

Part VIII

HOW WELL IS THE SYSTEM PERFORMING IN DELIVERING QUALITY HEALTH, DEVELOPMENT AND WELLBEING ACTIONS TO AUSTRALIA'S CHILDREN?

Many factors influence the health, development and wellbeing of Australian children. Most of the factors relevant to children—health status, health behaviours, socioeconomic and environmental factors, and the influence of families and communities—have been discussed in previous parts of this report. In addition to these, the capacity of systems to deliver high-quality services plays a major role in influencing the health and wellbeing of children.

In reference to health systems, the goals shared by OECD countries are to provide care that is accessible and high-quality, responsive to the population it serves, affordable and cost-effective (OECD 2004). Much work has been done in the measurement of health system performance. The National Health Performance Framework measures health system performance by the following components: effective, appropriate, efficient, responsive, accessible, safe, continuous, capable and sustainable (NHPC 2001). The same principles can be applied to the performance of systems other than health.

Part VIII presents indicators used to measure some of these components, and extends beyond the health system to look at quality child care and child protection resubstantiations. The indicators presented in this part are limited by the availability of information and the suitability of reporting on system performance indicators for children.

The following indicators are included in *Part VIII* to reflect how well systems are performing in delivering quality health, development and wellbeing actions to Australia's children:

- neonatal hearing screening
- childhood immunisation
- survival for leukaemia
- quality child care
- child protection resubstantiations.

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

Indicator		Value	Trend
Neonatal hearing screening	Children identified as requiring a hearing aid who are then fitted with a hearing aid by 6 and/or 12 months of age	Data not available	..
Childhood immunisation	Children on the Australian Childhood Immunisation Register who are fully immunised at 2 years of age (2008)	93%	✓
Survival of leukaemia	Five-year relative survival rate for leukaemia in children age 0–14 years (1998–2004)	83%	✓
Quality child care	Under development	Data not available	..
Child protection resubstantiations	Children aged 0–12 years who were the subject of a child protection resubstantiation in a given year	Data not available	..

Key: ✓ = favourable trend; .. = no trend data presented.

38 Neonatal hearing screening

Hearing impairment at birth often has major, lasting effects on language and communication. However, early diagnosis and intervention can improve language acquisition and, subsequently, educational outcomes and social development.

No national data are available on children identified as requiring hearing aids, which are then fitted by the age of 6 and/or 12 months.

Hearing impairment in children is associated with delayed language and speech, low educational attainment, increased behavioural problems, decreased psychosocial wellbeing and poor adaptive skills. Children with hearing impairment may have difficulty learning grammar, word order, idiomatic expressions, and other forms of verbal communication (US Preventive Services Task Force 2008). Hearing impairment that is severe enough to require amplification (that is, a hearing aid or cochlear implant) has serious and lasting effects on language development for many children. The estimated prevalence of congenital bilateral permanent hearing loss ranges from 1–3 per 1,000 live births (US Preventive Services Task Force 2008). Until the last decade, congenital hearing impairment among children was usually detected late, not until the age of 2 years or beyond (Wake 2002).

The goal of early hearing screening, diagnosis and treatment is to help children with hearing impairment to develop language and academic skills that are equal to those of children with no hearing impairment. The language development of children with hearing impairment identified in the first 6 months of life is significantly higher than for those identified after 6 months, with 'early-identified' children having language development at 80% of the typical development of children with no hearing impairment. Children diagnosed with hearing impairment after 6 months have language development at only 60% of typical development (Yoshinaga-Itano 2003).

However, early diagnosis does not translate into benefits—early diagnosis is only useful if followed by early intervention. Children with hearing loss who receive very early intervention have better language skills than those with later intervention, independent of the severity of hearing impairment, intelligence, and

socioeconomic status (Kennedy et al. 2006; Moeller 2000; Yoshinaga-Itano 2003). After diagnosis, factors that may affect outcomes in language development and speech perception include the age of fitting with a hearing device, the type of device used (most commonly a hearing aid, but also cochlear implants), the communication and education mode (sign, total communication or oral–aural), and the cause of the child's hearing impairment (Dahl et al. 2003). The quality of medical, audiological and educational intervention is also likely to have a significant impact on developmental outcomes for hearing-impaired children (Yoshinaga-Itano 2003). Quality services during infancy, preschool and primary school are also essential if early diagnosis of hearing impairment is to achieve the desired benefits (Wake et al. 2005).

With this new understanding of the importance of very early identification of congenital hearing loss, many countries have now implemented policies for universal neonatal hearing screening. The focus of these screening programs is on congenital hearing loss, as opposed to acquired or progressive hearing loss that may not be detected in the neonatal period.

There are two key approaches to screening the hearing of newborns—targeted screening of babies with risk factors, or universal screening of all newborns. Around 40–60% of children with congenital hearing loss have a recognised 'at risk' factor (Bailey et al. 2002), but the systematic identification of risk factors poses its own substantial challenges (Russ et al. 2005; Russ et al. 2002). Universal neonatal hearing screening is therefore a more effective approach to ensuring that most congenital cases of significant bilateral hearing impairment are detected early (US Preventive Services Task Force 2008).

NEONATAL HEARING SCREENING IN AUSTRALIA

In Australia, the implementation of universal neonatal hearing screening has been proceeding since 1998, when Western Australia introduced a partial metropolitan service in Perth. All states and territories now have some degree of neonatal hearing screening. In 2006, universal neonatal hearing screening programs were implemented in New South Wales, Queensland, South Australia and the Australian Capital Territory. Australia's particular challenges include the geographic spread of hospitals in which babies are born, and the difficulties of having appropriate equipment and trained health professionals to undertake the screening in all of these locations, particularly in regional and remote areas. A number of jurisdictions have resolved these issues, while others have yet to do so.

CHILDREN FITTED WITH HEARING AIDS

Key national indicator: Proportion of children identified as requiring a hearing aid who are then fitted with a hearing aid by 6 and/or 12 months of age

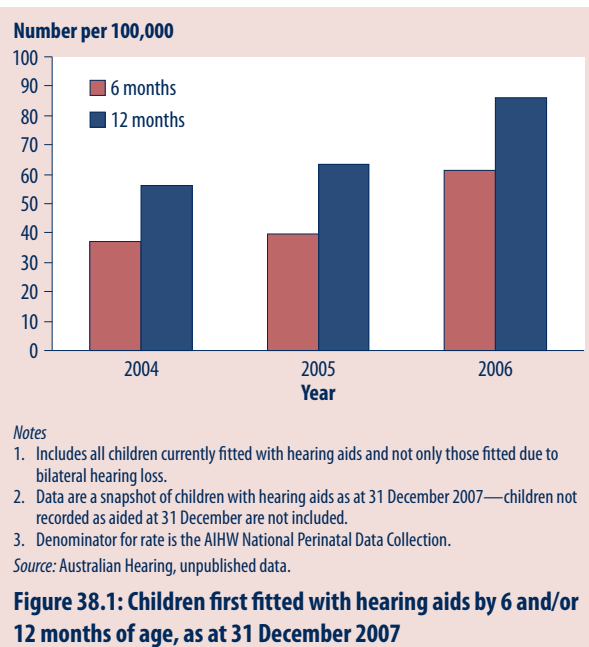
National data are not currently available on children who are identified as requiring a hearing aid, and who are consequently fitted by 6 or 12 months of age.

Data are available on the number of children first fitted with hearing aids by 6 and/or 12 months of age. However, this does not tell us the number of children who required hearing aids but were not fitted with them by 6 and/or 12 months.

As at 31 December 2007:

- Of infants born in 2006, 172 had been fitted with a hearing aid by 6 months, increasing to 241 infants by 12 months (61 and 86 per 100,000 births, respectively) (Figure 38.1).
- The rate of infants fitted with a hearing aid at both 6 and 12 months has increased for infants born between 2004 and 2006—by two-thirds at 6 months and by more than half (54%) at 12 months. This coincides with the increased implementation of neonatal hearing screening over this time throughout Australia.

Based on data from all states and territories on infants receiving neonatal hearing screens, an estimated 41% of Australian infants received a hearing screen in 2004, increasing to 56% in 2005 and 72% in 2006.



39 Childhood immunisation

Immunisation has been an important public health success, resulting in greatly reduced infant and child mortality. Immunisation coverage reflects the capacity of the health care system to effectively target and provide vaccinations to all children.

Most 2 year olds on the Australian Childhood Immunisation Register were fully immunised (93%), but immunisation coverage at 6 years of age (88%) was below target as at 30 September 2008.

Immunisation against childhood diseases is one of the most cost-effective public health interventions in preventing childhood morbidity and mortality (Pollard 2007). The rate of immunisation coverage reflects the capacity of the health care system to effectively target and provide vaccinations for all children. Increased immunisation coverage has been one of the most important public health successes since the 1970s, when there was virtually no coverage worldwide (England et al. 2001). Immunisation has resulted in the worldwide eradication of smallpox and the widespread elimination of poliomyelitis, largely achieved by limiting the spread of these diseases through mass immunisation. In developed countries, most infants are now covered for diphtheria, pertussis (whooping cough), tetanus, tuberculosis, measles and poliomyelitis (England et al. 2001). This rapid improvement in immunisation services has resulted in significant declines in infant and child mortality.

Australian children are protected against a number of communicable diseases through routine immunisation as part of the Immunise Australia Program (DoHA 2007). Large-scale immunisation programs exist for a wide variety of communicable diseases including diphtheria, tetanus, pertussis, rotavirus, poliomyelitis, measles, mumps, rubella, *Haemophilus influenzae type b* (Hib), hepatitis B, varicella (chickenpox), meningococcal C and pneumococcal disease. The human papillomavirus (HPV) vaccine has also been introduced from 2007, with vaccination recommended for routine school program immunisation of 12–13 year old girls to help prevent cervical cancer. Hepatitis A vaccination is funded for all Aboriginal and Torres Strait Islander children under 5 years of age living in Queensland, Western Australia, South Australia and the Northern Territory.

The Australian Childhood Immunisation Register (ACIR) was established in 1996 in response to a decline in

childhood immunisation in Australia and an increase in preventable childhood diseases. The ACIR records information on the immunisation status of children aged less than 7 years who are enrolled in Medicare (by the age of 12 months, this is estimated to be over 99% of children); children not eligible to enrol in Medicare can also be added to the ACIR (Medicare Australia 2009a; NCIRS 2007). The program offers financial incentives to parents and general practitioners. These initiatives have been very successful—immunisation coverage in Australia is now the highest on record and, as a result, notification rates of vaccine preventable diseases are low.

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

IMMUNISATION COVERAGE AMONG AUSTRALIAN CHILDREN

Immunisation coverage needs to exceed 90% in order to achieve and maintain the level of community immunity required to interrupt the ongoing transmission of vaccine-preventable diseases in the population (Lister et al. 1999). Coverage goals for Australia, recommended by the National Health and Medical Research Council in 2000, call for higher than 90% coverage of children at two years of age and near 100% coverage of children at school entry age. Due to a small percentage of conscientious objectors to immunisation and children with medical conditions that preclude immunisation, a 100% immunisation rate is not considered to be achievable.

This chapter reports on children at 1, 2 and 6 years of age on the ACIR who are fully immunised for coverage reporting purposes. 'Fully immunised' at these ages

has a different meaning in the context of the ACIR Due and Overdue Rules applied under the National Immunisation Program Schedule. ACIR coverage reflects a fully immunised child as having received the specified number of doses of the following vaccines: diphtheria, tetanus and pertussis (DTP); measles–mumps–rubella (MMR); poliomyelitis; hepatitis B; and Hib. In the context of the National Immunisation Program Schedule, a fully immunised child has received the scheduled doses of all vaccines listed above, as well as rotavirus, varicella, meningococcal C and pneumococcal conjugate for children up to 2 years of age. In time, the ACIR coverage definition of full immunisation may be expanded to cover all childhood vaccines included on the National Immunisation Program Schedule.

Headline Indicator: Proportion of children on the Australian Childhood Immunisation Register who are fully immunised at 2 years of age

As at 30 September 2008:

- Most 1 and 2 year olds were fully immunised (91% and 93%, respectively), coverage at these ages has been relatively stable since 2002. The 90% coverage target was met in 2000 for 1 year olds, and in 2003 for 2 year olds (Figure 39.1).
- The coverage at 6 years (88%) was below the near-100% target for children of school-entry age, and was 3–5 percentage points lower than for children aged 1 or 2 years. This lower coverage is due to children not receiving the scheduled doses of DTP, poliomyelitis and MMR vaccines at 4 years of age.

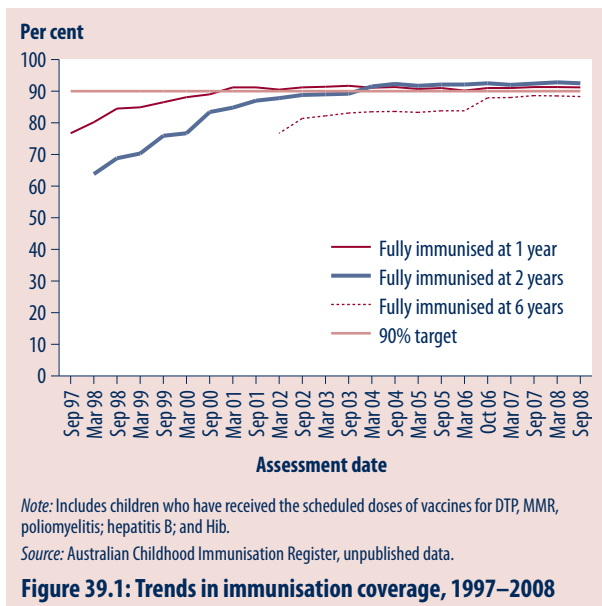


Figure 39.1: Trends in immunisation coverage, 1997–2008

Is immunisation coverage different for Aboriginal and Torres Strait Islander children?

Immunisation coverage at 1 year of age was lower among Indigenous children than for other children in 2007; however, by 2 years of age the proportions of fully immunised children were comparable (NCIRS 2008). See *Part IX* for more information on immunisation among Indigenous children.

How does Australia's immunisation coverage compare internationally?

Australia ranked unfavourably compared with other OECD countries for immunisation coverage among children aged 1 year. Australia ranked 19th out of 30 OECD countries with a combined average of 93% for DTP, poliomyelitis, Hib and measles vaccine in 2007 (Figure 39.2). The highest immunisation coverage was for the Slovak Republic, Hungary and Czech Republic (all recording at least 99%), while Japan had the lowest coverage (73%), due to Hib being excluded from Japan's immunisation schedule.

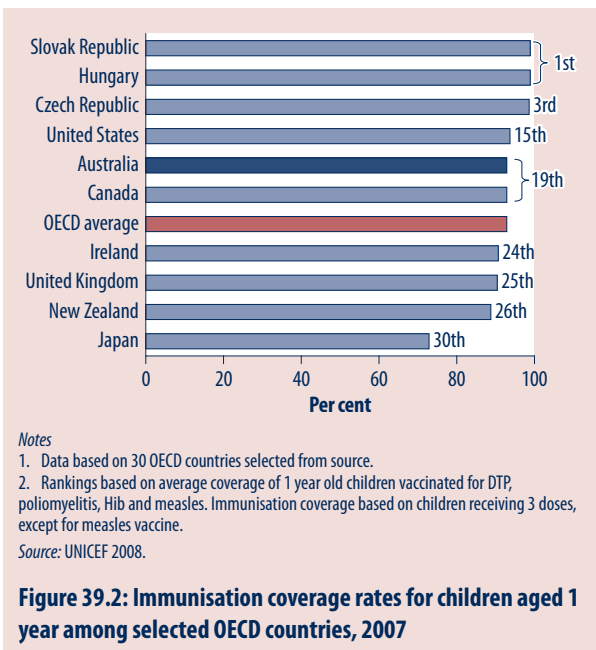


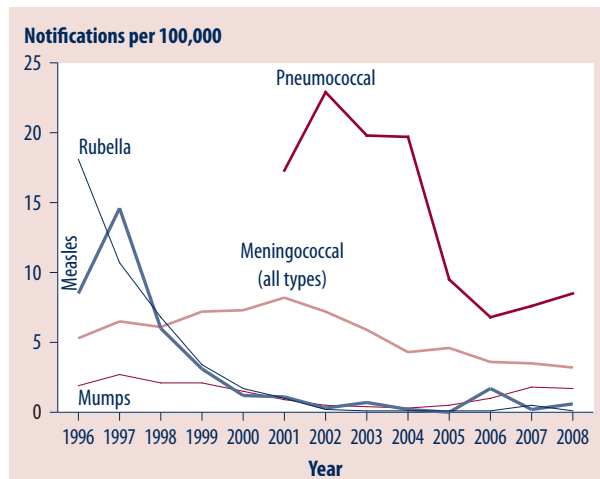
Figure 39.2: Immunisation coverage rates for children aged 1 year among selected OECD countries, 2007

NOTIFICATIONS OF CHILDHOOD DISEASES

Factors that influence notification rates for vaccine-preventable diseases include the natural history of a disease, immunisation coverage, the particulars of a vaccination program (full protection against pertussis, for example, requires four injections routinely given at 2, 4, 6 months and 4 years of age), and the length of time that an immunisation program has been in place.

In line with increased immunisation coverage, notification rates for a number of vaccine-preventable diseases have fallen dramatically over the last decade (Figure 39.3). For children aged 0–14 years:

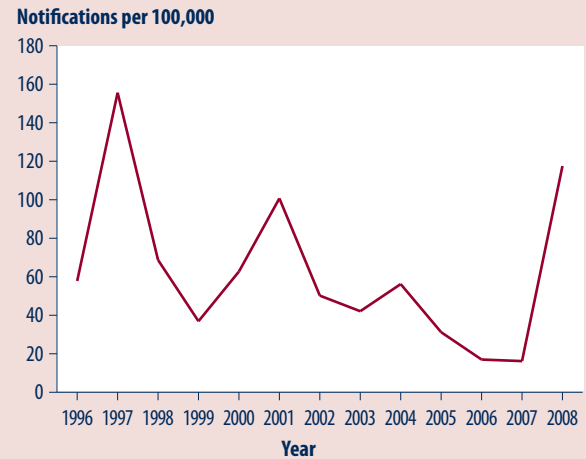
- There have been no notifications of poliomyelitis or diphtheria, and only one notification of tetanus, among children between 1996 and 2008 (NNDSS 2009).
- Notification rates for rubella and measles decreased from 18 and 9 notifications per 100,000 children in 1996 to 0.1 and 0.6 respectively in 2008.
- Notification rates for pneumococcal declined rapidly between 2002 and 2008, from 23 to 9 notifications per 100,000 children. Pneumococcal disease was added to the National Immunisation Program Schedule in 2001.



Source: AIHW analysis of National Notifiable Diseases Surveillance System.

Figure 39.3: Notification trends of selected communicable diseases, children aged 0–14 years, 1996–2008

The notification rate for pertussis increased sharply between 2007 and 2008 (from 16 per 100,000 to 118). Periodic epidemics of pertussis occur every 3–5 years in Australia (Figure 39.4). This is because the protection from the childhood vaccine decreases in adolescents and adults and they become an important reservoir, facilitating transmission to children who have not completed the recommended dose of the vaccine.



Source: AIHW analysis of National Notifiable Diseases Surveillance System.

Figure 39.4: Pertussis notification trend, children aged 0–14 years, 1996–2008

40 Survival for leukaemia

Leukaemia survival among children continues to improve through advances in early detection, treatment, research and technology, and the development of specialised treatment centres and protocols for children.

Five-year relative survival for children with leukaemia increased from 64% to 83% between 1982–1986 and 1998–2004.

Leukaemia refers to a group of cancers that affect the blood and blood-producing tissues of the body. Developing blood cells in the bone marrow become cancerous, multiply in an uncontrolled way, and replace or suppress healthy blood cells in the bone marrow. Cancerous blood cells may spread through the bloodstream to other organs such as the liver, spleen or brain, resulting in serious health complications, including death (Leukaemia Foundation 2007). Leukaemia is the most common cancer in childhood, accounting for almost 40% of childhood cancers between 2001 and 2005 (see *Chapter 5 Chronic conditions*).

Leukaemia is thought to develop from a complex interaction of genetic and environmental risk factors acting before and/or after birth. A small proportion of leukaemia cases have been directly linked to genetic and familial factors, ionising radiation (for example, through radiographs or x-rays) and cancer chemotherapy drugs; however, most have no known cause (Wong & Dockerty 2006). Leukaemia treatment varies depending on the characteristics of the leukaemic cells and their location, and can include chemotherapy, radiotherapy and bone marrow transplant.

Leukaemia survival among children in developed countries has improved considerably since the 1960s, particularly for the most common subtype, acute lymphoblastic leukaemia (McGregor et al. 2007; Ziegler et al. 2005). These improvements have followed developments in medical research and technology, and the creation of specialised treatment centres and protocols for children. Successful treatment of leukaemia depends upon the effectiveness of the health care system in a number of areas, including the early detection of leukaemia, access to appropriate treatment services, collaboration between health care professionals, and ongoing medical

research and clinical trials (McGregor et al. 2007). Despite improvements in survival, leukaemia remained one of the largest contributors to childhood cancer deaths in 2006 (see *Chapter 4 Mortality*), and children who survive may continue to experience long-term side-effects due to treatment (Mody et al. 2008; Ziegler et al. 2005).

LEUKAEMIA SURVIVAL AMONG AUSTRALIAN CHILDREN

This chapter looks at the 5-year relative survival for leukaemia, and improvements over time. Survival is presented for the two most common types of leukaemia—lymphoid and myeloid—which have very different survival patterns.

Relative survival is the ratio between the observed survival among a group of people with cancer and the expected survival among the same group had they not been diagnosed with cancer. For example, a relative survival of 100% indicates that the disease has made no difference to survival of the group over a given period, while a survival of less than 100% indicates that cancer did reduce survival compared with the population without cancer.

Key national indicator: Five-year relative survival for leukaemia in children aged 0–14 years

The 5-year relative survival for leukaemia among children aged 0–14 years in 1998–2004 was:

- 83%, with no statistically significant differences by gender or age
- statistically significantly higher for lymphoid leukaemia (87%) than myeloid leukaemia (66%)—the most common types of leukaemia among children (Table 40.1).

Table 40.1: Five-year relative survival for leukaemia, children aged 0–14 years, 1998–2004

Cancer type		Boys	Girls	Children
All leukaemia	Per cent	80.4	85.2	82.6
	95% CI	77.3–83.1	82.1–87.9	80.4–84.5
Lymphoid leukaemia	Per cent	84.3	90.2	87.0
	95% CI	81.0–87.0	87.1–92.7	84.7–88.9
Myeloid leukaemia	Per cent	66.2	66.7	66.4
	95% CI	58.0–73.2	57.4–74.4	60.4–71.8
All cancers	Per cent	77.6	79.5	78.5
	95% CI	75.7–79.4	77.5–81.4	77.1–79.8

Note: Refer to Table A1.2 for ICD-10 codes.

Source: AIHW National Cancer Statistics Clearing House.

There was a statistically significant increase in 5-year relative survival for leukaemia diagnosed between 1982–1986 and 1998–2004 (an 18 percentage point increase):

- The largest improvement occurred between 1992–1997 and 1998–2004 (an increase of 11 percentage points from 72% to 83%), after a period of very little change between 1987–1991 and 1992–1997 (Figure 40.1).
- Survival increased for both boys and girls—by 17 and 19 percentage points, respectively.
- Survival doubled for myeloid leukaemia over this period, increasing by 32 percentage points, compared with 16 percentage points for lymphoid leukaemia. Despite this, survival for myeloid leukaemia remains lower than that for lymphoid leukaemia.

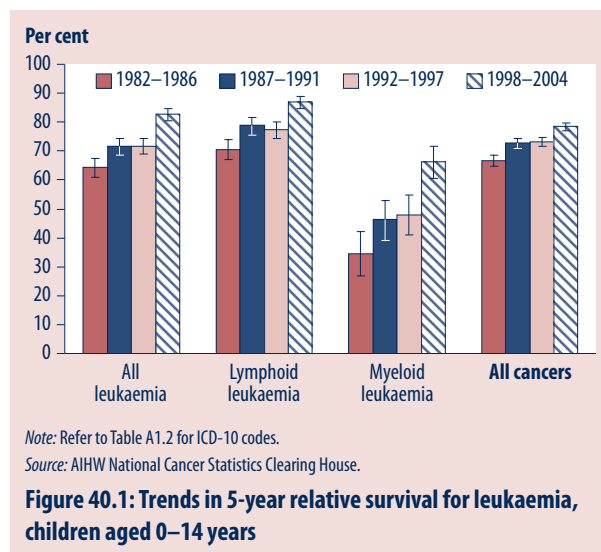


Figure 40.1: Trends in 5-year relative survival for leukaemia, children aged 0–14 years

How does leukaemia survival vary across population groups?

Between 2000–2004:

- Although leukaemia survival appeared higher among children in *Major cities* than in *Remote and very remote* areas (86% compared with 73%), this difference was not statistically significant (Figure 40.2).
- There was no statistically significant difference in leukaemia survival for children by socioeconomic status (87% for children from the lowest socioeconomic status (SES) areas compared with 83% from the highest SES areas) (Figure 40.2).

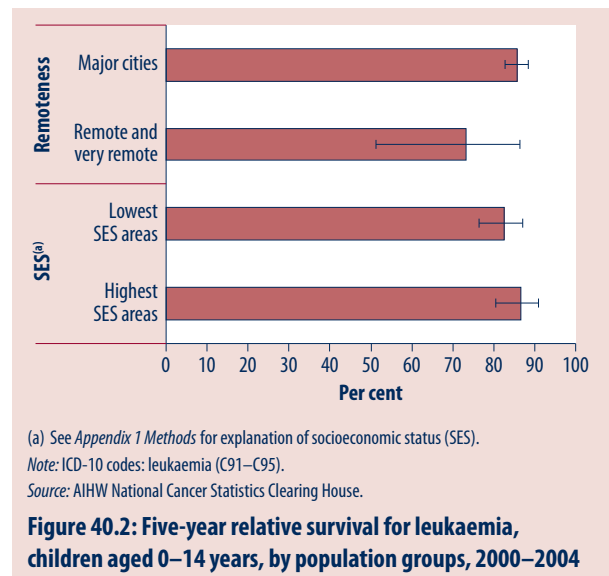


Figure 40.2: Five-year relative survival for leukaemia, children aged 0–14 years, by population groups, 2000–2004

41 Quality child care

Good-quality child care provides support for a child's learning, socialisation, development and their transition to school. Conversely, poor-quality child care may be associated with developmental risk.

No national data are available on quality child care due to definition and measurement difficulties.

The substantial and positive effects of quality early childhood care and education on children's social and cognitive development are well established. High-quality and integrated early childhood education and care services are seen as critical to increasing the proportion of children entering school with the basic skills for life and learning (COAG 2006).

There is strong evidence on the importance of birth to 3 years in children's development. The importance of quality child care provision has been increasingly recognised due to the increasing number of children being cared for outside their homes, and an increase in the average time children spend in care during these years (NCAC 2007a).

Extensive research into the effect of the quality of child care in the 'early years', has found high-quality child care to be beneficial to a child as it provides a stimulating, educational and caring environment that helps a child's social, educational and physical development (Cassells et al. 2005). High-quality care has also been found to have positive effects on children's social and emotional wellbeing, and has important social and economic effects on families (Elliot 2006; Harrison 2008). Further, children who attend high-quality child care centres perform better in cognitive and social skills, and are more ready to make the transition to preschool and primary school (House of Representatives Standing Committee on Family and Human Services 2006).

Evidence shows high-quality early childhood education and care can also be an effective intervention for children from socioeconomically disadvantaged backgrounds, and has been found to reduce future social problems such as crime, unemployment and teenage pregnancies (Buckingham 2007; Cassells et al. 2005).

The beneficial effects of child care are also dependent on factors such as the child's home environment, their age, the quality and type of care, time spent in care, stability of care arrangements and temperament of the child (Buckingham 2007).

HOW TO DEFINE 'QUALITY CHILD CARE'

Identification of the essential elements of high-quality child care is not straightforward. In Australia, there is presently no consensus on how 'quality child care' should be defined. Difficulty arises as to how to measure quality, whether quality means the same things across different types of care settings (such as long day care centres, family day care services, outside school hours services and Indigenous services), and what aspects of quality make a meaningful difference in the outcomes for children.

In relation to the development of strong quality standards, research indicates that the prime structural indicators of quality of formal care, sometimes referred to as the 'iron triangle', are staff to child ratios, qualified staff and group size. These factors affect the quality of interactions that can occur.

There is not, however, definitive evidence on what the actual ratios should be, and there is no research related to Australian settings and qualifications. Research suggests that smaller groups enable children to form caring relationships with one another, engage in meaningful shared experiences and discovery through play. Large groups can lead to a loss of intimacy, can be overly restrictive or controlling, and may lead to detached and uninvolved care giving. Group size affects factors such as noise level, the amount of stimulation and level of confusion. Small groups are particularly important for infants, as they are associated with a lower risk of infection and appear to improve the safety of children (CCCH 2006).

Further consultation and research are required in order to identify the important elements of a key national indicator on quality child care. As a result, there is currently no defined indicator.

Key national indicator: Under development

In the absence of a defined indicator, information on child care quality assurance is presented in this chapter. While the quality assurance systems are designed to assess the performance of the child care centres and child care providers according to a set of quality areas and principles, it has been argued that they are not a measure of quality child care as they do not taken into account many of the factors listed in the preceding paragraphs.

CHILD CARE QUALITY ASSURANCE

Currently in Australia, legislative regulations and accreditation systems are the two mechanisms for ensuring quality in the child care sector. Regulations specify the minimum standards that must be met for the service to operate, and accreditation processes focus on measuring the quality aspects of the services to be delivered (NCAC 2007a).

In December 2007, the COAG agreed to a partnership between the Commonwealth and state and territory governments to develop a national quality framework for early childhood education and care. This will include the development of a new integrated national quality standard and a quality rating system, to align regulatory and accreditation arrangements (Early Childhood Development Sub-group of the Productivity Agenda 2008).

Child care accreditation status

The National Childcare Accreditation Council publishes statistics on the accreditation status of approved long day care, family day care and outside school hours care services. Of the 5,597 long day care centres that were registered as at 30 June 2008, 4,796 (86%) had completed the five steps to accreditation and of these 4,419 (92%) were subsequently accredited (Table 41.1). While this is similar to the proportion of accredited long day care centres in 2007 (92%), it is a decline in the proportion of accredited long day care centres since 2006 (97%).

Table 41.1: Accreditation status of approved long day care centres, 2006 to 2008

	June 2006		June 2007		June 2008	
	Number	Per cent	Number	Per cent	Number	Per cent
Accredited	4,187	97.2	4,208	92.4	4,419	92.1
Not accredited	121	2.8	348	7.6	377	7.9
<i>Total completed five steps to accreditation</i>	4,308	100.0	4,556	100.0	4,796	100.0
New services	735	14.6	804	15.0	801	14.3
Total registered services	5,043	100.0	5,360	100.0	5,597	100.0

Source: NCAC 2006, 2007b, 2008.

42 Child protection resubstantiations

Resubstantiation rates are one measure of how well child protection systems are performing in preventing the recurrence of child abuse or neglect.

National data on resubstantiations are not available, as data are not comparable across jurisdictions.

Rates of child protection substantiation and children on care and protection orders are key indicators of reported levels of child abuse and neglect (see *Chapter 34 Child abuse and neglect*). A related indicator, the rate of children who were the subject of child protection resubstantiation, is one measure of how well child protection systems are performing in protecting children from abuse and neglect:

The 'resubstantiation rate' is an indicator of governments' objective to reduce the risk of harm and to prevent the recurrence of abuse and neglect or harm to children. This indicator also partly reveals the extent to which intervention by child protection services has succeeded in preventing further harm (SCRGSP 2009:15.47).

In recent years, state and territory departments responsible for child protection have been increasingly concerned about rising rates of re-notifications and resubstantiations (AIHW 2009c). A Victorian study in 2002 found that key underlying features leading to some families coming into contact with child protection systems, such as low income, substance abuse, mental health issues and the burden of sole parenting, were complex and chronic. The child protection system often did not effectively deal with these problems and many children were subject to re-notifications and resubstantiations. The report noted that helping families to deal with these problems required more sustained and less intrusive support than usually provided. It highlighted the need for strengthened prevention and early intervention services, and improved service responses for children and young people with longer term involvement in the child protection system (Vic DHS 2002).

RESUBSTANTIATIONS OF CHILD ABUSE AND NEGLECT

The resubstantiation rate is measured as the number of children who were the subject of a substantiation in a year, and who were the subject of a subsequent substantiation within 3 or 12 months. The data are reported against the year of the original substantiation, rather than the year of resubstantiation, and it is important to note that the resubstantiation does not necessarily refer to the same source or risk as the original substantiation (SCRGSP 2009).

Resubstantiation data should be interpreted with caution, as cases of resubstantiation do not necessarily imply that child protection agencies have failed to protect children from repeated abuse. The resubstantiation rate is affected by the finalisation of investigations into notifications of child abuse or neglect, and by factors beyond the control of the child protection system, such as changes in family situations (for example, illness, pregnancy or unemployment), which may place children in danger of being re-abused or neglected (see AIHW 2006b). Given the complexity of this issue, it can not be expected that the resubstantiation rate could ever be zero.

Data on resubstantiations are not comparable across jurisdictions because definitions of substantiation vary considerably, and this has a flow-on effect to rates of resubstantiation (AIHW 2008c; see also *Chapter 34 Child abuse and neglect*). Variations between jurisdictions in recorded cases of child abuse or neglect reflect the different legislation, policies and practices in each jurisdiction, rather than a true variation in the levels of abuse and neglect (see Bromfield & Higgins 2005).

Key national indicator: Rate of children aged 0–12 years who were the subject of child protection resubstantiation in a given year

Because data are not comparable across jurisdictions, national data can not be presented on child protection resubstantiations. Furthermore, only data for the 0–17 year age group are available for reporting on this indicator.

In 2006–07, rates of resubstantiation for 0–17 year olds varied considerably between jurisdictions, ranging from 1.8% of substantiations to 12.9% within 3 months, and from 7.9 to 28.2% within 12 months (Table 42.1).

Table 42.1: Children aged 0–17 years who were the subject of a resubstantiation within 3 and/or 12 months, 2006–07^(a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Subject of a resubstantiation within 3 months								
Number	1,316	119	681	40	167	46	88	32
Per cent ^(b)	10.0	1.8	6.2	2.8	9.5	4.3	12.9	5.0
Subject of a resubstantiation within 12 months^(c)								
Number	2,866	713	1,691	113	377	156	193	80
Per cent ^(b)	21.8	10.7	15.3	7.9	21.5	14.4	28.2	12.5

(a) Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Refer to SCRGSP 2009:15.46 for further notes related to this data.

(b) Per cent of all children who were the subject of a substantiation.

(c) This includes children who were the subject of a resubstantiation within 3 months.

Source: SCRGSP 2009.