5 students achieving at or above the national minimum standards for reading, by selected population groups, 2018

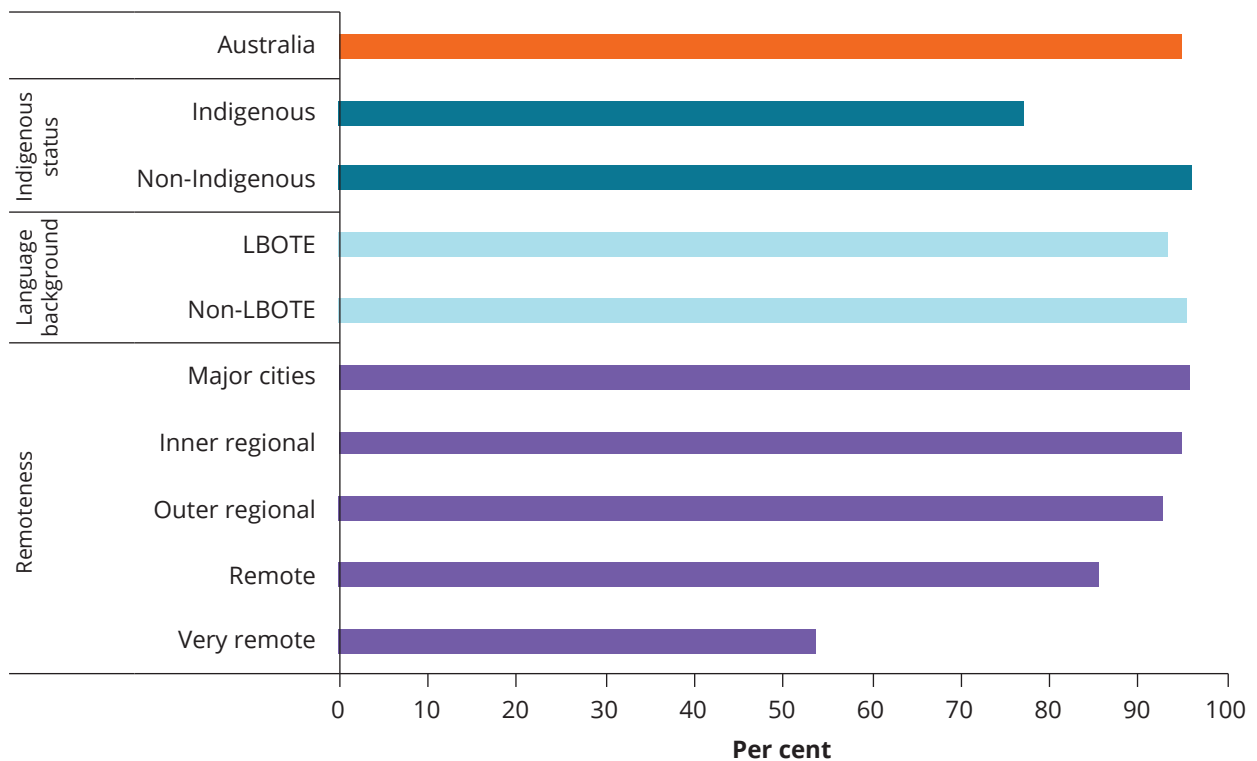


Chart: AIHW. Source: ACARA 2018.

Figure 4: Year 5 students achieving at or above the national minimum standards for numeracy, by selected population groups, 2018

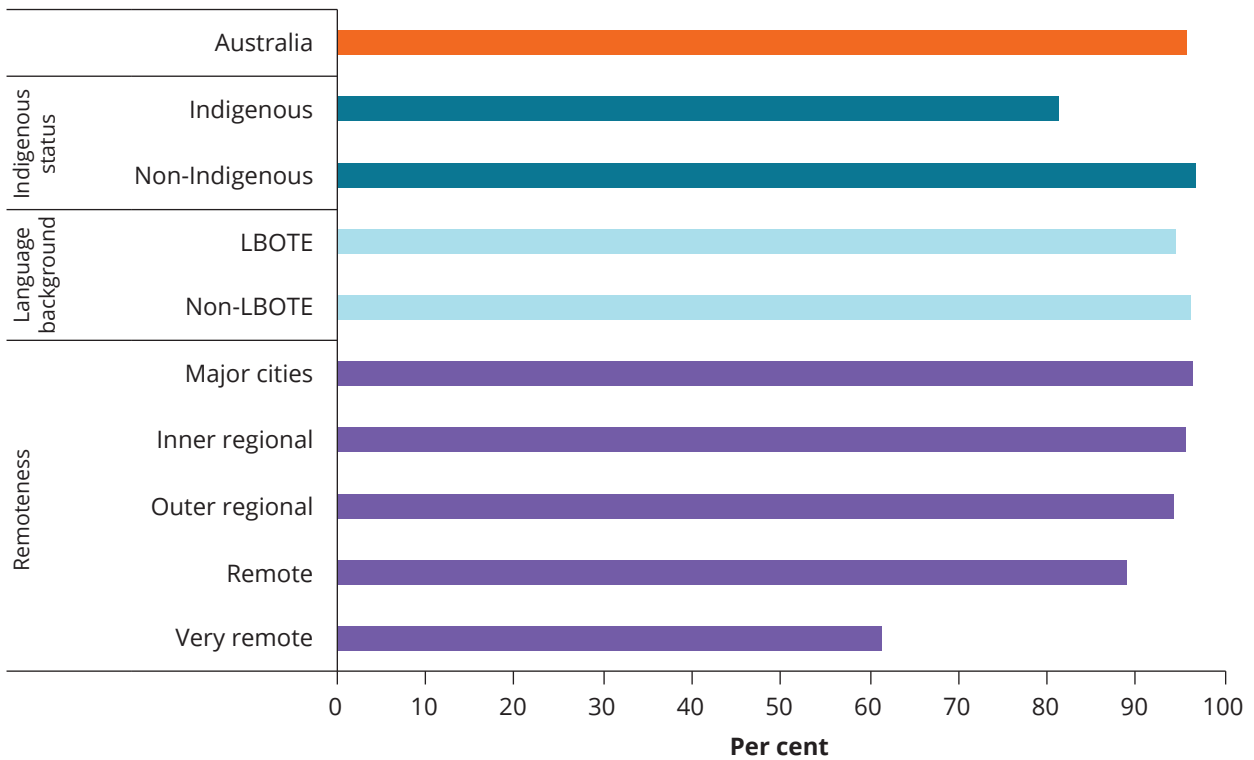


Chart: AIHW. Source: ACARA 2018.

Closing the Gap targets in literacy and numeracy

For Year 5 students, the COAG target to halve the gap in the proportion of Indigenous children at or above national minimum standards in reading and numeracy within a decade (by 2018) was not achieved. However, there have been substantial improvements with the gap narrowing. The proportion of Year 5 students at or above national minimum standards in reading increased by around 14 percentage points (63% in 2008 to 77% in 2018). For numeracy the increase was around 12 percentage points (69% in 2008 to 81% in 2018).

In 2018, the difference between Indigenous and non-Indigenous students increased with increasing remoteness:

- for reading, from 11 percentage points in *Major cities* (85% for Indigenous students compared with 96% for non-Indigenous students) to 58 percentage points in *Very remote* areas (93% compared with 36%)
- for numeracy, from 9 percentage points in *Major cities* (88% compared with 97%) to 49 percentage points in *Very remote* areas (46% compared with 96%) (Figure 5).

$$a^2 + b^2 = c^2$$

Figure 5: Year 5 students achieving at or above the national minimum standards for reading and numeracy, by Indigenous status, by remoteness, 2018

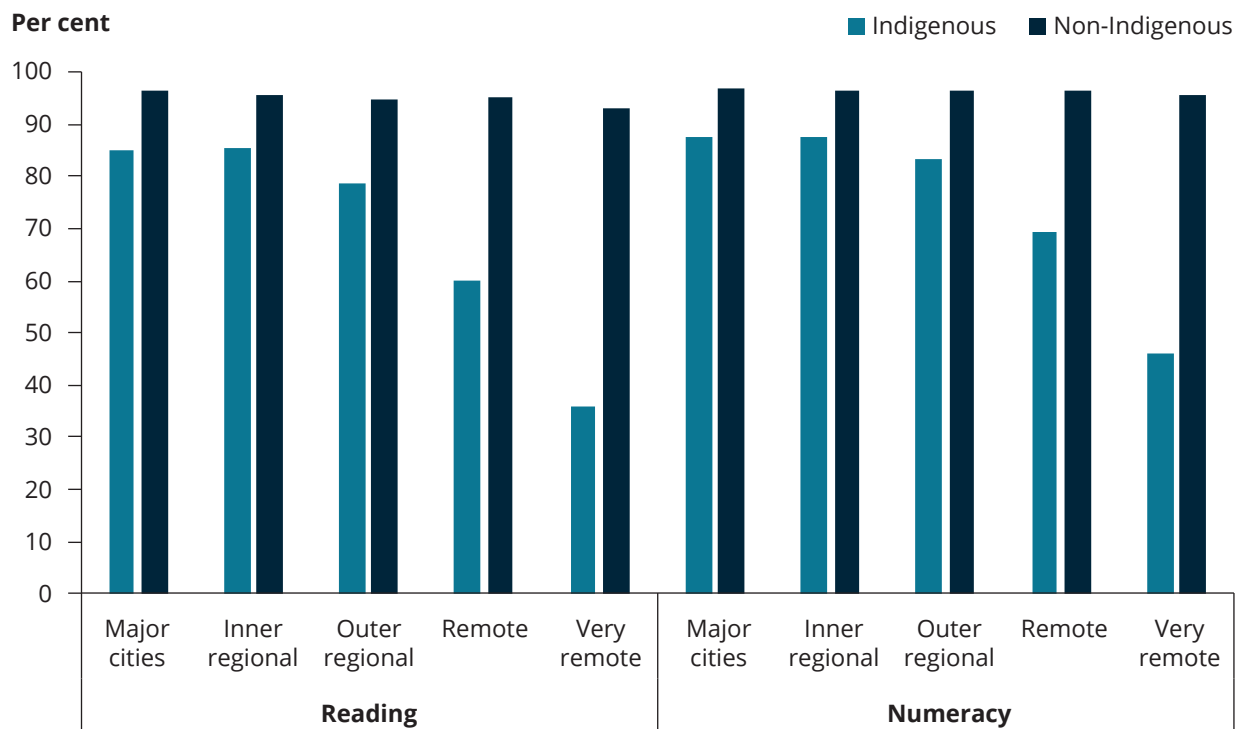


Chart: AIHW. Source: ACARA 2018.

Parental education and occupation

Most (98%) Year 5 students whose parents hold a bachelor’s degree or higher achieved at or above the national minimum standard for reading. At least 93% of students whose parents completed Year 12 or higher achieved at or above the national minimum standard in reading compared to 83% of students whose parents had not completed Year 12 (Figure 6).

Figure 6: Year 5 students achieving at or above the national minimum standards for reading, by parental education, 2018

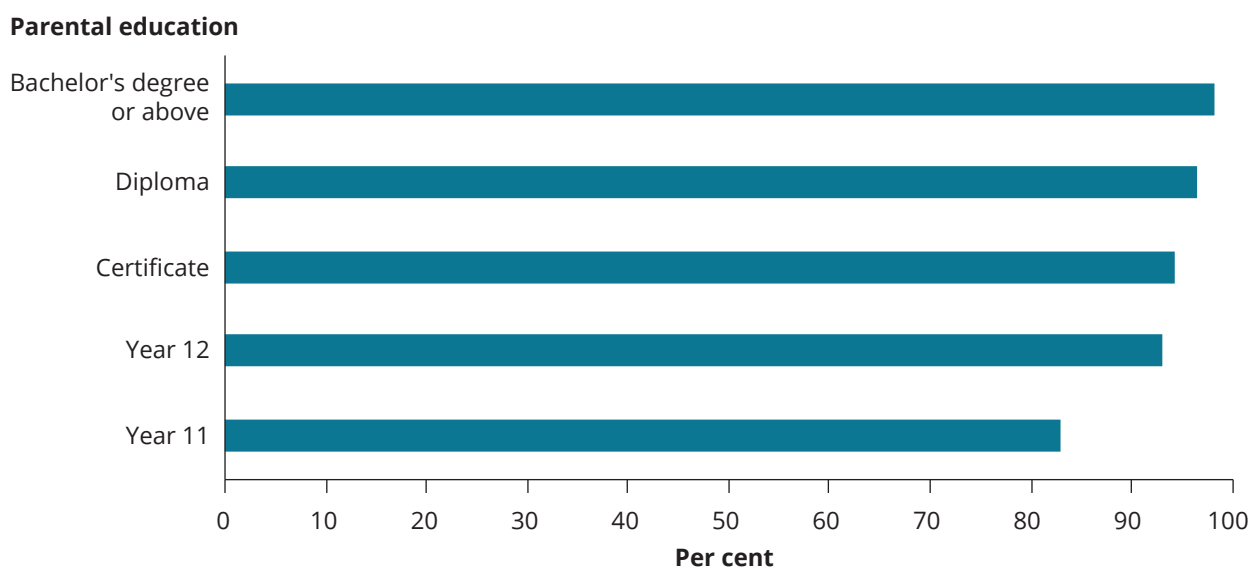


Chart: AIHW. Source: ACARA 2018.

Similar to reading, most (99%) Year 5 students whose parents hold a bachelor's degree or higher achieved at or above the national minimum standard for numeracy (99%). At least 94% of students whose parents completed Year 12 or higher achieved at or above the national minimum standard in reading compared to 86% of students whose parents had not completed Year 12 (Figure 7).

Figure 7: Year 5 students achieving at or above the national minimum standards for numeracy, by parental education, 2018

Parental education

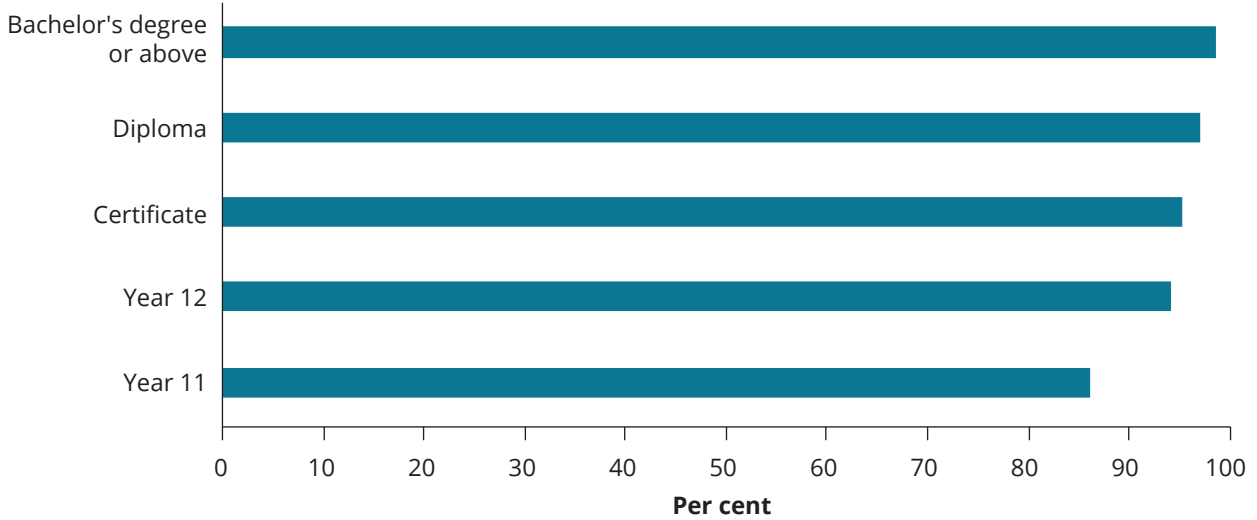
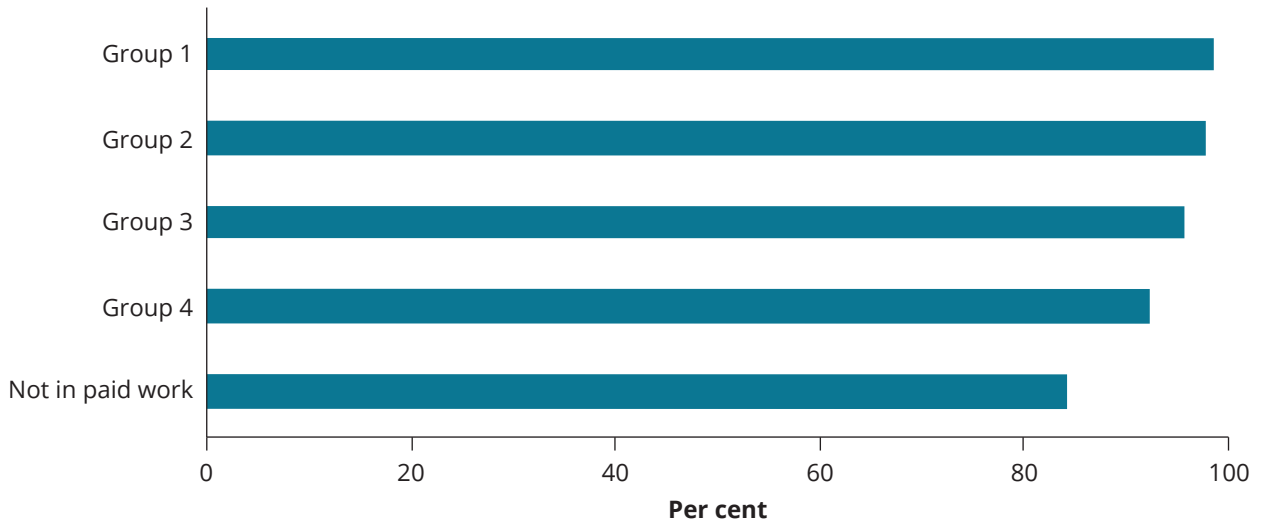


Chart: AIHW. Source: ACARA 2018.

The percentage of students who scored at or above the national minimum standard for reading or numeracy is also associated with parental occupation. Year 5 students with parents in Occupation Group 1 (which includes senior managers and qualified professionals) have the highest percentage of students who achieved at or above the national minimum standard for reading (99%). At least 92% of students whose parents were in paid work achieved at or above the national minimum standard in reading compared to 84% of students whose parents were not in paid work (Figure 8).

Figure 8: Year 5 students achieving at or above the national minimum standards for reading, by parental occupation, 2018

Parental occupation



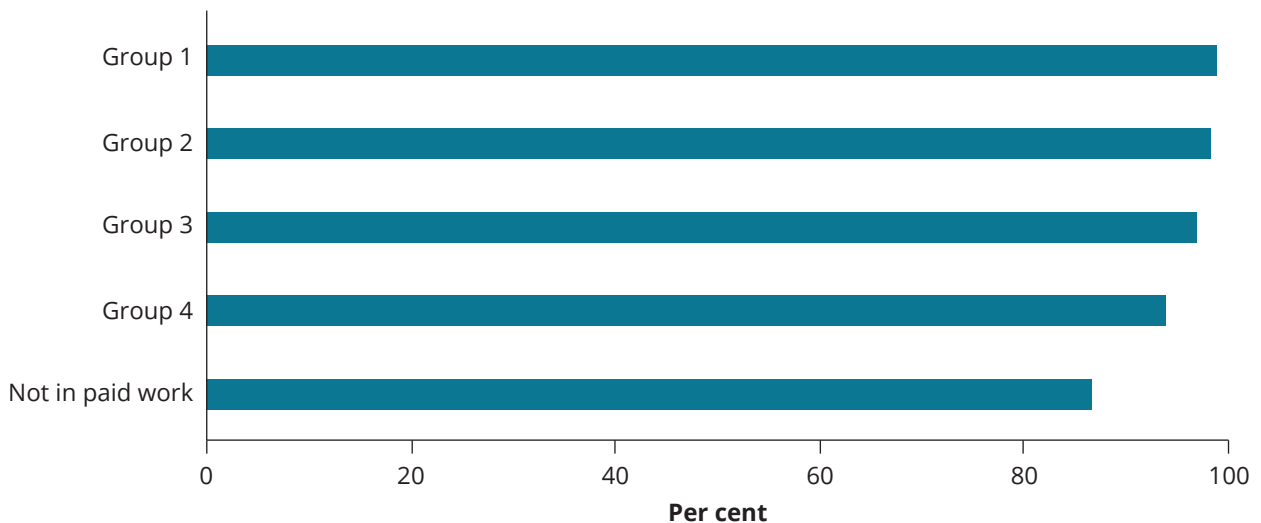
Note: Group 1: Senior management and qualified professionals; Group 2: Other business managers and associated professionals; Group 3: Tradespeople, clerks, skilled office, sales and service staff; Group 4: Machine operators, hospitality staff, assistants, labourers; Not in paid work: Not in paid work in the previous 12 months.

Chart: AIHW. Source: ACARA 2018.

Year 5 students with parents in Occupation Group 1 have the highest percentage of students who achieved at or above the national minimum standard for numeracy (99%). At least 94% of students whose parents were in paid work achieved at or above the national minimum standard in numeracy compared to 87% of students whose parents were not in paid work (Figure 9).

Figure 9: Year 5 students achieving at or above the national minimum standards for numeracy, by parental occupation, 2018

Parental occupation



Note: Group 1: Senior management and qualified professionals; Group 2: Other business managers and associated professionals; Group 3: Tradespeople, clerks, skilled office, sales and service staff; Group 4: Machine operators, hospitality staff, assistants, labourers; Not in paid work: Not in paid work in the previous 12 months.

Chart: AIHW. Source: ACARA 2018.

Children in care

Findings from data linkage of the Child Protection National Minimum Data Set with NAPLAN results found that in 2013, children in care were less likely to achieve at or above national minimum standards for literacy and numeracy than all students in Australia (Box 2 defines in care).

In 2013, 83% of Year 5 children in care achieved at or above the national minimum standard for literacy; 13 percentage points lower than the national rate (96%). For numeracy, the rate for children in care was 71%; 22 percentage points lower than the national numeracy rate (93%) (AIHW 2015). National minimum standard achievement rates for most domains generally decreased as year level increased from Year 3 to Year 9 (AIHW 2015).

It is important to note that the academic outcomes for children in care are likely affected by complex personal histories and multiple aspects of disadvantage (including poverty, maltreatment, family dysfunction and instability in care and schooling) (AIHW 2015). There is also evidence that children often have low educational performance when entering child protection services (AIHW 2015).

Box 2: Defining children in care

Children in care—for project which linked child protection data with NAPLAN data—is defined as children aged 0–17 whose care arrangements have been ordered through the Children’s Court, where parental responsibility for the child or young person has been transferred to the Minister/Chief Executive. Most children in care are also out-of-home care, but some are not.

Data are included for children from 6 jurisdictions (NSW, Vic, WA, Tas, ACT and NT).

The child population described in this section participated in 2013 NAPLAN testing for years 3, 5, 7 or 9 and were in care at the time of testing (14–16 May 2013) (AIHW 2015).

At the time of testing, around one-third of the study population had been in their current care situation (order or living arrangement) for less than 1 year.

Children with mental health issues

Average NAPLAN test scores for student with mental disorders were lower compared with those with no mental disorder across all domains (Grammar, Reading, Spelling, Writing, and Numeracy), and all year groups (3, 5, 7, and 9) (Goodsell et al. 2017). These findings are based on data from the 2013–14 Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Young Minds Matter) and participating children’s NAPLAN results from 2008–2016.

The proportions of students who perform at or above the national minimum standard were also lower for those with a mental disorder than for those without a mental disorder (Goodsell et al. 2017).

How does Australia compare internationally?

Literacy

In 2016, on average, Australian students performed better in the international PIRLS assessment for literacy, than students in 24 countries, including 3 other countries that tested in English: New Zealand, Trinidad and Tobago, and Malta. However, Australian students were outperformed by students in 13 countries, including Singapore, Hong Kong, Ireland, Northern Ireland and England (all testing in English), as well as the Russian Federation, Finland and Poland. The top performing countries were Singapore, Russian Federation and Hong Kong (Thomson et al. 2017a).

Of the participating Australian students, 16% performed very well (reached the Advanced international benchmark). This compares with:

- 29% of students in Singapore
- 26% in the Russian Federation
- 22% in Northern Ireland (Thomson et al. 2017a).

The average score for Australian students on PIRLS 2016 was 17 points higher than in PIRLS 2011, a statistically significant difference (Thomson et al. 2017a).

Numeracy

In 2016, Australia's average score on TIMSS for Year 4 students was 517 points. Australian students significantly outperformed students in 20 other countries, including Italy, Spain and New Zealand. However, Australian Year 4 students were outperformed by students in 21 other countries, including Northern Ireland, Ireland, England and the United States, as well as the participating East Asian countries Singapore, Hong Kong, Korea, Chinese Taipei and Japan (Thomson et al. 2017b).

Australia's 2015 Year 4 mathematics score is significantly higher than the corresponding score in 1995. This, however, is due to a single increase recorded in TIMSS 2007 with no change in the following years. For the past 3 cycles, Australia's Year 4 mathematics scores have remained the same (Thomson et al. 2017b).

Of the participating Australian students, 9% performed very well (achieved the Advanced international benchmark in mathematics), compared with 50% of students in Singapore and 27% in Northern Ireland.

Students who have many books in the home were found to score 19 score points higher than students with an average number of books in the home, and 74 score points higher than those who reported having a few books in the home (Thomson et al. 2017b).

Data limitations and development opportunities

Linkage of national data to improve understanding of children's educational outcomes, pathways and transitions, especially for priority populations, will give opportunities to enhance national reporting in the future.

For more information, see 'What's missing?' in [Child learning and development](#).

Where do I find more information?

For information on:

- NAPLAN results for Indigenous children, see: [Indigenous children](#)
- NAPLAN results, see: [Literacy and Numeracy in Children's Headline Indicators](#)
- NAPLAN, see: [NAPLAN national reports](#) and [Child and adolescent mental health and educational outcomes report](#).
- international literacy and numeracy results, see: [Progress in International Literacy Study \(PIRLS\)](#) and [Trends in International Mathematics and Science Study \(TIMSS\)](#)
- technical notes, see [Methods](#).

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Social
support

Social support

Social support comes in many forms, but broadly covers ‘support accessible to an individual through social ties to other individuals, groups, and the larger community’ (Lin et al. 1979).

Informal social support often comes from family, friends and community—people close to the individual.

Formal support refers to services and programs provided by government and non-government organisations, designed to enhance wellbeing. For children, social support provided to their parents, families and carers is also essential as it can influence the quality of social support they get directly and play a crucial role in how a child develops and their overall wellbeing (Department of Health 2019; Zubrick 2008).

Measures such as family cohesion and social networks are commonly used to examine social support. So too are measures of factors that may influence the nature of social support available to a child, such as parental health or drug use.

Drawing on sources providing different perspectives of social support, this domain aims to provide an overview of the types and quality of informal social support structures for children. Information on formal support provided to children could be the topic of future reports, noting some national [data gaps](#).

This domain has significant overlap with other domains. Strong social support can be a protective factor from negative outcomes discussed in other domains (for example, [neighbourhood safety](#), [family economic situation](#) and [housing stress](#)). In combination with individual circumstances, it can also potentially impact the quality and extent of other social support (WHO 2017; Worthen & Ahern 2013; Umberson & Montez 2010).

Many topics covered in this domain are also interrelated and there is overlap in the data presented throughout topic-based sections. For example, children who have strong family cohesion [families](#) may also have strong [social networks](#).

The governance supporting children’s access to social support

While parents, carers and other members of a child’s social network, for example friends and other family, play the primary role in providing children with adequate and appropriate social support, government and the wider community also play an important role.

Australian Commonwealth legislation provides the foundation for delivery of a wide range of formal social support to parents and families, according to specific criteria. Legislation related to social security (*Human Services (Centrelink) Act 1997*) and paid parental leave (*Paid Parental Leave Act 2010*) are some examples.

A range of other formal social support services are provided by states and territories and/or local governments, for example in the areas of disability, family support and community services.

Related national strategies for children

Ensuring that children and their families have access to quality informal and formal social support is a priority in national strategies and/or initiatives relevant to this domain (Table 1).

Table 1: National strategies and/or initiatives relevant to social support

Strategy and/or initiative
National Action Plan for the Health of Children and Young People: 2020–2030
National Framework for Protecting Australia’s Children 2009–2020, including the Fourth Action Plan 2018–2020
Select Committee on Intergenerational welfare dependence
Stronger places, stronger people
Australian Student Wellbeing Framework
Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health

What’s missing?

The sections in this domain include a number of established national indicators; however, consistent national reporting is not available in some areas due to lack of a suitable data source and/or indicator. For more information on national data gaps, see [Data gaps](#).

A number of topics were not included for other reasons but could be considered for future updates.

Children’s subjective view of their social support

There are currently limited national data on children’s view of their social support to support population monitoring. Subjective data have been included for a number of topics; however, there are some gaps relating to how children personally view their wellbeing, their community involvement and topics relating to family and community functioning. For example, there is no overarching national measure from the child’s perspective on how well their family gets along, or the strength and quality of their personal social networks.

Cultural identity

Cultural identity is an integral part of wellbeing for Aboriginal and Torres Strait Islander and culturally and linguistically diverse children and families. Development of cultural identity is supported by formal and informal social support structures.

Pathways, transitions and outcomes

National data on the longer-term outcomes of children receiving different types of formal and informal social support are lacking. Improved availability of data on some formal support, such as family support services, would assist. Sensitively combining information from multiple datasets, for example Centrelink recipient data with other data sources like health services or education, could improve understanding of the impact of formal social support on children.

Priority populations

Data on social networks for children from priority populations, such as children with disability, living in out-of-home care, or in shared parental care, are limited. The Longitudinal Study of Indigenous Children (LSIC) could be explored in future updates as a way of improving information on Indigenous children for topics covered in this domain.

Family functioning

The **families** section reports on some aspects of family functioning; however, there are some information gaps. For example, there is no nationally representative estimate of the number of children in shared care, or comprehensive data on the time a child spends with parents. Other areas which could be further explored include measures of warmth, responsiveness, sensitivity and security/safety provided by family members.

Parenting

All sections in this domain highlight the importance of parents, parenting practices and parent characteristics. However, parenting is a complex topic which is difficult to measure. Factors increasing the risk of poor parenting, for example data on children exposed to domestic violence, are limited.

Play and extracurricular activities

Some evidence shows the benefits of unstructured play without strict time restrictions for children. While some data are available, there is no regular and comprehensive reporting on how children typically spend their time, including in unstructured play. Similarly, children can further develop their social networks through participating in activities outside the home and school. While the AusPlay survey is a source for children participating in sport, there is currently no national population-level monitoring of participation in other extracurricular activities such as music, language or dance.

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Families

Key findings

- Data from the Longitudinal Study of Australian Children (LSAC) in 2016 estimated that 9 out of 10 primary carers of children aged 12–13, said their family's ability to get along with one another was good, very good or excellent.
- According to the 2014 Australian Child Wellbeing Project (ACWP), 59% of children with disability spent time having fun together with their family most days in the week—less than children who do not have disability (73%) (2014 ACWP).
- Data from LSAC in 2016 show that 9 out of 10 children aged 12–13 would talk to their mum and/or dad if they had a problem.
- 3 out of 5 children spent time taking care of their siblings or other family members at least once a week.

For most children, their family offers them love, support and a sense of belonging. While what constitutes a family can vary widely, the benefits of being part of a strong and positive family unit are more universal. A strong and positive family unit can:

- help children form social networks
- provide children with resources, care and a safe place to learn and explore
- teach children about the world and the rules that govern it (Scott 2013; Pezzullo et al. 2010).

Families are also considered to be an important determinant of how children view quality of life, with family ranked the most important domain for having a good life by all year levels participating in the 2014 ACWP (Redmond et al. 2016). Being part of a strong, positive family unit is known as positive family functioning. For this section, family functioning has been considered in terms of 6 overlapping domains (Table 1).

Table 1: Domains of family function

Domain	Characteristics include
Emotional	Closeness of relationships, warmth, responsiveness, sensitivity, support, community, and security/safety.
Governance	Age-appropriate rules, expectations and consistency in parenting.
Engagement and cognitive development	Family cohesion and quality time spent fostering various skills and interests.
Physical health	Access to services, products and activities aimed at improving or maintaining good physical health.
Intra-familial relationships	Quality of relationships between family members and their overall ability to get along with one another.
Social connectivity	Involvement in, and support of, activities and relationships outside the household.

Source: Pezzullo et al. 2010.

While most children live in a house where some or all aspects of their family are positively functioning, not all children do. For some children, families may not be able to provide a safe and supportive environment and the children may experience [abuse or neglect](#) and may end up living in [non-parental care](#).

There is no single overarching measure of family functioning and measurement is complex, given the concept is multi-dimensional.

This section provides a selection of national data which relate to 5 of the 6 domains of family functioning (Box 1).

Box 1: Measuring family functioning

Data from the [LSAC](#) and [ACWP](#) are used to provide insight into these domains of family functioning:

- emotional
- governance
- engagements
- cognitive development
- intra-familial relationships.

These domains are structured in 4 subsections:

1. **Relationships** examines how well families get along by reporting how often children believe their family members yell at each other and parent rating of family's ability to get along (LSAC).
2. **Family cohesion** reports the amount of quality time children spend with their family, including talking, having fun or learning (ACWP).
3. **Parenting** examines the emotional support children get from their parents by reporting the number of children who would talk to their mum and/or dad if they had a problem (LSAC). It also reports on the consistency of parenting (LSAC) and parental interest in school and homework (ACWP).
4. **Contributions to the household** examines the governance structures in the family by reporting on the amount of time children spent doing housework or caring for other family members (ACWP) and parent perception of their contributions to housework and child-rearing tasks.

A selection of statistically significant comparisons between population groups has been included for each of these subsections.

Some data relevant to other family functioning domains are available in [Health](#) and [Social networks](#).

Relationships

Conflict—or lack of conflict—is 1 measure of the quality of a family's relationships and ability to get along. Conflict among members, especially between parents, has been associated with negative outcomes for children, including higher rates of aggression, anxiety, depression and physical health problems (Davies & Cummings 1994; Zubrick et al. 2008).

Conflict between family members can be exacerbated by factors including:

- stressful life events
- family member with poor health or disability
- money troubles
- conflicting priorities outside the house (Hartley et al. 2017; Schermerhorn et al. 2017).

What constitutes conflict can range in severity from a disagreement between members to **family violence**. One indicator of the degree of family conflict is the amount people yell at each.

It is estimated using data from LSAC in 2012 that 55% (or 134,000) of children aged 12–13 never or hardly ever had people in their family yell at each other—11% reported that yelling happened often/always. For families where the child was reported as needing or using more medical care, mental health or educational services than is usual for children the same age, 20% said people in their family often/always yelled at each other.

It is estimated using data from LSAC in 2016 that 90% (or 214,000) of primary parents (the child's primary carer), to children aged 12–13, said their family's ability to get along with one another was good, very good or excellent (Figure 1).

Figure 1: Rating of family's ability to get along with one another, parents of children aged 12–13, 2016

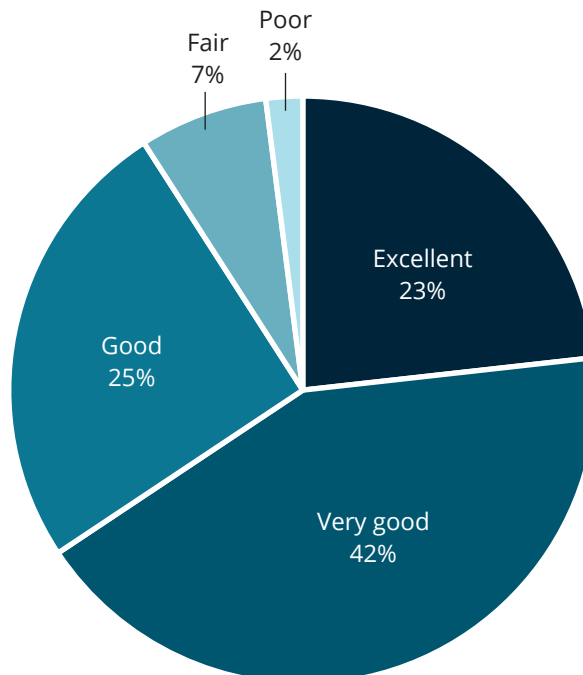


Chart: Australian Institute of Health and Welfare (AIHW). Source: AIHW analysis of the LSAC.

Family cohesion

Family cohesion refers to the quality time family members spend together that can lead to developing emotional bonds, boundaries, coalitions, shared interests and ability to make decisions together (Olson 1993; Redmond et al 2016).

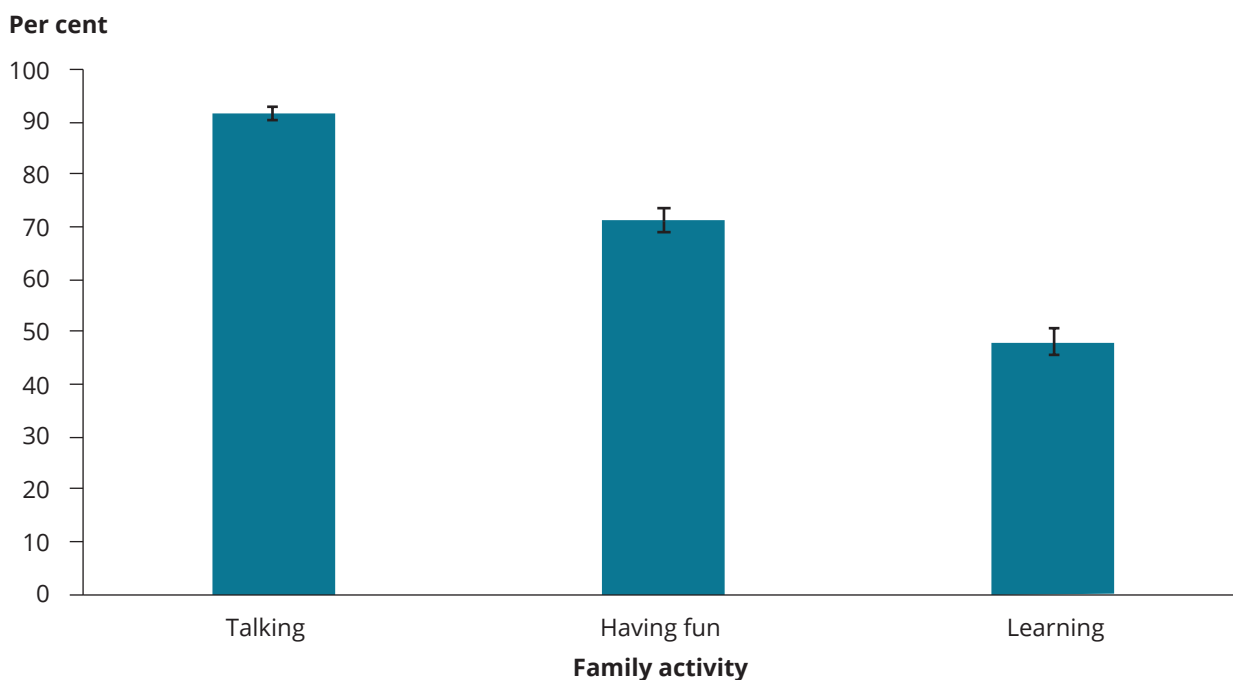
Strong family cohesion is associated with increased ability to cope with difficult situations, while lack of family cohesion is associated with:

- decreased ability to cope with problems
- increased social withdrawal
- anxiety
- depression
- delinquency
- aggressive behaviour (Altiere & von Kluge 2009; Hosseinkhanzadeh 2013; Joh et al. 2013).



The 2014 ACWP found that most children (94%) in years 4, 6 and 8, spent quality time with their family most days in the week before the survey (this includes at least 1 of talking, having fun or learning with their family most days—Figure 2).

Figure 2: Proportion of children who spent time most days talking, having fun and learning together with their family, 2014



Note: Children responded separately to each category so totals do not add to 100%.

Chart: AIHW. Source: AIHW analysis of the ACWP.

Children with disability spend less time having fun with their families

The 2014 ACWP found that 71% of children spent time having fun together with their family most days in the week before the survey (Figure 3). Responses differed for children with disability compared with children without disability (59% compared with 73%).

Figure 3: Proportion of children who spent time having fun together with their family most days in the week before the survey, by disability, 2014

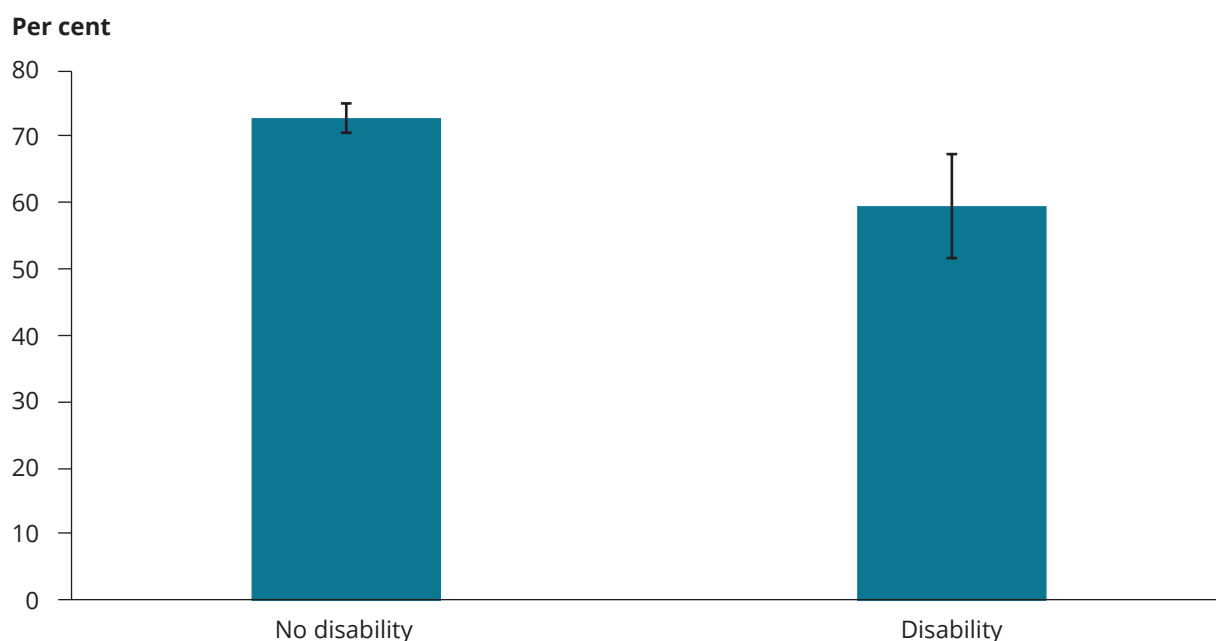


Chart: AIHW. Source: AIHW analysis of the ACWP.

1 in 2 children in years 4 and 6 spent time learning with their families most days

The 2014 ACWP found that about half (48%) of children spent time learning together with their family most days in the week before the survey (Figure 4). Older children were less likely to spend time learning together with their family—41% of Year 8 students reported spending time most days learning together with their family compared with 51% for Year 4 students and 52% for Year 6 students.

Figure 4: Proportion of children who spent time learning together with their family most days in the week before the survey, by school year, 2014

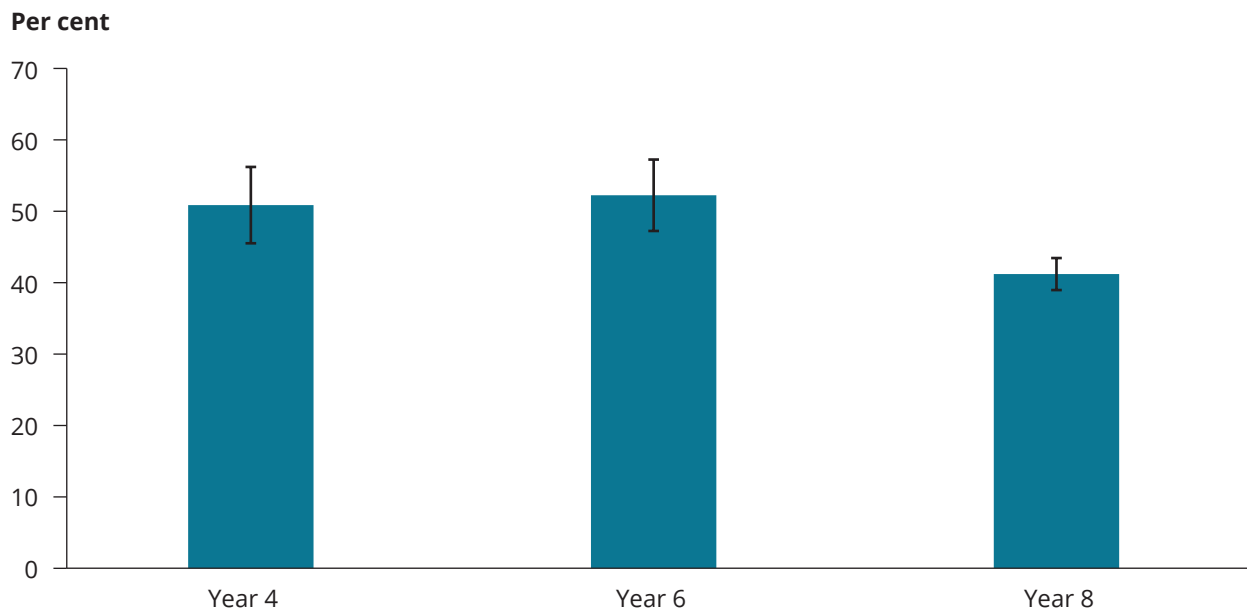


Chart: AIHW. Source: AIHW analysis of the ACWP.

Parenting

Parents play a key role in the overall functioning of a family. Parenting considered to be high quality and/or effective, tends to include elements of support (including presence of warmth and lack of hostility), consistency and interest in a child's life (Zubrick et al. 2008).

High quality and/or effective parenting has been linked to a wide range of positive child outcomes, including improved physical and mental health, cognitive development and educational attainment. Poor parenting has been associated with substance misuse, unemployment and juvenile offending (Davidov & Grusec 2006; Davis-Kean 2005; Repetti et al. 2002).

The quality and effectiveness of parenting can be influenced by factors including [parental health](#), parental education, culture and accessibility of resources, parenting and socioeconomic status are also positively related (Bornstein 2002; Davis-Kean 2005; Parenting Research Centre 2017; Zubrick et al. 2008).

Supporting parents to provide quality and effective parenting is considered important for improving the wellbeing of children and reducing social disadvantage (Department of Health 2019; Parenting Research Centre 2017; Parker & McDonald 2010). Looking at the concerns, needs and behaviours of parents, the [Parenting Today in Victoria survey](#) (Box 2) aims to understand parent experiences.

Box 2: Parenting Today in Victoria

The [Parenting Today in Victoria survey](#) was a 2016 state-wide survey. It was designed to explore the day-to-day experiences of today's parents. It looked at their attitudes, behaviours and practices, concerns and help-seeking behaviour.

Some key findings include:

- 41% of parents wished they did not become impatient with their child so quickly
- 28% felt they were sometimes too critical of their children
- 29% wished they were more consistent in their parenting behaviour
- 76% talked to their child about problems/issues quite a lot or very much
- 95% of parents reported agreeing with their partner on how to parent all or most of the time
- 62% of parents said they argued with, or yelled at, their child about their behaviour or attitude a little—28% not at all; 10% quite a lot or very much
- 93% of parents agreed or strongly agreed with the statement 'I know I am doing a good job as a parent'
- 89% of parents agreed or strongly agreed with the statement 'My parenting skills are effective'
- 91% of parents agreed or strongly agreed with the statement 'I have confidence in myself as a parent'
- 96% of parents agreed or strongly agreed with the statement 'I have all the skills necessary to be a good parent to my child'.

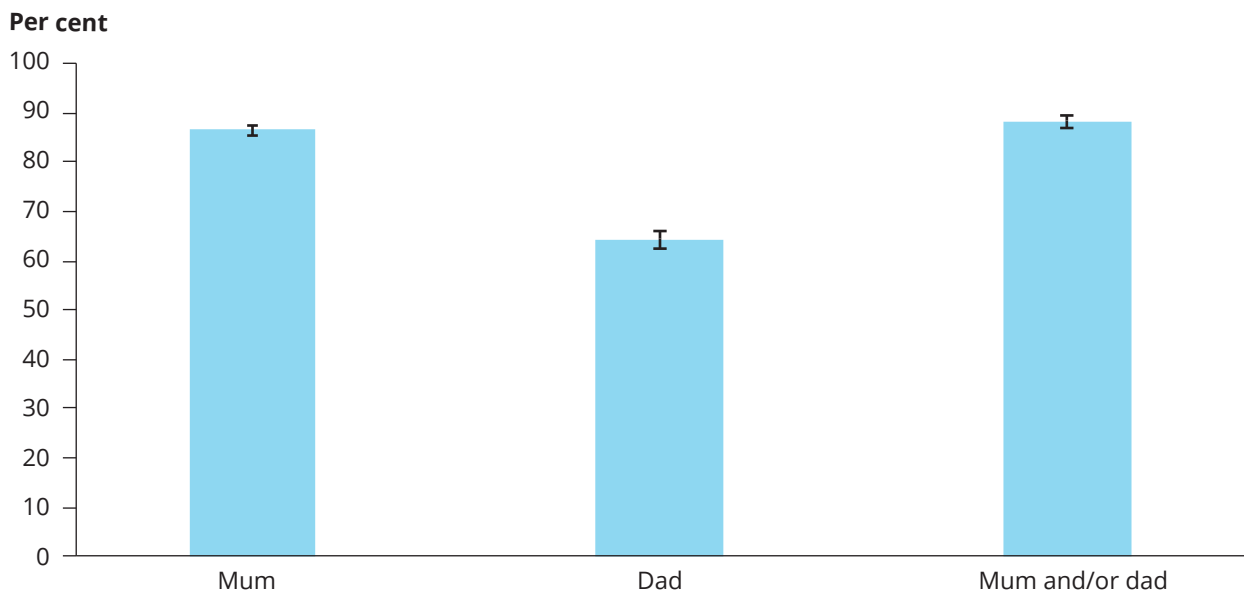
Most children rely on their parents for support when they have a problem

It is estimated using data from LSAC in 2016 that 88% (or 202,000) of children aged 12–13 would talk to their mum and/or dad if they had a problem (Figure 5).

Overall, children were more likely to talk to their mum than their dad (86% compared with 64%), with boys more likely to talk to their dad than girls (74% compared with 54%).



Figure 5: Proportion of children aged 12–13 who would talk to their parents if they had a problem, 2016



Note: Children may choose to speak to more than 1 person so totals do not add to 100%.

Chart: AIHW. Source: AIHW analysis of the LSAC.

Most parents are consistent in how they parent

It is estimated using data from LSAC in 2016 that, according to a consistent parenting scale 95%, or 221,000, primary parents to children aged 12–13 reported providing consistent parenting about half the time or more often (Box 3).

Box 3: Measuring consistent parenting

The LSAC consistent parenting scale is a series of 5 questions answered on a scale of 1 to 5. These questions ask both parents if they make sure their child does something when asked, and if they punish their child when they said they would. A score of 3 or higher indicates that parents provide consistent parenting about half the time or more often.

Children who attend schools in lower socioeconomic areas are less likely to have parents interested in homework

The 2014 ACWP found that most (85%) children said their parents asked them what they were learning in school weekly or more often. Similarly, 86% said their parents made sure they set time aside for their homework weekly or more often (Figure 6).

Children attending schools in the highest socioeconomic areas were more likely to say their parents made sure they set time aside for their homework weekly or more often compared with children attending schools in the lowest socioeconomic areas (89% compared with 81%, respectively).

There were also differences between Indigenous and non-Indigenous children (70% compared with 87%, respectively).

Figure 6: Proportion of children who said their parents made sure they set time aside for their homework weekly or more often, by socioeconomic position of school, 2014

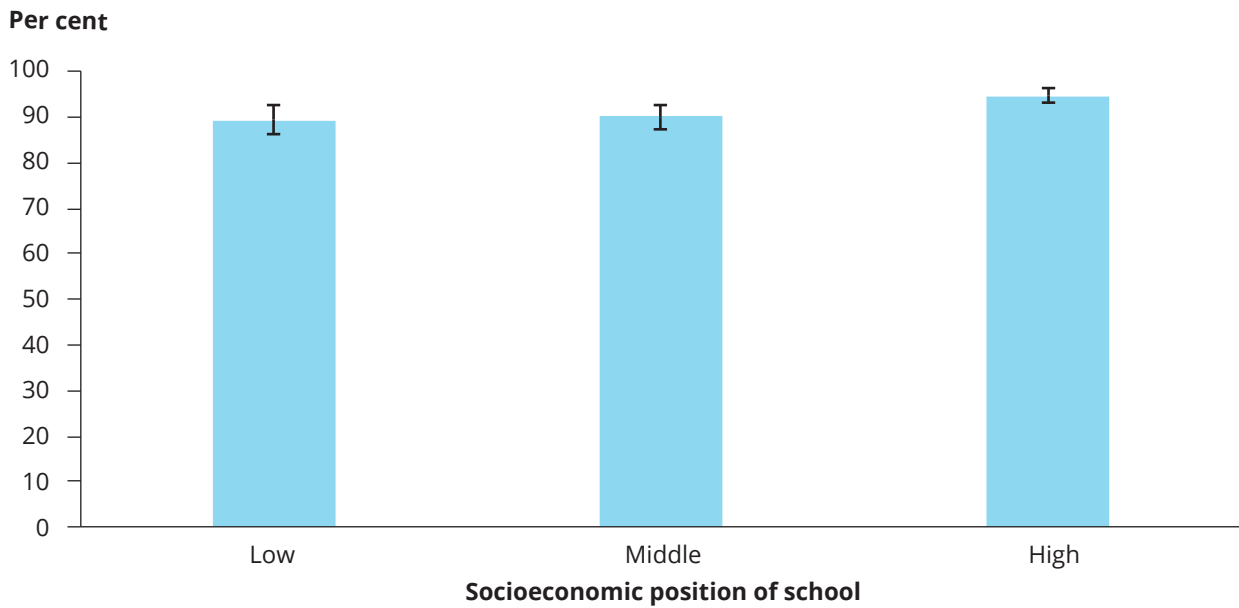


Chart: AIHW. Source: AIHW analysis of the ACWP.

More than half (56%) of students said their parents talk to their teachers at least once a term (Figure 7). This rate decreased with age, and Year 8 students (38%) were less likely to say their parents talk to their teacher once a term or more often than Year 4 and Year 6 students (68% and 61%, respectively).

Figure 7: Proportion of students who said their parents talk to their teachers at least once a term, by school year level, 2014

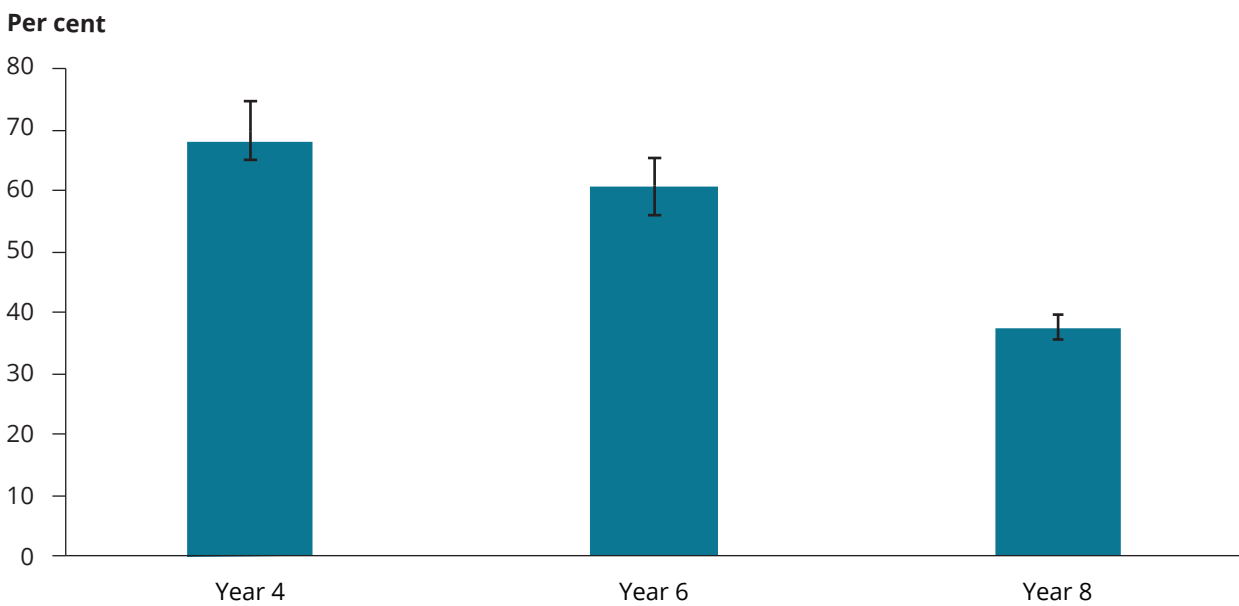


Chart: AIHW. Source: AIHW analysis of the ACWP.

Social support

Contributions to the household

Another aspect of families and how well they function is the perceived equity of member contributions to the household. The perception that the distribution of types of contributions—financial, household chores and child care—is fair to all members, has been associated with decreased tension and conflict, and increased cohesion (Cerrato & Cifre 2018; Newkirk et al 2017). What constitutes fair can differ dramatically depending on family factors including, but not limited to, agreed roles, age and capacity of individual members and [Parental health and disability](#) (AIFS 2015; Coltrane 2000; Putnick & Bornstein 2016)

Completing household chores, including looking after another family member, can serve as a way of teaching children important life skills, providing them with a sense of achievement and enabling them to earn rewards such as praise or pocket money—all contributors to positive wellbeing (Putnick & Bornstein 2016; The University of Minnesota 2014).

However, this is only in the case with age-appropriate chores and responsibilities (Putnick & Bornstein 2016).

4 out of 5 children help with housework at least weekly

The 2014 ACWP, which found a positive relationship between children who do housework and spend time caring for relatives and overall wellbeing, reported that almost 4 out of 5 (78%) students said they helped with housework weekly or more often (Redmond et al. 2016). Figure 8 shows, this rate increased with age, with Year 4 students (71%) less likely to say they helped with housework weekly or more often than year 6 and 8 students (81% and 82%, respectively).

The ACWP also found that 63% of children spent time taking care of their siblings or other family members at least once a week.

Figure 8: Proportion of children who spent time helping with housework weekly or more often, years 4, 6 and 8, 2014

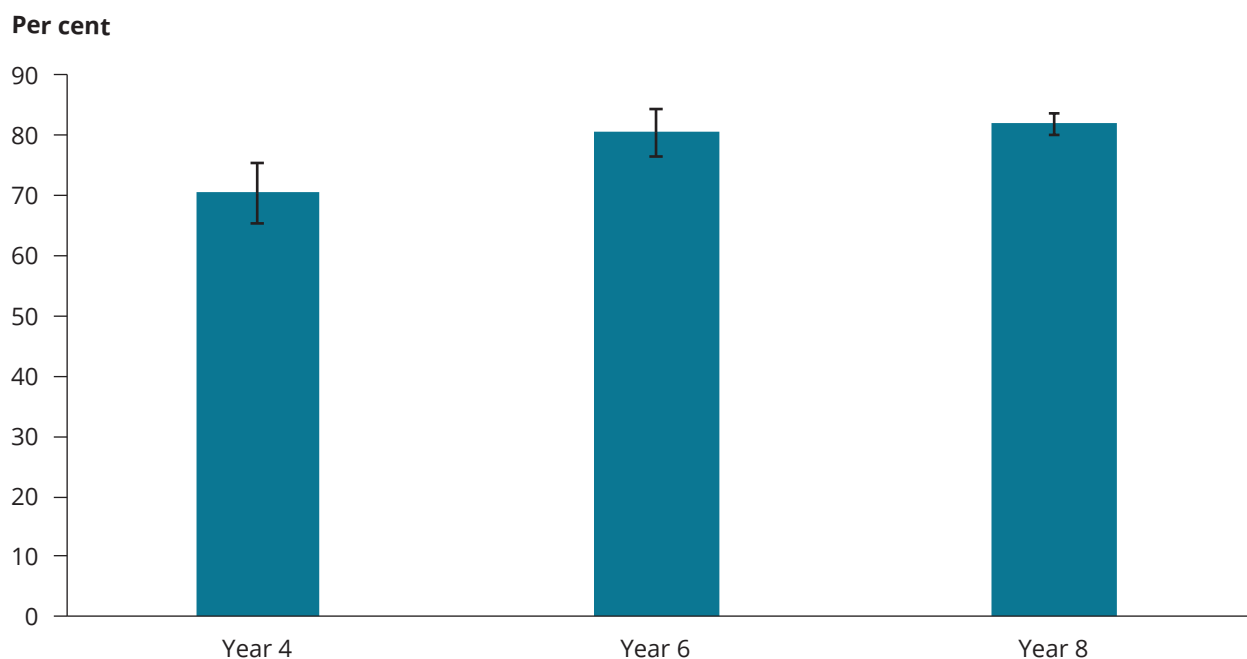


Chart: AIHW. Source: AIHW analysis of the ACWP.

Half of primary parents feel they do more than their fair share of domestic chores and child-rearing tasks

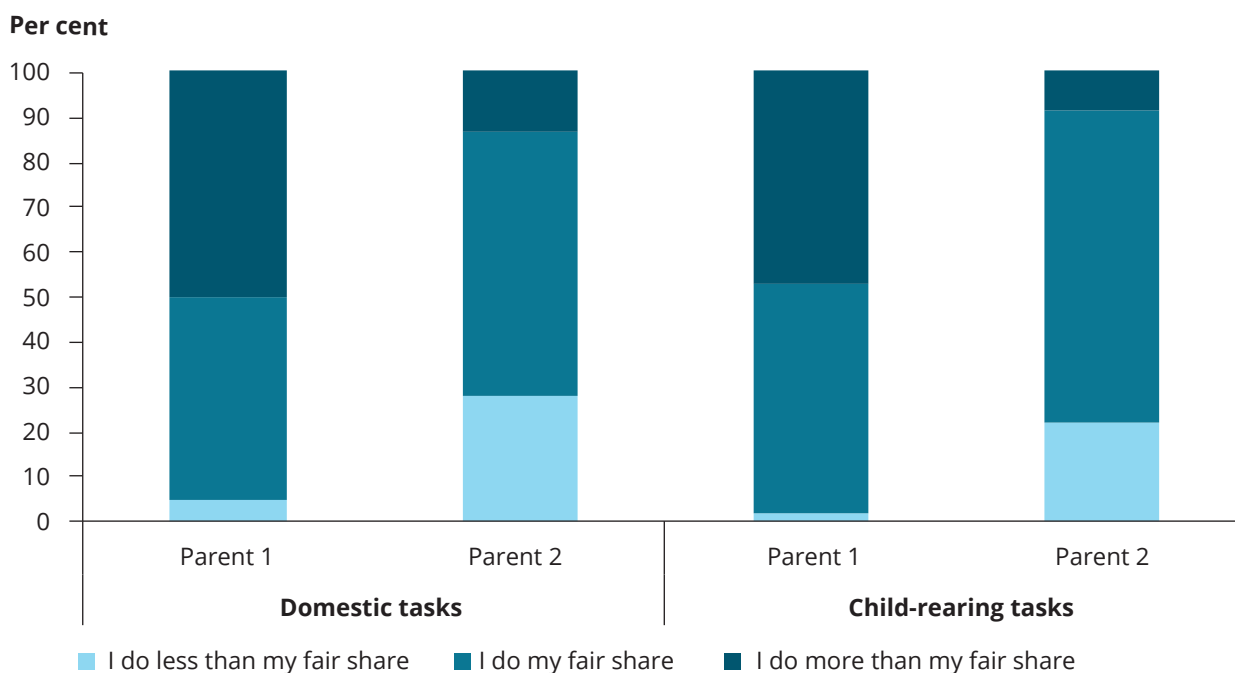
It is estimated using data from LSAC in 2016 that for 2-parent households, 45% of primary parents of children aged 12–13 said they did their fair share of domestic tasks (such as housework, home maintenance, shopping and cooking), and 51% said they did more than their fair share. This differed significantly from secondary parents in 2-parent households:

- 59% said they did their fair share of domestic tasks
- 14% did more than their fair share.

Similarly, 51% of primary parents in 2-parent households said they did their fair share of the child-rearing tasks (physical and emotional care), and 47% said they did more of their fair share, compared with 70% of secondary parents who said they did their fair share and 8.5% who said they did more.

In 39% of 2-parent households, both parents said they did their fair share of child-rearing tasks (Figure 9).

Figure 9: Share of tasks completed by parents of children aged 12–13, by parent, by type of tasks, 2016



Note: Parent 1 is defined as the child's primary carer (in most cases this is the child's biological mother). Parent 2 is Parent 1's partner or another adult in the home with a parental relationship to the study child (in most cases this is the biological father, but stepfathers are also common). 1-parent households are not included.

Chart: AIHW. Source: AIHW analysis of the LSAC.

Data limitations and development opportunities

Except for the National Framework for Protecting Australia's Children indicator on family functioning, which uses LSAC data to report on families' ability to get along, there are no nationally defined indicators for family functioning. Also, relevant information on family functioning in ongoing, national population surveys is limited.

For more information on family functioning, see: What's missing? in [Social support](#).

Where do I find more information?

For more information on:

- family functioning, see: [Family functioning indicator](#) in the [National Framework for Protecting Australia's Children](#).
- technical notes relating to this section, refer to [Families](#) in the online report. See also [Methods](#).

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Parental health and disability

Key findings

- In 2017, a higher proportion of parents in 2-parent families (53%) rated their health as excellent or good than parents in 1-parent families (38%).
- In 2015, it was estimated that 15% (669,000) of children aged 0–14 lived with 1 or both parents with disability.
- In 2017, among parents with co-resident children aged 0–14, an estimated 16% of parents reported a poor level of mental health.
- In 2016, an estimated 14% of adults with a child aged 0–14 used an illicit substance within the 12 months before being surveyed.

Being a parent comes with many responsibilities. Parents with a physical or mental health condition, or with disability, can face extra challenges. Whether these conditions affect parenting and/or impact the child depends on the:

- health issue
- age of the child
- extent to which services and supports assist parents to manage their health.

Parents with a chronic illness or disability often need extra support from health care professionals, friends and family. In situations where the parent does not have an adult friend or family member to support them, they may depend on the child.

Caring for a parent can be personally rewarding and may cause children to engage with different cognitive and adaptive processes to understand their parent's condition, and cope with it (Chen 2017). Caring for a parent with a mental illness can result in close family ties and promote independence (Reupert & Maybery 2016). However, caring for their parent at a young age can also come at the cost of the child's engagement in typical childhood behaviour (Warren & Edwards 2017).

Parental substance use can also impact child outcomes (AIFS 2010). Parents experiencing intoxication and withdrawal may find it difficult to maintain household routine, potentially leading to the child's emotional and physical needs being unmet, and causing concern for the parent's wellbeing and safety (AIFS 2010).



Box 1: Data sources on parental health

Physical and mental health

Data on parental self-assessed physical health and mental health are sourced from the Household, Income and Labour Dynamics in Australia (HILDA) survey. HILDA surveys the same cohort of 17,000 Australians yearly on their economic and wellbeing information.

HILDA surveys participants on their self-assessed physical health, which can be rated as excellent/very good, good or poor. Mental health is measured by a Mental Health Component score, calculated from the results of a short health survey form filled out by participants (Box 3). Within the survey, a parent may be natural, adopted, step or foster. A parent's de facto partner also counts as a parent.

Disability

Data on parental disability is sourced from the Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC), which measures the prevalence of disability in Australia. Within the survey, a person has disability if they reported having a limitation, restriction or impairment, which has lasted, or is likely to last, for at least 6 months and restricts everyday activities.

The survey also estimates the need for support of older people and those with disability, and the number of carers to people with disability, long-term health condition/s or older people. Carers were people who provided any informal ongoing assistance to people with disability or older people for at least 6 months.

Alcohol and drug use

Data on parental alcohol and tobacco use is sourced from the AIHW National Drug Strategy Household Survey (NDSHS) which collects information on alcohol and tobacco consumption, and illicit drug use among the general population in Australia. The survey includes data on people's attitudes and perceptions on tobacco, alcohol and other drug use. The 2016 NDSHS surveys individuals aged 12 years and older. The survey has been conducted every 2 to 3 years since 1985.

How many parents rated their health as very good or excellent?

In 2017, among parents of co-resident children aged 0–14:

- 88% of parents (or an estimated 4.1 million) rated their overall health as good, very good or excellent
- 13% of parents (or around 588,000) rated their health as fair or poor (Figure 1).

A higher proportion of parents in 2-parent families (52%) rated their health as excellent or very good than parents in 1-parent families (38%).

Figure 1: Self-assessed health status of parents with co-resident children aged 0-14, by family type, 2017

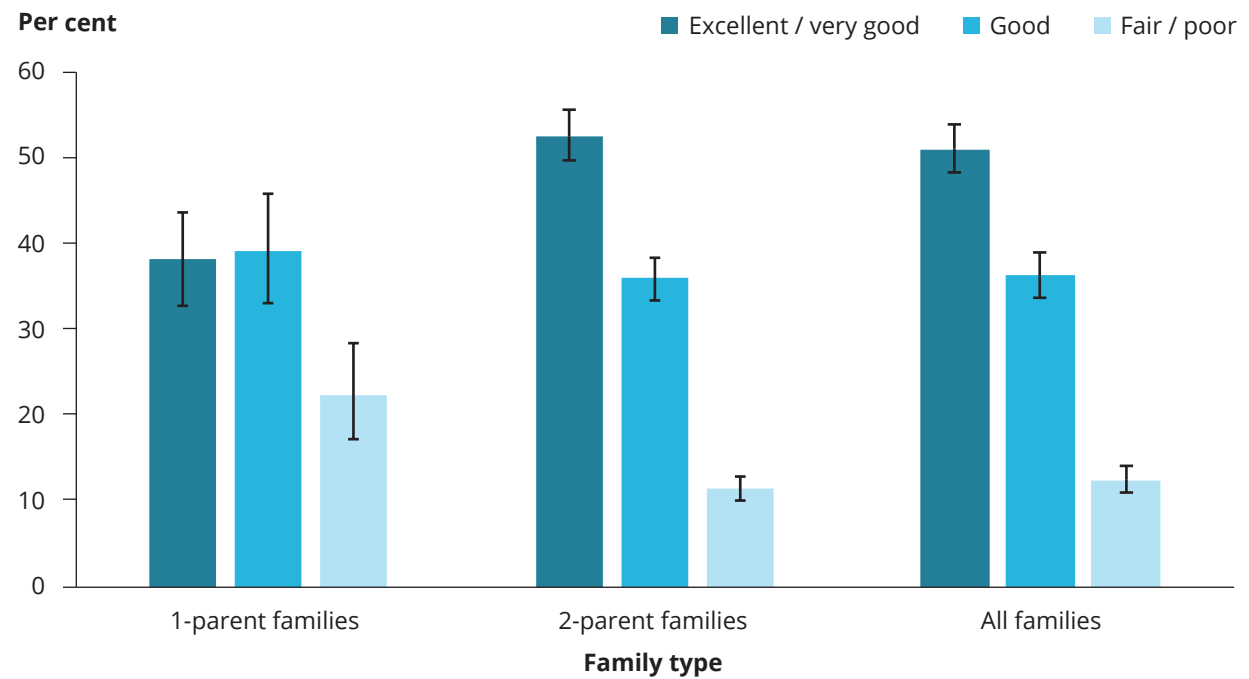


Chart: AIHW. Source: HILDA.

The proportion of parents from 1 and 2-parent families that assessed their health as excellent or very good remained relatively stable between 2009 (43% and 55%, respectively) and 2017 (38% and 53%, respectively) (Figure 2).

Figure 2: Parents with co-resident children aged 0-14 with an excellent or very good self-assessed health status, by family type, 2009-2017

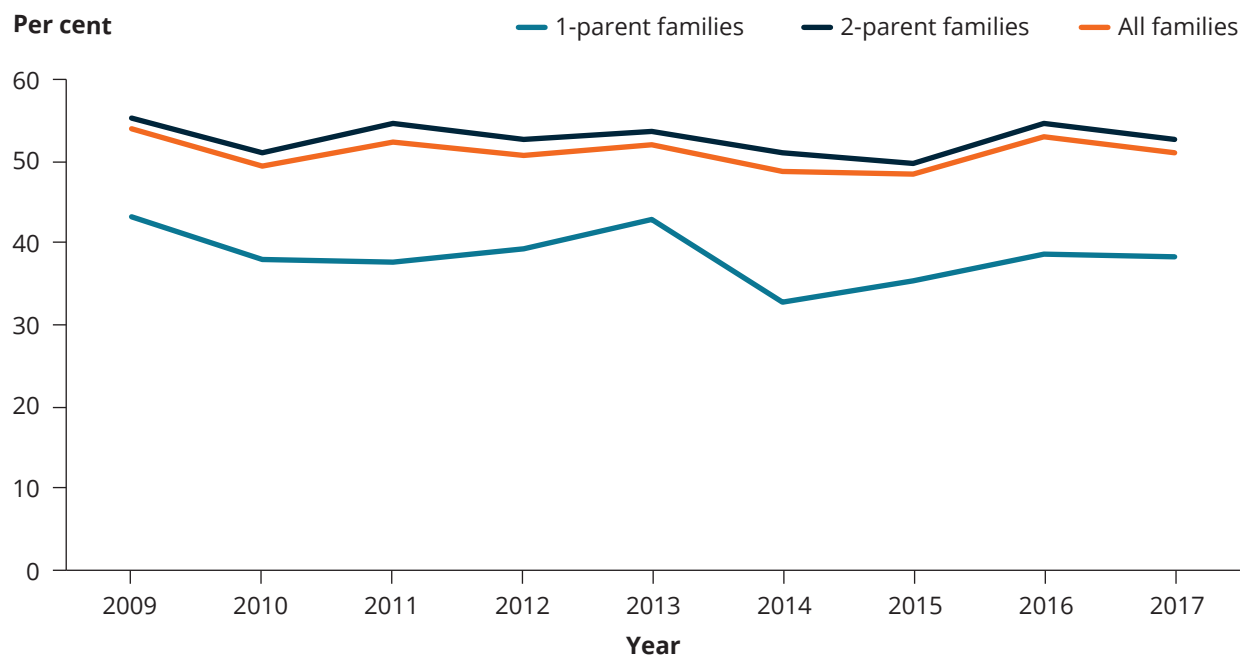


Chart: AIHW. Source: HILDA.

Does everyone rate their health the same?

In 2017, a higher proportion of parents living in the highest socioeconomic areas rated their health as excellent or very good compared with parents living in the lowest socioeconomic areas (59% and 41%, respectively) (Figure 3).

Parents living in the lowest socioeconomic areas were also more likely to assess their health as fair or poor compared with parents living in the highest socioeconomic areas (21% and 9.8%, respectively).

A higher proportion of parents in *Remote, Very remote* and *Outer regional* areas rated their health as fair or poor compared with parents living in *Major cities* (16% and 12%, respectively).

In 2017, there was no statistically significant difference between the proportions of Indigenous parents who rated their health as excellent or very good compared with non-Indigenous parents (43% and 51%, respectively) (Figure 3). Similarly, there was no statistically significant difference between the proportions of Indigenous and non-Indigenous parents that rated their health as fair or poor (17% and 12%, respectively). The rate of Indigenous parents assessing their health as excellent or very good fluctuated between 2009 and 2017, but showed no overall change.

Figure 3: Parents with co-resident children aged 0–14 with an excellent or very good self-assessed health status, by population group, 2017

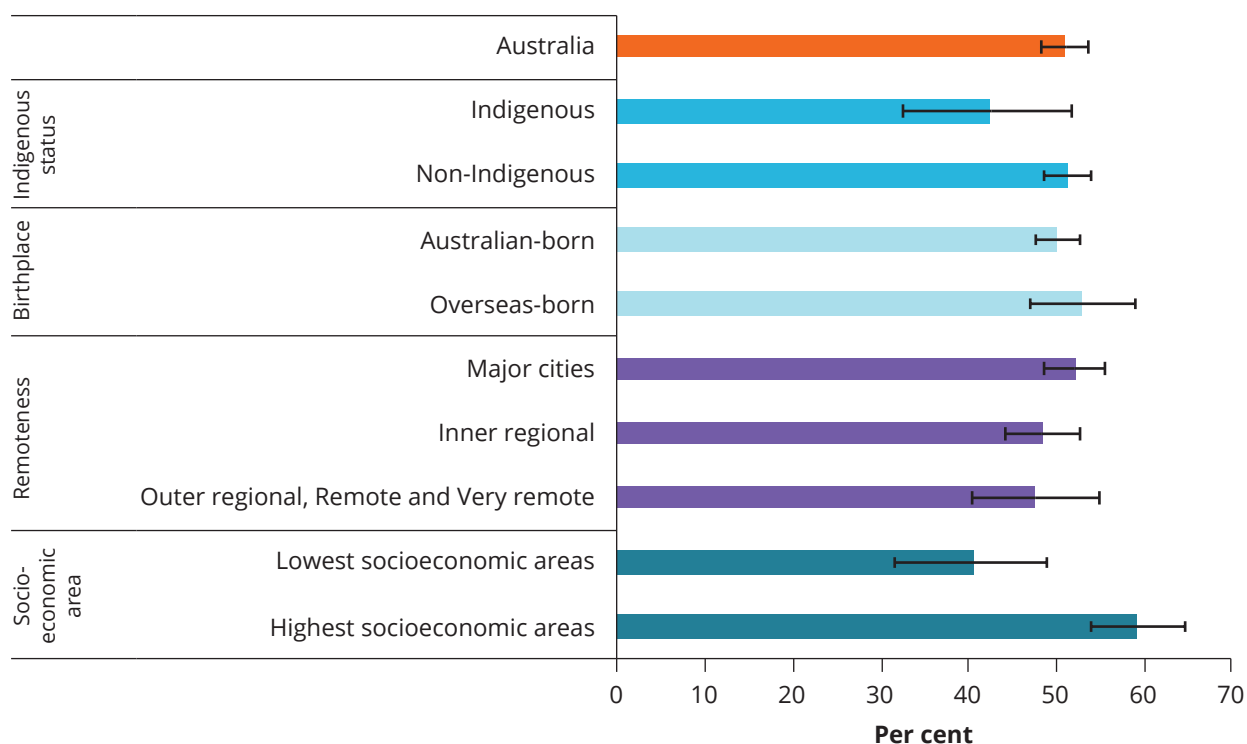


Chart: AIHW. Source: HILDA.

How many parents have disability?

In 2015, it was estimated that among children aged 0–14, 15% (669,000) lived with 1 or both parents with disability. There was a higher proportion of parental disability in 1-parent families compared with 2-parent families (19% and 14%, respectively) (ABS 2015).

Around 38,900 children aged 0–14 provided ongoing informal assistance (care) to a parent with disability, representing around 5.8% of all children with a parent with disability (ABS 2015).

The SDAC estimates that 5,500 children were unconfirmed primary carers in 2015 (ABS 2015) (Box 2). Note that while these estimates are for children aged 0–14, it is unlikely that children under the age of 5 provided informal assistance.

Box 2: Primary carer and unconfirmed primary carer

In the SDAC, a carer is defined as a person who provides informal assistance—help or supervision—to people with disability or older people (aged 65 years and over). Assistance must be ongoing, or likely to be ongoing, for at least 6 months.

A primary carer provides the most informal assistance to a person with 1 or more disabilities, with 1 or more of the core activities of mobility, self-care or communication. In the SDAC, primary carers are 15 years and over.

Children under the age of 15 identified as a primary carer by the recipient were not interviewed and were therefore classified as an unconfirmed primary carer (ABS 2018).

Parental mental health

In the National Framework for Protecting Australia’s Children, parental mental health problems and substance abuse are identified as risk factors for child abuse and neglect, alongside homelessness and domestic violence (COAG 2009; DSS 2018).

While children of parents with mental illness can experience adverse outcomes, this is not always the case (Reupert et al. 2012). The type of mental illness, the presence of other disorders (such as substance use) and the duration and severity of illness are factors influencing parenting (Reupert et al. 2012). The family context, and available social support available for the family, also influence outcomes for children (Reupert et al. 2012). Evidence-based intervention, prevention and treatment programs can provide support to parents with mental illness, reduce risks and enhance resilience in the children concerned (RANZCP 2016).

Box 3: Mental Health Component Summary Score

Mental health data reported here are measured by a Mental Health Component (MCS) score. This is calculated from results of the Short Form-36 Health Survey—a self-reported survey included in the HILDA survey.

The Short Form-36 Health Survey covers 8 domains of health—4 relating to physical health and 4 relating to mental health.

While data from all 8 domains contribute to the MCS score, the 4 mental health domains (mental health, role emotional, vitality and social functioning) contribute the most (Fawkes 2013).

An analysis of population averages suggests that a MCS score of less than 41 indicates a poor level of mental health (AIHW 2012). This cut-off is used to define poor mental health in this section.

In 2017, among parents with co-resident children aged 0–14, an estimated 16% had a poor level of mental health based on the MCS (Box 3 for information) (Figure 4). Parents were more than twice as likely to have poor mental health when they were in a 1-parent family compared with those in a 2-parent family (36% and 14%, respectively).

Figure 4: Parents with co-resident children aged 0–14 with a Mental Health Component Summary score of less than 41, by family type, 2009–2017

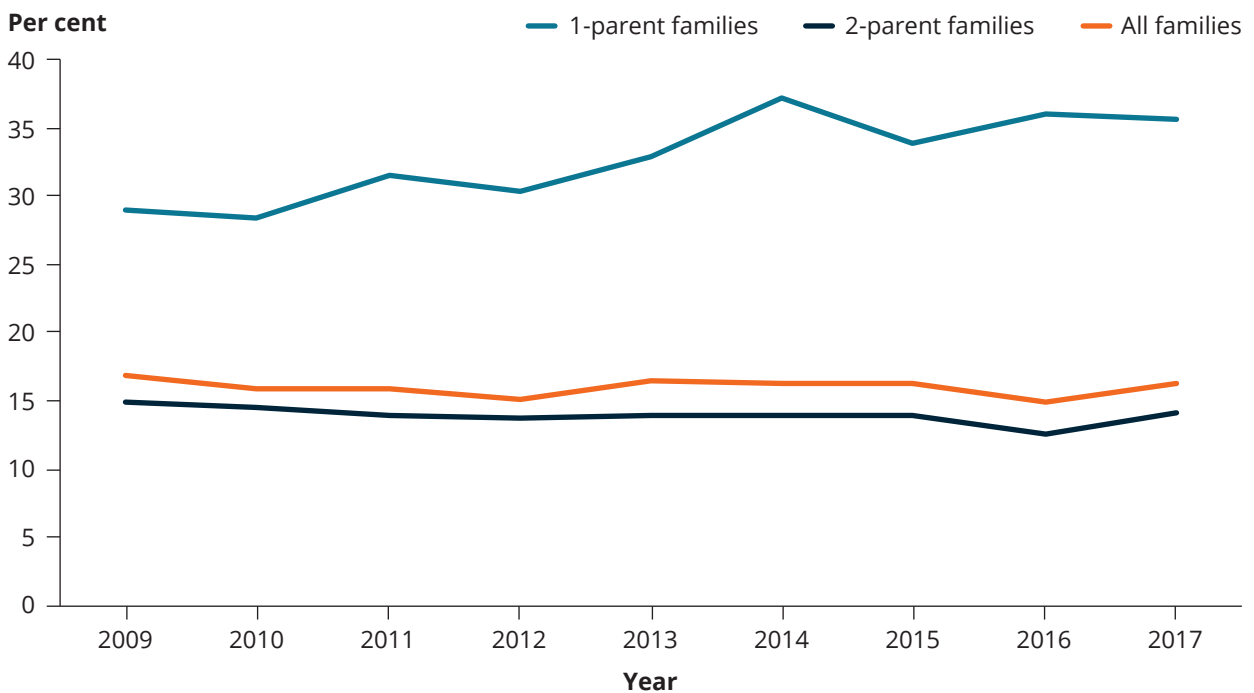


Chart: AIHW. Source: HILDA.

Does everyone rate their mental health the same?

In 2017, a higher proportion of parents living in the lowest socioeconomic areas had poor mental health compared with parents living in the highest socioeconomic areas (23% and 14%, respectively). The proportions were not statistically different for Indigenous parents and non-Indigenous parents with poor mental health (23% and 16%, respectively). There was also no overall change in the proportion of Indigenous parents with poor mental health between 2009 and 2017 (Figure 5).

Figure 5: Parents with co-resident children aged 0–14 with a Mental Health Component Summary score of less than 41, by population group, 2017

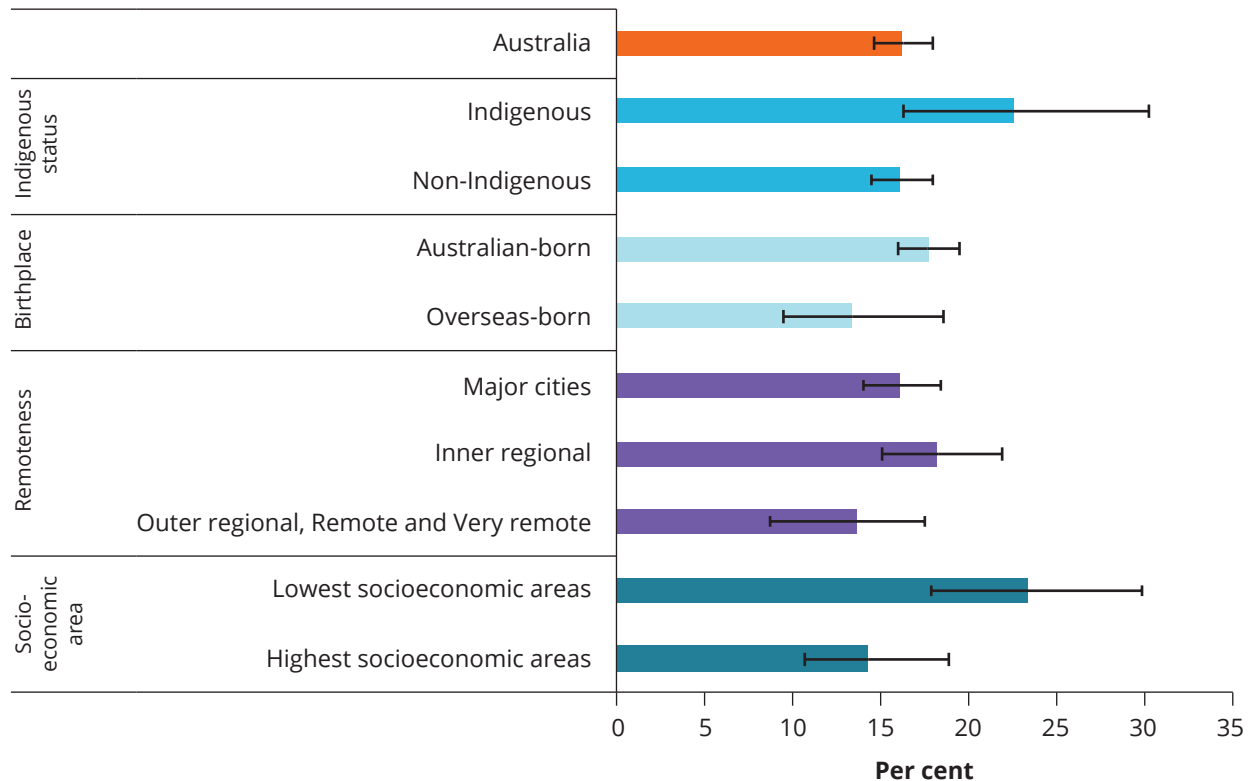


Chart: AIHW. Source: HILDA.

Parental substance abuse

This section looks at parental risky drinking and illicit drug use.

For information on:

- smoking and drinking during pregnancy, see [Smoking and drinking in pregnancy](#)
- smoking in the home, see [Smoking and drinking behaviour](#).

Alcohol

According to the NDSHS, the proportion of parents who engaged in single-occasion risky drinking at least once a week decreased from 15% in 2010 to 12% in 2016. The proportion of parents who were lifetime risky drinkers decreased from 20% in 2010 to 16% in 2016 (Box 4).

Box 4: Defining risky drinking

The National Health and Medical Research Council published the 2009 guidelines for reducing health risks of drinking alcohol.

Guideline 1 (lifetime risk)

To reduce the risk of alcohol-related harm over a lifetime—such as chronic disease or injury—a healthy adult should drink no more than 2 standard drinks a day.

Guideline 2 (single-occasion risk)

To reduce the risks of injury on a single occasion of drinking, a healthy adult should drink no more than 4 standard drinks on any 1 occasion (NHMRC 2009).

The data for alcohol risks in this report are reported against these 2 guidelines and for a combined measure of lifetime or single-occasion risk.

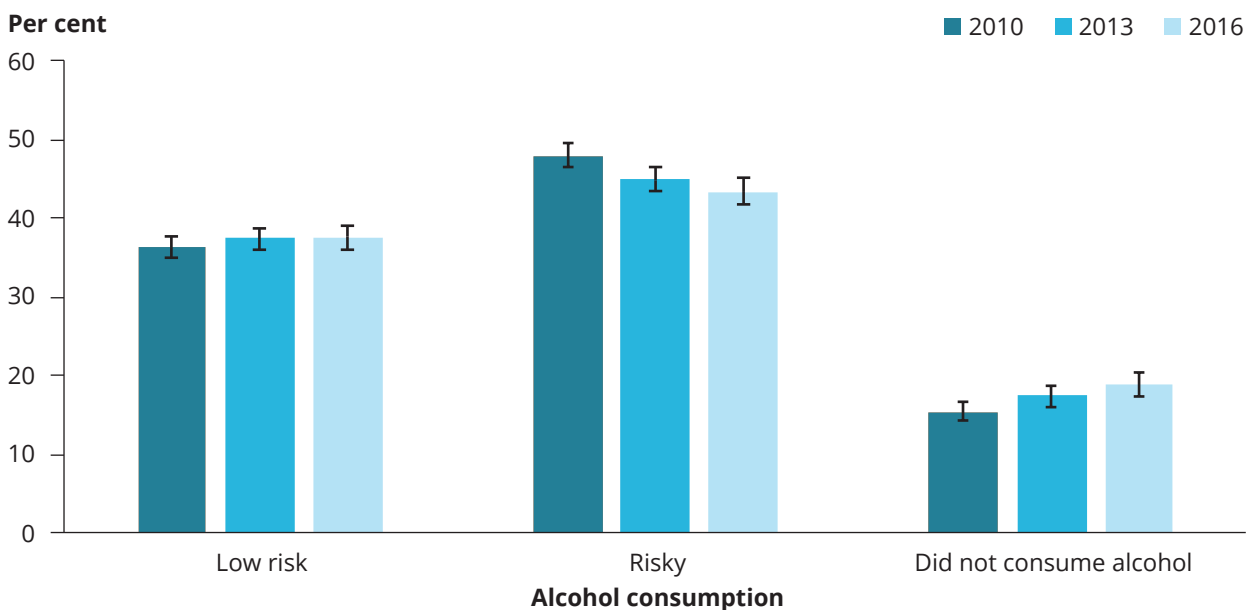
In the context of the combined measure:

Low risk refers to parents who, on average, had no more than 2 standard drinks per day, and never had more than 4 standard drinks on any occasion (that is, low risk for both lifetime risk and single-occasion risk).

Risky refers to parents who either, on average, had more than 2 standard drinks per day, and/or had more than 4 standard drinks on a single occasion at least yearly (that is, risky for lifetime risk and/or single-occasion risk).

Between 2010 and 2016, the proportion of parents who engaged in risky drinking (combined measure single occasion or lifetime) declined (Figure 6). The proportion of parents who did not consume alcohol at all increased from 16% in 2010 to 19% in 2016.

Figure 6: Parents, with children aged 0–14 years, by levels of risky drinking (combined measure), 2010, 2013 and 2016



Note: See Box 4 for definitions of low risk and risky drinking.

Chart: AIHW. Source: AIHW 2017.

Substance use

In 2016, an estimated 14% of adults with a child aged 0–14 used an illicit substance within the 12 months before being surveyed (Box 5).

Box 5: Illicit substance use

Illicit substance use includes:

- illegal drugs (such as cannabis, amphetamines and heroin)
- use of pharmaceuticals for non-medical purposes (such as pain-killers or tranquilisers)
- other psychoactive substances used inappropriately (such as inhalants).

Around 29% of adults who reported using illicit substances used pharmaceuticals for non-medical purposes, and around 80% used illegal drugs (these categories do not sum to 100% as some parents may use both illicit substances and pharmaceuticals for non-medical purposes). Due to the illegal nature of illicit drugs it is likely that self-reported data underestimates the number of people using drugs.

While the proportion of parents using illegal drugs remained stable from 2010 to 2016, the proportion of adults using pharmaceuticals for non-medical purposes increased from 3.1% in 2010 to 4% in 2016 (Figure 7).

Figure 7: Parents with children aged 0–14, who have used any illicit drug within the last 12 months, 2010, 2013 and 2016

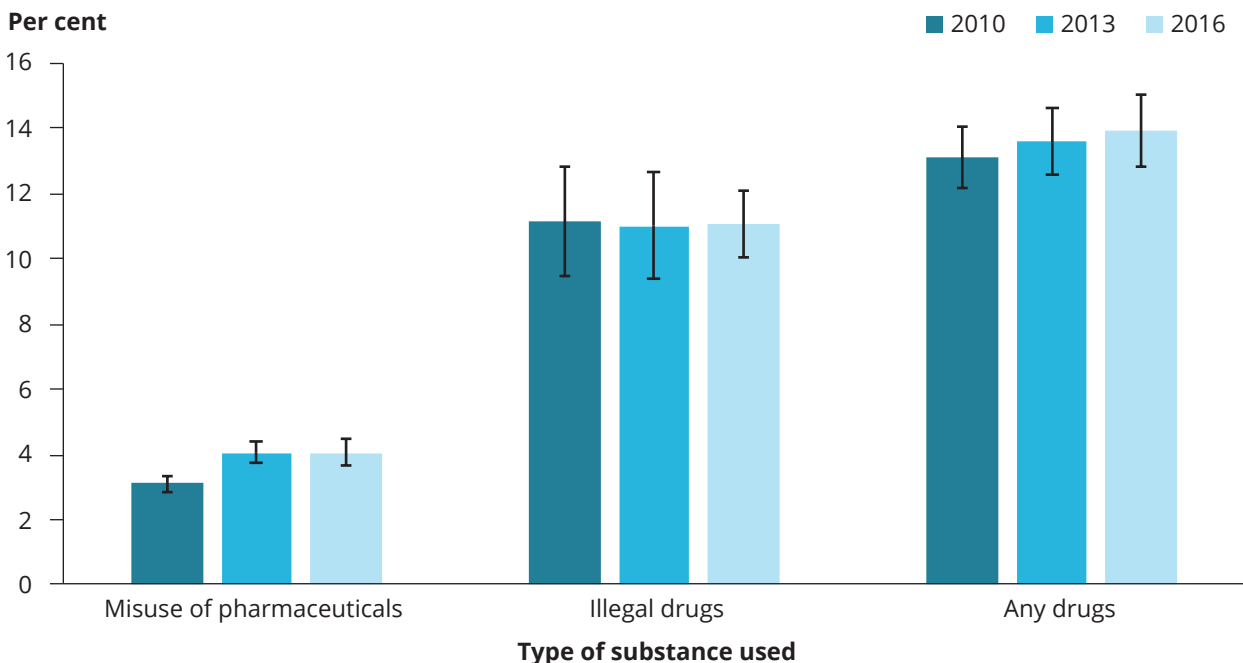


Chart: AIHW. Source: AIHW 2017.

Data limitations and development opportunities

In recent years there has been increased recognition of the role that families, especially parents, play in providing children with social support. To support them in their role, parents in turn need to be provided with adequate formal support mechanisms as highlighted by a number of priority action areas in the [National Action Plan for the Health of Children and Young People: 2020–2030](#). However, there are few well-established national indicators that measure parenting factors and their relationship to child health. More research could be undertaken to develop a set of parenting indicators.

Where do I find more information?

For information on:

- Indigenous children and parental physical health, see: [Indigenous children](#)
- parental health indicators, see: [Parental substance use \(alcohol\)](#) and [Parental substance use \(drugs\)](#) in the [National Framework for Protecting Australia's Children](#).
- drug and other substance use, see: [National Drug Strategy Household Survey 2016: detailed findings](#).
- technical notes relating to this section, refer to [Parental health and disability](#) in the online report. See also [Methods](#).

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Social networks

Key findings

- Data from Longitudinal Study of Australian Children (LSAC) in 2016 estimated that 97% of children had someone to talk to if they have a problem.
- Parents whose children need or use additional care or services have less social support compared with other parents—54% have support available most or all of the time compared with 63% of other parents.
- According to the 2014 ABS General Social Survey (GSS), most (96%) respondents aged 18 and over living in households with children aged 0–14 felt they were able to get support in times of crisis.

Social networks provide people with a sense of connection and can be a source of support both generally and in times of need. They consist of relationships and contacts developed through social interactions and can be developed face-to-face or through another medium such as the telephone or the Internet. For most children, their family forms the foundation of their social network, but friends and teachers play a progressively important role as children get older (Korkiamaki & Ellonen 2008). Increasingly, children are using social media and other digital technologies to facilitate the development of their social networks (Allen et al. 2014; Office of the eSafety Commissioner 2018)

The quality of a child's social network can impact their health, development and overall wellbeing (Klocke & Stadtmüller 2019). For children, the benefits of social networks include:

- positive mental health and behavioural outcomes in childhood and later life
- reduced school dropout rates
- increased likelihood of gaining meaningful employment (Croninger & Lee 2001; Ferguson 2006; Klocke & Stadtmüller 2019; Korkiamaki & Ellonen 2008).

For children, it is not just their personal social networks that can impact their wellbeing, but also those of their family. Families with strong social networks have been found to have increased access to information, material resources, and friends and neighbours to assist them in managing their daily lives and problems (Marshall et al. 2001; Armstrong et al. 2005; Heaney & Israel 2008). Having someone to rely on in an emergency is an important safety net, especially for families with children.

For school-aged children, the school environment plays a key role in the quality of social networks (Korkiamaki & Ellonen 2008). Children who have more friends are more likely to be self-confident, have good social and emotional skills and are more likely to perform better at school (DSS 2015). A strong social network at school is likely to lead to a sense of belonging which has been associated with higher reading achievement (see [Education](#)).

National representative data on children's perspectives of their social networks is limited with 1 self-reported measure of social support included in this section. This section predominately focuses on the self-reported perceptions of the type of social networks available from the perspective of adults who live in households with children aged 0–14 (Box 1).

Box 1: Measuring social networks

The [ABS GSS](#) measures social networks in terms of social contact and support in times of crisis. Results for respondents (aged 18 and over) living in households with at least 1 child aged 0–14 are reported here.

The [LSAC](#) measures social networks in terms of support available to both the child and their primary parent (the parent who knows the child best). Children are asked directly who they would talk to if they had a problem and were able to select multiple responses.

The primary parent was asked a series of questions to form a social support scale to measure how often different types of support are available to parents. The social support scale is the average of 15 questions designed to measure the availability of:

- emotional or informational support
- tangible support
- affectionate support
- positive social interaction
- total social support.



Social connection

Social isolation and loneliness can be harmful to mental and physical health. Having regular contact with (or connecting to) people, especially with family and friends, is an important component of having a strong or positive social network. Living in isolation, especially from extended family networks and support services, has been associated with less effective parenting behaviours and practices and poorer parental mental health, which are, in turn, associated with poorer health, development and wellbeing outcomes for children (Wise 2003; Zubrick et al. 2008).

According to the ABS 2014 GSS, 77% of respondents (aged 18 and over) living in households with at least 1 child aged 0–14 had face-to-face contact with family or friends living outside their household at least once a week. This increased to 94% for non-face-to-face contact, such as phone or video calls, emails, or text messages at least once a week. This is in line with research that suggests more and more people are turning to non-traditional forms of social connection as a way of expanding or better maintaining their social networks (Collin et al. 2011; Office of the esafety Commissioner 2018).

Access to social support

Being able to get support or help when needed is a good indicator of the quality of the strength of social networks (AIHW 2010, 2012).

For children, social support is often measured by whether they felt they had someone they could talk to about their problems (AIHW 2012).

For adults, social support is often broader, including more tangible support such as financial or physical assistance. Having access to a broad range of social supports can support better parenting and result in improved outcomes for children, including:

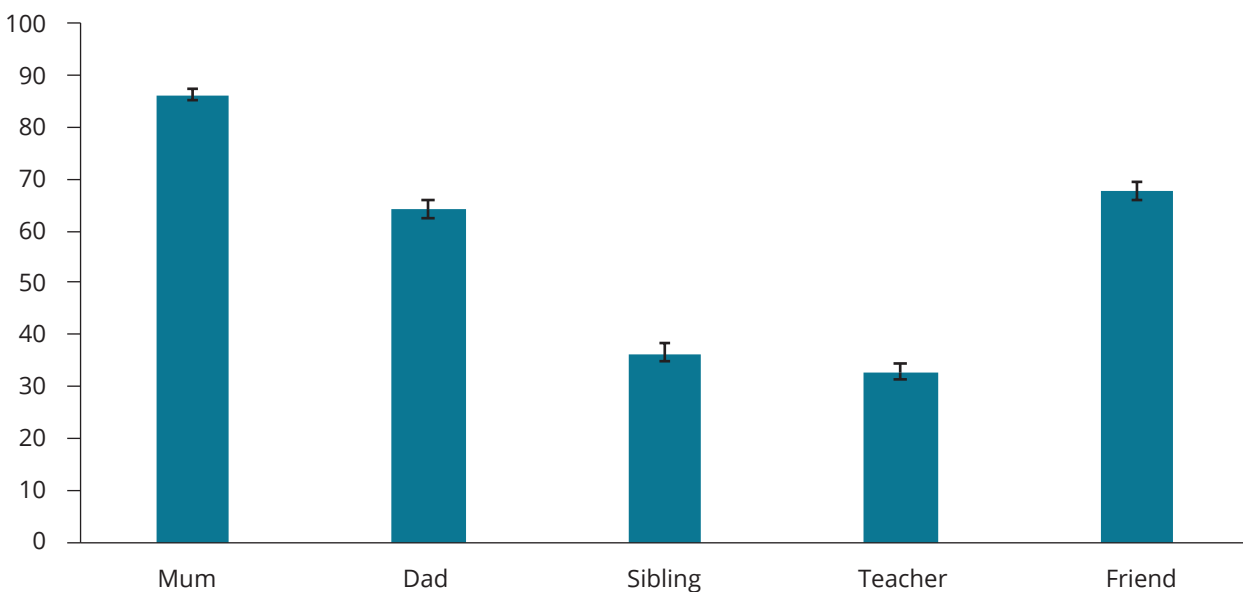
- positive behavioural outcomes
- decreased likelihood of dropping out of school
- decreased likelihood of becoming involved in delinquent behaviour
- lower levels of depression in at-risk teens (Ferguson 2006; Korkiamaki & Ellonen 2008).

97% of children had someone to talk to if they have a problem

It is estimated using data from LSAC in 2016 that most children (97% or around 223,000) aged 12–13 had a least 1 person they could talk to if they had a problem. Around 88% (or 202, 000) would talk to their mum and/or dad, with more likely to talk to their mum than their dad (86% compared with 64%). Children were also likely to talk to a friend (68%) if they had a problem (Figure 1).

Figure 1: Proportion of children aged 12–13 who would talk to someone if they had a problem, by person they would talk to, 2016

Per cent



Note: Children may choose to speak to more than 1 person so totals do not add to 100%.

Chart: AIHW. Source: AIHW analysis of the LSAC.

Parents whose children need or use additional care or services have less social support

It is estimated using data from LSAC in 2016 that 62% of (or 142, 000) primary parents said they have social support most or all the time. Just over 2% said they had no social support.

Primary parents of children who need or use more medical care, mental health or educational services than is usual for most children of the same age were less likely to have support available most or all of the time compared with other primary parents (54% compared with 63%) (Figure 2).



Figure 2: Proportion of primary parents of children aged 12–13 who have social support available most or all of the time, by type of social support and whether children need or use more services than usual, 2016

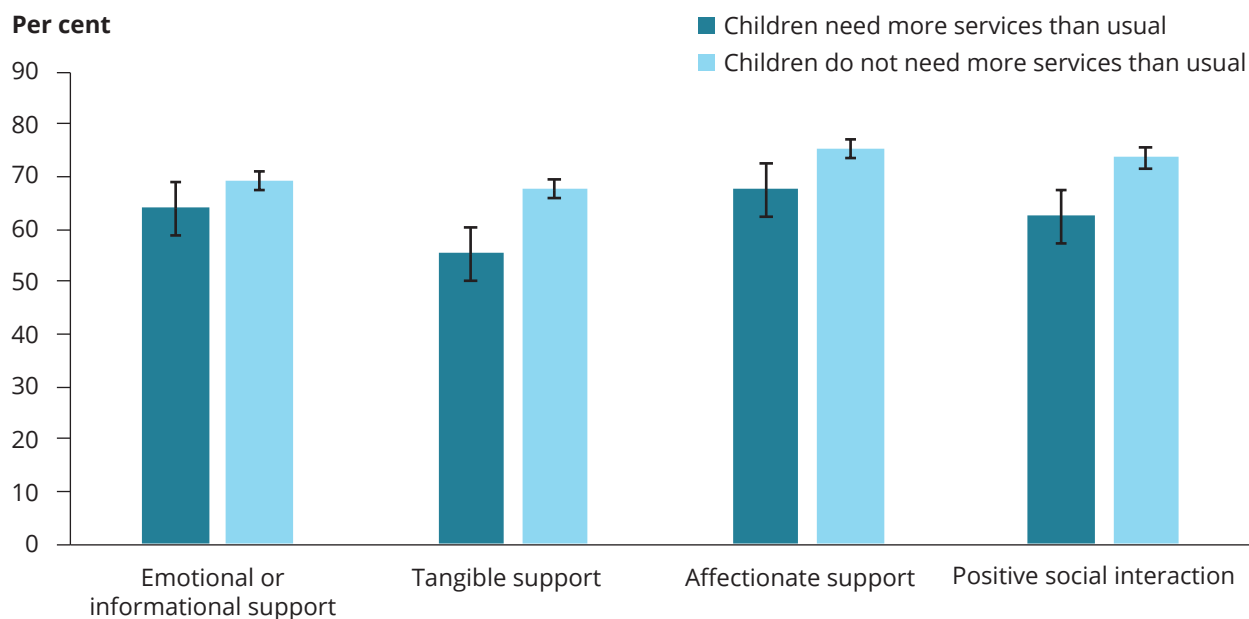


Chart: AIHW. Source: AIHW analysis of the LSAC.

Most adults living with a child aged 0-14 can get support in times of crisis

According to the 2014 GSS, most (96%) respondents aged 18 and over living in households with children aged 0–14 felt they were able to get support in times of crisis. Fewer (87%) somewhat agreed or strongly agreed that they could find someone to help when needed (not necessarily a crisis).

There was very little difference in availability of support in times of crisis between population groups.

4 in 5 adults living with a child aged 0-14 get support from a family member in times of crisis.

The 2014 GSS found that respondents living in households with children aged 0–14 had sources for support, including:

- family members
- friends
- neighbours
- work colleagues
- community, charity or religious organisations
- local council or other government services
- health, legal or financial professionals.

Family members and friends were the most commonly reported source of support (82% and 71%, respectively). Very few (4%) reported they had no source of support (consistent with the percentage of people who indicated they were able to get support in times of crisis).

Data limitations and development opportunities

Children are increasingly using digital technology to form social networks (Office of the eSafety Commissioner 2018; O’Keeffe & Clarke-Pearson 2011; Wilson 2016). This is supported by the 2016 Digital Participation survey which found that more than one-third (34%) of participants aged 8–13 used social media (Office of the eSafety Commissioner 2016). More detailed analysis of children’s engagement in digital social networks, including the quality of these networks and/or if they impact social networks formed in more traditional ways, would be informative.

Where do I find more information?

For more information on:

- family support, see: [Family social network](#) in [Children’s Headline Indicators](#).
- LSAC, see [Growing Up in Australia](#).
- technical notes relating to this section, refer to [Social networks](#) in the online report. See also [Methods](#).

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Income,
finance and
employment

Income, finance and employment

The wellbeing of families and the conditions they live in play an important role in shaping outcomes for children. Factors relating to income, finance and employment can affect children directly and indirectly, by impacting their education, home environment, housing conditions and household's access to resources (AIHW 2012; Warren 2017).

A child's earliest years can fundamentally shape their life chances, and families provide an important environment in which children develop critical competencies, attitudes and habits (McLachlan et al. 2013). The relationship between economic disadvantage and children's outcomes is important as it can help determine the most effective way to improve outcomes for children from disadvantaged families (Warren 2017).

For most families, regular adequate income is the single most important determinant of their economic situation. Low income can make a family vulnerable to food insecurity and affect a child's diet and access to medical care (AIHW 2012; Rosier 2011). Low income can also impact the safety of a child's environment, the quality and stability of their care, and the provision of appropriate housing, heating and clothing (AIHW 2012; Warren 2017).

Material deprivation—when people do not have and cannot afford essential items or activities—can also be used to assess a household's level of economic disadvantage. Material deprivation is an especially valuable measure of economic disadvantage among children, as resources are not always shared equitably within households (Saunders et al. 2018). Measures of material deprivation can also be adapted to reflect children's perspectives of what is essential for an acceptable standard of living, and many recent studies have completed surveys of children across a range of age groups.

Economic disadvantage is 1 aspect of disadvantage (Box 1). This domain includes sections on family economic situation and material deprivation to provide some insight into children living in economic disadvantage. More general data on the socioeconomic status of families with children is provided in the [Introduction](#).

Box 1: What is disadvantage?

Disadvantage is best characterised as the lack of opportunity to participate fully in society. Disadvantage can encompass factors such as low income, material deprivation and social exclusion. These concepts often overlap; however it is possible for a person or family to experience 1 element at a time (PC 2018).

This multi-dimensional approach extends on conventional measures of income poverty to better capture a person's or family's wellbeing, living standards and quality of life (McLachlan et al. 2013). Examining multiple dimensions of disadvantage is also more appropriate for children, who are unlikely to have sources of income and or make decisions about resource distribution within households (Saunders et al. 2018).

Policies supporting the economic situation of children

The Australian Government delivers support and services to help families with the cost of raising children, along with targeted early intervention services. The foundation of this support is providing income and family support payments to provide a broad social safety net and specific support for parents (COAG 2009).

The effects of economic disadvantage span across multiple life domains, and efforts to reduce the impact of disadvantage on children can be found in policy initiatives, such as:

- [National Framework for Protecting Australia's Children 2009–2020](#)
- [Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health](#).

In recent years, work has also been undertaken to identify and address the longer-term impacts of disadvantage across generations (see [Australia's Welfare 2019: data insights](#)). In 2018, the [Select Committee on Intergenerational Welfare Dependence](#) was appointed to inquire and report on matters relating to welfare dependence of families and outcomes for children.

States and territories are also working to prioritise services for those with the greatest need and improve the evidence base. Some initiatives include:

- [Their Futures Matter](#), New South Wales
- [Vulnerable Children Project](#), South Australia
- [Great Start Great Future: Early Years Strategic Plan 2016–2020](#), Northern Territory
- [Children and Young People's Commitment 2015–2025](#), Australian Capital Territory.

What's missing?

The sections in this domain include a number of established national indicators; however, consistent national reporting is not available in some areas due to lack of a suitable data source and/or indicator. For more information on national data gaps, see [Data gaps](#).

A number of topics were not included for other reasons but could be considered for future updates.

Children's subjective view of their economic situation

The material deprivation module in the Household, Income and Labour Dynamics in Australia (HILDA) survey captures an adult respondent's perspective of what is considered essential. Preferences recorded in HILDA may not reflect the priorities and perspectives of children in the household. In recent years, work has been undertaken to understand better how children and young Australians conceptualise and perceive their own wellbeing (see [Material Deprivation Box 2](#)), which include components of material deprivation.

Priority populations

Reporting by priority populations—such as Aboriginal and Torres Strait Islander children, children from non-English speaking backgrounds or children born overseas—is limited. For example, data about individual and personal characteristics are only available for those aged 15 years and over in the HILDA survey. Because of this, there are no nationally comparable data on material deprivation among children aged 0–14 from these groups.

Other related factors

Family economic situation and material deprivation capture only 2 dimensions of disadvantage. Other factors related to income, finance and employment can affect the overall health and wellbeing of children. These include parental underemployment, social exclusion, housing security and financial stress.

Future updates to this domain could include more detailed information on families' use of income and family support government payments, as well as child support arrangements and entrenched disadvantage.

Information on the employment arrangements of carers, such as hours worked and work-life balance, and how these factors impact the time carers spend with their children or affect overall family stress could also be included.

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Family economic situation

Key findings

- In 2017–18, there were 489,000 low-income households with children aged 0–14. This represented 24% of all low-income households in Australia.
- In low-income households with children, the average real equivalised disposable income was \$558 per week.
- In 2019, around 11% (289,000) of households with children aged 0–14 were jobless families—households with dependent children and no paid employment.

The economic wellbeing of households plays a critical role in the health, education and self-esteem of children. Economic disadvantage in the form of inadequate resources can adversely affect children's social and educational opportunities, as well as health outcomes in the short and long term (PC 2018; Ryan et al. 2012).

Economic disadvantage encompasses many factors, including low income, material deprivation and social exclusion (PC 2018). These concepts often overlap; however it is possible for a person or family to experience 1 element at a time. Economic disadvantage is also highly dynamic, and most people only experience it for short periods. Only a small proportion of Australians live in ongoing or persistent disadvantage (McLachlan et al. 2013).

For most families, regular adequate income is the single most important determinant of their economic situation. Low income can make a family vulnerable to food insecurity and affect a child's diet and access to medical care (AIHW 2012; Rosier 2011). Low income can also impact the safety of a child's environment, the quality and stability of their care, and the provision of appropriate housing, heating and clothing (AIHW 2012; Warren 2017).

This section explores economic disadvantage by focusing on the level and source of household income for households with children aged 0–14.

Box 1: Data source and definitions

Data on household income, sources of income and other characteristics are taken from the Australian Bureau of Statistics' (ABS) Survey of Income and Housing (SIH). The survey collects data about a range of household and personal characteristics such as income levels, income sources, employment status and family composition. These data help provide a richer understanding of the living standards and economic wellbeing of Australians (ABS 2019a).

SIH data can be used to identify and compare households with at least 1 dependent child aged 0–14. Data are collected from residents in private dwellings in Australia (excluding very remote areas) every 2 years, and the latest data are available for 2017–18.

How is income measured?

A household's access to resources or income can be measured in the form of **average weekly equivalised disposable household income**. This measure of income is adjusted (or equivalised) according to household size and composition. Equivalising income accounts for larger households needing more resources to achieve the same standard of living as a smaller household. It also allows for comparisons across household types.

To determine the economic wellbeing of children this section focuses on children living in **low-income households**. These households are defined as those in the 2nd and 3rd income deciles of equivalised household income. Households in the lowest decile are excluded because household income is not always a good measure of the total economic resources available to those with an income close to nil or negative. Some people in the lowest decile may own their homes and have low housing costs, some may be between jobs, or on holiday without pay and some may report negative returns on investments (AIHW 2018).

Data from the SIH are available for Australian households between 2007–08 and 2017–18. Data for all years are expressed in 2017–18 dollars.

How many children live in low-income households?

In 2017–18, according to the SIH, there were 2 million low-income households in Australia. An estimated 24% (or 489,000) of these had dependent children aged 0–14. For these households, the average real equivalised disposable income was \$558 per week (ABS 2019a).



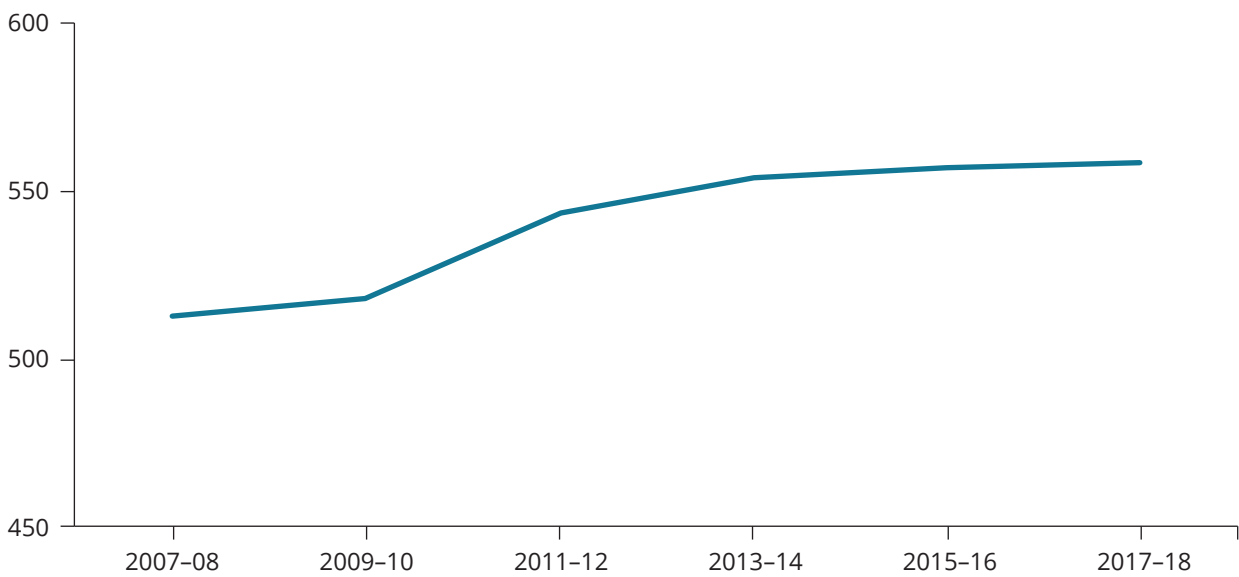
Have there been changes over time?

Over the 6 surveys between 2007–08 and 2017–18, the proportion of low-income households with children aged 0–14 decreased from 32% to 24%.

Over the same time, the average weekly real equivalised disposable household income increased from \$513 in 2007–08 to \$558 in 2017–18 for these households. These increases occurred year-on-year, and are given in real 2017–18 dollars, adjusted for inflation (Figure 1) (ABS 2019a).

Figure 1: Real equivalised household weekly income, households with dependent children aged 0–14 in the 2nd and 3rd income deciles, Australia, 2007–08 to 2017–18

Weekly equivalised disposable income (\$)



Note: Income is given in 2017–18 dollars, adjusted using changes in the Consumer Price Index.

Chart: AIHW. Source: ABS 2019a.

Does low income vary by population groups?

Among low-income households with children, there were some notable differences in equivalised disposable income according to family types.

In 2017–18, couple-family households had higher average weekly disposable income (\$562 per week) compared with multiple family households (\$555 per week) and 1-parent family households (\$546 per week).

Across remoteness categories, household equivalised disposable income was similar—\$560 in *Major cities* and *Inner regional* areas and \$561 per week in *Outer regional and remote* areas.

In 2017–18, there was little difference in income between households where the eldest dependent child was aged 0–4 (\$565 per week) and those where the eldest dependent child was aged 5–14 (\$560 per week) (ABS 2019a).

Overall, disposable household income in low-income households with children aged 0–14 increased for most population groups and household types between 2007–08 and 2017–18. However, in some groups, such as multiple family households and those in *Inner regional* areas, there was more variation over time (ABS 2019a).

What are the sources of income?

Household income can come from a range of sources, including employment, investments, businesses, government pensions and government allowances.

Government pensions and allowances are administered under the Australian social security system and serve as an important 'safety net' to a vast majority of people (Box 2) (Select Committee on Intergenerational Welfare Dependence 2019; Wilkins 2019).

A range of government pensions and allowances are available to support families with their work and family responsibilities. Family Assistance payments (Box 2) are provided to families to assist with the cost of raising children. These payments can provide additional financial assistance to income support recipients (those generally receiving government payments as a primary source of income) and others needing support.

A range of other payments are available recognising the impact that caring for a young child can have on a parent's capacity to undertake full-time employment, such as:

- Parenting Payment (Single/Partnered)
- Carer Payment
- Carer Allowance
- Carer Supplement.

Box 2: Family Tax Benefit

Family Tax Benefit (FTB) has 2 parts:

- FTB Part A is a per child payment to assist with the cost of raising children (dependent child aged 0–15, or 16–19 in full-time secondary study). A supplement may be paid at the end of the financial year for families with an adjusted taxable income of \$80,000 or less. Part A is income tested on family income.
- FTB Part B is a per family payment to single parents, non-parent carers, grandparent carers and families with 1 main income to assist with the cost of raising children. A supplement may be paid at the end of the financial year. Part B is income tested, with single-parent families automatically receiving maximum payment if their income is less than \$100,000 (as at 1 July 2015, before that date the income was less than \$150,000) (AIHW 2019a).

As at 29 June 2018, 1.4 million Australians were receiving FTB payments, supporting 2.8 million children aged 0–15 (or 16–19 and in full-time secondary study). Of these recipients:

- 77% (1.1 million) received FTB Part A and Part B
- 22% (311,000) FTB Part A only and 1.2% (16,800) Part B only (AIHW 2019a).

Some households with children are also eligible for financial support under the Child Support Scheme. While these payments are not issued by the Australian Government, the Government can facilitate these payments and provide services to assist with child support needs (Box 3).

Box 3: Child support transfers

The Child Support Scheme aims to ensure that children receive an appropriate level of financial support from parents who are separating or are separated. The Department of Human Services provides services to families with children under the age of 18 (or under 19 and in full-time secondary study), such as: child support assessment, registration, collection and disbursement. The department also provides referral services and products to assist with child support needs.

How does child support work?

A person entitled to receive child support payments can elect to transfer child support privately (Private Collect) or ask the department to collect on their behalf (Child Support Collect). In 2017–18, more than half (52%) of cases used Private Collect. Parents are encouraged to manage their child support responsibilities independently; however compliance and enforcement programs to ensure payments are made.

How much child support is transferred between parents?

In 2017–18, \$3.6 billion was transferred between parents to support approximately 1.2 million children. Of the \$3.6 billion, \$1.6 billion was transferred through Child Support Collect, and \$2 billion through Private Collect (Department of Human Services 2019).

Reliance on government support

In addition to data on levels of household income, the SIH contains information about sources of income and the proportion contributed by government pensions and allowances. In lower-income households, government pensions and allowances make up a larger proportion of household income than in higher-income households (ABS 2019a). In some households, the proportion of income drawn from government payments is sufficiently high that the household is considered reliant on government support (Box 4).

Box 4: Reliance on government support

Government support refers to pensions, allowances and other payments paid by the government to people under social security and related government programs. These include:

- pensions and allowances that the aged, people with disability, unemployed and sick people receive
- payments for families and children, veterans or their survivors
- study allowances for students (ABS 2019a).

The extent and duration of government support varies across households.

Reliance on government support is defined as having more than 50% of gross household income sourced from government pensions and allowances (AIHW 2019b).

Data from the ABS SIH are available to report on the number of children living in households receiving government support.

Reliance on government support is a cause for policy concern as it is often associated with long-term poverty, social exclusion and other adverse outcomes for recipients and their children (Wilkins 2019). Children living in households receiving a large proportion of income from government pensions and allowances can be vulnerable to long term or entrenched disadvantage. Research has shown that young people aged 18–26 are almost twice as likely to need welfare if their parents have a history of receiving welfare (Cobb-Clark et al. 2017; Select Committee on Intergenerational Welfare Dependence 2019).

How many children live in households reliant on government support?

In 2017–18, 12% (309,000) of households with children aged 0–14 received at least 50% of their gross household income from government pensions and allowances (ABS 2019a).

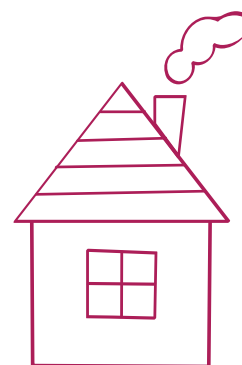
Does reliance on government support vary by population group?

In 2017–18, the proportion of households reliant on government support payments differed substantially according to family type:

- 47% (181,000) of 1-parent families were reliant on government support
- 5.1% (120,000) of couple families were reliant.

These findings reflect how childrearing responsibilities can limit a person's ability to gain employment, especially when there are no co-resident parents to share parenting duties (AIHW 2018; McLachlan et al. 2013).

There were also differences in reliance on government support according to remoteness. Households with children in *Major cities* were less likely reliant on government support than those in *Inner regional* areas (11% compared with 16%). Further, households in *Remote* areas were more likely to rely on government support (17%) compared with those in *Outer regional* (14%) and *Inner regional* (16%) areas (ABS 2019a).



Have there been changes over time?

Between 2007–08 and 2017–18, the proportion of households with children aged 0–14 reliant on government support remained relatively stable, with small variations over time. This trend was similar among couple families and 1-parent families, and households in *Major cities*, *Inner regional* and *Outer regional* areas (ABS 2019a).

Labour force status

A family's economic situation is closely related to the labour force status of the individuals within the household.

A person's labour force status is determined by if they are employed, unemployed or not looking for work (ABS 2016). Parental employment is an important source of income, and often determines the household's access to resources. Stable employment can also provide financial security, confidence and social contact for parents, with positive effects flowing on to children (PC 2018). In contrast, parental unemployment can have a range of impacts on children's behaviour, educational attainment and future employment (McLachlan et al. 2013). Children living in jobless families are especially vulnerable across multiple measures of disadvantage (Box 5)

Box 5: What is a jobless family?

Joblessness is a broader categorisation than unemployment and includes those of working age who are not in the labour force for reasons including disability, illness or caring responsibilities (PC 2018). A **jobless family** is a household with:

- no paid work
- at least 1 dependent child under the age of 15.

Joblessness can increase a family's risk of disadvantage, reduce social status and constrain engagement in meaningful activities. Australia is reported to have 1 of the highest rates of family joblessness in the Organisation for Economic Co-operation and Development (McLachlan et al. 2013).

Data about jobless families in Australia are available from many sources. Estimates vary between sources due to different reporting periods and survey methodologies. Data presented in this section are taken from the ABS Labour Force Status and Other Characteristics of Families publication, produced from the ABS Labour Force, Australia survey. Data may differ from estimates reported using the SIH or HILDA survey.

How many children live in jobless families?

As at June 2019, 11% (289,000 of 2,667,900) of households with children aged 0–14 were jobless households. One-parent families were more likely than couple families to be jobless—37% (194,000) compared with 4.4% (94,800), respectively (ABS 2019c).

These numbers are similar to those at June 2017, when 12% of households with children aged 0–14 were jobless families (5.1% of couple families; 40% of 1-parent families) (ABS 2017).

How does family joblessness affect children?

Family joblessness can affect children by reducing a family's overall financial security and economic wellbeing. Joblessness denies families an important income stream, and the associated financial constraints can increase financial stress and reduce parental investment in children's needs such as education, food and housing (Baxter et al. 2011).

Research using the Longitudinal Study of Australian Children has shown that long exposure to family joblessness is associated with poorer cognitive, emotional and physical development outcomes for children (Gray et al. 2011; Gray & Baxter 2012). Further, the negative impacts of joblessness on parenting can be passed onto children who do not learn the skills required to find and retain jobs and may have diminished desire to succeed in education and employment (Baxter et al. 2011). Children in jobless families are significantly more likely living in deprivation across multiple health and wellbeing indicators (Sollis 2019).

For more information on how children in jobless families' experience deprivation, see [Material deprivation](#).

Data limitations and development opportunities

Income measures assume an equal distribution of resources within households and do not necessarily capture the extent to which economic disadvantage is experienced by children. To overcome these limitations, other measures of disadvantage, such as material deprivation, should be considered in combination. Some data are available, and these are discussed in [Material Deprivation](#).

In addition, disadvantage is highly dynamic and data for this section are taken from a single point. Additional analysis of longitudinal data is required to better understand:

- who is at risk of persistent disadvantage
- how families enter and exit disadvantage
- risk and protective factors.

Longitudinal analysis can also uncover the intergenerational effects of disadvantage, especially how socioeconomic status is passed from parents to children across domains such as wealth, earnings, income, education, health and consumption patterns. Many factors that may be responsible for tying children's life chances to the family circumstances in which they are born (Cobb Clark et al. 2017).

Where do I find more information?

For more information on:

- the effects of a family's economic situation on children aged 0–14, see: [Children's Headline Indicators, National Framework for Protecting Australia's Children indicators and Growing up in Australia: The Longitudinal Study of Australian Children](#).
- government pensions and allowances for families, see: [Family assistance payments and Unemployment and parenting income support payments](#).
- technical notes relating to this section, refer to [Family economic situation](#) in the online report. See also [Methods](#).

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Material deprivation

Key findings

- In 2014, around 1 in 6 (16%) children aged 0–14 lived in households deprived of at least 2 essential items—this increased to more than 1 in 3 (35%) for 1-parent households.
- Children in jobless families were especially vulnerable—almost half (48%) were deprived of 2 or more essential items.
- Around 1 in 6 (17%) children lived in households that did not have \$500 in savings for an emergency and 1 in 16 (6%) lived in households that could not afford dental treatment when needed.

Economic disadvantage can be made up of multiple factors, including low income, material deprivation and social exclusion (PC 2018). While low income can be used to assess the level of resources available to a household, material deprivation illustrates the balance between resources available and living standards achieved with those resources (Wilkins 2016).

Material deprivation exists when people do not have, and cannot afford, items or activities widely regarded as essential for participating fully in a society (Box 1). Material deprivation can be a valuable measure of disadvantage among children, especially as resources are not always shared equitably within households (Saunders et al. 2018). Measures of material deprivation can be also adapted to reflect children’s perspectives of what is essential for an acceptable standard of living (Box 2).

This section complements [Family economic situation](#) by focusing on material deprivation as a form of economic disadvantage among children in Australia. Data from the Household, Income and Labour Dynamics in Australia (HILDA) survey are available to report on material deprivation among households with children aged 0–14; however these data are recorded at household level and reflect the priorities of adult respondents (Box 1).

Box 1: Data sources and definitions

Data sources

Data on material deprivation are from the HILDA survey. HILDA is a longitudinal household study that collects information about economic and personal wellbeing. Data on material deprivation are collected at household level, with selected items asked only of households with school-aged children. The module is completed by an adult living in the household, and is repeated every 4 years, with the latest data available from 2014.

How is material deprivation measured?

The material deprivation module in HILDA is derived from previous studies conducted by the Social Policy Research Centre on material deprivation among adults (Saunders et al. 2007; Saunders & Wong 2012). The module asks a respondent from each household to specify if they

consider these items essential, whether they have an item, or if they do not, if it is because they cannot afford it:

1. getting together with friends or relatives for a drink or meal at least once a month
2. medical treatment when needed
3. furniture in reasonable condition
4. decent and secure home
5. medicines when prescribed by a doctor
6. warm clothes and bedding, if it is cold
7. television
8. substantial meal at least once a day
9. week's holiday away from home each year
10. roof and gutters that do not leak
11. telephone (landline or mobile)
12. home contents insurance
13. washing machine
14. motor vehicle
15. access to internet at home
16. comprehensive motor vehicle insurance
17. at least \$500 in savings for an emergency
18. home with doors and windows that are secure
19. dental treatment when needed
20. buying presents for immediate family or close friends at least once a year
21. when cold, able to keep at least 1 room of the house adequately warm
22. separate bed for each child
23. yearly dental check-up for each child
24. hobby or regular leisure activity for children
25. new school clothes for school-age children every year
26. children being able to participate in school trips and school events that cost money.



Of the 26 items presented in the module, 22 were considered essential by most respondents. The items not considered essential by most respondents were:

- a television
- a week's holiday away from home once a year
- access to the internet at home
- buying presents for immediate family or close friends at least once a year (Wilkins 2016).

This approach is often referred to as the consensual approach as it relies on a common understanding of what constitutes an acceptable standard of living. A person's individual level of deprivation can be determined by the number of essential items their household does not have and cannot afford. Deprivation levels can be used to calculate the average number of items people are deprived of across a group, also referred to as the 'mean deprivation score'.

This section uses a 2-item measure of deprivation to allow for response errors. A person is considered living with material deprivation if they do not have, and cannot afford, at least 2 essential items.

How many children live with material deprivation?

In 2014:

- 1 in 6 (16%) children aged 0–14 lived in households deprived of 2 or more essential items
- 1 in 10 (10%) in households deprived of 3 or more items.

On average, children aged 0–14 lived in households with higher levels of deprivation than people aged 15 years and over. The mean deprivation score for children aged 0–14 was 0.7 items compared with 0.4 for those aged 15 years and over.

These findings are based on shared household items, and adult perceptions of what is considered essential.

For more information on how material deprivation measures can be adapted for children, see Box 2.

Box 2: Material deprivation from a child's perspective

Many recent studies have adopted a deprivation approach to better understand children's experiences of disadvantage. Saunders et al. (2018) reported on material deprivation among high school students in years 7–10 in New South Wales, using the consensual approach to identify items that young people consider essential.

The study developed a Child Deprivation Index to compare the circumstances of different groups and highlight factors associated with higher levels of deprivation (Saunders et al. 2018).

In a similar study, Redmond et al. (2016) identified the items essential to children in years 4–6 and reported levels of material deprivation based on those items. The items were assumed to reflect a child's socioeconomic background and included:

- an iPod or other personal music player
- right clothes to fit in
- money to spend
- a mobile phone
- money for school camp.

The most common deprivations experienced were not having:

- a mobile phone
- money to save each month
- an iPod or other music player.

More than one-quarter (26%) of year 4 and 6 students were deprived of 2 or more items; however deprivation differed considerably according to age with 65% of Year 8 students having no deprivations.

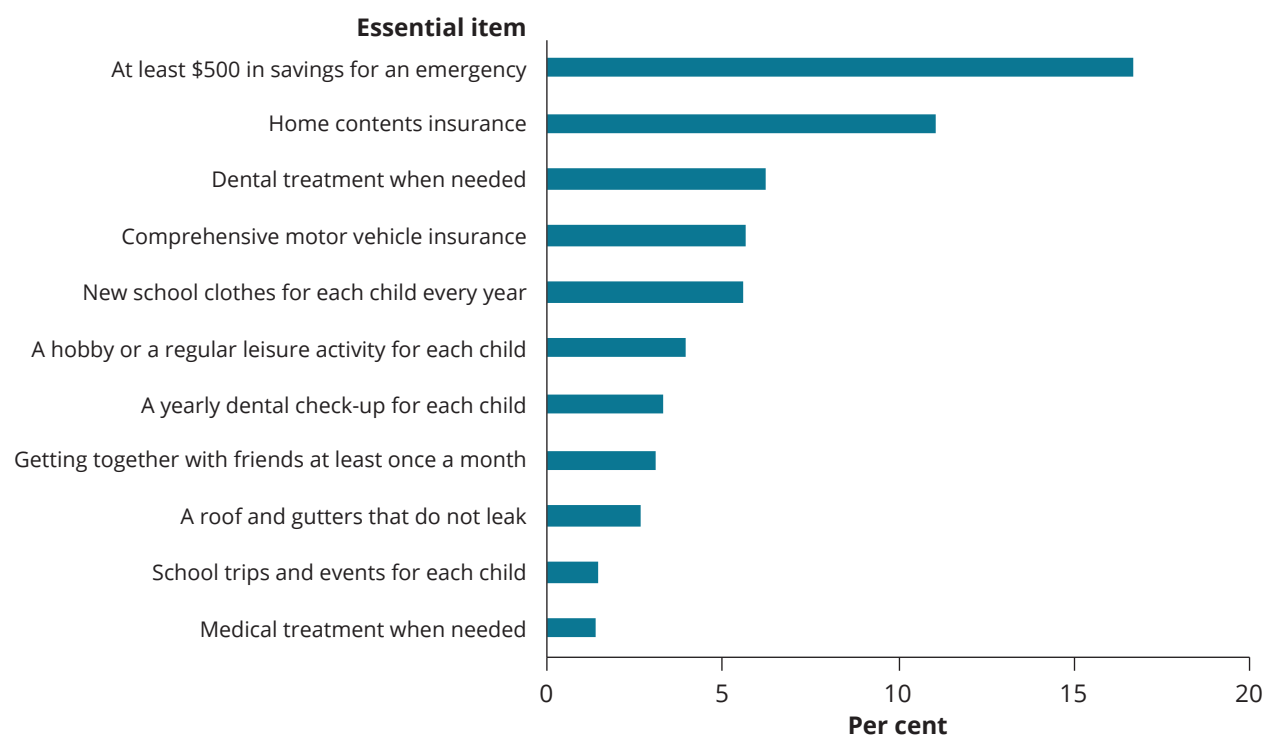
The study reiterated the importance of including children's perspectives to better understand their needs, priorities and experiences of deprivation.

How is material deprivation commonly experienced?

In 2014, according to HILDA, the most common items households with children did not have, and could not afford, were at least \$500 in savings for an emergency, home contents insurance, and dental treatment when needed.

- around 1 in 6 (17%) children lived in households that did not have \$500 in savings for an emergency
- 1 in 9 (11%) in households that could not afford home contents insurance
- 1 in 16 (6%) in households that could not afford dental treatment when needed (Figure 1).

Figure 1: Proportion of children aged 0–14 deprived of select essential items, 2014



Note: Questions about motor vehicle insurance were only asked to households with a motor vehicle.

Chart: AIHW. Source: AIHW analysis of HILDA.

The material deprivation module also asked households if they could afford certain items for each school-aged child in the household. The data showed that:

- 5.6% of households did not have, and could not afford, new school clothes for each child every year
- 3.9% of households did not have, and could not afford, a hobby or regular leisure activity for each child
- 3.3% of households that did not have, and could not afford, yearly dental check-ups for each child.

How does material deprivation differ between groups?

In 2014, children in 1-parent households were more likely to experience material deprivation compared with children living in couple-family households.

More than one-third (35%) of children in 1-parent households were deprived of 2 or more items, compared with 12% in couple-family households. Similarly, one-quarter (25%) of children living in 1-parent households experienced deprivation of 3 or more items, compared with 6.8% in couple-family households.

Levels of material deprivation increased with remoteness. The proportion of children living in households deprived of 2 or more items was higher in *Outer regional* areas (26%) than in *Inner regional* areas (20%) or *Major cities* (14%). However, limited data are limited on the experiences of deprivation among children in *Remote* or *Very Remote* areas.

Levels of household income, sources of income and other related factors such as parental employment are key determinants of material deprivation among children. Half (50%) of all children living in households where government payments were the primary source of income were deprived of 2 or more essential items. This is 4 times as high as deprivation among children in households where the primary source of income was wages or salaries (9.5%).

Government payments include:

- income support payments, such as pensions, allowance and government payments
- non-income support payments, such as family payments and mobility and carer allowances.

Almost half (48%) of children living in jobless households were deprived of 2 or more essential items. Jobless households are those with children under the age of 15 that have no paid employment.

The proportion of children in jobless households experiencing material deprivation of 2 or more items is substantially higher (48%) than households where at least 1 person was in paid employment (12%). Children in jobless households (35%) were also more likely deprived of 3 or more items compared with children in households with paid employment (6.9%).

Data limitations and development opportunities

There are limitations in measuring an individual's level of deprivation by counting the number of items they cannot afford. This approach gives equal weight to different goods, services and activities and does not account for the seriousness of different forms of deprivation. The impact of not being able to afford getting together with friends or relatives for a drink or meal at least once a month may differ substantially from being deprived of getting medical treatment when

needed (McLachlan et al. 2013). More work is therefore required to determine how the items outlined in Box 2 should be viewed relative to each other. An alternative is to place greater weight on deprivation of items considered essential by larger proportions of the population (Saunders et al. 2019).

There is limited scope to analyse material deprivation over time. Because material deprivation is relative to society's perception of what is essential at a given point, it is subject to change. While some items, such as medical treatment, a substantial meal, or warm clothes, may continue to be seen as essential, the number and composition of items considered essential are likely to evolve as preferences change (McLachlan et al. 2013).

Where do I find more information?

For information on technical notes, see [Methods](#).

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Housing

Housing

A child's access to safe, stable and adequate shelter is recognised as a basic human need. Shelter is generally considered to be a safe and secure place of one's own where the routines of daily life can be established, enabling children and their families to engage with the wider community—socially, recreationally, and economically. Having adequate housing is also important for physical and mental health (AIHW 2018).

Shelter is closely linked to the social and emotional aspects of a child's wellbeing, as it acts as a secure base from which children can engage in social interactions, enhance self-esteem and maintain self-identity.

The housing components affecting children's development and wellbeing include:

- home ownership
- housing costs (related to mortgage repayments or rent) and associated financial stress
- mobility (frequency of house moves)
- homelessness
- overcrowding
- characteristics of the dwelling, including environmental allergens, cleanliness and disrepair (AIHW 2018; Sartbayeva 2016).

This domain focuses on homelessness, overcrowding and housing stress.

Why is housing important?

Access to safe, stable and adequate housing is important for the health and wellbeing of children. Homeless children can experience schooling disruptions, food insecurity and an increased risk of being homeless as adolescents and adults (Crawford et al. 2015; Fantuzzo et al. 2012; Flatau et al. 2012).

Children living in overcrowded housing have an increased risk of emotional and behavioural problems and reduced school performance as overcrowded living arrangements may disrupt their sleep, ability to concentrate, and reduce space for study (Solari & Mare 2012).

Children in families experiencing housing stress (spending more than 30% of their income on housing costs, such as mortgage repayments or rent) are also at risk of adverse health and wellbeing outcomes.

Increased housing stress may compromise parental mental health and reduce the money available to spend on children's food, healthcare and education (Robinson & Adams 2008; Taylor & Edwards 2012). In contrast, better housing affordability is often associated with better health, academic achievement and school engagement for children (Clair 2018).

The governance supporting children's access to housing

While parents and carers have the primary role in providing a safe and secure living arrangement for their children, governments determine the policy framework within which the housing market operates and intervene to support housing outcomes for particular groups ([Department of Social Services 2019](#)).

The National Housing and Homelessness Agreement (NHHA), which came into effect on 1 July 2018, replaced the National Affordable Housing Agreement and National Partnership Agreement on Homelessness.

The NHHA is an agreement between the Australian Government and state and territory governments. It aims to improve access to affordable, safe and sustainable housing, prevent and address homelessness, and support social and economic participation (AIHW 2019a).

The Australian Government provides funding under the NHHA to states and territories to improve access to affordable, safe and sustainable housing across the housing spectrum. This includes funding to prevent and address homelessness and support social and economic participation (Council of Federal Financial Relations 2018). The Australian Government is responsible for monitoring the expenditure of specialist homelessness programs, and monitoring and assessing performance under the NHHA to ensure outputs are delivered on time.

Australian Government responsibilities

- Under the NHHA, the Australian Government is also responsible for:
- financial sector regulations and Commonwealth taxation settings that influence housing affordability
- income support and Commonwealth Rent Assistance
- Commonwealth own-purpose housing and homelessness-related programs and services
- the operations of the National Housing Finance Investment Corporation
- the collection and publication of housing, homelessness and housing affordability-related data.

State and territory government responsibilities

State and territory governments also provide funding under the NHHA and are primarily responsible for service delivery. These governments ensure housing and homelessness programs are within NHHA scope and are useful to the community.

Under the NHHA, state and territory governments are also responsible for:

- the collection of data from housing providers and agencies providing services to people who are homeless
- land use, supply and urban planning and development policy, as well as tenancy legislation and regulation
- legislation to support community housing operations
- housing-related state taxes, and state-based policy and services associated with residential development (CFFR 2018).

Australian Institute of Health and Welfare (AIHW) responsibilities

The AIHW plays a role in developing and maintaining the national metadata standards for national data collection on social housing and homelessness.

Data on social housing are provided annually to the AIHW by the states and territories. Data about specialist homelessness services are provided directly to the AIHW by agencies and state/territory government departments monthly for more than 1,500 homelessness agencies to include in the Specialist Homelessness Services Collection (SHSC).

National housing strategies and agreements supporting children

Along with the NHHA, the importance of safe, stable and adequate housing is acknowledged in several other national strategies or agreements (Table 1).

The priority homelessness reform areas identified by the NHHA are:

- achievement of better outcomes for people
- early intervention and prevention
- commitment to service program and design (AIHW 2018).

The NHHA identifies a number of national priority groups, including:

- children and young people
- women and children affected by family and domestic violence
- people exiting institutions and care into homelessness.



The National Framework for Protecting Australia's Children 2009–2020 (the National Framework) was endorsed by the Council of Australian Governments in 2009. It is a long-term approach to ensure the safety and wellbeing of Australia's children. A supporting outcome for the National Framework is that risk factors for child abuse and neglect are addressed. Unstable family accommodation and homelessness is a risk factor for child abuse and neglect. Assistance through homelessness services has therefore been included as an indicator in the national framework (DSS 2009).

The Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in 2015 and provides a 10-year overarching vision of child and youth health. The framework recognises the importance of adequate housing for children. One of its priorities to support children and young people to live in healthy and safe homes, communities and environments (AHMAC 2015).

Table 1: National strategies and agreements relevant to housing

Topic area	Strategy
Homelessness	National Housing and Homelessness Agreement
Homelessness	National Framework for Protecting Australia's Children 2009–2020
Housing	Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health

What's missing?

The sections in this domain include a number of established national indicators; however, consistent national reporting is not available in some areas due to lack of a suitable data source and/or indicator. For more information on national data gaps, see [Data gaps](#).

A number of topics were not included for other reasons but could be considered for future updates.

Children's subjective view of housing and other living arrangements

Subjective data on how children view their living situation, including problems associated with homelessness, overcrowding and housing stress, are limited.

Pathways, transitions and outcomes

Some data are available on the housing outcomes of specialist homelessness services' clients at the end of each financial year (AIHW 2019b), and on the characteristics of children in contact with specialist homelessness services, and the child protection and youth justice systems (AIHW 2016). However, routinely collected national data are not available on the:

- pathways into and out of homelessness for children and their families
- longer-term outcomes of young people who experience homelessness, overcrowding and housing stress, such as housing, health, education and employment.

National comprehensive prevalence data on homelessness

National data on the prevalence of homeless is based on the Australian Bureau of Statistics Census of Population and Housing, which relies on the self-reporting of living arrangements. Census data are unlikely to capture the true extent of homeless especially among specific sub-populations, such as young people who are homeless and couch surfing and people experiencing homeless due to domestic and family violence (ABS 2018).

Other related factors

Many other related factors are important to the overall health and wellbeing of children, such as housing:

- tenure
- assistance
- quality
- mobility.

For more information on some of these factors, see: [Housing data](#) dashboard.

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Housing stress

Key findings

- In 2016, more than one-fifth of children aged 0–14 lived in households experiencing housing stress.
- More than half (52%) of children in 1-parent households were living under housing stress.
- Housing stress decreased with remoteness—ranging from 24% of households in *Major cities* to 9% in *Remote and very remote* areas.

The housing conditions in which people live and the security of those living arrangements can influence a person or family's health and wellbeing (McLachlan et al. 2013). Housing costs, such as rent payments, rate payments, or mortgages, are often the largest regular expense in a household's budget and a household's capacity to cover these costs varies according to [family economic situation](#).

Secure housing gives people a sense of autonomy, certainty and control that can lead to lower levels of stress and greater family stability (Taylor & Edwards 2012). Children in households that can afford adequate housing often have better health and school engagement (Clair 2018). In contrast, high housing costs can cause housing stress. This stress and resulting financial hardship can:

- affect parental mental health
- reduce investment in children's food, health and education
- increase a child's risk of [material deprivation](#) and social exclusion (Robinson & Adams 2008; Taylor & Edwards 2012; Yates et al. 2007).

This section looks at the number of children aged 0–14 living with financial stress due to high housing costs.

Box 1: Data source and definitions

Data on housing stress are taken from the ABS Census of Population and Housing. The Census collects information on welfare-related topics, including housing and income. It is administered by the ABS every 5 years, with the latest data available for 2016.

How is housing stress defined?

In general terms, housing stress is experienced when housing costs are high relative to income (ABS 2019). In these situations, high housing costs are likely to cause financial stress and reduce the household's ability to afford other living costs such as food, clothing, transport and utilities (Rowley & Ong 2012).

Housing stress can be defined in many ways, but for this section, households are considered to be under housing stress if more than 30% of gross household income is spent on housing costs. This definition—which includes all households with children aged 0–14 years regardless of income level—is broader than housing stress measures limited to low-income

households (AHURI 2019). This approach is consistent with data reported against the [Children's Headline Indicators](#).

For more information on different methodologies, see Data limitations and development opportunities below.

How many children live in households experiencing housing stress?

In 2016, more than one-fifth (22% or around 975,000) of children aged 0–14 lived in households experiencing housing stress (ABS 2018).

- Boys and girls were equally as likely to live in households experiencing housing stress (both 22%).
- Younger children aged 0–4 were slightly more likely than older children aged 5–14 to live in households experiencing housing stress (23% compared with 22%).

Have rates of housing stress changed over time?

The proportion of children aged 0–14 living in households experiencing household stress increased from 15% in 2001 to 26% in 2011, before dropping slightly to 22% in 2016 (Figure 1).

Figure 1: Proportion of children aged 0–14 living in households experiencing housing stress, 2001–2016

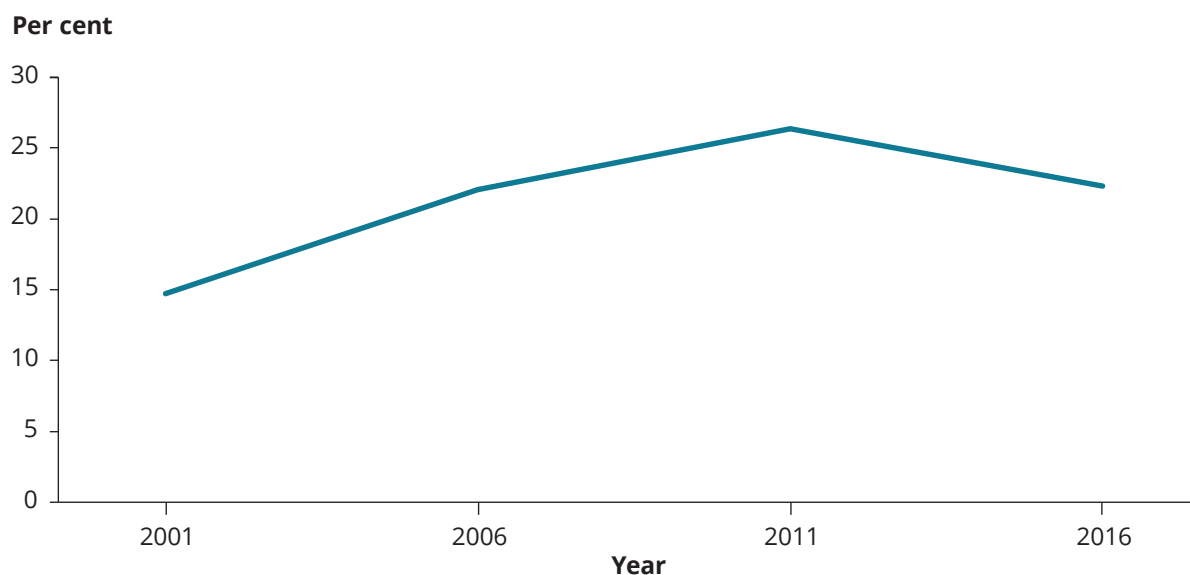


Chart: AIHW. Source: Census data.

Are rates of housing stress the same for everyone?

Children born overseas were more likely than children born in Australia to live in households experiencing housing stress (29% compared with 23%, respectively). More than half of children from 1-parent families were living in households with housing stress (52%). This was nearly 3 times the proportion of children from couple families (18%) and more than 5 times the proportion of those from households with multiple families (10%).

Children living in *Major cities* were the most likely to be living in households experiencing housing stress (24%), while children living in *Remote and very remote* areas were the least likely (9.4%).

Children living in the lowest socioeconomic areas were more likely than children in highest socioeconomic areas to live in households experiencing housing stress (29% compared with 17%). Level of socioeconomic disadvantage is determined by the area a person is living in and not by individual perceptions or responses.

In 2016, the proportion of children aged 0–14 living in households experiencing housing stress was higher among Aboriginal and Torres Strait Islander children (27%) than non-Indigenous children (23%) (Figure 2).

Figure 2: Proportion of children aged 0–14 living in households experiencing housing stress, by priority population group, 2016

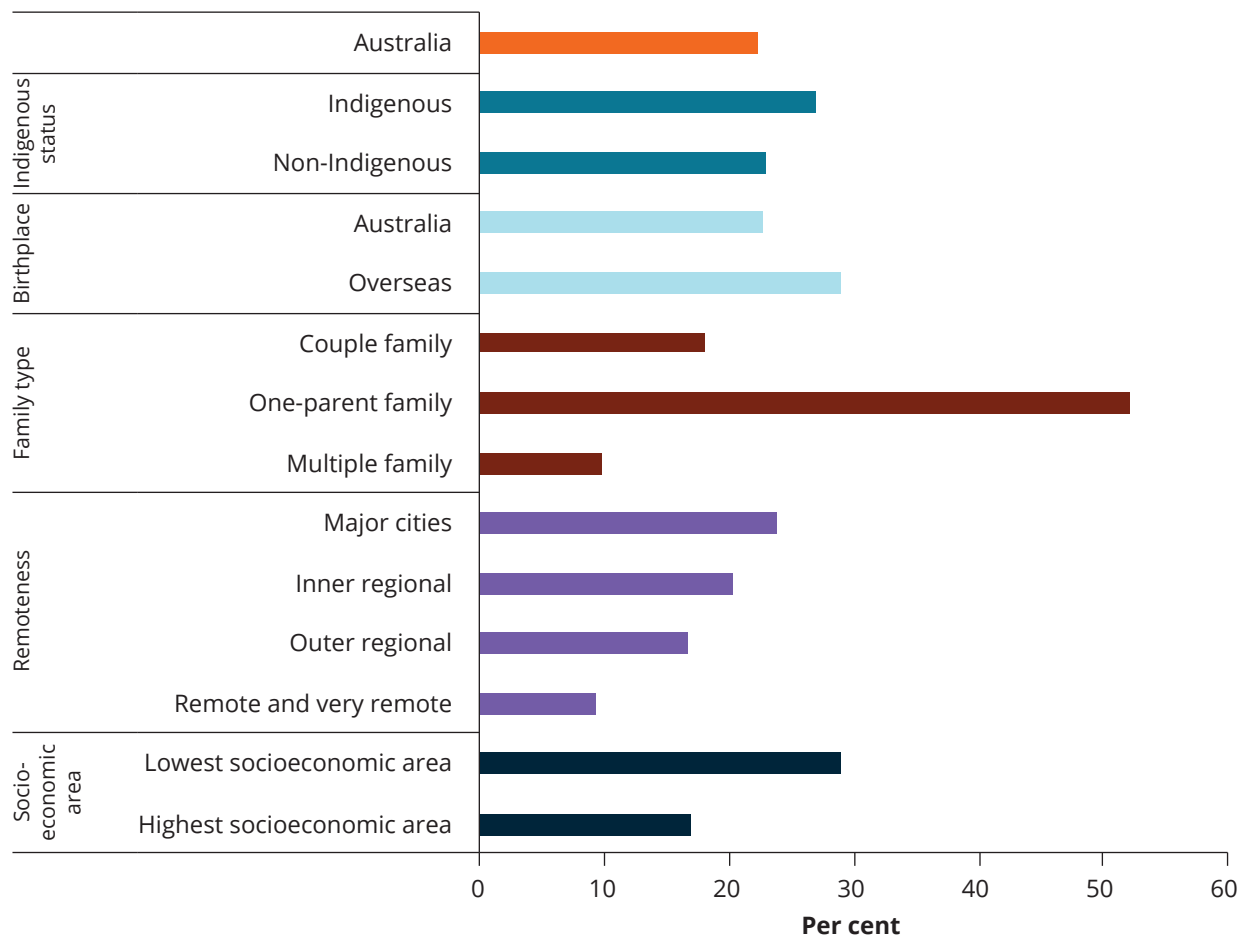


Chart: AIHW. Source: ABS Census.

Data limitations and development opportunities

This section looks at children living in households with housing stress, regardless of household income level (low, medium or high).

The burden of high housing costs disproportionately affects households with low incomes. High housing costs can reduce a low-income household's ability to buy necessities such as food, healthcare or educational resources (Taylor & Edwards 2012; Warren 2018). In comparison, those on higher incomes who pay more than 30% on housing are more likely to do so as a choice, and they can afford to do so without forgoing essential items (AHURI 2019; McLachlan et al. 2013).

Data disaggregated by income groups focusing on low-income households, would provide further insights into the level of housing stress experienced by vulnerable populations. There is scope to review the Children's Headline Indicator to ensure it reflects contemporary information needs.

The AIHW has published some data on housing stress by tenure and income levels in the [Housing affordability](#) snapshot of Australia's Welfare and the AIHW [Housing data dashboard](#).

For more information on defining housing stress, see [Understanding the 30:40 indicator of housing affordability stress](#).

Where do I go for more information?

For more information about:

- Indigenous children and housing stress, see: [Indigenous Children](#)
- housing stress among children aged 0–14, see: [Children's Headline Indicators](#).
- financial housing stress, see: [Housing Assistance in Australia: Financial assistance](#).
- home ownership and housing tenure, see: [Home ownership and housing tenure](#).
- housing affordability, including housing stress among low-income households—the 30:40 rule (including families), see: [Housing affordability](#).

See also [Methods](#).

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Overcrowding

Key findings

- In 2016, around 18,900 children (0.4%) aged 0–14 were living in overcrowded housing on Census night.
- The proportion of children living in overcrowded housing remained relatively stable between 2006 and 2016.
- Children living in low socioeconomic areas were 12 times as likely to be living in an overcrowded situation (1.2%) as those from high socioeconomic areas (0.1%).

Safe, secure and stable access to room for study, play and uninterrupted sleep is critical for children's health and development. However, a number of children live in overcrowded dwellings—homes that are too small for the size and composition of the household—limiting their access to such space.

At increased risk of experiencing overcrowding are:

- families with low household incomes due to the high cost of housing in many parts of Australia (Easthope et al. 2017)
- parents and children leaving family and domestic violence who are in situations where access to financial resources and social support is limited (Mission Australia 2019).

Overcrowding extends beyond 2 siblings sharing a room. It is characterised by uncomfortable or irregular sleeping arrangements, with multiple children of different ages and sexes sharing bedrooms, parents forced to share bedrooms with their children, and single adults or multiple couples sharing a room. Families often resort to sleeping in living and dining rooms in the absence of space (Shelter 2005). For more information on how overcrowding is defined, see Box 1.

Overcrowding has been associated with increased risk of emotional and behavioural problems and reduced school performance, likely due to disrupted sleep, lack of space to study and the impact of noise levels on concentration (Solari & Mare 2012). Lack of privacy can impact family relationships, leading to family conflict. It can contribute to childhood mental health problems including anxiety, depression and stress (Solari & Mare 2012). Distress over lack of control of living conditions is frequently reported by adults living in crowded dwellings (Lowell et al. 2018).

Overcrowding can also impact children's physical health, with asthma frequently reported by families experiencing overcrowding (Shelter 2005; Solari & Mare 2012).

Overcrowding is higher among Indigenous households and therefore can impact children's health, including ear, skin and other infections. Overcrowding can also compromise children's access to adequate nutrition, with flow-on effects to their health and development (Lowell et al. 2018; Thurber et al. 2017).



Box 1: Data source and definition of overcrowding

Data on overcrowding come from the [ABS Census of Population and Housing](#). The Census is collected by the ABS every 5 years with the most recent data available for 2016. The 2016 Census collected information on welfare-related topics, including overcrowding.

In this section, households are considered overcrowded if they are estimated to require 3 extra bedrooms according to the Canadian National Occupancy Standard (CNOS) (ABS 2018).

Persons living in overcrowded dwellings are considered a marginal housing group and may be at risk of homelessness. Persons living in severely overcrowded situations (households requiring 4 or more extra bedrooms) are considered homeless and are not included here. They are instead included in homelessness estimates.

In 2016, approximately 40% of children living in households requiring 3 or more extra bedrooms were considered homeless.

The ABS definition of overcrowding differs from that used in National Housing and Homelessness Agreement reporting and the Report on Government Services, where overcrowding is defined as households requiring 1 or more additional bedrooms (SCRGSP 2019).

Canadian National Occupancy Standard

The CNOS assesses the bedroom requirements of a household based on these criteria:

- There should be no more than 2 persons per bedroom.
- Children less than 5 years of age of different sexes may reasonably share a bedroom.
- Children 5 years of age or older of opposite sex should have separate bedrooms.
- Children less than 18 years of age and of the same sex may reasonably share a bedroom.
- Single household members 18 years or older should have a separate bedroom, as should parents or couples (AIHW 2017).

Overcrowding can be assessed at household level or individual level.

This section reports on overcrowding at individual level.

How many children live in overcrowded housing?

In 2016, around 18,900 children aged 0–14 lived in overcrowded housing, a proportion of 0.4%.

- There were no differences in the proportion of boys and girls living in overcrowded housing (both 0.4%).
- Rates were the same across age groups, with children aged 0–4, 5–9 and 10–14 all equally as likely to live in overcrowded housing (all 0.4%).
- Children aged 0–14 were slightly over-represented in overcrowded living situations, making up nearly one-quarter (23%) of all people living in overcrowded housing while comprising just under one-fifth (19%) of the Australian population.

Have rates of overcrowding improved over time?

The proportion of children aged 0–14 living in overcrowded housing remained relatively stable between 2006 (0.3% or 13,100) and 2016 (0.4% or 18,900).

Are rates of overcrowding the same for everyone?

In 2016, the proportion of children aged 0–14 living in overcrowded housing varied by population group.

Children from households with multiple families were more likely living in an overcrowded situation (1.6% or 8,100) than children in 1-parent families (0.5% or 3,300) and couple families (0.2% or 7,400).

More children were living in an overcrowded situation in *Remote and very remote* areas (2.4% or 2,600) than in *Outer regional* (0.4% or 1,500), *Major cities* (0.4% or 12,900) and *Inner regional* (0.2% or 1,900) areas.

Children living in the lowest socioeconomic areas were also more likely than those as in the highest socioeconomic areas to be living in an overcrowded situation (1.2% or 9,700 compared with 0.1% or 760).

Differences were also evident between children born overseas and children born in Australia (0.9% or 3,300 compared with 0.4% or 15,300), and between Aboriginal and Torres Strait Islander children and non-Indigenous children (1.8% or 3,900 compared with 0.4% or 14,700) (Figure 1). However, rates of overcrowding among Indigenous children showed a positive change between 2006 and 2016, decreasing from 2.5% to 1.8%.

Figure 1: Proportion of children aged 0–14 living in overcrowded housing, by priority population group, 2016

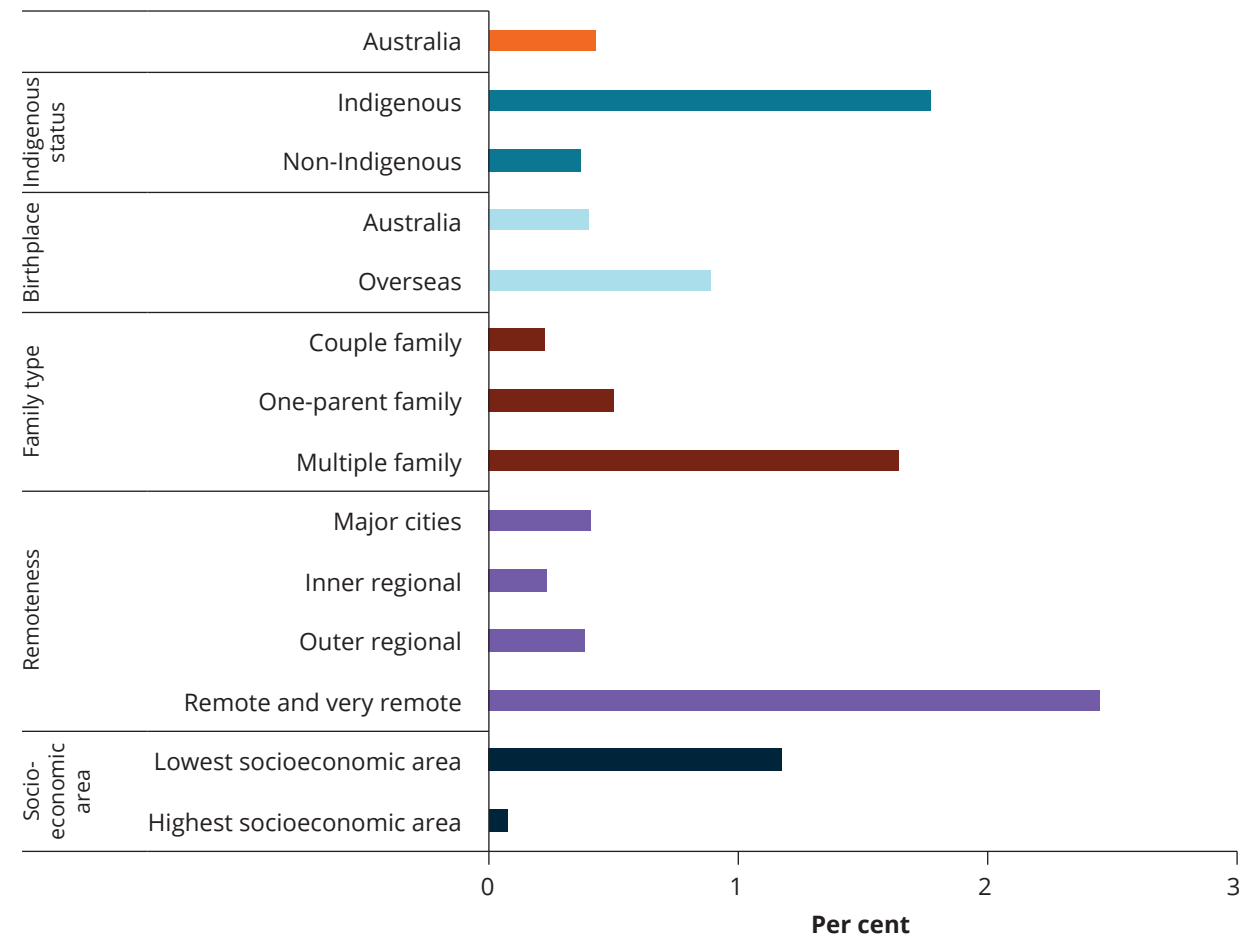


Chart: AIHW. Source: ABS 2018.

Data limitations and development opportunities

Limitations to the way family relationships are coded in the Census can result in the misclassification of relationships, especially for large households with complex family relationships or multiple families. If relationships are incorrectly recorded, households including more than 1 couple may look like crowded group households as single adults require their own bedroom while couples can share a bedroom under the Canadian National Occupancy Standard. This may inflate the number of children recorded as living in overcrowded housing. The ABS has recently started exploring the definitions of family across its full suite of surveys and data sources.

Where do I go for more information?

For more information on:

- Indigenous children and overcrowding, see: [Indigenous children](#)
- overcrowding by states and territories, see: [Children's Headline Indicators](#).

See also [Methods](#).

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Homelessness

Key findings

- In 2016, around 19,400 children (0.4%) aged 0–14 were homeless on Census night.
- In 2017–18, almost half of children (45% or 29,600) receiving specialist homelessness services accessed these services for interpersonal reasons such as domestic and family violence or family breakdown.

While access to safe, stable and adequate housing is essential for children's health and wellbeing, each night some Australian children experience homelessness. They may be spending the night:

- in supported accommodation for the homeless
- sleeping in temporary accommodation
- couch surfing
- sleeping on the street
- living in severely crowded dwellings (ABS 2018).

Some children under the age of 16 live in families experiencing homelessness, while others experience homelessness on their own (Cooper 2017).



Poverty is a key driver of homelessness for children and their families, while the experience of overcrowding and poor housing conditions are common pathways into homelessness (Buckner 2008; Embleton et al. 2016;). Family conflict and domestic and family violence are also key pathways into homelessness for children and their families, as many people fleeing violence do not have the resources or support networks to find suitable emergency housing (Embleton et al. 2016; Mission Australia 2019). Children experiencing homelessness are also at increased risk of being homeless as adolescents and adults (Flatau et al. 2012).

Children experiencing homelessness are an especially vulnerable population. Preschool and school-aged children experiencing homelessness are more likely to experience mental health problems than housed children, and some evidence suggests that homeless children are more likely to have physical disability, emotional or behavioural problems than housed children (Bassuk et al. 2015; Clair 2018). Food insecurity is also frequently reported by young people experiencing homelessness, putting them at increased risk of adverse health outcomes (Crawford et al. 2015).

Homelessness can be disruptive to children's education. It is associated with decreased engagement in the classroom and, when coupled with frequent school moves, is associated with poor academic achievement (Fantuzzo et al. 2012). Continuity of schooling provides stability for children experiencing homelessness and can contribute to wellbeing later in life (Gibson et al. 2010).

Box 1: Data sources and definitions of homelessness

ABS Census of Population and Housing

Data on children experiencing homelessness come from the ABS Census of Population and Housing. The Census is collected by the ABS every 5 years with the most recent data available for 2016. The 2016 Census collected information on a range of welfare-related topics and estimates the number of people experiencing homelessness on Census night. The Census is completed by the householder, if present, or any adult member of the household, on behalf of any children in the household (ABS 2016).

The ABS also has strategies targeting rough sleepers, couch surfers and people living in supported accommodation to maximise the number of homeless people counted on Census night (ABS 2018).

According to the ABS, a person is considered to be experiencing homelessness if they are:

- living in an improvised dwelling, tent or sleeping out
- in supported accommodation for the homeless
- staying temporarily with another household, including couch surfing
- staying in a boarding house or other temporary lodging
- living in a severely overcrowded situation.

People living in severely overcrowded housing (those living in a residence requiring 4 or more additional bedrooms according to the Canadian National Occupancy Standard (see [Overcrowding](#)) are considered homeless because they do not have control of, or access to, space for social relations (ABS 2018). This definition of homelessness recognises that a home should be secure, stable and safe, with access to privacy for adults and children as well as space for sleep, study and play (CHP 2018).

Specialist Homelessness Services Collection

Data on children receiving assistance from specialist homelessness services comes from the Specialist Homelessness Services Collection (SHSC), which collects information about people who seek assistance from specialist homelessness services agencies. Data are collected on an ongoing basis and submitted to the AIHW monthly.

Specialist homelessness services (SHS) agencies provide assistance to people who are homeless or at risk of homelessness. A client's **homeless** status is based on their housing circumstances at the beginning of their first support period (AIHW 2019).

The SHSC considers people to be experiencing **homelessness** if they:

- have no shelter or are living in an improvised/inadequate dwelling
- are living in short term temporary accommodation
- are couch surfing or living with no tenure in a house, townhouse or flat.

People are considered **at risk of homelessness** if they are living in:

- public or community housing, either as a renter or rent free
- private or other housing, as a renter, rent free or owner
- institutional settings.

How many children are homeless?

According to the ABS Census, around 19,400 children (0.4%) aged 0–14 experienced homelessness on Census night in 2016. These children made up around 17% of the homeless population.

Rates of homelessness were the same for boys and girls (both 0.4%) and were similar between younger children aged 0–4 (0.5%) and older children aged 5–9 and 10–14 (both 0.4%).

The majority (62% or 12,000) of children experiencing homelessness were living in severely overcrowded dwellings, and one-quarter (25% or 4,900) were living in supported accommodation for the homeless.

Around 8.1% (1,600) were staying temporarily with other households and another 2.9% (around 560) of homeless children were 'sleeping rough' (living in improvised dwellings, tents or sleeping out).

Have rates of homelessness improved over time?

While the number of children aged 0–14 living in homeless situations increased slightly from 19,100 in 2006 to 19,400 in 2016, the proportion of children living in homeless situations remained relatively stable between 2006 (0.5%) and 2016 (0.4%).

Are rates of homelessness the same for everyone?

Rates of homelessness among children aged 0–14 years vary across different types of households. In 2016, children living in multiple family households were 4 times as likely to be homeless as children in 1-parent family households (2.4% or 11,700 compared with 0.6% or 4,000, respectively) and 24 times as likely as those in couple family households (0.1% or 3,600).

Rates of homelessness were highest among children living in *Remote and very remote* areas (5.2% or 5,400) compared with *Major cities* (0.3% or 10,200), *Inner regional* (0.3% or 2,100) and *Outer regional* (0.4% or 1,600) areas. Higher rates of homelessness in *Remote and very remote* areas is due to higher rates of overcrowding in these areas (see [Overcrowding](#)). Children living in areas of greater socioeconomic disadvantage were also more likely homeless (1.3% or 11,100) than those living in areas of least disadvantage (0.1% or 710) (Figure 1).

Differences were also evident between Aboriginal and Torres Strait Islander children and non-Indigenous children (3.3% or 7,200 and 0.3% or 10,900, respectively). However, the proportion of Indigenous children living in homeless situations has shown a positive change between 2006 and 2016, decreasing by 2 percentage points from 5.3% to 3.3%. Most Indigenous children who were homeless (80%) were living in severely overcrowded household.

Figure 1: Proportion of children aged 0–14 who are homeless, by priority population group, 2016

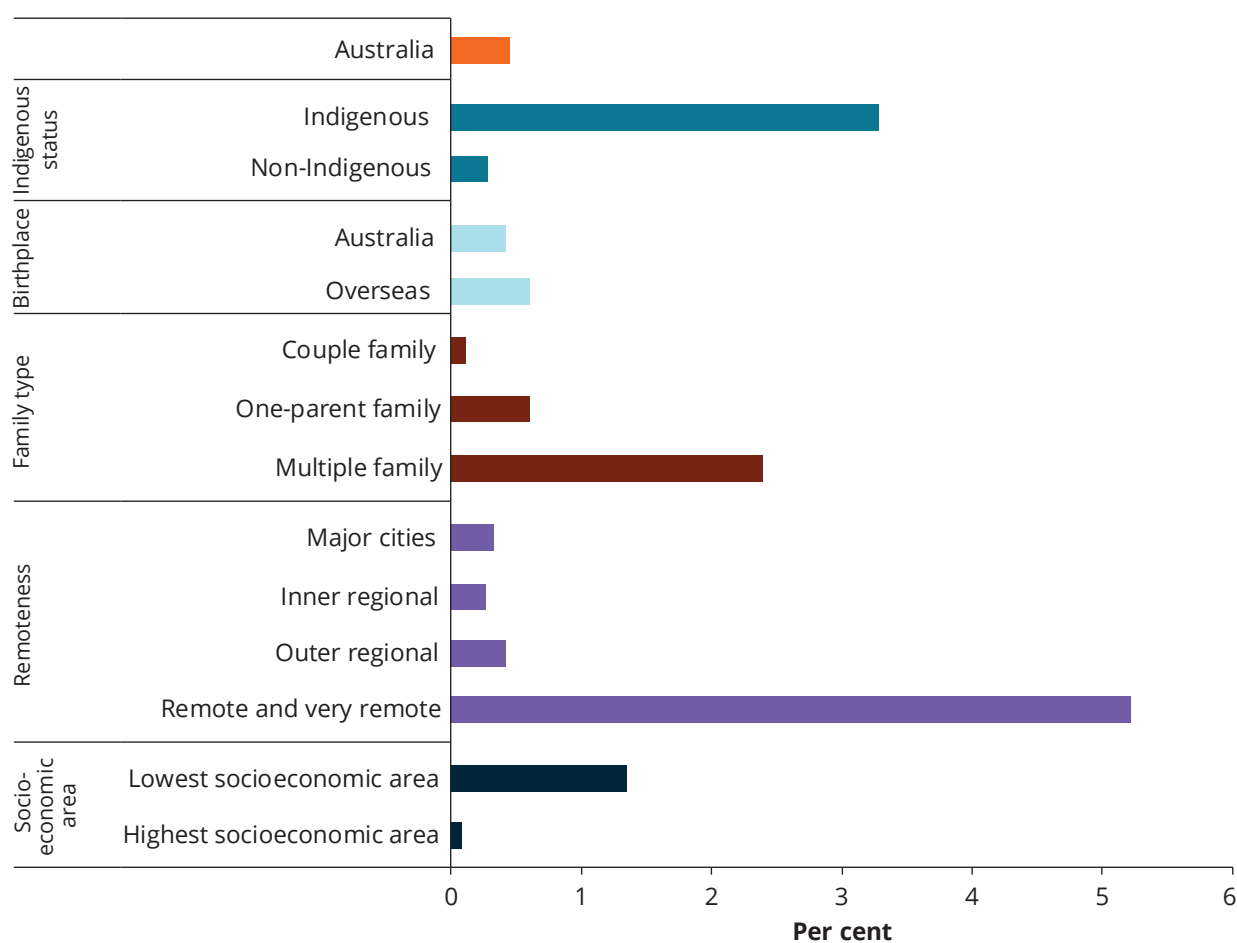


Chart: AIHW. Source: ABS 2018.

Specialist homelessness services

In 2017–18, nearly 65,600 children (14.1 per 1,000 children aged 0–14) received assistance through homelessness services. Children made up nearly one-quarter (23%) of people receiving assistance from specialist homelessness services. Of these:

- More than one-third (35% or 23,000) were recorded as homeless at the time they received SHS, and nearly half (48% or 31,500) were at risk of homelessness. The remaining 17% (10,800) had no living situation recorded.
- The majority (90% or 58,900) presented to homelessness services as part of a ‘related group’ (family), 9.4% (6,200) presented alone, and 0.9% (560) presented as part of an ‘other group’.
- The majority of children (45% or 29,600) who received homelessness services did so for interpersonal reasons as their main reason, including domestic and family violence and family breakdown. Another 29% (19,000) received services due to issues with accommodation, such as housing crisis or inadequate or inappropriate dwelling conditions, 11% (7,000) for financial reasons, 1% (540) for health reasons and 13% (8,700) for other reasons.

Rates of homelessness service use were similar between boys and girls (13.9 and 14.2 per 1,000 boys and girls, respectively).

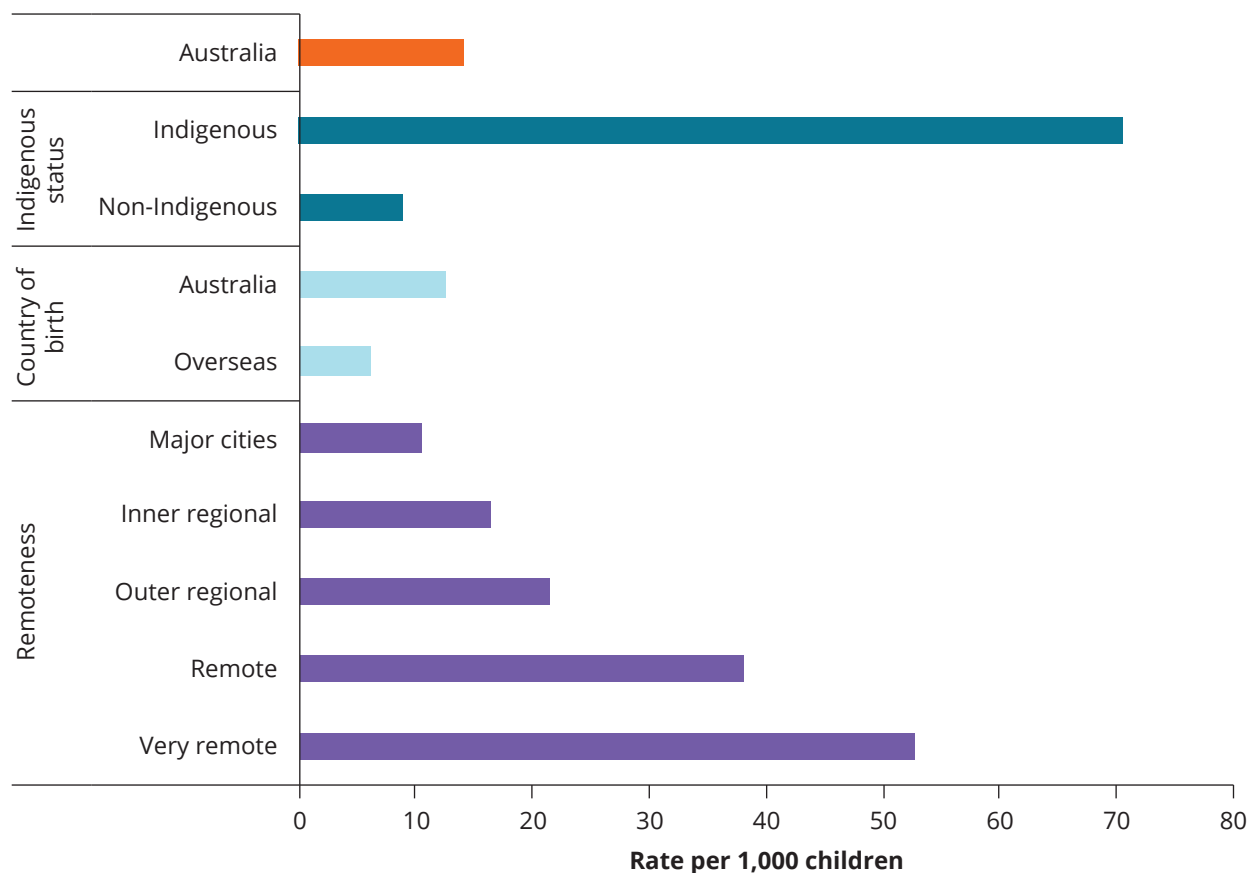
Do rates of service use vary across populations?

Indigenous children aged 0–14 were more likely to receive assistance through homelessness services than non-Indigenous children (71 per 1,000 Indigenous children compared with 9.0 per 1,000 non-Indigenous children).

Children born in Australia were twice as likely as those born overseas to receive assistance through specialist homelessness services (12.6 per 1,000 children compared with 6.1, respectively).

While children in *Major cities* made up the majority of all children accessing homelessness service (52%), children living in *Very remote* areas were more than 5 times as likely to receive assistance as those in *Major cities* (10.4 children per 1,000, compared with 52.6, respectively) (Figure 2).

Figure 2: Children aged 0–14 who received assistance through specialist homelessness services, by priority population group, 2017–18



Note: 'Indigenous status' excludes 6,900 children whose Indigenous status was recorded as 'Not stated'.

Chart: AIHW. Source: AIHW Specialist Homelessness Services Collection.

Data limitations and development opportunities

Current national data sources are likely to underestimate the number of children who are homeless as they rely on self-reporting through the ABS Census and/or the use of specialist homelessness services.

Where do I go for more information?

For more information about:

- Indigenous children and homelessness, see: [Indigenous children](#)
- homelessness by states and territories, see: [Children's Headline Indicators](#) and [Homelessness and homelessness services](#).
- young people in the youth justice and child protection systems who have experienced homelessness, see: [Vulnerable young people: interactions across homelessness, youth justice and child protection](#).
- persons seeking assistance from specialist homelessness services, see: [Specialist homelessness services annual report 2017–18](#).
- technical notes relating to this section, refer to [Homelessness](#) in the online report. See also [Methods](#).

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Justice
and safety

Justice and safety

Safety and fairness is important to children (AHRC 2016, 2017). Most children grow up in an environment where they feel safe. However, this is not the case for all children, with some being exposed to crime, violence and other harmful behaviours or environments. These experiences can have a negative influence on a child's wellbeing and potentially lead to adverse long-term outcomes for the child and the communities they live in. Childhood experiences with violence and/or other unsafe environments can also have an economic impact on society as children who have been exposed to harm may require increased need for support and services for related issues.

Drawing on sources providing different perspectives of justice and safety, this section provides an overview of children's exposure to violence and crime in their neighbourhoods, homes and schools, and their involvement with the justice system.

Many topics covered in this domain are interrelated and there is overlap in the data presented throughout the topic-based sections. For example, children who may have been the victim of a recorded crime, may also have been in contact with the child protection system, and/or hospitalised as a result of that crime.

The ability to properly explore the overlap between topic areas is limited because of the data sources used. Similarly, national insight on the relationship between topics, such as child protection and youth justice, or maltreatment and health, is only possible through de-identified linkage of multiple data sources. Linkage supports better understanding of protective and risk factors related to childhood harm, outcomes related to harm, and children's related pathways through the health and welfare system.

The governance supporting children's safety

While parents and carers play the primary role in ensuring their children are safe, this is a shared responsibility with the wider community and governments.

The safety and appropriate treatment of Australia's children are governed by policies and legislature at the Australian Government and state and territory government levels.

For most aspects of violence against children, child protection and youth justice systems, states and territories generally have their own legislature. The Commonwealth *Family Law Act 1975* and the *Australian Human Rights Commission Act 1986* provide a foundation for states and territories to build upon (AIFS 2018). State and territory legislation is in place to help protect Australia's children are based on the guiding principle that decisions and actions should be in the best interest of the child.

Legislation is listed and further explored in an [Australian child protection legislation Child Family Community Australia \(CFCA\) Resource Sheet](#) (AIFS 2018).

Related national strategies for children

The safety of children is a priority within a range of national strategies and/or initiatives relevant to most or all snapshots (Table 1).

Table 1: National strategies and/or initiatives relevant to justice and safety

Strategy and/or initiative
National Framework for Protecting Australia's Children 2009–2020, including the Fourth Action Plan 2018–2020
National statement of Principles for Child Safe Organisations
National plan to reduce violence against women and their children 2010–2022
National Standards for Out-of-Home Care
Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health
Australian Student Wellbeing Framework

In recent years, the need to improve the wellbeing and, specifically, the safety of Australian children has been highlighted by both government and non-government sectors. This includes recognising that current data and reporting are not sufficient, as evidenced by data-related recommendations in reports from the:

- [Royal Commission into the Protection and Detention of Children in the Northern Territory](#)
- [Royal Commission into Institutional Responses to Child Sexual Abuse](#)
- [Royal Commission into Family Violence](#)
- [Australian Human Rights Commission](#).

The Council of Australian Governments has also established a [Bullying and Cyberbullying Senior Officials Working Group](#) to consider strategies and potential initiatives to help reduce bullying, and anti-bullying programs.

What's missing?

The sections in this domain include a number of established national indicators, however, consistent national reporting is not available in some areas due to lack of a suitable data source and/or indicator. For more information on national data gaps, see [Data gaps](#).

A number of topics were not included for other reasons but could be considered for future updates.

Children's subjective view of safety

Where available, subjective data have been included. Additional, regular, national data on the child's perspective of safety is essential for more complete understanding, and evidence suggests that children want to discuss their personal challenges and experiences (Noble-Carr et al. 2017; Queensland Child and Family Commission 2018).

However, there are some challenges to collecting data directly from children which limit availability, including parental consent and issues relating to child disclosure of sensitive or criminal behaviour; for example, instances of child abuse or neglect.

Pathways, transitions and outcomes

National data on the longer term outcomes of children exposed to violence and crime in their neighbourhoods, homes and schools are limited, as is information about their pathways through the health and welfare system. Linkage of relevant data collections, such as child protection, with other sources, including health services, education, or Centrelink data could assist in this area.

Priority populations

National data on exposure to violence and crime in neighbourhoods, homes and schools for children in priority populations are limited. The Longitudinal Study of Indigenous Children (LSIC) could be explored in the future as a way of improving information on Indigenous children for topics covered in this domain.

The new Indigenous survey, Family and Community Safety study (FaCtS) for Aboriginal and Torres Strait Islander people will also assist, as may the First national study of child abuse and neglect in Australia: prevalence, health outcomes, and burden of disease, being conducted from 2019–2023.

Bullying (including cyberbullying)

The [Bullying](#) section draws on multiple data sources to provide some insight into bullying at a national level but the data sources are not comparable and there are some definitional issues.

Multiple exposure to violence and crime

Data sources used to report on children's exposure to crime (including family violence) and bullying do not support analysis of multiple exposure either as victim or perpetrator. Being able to identify children who have had multiple exposures would allow insight into how many children are actually involved in crime and bullying and greater understanding of risk factors and social environments that can be targeted for improvement.

National comprehensive prevalence data on child abuse and neglect

There are currently no comprehensive national data on the prevalence of child abuse and neglect, including re-occurrence, so proxy data from child protection service agencies are used. Australia's first national study of child abuse and neglect, being conducted from 2019–2023, may provide some insight in this respect.

Specific areas related to children living in non-parental care

A number of topics related to [Children in non-parental care](#) are not adequately covered, although development work is underway to collect information on some of these, including:

- data on children living in non-parental care who have not had contact with the child protection system, including other family-based care arrangements
- children the subject of a substantiation while in out-of-home care
- children who maintain contact with their birth families
- children who are reunified with their families following a placement.

Specific areas related to youth justice

National data on the health and welfare status of children under youth justice supervision, including their health service use, are limited. National data on diverting young people from further involvement in the youth justice system are also not currently available.

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Children and crime

Key findings

- In 2018, there were around 7,900 sexual assaults against children aged 0–14. The rate of sexual assault was 3.5 times higher for girls than boys (266 sexual assaults per 100,000 girls, compared with 72 sexual assaults per 100,000 boys).
- In 2016–17, parents, carers and other family members were identified as the perpetrators for almost half (48%) of all assault-related hospitalisations for children aged 0–14.
- In 2012–14, there were 35 deaths due to homicide among children aged 0–14, a rate of 0.4 per 100,000 children—this increased to 2.3 per 100,000 for infants under the age of 1.
- In 2017–18, more than two-thirds (around 68% or 9,400) of the 13,800 criminal offences committed by children aged 10–14 were committed by boys.

Children can be exposed to crime as victims or witnesses within their home or the broader community. In a small number of cases, children may also be offenders. Any type of exposure to crime at a young age can have potentially detrimental impacts on a child's health, safety and development (ANROWS 2018; WHO 2016). The types of crime children can be exposed to vary from non-violent crime, such as theft or fraud, to highly violent crime, such as aggravated sexual assault or homicide (ABS 2011a).

There can be physical and/or emotional impacts for children who are victims of, or who witness crime. In some cases, these may be short-term, such as a broken bone, temporary guilt, or behaviour regression; however, in many cases, the consequences can involve much longer-term developmental, mental, physical and social problems (ANROWS 2018; Finkelhor et al. 2009; Lewis et al. 2010; WHO 2016). For example, children exposed to crime, especially violent crime or crime involving weapons, may have:

- increased likelihood of depression
- suicidal ideation and behaviour
- psychopathology and other psychological disorders
- future victimisation and offending
- homelessness (AIHW 2018; Bland & Shallcross 2015; Campo 2015; Holt et al. 2008; Jaffe et al. 2012; Knight 2015; Lewis et al. 2010; Mitchell et al. 2015).

Children who are themselves offenders are more likely to have diminished educational attainment and social participation, interpersonal difficulties and are at higher risk of future offending (Aizer & Doyle 2015; Gann et al. 2015; Hagell & Jeyarajah-Dent 2006).

Research indicates that the negative impacts resulting from a child's direct exposure to crime are cumulative, with negative impacts increasing with the number and types of exposures (Finkelhor et al. 2007a, 2007b; Mitchell et al. 2015). While the greatest negative impacts on children tend to result from exposure to violent interpersonal crimes, property related crime can also have an impact, for example burglary and fraud have been found to have long lasting emotional and relational impacts on children (Dinisman & Moros 2017).

Some, but not all, crimes are identified when police become involved or a hospitalisation occurs as a direct result of the crime (ABS 2011a). This chapter focuses predominately on children who are victims of crime using Australian Bureau of Statistics (ABS) 2017 Recorded Crime data (Box 1). Some data on recorded crimes perpetrated by children are also provided. As not all incidents of crime are reported to police, recorded crimes data are likely to underestimate the true rate of crime involving children.

Children who are victims of assault may receive medical attention and/or support in various ways, for example, through a general practitioner, pharmacist, teacher, or emergency department. Data on assaults resulting in hospitalisation are included as 1 example of related health service use.

Box 1: Data sources

Data on crimes committed against or by children are drawn from the 2018 Recorded Crime—Victims and 2017–18 Recorded Crime—Offenders statistics published by the Australian Bureau of Statistics (ABS). Crimes are reported to police in each state and territory and published according to the National Crime Recording Standard categories.

ABS Recorded Crime data include offences classified to selected divisions and/or subdivisions of the Australian and New Zealand Standard Offence Classification (ANZSOC).

Recorded Crime data reflect unique offences, not unique people.

For victims' data, only 1 offence is counted for a single incident unless there are multiple offences within the incident that fall under different ANZSOC offence categories. Incidents that include multiple offences within the same offence category are counted only once.

For offenders' data, only the principal offence within an incident is counted. It should be noted that alleged offences may be later withdrawn or not be substantiated, and not all incidents of crime are reported to the police.

Data in this chapter on assault resulting in hospitalisation are from the AIHW National Hospital Morbidity Database and include hospitalised assault injuries where the episode of admitted patient care ended during the financial year (1 July 2016 to 30 June 2017). Hospital morbidity data reflect unique hospitalisations, not unique people. These data represent a subset of children receiving care for assault, as some children may access other services, for example emergency department care and/or care from general practitioners. In addition, some children may not need or be able to seek help.

Data in this chapter on homicide are sourced from the AIHW National Mortality Database.

Often children who are assaulted, sexually or otherwise, may have contact with state and territory child protection systems (see [Child abuse and neglect](#) and [Children in non-parental care](#)) and there would be some overlap in recorded crime and child protection data presented in this report.

When assault is perpetrated by a family member it is considered family violence (see [Children exposed to family violence](#)). Extreme cases of bullying may also be considered assault (see [Bullying](#)).



How many children are victims of crime?

According to the ABS 2018 Recorded Crime statistics, there were around 9,300 sexual assault, kidnapping/abduction, robbery and blackmail/extortion offences against children aged 0–14. Sexual assault accounted for the large majority of these (85% or around 7,900 cases). There was also around 8,600 other assault offences, such as grievous bodily harm, torture, and use of a weapon, perpetrated against children aged 0–14 in the 6 jurisdictions for which data were available—New South Wales, South Australia, Western Australia, Tasmania, Northern Territory and the Australian Capital Territory (ABS 2019a).

Recorded crime data for 2018 assaults resulting in death (homicide) were not separately available for children aged 0–14; however, 2012–14 data on homicides involving children are presented in a subsequent section.

As sexual assault and other assault (Box 2) account for the large majority of recorded crimes against children aged 0–14, they will be the main focus here.

Box 2: Defining and measuring assault

Sexual assault refers to any physical contact, or intent of contact, of a sexual nature directed toward another person where that person does not give consent, gives consent as a result of intimidation or deception, or consent is unable to be given because of youth, temporary/permanent (mental) incapacity or familial relationship (ABS 2019a). Includes aggravated sexual assault and non-aggravated sexual assault (ABS 2011b).

Other assault refers to the direct infliction or threat of force, injury or violence where there is an apprehension that the threat could be enacted (ABS 2019a). Includes serious assault resulting in injury, serious assault not resulting in injury and common assault (ABS 2011b).

How many children experience assault?

Sexual assault

According to ABS Recorded Crime—Victims data, around 7,900 sexual assaults were perpetrated against children aged 0–14 in 2018. This equates to a rate of 167 sexual assaults per 100,000 children (Figure 1). Around two-fifths (3,100) of these were considered to be related to family violence, and these data are explored further in [Children exposed to family violence](#).

In 2018, sexual assault was:

- 4 times as likely to be perpetrated against older children aged 10–14 than younger children (338 sexual assaults per 100,000 children compared with 86 sexual assaults per 100,000)
- more than 3.5 times as likely to be perpetrated against girls than boys (266 sexual assaults per 100,000 girls, compared with 72 sexual assaults per 100,000 boys).

Figure 1: Victims of sexual assault by age and sex, 2018

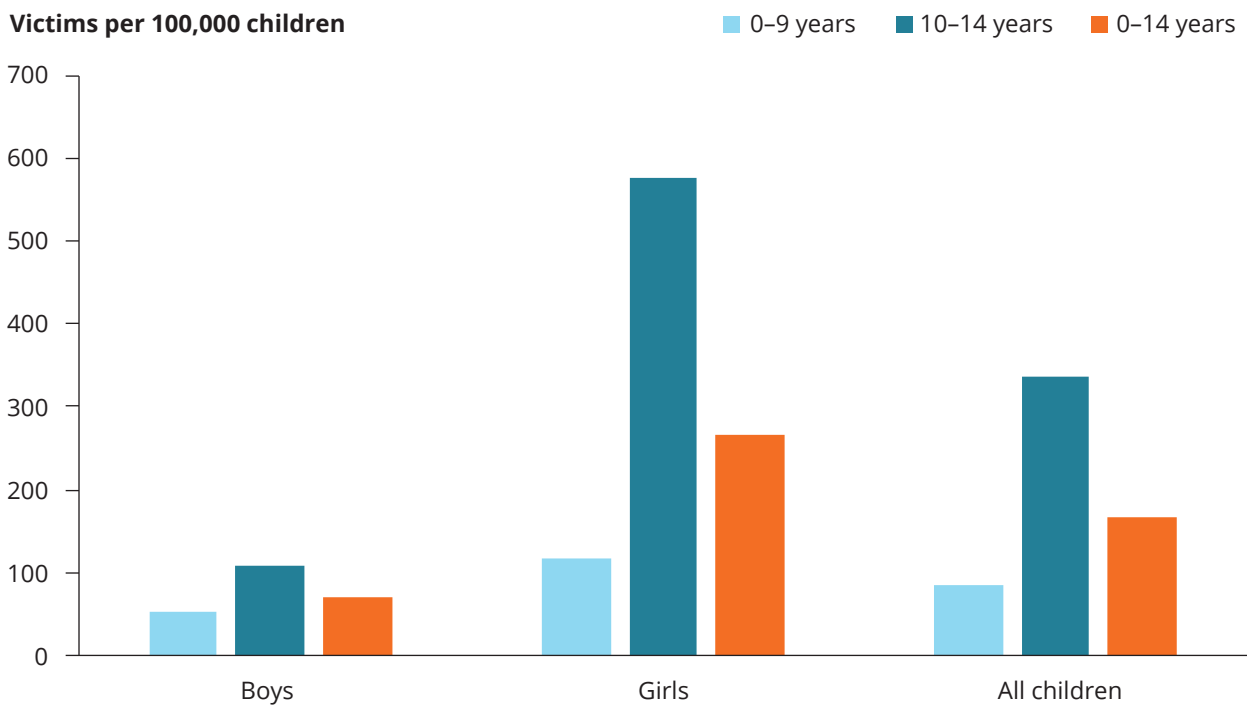


Chart: AIHW. Source: ABS 2019a.

Other assault

Other assault rates for children aged 0–14 in 2018 varied between states and territories. The highest rate was 492 assaults per 100,000 children in the Northern Territory and the lowest rate was 160 assaults per 100,000 children in Tasmania (Figure 2) (ABS 2019c).

For all states and territories presented, other assault was perpetrated against children aged 10–14 at a much higher rate than younger children. The discrepancy was greatest in Tasmania, where other assault was perpetrated against children aged 10–14 at a rate 8 times that for children aged 0–9 (377 assaults per 100,000 compared with 47) (ABS 2019c).

Figure 2: Victims of other assault by age and selected state and territory, 2018

Victims per 100,000 children

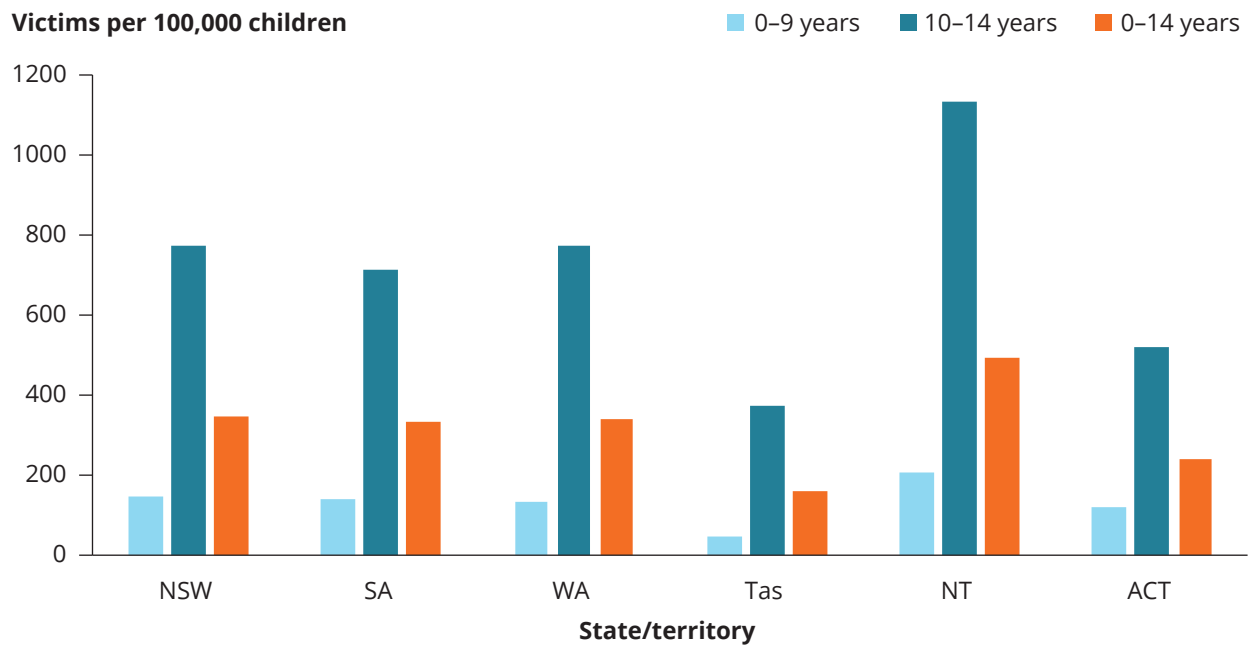


Chart: AIHW. Source: ABS 2019c.

Except for the Northern Territory, other assault was perpetrated against boys at higher rates than girls (Figure 3). Girls in the Northern Territory had the highest rate overall, at 628 assaults per 100,000 children (ABS 2019c).

Figure 3: Victims of other assault by sex and selected state and territory, 2018

Victims per 100,000 children

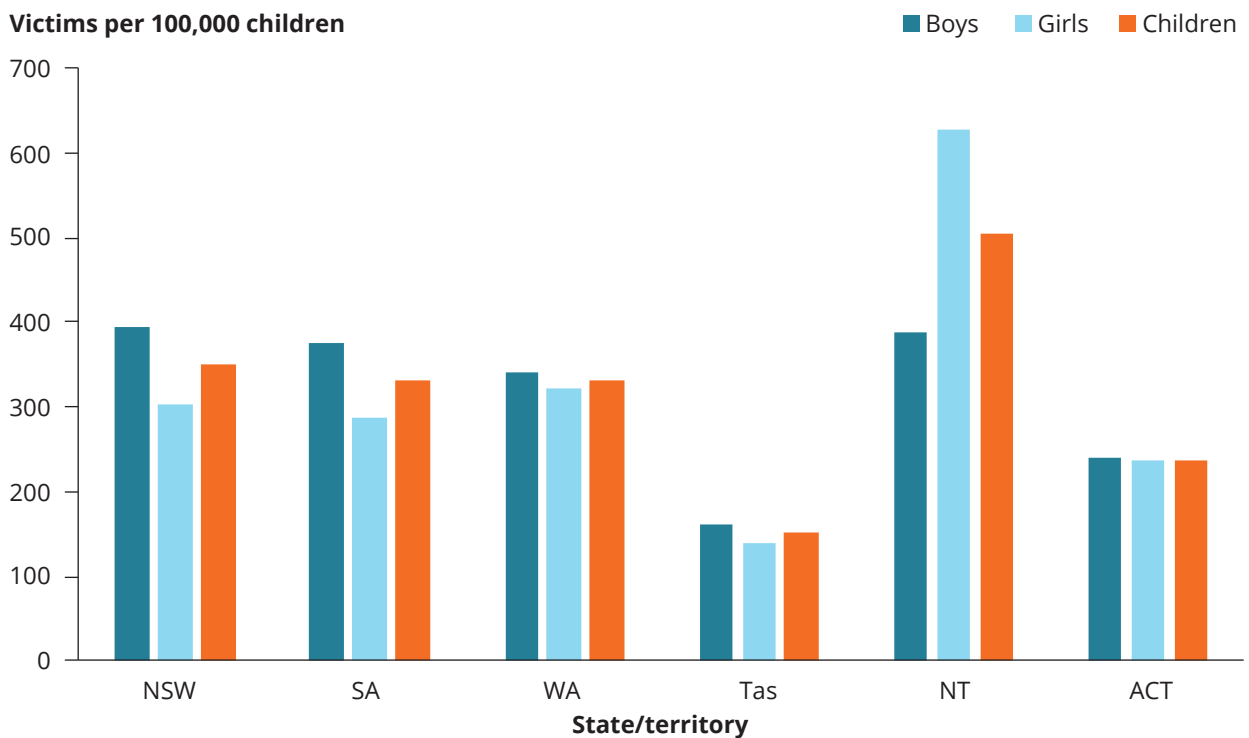
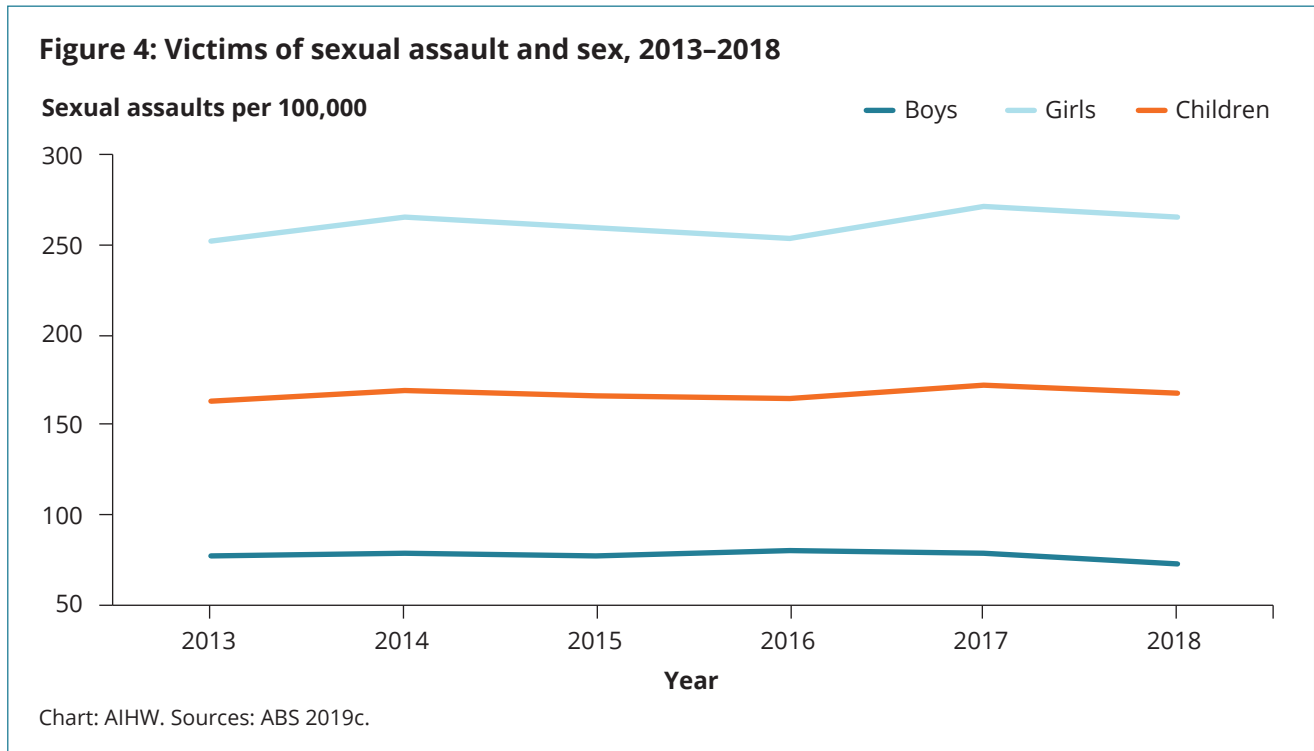


Chart: AIHW. Source: ABS 2019c.

Has the rate of assault changed over time?

Sexual assault

Rates of sexual assault have remained relatively stable in the 5 years leading up to 2018 for both boys and girls, with sexual assault consistently being perpetrated against girls at a far higher rate than boys (Figure 4).



Other assault

The rate of other assault being perpetrated against children in the Northern Territory fluctuated overtime, but remained consistently higher than all other states and territories (Figure 5).

The Northern Territory's rate decreased by 13%—the largest decrease—from 565 per 100,000 children in 2013 to 493 per 100,000 children in 2018. The Australian Capital Territory experienced the largest increase, almost doubling from 133 assaults per 100,000 children in 2013 to 244 assaults per 100,000 children in 2018 (ABS 2019c).

Figure 5: Victims of other assault by jurisdiction, 2013–2018

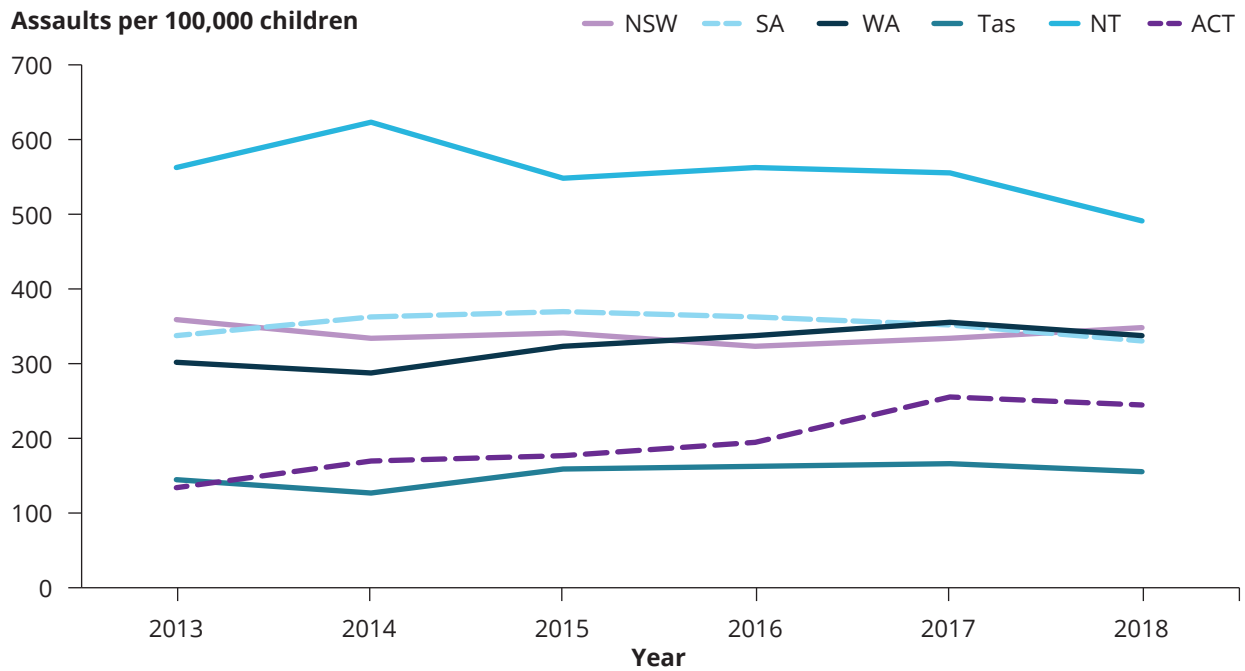


Chart: AIHW. Source: ABS 2019c.

How many children were hospitalised due to assault?

In 2016–17, there were 612 hospitalised assault cases —a rate of 13.3 cases per 100,000 children aged 0–14. Rates of hospitalised assault cases varied for different groups (figures 6, 7 and 8).

The rate of hospitalised assault cases increased with remoteness. Rates for children living in *Very remote* areas were 8.5 times as high as rates for children living in *Major Cities* (87 per 100,000 compared with 10 per 100,000).

Children in the lowest socioeconomic areas were also more likely to be hospitalised due to assault than those living in the highest socioeconomic areas (23 and 5 hospitalised cases per 100,000 children, respectively).

Differences were also evident between Indigenous and non-Indigenous children (62 and 10 per 100,000 children, respectively).

Figure 6: Hospitalised assault cases for children aged 0–14, by sex and age, 2016–17

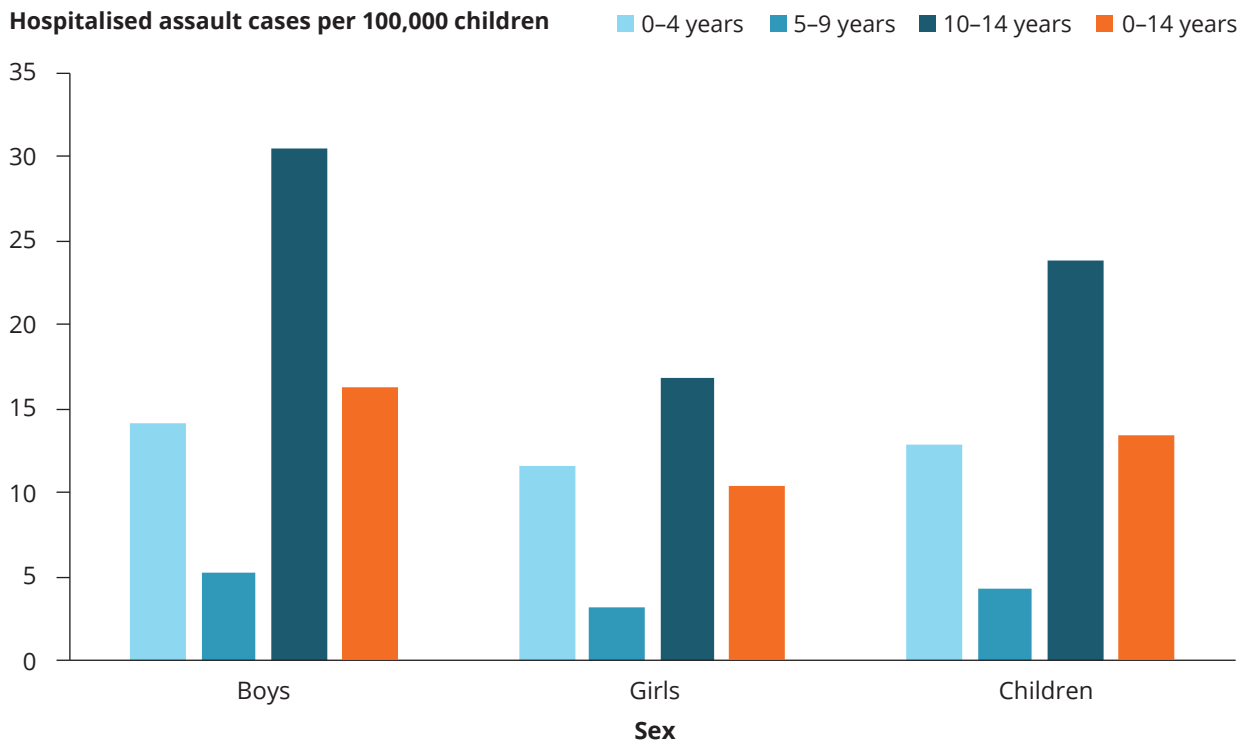


Chart: AIHW. Source: AIHW National Hospital Morbidity Database.

Figure 7: Hospitalised assault cases for children aged 0–14, by age and Indigenous status, 2016–17

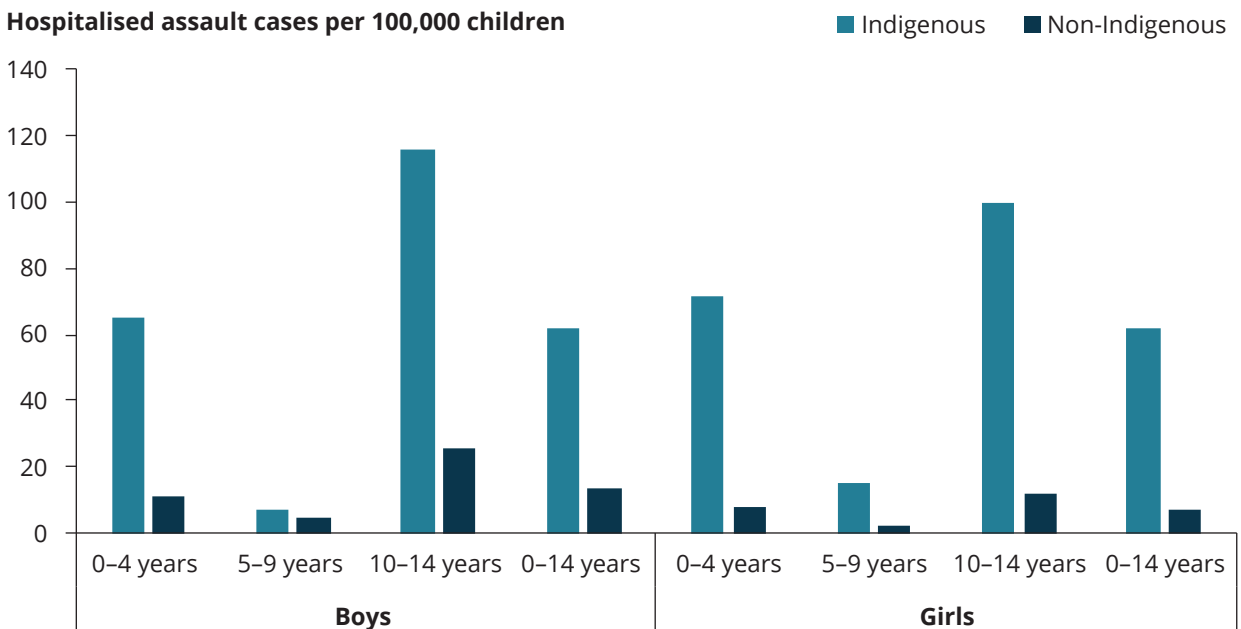


Chart: AIHW. Source: AIHW National Hospital Morbidity Database.

Figure 8: Hospitalised assault cases for children aged 0-14, by selected population characteristics, 2016-17

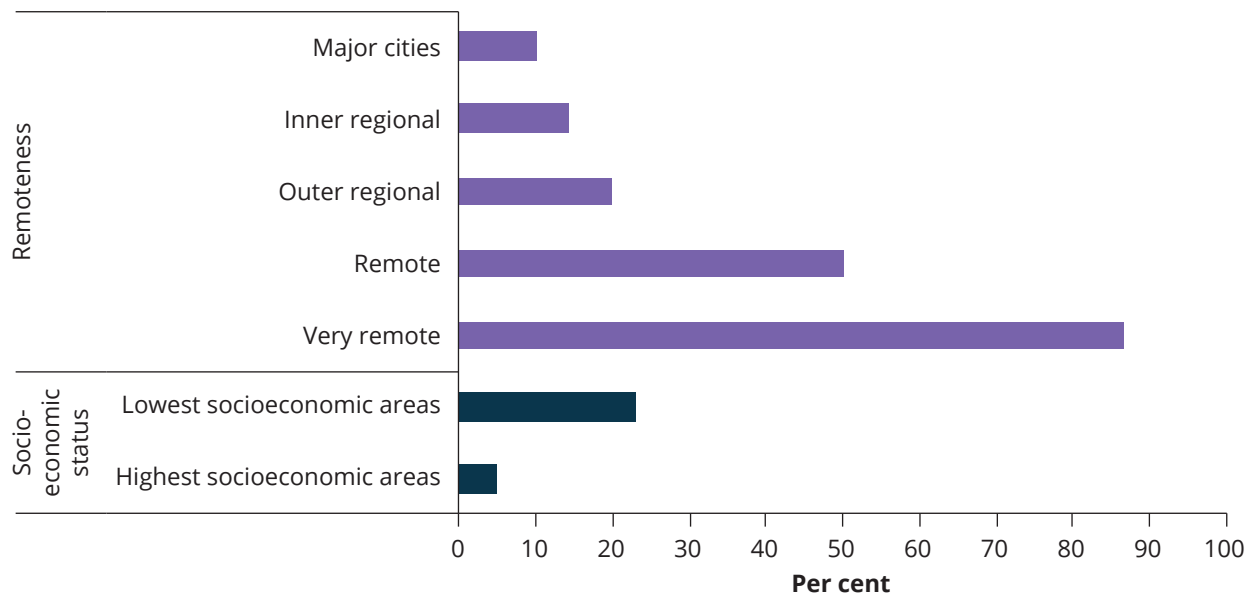


Chart: AIHW. Source: AIHW National Hospital Morbidity Database.

In just under half of all hospitalised assault cases (48%) the perpetrator was a parent, carer or other family member (Figure 9). The perpetrator was unspecified or other in 30% of cases, and identified as an acquaintance or friend in 14% of cases.

Assault by bodily force (48%) was the most common type of assault resulting in a hospitalised assault cases. Other maltreatment syndromes were the second most common, representing 25% of all hospitalised cases.

More information on hospitalised assault cases perpetrated by a parent or other family member (family violence) is available in [Children exposed to family violence](#).

Figure 9: Hospitalised assault cases for children aged 0-14, by perpetrator, 2016-17

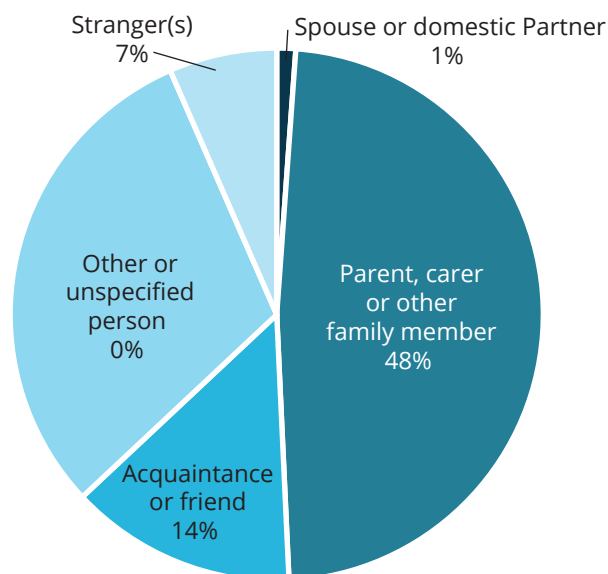
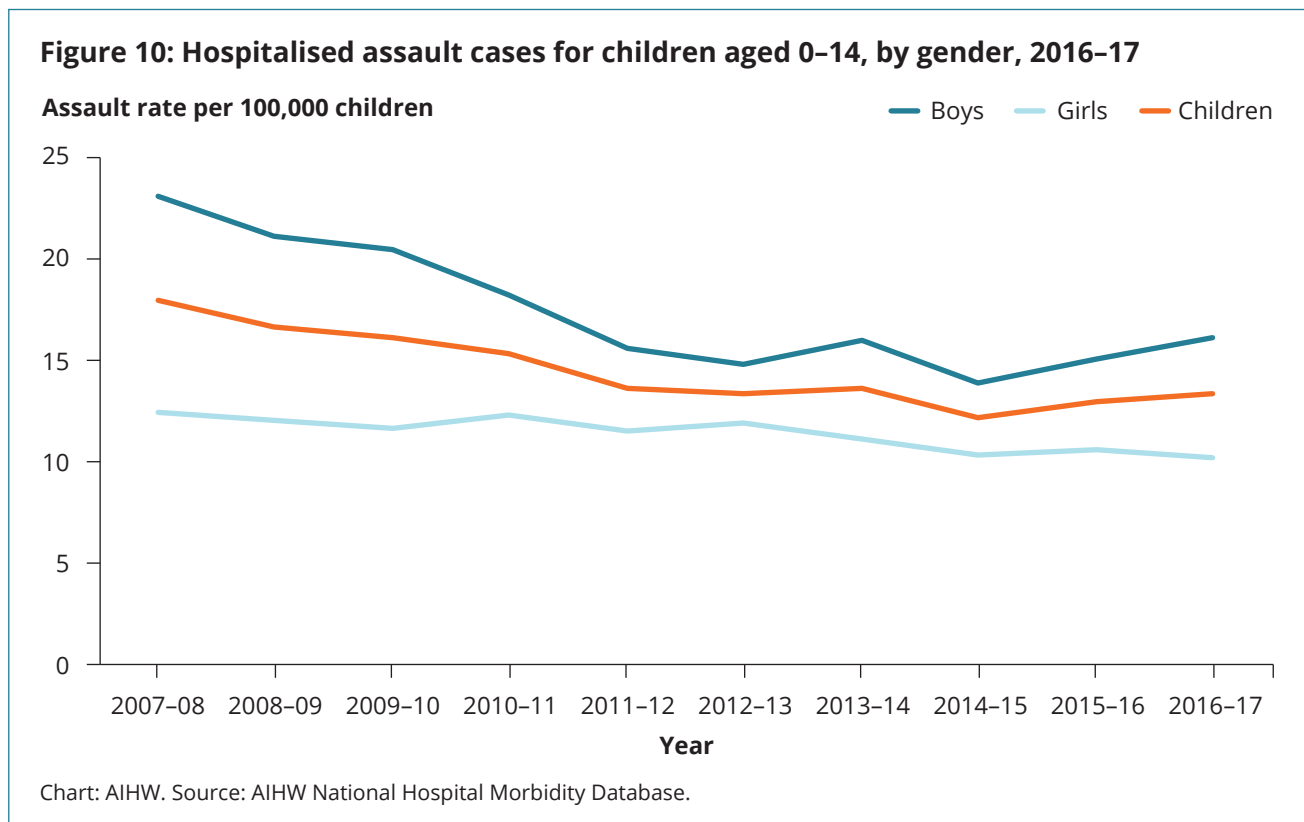


Chart: AIHW. Source: AIHW National Hospital Morbidity Database.

Has the rate of child hospitalised assault cases changed over time?

Between 2007–08 and 2012–13, the rate of hospitalised assault cases for all children aged 0–14 decreased by around 25%, from 17.9 per 100,000 children to 13 per 100,000 (Figure 10). The rate was consistently higher for boys than girls, with the rate for boys showing greater fluctuation while the rate for girls remained more stable.



How many children die as a result of homicide?

In 2012–14 there were 35 deaths due to homicide among children aged 0–14, a rate of 0.4 per 100,000 children (Figure 11). There was no difference in the rates of homicide among boys and girls.

The rate for infants under the age of 1 were at least 8 times as high as those for the other 2 age groups (2.3 per 100,000 compared with 0.3 and 0.2 per 100,000 for children aged 1–9 and 10–14, respectively). Homicides were 1.7 times as likely to happen to infant boys as infant girls (2.9 and 1.7 per 100,000, respectively).

Figure 11: Assault deaths (homicides) among children aged 0–14, 2012–14

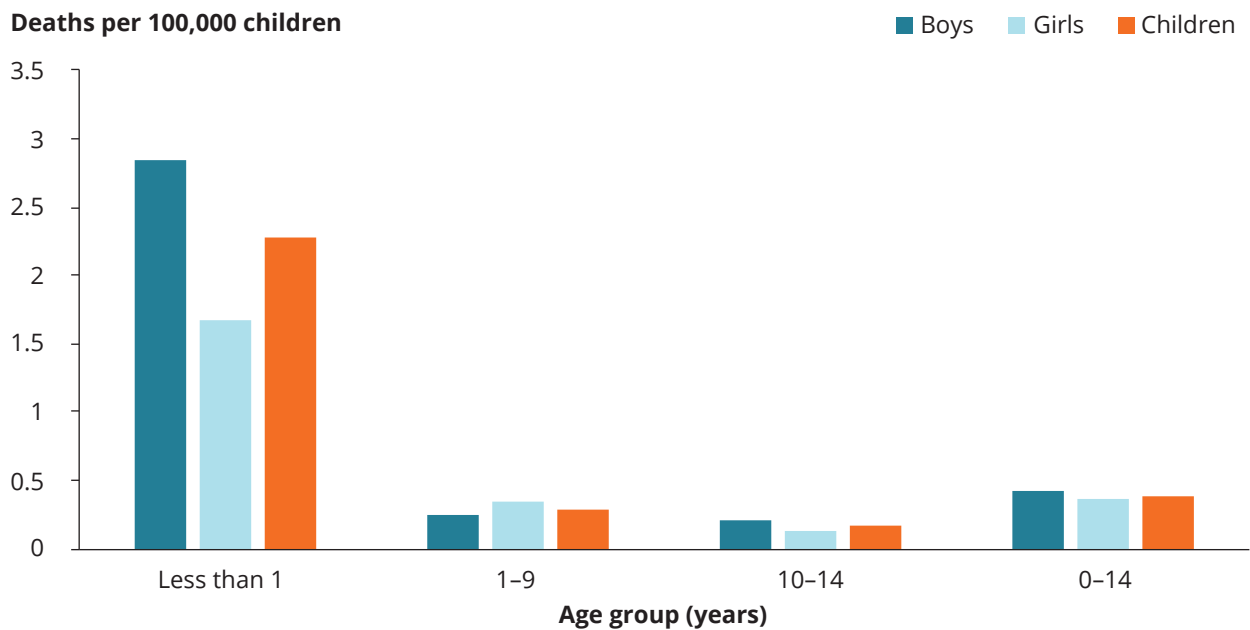


Chart: AIHW. Source: AIHW analysis of Bryant & Bricknell 2017.

How many crimes are perpetrated by children?

Children younger than 10 cannot be charged with a criminal offence in Australia (Box 3). In 2017–18, around 13,800 criminal offences were committed by an unknown number of children aged 10–14. More than two-thirds of these (around 68% or 9,400) were committed by boys and more than two-fifths (around 44% or 6,100) by children aged 14.

Box 3: Age of criminal responsibility

Age of criminal responsibility refers to the age at which a child can be charged with committing a criminal offence. In Australia, this is 10 for all states and territories. However, as children aged 10–14 are not considered to be as capable of understanding the difference between right and wrong as older children, adolescents and adults, prosecutors must demonstrate that a child knew their actions were wrong at the time of the offence for the child to be found guilty and convicted.

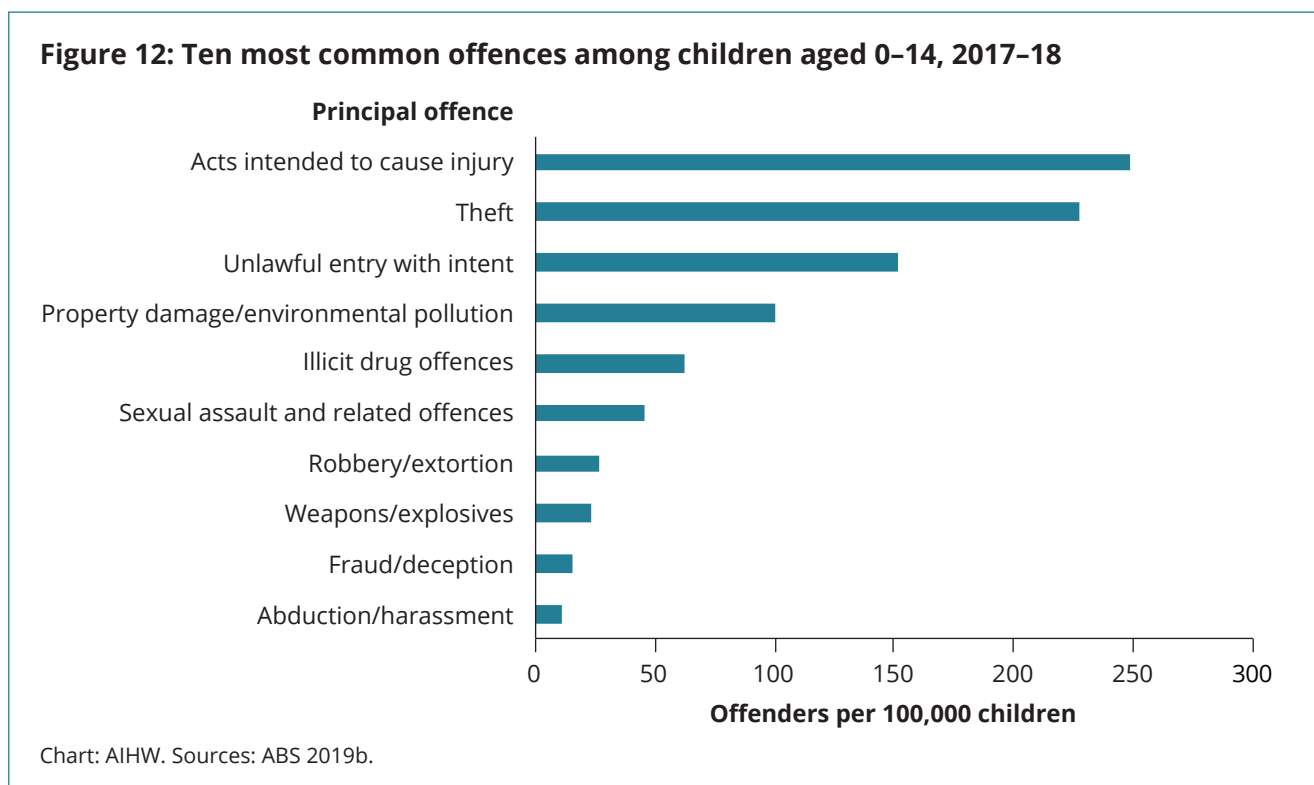
The age of criminal responsibility in Australia is 10—one of the lowest ages of criminal responsibility in the world. The United Nations (UN) Human Rights Commission Convention on the Rights of the Child recommends that age of criminal responsibility be no lower than age 12 (UN 2007).

Both the Royal Commission into the Protection and Detention of Children in the Northern Territory and the Royal Australasian College of Physicians (RACP) have recommended that Australia increase the age of criminal responsibility. The RACP suggests that raising the age to 14 allows time for additional brain development especially in terms of decision making, organisation, impulse control and planning a future (RACP 2017, 2011).

The most common principal offences committed by children aged 10–14 varied and included violent and non-violent crimes such as sexual assault and related offences, fraud/deception and illicit drug offences (Figure 12).

The most common principal offence committed by children aged 10–14 was acts intended to cause injury, which includes assault, at a rate of 248 offences per 100,000 children aged 10–14. Homicide and related offences were uncommon among this age group with only 0.2 offences being committed per 100,000 children aged 10–14.

The prevalence rate for all types of offences increased with age with more offences perpetrated per 100,000 14 years old than per 100,000 10 years old. This was especially true for sexual assault and related offences, robbery/extortion, and illicit drug offences.



Some children who committed criminal offences will go on to have contact with Youth justice (see [Children under youth justice supervision](#)).

Data limitations and development opportunities

There is currently no comprehensive national data source about children involved in crime—as victims or offenders—beyond selected administrative data sources, such as those data presented here.

While administrative data collections, including police, hospital, and child protection data, can provide some insights, these data sources do not capture all crime and are likely to underestimate the true extent of violence against children (Stoltenborgh et al. 2011, 2013).

There are many reasons why a crime may go unrecorded, but of special relevance to children is that the perpetrator may be known to them or is in a position of power (for example, older or an

authority figure) (ABS 2011a). The scope of population surveys which allow individuals to disclose their experience with crime privately, such as the ABS Personal Safety Survey, is older people aged at least over 15 years, and respondents are asked to recall childhood crime experience retrospectively.

Where do I find more information?

For more information on:

- specific types of violence experienced by children, see: [Child homicide](#), [Domestic Violence](#) and [Child sexual assault](#) in the [National Framework for Protecting Australia's Children](#)
- family, domestic and sexual violence, see: [Family, domestic and sexual violence in Australia: continuing the national story](#).
- technical notes relating to this section, refer to [Children and crime](#) in the online report. See also [Methods](#).

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Neighbourhood safety

Key findings

- Data from the Longitudinal Study of Australian Children (LSAC) in 2015–16 estimated that 91% of children aged 12–13 felt safe in their neighbourhood.
- 9 out of 10 adults aged 18 and over living in households with at least 1 child aged 0–14 who were home alone during the night, felt safe/very safe.
- The PIRLS 2016 found that more Australian teachers judged their schools to be very safe and orderly than the international average (78% compared with 62%).

Healthy neighbourhoods generally involve quality housing, services, green spaces, and strong social connections. High neighbourhood quality is associated with a wide range of positive child outcomes, including positive physical and mental health, higher educational attainment, and lower rates of child maltreatment and youth justice involvement (Dupere et al. 2010; Edwards & Bromfield 2010; Mingh et al. 2017; Webb et al. 2017; White & Cunneen 2015).

One commonly used indicator of neighbourhood quality is neighbourhood safety, with measures of perceived safety and victimisation regularly used (Berglund et al. 2017; Ferguson 2006) (Box 1).

Box 1: Defining neighbourhood safety

Neighbourhood safety is a broad term comprising many physical and non-physical aspects. It includes, but is not necessarily limited to:

- neighbourhood crime rate
- safety of public places and schools
- safety of infrastructure and open spaces (for example, public transport, roads, parks),
- quality safe relationships within the local area (for example, neighbours that you can trust)
- levels of social unrest (Berglund et al. 2017; Goldfeld et al. 2017; Queensland Child and Family Commission 2018).

Perceived neighbourhood safety is often measured by surveying how safe and/or vulnerable people feel during different times of the day under varying circumstances, for example home alone at night (Ferguson 2006).

Both household experiences with crime and parental perception of neighbourhood safety have been found to impact a child's daily life by shaping the activities parents allow children to be involved in outside the home (Glaster & Santiago 2006; Goldfeld et al. 2017; Molnar et al. 2004). For example, negatively perceived neighbourhood safety is associated with increased sedentary behaviour among adolescents and increased risk of poor future health outcomes such as cardiovascular disease and obesity (Lenhart et al. 2017). Children's personal perceptions of safety and their behaviour can also be influenced by neighbourhood safety, a sentiment explored in *This place I call home: the views of children and young people growing up in Queensland* (Goldfeld et al. 2017; Queensland Child and Family Commission 2018).

Data on children's perspectives of safety in their environment are presented in this section. Self-reported perceptions of neighbourhood safety are also reported; specifically, the perception of adults who live in households with children aged 0–14, and the perception of Year 4 teachers on the safety of their school and its neighbourhood (Box 2).

Children's perspectives of bullying are discussed in [Bullying](#).

Box 2: Measuring perceived neighbourhood safety

The LSAC measures perceived safety in a number of ways, including directly asking children if they feel safe in their neighbourhood. Data included are for children aged 10–11 in 2009–10, and aged 12–13 in either 2011–12 or 2015–16.

The ABS General Social Survey (GSS) measures perceived neighbourhood safety by asking respondents how safe they felt alone at home during the night and walking in the local area during the night on their own. In previous years, the GSS also reported on individual perceptions of safety while at home during the day. These data were not available for 2014.

Updated GSS data are not expected until 2020. In the interim, the ABS 2016 Personal Safety Survey (PSS), which uses the same measure, has been used. While not reported here, the GSS also includes a measure of experienced crime, and results indicated some similarities between perceived and experienced crime.

The Progress in International Reading Literacy Study (PIRLS) measures how safe and orderly a school is by asking teachers of those Year 4 students completing PIRLS to rate their agreement on a series of 8 statements which combine to form the Safe and Orderly School scale. This scale includes 3 statements which relate directly to safety:

- This school is located in a safe neighbourhood.
- I feel safe at this school.
- This school's security policies and practices are sufficient.

All other questions focus on student conduct and school rules relating to conduct. This measure is used here as a proxy for neighbourhood safety.

How safe do people feel in their neighbourhood?

Most children feel safe in their neighbourhood

According to data collected as part of LSAC in 2015–16, most (91%) children aged 12–13 felt safe in their neighbourhood. Very few (<1%) did not feel safe and less than one-tenth (8%) indicated they sometimes felt safe but not all the time. This aligns relatively well with their parents' perceptions of the neighbourhood, with 95% of their parents agreeing with the statement 'this is a safe neighbourhood'. These results are also consistent with results from 2011–12 which found that 89% of children aged 12–13 felt safe in their neighbourhood.



Most adults with children in their household feel safe at home alone at night

According to the ABS 2014 GSS, the majority (89%) of respondents (aged 18 and over) living in households with at least 1 child aged 0–14 at home alone during the night, felt safe/very safe. Of those who walked alone in the local area during the night on their own, 65% felt safe/very safe. This pattern was similar regardless of the youngest age of the child in the household.

The proportion of respondents that felt safe/very safe at home alone during the night or walking in the local area during the night increased slightly between 2006 and 2014 (Figure 1) (ABS 2015).



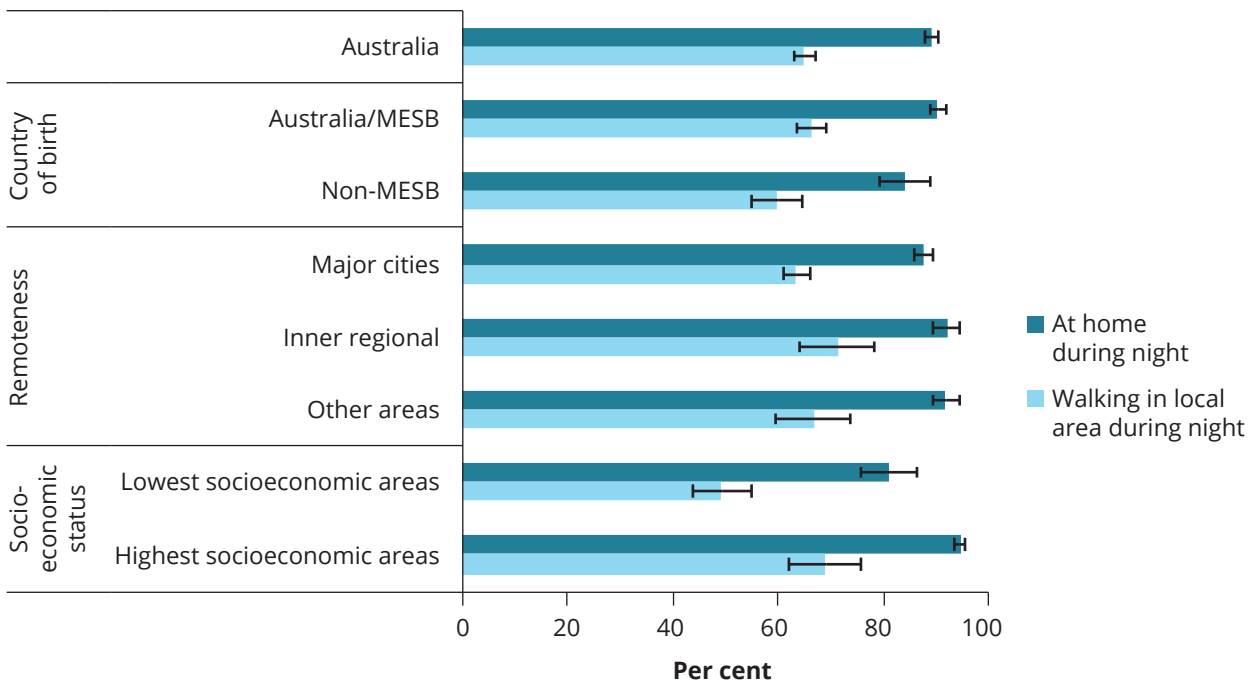
Similar to these findings, the 2016 PSS found that 92% respondents home alone after dark said they felt safe. Of those respondents who walked in the local area during the night on their own, 86% felt safe. However, 45% of all respondents indicated they did not walk in the local area alone after dark—one-third of these said it was because they did not feel safe.

Perceptions of neighbourhood safety varied depending on population groups

Respondents living in the highest socioeconomic areas were more likely to feel safe/very safe at home alone at night and walking in their local area at night compared with those living in the lowest socioeconomic areas (94% and 69% compared with 81% and 49%, respectively) (Figure 2).

Respondents born in Australia or other mainly English-speaking countries were more likely to feel safe/very safe at home at night than other respondents (90% compared with 84%). They were also more likely to feel safe/very safe walking in the local area at night (66% compared with 60%).

Figure 2: Perceived neighbourhood safety by selected population groups, 2014



Note: Mainly English-speaking background (MESB) countries include Canada, Ireland, New Zealand, South Africa, United Kingdom and United States of America.

Chart: AIHW. Source: ABS 2015.

Safety at school

8 out of 10 teachers perceive their school to be very safe and orderly

The PIRLS 2016 found that more than three-quarters (78%) of participating Year 4 students attended schools judged by their teachers as Very safe and orderly (Figure 3). This was higher than the international average (62%).

Schools categorised as more affluent (Box 3) were more likely perceived as Very safe and orderly than schools categorised as more disadvantaged (86% compared with 61%).

Figure 3: Perceived school safety, 2016

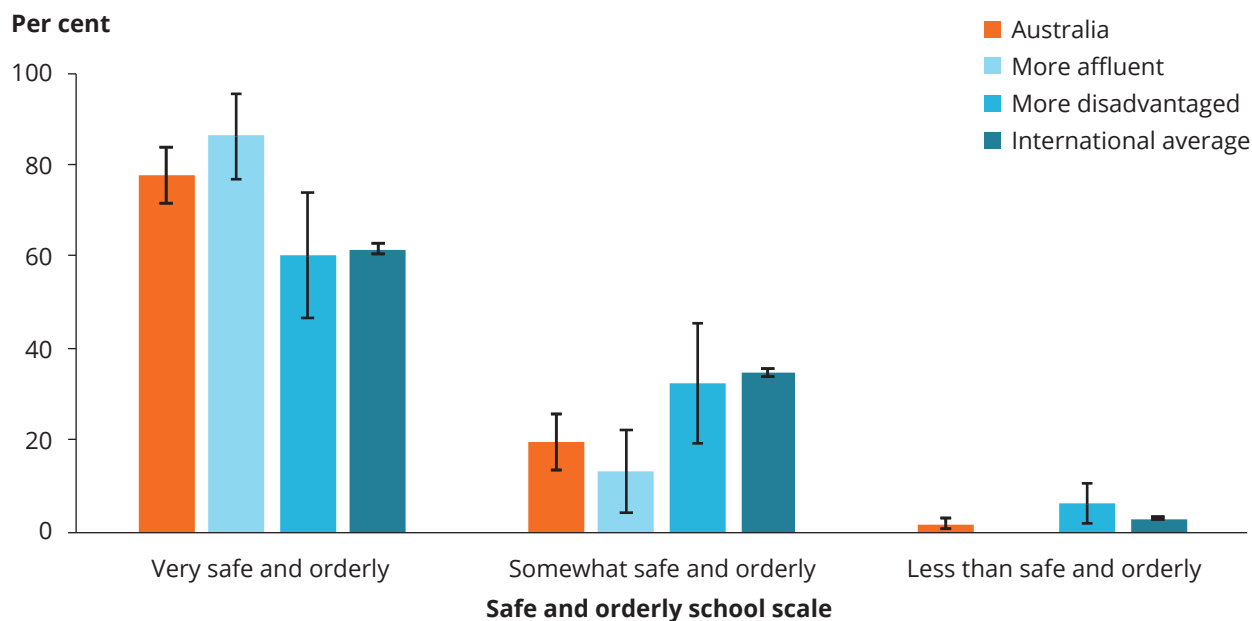


Chart: AIHW. Source: Thomson et al. 2017.

Box 3: Defining socioeconomic affluence and disadvantage in PIRLS

School principals were asked to report on the socioeconomic composition of their school by indicating what percentage of students came from economically affluent homes and what percentage came from economically disadvantaged homes. Responses were then used to create 3 categories of school socioeconomic composition:

1. More affluent: more than 25 per cent of the student body comes from economically affluent homes and not more than 25 per cent from economically disadvantaged homes.
2. More disadvantaged: more than 25 per cent of the student body comes from economically disadvantaged homes and not more than 25 per cent from economically affluent homes.
3. Neither more affluent nor more disadvantaged: all other response combinations (Thomson et al. 2017).

Data limitations and development opportunities

National data on neighbourhood safety for children is currently limited to perceived safety reported by adults. The integration of a number of measures (perceived and/or otherwise) into an index of neighbourhood safety specifically applicable to children could provide a more complete picture. The types of measures that could be considered include access to pedestrian crossings, traffic exposure and crime statistics. A broader view of neighbourhood safety was incorporated in the Kids in Communities Study which looked at the relationship between the environment children live in and its impact on early childhood development (Goldfeld et al. 2017).

Where do I find more information?

For more information on:

- neighbourhood safety, see: [Perceived safety](#) in the [National Framework for Protecting Australia's Children](#).
- LSAC, see: [Growing Up in Australia](#).
- technical notes relating to this section, refer to [Neighbourhood safety](#) in the online report. See also [Methods](#).

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Child abuse and neglect

Key findings

- In 2017–18, approximately 26,400 children aged 0–12 had 1 or more child protection notifications substantiated (excluding New South Wales as data were not available).
- Children aged under 1 were around twice as likely as other age groups to have at least 1 child protection substantiation.
- Emotional abuse was the most commonly reported primary abuse type for substantiations (59%).
- More than one-third (35%) of children aged 0–12 who had at least 1 substantiation were in the lowest socioeconomic group. The highest socioeconomic group accounted for 6%.

While most children in Australia grow up in families that provide them with environments where they are safe, happy and healthy, some children are the subject of maltreatment (any abuse and/or neglect) (COAG 2009).

Child abuse and neglect is a broad term covering any intentional and non-intentional behaviours by parents, caregivers, or other adults considered to be in a position of responsibility, trust or power that results in a child being harmed physically or emotionally (AIFS 2014; WHO 1999).

For details on the types of child maltreatment see Box 1.

Box 1: Defining child maltreatment

Child maltreatment includes physical, sexual and emotional abuse, and neglect inflicted upon a child by a person responsible for their care and wellbeing.

Physical abuse includes any non-accidental physical act inflicted upon a child that causes harm.

Sexual abuse includes any act that exposes the child to, or involves the child in, sexual processes beyond their understanding, or contrary to accepted community standards.

Emotional abuse includes any act that results in the child suffering significant emotional deprivation or trauma, including suffering caused by exposure to family and domestic violence.

Neglect includes any serious act or omission that, within the bounds of cultural tradition, constitutes a failure to provide conditions essential for the healthy physical and emotional development of a child (AIHW 2019a).

The 2016 ABS Personal Safety Survey (PSS) estimates that about 2.5 million Australian adults (13%) experienced physical and/or sexual abuse during childhood (ABS 2019). Those who experienced both physical and sexual abuse were younger on average at the time of the first incident than those who experienced physical assault only or sexual assault only (average age of 6.8 years compared with 8.1 and 8.8 years, respectively).

The majority of adults who reported childhood physical abuse only (97%) and sexual abuse only (86%) knew the perpetrator, with 81% of those who experienced physical abuse only being abused by a family member. These cases would be considered [family violence](#).

Child abuse and neglect can have a wide range of significant adverse impacts on a child's development and later outcomes, including but not limited to:

- reduced social skills
- poor school performance
- impaired language ability
- higher likelihood of criminal offending
- negative physical health outcomes
- mental health issues such as eating disorders, substance abuse, depression and suicide (ABS 2019; AIFS 2014).

Recent Australian linkage projects have found that children who have contact with the child protection system were more likely than other children to have contact with the juvenile justice system and homelessness services, and to have lower literacy and numeracy achievement than all students (AIHW 2015, 2016, 2017).

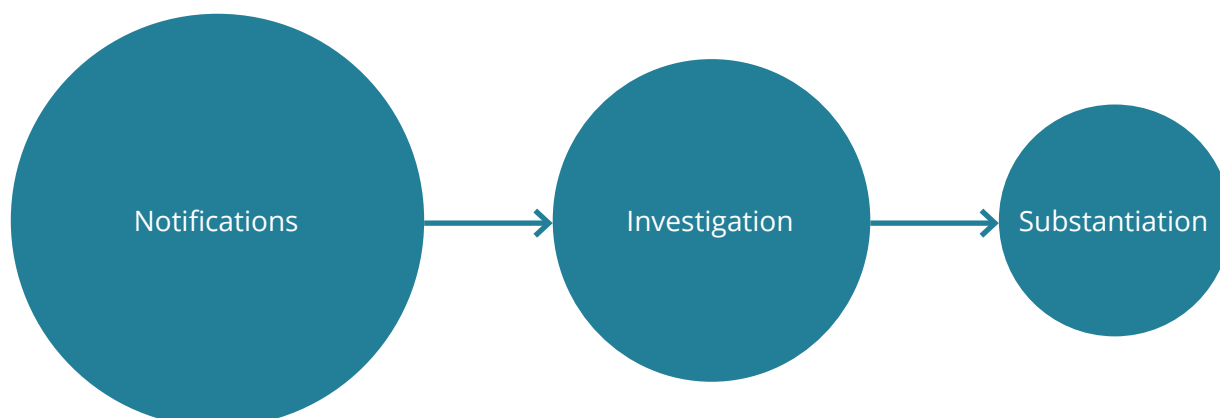
Further, analyses on the South Australian Early Childhood Data Project—a multi-source linked data asset—indicated that children who had contact with child protection agencies were more likely to have developmental vulnerabilities on school entry compared with children who did not have contact, and that vulnerability increased with level of contact. Children who had experienced out-of-home care were almost 1.5 times as likely to have developmental vulnerabilities at age 5 compared with those who had a notification to a child protection department only (Pilkington et al. 2019). See also, [Children under youth justice supervision, Homelessness and Education](#).

From a health perspective, 3 conditions directly linked to child abuse and neglect—[anxiety disorders](#), [depressive disorders](#), and [suicide and self-inflicted injuries](#)—were estimated to have been responsible for 0.5% of all deaths and 2.2% of the burden of disease and injury in 2015 (AIHW 2019b). More specifically, it was estimated that there would have been 26% less suicide and self-inflicted injuries, 20% less depressive disorders and 27% less anxiety disorders in 2015 if no one in Australia had ever experienced child abuse and neglect during childhood (AIHW 2019b).

In the absence of comprehensive national data on the prevalence of child abuse and neglect in Australia, this snapshot focuses on children who have been in contact with the child protection system, especially those where a notification to a child protection department has been substantiated. A substantiation indicates cases where there is sufficient reason to believe the child has been, is being, or is likely to be harmed in some way (Box 2). These data are sourced from the Child Protection National Minimum Dataset (CP NMDS) and are likely to underestimate the prevalence of child abuse and neglect, given that not all cases may come to the attention of child protection authorities (Besharov 2005; Matthews et al. 2015). In addition, there are some definitional differences between states and territories which may impact the comparability of substantiation data (see Technical notes in the [Child abuse and neglect](#) section of the online report).

Box 2: Measuring child abuse and neglect

For this snapshot, children are considered to have been the subject of child abuse and/or neglect if a child protection notification has been investigated and subsequently substantiated. Not all notifications are investigated and not all investigations are substantiated.



Notifications consist of contacts made to an authorised department by people or other bodies alleging child abuse or neglect, child maltreatment, or harm to a child. A notification can only involve 1 child. Where it is claimed that 2 children have been abused, neglected or harmed, this is counted as 2 notifications. Where there is more than 1 notification about the same event involving a child, this is counted as 1 notification. Where there is more than 1 notification for the same child relating to different events, these are counted as separate notifications.

Investigation is the processes whereby the relevant department obtains more detailed information about a child who is the subject of a notification. Departmental staff assess the harm or degree of harm to the child, and their protective needs. An investigation includes sighting or interviewing the child where it is practical to do so.

Substantiations are notifications where an investigation concluded there was reasonable cause to believe the child had been, was being, or was likely to be, abused, neglected or otherwise harmed. Substantiations might also include cases where there is no suitable caregiver, such as children who have been abandoned or whose parents are deceased (AIHW 2019a).

Children and the child protection system

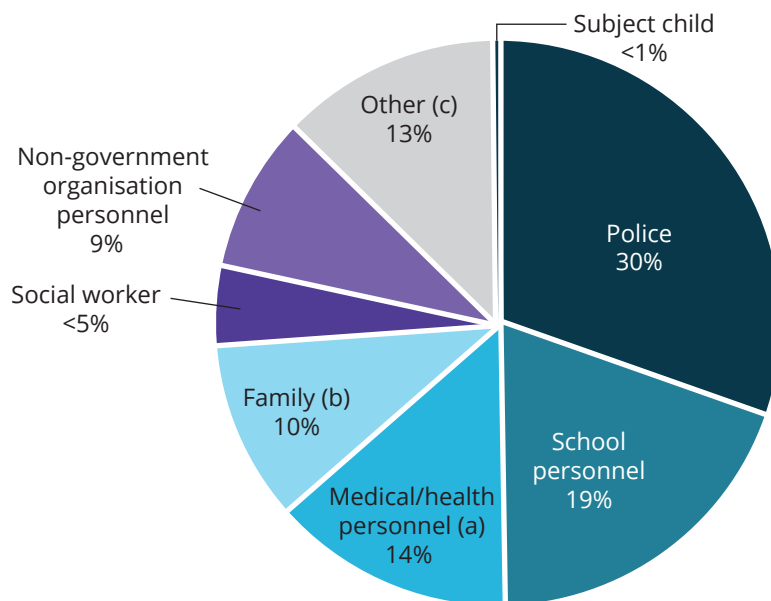
In 2017–18, for states and territories with available data (excluding New South Wales), around 116,000 children aged 0–12 had 1 or more notifications to child protection authorities, alleging child abuse or neglect. These children accounted for around 173,000 notifications during this time, of which approximately 40% were investigated. The remaining notifications were dealt with by other means, such as referral to a support service.

The most common-known source of notification for those investigated cases was:

- police (30%)
- school personnel (19%)
- medical/health personnel (14%) (Figure 1).

Cases where the child involved was the source of notification accounted for less than 1%.

Figure 1: Investigations, by source of notification, 2017–18 (%)



(a) Medical/health personnel include medical practitioners, hospital and other health personnel.

(b) Family includes parent/guardian, sibling and other relative.

(c) Other category includes friend/neighbour, departmental officer, child care personnel and cases where the source of notification was anonymous and may include the person responsible.

Note: This table excludes children for whom source of notification was unknown.

Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

How many children have child protection notifications substantiated?

For states and territories with available data (excluding New South Wales), approximately 26,400 children aged 0–12 had 1 or more child protection notifications substantiated in 2017–18.

This equates to a rate of 9.5 per 1,000 children aged 0–12 (Figure 2).

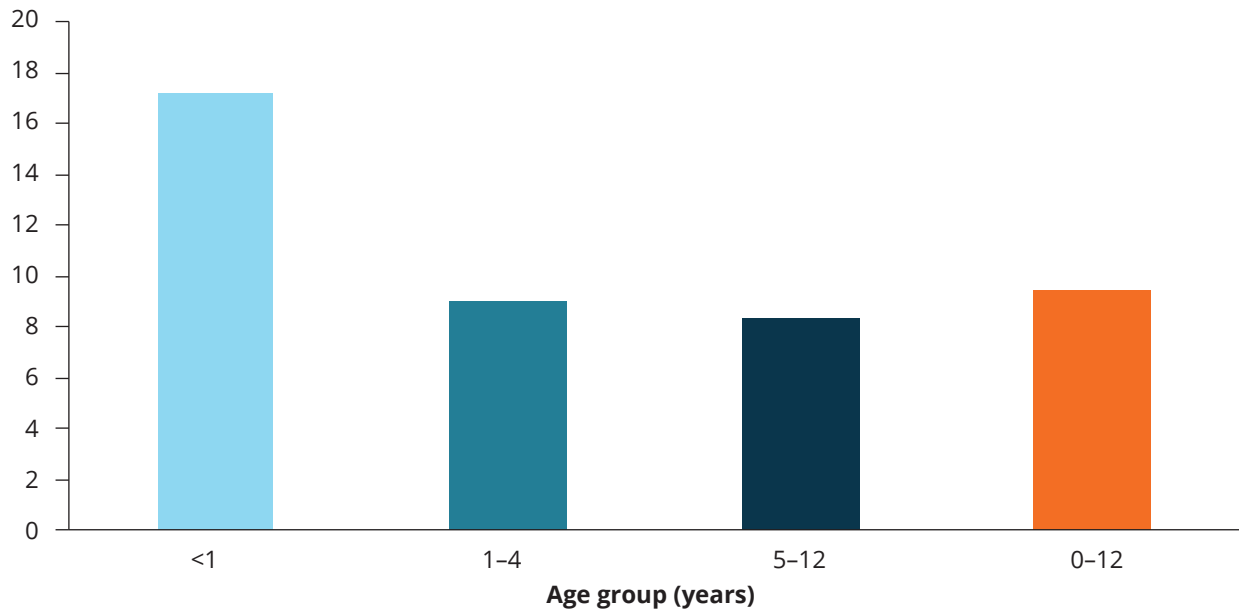
Children aged under 1 were around twice as likely to have at least 1 child protection substantiation as children aged 1–4 or 5–12 (17 per 1,000 children compared with 9.0 and 8.3 per 1,000 children, respectively).

Substantiation rates were similar for boys and girls.



Figure 2: Children aged 0–12 with 1 or more substantiations, by age group, 2017–18

Number per 1,000 children



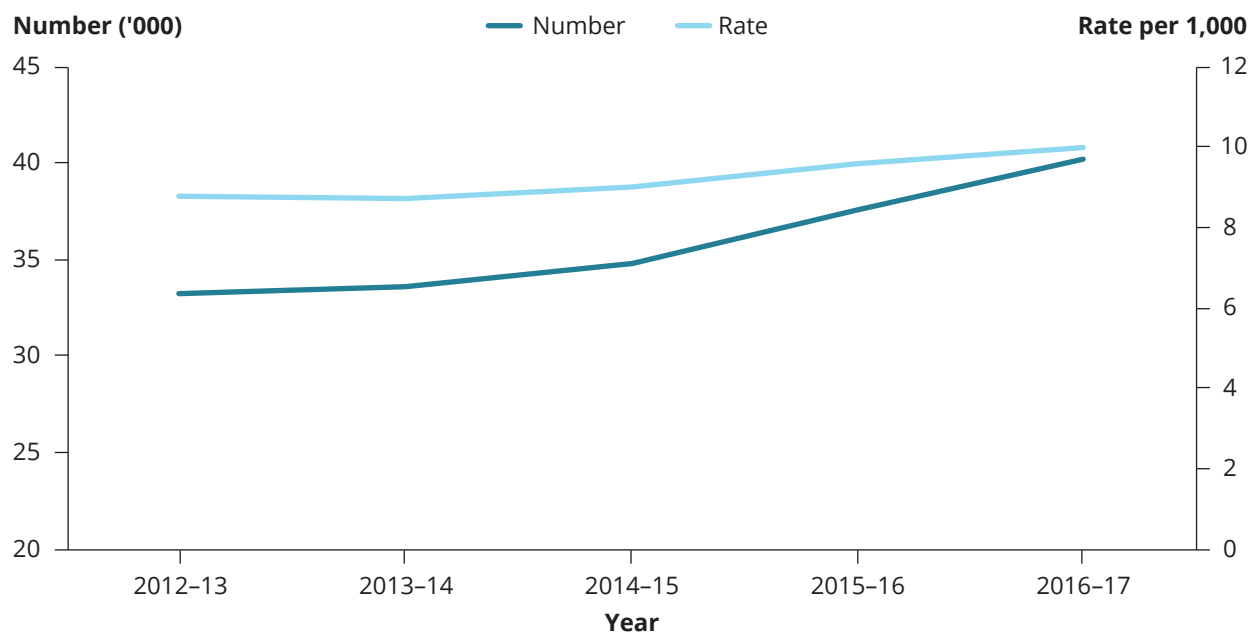
Note: Excludes New South Wales, which implemented a new client management system in 2017–18 and provided limited data. New South Wales is working to improve the quality and completeness of data for future reporting.

Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

Between 2012–13 and 2016–17, there was a steady increase in both the number and rate of children aged 0–12 who were the subject of 1 or more substantiations (Figure 3).

The number of children who had a substantiation rose from around 33,200 in 2012–13 to around 40,200 in 2016–17. This represents rates of 8.8 per 1,000 children and 10.0 per 1,000 children, respectively.

Figure 3: Children aged 0–12 with 1 or more substantiation, 2012–13 to 2016–17



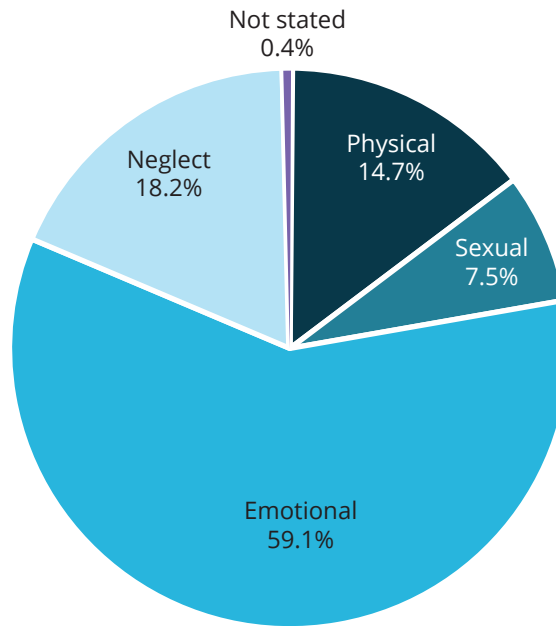
Note: New South Wales substantiation data are unavailable for 2017–18. As a result, 2017–18 data have been excluded from time series analyses to maintain comparability.

Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

What types of abuse and neglect are being reported?

The most commonly reported primary abuse type for substantiations in 2017–18 was emotional abuse (59% of substantiations) (Figure 4). This was true for both Indigenous (50%) and non-Indigenous children (64%) in states and territories with available data (excluding New South Wales and Tasmania). Most abuse and neglect cases are likely considered [family violence](#).

Figure 4: Children aged 0–12 who were the subjects of substantiations, by type of abuse, 2017–18



Note: Excludes data for New South Wales due to data quality and completeness issues.

Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

Do rates of substantiations vary by population group?

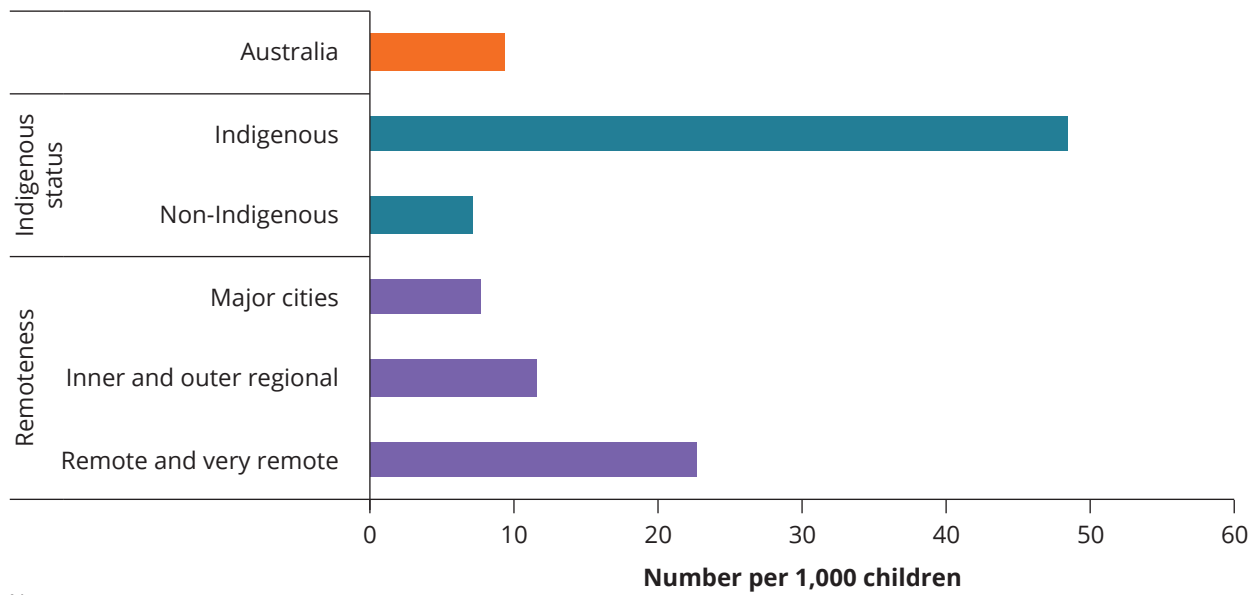
The rate of children aged 0–12 who had at least 1 substantiation in the 2017–18 year varied between population groups (Figure 5).

The rate of children who had at least 1 substantiation increased with remoteness of the child's residence. There was a three-fold difference between rates for *Major cities* and *Remote and very remote* areas (7.8 per 1,000 children compared with 23 per 1,000 children).

Based on states and territories where data were available (excluding New South Wales and Tasmania), Indigenous children were more likely than non-Indigenous children to have had a substantiation in 2017–18 (48 per 1,000 children compared with 7.2 per 1,000).

Rates for Indigenous and non-Indigenous children increased between 2012–13 and 2016–17 (includes data from all states and territories).

Figure 5: Children aged 0–12 with 1 or more substantiation, by select population groups, 2017–18



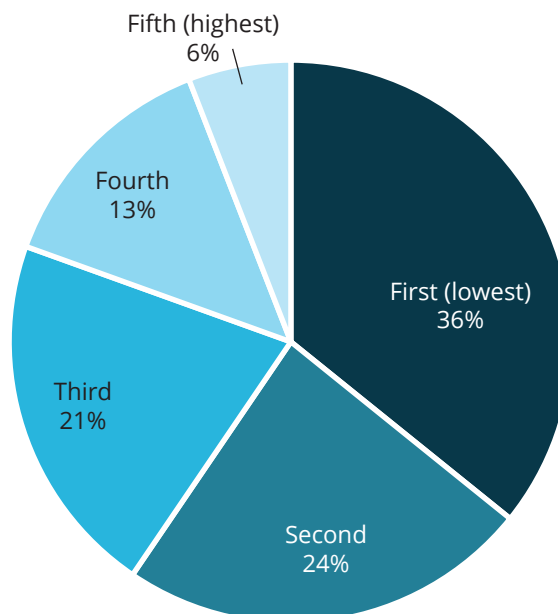
Notes

1. Excludes data for New South Wales due to data quality and completeness issues in 2017–18.
2. Results disaggregated by Indigenous status exclude data from Tasmania due to data quality and completeness issues in 2017–18.

Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

More than one-third (36%) of children aged 0–12 who had at least 1 substantiation were in the lowest socioeconomic group. Those in the highest socioeconomic groups accounted for 6% in 2017–18 (Figure 6).

Figure 6: Children with 1 or more substantiation, by socioeconomic group, 2017–18 (%)



Notes:

1. Excludes children for whom socioeconomic area was unable to be established.
2. Excludes data for New South Wales due to data quality and completeness issues.

Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

How many children are on care and protection orders?

Around 39,700 children aged 0–12 were on a care and protection order in Australia on 30 June 2018 (Box 3). This equates to a rate of 9.6 per 1,000 children.

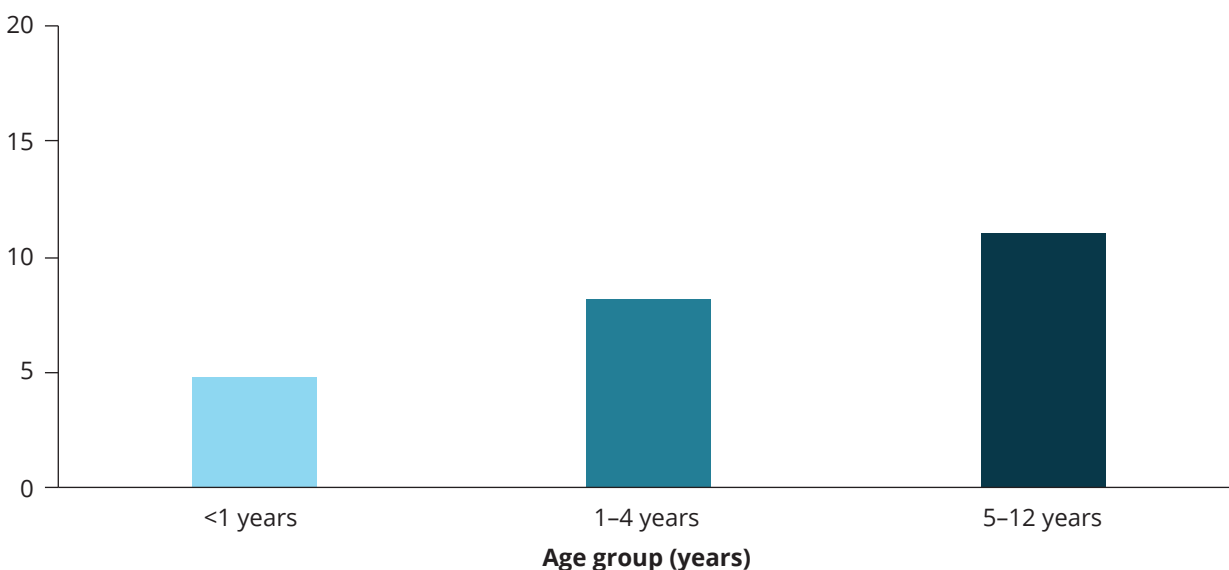
Box 3: Defining and measuring care and protection orders

Care and protection orders are legal orders or arrangements that give child protection departments partial responsibility for a child's welfare. For this report, children are counted only once, even if they were admitted to, or discharged from, more than 1 order, or were on more than 1 order at 30 June of given year.

There were less children aged under 1 on care and protection orders than older children at 30 June 2018 (4.8 per 1,000 compared with 11.0 per 1,000 children aged 5–12) (Figure 7). This reflects the fact that children aged under 1 had less time than older children to be placed on an order by 30 June.

Figure 7: Children on a care and protection order at 30 June 2018

Number per 1,000 children



Note: Indigenous children were more likely on care and protections orders than non-Indigenous children (66.8 per 1,000 children compared with 6.3 per 1,000 children) (excludes Tasmania).

Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

Data limitations and development opportunities

As there are currently no comprehensive national data on the prevalence of child abuse and neglect, including re-occurrence, proxy data from child protection service agencies are used. These data are likely to underestimate child abuse and neglect in Australia as they do not include cases of child abuse and neglect that go unreported to child protection authorities. Further, variations between jurisdictions in recorded cases of child abuse or neglect reflect the legislation, policies and practices in each jurisdiction, rather than a true variation in the levels of recorded abuse and neglect. (See Technical notes in the [Child abuse and neglect](#) section of the online report).

The sensitive collection of information directly from children on their recent experience of abuse and neglect would be an important supplement to the data already collected. The First national study of child abuse and neglect in Australia, being conducted from 2019–2023, will provide a retrospective view of maltreatment in younger years by respondents aged 16 and over (QUT 2019). However, recent research suggests that large discrepancies exist between reporting recent or ongoing childhood maltreatment as a child and recalling childhood maltreatment as an adult (Baldwin et al. 2019).

Where do I find more information?

For more information on:

- Child protection substantiations for Indigenous children, see: [Indigenous children](#)
- child protection substantiations, see: [Child abuse and neglect in Children’s Headline Indicators and Child protection substantiations in the National Framework for Protecting Australia’s Children](#)
- child protection data, see: [Child Protection National Minimum Data Set \(CP NMDS\), Child protection Australia 2017–18 and Report on Government Services, Chapter 16: Child Protection Services.](#)
- technical notes relating to this section, refer to [Child abuse and neglect](#) in the online report. See also [Methods](#).

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Children exposed to family violence

Key findings

- The 2016 Personal Safety Survey (PSS) estimates that about 1 in 6 women (16% or 1.5 million) and 1 in 9 men (11% or 992,000) experienced physical and/or sexual abuse before the age of 15.
- According to the 2018 ABS Recorded Crime data, more than two-fifths of all sexual assaults recorded against children aged 0–14 (around 3,100) were perpetrated by a family member.
- Sexual assaults perpetrated by family members were almost 4 times more likely perpetrated against girls than boys (107.0 sexual assaults per 100,000 girls compared with 28.3 sexual assaults per 100,000 boys).
- Where the perpetrator was specified, a parent or another family member was the perpetrator in more than half (58%) of assault-related hospitalisations involving children aged 0–14 in 2016–17.

Violence comes in many forms, including:

- family or domestic violence
- sexual and other physical assault
- maltreatment
- bullying
- emotional or psychological abuse (WHO 2016).

A child can be exposed to violence either by:

- directly experiencing the violence (being the target)
- witnessing violence being inflicted upon somebody else (Kulkarni et al. 2011).

When a child is exposed to violence within their family this is considered family violence (AIHW 2019) (Box 1). When children themselves directly experience family violence, the perpetrator is generally the child's parent/guardian or in a relationship with the child's parent/guardian, or more broadly speaking a person in a position of trust (AIHW 2018; Campo 2015).

Box 1: Defining family, domestic and sexual violence

Family violence refers to any violence between family members, typically where the perpetrator exercises power and control over another person. This violence can be sexual or non-sexual. Family violence is the preferred term for violence between Indigenous people, as it covers the extended family and kinship relationships in which violence may occur (COAG 2011).

Domestic violence is considered a subset of family violence. It refers to violent behaviour between current or previous intimate partners (AIHW 2019). **Sexual violence** refers to behaviours of a sexual nature carried out against a person's will. It can be perpetrated by a current or previous partner, other known people, or strangers.

Being exposed to family violence can have a wide range of detrimental impacts on a child's development, mental and physical health, housing situation and general wellbeing (AIHW 2019; ANROWS 2018; WHO 2016). More specifically, research has found exposure to family violence is associated with a range of outcomes, including:

- diminished educational attainment
- reduced social participation in early adulthood
- physical and psychological disorders
- suicidal ideation
- behavioural difficulties
- homelessness
- future victimisation and/or violent offending (AIHW 2018; Bland & Shallcross 2015; Campo 2015; De Maio et al. 2013; Holt et al. 2008; Jaffe et al. 2012; Knight 2015).

The impacts of childhood exposure to family violence will be explored as part of the First national study of child abuse and neglect in Australia, being conducted from 2019–2023 (QUT 2019).

When a child is exposed to family violence along with multiple risk factors, such as socioeconomic disadvantage, parental mental ill health, and parental substance abuse, more extreme negative outcomes are likely (Casey et al. 2009; Campo 2015; Fergusson et al. 2006; Fulu et al. 2013).

However, exposure to family violence alone does not mean a child will necessarily experience negative outcomes. With the right support, children exposed to family violence may have increased resilience later in life (Alaggia & Donohue 2018; Campo 2015; Jaffe et al. 2012).

For this section, children who have directly experienced family violence are identified through 2018 Recorded Crime—Victims data and the AIHW National Hospital Morbidity Database, where information on the relationship of the perpetrator to the victim are available (Box 1 in [Children and crime](#)). These data are a subset of the relevant assault data discussed in [Children and crime](#). Some data from the 2016 ABS PSS on children who witness violence in their home, and adults who experienced family violence as a child, are also included (Box 2).

Often children exposed to family violence may have contact with state and territory child protection systems (see, [Child abuse and neglect](#) and [Children in non-parental care](#)). While this section focuses on children who have experienced family violence, there are other instances where a child experiences violence, including those described in [Children and Crime](#) and [Bullying](#).

Box 2: ABS Personal Safety Survey

The [ABS 2016 PSS](#) provides national data on the prevalence of violence experienced by women and men. Violence refers to any incident involving the occurrence, attempt or threat of either physical or sexual assault. Where a person has experienced more than 1 type of violence, their experiences are counted separately for each type.

The PSS collected in-depth information from 15,589 women and 5,653 men (21,242 persons in total) aged 18 and over about:

- any violence experienced since the age of 15
- any violence experienced in the 12 months before the survey
- current and previous partner violence and emotional abuse since the age of 15
- stalking since the age of 15
- physical and sexual abuse before the age of 15
- witnessing violence between a parent and partner before the age of 15
- lifetime experience of sexual harassment
- general feelings of safety (ABS 2017).

Children exposed to family violence

The 2016 PSS estimates that about 1 in 6 women (16% or 1.5 million) and 1 in 9 men (11% or 992,000) experienced physical and/or sexual abuse before the age of 15.

Parents were the most common perpetrators of physical abuse before this age. Around 45% of adults experienced physical abuse before the age of 15 by a father or stepfather, and 24% by a mother or stepmother. Where mothers or stepmothers were identified as the perpetrator, victims were more likely their daughters (66%) than their sons (35%) (ABS 2018a).

Of those adults who experienced sexual abuse before the age of 15, nearly 8 in 10 (79%) were abused by a relative, friend, acquaintance or neighbour. A minority were abused by a stranger (11%) (ABS 2018a).

The 2016 PSS also estimated that of those who had experienced violence from a previous partner and had children in their care when the violence occurred, 418,000 women (68%) and 92,200 men (60%) reported that the children had seen or heard the violence.

Police responses

Sexual assault

According to ABS Recorded Crime data, in 2018 around 3,100 sexual assaults against children aged 0–14 were perpetrated by a family member (see [Children and crime](#)). This represented more than two-fifths of all sexual assaults recorded against children aged 0–14.

Sexual assaults perpetrated by family members were:

- more likely perpetrated against girls than boys, with a rate of 107.0 sexual assaults per 100,000 girls aged 0–14, compared with 28.3 sexual assaults per 100,000 for boys aged 0–14 (Figure 1)
- highest for girls aged 10–14, with a rate of 197.8 sexual assaults per 100,000.

Rates showed no real variation between 2014 and 2018. This was true for all age and sex groups.

Figure 1: Victims of sexual assault by a family member, by age, 2018

Victims per 100,000 children

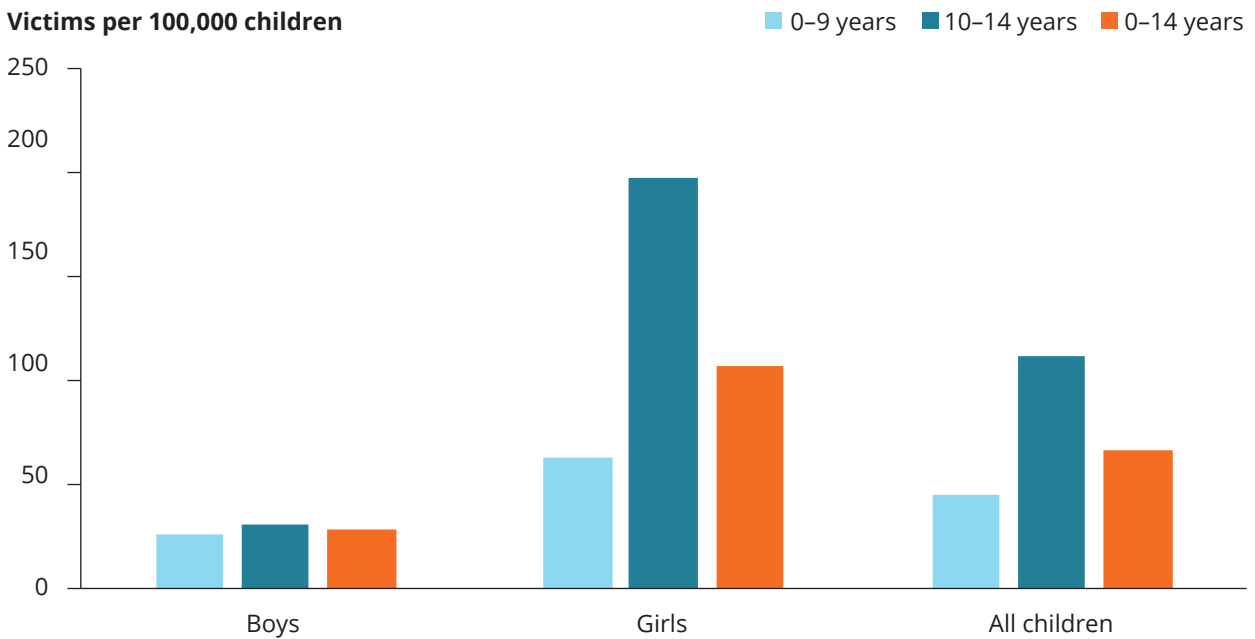


Chart: AIHW. Source: ABS 2019.

Other assault

For the 6 states and territories that had assault data available, around 3,900 assaults against children aged 0-14 in 2018 were considered family violence. More than half of these (55%) were for children aged 10-14. Except for Tasmania, rates of assault for children aged 10-14 were double or more the rates of children aged 0-9 for all states and territories.

The rate of other assaults perpetrated by a family member against children was higher in the Northern Territory than in other states and territories (237.3 assaults per 100,000 children aged 0-14) (Figure 2). Western Australian and Northern Territory had the highest rate of assault perpetrated by a family member against children aged 10-14 years (327.2 assaults per 100,000 children aged 10-14 and 436.7 assaults per 100,000 children, respectively).

Figure 2: Victims of assault by a family member, by jurisdiction and age, 2018

Number per 100,000 children

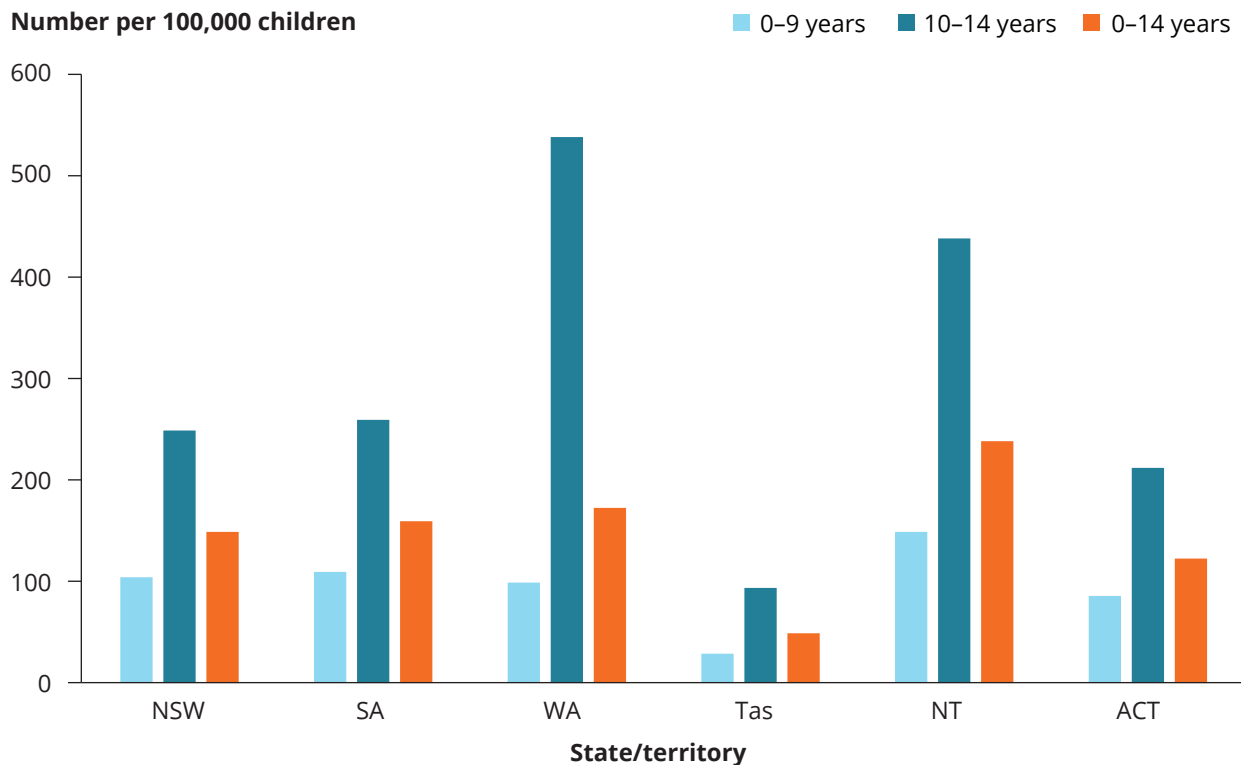


Chart: AIHW. Source: ABS 2019.

Hospitalised cases due to family violence cases

In 2016–17, there were more than 600 hospitalised assault cases of children aged 0–14, including 156 Indigenous children.

For cases where the perpetrator was specified (79%, or 481), nearly:

- 1 in 2 (45%, or 217) children were assaulted by a parent
- 1 in 8 (13%, or 71) by another family member.

For Indigenous children, about 2 in 3 (68%, or 83) assaults were perpetrated by a parent or family member.

Of the 131 hospitalised assault cases of girls due to family violence:

- 44 (34%) involved assault by bodily force
- 11 (8%) with an object
- 14 (11%) neglect and abandonment by family.

Of the 157 hospitalised assault cases of boys due to family violence:

- 42 (27%) involved assault by bodily force
- 13 (8%) with an object
- 18 (11%) neglect and abandonment by family (Figure 3).

Figure 3: Hospitalised assault cases by a family member, children aged 0–14, by type of assault, by sex, 2016–17

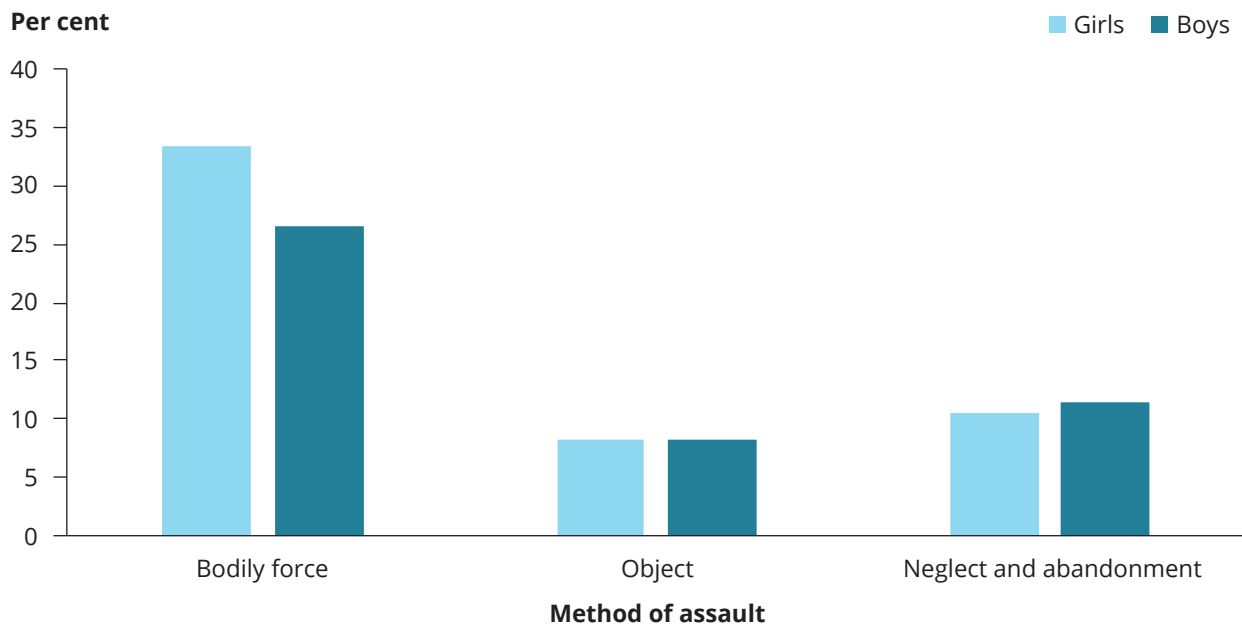


Chart: AIHW. Source: AIHW National Hospital Morbidity Database.

Data limitations and development opportunities

It is difficult to obtain complete and robust data on children’s exposure to family violence due to the sensitivity of the subject, with administrative sources only able to identify reported cases and most large-scale population surveys focusing on adult experiences and/or their perceived knowledge of child experiences.

While administrative data collections, such as police and hospital data, can provide some insights, these data sources are likely to underestimate the true extent of children exposed to family violence, with many children (and non-perpetrating parent/guardians) reluctant to report family violence to the police or seek necessary medical attention (ABS 2011; Stoltenborgh et al. 2011, 2013).

To enhance current administrative data on family violence, the identification and collection of data on family violence in other routinely collected administrative data sources is important. Improvements to existing collections, for example child protection, specialist homelessness services, and perinatal, are underway (AIHW 2019).

To supplement administrative data, the First national study of child abuse and neglect in Australia, being conducted from 2019–2023, may provide additional insight into family violence by retrospectively reporting on childhood experiences of family violence for respondents aged 16 and over (QUT 2019). In addition to collecting data on childhood experiences retrospectively, data collected directly from children is also important (see ‘What’s missing’ in [Justice and safety](#)).

Where do I find more information?

For more information on:

- children's exposure to family violence, see: [Domestic violence in the National Framework for Protecting Australia's Children](#)
- family, domestic and sexual violence, see: [Family, domestic and sexual violence in Australia: continuing the national story 2019](#).
- technical notes relating to this section, refer to [Children exposed to family violence](#) in the online report. See also [Methods](#).

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Children in non-parental care

Key findings

- At 30 June 2018, around 33,000 children aged 0–12 were living in out-of-home care.
- Children living in *Remote and very remote* areas were more than twice as likely in out-of-home care than children living in *Major cities* (14 per 1,000 children compared with 6 per 1,000 children).
- Based on data from Queensland, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory, the proportion of children aged 0–12 with a disability in 2018 was higher in out-of-home care compared with the general population (8.9% compared with 7%).
- According to the 2016 Census, more than 35,200 children aged 0–12 were living with 1 or more grandparent as their primary care giver.
- In 2017–18, 428 children were receiving supported accommodation services funded under the National Disability Agreement.

While the vast majority of children in Australia live with 1 or both of their parents, there are some cases where parents are unable to care adequately for their children and children are placed in non-parental care, temporarily or on an ongoing basis. The circumstances which may lead to this vary and include:

- abuse or neglect
- parental substance abuse
- mental or physical illness
- family violence
- incarceration of a parent
- death of 1 or both parents
- child's disability or poor health
- child's need for a more protective environment (AIHW 2012a, 2019a).

Children living in non-parental care can be a vulnerable group—especially if they have suffered family breakdown or situations involving emotional or physical trauma before being placed in non-parental care and/or have suffered additional trauma while in non-parental care (AIHW 2019a; McDowall 2013).

Research suggests that children living in non-parental care have poorer outcomes, when compared with the broader population, for:

- educational attainment
- physical and mental health
- cultural identity
- appropriate attachment behaviours
- community connections when compared with the broader population (McDowall 2013; Mclean 2016; Osborn & Bromfield 2007).

The 2016 Royal Commission into Institutional Responses to Child Sexual Abuse highlighted the vulnerability of children living in non-parental care (Box 1). However, this is not to say that all children living in these arrangements have negative experiences, are unhappy or do not feel safe, with negative outcomes more likely tied to negative experiences, such as abuse, and continuity of care rather than care itself (McDowall 2013).

Box 1: Royal Commission into the Institutional Responses to Child Sexual Abuse

The Royal Commission into Institutional Responses to Child Sexual Abuse was a 5-year inquiry undertaken to help better understand the extent and impacts of child sexual abuse victims and survivors.

It found that children in out-of-home care are highly vulnerable to sexual abuse. Separation from family of origin and instability of placements can leave children feeling isolated, lacking established relationships with trusted adults. This makes them more accessible for potential perpetrators to take advantage of opportunities for regular, unsupervised, private interactions with children, or exploit the close relationships that develop between carers and children under their care.

Aboriginal and Torres Strait Islander children, children with disability and children from culturally and linguistically diverse backgrounds are likely to encounter circumstances that put them at greater risk and are less likely to disclose abuse and/or receive an adequate response if they do (Royal Commission into Institutional Responses to Child Sexual Abuse 2016).

More than 30 of the Royal Commission's recommendations suggest changes to aspects of the out-of-home care system to help better protect vulnerable children from sexual abuse while in care. A number relate to national child protection data collection and reporting.

The AIHW is working with the Australian and state/territory governments to progress a number of these recommendations, including updating the Child Protection National Minimum Data Set (CP NMDS) to include information about children who were the subject of a substantiation for sexual abuse while in out-of-home care.

This section focuses on children living in out-of-home care as a result of contact with child protection authorities in each Australian state and territory (Box 2).

These data are sourced from the CP NMDS. Also included are some data on children's experiences living in out-of-home care and children living in grandparent families, at the time of the 2016 Census (see Technical notes in the [Children in non-parental care](#) section of the online report).

Box 2: Defining children in out-of-home care

Out-of-home care is overnight care for children aged 0–17, where the state or territory pays the carer (or offers to pay, but the carer declines the offer) as the child is in need of care and protection and is unable to live with their parents (AIHW 2019a). It is considered an intervention of last resort and, wherever possible, attempts are made to reunite children with their families.

There are 5 main types of out-of-home care:

Residential care—Children are placed in a residential building the purpose for which is to provide placements for children, and where there are paid staff.

Family group homes—Children are placed in homes provided by a department or community-sector agency that have live-in, non-salaried carers, who are reimbursed and/or subsidised for providing care.

Home-based care—Children are placed in the home of a carer, who is reimbursed (or who has been offered but declined reimbursement) for expenses for the care of the child. This is broken down into: relative/kinship care, foster care, third-party parental care arrangements, and other home-based out-of-home care.

Independent living—Accommodation where the child lives independently, such as private board or part of a lead tenant households.

Other—Placements not otherwise classified, and unknown placement types, such as boarding schools, hospitals and hotels/motels. This does not include children living outside the home in supported accommodation or in placements solely funded by disability services, medical services, psychiatric services, juvenile justice facilities, or overnight child care services (AIHW 2019a).

How many children are in out-of-home care?

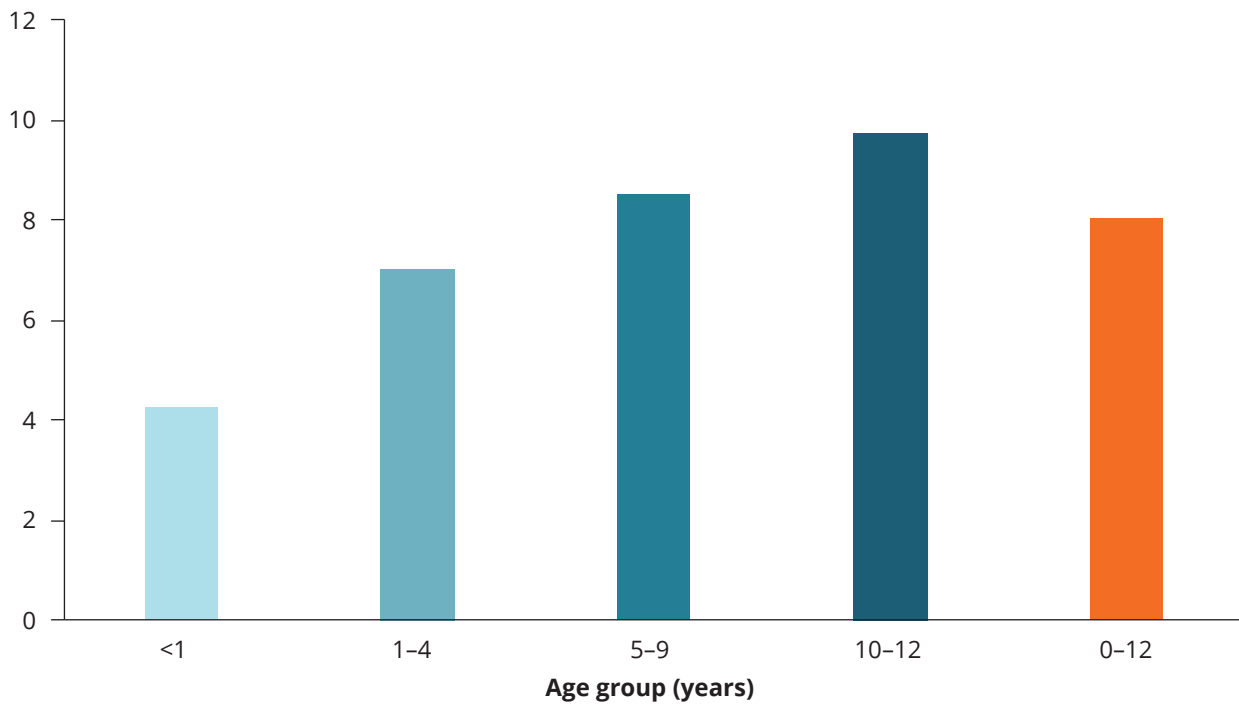
Around 33,100 children aged 0–12 were living in out-of-home care as at 30 June 2018, a rate of 8.0 per 1,000 children (Figure 1).

More boys (around 17,200) than girls (around 15,800) were in out-of-home care, a rate of per 8.1 and 7.9 per 1,000 children, respectively.

The lowest rate of children in out-of-home care was for children under the age of 1 (4.2 per 1,000). However, the rate of admission for children under the age of 1 was higher than for any other age group; consistent with the pattern seen for substantiation rates.

Figure 1: Children aged 0–12 in out-of-home care, by age group, at June 30, 2018

Number per 1,000 children



Note: For 2017–18, Victoria out-of-home care data excludes children on third-party parental responsibility orders. This aligns with New South Wales and Western Australia where this change was implemented in 2014–15 and 2015–16, respectively.

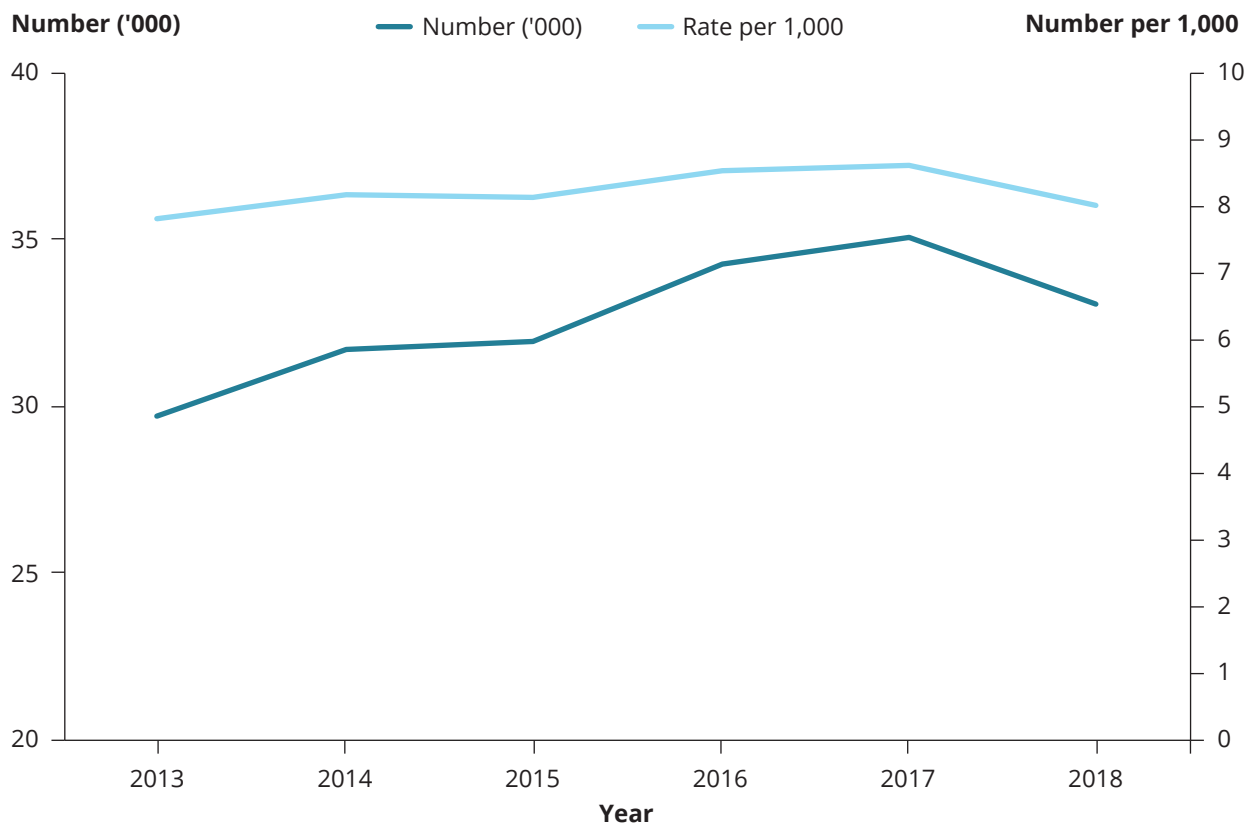
Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

Has the number of children living in out-of-home care changed over time?

The rate of children aged 0–12 in out-of-home care in Australia stayed relatively stable between 30 June 2013 and 30 June 2018 (Figure 2). The only exceptions were 2016 and 2017 when the rates were slightly higher (8.5 and 8.6 per 1,000 children, respectively).

The number of children ranged from around 29,700 at 30 June 2013, up to around 35,000 at 30 June 2017, before slightly declining to around 33,100 at 30 June 2018.

Figure 2: Children aged 0–12 in out-of-home care, 30 June 2013 to 30 June 2018



Note: For 2017–18, Victoria out-of-home care data excludes children on third-party parental responsibility orders. This aligns with New South Wales and Western Australia where this change was implemented in 2014–15 and 2015–16, respectively.

Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

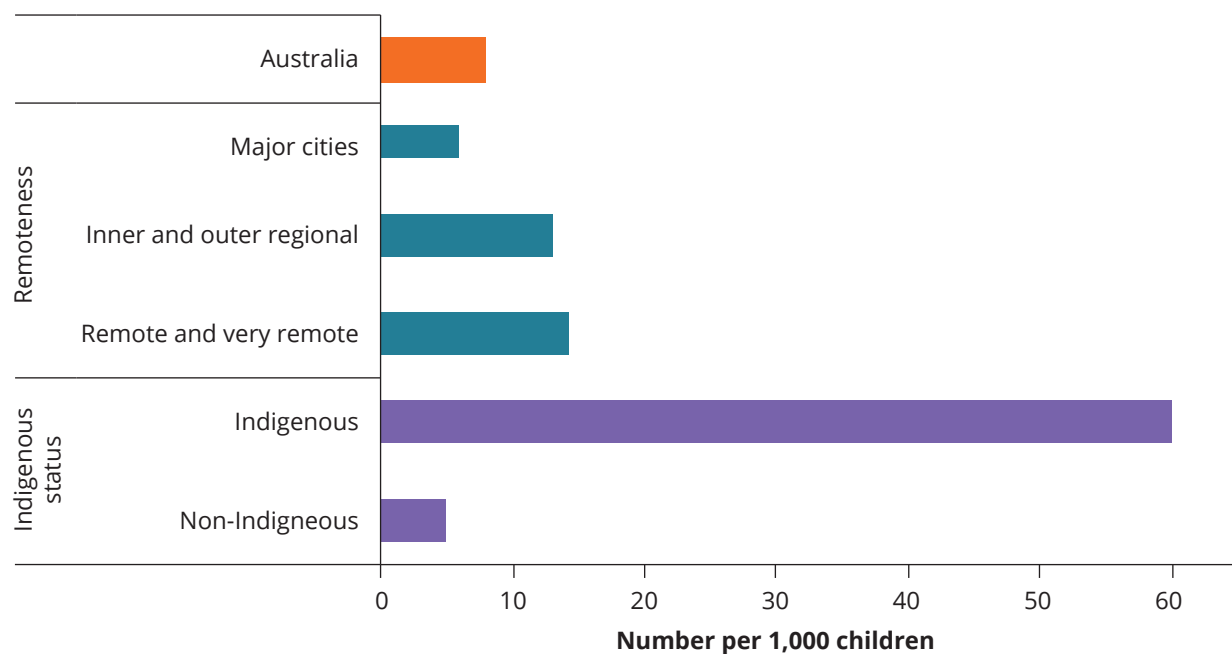
Do rates of children in out-of-home care vary by population group?

The rate of children aged 0–12 living in out-of-home care at 30 June 2018 varied depending on population group (Figure 3).

The rate increased with remoteness. Children living in *Remote and very remote* areas were more likely in out-of-home care as children living in *Major cities* (14 per 1,000 children compared with 6 per 1,000 children).

Indigenous children (excluding Tasmania) were also more likely than non-Indigenous children to be living in out-of-home care (60 per 1,000 children compared with 5 per 1,000).

Figure 3: Children aged 0–12 in out-of-home care at 30 June, 2018



Notes

1. For 2017–18, Victoria out-of-home care data excludes children on third-party parental responsibility orders. This aligns with New South Wales and Western Australia where this change was implemented in 2014–15 and 2015–16, respectively
2. Due to data quality issues, Indigenous status disaggregation exclude Tasmania.

Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

For the 5 jurisdictions with available data—Queensland, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory—it was estimated that under 10% of children aged 0–12 living in out-of-home care had a disability. This was true for both 2017 and 2018 (9.6% and 8.9%, respectively) (see Technical notes in the [Children in non-parental care](#) section of the online report). It was higher than the proportion of children with a disability in the general population (7%) (see [Children with disability](#)).

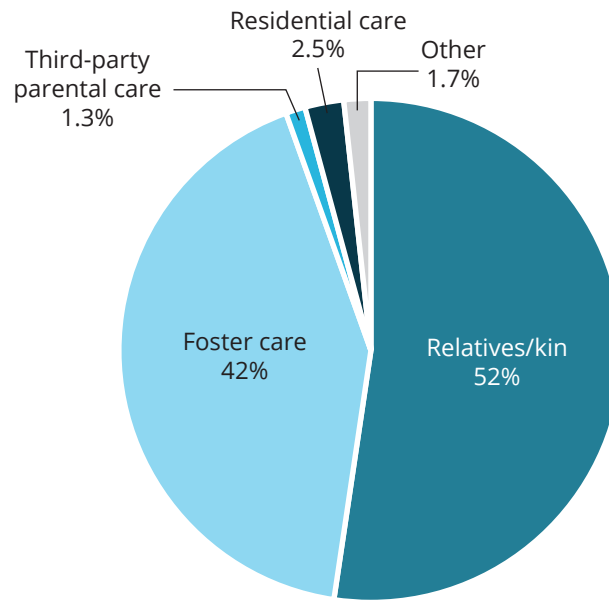
What are the different living arrangements for children in out-of-home care?

A child can be placed in 5 main types of out-of-home care (Box 2).

By far the most common type is home-based care (96% of all out-of-home care for children aged 0–12) (Figure 4), which includes relative/kinship care, foster care and third-party parental care arrangements.

Residential care accounted for just over 2% of all out-of-home care arrangements, and all other types combined accounted for less than 2%.

Figure 4: Proportion of children aged 0–12 in out-of-home care, by type of care at 30 June 2018



Note: For 2017–18, Victoria out-of-home care data excludes children on third-party parental responsibility orders. This aligns with New South Wales and Western Australia where this change was implemented in 2014–15 and 2015–16, respectively.

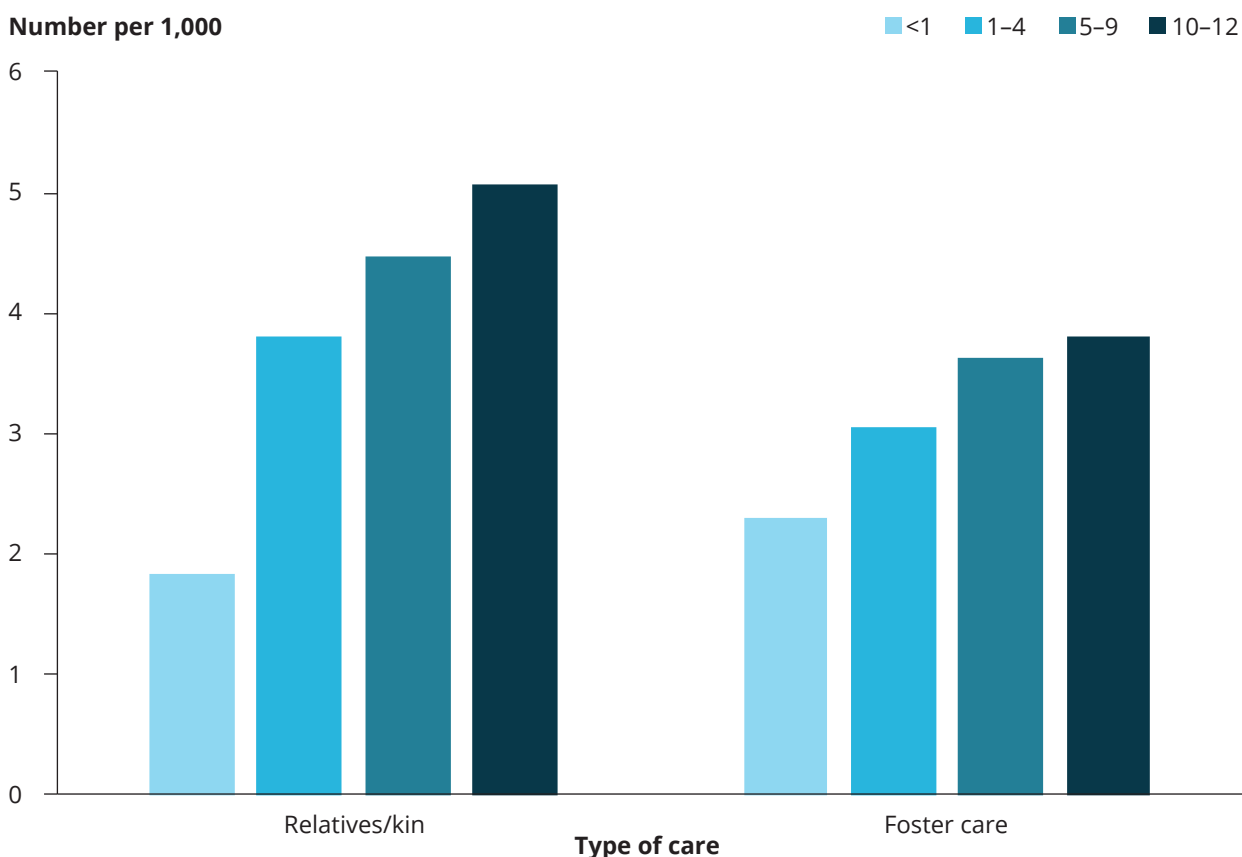
Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

For children living in home-based care, relative/kinship care was the most common and foster care the second most common (rates of 4.2 and 3.4 per 1,000 children respectively). This was true for all age groups, except for children under the age of 1, where foster care was the most common (a rate of 2.3 per 1,000 children for foster care compared with 1.8 for relative/kinship care) (Figure 5).

Rates of children in relative/kinship and foster care increased with age. Children aged 10–12 were twice as likely as children under the age of 1 to be in relative/kinship care (5.1 per 1,000 compared with 1.8).



Figure 5: Children aged 0–12 in out-of-home care, by type of care and age at 30 June 2018



Note: For 2017–18, Victoria out-of-home care data excludes children on third-party parental responsibility orders. This aligns with New South Wales and Western Australia where this change was implemented in 2014–15 and 2015–16, respectively.

Chart: AIHW. Source: AIHW Child Protection National Minimum Data Set.

Indigenous children (excluding Tasmania) had higher rates than non-Indigenous children for all types of care. Relative/kinship care was more common than foster care and residential care for Indigenous children (30.9 per 1,000 children compared with 25 and 1.7 per 1,000 children, respectively).

What do children think about living in out-of-home care?

Results from the 2018 national survey of children in out-of-home care provide some insight on the views of children living out of home.

The survey included children aged 8–17 and according to responses:

1. Most children aged 8–9 and 10–14 felt both safe and settled in their current placement (91% and 93%, respectively).
2. More children aged 10–14 (67%) felt ‘they usually got to have a say and usually felt listened to’ compared with children aged 8–9 (53%).
3. Around two-thirds of children aged 8–9 and 10–14 felt they received adequate support to participate in all activities (64% and 65%, respectively).
4. Most children aged 8–9 and 10–14 felt close to their co-resident family, non-co-resident family or both in their current placement (94% and 96%, respectively).

5. More children aged 10–14 (71%) were satisfied with 1 or more types of contact with family members compared with children aged 8–9 (59%).
6. Most children aged 8–9 and 10–14 reported having at least some knowledge of family background (85% and 91%, respectively).
7. A large number of children aged 8–9 and 10–14 reported having at least some perceived support to follow their culture (84% and 83%, respectively).
8. Around four-fifths children aged 8–9 and 10–14 reported at least some satisfaction with contact with close friends (77% and 80%, respectively).
9. Nearly all (98%) children aged 8–9 and 10–14 reported they had a significant adult in their life (AIHW 2019b).

Other data on non-parental care

Grandparent families

According to the 2016 Census, around 60,600 families in Australia would be considered grandparent families at the time of the 2016 ABS Census (see Technical notes in the [Children in non-parental care](#) section of the online report). Within those families, more than 35,200 children aged 0–12 were living with 1 or more grandparent as their primary care giver. Two-fifths (40%) of these were aged 5–9, and 5% under the age of 1. This age distribution was very similar to children living in out-of-home care.

Some children living in grandparent families will also be included in the number of children living with relatives/kin in out-of-home care. In addition to grandparent families, a child can be placed in other family-based care arrangements, such as with an aunt and/or uncle. Data of these arrangements are unavailable.

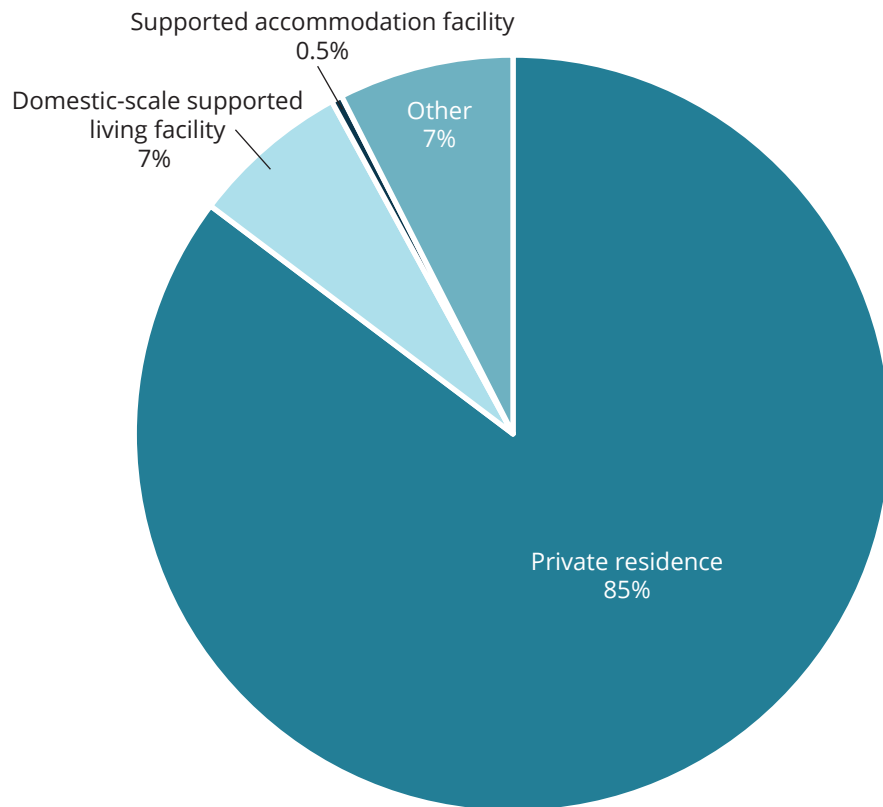
Children living in disability supported accommodation facilities

Children with disability can access a range of accommodation support services funded by state and territory governments. In 2017–18, just over 1% (428) of the approximately 38,200 children aged 0–14 accessing disability support services received supported accommodation services funded under the National Disability Agreement. A small proportion of these lived outside a private dwelling—7% (around 30 children) lived in a supported accommodation facility or a domestic-scale supported living facility (Figure 7). Most (82%) children who received accommodation support while living in a private residence had a co-resident parent as their primary carer.

Older children were more likely living in a supported accommodation facility or domestic scale-supported accommodation facility than younger children. Most (87%) of these children were aged 10–14 (AIHW 2019c).

These data underestimate the proportion of children living in a supported accommodation facility, as children receiving support through the National Disability Insurance Scheme are not included in these data. There may also be some children with disability living in non-parental care; for example, foster care, who are not represented in disability data or separately identified in child protection data.

Figure 6: Children aged 0–14 who received disability accommodation support services, by residential setting, 2017–18



Note: Other includes 'not stated'.

Chart: AIHW. Source: AIHW Disability Services National Minimum Data Set.

Data limitations and development opportunities

National data development work is underway to support national reporting on the stable long-term care arrangements of children, such as:

- with third parties
- through implementation of the Aboriginal and Torres Strait Islander Child Placement Principle
- through transition outcomes for children exiting out-of-home care, including reunification with parents.

More comprehensive national data on the reasons why children are placed in out-of-home care—beyond the type of abuse a child experienced before placement—and the contact children in care have with their birth families would also be informative.

Where do I find more information?

For more information on:

- Indigenous children in out-of-home, see: [Indigenous children](#)
- children in out-of-home care, see: [Out-of-home care in the National Framework for Protecting Australia's Children](#)

- on child protection data, see: [Child Protection National Minimum Data Set \(CP NMDS\)](#) and [Child Protection Australia 2017–18](#)
- the second national out-of-home care survey, see: [The views of children and young people in out-of-home care: overview of indicator results from second national survey, 2018](#).
- technical notes relating to this section, refer to [Children in non-parental care](#) in the online report. See also [Methods](#).

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Children under youth justice supervision

Key findings

- In 2017–18, around 1,100 children aged 10–14 were under youth justice supervision in Australia on an average day.
- Among children aged 10–14, boys were more than 3 times as likely under supervision as girls (110 per 100,000 compared with 33 per 100,000).
- The rates of children aged 10–14 under youth justice supervision and community-based supervision both decreased between 2008–09 and 2017–18 (95 per 100,000 children to 73 per 100,000 and 78 per 100,000 to 56 per 100,000, respectively).
- Children from areas of greatest socioeconomic disadvantage were 10 times more likely than those living in areas of least disadvantage to be under supervision (140 per 100,000 compared with 14 per 100,000).

Children and young people aged 10–17 who commit, or allegedly commit, a crime are usually dealt with under the youth justice system (for information on the age of criminal responsibility, see [Children and crime](#)).

In Australia, youth justice is the responsibility of state and territory governments and each jurisdiction has its own legislation, policies and practices. In general, the youth justice system is based on the principle that children who break the law should have opportunities for rehabilitation, with detention considered a last resort. As such, diverting children from the formal system by the police or the courts, and into support programs and services is a major feature of youth justice in Australia.

If a young person is not diverted and is found guilty of an offence, the Court may order them to serve an unsupervised community-based sentence (such as a good behaviour bond), a supervised community-based sentence (such as probation), or a detention sentence.

Supervised community-based and detention sentences—both known as youth justice supervision—are the focus of this report.

Children under youth justice supervision are an especially disadvantaged group (RACP 2011). Research indicates that young people in the youth justice system have often experienced:

- high rates of child maltreatment and neglect, including time spent in out-of-home care (Cashmore 2011; Stewart et al. 2002)
- drug and alcohol abuse (Kenny & Nelson 2008; Prichard & Payne 2005)
- trouble at school, including issues with poor school attendance and performance
- parental substance abuse
- parental incarceration
- homelessness or unstable accommodation (JH&FMHN 2017).

These children are also more likely to have poor physical and mental health, reduced cognitive ability, and be parents themselves (JH&FMHN 2017; Kenny & Nelson 2008), although there is a lack of health data available for this priority population, see [Health](#).

While many young people stop criminal offending and delinquency behaviours as they get older, research suggests a number involved in the youth justice system will go on to offend in adulthood (Fagan & Western 2005; Lynch et al. 2003).

Box 1: Data source for youth justice supervision

Data on children under youth justice supervision comes from the [Juvenile Justice National Minimum Data Set](#), which contains information on all children and young people in Australia who were supervised by youth justice agencies in the community and in detention. Data are extracted from the administrative systems of the state and territory departments responsible for youth justice in Australia.

This section focuses on those children aged 10–14 under youth justice supervision.

How many children are under youth justice supervision?

In 2017–18, around 1,100 children aged 10–14 were under youth justice supervision in Australia on an average day, making up 20% of all children and young people under youth justice supervision on an average day. This equates to a rate of 73 per 100,000 children aged 10–14 (Figure 1).

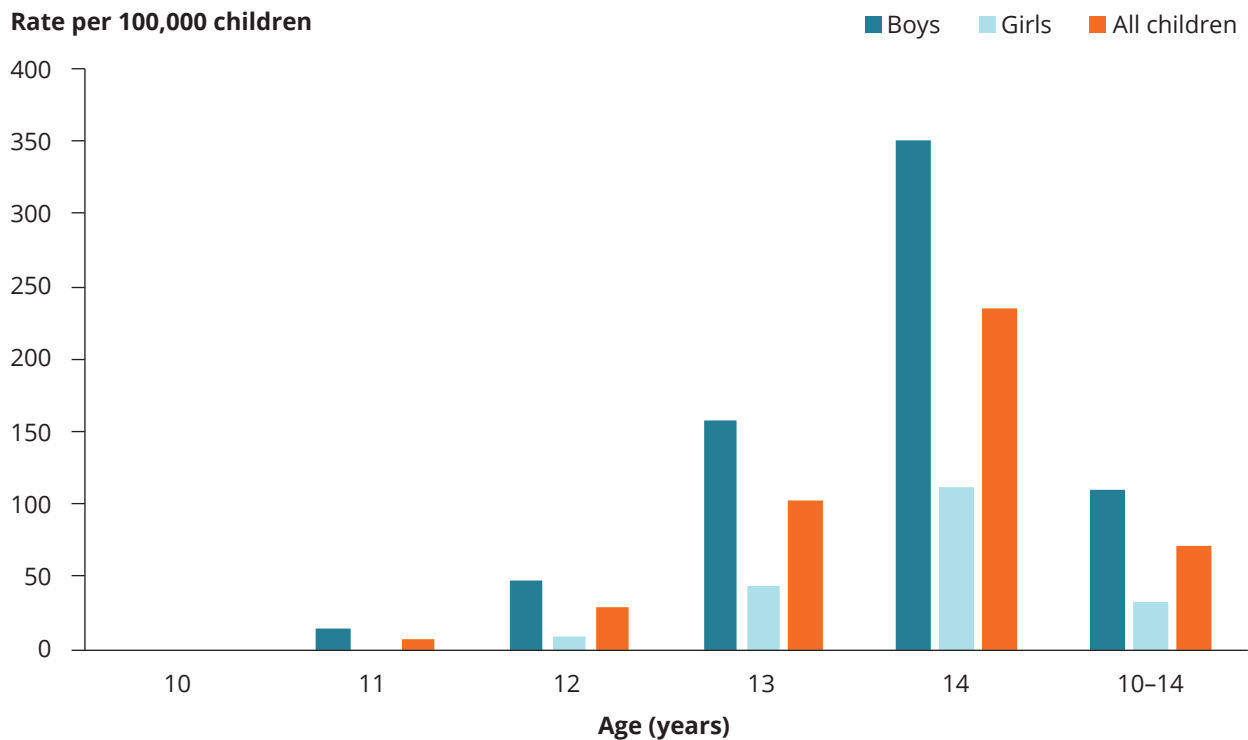
Boys were more than 3 times as likely under supervision as girls (110 per 100,000 compared with 33 per 100,000), making up nearly 4 in 5 (78%) children aged 10–14 under supervision on an average day.

Children aged 14 were more than 8 times as likely under supervision as those aged 12 (236 per 100,000 compared with 29 per 100,000). Boys aged 14 were most likely under supervision (352 per 100,000), making up nearly half (48%) of all children aged 10–14 under supervision.

Nearly 4 in 5 (78%) children under supervision were being supervised in the community, with the remainder in detention. Children were more than 5 times as likely under community-based supervision as in detention (56 compared with 11 per 100,000).



Figure 1: Children aged 10–14 under youth justice supervision on an average day by age, 2017–18



Notes

1. Rates are not published where there are fewer than 5 young people.
2. Total includes young people with unknown sex.
3. Age calculated as at start of financial year if first period of supervision in the relevant year began before the start of the financial year, otherwise age calculated as at start of first period of supervision in the relevant year.

Chart: AIHW. Source: AIHW Juvenile Justice National Minimum Data Set.

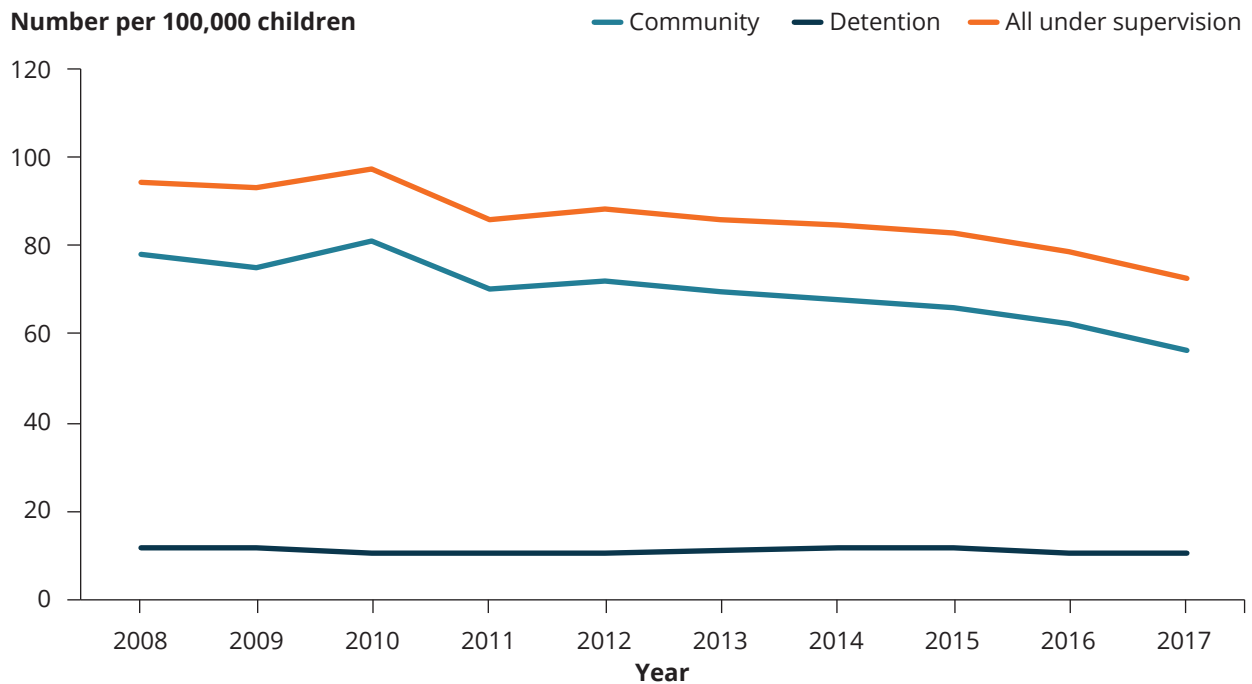
Has the number of children in youth justice supervision improved over time?

Over the last 10 years, the rate of children aged 10–14 under youth justice supervision decreased steadily from 95 per 100,000 children in 2008–09 to 73 per 100,000 in 2017–18, after peaking slightly at 97 per 100,000 in 2010–11.

The rate of children under community-based supervision followed a similar trend, decreasing steadily from 78 per 100,000 to 56 per 100,000 between 2008–09 and 2017–18, after peaking at 81 per 100,000 in 2010–11.

The rate of children under detention remained steady over the 10-year period at around 11 per 100,000 children (Figure 2).

Figure 2: Children aged 10–14 under youth justice supervision on an average day by type of supervision, 2008–09 to 2017–18



Notes

1. The Northern Territory did not supply data for 2008–09, 2009–10, 2010–11 and 2011–12, so estimates have been used.
2. Trend data may differ from those previously published due to data revisions.

Chart: AIHW. Source: AIHW Juvenile Justice National Minimum Data Set.

Is youth justice supervision the same for everyone?

The number of children under youth justice supervision, and the type of supervision they are under, varies across population groups.

In 2017-18, most children aged 10–14 under supervision on an average day were from:

- *Major cities* (41%)
- *Inner regional* (21%)
- *Outer regional* (20%).

However, rates of children under supervision increased with remoteness (502 per 100,000 children in *Very remote* areas compared with 43 per 100,000 in *Major cities*) (Figure 3).

Similar patterns occurred among children in detention and under community-based supervision. Children from areas of greatest socioeconomic disadvantage were also more likely than those living in areas of least disadvantage to be under supervision on an average day (140 per 100,000 compared with 14 per 100,000).

Differences were also evident between Indigenous and non-Indigenous children (835 per 100,000 compared with 28 per 100,000) (Figure 3).

Length of time spent under supervision also differed by population group (Box 2).

Box 2: Length of time spent under supervision

When all the time spent under supervision during 2017–18 is considered, young people aged 10–17 supervised spent, on average, 189 days or about 6 months under supervision (AIHW 2019).

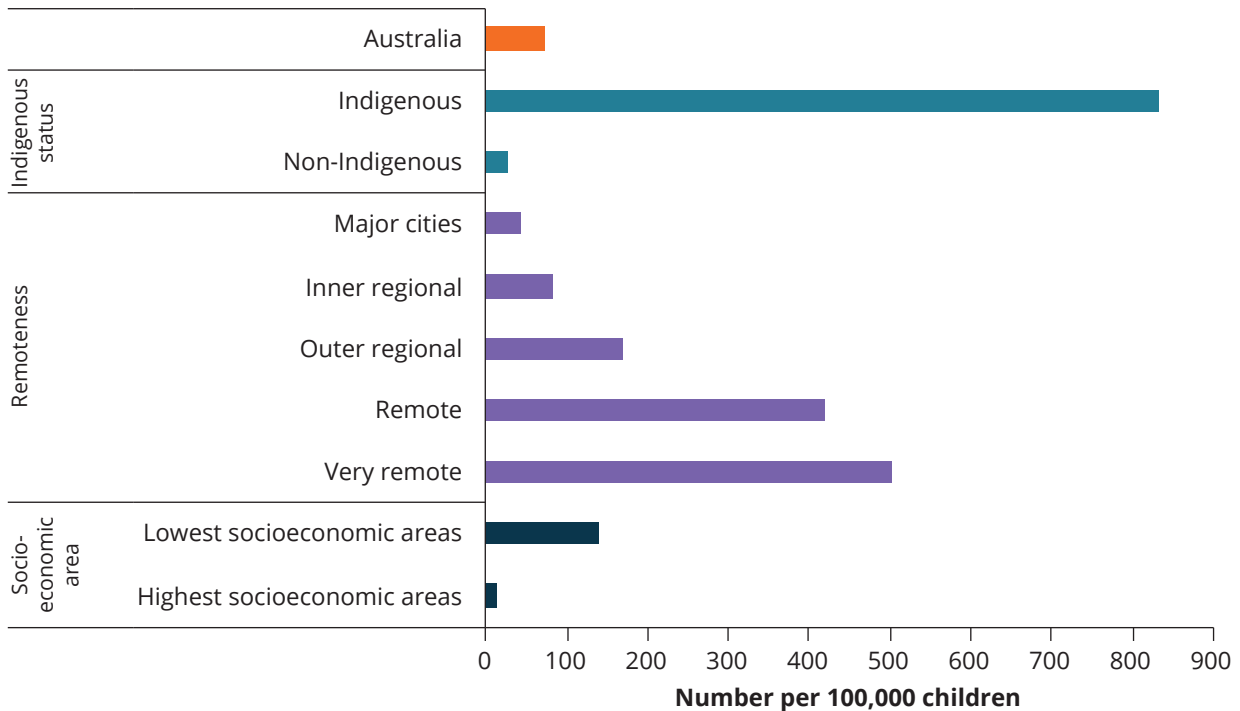
Compared with non-Indigenous young people aged 10–17, Indigenous young people spent, on average:

- 11 days longer under supervision during the year (197 days compared with 186)
- a similar length of time in detention (74 days compared with 71)
- a similar length of time under community-based supervision (178 days compared with 176) (AIHW 2019).

While Indigenous and non-Indigenous young people spent similar lengths of time in detention, Indigenous young people spent:

- 8 days longer on average in unsentenced detention (52 days compared with 44)
- 12 days less in sentenced detention (102 days compared with 114) (AIHW 2019).

Figure 3: Children aged 10–14 under youth justice supervision on an average day by selected population groups, 2017–18



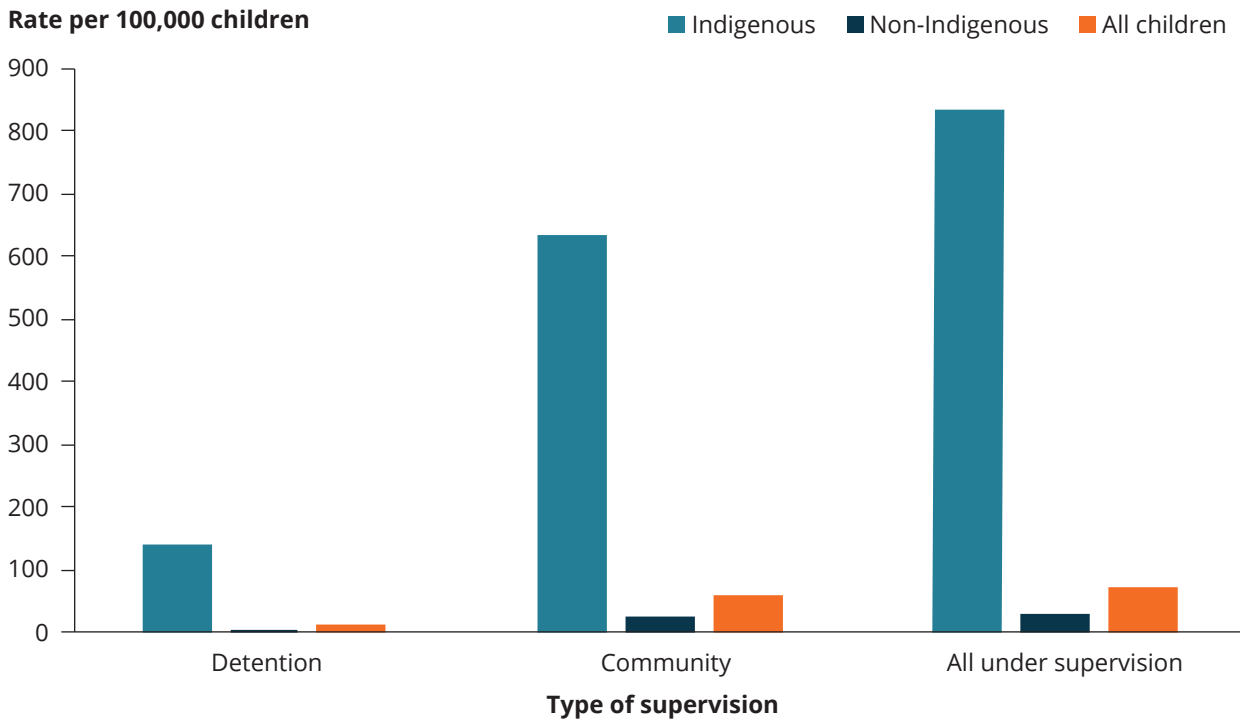
Notes

1. Rate for Australia includes young people with unknown sex and Indigenous status.
2. Socioeconomic areas use Socio-Economic Indexes for Areas' Index of Relative Socio-Economic Disadvantage. A Picture of Australia's Children 2012 used the Index of Relative Socio-economic Advantage and Disadvantage, so the numbers are not comparable.

Chart: AIHW. Source: AIHW Juvenile Justice National Minimum Data Set.

Indigenous boys had the highest rate under supervision on an average day, 1 in 77 (1,296 per 100,000). The disparity was greatest for those detained in youth justice (Figure 4).

Figure 4: Children aged 10–14 under youth justice supervision on an average day by Indigenous status and type of supervision, 2017–18



Notes

1. Total includes young people with unknown Indigenous status.

Chart: AIHW. Source: AIHW Juvenile Justice National Minimum Data Set

Box 3: Returns to youth justice and overlap with other services

The AIHW reports on the number of children and young people who return to youth justice supervision to better understand the pathways of these young people and the effectiveness of youth justice services (AIHW 2018c).

In general, most young people aged 10-17 who receive a supervised youth justice sentence serve only 1 sentence (61%) before turning 18, and do not return. However, the younger a person was at their first supervised sentence (community based or detention), the more likely they were to return to sentenced youth justice supervision.

The AIHW has also used linked data to better understand the disadvantage that children and young people under youth justice supervision experience, by examining how they come into contact with multiple cross-sector services, such as child protection, alcohol and other drug treatment services and homelessness services.

Key findings

- Nearly half of those under youth justice supervision had also received child protection services (AIHW 2018b).
- Young Indigenous Australians were more likely than non-Indigenous Australians to have received both child protection services and youth justice supervision (AIHW 2018b).
- In comparison with people who have only experienced specialist homelessness services, those who have experienced both these services and youth justice supervision were more likely to report having a drug and/or alcohol issue, and to end specialist homelessness services support sleeping rough (AIHW 2016).
- Young people who received an alcohol and other drug treatment service were 30 times as likely as the Australian population to be under youth justice supervision (AIHW 2018a).

Data limitations and development opportunities

Linkage of de-identified youth justice data would offer further insight into the youth justice population. See 'What's missing?' in [Justice and safety](#).

Where do I find more information?

For more information on:

- Indigenous children in youth justice, see: [Indigenous children](#)
- children in the youth justice system, see [Youth justice in Australia 2017–18](#).
- detention, see: [Youth detention population in Australia 2018](#).
- youth justice and child protection systems, see: [Young people in child protection and under youth justice supervision: 1 July 2013 to 30 June 2017](#).

See also [Methods](#).

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Bullying

Key findings

- Data from the Longitudinal (LSAC) in 2016 shows that 7 in 10 children aged 12–13 experienced at least 1 bullying-like behaviour within a year.
- According to the Trends in International Mathematics and Science Study (TIMSS) 2015, 1 in 5 Year 4 students experience bullying on a weekly basis.
- 1 in 4 children aged 8–12 who completed the eSafety Commissioner’s Youth Digital Participation Survey showed experienced unwanted contact and content while online.
- Data from LSAC in 2016 found that almost half (46%) of children aged 12–13 who experienced at least 1 bullying-like behaviours within a year also used bullying-like behaviours against another child.

Bullying refers to any intentional and repeated behaviour which causes physical, emotional or social harm to a person who has, or is perceived to have, less power than the person who bullies (Australian Education Authorities 2019; Kids Helpline 2019; Australian Human Rights Commission 2012).

Bullying is a complex issue. It comes in many forms, occurs in various settings, and affects many population groups (Australian Education Authorities 2019; ReachOut Australia 2017).

Bullying can have substantial impacts on victims, perpetrators and witnesses, as well as the broader social environment (ReachOut Australia 2017; Rigby & Johnson 2016).

For further details on the types of bullying, see Box 1.

Box 1: Defining bullying

Bullying can be physical, verbal or social.

Physical bullying includes actions that physically harm an individual or their belongings, including stealing from them.

Verbal bullying includes spoken or written words intended to insult or otherwise cause emotional pain to a person.

Social bullying includes actions intended to socially isolate another person or otherwise attack their social standing, for example by sharing personal information with others (Australian Education Authorities 2019; Kids Helpline 2019; Australian Human Rights Commission 2012).

Bullying-like behaviour includes behaviours related to bullying that may not have occurred repeatedly. In some cases, this section includes data on bullying-like behaviour.

Children can be exposed to bullying as **victims, perpetrators, bystanders or upstanders**. Upstanders, also known as supportive bystanders, attempt to help the victim of bullying in some way by, for example, taking action to stop the bullying or supporting the victim following an incident (Salmivalli 2014; Australian Education Authorities 2019; NSW Department of Education 2019).

Bullying can happen:

- anywhere (for example, at school, home or in the neighbourhood)
- in person or online
- in an obvious or hidden manner (Australian Education Authorities 2019).

Physical, verbal and social bullying can all occur in person.

Cyberbullying, also referred to as **online bullying**, is a subset of verbal and/or social bullying carried out through technology, such as the internet and mobile devices (Australian Education Authorities 2019; Office of the eSafety Commissioner 2018).

In the absence of a single comprehensive national data source on children who experience bullying, this section draws on multiple data sources to provide some insight into the topic.

While children can be bullied by anyone; for example, peers, siblings or adults, the focus of this section is behaviours carried out by a child's peers in any setting (for example, at school or online) (Australian Education Authorities 2019; Dantchev & Wolke 2019; National Academies of Sciences, Engineering, and Medicine 2016).

For more information on each data source used throughout this section, see Box 2.

Box 2: Measuring bullying

The data used throughout this section are from data sources that asked children how often they experienced behaviours related to bullying, at least once or repeatedly over a specific period.

Some data sources combine responses to questions about bullying to assign children an overall bullying status, while others report the experience of any bullying-like behaviour.

Physical, verbal and social behaviour that occurs face-to-face or online, are in scope of all data sources presented.

Each data source represents different populations and defines and measures bullying differently. They are not comparable.

Longitudinal Study of Australian Children (LSAC)

This study follows the development of 10,000 young people and examines a broad range of areas over their life course. Data are used from children aged 12–13 in 2016. Population estimates from the LSAC represent the population of children aged 0–1 in Australia in 2004. Data are not representative of children who immigrated to Australia.

The LSAC is conducted in partnership between the Department of Social Services, Australian Institute of Family Studies (AIFS) and the Australian Bureau of Statistics (ABS).

At various points throughout the study, children have been asked about the different types of behaviours they experienced.

Australian Child Wellbeing Project (ACWP)

This survey was led by a team of researchers at Flinders University and the University of New South Wales and administered in 2014 to 5,400 students in Years 4, 6 and 8. It asked children about the types of behaviours they experienced.

Trends in International Mathematics and Science Study (TIMSS) and Progress in International Reading Literacy Study (PIRLS)

These studies regularly collect data on bullying as part of internationally comparable educational assessments for children in Years 4 and 8. They are internationally managed by the International Association for the Evaluation of Educational Achievement and in Australia they are conducted by the Australian Council for Educational Research (ACER) on behalf of the federal and state and territory governments.

Second Australian Child and Adolescent Survey of Mental Health and Wellbeing

This is also referred to as the Young Minds Matter survey. It examined the emotional and behavioural development of children and asked participants about their involvement in bullying.

Youth Digital Participation Survey

This Office of the eSafety Commissioner's 2017 survey asked more than 3,000 young Australians aged 8–17 about their experiences and behaviours related to safety online.

A selection of statistically significant comparisons between population groups have been included throughout.

For details on the specific questions that children were asked in each data source, see Technical notes in the [Bullying](#) section of the online report.

How many children are bullied?

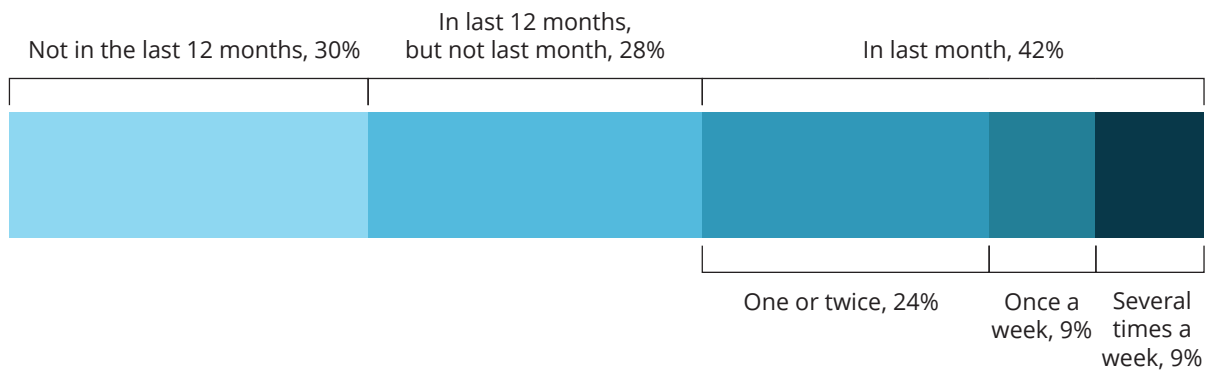
The proportion of children who have been bullied or experienced bullying-like behaviours varied depending on the source. This is due to variation in the definition of bullying, and/or the nature and scope of questions asked.

160,000 children aged 12–13 experienced at least 1 bullying-like behaviour within a year

It was estimated using data from LSAC in 2016 that 70% (or 160,000) of children aged 12–13 had experienced at least 1 bullying-like behaviour in the 12 months before the survey (Figure 1). Approximately 60% of the 96,800 children who had experienced bullying-like behaviour, had experiences in the month before the survey.

Of those children who had experienced bullying-like behaviour in the month before the survey, more than two-fifths (43%, or 41,300) had experienced this behaviour about once a week or more frequently (Figure 1) (AIHW analysis of the LSAC).

Figure 1: Proportion of children aged 12–13 who experienced bullying-like behaviour in the 12 months before the survey, 2016



Note: The frequency in the last month refers to the frequency of the main bullying-like behaviour experienced by a child, rather than the frequency of bullying incidents (which may include different behaviours).

Chart: AIHW. Source: AIHW analysis of the LSAC.

Similar to these findings, the 2014 ACWP found that 60% of students in Years 4, 6 and 8 experienced at least 1 bullying-like behaviour in the same school term the survey was conducted (AIHW analysis of the ACWP).

60% of children experienced 2 or more bullying behaviours

It was estimated using data from LSAC in 2016 that more than half (66%) of the approximately 96,800 children who experienced bullying-like behaviour in the month before the survey experienced 2 or more bullying-like behaviours. Almost 11% experienced 2 or more once a week and about 9% experienced 2 or more several times a week.



Younger students are bullied more than older students

According to the TIMSS 2015, Year 4 students (average age 10) were more likely to have been bullied than Year 8 students (average age 14). About 56% of Year 4 students and 43% of Year 8 students had been bullied monthly or weekly during the school year (Figure 2) (Thomson, Wernert et al. 2017).



A decrease in bullying with age is consistent with international research findings, with suggested explanations including:

- differences in behaviours included in the definition
- less sensitivity to certain bullying-like behaviours resulting in less self-reporting
- improved social skills (Smith et al. 1999; Eslea & Rees 2001; Ryoo et al. 2015).

Figure 2: Proportion of children bullied during the school year, by frequency of bullying, by year level at school, 2015

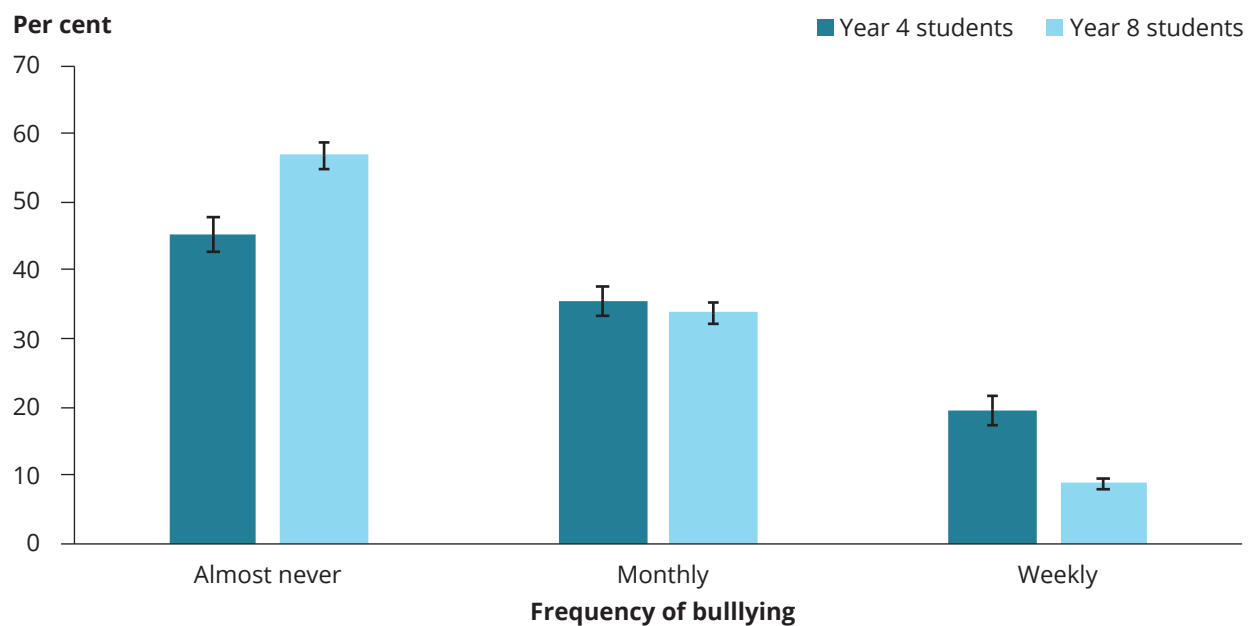


Chart: AIHW. Source: Thomson, Wernert et al. 2017.

How common is cyberbullying?

Box 3: What makes cyberbullying different?

Cyberbullying can cause a victim to suffer more acutely and the child who bullies may not be reprimanded for their behaviour. Reasons for this include:

- Invasive nature. Cyberbullying cannot be physically escaped in the same way in-person bullying can. It can happen anywhere and anytime of the day.
- Rapidly and widely spread material. The use of technology means that harmful material, such as images and rumours, can be spread far more quickly than they can in person, and cannot be retrieved or destroyed in the same way physical material can.
- Anonymity and physical distance. Cyberbullies may feel a sense of anonymity as a result of their physical distance from the victim. This can leave a bully feeling more confident in their actions and less likely to stop (Australian Education Authorities 2019; Robinson 2013).

1 in 5 children experienced online bullying-like behaviours in the last month

Data from LSAC in 2016 shows that 17% of all children aged 12–13 experienced online bullying-like behaviour in the month before the survey. Of the 96,800 children aged 12–13 who did so, 10% experienced online bullying-like behaviour only and 32% both online and face-to-face bullying-like behaviours (ABS analysis of the LSAC).

The eSafety Commissioner's Youth Digital Participation Survey did not specifically ask children about cyberbullying. Rather, it collected information on negative online experiences, which can include some cyberbullying behaviours such as social exclusion or threats and abuse.

Results from the survey showed that unwanted contact and content was the most commonly reported negative online experience for children aged 8–12, with 24% of all children experiencing it. Boys and girls had similar rates for all of the different online negative experiences examined (Figure 3) (Office of the eSafety Commissioner 2018).

Figure 3: Proportion of children aged 8–12 who had negative online experiences, by sex, July 2016 to June 2017

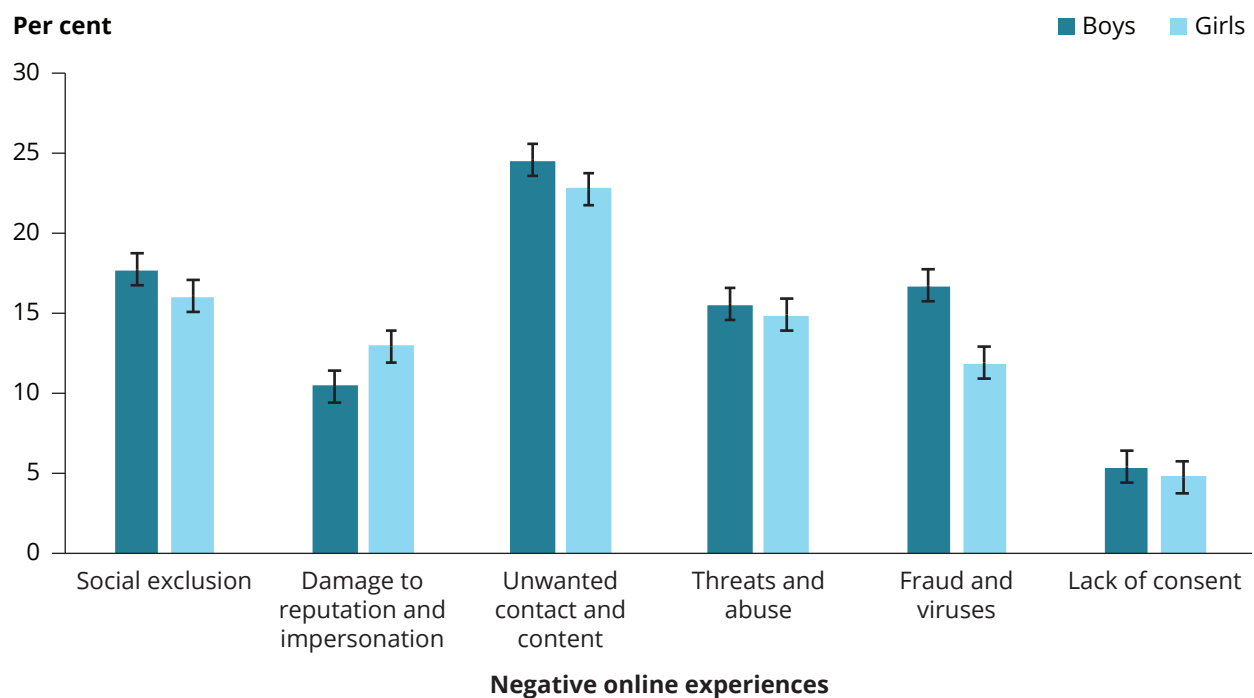


Chart: AIHW. Source: Office of the eSafety Commissioner 2018.

Are some kids bullied more?

While children in any population group can be victims of bullying, those who belong to certain groups or are viewed as being different from their peers tend to be more vulnerable (Australian Education Authorities 2019).

Bullying is more common among children:

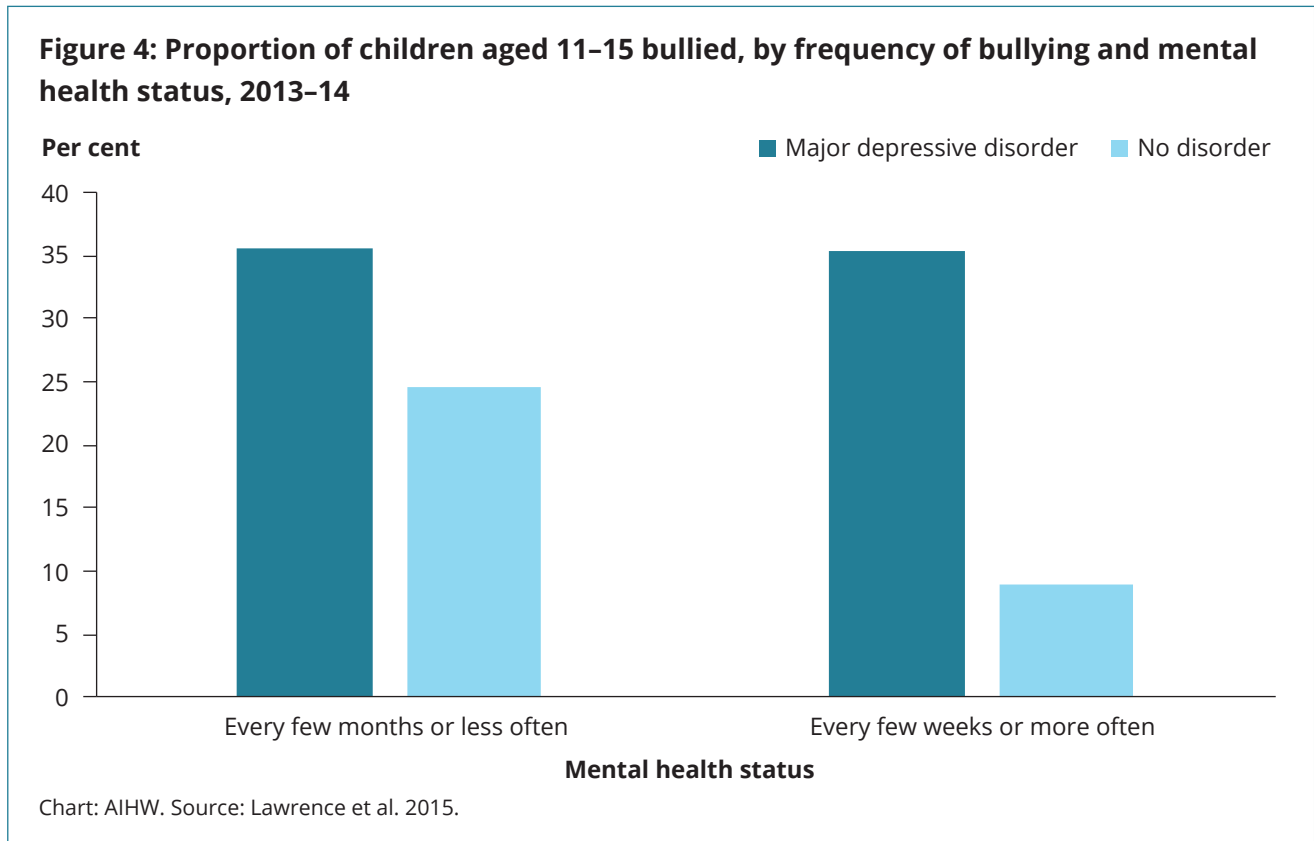
- with disability
- from culturally and linguistically diverse backgrounds
- who identify as lesbian, gay, bisexual, trans and gender diverse, or children who have intersex variations (Australian Education Authorities 2019; Rigby & Johnson 2016).

Children with a disability are bullied more

The 2014 ACWP found that more children with disability experienced bullying-like behaviours in the same school term the survey was conducted than children without disability (74% compared with 59%, respectively) (AIHW analysis of the ACWP).

Children with major depressive disorder

In the 2013–14 Young Minds Matter survey, children aged 11–15 with major depressive disorder (based on self-report) were more likely to have experienced frequent bullying in the 12 months before the survey than children with no disorder (Figure 4). In this survey it is not possible to determine if major depressive disorder was caused by, or contributed to, the bullying (Lawrence et al. 2015).



Children from socioeconomically disadvantaged schools were bullied more

The PIRLS 2016 found that a higher proportion of Year 4 students from more socioeconomically disadvantaged schools experienced frequent bullying than those attending more affluent schools. About 57% of children from disadvantaged schools had experienced bullying in the 12 months before the survey (23% experienced bullying about weekly) compared with half (50%) of children from affluent schools (15% about weekly) (Thomson, Hillman et al. 2017).

What are the impacts of bullying?

Consequences of bullying

There can be a range of physical, psychological, social and academic consequences for children who are victims, perpetrators, bystanders and upstanders of bullying (National Academies of Sciences, Engineering, and Medicine 2016).



Children who are bullied, as well as those who witness or intervene in bullying, may experience immediate physical or emotional consequences (such as injuries or embarrassment).

Children victims of bullying are also:

- more likely to have poor academic performance
- at risk of struggling with transition points throughout life, such as adjusting to secondary school
- more likely to have mental health concerns, such as feelings of anxiety and depression
- at higher risk of suicide (AIFS 2017; Rigby & Johnson 2016).

Bullying and educational attainment

On average, Year 4 students who were bullied achieved lower scores in TIMSS and PIRLS than children who were not, and there was a relationship between the average score achieved by children and the frequency of bullying (Figure 5). A similar pattern was observed among Year 8 students (Thomson, Hillman et al. 2017 & Thomson, Wernert et al. 2017).

Figure 5: Average score on TIMSS 2015 and PIRLS 2016, Year 4 students, by frequency of bullying

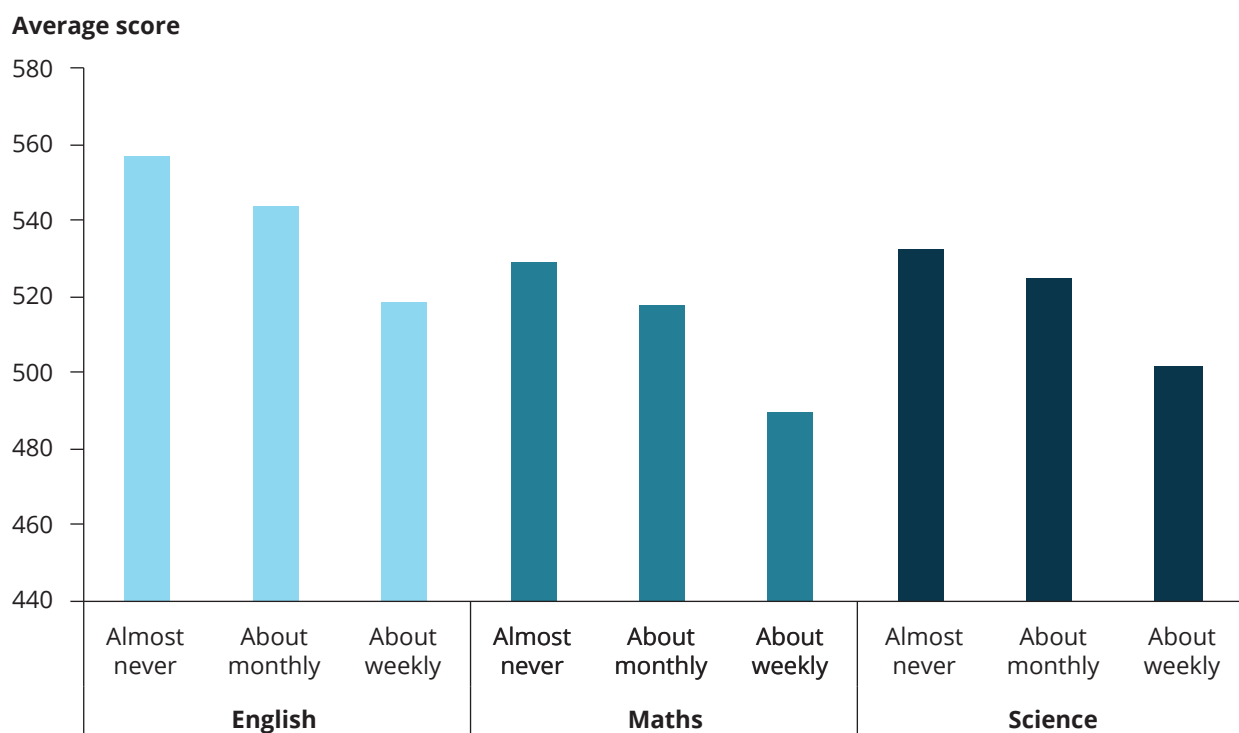


Chart: AIHW. Source: Thomson, Hillman et al. 2017 & Thomson, Wernert et al. 2017.

Victims of bullying experience distress

In the Young Minds Matter survey, about 33% of children aged 11–15 who had been bullied said they had experienced a lot of distress caused by bullying in the 12 months before the survey.

The rate is higher among children with major depressive disorder who had been bullied—69% of children with major depressive disorder who had been bullied said they experienced a lot of distress caused by bullying, compared with 29% of children with no disorder (Figure 6) (Lawrence et al. 2015).

Figure 6: Proportion of children aged 11–15, by mental health status, by level of distress caused by bullying, 2013–14

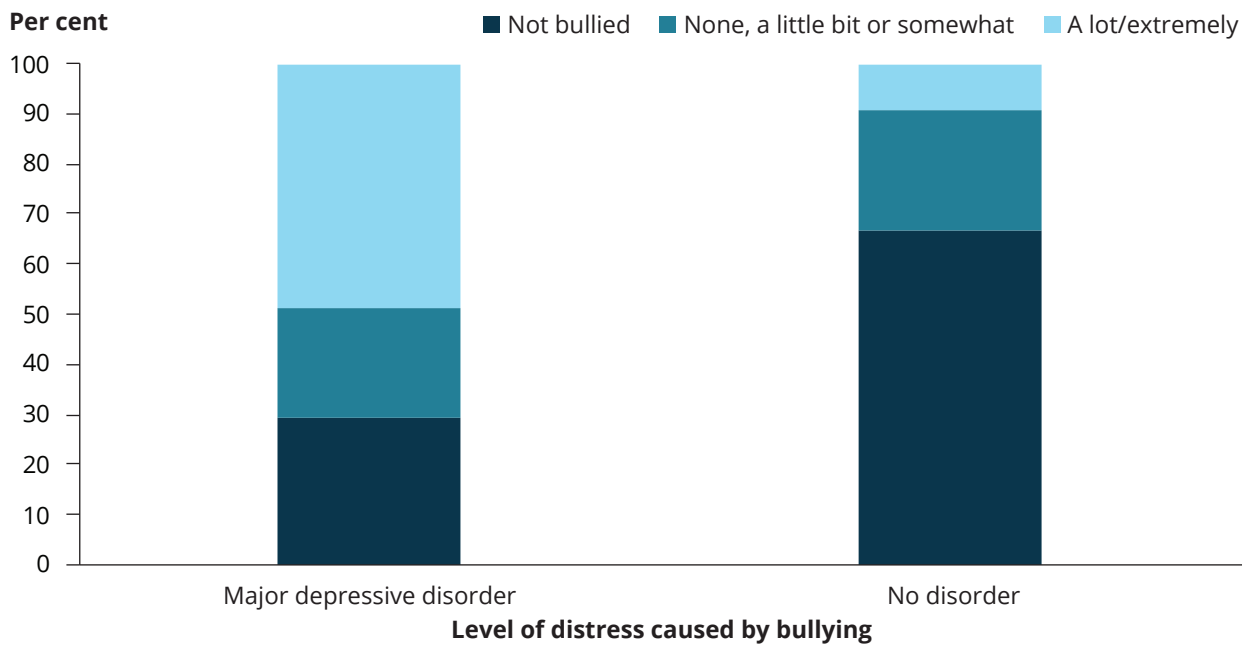


Chart: AIHW. Source: Lawrence et al. 2015.

Children who bully others

Data from the LSAC in 2016 showed that about 34% of children aged 12–13 used bullying-like behaviours against another person in the 12 months before the survey, including 14% who used these behaviours in the month before the survey (Figure 7). Of those children who used bullying-like behaviours against another person in the month before the survey, almost half (49%) had used 2 or more types of bullying-like behaviours (AIHW analysis of the LSAC).

Figure 7: Proportion of children aged 12–13 who used bullying-like behaviours against another person in the previous 12 months, 2016

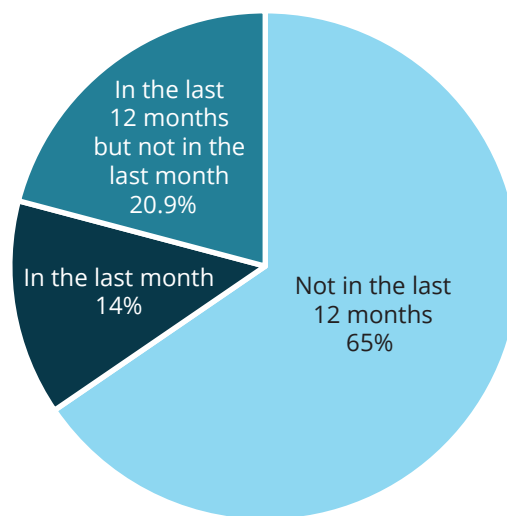


Chart: AIHW. Source: AIHW analysis of the LSAC.

The ACWP showed that 11% of Year 4 students and 8% of Year 6 students had used bullying-like behaviours against another child in the same school term the survey was conducted (AIHW analysis of the ACWP).

Many children who bully have also been the victim of bullying themselves

Data from the LSAC showed that more children who experience bullying-like behaviours use these behaviours against others than those who do not. About 46% of children aged 12–13 who experienced bullying-like behaviours in the 12 months before the survey had also used these behaviours against another child in the same period, compared with 7.4% of children who did not experience any of these behaviours. Around 94% of children who used bullying-like behaviours against someone else in the 12 months before the survey had also experienced such behaviours in the same period (ABS analysis of the LSAC).

Overall, there was a large amount of overlap between children who experience bullying-like behaviours and those who use these behaviours against others than those who do not (Figure 8).

Figure 8: Children aged 12–13 who have experienced bullying behaviours and children who have used bullying behaviours in the previous 12 months, 2016

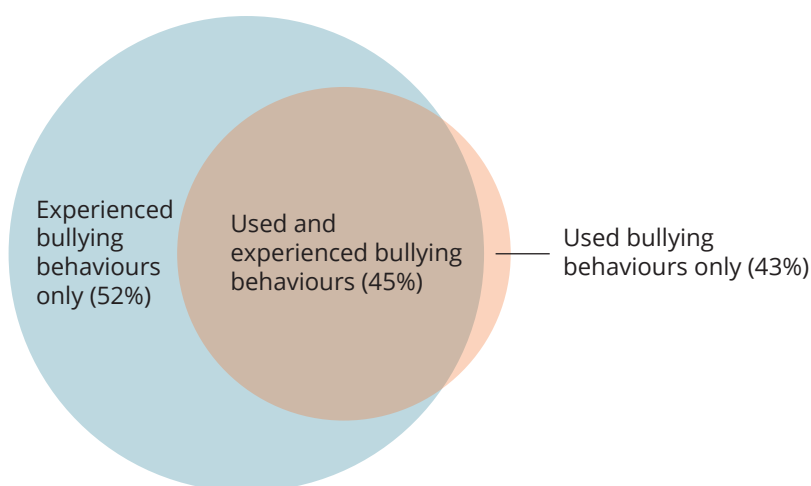


Chart: AIHW. Source: AIHW analysis of the LSAC.

What are the impacts for children who bully?

Research suggests that children who bully other children are:

- more likely to engage in criminal offending and substance abuse
- more likely to have poor educational and employment outcomes
- at higher risk of depression later in life (Australian Education Authorities 2019; National Academies of Sciences, Engineering, and Medicine 2016; Lodge 2014; Vaughn et al. 2010).

Data limitations and development opportunities

There is currently no ongoing comprehensive national data source of children involved in bullying—as victims, perpetrators, bystanders or upstanders—and there are no time-series data available for reporting.

There are a number of opportunities for the development of regular, national data on bullying that could be further explored. These include:

- additional analysis of PIRLS and TIMSS data
- school and/or student level data collected as part of school-based anti-bullying programs (for example, [Friendly Schools Plus](#))
- future eSafety Commissioner data collections
- emerging data sources such as [Rumble's Quest](#).

Where do I find more information?

For more information on:

- bullying, see: [Friendly Schools Plus](#), [Cool Schools](#) and [Bullying No Way!](#)
- LSAC, see: [Growing Up in Australia](#).
- technical notes relating to this section, refer to [Bullying](#) in the online report. See also [Methods](#).

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Data gaps

Data gaps

While much is known about the health and welfare of children in Australia, there are still notable gaps and limitations which limit national population-level monitoring over time. Some gaps relate to specific topics, while others are overarching and impact the quality of reporting against all, or most, of the 7 domains of children's wellbeing (see Introduction).

This section discusses some key nationally relevant data gaps identified in Australia's children, and potential opportunities for development. The information is intended to form the basis for future discussions on national data and information development priorities. It is not exhaustive.

National relevancy has been established based on whether the topics have been identified as national policy priorities, such as those outlined in *Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health* and the *National Action Plan for the Health of Children and Young People: 2020–2030*, and/or raised by a national expert group as topics for which data gaps exist.

Overarching data gaps

Some data gaps do not relate to a specific topic, and can be relevant to a range of subject areas. Three major data gaps identified in this report relate to all or several domains of children's wellbeing.

Priority groups

Reporting data for various population groups is critical to informing matters of equity (providing services and resources based on need). However, data are often unable to be reported by population groups, particularly from surveys with small sample sizes that may not be representative of smaller population groups.

The range of population groups for which data are not readily available, include:

- children of refugee and asylum seeker families
- children from culturally and linguistically diverse backgrounds or children born overseas
- children living in out-of-home care
- incarcerated children and young people
- children with disability
- children who identify as lesbian, gay, bisexual, trans and gender diverse, or children who have intersex variations.

Pathways, transitions and outcomes

There are currently no national indicators to measure how children transition through major development stages, or how children interact with services and move through different systems. While data may be available for specific services or stages of a child's life; for example data from hospitals, education or early childhood assessments, there is limited ability to track children through different data sources to assess their outcomes. This makes it difficult for governments and others to effectively evaluate services.

Data linkage, or the joining of data sets, may provide the information needed to track the pathways of children through different systems and determine how this impacts their outcomes.

Data linkage is discussed in more detail later in this section.

Voice of the child

Current ongoing, national data sources which support population-level monitoring over time are predominantly:

- administrative (information collected as part of service delivery)
- surveys (which are generally administered only to adults).

This means that measures of children's subjective wellbeing, including their cultural and racial identity, are very limited among these sources (see [Children's perspective of wellbeing in Introduction](#)). It also means data are limited for monitoring children's subjective wellbeing over time.

While a number of studies provide useful insight into children's experiences through the 'voice of the child', such as work of the National Children's Commissioner, state and territory children's commissioners, the Longitudinal Study of Australian Children and the Australian Child Wellbeing Project, there are many areas where children's opinions or experiences are not collected.

For example, the:

- Australian Bureau of Statistic' (ABS) Personal Safety Survey asks adults aged 15 and over about whether children had seen or heard violence in the home but information is not collected from children about experiencing or witnessing violence.
- Household, Income and Labour Dynamics in Australia (HILDA) Survey can be used to measure material deprivation (when people do not have and cannot afford items or activities widely regarded as essential for participating fully in a society); however it only reflects what adults aged 15 and over consider to be essential resources and services, which may differ from children's perspectives.

Collecting information directly from children more regularly and on a broader range of topics gives them a voice on what matters to them. However, there are challenges to collecting these data, including parental consent and issues relating to child disclosure of sensitive or criminal behaviour, such as instances of child abuse or neglect.

Other overarching gaps

Australia's children provides information on a range of established indicators at national level.

Future reports in this series could explore the reporting of data by lower geographic areas, and/or service use by children across Australia. However, nationally, some data gaps also exist in these areas.

Geographic areas

The quality and consistency of geographic units (such as postcode or [ABS Statistical Area Level 2](#)) varies between data sets. Where geographic data are available, it may not be able to be presented due to concerns about confidentiality and statistical validity of reporting data from small populations, or it may be based on service location rather than child's location. High-quality data reported by geographical areas would provide information such as how far children travel to access certain services, or identify areas with higher rates of disease where services should be targeted.

Community services, including maternal and child health

A range of organisations provide health and community services to children and their families, such as:

- allied health care services
- family support services
- dental services
- family, domestic and sexual violence services.

These services may be delivered by governments, or by non-government organisations (for-profit and not-for-profit). Many services collect data in their daily operations. While some services have data collated and routinely reported at national level (such as specialist homelessness services and child protection services), many do not. This may be because:

- data are inconsistently collected
- there is no national mechanism for collating and/or reporting
- collated data are not nationally comparable.

Greater reporting of community services, including maternal and child health data, could provide a more complete picture of service use by children across Australia. It could also help inform service planning by identifying the most in-demand services and the key needs of children accessing the services, and using this with other data on prevalence and experiences, to predict demand and needs.

Topic-specific gaps

Australia's children aims to provide a national overview of how Australian children are faring at a particular point in time, which can be regularly updated and progress tracked. For this reason, the report focuses mainly on national data, collected periodically and which supports population-level comparisons. Table 1 summarises current topics where national data for this purpose are not available or limited.

Topics are grouped according to the child-centred domains, and a separate category—the Environment. Environment includes built and natural environment topics as well as those covering contextual factors, such as service availability.

Table 1: Topic gaps in national reporting of children wellbeing by domains

Health	Social support	Housing
Fetal Alcohol Spectrum Disorder	Parenting	Impact of physical address
Overall mental health and wellbeing	Play	Income, finance and employment
Impact of device and social media usage on health	Cultural identity	Parental underemployment
Body image	Children’s personal social networks	Environment
Sleep	Family functioning-related topics	Physical environment (built and natural)
Neonatal hearing screening	Shared care arrangements	Social environment
Medical technology and devices used by children with health conditions	Extracurricular activities	Service availability
Education and skills	Justice and safety	Community governance
School expulsions and suspensions	Prevalence of child abuse and neglect	
Student engagement (cognitive)	Children’s exposure to violence	
Quality and time of early learning experiences	Bullying	
	Non-parental care living arrangements	

What could be done to improve the evidence?

A number of options are available for improving national information on children’s wellbeing. These options are not exhaustive, and different options will meet different information needs.

Enhance existing data sets

Many data gaps can be filled by enhancing existing data sets. The several potential approaches for this include:

- adding flags or data items to data sets for specific population groups or geographies, for example adding a flag to child protection data to identify children who have been victims of family or domestic violence
- adopting appropriate sampling techniques to ensure survey data can more accurately represent smaller population groups, such as culturally and linguistically diverse children
- adding new questions to capture data related to a topic not captured elsewhere.

Safely share and link data

Data linkage can be used to combine data from 2 or more sources, while preserving privacy, to tell a much more powerful story than would be possible from a single source.

By combining information from multiple data sets, it is possible to improve understanding of:

- how children transition between key developmental stages and their outcomes at different stages of their life
- the pathways children take through different services and the points where intervention would be most effective
- the relationships between risk factors, protective factors and outcomes, which interventions are most likely to provide positive outcomes, and which indicators can be used as predictive tools for monitoring
- how children's wellbeing or service use differs among different population and geographic groups, where data on a specific population group may only be available in 1 data set.

Revisions to existing national child indicators

The key national indicators for child health, development and wellbeing, which include the [Children's Headline Indicators](#), underpin this report.

In 2006, the 19 priority areas of the Children's Headline Indicators were endorsed by 3 ministerial councils. One ministerial council focused on health, another on education, and another on community and disability services. There is scope for a comprehensive review of these areas and the indicators to ensure they reflect contemporary information needs.

Indicator development

Linked data sets provide the opportunity to develop and report new, more comprehensive, indicators which provide additional insights into children's wellbeing. For example, information on potentially vulnerable households could be gained by linking Centrelink data to other sources relating to vulnerability; such as data on homelessness or hospitalisations. Similarly, linked longitudinal data could be used to measure the proportion of children in child protection who go on to be involved in the youth justice system.

New data collection

In some cases, establishing a new data collection may be required to capture information on topics for which data are not available, or could not be collected by enhancing existing data collections.

Child-focused data platforms

Demand is increasing for locally-relevant data about children which spans multiple aspects of their experience. There is potential to take the sort of data presented in this report and build on it to produce a layered national data and reporting platform to support collating, presenting and sharing people-centred data about children, across multiple domains and according to place or location. This would inform a wide range of information needs on children's wellbeing in Australia.

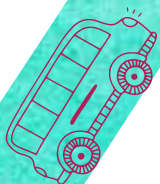
Where do I find more information?

Data gaps

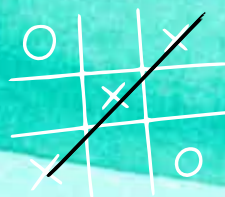
- [Australia's Welfare 2019](#) and [Australia's Health 2018](#) touch on a broad range of data gaps that impact reporting on the wellbeing of children.
- The AIHW's discussion paper, [Scoping enhanced measurement of child wellbeing in Australia](#) discusses opportunities for enhancing measurement of child wellbeing, focuses primarily on the national data and information landscape.

Linkage

- A range of standalone AIHW reports highlight how linking across data sources can provide information on the pathways and outcomes of children in priority populations:
 - [Young people in child protection and under youth justice supervision: 1 July 2013 to 30 June 2017](#)
 - [Young people in child protection and under youth justice supervision 2014–15](#)
 - [Young people in child protection and under youth justice supervision 2013–14](#)
 - [Vulnerable young people: interactions across homelessness, youth justice and child protection: 1 July 2011 to 30 June 2015](#)
 - [Educational outcomes for children in care: linking 2013 child protection and NAPLAN data](#)
 - [Overlap between youth justice supervision and alcohol and other drug treatment services: 1 July 2012 to 30 June 2016](#)
- [Australia's welfare 2019: data insights](#) also includes a feature article on linked data and its opportunities to improve our understanding of the wellbeing of children in Australia (see [Chapter 8 An innovative linked data platform to improve the wellbeing of children—the South Australian Early Childhood Data Project](#)).



Childhood is an important time for healthy development, learning, and establishing the foundations for future wellbeing. Most Australian children are healthy, safe and doing well. However, childhood is also a time of vulnerability and a child's outcomes can vary depending on where they live and their family's circumstances. This report brings together a range of data on children's wellbeing and their experiences at home, school and in the community.



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