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Children and Young People in Queensland

a snap shot

Commission for Children and Young People

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Abbreviations

ABS – Australian Bureau of Statistics
AIHW - Australian Institute of Health and Welfare
ARAFCAY - Australian Research Alliance for Children and Youth
CCCH - Centre for Community Child Health
CCYP - Commission for Children and Young People
CROC – Convention on the Rights of the Child
FaCS - Family and Community Services
LSAY – Longitudinal Survey of Australian Children
NCA - National Children's Agenda
NCS - National Children's Strategy
NHMRC - National Health and Medical Research Council
NIFTeY - National Investment For The Early Years
QLD – Queensland
QSCC - Queensland School Curriculum Council
SAAP – Supported Accommodation Assistance Program
UNESCO – United Nations Educational, Scientific and Cultural Organisation

Foreword

The Commission for Children and Young People considers the monitoring of the well-being of children in Queensland, particularly relating to governmental services, a key imperative for the State Government. The Commission is pleased to release this first 'snap shot' of children and young people in Queensland.

In coming years, this will be a briefer, more succinct document, focussing on key indicators across time. However, this inaugural report is a broader examination of the literature, data and difficulties associated with gaining a snapshot of the general health and well-being of children and young people in Queensland.

The Commission for Children and Young People is committed to identifying and disseminating information on issues relevant to the rights, interests and well-being of children and young people. This document provides a 'first step' in profiling children and young people in Queensland, across a variety of health, education, victimisation and criminality measures.

It is hoped the report will be a useful resource for all those interested in the well-being of Queensland's children and young people. It aims to highlight the available data that *can* provide useful indications of the levels of well-being of children and young people in Queensland, and the data not currently available that *could* provide such indications.

The importance of this is already acknowledged by the State Government's commitment to annual performance reports. This is demonstrated in the *Charter of Fiscal and Social Responsibility*, and a recent whole of government initiative being led by the Department of Families focussing on departmental collaboration in the management and sharing of client information.

In considering the policy implications of the data presented, we have been struck by our inability to effectively monitor the state of children and young people in Queensland because of the lack of comparable measures across government data bases. Comparable measures are required to ensure children's well-being is being effectively sponsored by the agencies responsible for their care.

There is a clear need to integrate data systems across relevant agencies, especially in terms of definitions, measures and variables. The importance of this need has already been acknowledged by a whole-of-government initiative led by the Department of Families, which focuses on departmental collaboration in managing and sharing client information. This kind of initiative is invaluable to help improve information sharing between government departments that respond to the needs of children and young people and their families.

We hope a wide range of government agencies will consider the issues raised in this report so we can collectively better fulfil our responsibilities to the children and young people of Queensland.

Dr Robin Sullivan
Commissioner for Children and Young People

Executive summary

Literature

Much of the work examining children and young people in Australia and overseas is increasingly characterised by an acknowledgment of the complex array of social factors which impact on their well-being. Diverse fields such as psychology, biology, sociology, criminology and neuro-science can all contribute to investigations into the nature of childhood and adolescence. However, an exhaustive appraisal and critique of all research approaches to children and young people is beyond the scope of this report.

Instead, in seeking to provide a snapshot of Queensland's children and young people, this report focuses specifically on examinations of children and young people that allow the development of measurable 'indicators of well-being'. That is, it focuses on literature that allows the *categorisation* of specific factors that may provide *measures* of children and young people's health, safety, education and general 'well-being'. This is followed by an examination of the available data held by government agencies on children and young people in Queensland, and the policy implications resulting from an analysis of such data.

Key Findings

Health

- There were a total of 47 078 births in Queensland in 2000. There was a far higher likelihood of Indigenous children born in remote and inaccessible regions than non-Indigenous children. However, the vast majority of non-Indigenous children (71 per cent) were born in highly accessible areas.

- The majority of both Indigenous and non-Indigenous mothers were aged 20 - 29 years. However, Indigenous mothers were more likely to be aged under 19 years. Conversely, non-Indigenous mothers were more likely to be aged 30 - 39 years.

- The 'top five causes' of morbidity for children aged 0 - 18 years were:

1. respiratory diseases
2. injuries and poisoning
3. abnormal clinical lab findings
4. digestive diseases
5. infectious diseases.

- For Indigenous children and young people, pregnancy, childbirth and puerperium complications rank in the top seven causes of morbidity.

- The mortality rate in 2000 was lower than that of 1999 for all people aged 0 - 18 years. For this age group, the mortality rate in 2000 was 54.4 per 100 000 compared with 55.6 per 100 000 in 1999. However, for the high-risk age group of less than one year, the mortality rate grew from 580.7 per 100 000 to 627.8 per 100 000 in this period.

- The highest five causes of mortality for children aged 0 - 18 years were:
    1. external causes
    2. peri-natal causes
    3. deformation
    4. clinical abnormalities, and
    5. diseases of the nervous system.

- The rate of suicide for young people in Queensland was substantially lower than for other age groups at 7.5 per 100 000. This compared with 20 - 39 year olds, who were

most likely to commit suicide, at a rate of 23.4 per 100 000. Young males were more than twice as likely to commit suicide then young females, at a rate of 10.5 per 100 000 compared with 4.4 per 100 000.

Disabilities

- Developmental delays were the primary disability registered by those aged 0 - 4 years (33 per cent) of all disabilities.
- For those registered as having a disability aged 5 - 9 years, autism was the most common primary disability recorded (31 per cent).
- For those aged 10 - 14 years, 37 per cent were registered as having an intellectual disability as their primary disability.
- For those aged 15 - 18 years, 57 per cent were registered as having an intellectual disability as their primary disability.

Access to Housing

- Young people are a relatively small proportion of SAAP clients. Young females appear to be more likely to require assistance and accommodation than young males.

Education and childcare

- One concerning trend relates to Indigenous students' rates of literacy and numeracy. Indigenous children in Year three recorded lower mean scores in both reading and number skills than non-Indigenous students, and the gap between Indigenous and non-Indigenous children increased when the performance of students in Years three, five and seven in 2000 were compared.
- The largest difference between females and males could be seen in reading skills. Females scored higher than males on this measure.
- Long day care attracted the largest number of children across all categories when licensed child care services were compared.

Victimisation

- Children under one year of age were most likely to be subject to a child protection notification and were most likely to be admitted to a child protection order.
- In terms of the types of harm children experience, there were quite different trends in different age groups. For the category of neglect, those aged 0 - 4 years were the most at risk. A similar trend, although lesser numbers, was evident for emotional harm. In contrast, physical harm appears to increase with age. There appears to be a similar trend which increases with age for sexual harm, although the numbers were so small they should be interpreted with caution.
- Police victim data indicated that the rate of sexual offences against children was reasonably high, peaking for those aged 13 - 15 years before dropping again at age 16 - 18 years. However, the likelihood of a child being a victim of assault increases steadily with age. Young males were the most likely to experience assault, while young females were most likely to experience a sexual offence.

Criminality

- In terms of offences committed by young people (obtained from police data), the most common offence for both females and males was property offences. All offences increased with age.

- Of children appearing in court, both males and Indigenous young people were over-represented, particularly in the 15 - 17 year category.

- Unsupervised orders were the most common youth justice order. Indigenous young people were over-represented in both supervised and unsupervised orders. Males were substantially more likely to be placed on a supervised order than females.

Policy

The development of Queensland policy aimed at promoting the well-being of children and young people is still being hampered by the nature of the available data. To better address the gaps highlighted by the data presented in this report, there must be:

- greater attention paid to comparable administrative data sources, and
- greater recognition of the importance of appropriate survey data.

Comparable administrative data

It is essential for Queensland services currently assisting children and young people to examine seriously the nature of their data and how to ensure comparability across programs.

At present, the absence of coordinated administrative data systems means the cost-benefit of policy options cannot be effectively evaluated because agency outputs cannot be measured with any validity or reliability. More importantly, comparable across-agency measures are required to ensure children's well-being is being sponsored by the agencies responsible for their care.

There is a clear need to start integrating data systems across relevant agencies and to ensure there is a degree of comparability in definitions, measures and variables between data systems.

Appropriate Survey data

There is also a pressing need to collect appropriate survey data on children and young people's well-being, to more effectively *sponsor* children and young people's well-being.

The Longitudinal Survey of Australia's children represents a welcome acknowledgment of the importance of having national level data on children in Australia. However, there is a need for state and territory-level data which allows individual jurisdictions to develop policies relevant to their roles and responsibilities.

Options may include replicating Canadian policies and practices by implementing an Early Development Instrument (EDI) or mapping community resources. The data that would result would be invaluable in ensuring the well-being of children and young people in Queensland.

Introduction

The Queensland Commission for Children and Young People (CCYP) is an independent statutory authority with both ombudsman and advocacy functions. Its work embraces many of the principles of the *United Nations Convention on the Rights of the Child.* One of the Commission's central roles is to identify and disseminate information on issues relevant to the rights, interests and well-being of children and young people in Queensland.

A key question arising from this work is "What do we know about children and young people in Queensland?" While there is a great deal of information collected and a great deal written about Queensland children, there is currently no overall picture on which to base future policies and strategies. Recognising this gap, the Commission is conducting a project to ascertain what data state government bodies collect about Queensland's children, and what this data tells us.

The purpose of this document is to provide a snapshot of children and young people in Queensland, using data currently collected by government bodies. This has been done in an attempt to identify long term trends and service gaps, and as a guide to initiatives aimed at protecting children and young people from harm (Queensland Commission for Children and Young People Strategic Plan, 2001-2005).

This report should be considered a 'first step' towards profiling children and young people in Queensland. It aims to highlight some of the available data that *can* provide useful indications of the levels of well-being of children and young people in Queensland, and point to data not currently available that *could* provide such indications.

The report should be considered a resource document for all organisations that monitor and assist children and young people's well-being throughout Queensland. To help identify the most useful data for this purpose from the vast amount available, the literature around "indicators of well-being" has been examined.

This report seeks to explore three key questions:

- What measures provide key indicators of children and young people's well-being?
- What measures are most useful in terms of future policy and practice?
- How could the administrative data files maintained by various government agencies more effectively allow the monitoring of the state of children in Queensland?

To address these three discrete but related foci, the remainder of this report is divided into three sections.

First, previous research relating to indicators of children's health and well being is analysed.

The next section provides a snapshot of Queensland's children using data relating to safety, health, education and welfare of children and young people in Queensland as recorded by a range of administrative data sources.

The conclusion of the report provides suggestions for how Queensland could improve service delivery processes by adopting a more sophisticated approach to information management on the part of government agencies whose core business involves the well-being of children and young people.

Indicators of well-being

> *An ongoing effort to measure and monitor children's well-being will enable societies to inform their policies, galvanise and reward effort, mark their achievements, introduce accountability, and be a means by which sustained pressure can be brought to bear for the fulfilment of political promises* (Adamson and Morrison, 1995, cited in Ben-Arieh et al, 2001: 7)

Introduction

This section of the report examines the current literature addressing various theoretical approaches to indicators of well-being for children and young people. It is important to note that concepts such as well-being are difficult to define, as objective and subjective factors affect what constitutes well-being.

Nonetheless, many researchers have attempted to outline key 'building blocks' for well-being, often incorporating aspects of health, learning and social engagement. Other researchers have identified factors that can contribute to flexible pathways for children and young people. From this literature it is possible to identify some key indicators which can provide a 'snapshot' of the well-being of children and young people in Queensland.

What is well-being?

This is a more complex question than it may first appear. Well-being incorporates a variety of objective factors such as good health, being safe (from crime or violence), financial security and access to resources, including education, culture, roads and transport.

However, well-being also incorporates more subjective factors, such as happiness (and/or contentedness), feeling connected to one's community and having the capacity to cope with adverse life events. These factors are intrinsic to well-being but are usually difficult to observe or operationalise in terms of specific measures.

The issue becomes further complicated by the question of whether the well-being of children and young people is the same as the well-being of adults. For children and young people, what constitutes community may be very different from what constitutes community for adults. It may be argued that while some factors such as health, safety, and financial security may stay the same, other factors such as engagement in globalisation may be more of a priority for young people than engagement in a geographically defined community, which may be seen as particularly important by adults. A sense of community for children and young people may be defined by global media-based culture, rather than more localised geographical considerations[1].

Similarly, for those committed to promoting the rights of the child, sponsoring well-being can mean assisting children and young people to participate *actively* in wider citizenship roles, to recognise their right to influence decisions, to be taken seriously and to make their own choices.

If a young person leaves an unsafe home and chooses to live on the streets rather than in foster care, that is seen as a choice to be respected and accepted by adults. However, those wanting to ameliorate risk factors and promote protection factors are likely to assert that

[1] Community engagement for the young may mean the access to 'virtual peers' provided by ever more globalised economies and emergent internet based technologies more than it means access to a local park (ie a community of 'interest' rather than a community of 'place').

adults are responsible for ensuring that children and young people live in safe and healthy environments. They may also argue that family services workers, health professionals and teachers are obligated to make decisions on behalf of children and young people to ensure their safety, education and health, even if this challenges the rights of the child or young person.

It is also important to note that attempts to identify indicators of well-being occur within a broader debate about whether the focus should be on measuring positive or negative indicators (Ben-Arieh, 1999). Traditionally, government and academics have tended towards negative measures of well-being. For example, they have focused on mortality or epidemiology and how many children die or suffer diseases according to gender, age and region. Such information has allowed government agencies in particular to identify where they need to focus their resources and who is most in need of assistance.

However, more recently, there has been a move towards focusing on positive indicators of well-being, specifically on what services are the most effective and efficient. This approach allows strategies such as the measurement of immunisation rates rather than mortality, so agencies can be informed about successes as well as service gaps.

It is unfortunate that the two approaches are seen as opposing rather than complementary measures of well-being. It is simply not the case that one can adopt either positive or negative indicators, and think that one is measuring the same characteristic from opposite perspectives.

Measuring survival rates is not simply the flip side of measuring mortality rates. The negative measure of a low mortality rate does not give us the same information as the positive measure of a high survival rate. The mortality rate may be a function of lack of access to particular services - the survival rate may derive from quite different, albeit related, factors. These are different measures revealing quite different aspects of well-being. The importance of understanding this distinction can be seen more clearly by comparing risk factors with protective factors. For example, a familial risk factor for adolescent involvement in crime is experiencing victimisation early in life in one's family. However, a protective factor is strong emotional support from a primary caregiver. While the two factors are obviously different, they are not opposite ends of a continuum of behaviour.

Finally, social indicators which impact on children's well-being include a wide variety of factors that we know, or can presume, impact on their well-being. Health, education and socio-economic status are three key social variables that impact on children and young people. There are also a range of other factors which may impact on children specifically. For example, violence, either through child abuse or witnessing domestic violence, impacts differently on children than on adults in the family. The fact we cannot gauge children's experience of violence by assessing adult interpretations of that violence has led to recent investigations of the impact of family violence on children, a relatively new area of research.

Despite the difficulties of taking issues like these into account, there has been considerable interest internationally in tackling comprehensive measures of 'well-being', particularly for children and young people. As the Australian Bureau of Statistics (ABS) argues:

> *There can be no single measure of well-being that satisfies all parties interested in helping people improve their lives. Rather, a range of measures needs to be available to researchers, policy makers, welfare providers and other community groups and members, who will select from this range to inform their own particular issues of interest. While some indicators are fundamental to the measurement of well-being (eg mortality rates, inequality measures, unemployment rates), at any one time the range of social indicators....will be a subset of all possible well-being indicators, influenced by the preoccupations and concerns of contemporary culture* (ABS, 2001: 6).

Indicators of well-being

International interest in developing databases and records of the state of children and young people has been intensifying, particularly in the last decade. Most notably, UNESCO has been involved in this area, developing the UNESCO Early Childhood Databases, the *UNESCO Early Childhood Care and Education: Basic Indicators on Young Children* and the *UNESCO Early Childhood Research: Research Relevant to Early Childhood Care and Development*.

In America, the Federal Interagency Program on Child and Family Statistics (1998) produced *America's Children: National Indicators of Well-being,* and the Annie E. Casey Foundation (1997) developed the *Kids count data book: State profiles of child well-being.*

In Canada, a number of projects have also been conducted, predominantly using their longitudinal survey of children and youth. This includes the Canadian Council on Social Developments' reports such as *Canadian Children in the 1990's: Selected findings of the Longitudinal Survey of Children and Youth Canadian Social Trends* (1997) and *The progress of Canada's Children into the Millennium 1999-2000* (2000).

In Europe, Ben-Arieh and his colleagues have been involved in a project which includes representatives from 20 different countries which has attempted to develop indicators which best measure the well-being of children beyond survival (*see* Ben-Arieh, Hevener-Kaufman, Bowers Andrews, George, Bong Joo Lee and Aber, 2001; Bowers-Andrews and Ben-Arieh, 1999; Ben-Arieh and Wintersberger, 1997).

In Ireland, the National Children's Strategy has produced *Our Children – Their Lives* which outlines a strategy for identifying the needs of children in Ireland, and how best to meet those needs by empowering families and communities (*see* National Children's Strategy, 2000a; 2000b; 2000c). There are a number of governments trying to meet the challenge of developing approaches based on findings like these.

Australian researchers and institutions have embarked on related initiatives. Especially notable is the research being conducted in Western Australia by the TVW Telethon Institute for Child Health Research (*see* Zubrick et al, 1995; Zubrick et al, 1997; Silburn et al, 1996). This research has used the Western Australian Child Health Survey to examine issues of child well-being in relation to health, education, family and community. At the time of writing, the complementary Western Australian Aboriginal Child Health survey is also underway.

Similarly, the research conducted by the Mater University Study of Pregnancy (MUSP) is relevant in terms of child morbidity, child socialisation, maternal smoking and the development of antisocial behaviours (*see* Bor et al, 1993; 2001; Williams et al, 1998; Najman et al, 1994; 1997).

The Australian Bureau of Statistics (ABS) has also produced several relevant reports, including its 1999 monograph *Children, Australia: A Social Report*[2], and the 1997 report

[2]See also:
Children's Participation in Cultural/ Leisure Activities Australia: 2000 (Catalogue No. 4901.0)
Child Care, Australia (Catalogue No. 4402.0)
Births, Australia (Catalogue No. 3301.0)
Causes of Infant and Child Deaths, Australia (Catalogue No. 4398.0)
Children's Health Screening 1995 (Catalogue No. 4337.0)
Children's Immunisation, Australia 1995 (Catalogue No. 4352.0)
WA Child Health Survey: Developing Health and Well-being in the Nineties 1993 (Catalogue No. 4303.5)
WA Child Health Survey: Family and Community Health and Well-being 1993 (Catalogue No. 4304.5)
WA Child Health Survey: Education, Health and Competence 1993 (Catalogue No. 4305.5)

Youth, Australia: A Social Report. Most recently it has *produced Measuring Well-being: Frameworks for Australian Social Statistics* (ABS, 2001) - an extensive volume outlining key social indicators and recommended national measures.

The main purpose of this preceding research has been to describe the situation of children and young people in terms of the key focus of each organisation. However, different research makes use of differing indicators and measures. The question is - what are the most appropriate indicators of children and young people's well-being?

For Ben-Arieh et al, (2001), three key concepts impact on understanding factors of well-being. First is society's well-being as a whole, as particular societies and cultures will impact on children differently. Secondly, we need to focus on children's individual well-being, independent of their social context. Finally, "we should deal with the *level of analysis*; in particular, we should consider the need for knowledge about children's well-being at the local, regional, national, and international levels and the potential usefulness of such knowledge at each level" (2001: 3 emphasis added).

Much advocacy and public sector research attempting to identify 'indicators' relates to specific recommendations made in the United Nations *Convention on the Rights of the Child*. The convention incorporates an explicit holistic perspective that acknowledges the diverse needs of children, including the right to: "adequate living conditions for physical, mental, spiritual, moral and social development. Through the implementation of this declaration, nations are essentially called to move beyond promoting childhood survival and subsistence to include support for fulfilment of human potential" (Andrews, 1999: 5). The Convention contains more than forty articles, which can be summarised into five broad areas of developmental rights.

- Physical development - including wellness, disease or disability management and exercise of physical abilities
- Mental development - including cognitive potential, emotional stability and mental health
- Spiritual development - including self appreciation within a broad social context and freedom of thought, conscience and religion
- Moral development - including tolerance and the responsibility to respect one another's lives, and
- Social development - including healthy and productive connections between the child and other social players such as families and communities (*see* Bowers-Andrews, 1999: 5-7).

In Ireland, the government has been quite specific about taking a 'whole child' perspective, which "allows those working with or supporting children to focus on their particular interest and responsibility while, at the same time, recognising the multi-dimensional aspect of children's lives. It identifies the capacity of children to shape their own lives as they grow, while also being shaped and supported by the world around them" *(National Children's Strategy*, 2000a: 24).

The National Children's Strategy (NCS) incorporates:

- the extent of children's own abilities
- the multiple interlinked dimensions of children's development
- the complex mix of informal and formal supports that children rely on (National Children's Strategy, 2000a: 25).

The NCS stresses the vital point that "while it is helpful to unpack the elements of the perspective for illustrative purposes, it is only through considering all three together that the 'whole child' is recognised" (NCS, 2000a: 25).

Similarly, the Canadian *National Children's Agenda* (NCA) (2000)[3] argues:

> *Childhood is a series of developmental stages, each of which is to be valued. Through these various stages of growing up, the foundations are laid for well-being in adult life. By building on early opportunities to develop social responsibility, childhood years also provide a preparation for taking on the responsibilities of active citizenship in later life. Children achieve outcomes at each of these stages of development. It is helpful to consider these outcomes as expressions of a set of relatively discrete but interrelated dimensions along which children make gains over time and which eventually together provide the capacity for coping with adulthood* (Ward, 1995 cited in NCA, 2000).

The NCA identifies nine such dimensions:
- physical and mental health
- emotional and behavioural well-being
- intellectual capacity
- spiritual and moral well-being
- identity
- self-care
- family relationships
- social and peer relationships, and
- social presentation (NCA, 2000a: 25).

These dimensions can be reduced to more concrete goals, with the NCA arguing that Canada needs children who are:
- healthy – physically and emotionally
- safe and secure
- successful at learning, and
- socially engaged and responsible (NCA, 2000).

Zubrick and colleagues (2000) are more specific, arguing there are "five key resource domains for social and family functioning relevant to child health and well-being outcomes" (2000: xi):
- time
- income
- human capital
- psychological capital, and
- social capital.

While these are excellent indicators in principle, they are extremely difficult to measure when using administrative data, (for example, what government database allows an examination of 'psychological capital')?

With issues like this in mind, the Australian Bureau of Statistics (ABS) has attempted to take into account the macro-level concerns of social scientists as well as the day to day realities of public service practice and procedures. They have tried to do this by outlining broad aspects of life which contribute to well-being for which there are readily available units of measurement. These include:
- support and nurture through family and community
- freedom from disability and illness
- realisation of personal potential through education
- satisfying and rewarding work both economic and non-economic

[3] The formal citation for the National Children's Agenda is : Federal-Provincial-Territorial Council of Ministers on Social Policy Renewal (2000) *A National Children's Agenda : Measuring Child Well-Being and Monitoring Progress* Council of Ministers on Social Policy Renewal: Canada

- command over economic resources, enabling consumption
- shelter, security and privacy through housing
- personal safety and protection from crime
- time for and access to cultural and leisure activities (ABS, 2001).

Although these ‘measurable’ indicators have been identified, the picture is limited by the available data that might reflect these indicators. While the ABS has access to national minimum data sets and national level surveys which allow it to effectively calculate measures of their eight key indicators, individual jurisdictions’ administrative data are rarely well coordinated, and there are substantial difficulties associated with attempting to measure well-being at a detailed, local level.

A similar issue arises in examining the developmental perspectives of ‘risk’ and ‘protective’ factors. One of the most detailed and specific lists provided to date which enables identification of the key areas of children’s lives government services should focus on, is that summarised below by Homel and his colleagues of the Developmental Crime Prevention Consortium (1999). While the factors identified relate specifically to risk and protective factors for engaging in criminality[4], they can also be applied more widely in regard to general disadvantage.

[4] It is worth noting that social scientists in other areas have identified the same risk and protective factors, although usually with a more limited list. See for example, Huffman et al’s (2000) risk and protective factors for academic behavioural problems in school and Stanley’s (2001b) risk and protective factors for depression.

	Child	Family	School	Life Events	Community and Culture
Risk Factors	▪ prematurity ▪ low birth weight ▪ disability ▪ prenatal brain damage ▪ birth injury ▪ low intelligence ▪ difficult temperament ▪ chronic illness ▪ insecure attachment ▪ poor problem solving ▪ beliefs about aggression ▪ poor social skills ▪ low self esteem ▪ lack of empathy ▪ alienation ▪ hyperactivity/ disruptive behaviour ▪ impulsivity	▪ teenage mothers ▪ single parents ▪ psychiatric disorders, especially depression ▪ substance abuse ▪ criminality ▪ antisocial models ▪ family violence and disharmony ▪ marital discord ▪ disorganised environment ▪ negative interaction/social isolation ▪ large family size ▪ father absence ▪ long term parental unemployment ▪ poor supervision and monitoring of child ▪ discipline style (harsh or inconsistent) ▪ rejection of child ▪ abuse ▪ lack of warmth and affection ▪ low involvement in child's activities ▪ neglect	▪ school failure ▪ normative beliefs about aggression ▪ deviant peer group ▪ bullying ▪ peer rejection ▪ poor attachment to school ▪ inadequate behaviour management	▪ divorce and family breakup ▪ war or natural disasters ▪ death of a family member	▪ socioeconomic disadvantage ▪ population density and housing conditions ▪ urban area ▪ neighbourhood violence and crime ▪ cultural norms concerning violence as an acceptable response to frustration ▪ media portrayal of violence ▪ lack of support services ▪ social or cultural discrimination

	Child	Family	School	Life Events	Community and Culture
Pro-tective Factors	▪ social competence ▪ social skills ▪ above average intelligence ▪ attachment to family ▪ empathy ▪ problem solving ▪ optimism ▪ school achievement ▪ easy temperament ▪ internal locus of control ▪ moral beliefs ▪ values ▪ self related cognitions ▪ good coping style	▪ supportive caring parents ▪ family harmony ▪ more than two years between siblings ▪ responsibility for chores or required helpfulness ▪ secure and stable family ▪ supportive relationship with other adult ▪ small family size ▪ strong family norms and morality	▪ positive school climate ▪ responsibility and required helpfulness ▪ sense of belonging/ bonding ▪ opportunities for some success at school and recognition of achievement ▪ school norms concerning violence	▪ meeting significant person ▪ moving to new area ▪ opportunities at critical turning points or major life transitions	▪ access to support services ▪ community networking ▪ attachment to the community ▪ participation in church or other community group ▪ community/cultural norms against violence ▪ strong cultural identity and ethnic pride

(adapted from Developmental Crime Prevention Consortium 1999: 150 and 153)

These lists reveal an immediate problem in developing indicators of well-being on the basis of administrative data. While some risk factors such as low birth weight, disability and chronic illness may be examined using the available administrative data, more multi-dimensional concepts such as empathy, problem solving and optimism are far more difficult to measure. But the potential does exist to extract some key factors which may be useful indicators of well-being and/or adversity. It is useful then to consider the risk/resilience literature more thoroughly.

Theoretical Approaches to Children and Young People

When measuring well-being, we first need to be able to identify factors that will be indicators of well-being, that is, we need measures or gauges of how *happy*, *healthy* and *safe* children and young people are. One promising approach to identifying such factors is provided by those researchers who have focused on the identification of both risk and protective factors, as mentioned above.

This approach is particularly useful when coupled with a developmental perspective. Such a perspective regards childhood as a trajectory, throughout which different milestones are achieved, subject to the impacts of specific social, cultural or biological factors. This is the complex range of developmental factors that much current literature on children and young people addresses. Such factors can include negative experiences early in life and their subsequent impact on physical and/or mental health, crime and delinquency and general disadvantage (Barker, 1998; Bor, Najman, O'Callaghan, Williams and Anstey, 2001; Jessor, 1998; Loeber and Farrington, 1994; Rushton and Greenberg, 1999; Silva and Stanton, 1996; Werner and Smith, 1992).

These negative experiences have frequently been described as risk factors. Enough adverse experiences or realised risk factors at critical points of development increase the probability of entering an adulthood characterised by economic disadvantage, social isolation, criminality and poor health. However, this approach can also include the identification of protective factors that can mitigate the effects of exposure to risk factors (Developmental Crime Prevention Consortium, 1999; Garmezy, 1991; Howard and Bruce, 2000; Howard and Johnson, 2000; Marsten, Best and Garmezy, 1990; Robins and Rutter, 1990; Silva and Stanton, 1996; Werner and Smith, 1989, 1992).

In Australia, one of best known proponents of this research focus is Fiona Stanley (see Stanley, 2001). Stanley's work addresses mainly child health issues and the importance of understanding the social domain in conjunction with the biological/medical domain if society is to engage in preventative rather than reactive health strategies. Stanley's commitment to this perspective has been influential in Australia, doing much to bring about the recent *Australian Research Alliance for Children and Youth* (ARAFCAY) (to be discussed further in the conclusion).

Stanley's work allows a very useful cataloguing of children's health in Australia that takes into account the social, cultural and historical contexts.

> *While the perinatal and infant period is still one of life's most risky, the chances of survival now are much higher than 100 years ago, and once through to the end of the first year, the risk of dying in childhood is very low and only starts to rise again in older teenagers (15-19 years old), particularly in males. However, there is now possibly excessive emphasis on using expensive technologies to prevent death in children who are severely compromised, with much less effort into researching the antecedents to prevent the conditions which lead to the problems in the first place. And in later childhood and adolescence, risks are dominated by factors associated with lifestyle and mental health problems which require a complex range of preventive strategies over many years* (Stanley, 2001).

In general, three key areas identifying risk and/or resiliency have been identified:

- individual characteristics such as being optimistic or pessimistic

- family characteristics, such as having high parental support or experience of neglect, and
- community factors such as having strong connections with schools or being marginalised from community networks (*see* Garmezy, 1985; National Crime Prevention Consortium, 1999; Tomison and Wise, 1999).

In their Kauai Longitudinal Study, Werner and Smith (1989; 1992) note that individual factors, such as sociability and communication competence, mediating factors such as family ties, and external factors such as support systems, all work to foster resilience, even in groups of children characterised by poverty and disadvantage.

Howard and Stanton report similar findings:

> *...protective factors and processes may be located in the young person (learned attitudes, beliefs) or they may be found in the family context (caring adults). The school and community can also be sources of protective factors and processes (for example, schools that teach mastery, and local councils that provide recreational facilities and opportunities for young people to socialise). There is no single combination of protective factors and processes that can be identified as being better than any other - resilient children will draw on what is available* (2000: 5).

The recent focus on strengths-based programs also builds on the interest in promoting resiliency and overcoming risk. Strengths-based approaches aim to promote "people skills, people resources, trusting relationships, and the strength of collaborative networks and partnerships, both formal and informal, existing within the community" (Mudaly, 1999: 47). The focus of these approaches is "the process of, capacity for, or outcome of, successful adaptation despite challenging or threatening circumstances" (Marsten, Best and Garmezy, 1990: 425).

Werner and Smith (1992) note that:

> *resilience and protective factors are the positive counterparts to both vulnerability, which denotes an individual's susceptibility to a disorder, and risk factors, which are biological or psychosocial hazards that increase the likelihood of a negative developmental outcome in a group of people* (Werner and Smith, 1992: 3).

As with those interested in risk, these theorists attempt to identify the specific factors that serve to protect young children, and foster well-being, especially for those living in environments otherwise characterised by disadvantage. Gramezy notes that:

> *...the evidence is sturdy that many children and adults do overcome life's difficulties. Since good outcomes are frequently present in large numbers of life histories, it is critical to identify those 'protective' factors that seemingly enable individuals to circumvent life stressors. Unfortunately, such positive outcomes have not typically been the focus of investigators, and comparatively little is known about persons who escape those too frequent cycles of disadvantage* (1991:421).

It has been argued that research focused on identifying risk factors actually engages in further labelling and stereotyping of disadvantaged children and young people. That is, "young people who do not conform to the standards of the mainstream are identified as 'at risk', requiring specific attention to bring them into line with the mainstream" (Wyn and White, 1997:52).

However, it is important to note that factors such as adversity or resilience should not be considered as *immediately* 'causal'. Increasingly, there is a commitment to better understand why some children and young people become involved in different trajectories to others with similar background experiences. For example, the Developmental Crime Prevention Consortium (1999) argues:

> *The need for understanding of process is apparent when one considers the complex ways in which risk and protective factors can be related to one another and to outcomes. One source of complexity is the fact that many risk factors tend to co-occur and to be interrelated. It then becomes difficult, but necessary, to tease out the effects of any single variable....Also contributing to the complexity is the fact that risk factors operate cumulatively, with some factors contributing to chains of risk. Direct linear relationships are seldom discovered ...To add one more source of complexity... it may be the interaction or combination of risk factors that is critical* (Developmental Crime Prevention Consortium, 1999: 151-153).

The Centre for Community Child Health (CCCH) (2000) similarly argues:

> *...a traditional focus on trying to identify single biological and/or environmental factors that cause developmental delay has in recent years been replaced by a model of child development that emphasises the complex dynamic interplay between biological factors within the child and caretaking environment. This transactional model postulates that developmental outcomes are the end result of a complex transaction between intrinsic or within child factors (eg. genes, central nervous system development, temperament) and environmental factors (eg. parenting style, amount of stimulation, socio-economic status)* (CCCH, 2000:3).

So what are the specific factors that either diminish or promote children and young people's well-being?

Key factors

There is a wide range of factors that may impact positively or negatively on children and young people. Lack of access to resources, poverty, poor health, violent families, offending peers and engagement in care and protection services have all been cited as risk indicators which can lead to negative adulthoods.

If we compiled a dream list of indicators of well-being we may want to consider:

- **health** - both physical and mental health, including factors such as mortality and morbidity rates, but also other factors such as physical exercise, self-esteem and alienation
- **education** - basic literacy and numeracy, and also engagement with school, engagement in learning and opportunities for higher education
- **safety** - being safe from criminal violence, but also from abuse, harassment and discrimination and feeling safe and secure
- **risk-taking behaviours** - officially defined criminality and engagement in behaviours such as smoking and binge-drinking (it is also important to note that risk-taking may not necessarily be a negative measure, with engagement in extreme sports, for example, being a potentially positive measure for peer relationships, health and community engagement)
- **peer relationships** - factors such as sociability and interaction
- **family relationships** - parenting styles and emotional support provided
- **community engagement** - participating and a sense of belonging. This could include attending church or being involved in a sporting team, but could also include a community of children and young people's choice, such as an Internet chat room (see page 10)
- **access to resources** - including a variety of possible factors such as poverty, access to affordable housing, access to employment and access to child care.

Obviously these factors are not mutually exclusive, and many are interactive and contingent on one another. A family's access to resources for example, may impact on

their parenting practices, which may in turn impact on a child's physical and mental health.

For the purposes of this report, we cannot examine all the potentially relevant factors that may impact on children and young people's wellbeing. Instead, we have drawn on the key issues from the literature, ie. the five main areas identified as influencing children and young people's trajectories. These five areas were chosen primarily because they can be analysed through administrative data available in Queensland.

It is important to remember that it is not the work of government departments to collect data other than that relevant to their core business, so even in these broad categories, we will examine factors such as morbidity and mortality rather than, for example, sense of self or alienation.

The five broad areas investigated in this report are:

1. **health**
2. **access to housing**
3. **education**
4. **victimisation, and**
5. **criminality.**

Health

Keating and Hertzman (1999) draw attention to a phenomenon they label the "gradient effect", where higher socioeconomic standing is associated with better health, regardless of whether income, education or occupation is used to define socioeconomic status (Hertzman, 2000:11).

In turn, factors as maternal depression, poor nutrition and foetal growth retardation lead to developmental and learning problems, bullying, aggression and antisocial behaviour, teenage pregnancy, child abuse and neglect, alcohol and drug abuse, eating disorders, suicide and depression (Keating and Hertzman, 1999).

This perspective is similar to life-span perspectives which recognise that "families are dynamic systems that continually change throughout a child's life from infancy to late adolescence and beyond" (Sanders, Gooley and Nicholson, 2000:70 *see also* Kandel, 1998).

But most importantly, there is an increasing emphasis on recognising that biological factors such as chromosomal abnormalities need to be understood as risk factors which can increase individual vulnerability to a wide range of other negative developments, depending on the nature of the child's environment. To be born underweight is not itself an indicator of future developmental challenges. However, to be born underweight in a family characterised by poverty and lack of access to services may point to such developmental challenges (CCCH, 2000).

However, as with most of these issues, it is also important to note that the issue of health cannot be easily reduced to hard and fast rules such as *this* is a precursor to *that*. The range of potentially important causal factors is extremely broad, including longer term associations such as that between foetal alcohol syndrome and the mental health of adolescents. The issue of adolescent mental health provides an especially clear demonstration of what is being considered in this report. The Queensland Young People's Mental Health Survey (Donald, Dower, Lucke and Raphael, 2000) argues that:

> *young people's health and well-being is a broad area that encompasses a range of issues from young people's cultures; leisure activities and hobbies; health related behaviours such as drug/alcohol use and sexual health; family influences; quality of life; common sources of distress such as interpersonal relationships; criminal and delinquent behaviour; social issues such as unemployment and poverty; through to conditions such as depression, schizophrenia and eating disorders (2000:1).*

The importance of understanding health as a broad, complex domain can be seen when we look at a specific phenomenon, such as suicide. There is no one cause of youth suicide, but a complex array of cultural, social, biological and psychological factors. It is argued that factors contributing to suicide include social disadvantage, mental health factors, family violence and stressful life events (NHMRC,1999). The number of suicides throughout Australia has remained relatively stable at around 2,500 for the last few years, with a slight increase recently (Harrison and Steenkamp, 2000:10).

While the overall numbers have remained stable, certain groups do appear to be particularly vulnerable. For example:

> *Youth suicide, unknown amongst Aborigines until three decades ago, is now double, perhaps treble, the rate of non-Aboriginal suicide. In 1997, the male youth rate was five times the already high national rate of between 24 and 26 per 100,000 of the population* (Tatz, 1999).

While the causes of suicide are complex and there are differences in the occurrence of suicide across distinct groups, in general, it is agreed that "suicidal behaviours in young people are frequently the end point of adverse life sequences in which multiple risk factors combine to encourage the development of suicidal behaviours" (NHMRC, 1999:250).

Access to housing

Access to affordable housing is a potential indicator of access to resources, with homelessness being the extreme end of this measure. The causes of homelessness are complex and frequently inter-related, including external factors such as poverty and lack of affordable housing, and situational factors such as experiences of physical and/or sexual abuse or drug and alcohol abuse (Crane and Brannock, 1996). Given the complex interaction between many of these factors, it is difficult to identify what causes homelessness. In turn, it is equally difficult to count homelessness rates (Chamberlain, 1999). Given that homeless young people are almost by definition transient and lacking a fixed abode, research techniques relying on mail outs, telephones or door knocking are inefficient in ascertaining the number of homeless young people.

Education

Education has long been considered a critical component of children and young people's development. Healthy, happy children are likely to receive the most benefit from education. As noted by the National Education Goals Panel:

> *Children's school experience is more positive and productive when they have a sense of personal well-being, grounded in stable caring relationships in their early lives. Unhappy, fearful, or angry children are preoccupied, unable to give their full attention and engagement to learning experiences* (1999:3).

In turn, it has been argued that:

> *Education is fundamental to the success of any modern society. It is particularly central during periods of social transition, when the flexibility and adaptability of populations and institutions are most seriously challenged. In these circumstances, a society's ability to foster new skills, new concepts, and new patterns of learning depends heavily on its ability to renew educational institutions and practices* (Keating, 1996: 461).

Research has consistently shown that those with high levels of attachment and commitment to school are less likely to become involved in truancy, criminality and drug use (*see* Hirschi, 1969, LeBlanc, 1994). Similarly, the far cruder measure of low grades

and academic failure has been associated with everything from having a court record (Farrington, 1991) to engaging in moderate delinquency (LeBlanc, 1994). Higher levels of education are also positively associated with better health (Keating and Hertzman, 1999) and better socio-economic outcomes (Western, 2000). It is important to note here that low grades are themselves linked to a variety of factors that also impact on negative trajectories, such as family backgrounds.

Schools can also impact either favourably or negatively on children and young people depending on their physical and organisational structure, level of resourcing and general governance processes (Gottfredson, 2001; Hill, 1998; Lingard, Hayes and Mills, 2002). It has been shown that staffing, size and resources, governance, educational climate, social climate and student socialisation all influence young people's behaviour and beliefs (as well as promoting or disabling possibilities for learning).

Schools with fewer resources, punitive and/or ambiguous governance strategies and lower student attachment to conventions are all likely to experience higher levels of disorder (Gottfredson and Gottfredson, 1985). Conversely, schools which actively engage students in learning, with consistent, fair rules and teachers who promote positive social and cognitive goals, promote well-being and cognition (Gottfredson, 2001).

In Australia, research developing from the Longitudinal Surveys of Australian Youth has demonstrated that:

> *The most effective schools are those schools that give students confidence in their own abilities and provide an environment conducive to leaning, and in which the students are likely to experience high expectations for educational success* Marks, McMillan and Hillman, 2001: 56).

The Queensland School Reform Longitudinal Study has also demonstrated that productive classroom practices, enhanced school organisational capacity, together with high quality external support, produces improved social and academic outcomes for students (The State of Queensland, Department of Education, 2001). Other research has shown that "programs aimed at reducing children's problem behaviours and promoting social skills, initiated during the preschool and early school years, may prevent severe conduct disorders during middle childhood and later delinquent behaviours during adolescence" (Sanders, Gooley, and Nicholson, 2000:70).

Factors associated with victimisation and/or criminality

A variety of family-related factors have been implicated in later adverse experiences involving care and protection orders of some type. These factors include family violence, lack of parental support and parental conflict, (Juby and Farrington, 2001; Silva and Stanton, 1996). International research shows that programs in which poor adolescent single parents receive visits over the long term significantly impact on child abuse. Reports of child abuse or neglect during the first two years where home visits were made were substantially less than among control groups not receiving visits (Olds *et al*, 1986; 1997; 1999).

Similar findings have been found in Australia, where intervention targeted at vulnerable families has been shown to improve short term outcomes for infants and their families (Armstrong et al, 1999). Not surprisingly, communities with community networks and social connectedness have been shown to have lower rates of child maltreatment than communities of similar socio-economic status, which lack the same familial or community ties (Vinson, Baldry and Hargreaves, 1996).

Many researchers have also argued that negative childhood experiences can lead to later criminality (Falshaw and Browne, 1997), and that certain specific early childhood interventions have been shown to reduce adolescent criminality (Farrington, 1989; 1994; Reynolds, Temple, Robertson and Mann, 2001; Yoshikawa, 1995).

There is persuasive evidence that children who have previously been wards of the state are more likely to come into contact with the juvenile justice system, particularly detention, than those who have not (*see* Carrington, 1993; Cashmore and Paxman, 1996). Research using child protection and law enforcement agency records show children with records of physical abuse and neglect are more likely to have been arrested for criminal offences (excluding traffic offences) (Maxfield and Widom, 1996).

Summary

So what does this research tell us and where should we go from here? When we talk about child development, we are talking about physical, social, emotional and cognitive development. It is important that whatever specific issues we focus on, we remember that a range of sometimes disparate factors will affect an individual's well-being.

Because there is a wide range of factors that need to be considered when trying to ascertain children's well-being, we need to begin by clarifying what we are identifying as key constituents of well-being. This is a difficult exercise with many social, biological and cultural factors capable of contributing to this elusive concept.

Secondly, we need to identify key *indicators* of the factors identified as central to well-being. The initial identification of key concepts is relatively easy, but it becomes more difficult to identify measurable indicators. Some key concepts such as health, education, victimisation and criminality can be viewed as indicators of children and young people's well-being. But even these concepts may be open to debate in terms of their ability to effectively represent children and young people's overall well-being, compared with alternative indicators such as having supportive caring parents, opportunities for success or being socially engaged.

The next section of this report addresses these issues, and provides a snapshot of children and young people from Queensland administrative data.

Children and young people in Queensland: what does the data tell us?

> *The lack of data on children's well-being is due, in part, to a lack of demand, the absence of any institutionalised means of collecting data on children, and the lack of agreed-on indicators of well-being, which would permit consistent collection of data and comparisons over time and place* (Ben-Arieh et al, 2001: 3).

Introduction

This section of the report will consider the data available and the limitations of the use of administrative data for analysing the well-being of children and young people in Queensland. It will then provide a profile of children and young people in Queensland drawn from a variety of administrative data sources. It is important to note that this profile does not represent all possible data available on children and young people. Some agencies such as Queensland Health have extremely large data bases on a variety of key areas which could not be included in this report. Most agencies collect more specific information on particular areas of their core business. This data can often be found in departmental Annual Reports.

Census data

In discussing the difficulties involved in examining data which provides effective indicators of well-being, it must be acknowledged that the data available ultimately determines the range of possible indicators we can draw on in any profiles of the state of children and young people in Queensland. This limitation is a reminder that survey data are in many ways the most useful data source for examining factors that we know impact either negatively or positively on children and young people.

For example, if we consider what information is available on Queensland's children and young people, the 1996 Australian census provides critical basic information.

We know that of young people aged 12 - 25 years of age in Queensland:

- From 1986 to 1996 the number increased by 29 per cent. This was the highest growth rate of all states and territories.
- Nearly 4 per cent (3.9) reported being of Indigenous origin. This figure was greater than the national figure of 2.7 per cent and much higher than the proportion of those aged 26 years and over (1.8 per cent) who identified as being Indigenous.
- Over 28 per cent born overseas were born in New Zealand, followed by the United Kingdom (15 per cent), Papua New Guinea (6 per cent), and Taiwan (4 per cent). Queensland had the highest proportion of this age group born in New Zealand of all States and Territories - well above the National figure of 12 per cent.
- About 56 per cent were still living with their parents at the time of the 1996 census. Thirty nine per cent were dependent children (under 15 years) or dependent students (aged 15 to 24 years). This figure was slightly lower than the national figure of 42 per cent. The remaining 17 per cent of children and young people were living with parents as non-dependent children.
- A higher proportion (28 per cent) were living independently than in any other State or Territory. This includes people living as couples, lone parents, members of a group household and lone persons.
- From 1991 to 1996, the proportion attending an educational institution increased slightly from 48 per cent in 1991 to almost 50 per cent in 1996.
- Between 1991 and 1996, the proportion of 15 to 25 year olds working part-time increased from 16 per cent to 21 per cent (ABS, 1998a)

Further detailed information has also been produced by the Australian Institute of Health and Well-Being (AIHW) on children and young people in Australia. This covers major risk factors, injuries and diseases of young people, and focuses on Indigenous youth, young people in rural and remote locations, and those from socioeconomically disadvantaged groups (see AIHW, 1998; 1999).

At the time of writing, the AIHW was also involved in preparing a set of indicators for monitoring and reporting on youth health. While this information is critical base line information, such data cannot provide information on factors like parental bonds or readiness for learning which we know are important indicators of children and young people's well-being. Many potential indicators of well-being are inherently multi-dimensional concepts that are impossible to extract in any reliable way from either census type survey data or administrative data sources.

Survey data

In contrast, useful sources of data on *specific* aspects of well-being are available from survey data. For example, a survey of smoking and skin protection among Year 7 to 12 students in Queensland (Lowe, Carmont, Ballard and Stanton, 2000) noted that smoking prevalence between 1996 and 1999 has generally increased for young people in Years 9 and 11, remained reasonably stable for those in Years 8, 10 and 12 and decreased for those in Year 7 (Lowe et al, 2000: 13).

Table 1: Change in smoking prevalence rates between 1996 and 1999 – Queensland

	Year level	*7*	*8*	*9*	*10*	*11*	*12*
• **Have not smoked in the last 12 months**	**Male**	6	-3	-5	2	-8	2
	Female	2	3	-3	0	-10	-1
• **Have smoked in the last 12 months, but not in the last four weeks**	**Male**	-3	2	1	0	-1	-5
	Female	-3	-4	5	6	0	0
• **Have smoked in the last four weeks, but not in the last seven days**	**Male**	2	2	-3	-3	0	-3
	Female	1	-2	0	0	0	2
• **Have smoked in the last seven days**	**Male**	-4	-1	6	1	10	7
	Female	0	3	-2	-5	9	1

Reproduced from Lowe, Carmont, Ballard and Stanton, 2000: 14

The Office of the Queensland Government Statistician also conducts a census at schools, which asks Queensland students a variety of questions on their school and family life[5]. If we focus on primary students, we can see that their favourite subjects were Art at 32.2 per cent and Physical Education (P.E.) at 29.5 per cent. Math ranks quite low at 11.4 per cent, and English even lower at 3.6 per cent.

[5] See http://www.oesr.qld.gov.au/censusatschool/home.htm for more information on the census at school.

Table 2: Favourite subject of responding students: primary schools – Queensland

	Male %	Female %	All %
Art	20.9	43	32.2
English	1.9	5.2	3.6
Language	2	3.6	2.8
Maths	12.9	10	11.4
Phys. Ed.	37.4	22	29.5
Rel. Ed.	0.7	1.1	0.9
Science	6.1	3.1	4.6
Computers	13.1	5.6	9.3
Social Studies	1	1.3	1.2
Other	3.9	5	4.5

Note: Excludes 45 non-responses
Source: Reproduced from Office of the Queensland Government Statistician, "Census At School"

The Centre for Population Health has also carried out a survey on Queensland young people aged 15 - 24 years of age covering a wide range of mental health issues together with a wider range of health risk topics (Donald et al, 2000). They report that the most common causes of distress for young people were interpersonal relationships, particularly in relation to family and friends. One in three young people reported that they had had suicidal thoughts at some time in their life and seven per cent of young people reported having attempted suicide at some time in their life (Donald et al, 2000: 15-25). The same survey also measured illicit drug use in Queensland, noting that only a small number of people in their sample had ever used illicit drugs. Of the illicit drugs recorded, hallucinogens were the drugs most commonly used, followed by amphetamines and sedatives (Donald et al, 2000:33).

Table 3: Prevalence of illicit drug use - Queensland

Type of Drug	Number 15-24 years	% 15-24 years	Males % 15-17 years	Females % 15-17 years
Hallucinogens	404	13.3	7.5	8.9
Amphetamines	271	9.0	2.7	4.1
Sedatives	184	6.1	2.1	6.3
Tranquilizers	124	4.1	2.0	2.5
Ecstasy	103	3.4	0.8	1.2
Inhalants	102	3.4	2.9	3.6
Cocaine/Crack	64	2.1	0.8	1.4
Heroin	57	1.9	0.5	1.4

Adapted from Donald et al, 2000: 32
Note the total sample refers to young people aged 15 to 24 years. Participants were able to record more than one option. For more information on the survey see Donald et al, 2000

In terms of offending behaviours, the Sibling Study project (see Western, Lynch and Ogilvie, 2001) reports that the most common activities engaged in by their respondents (young people aged 12 - 19 years) included telephone pranks, buying and drinking alcohol in a public place, using cannabis, getting into group fights and shop lifting. The least common offences were forced sex, drink driving, racing with other cars, joy riding in a stolen car and stealing car or bicycle parts.

Table 4: Percentage of self-reported delinquent involvement of sibling study respondents

	Participation (%)
ASRDS item	**Total (n=885)**
Forced sex	2.8
Used ecstasy/acid/speed	15.3
Joy-riding in stolen car	13.3
Break and enter	17.5
Starting a fire	8.2
Driven after drinking	11.6
Stolen parts from car	12.8
Stolen a bicycle or parts	11.4
Driven unregistered car	13.7
Damage public property	14.8
Used weapon in fight	14.6
Raced with other cars	13.6
Used medicines for fun	14.7
Stolen $10 or less	22.9
Run away from home	18.2
Used force to get things	17.9
Stolen from dispenser	16.7
Damage private property	21.2
Damage school property	20.7
Nasty phone calls	17.6
Drinking in public place	29.7
Beaten someone up	26.0
Graffiti on public places	23.6
Shoplifted	29.5
Not paid entrance fee	26.1
Seen an R-rated film	25.3
Used marijuana/hash	35.5
Driven without licence	29.8
Stolen $10 or more	25.3
Group fight	31.3
Skipped class/school	33.9
Bought alcohol	37.6
Telephone tricks	38.4

Adapted from Western, Lynch and Ogilvie, 2001.

The Sibling Study also includes questions of victimisation. A disturbing 24 per cent of respondents report being the victim of unfortunate events (roughly two-thirds of which are criminal offences).

Table 5: The 'victim/trauma status' of sibling study respondents

Victim/trauma status	Frequency	%
Have not experienced	793	76
Have experienced	244	24

Note: The 'victim/trauma status' variable includes sexual assault, sexual abuse, physical assault, attempted murder, attempted sexual assault, attempted physical assault, maltreatment, robbery, stalking, police harassment, abduction/attempted abduction, threats of violence, theft, break and enter, car theft/vandalism, racial harassment, sexual harassment, death of a family member, death of a significant other, suicide attempt by significant other, separated from parents, fostered/adopted out, health problems, family alcohol use, family member arrested, being bullied. The figures in the 'frequency' and 'percentage' columns are derived from the data recorded in the victim/trauma status column, but entries by respondents of having been victimised have in all cases been counted as a single instance of a respondent who has been the victim of some (or multiple) event/s.

Reproduced from Ogilvie and Lynch, 2002.

Another potential indicator of well-being is homelessness. Empirically investigating homelessness is problematic in terms of both survey and census type data because of the difficulties in locating and collecting information from children and young people with no fixed address. Nonetheless, some data are available from organisations (especially non-government agencies) which work with the homeless as a part or the entirety of their client base. However, data from these sources may not be truly indicative of the problem, as it covers only the proportion of children and young people who know about these agencies and feel comfortable accessing them.

One of the few state level sources of data is that available from Kids Help Line, a national 24 hour telephone counselling service for children and young people in Australia. In 2000, Kids Help Line counsellors responded to 11 500 calls from young people who said they lived in Queensland. The overall proportion of calls on concerns about leaving home and homelessness were quite low, although it is concerning that Queensland's calls relating to homelessness were 6 per cent, which is higher than the national figure of 4.5 per cent (see Table 6).

Table 6: Counselling calls to Kids Help Line on leaving home/ homelessness concerns - Queensland 2000

	National %	QLD %	QLD numbers
Leaving home/homelessness	4.5	6.0	686

Adapted from Kids Help Line, State Reports, Queensland, 2002.
Given that 40% of callers choose not to reveal their location, this figure may be a significant understatement.

In addition, Kids Help Line noted that "these issues (of leaving home and homelessness) are of most concern to older callers aged between 15 - 18 years (76 per cent of calls). Almost half (321) of the 686 Queensland callers had left home, with 67 per cent of these having nowhere to stay at the time of their call. A further 19 per cent of young people had been told to leave their home. The remaining 34 per cent of callers were seeking information or contemplating leaving" (Kids Help Line, 2002).

These types of data provide key indicators of the current wellbeing of Queensland's children. Other examples of specific surveys focussing on key issues of concern relating to children and young people, include the Mater University Study of Pregnancy (see Najman et al, 1997) and the Queensland School Reform Longitudinal Study (see Department of Education, 2001). However, surveys are a resource intensive exercise for agencies, requiring funds and expertise that could otherwise be directed towards assisting, rather than researching, those in need. Administrative data has the additional benefits that it is frequently available annually. This means agencies tend to rely on administrative data to inform policy and practice, as it is both available and accessible.

Administrative data

A reliance on administrative data, because of the relative scarcity of large scale survey data, also means prioritising particular governmental/regulatory understandings of children and young people's well-being rather than tapping children's own perspectives or experiences (*see* Ben-Arieh, 1999; Boyden, 1997). Despite this, as Ben-Arieh notes:

> *...administrative data may be the best option for quickly developing community-based indicators of children's well-being. Given the cost of new or continuing social surveys, and given that administrative data already exists, this source is ideal for the short term development of indicators that can be used to inform the public and policy makers* (Ben-Arieh, 1999: 39).

Even if quickly accessible cost effective data is used to develop indicators of well-being for children and young people, data difficulties do not end with the decision to use existing administrative data sources rather than commissioning more targeted survey data. The desirability of *comparable* data further complicates the issue of access to *appropriate* data.

Since at least the mid-80s, the Queensland Government has recognised that the lack of common business rules and uniform counting methods means it is not possible to profile discrete sectors of the population in terms of a range of indicators. Because different arms of government have different rules for the management of their administrative data, it is not possible to match or merge data drawn from different sources. For example, health data cannot be matched with education data.

Even within sectors, it is frequently not possible to easily reconcile different administrative data. For example, if we consider the criminal justice system data, we find that police data presents a very different picture to that derived from court data, and the data available from both are very different from that maintained by corrective services.

The Office of the Premier and Cabinet is currently pursuing greater coordination of administrative data as part of an increasing interest in implementing whole-of-government strategies. The Law and Justice Policy Division of the Office of the Premier and Cabinet is particularly active in this regard, as is Queensland Treasury.

For Queensland Treasury, the absence of coordinated administrative data systems means the cost-benefit of various policy options cannot be effectively evaluated as agency outputs cannot be measured with any validity or reliability. The implementation of *Managing For Outcomes*/accrual accounting across government can be seen as one aspect of Queensland Treasury's support for more coordinated data collection and collation across government.

It should also be noted that Queensland Treasury is demanding increasing precision in government agencies' annual strategic plans regarding their outputs and performance indicators. Queensland Treasury must be able to aggregate these performance measurement/output indicators so government can judge its performance overall and the performance of individual agencies with respect to each other. Increasingly, agency funding will be a function of Queensland Treasury scrutiny of these data (*see* Lynch and Bell, 2000).

It is precisely because of these methodological problems that the Canadian government has supported the 'What is the best policy mix for Canada's children?' research. This project involves the large scale and comprehensive surveying of children to obtain the breadth of data necessary for high-level policy decision making.

The data available from our Federal Government's Longitudinal Survey of Australian Children (LSAC) promises to contribute significantly to Australia's ability to conduct similar research. The benefits of such large-scale information is that it can examine "resource domains, rather than focussing on a single measure" (Zubrick et al, 2000: 14).

For example:

> *children may live in families which are rich in income but poor in the amount or quality of time they have available for their children (ie families described as being 'cash rich and time poor'). Such a scenario may arise for two-income families where both parents are working full time, where work-demands and personal stress are high, and where there are reduced opportunities for interacting with children. Similarly, Australia's Indigenous community presents an example of accumulated risk exposure, where resources of income, human capital and psychological capital are poor, and where social capital has been eroded, cumulatively impacting on the health and well-being and academic outcomes for Indigenous people* (2000: 14-15).

It should be stressed that administrative data allows only for the identification of specific risks or resources. It does not currently allow the examination of the *accumulation* of risks or resources. Just as importantly, it does not allow examination of the way in which these resource domains interact (Zubrick et al, 2000: 15). For example, "loss of income may result in increased stress, increased marital conflict and a change in parental discipline style, all of which may accelerate the child's development of conduct disorders. These resources cumulatively interact and contribute to whether the child feels a sense of belonging, a sense of being valued, and a sense of being supported through developmental life stages" (Zubrick et al, 2000: 15).

However, there are still *some* benefits in examining administrative data from a range of agencies. As noted by Ben-Arieh:

> *...the assessment of children's well-being is only one part of the equation – literally, the state of children is about their conditions and their lives. If positive change is to be promoted, a community must also assess resources available to children. This requires assessing information about the environmental context of the child, including such factors as immediate and extended family characteristics, social networks, concrete resources such as food, water, housing or transportation, and community institutions such as schools, recreational resources, and work opportunities* (Ben-Arieh et al, 2001:107).

These are precisely the kind of reviews that can be done by examining administrative data.

Given the above discussion, it is critical to note that the data from different agencies presented in this report cannot be used in department-to-department comparisons. Different agencies employ different counting criteria and different definitions, making comparison impossible. An example can be seen in the way in which different agencies identify Indigenous status. Most departments use self-identification. Others, such as Queensland Health, also use sampling strategies to focus on communities where more than 90 per cent of the population identify as Indigenous (*see* Health Information Centre, Technical Paper, 2001). The Queensland Police Service does not release and/or collect any Indigenous identifiers at all. Even if the same definition was introduced by different agencies, different counting strategies may be used, which again makes comparisons impossible.

The problem of different definitions becomes particularly clear if we examine rural and urban status. Queensland Health uses the Remote Rural Metropolitan Area (RRMA) classification. This classification has seven different categories:

- Capital City Statistical Division
- Other Metropolitan Areas
- Large Rural Areas
- Remote Centres
- Other Remote Areas

- Small Rural Areas
- Other Rural Areas.

Queensland Health's Rural category comes from grouping the Remote Centres and Other Remote Areas into one. All other categories fall into the other group.

In contrast, the Office of Economic and Statistical Research uses the Accessibility/ Remoteness Index of Australia (ARIA), which includes five categories:
- Highly Accessible - relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction
- Accessible - some restrictions to accessibility of some goods, services and opportunities for social interaction
- Moderately Accessible - significantly restricted accessibility of goods, services and opportunities for social interaction
- Remote - very restricted accessibility of goods, services and opportunities for social interaction
- Very Remote - locationally disadvantaged - very little accessibility of goods, services and opportunities for social interaction.

These can then be collapsed into the three categories of accessible (1 and 2), moderately accessible (3) and remote (4 and 5).

Education Queensland uses its own location classification. With respect to rural and urban areas:
- rural indicates whether the school is located in a rural area - a rural area is defined as a locality comprising less than 10 000 people
- urban indicates whether the school is located in an urban area - an urban area is defined as being a locality comprising 10 000 or more people.

In contrast, the Queensland Police Service maintains its own geographical boundaries as does the Department of Families in relation to its urban/rural classifications. However, it is important to note that the Department of Families also routinely collects data to produce some standard annual tables with breakdowns of data for child protection and youth justice indicators by ABS statistical division and/or by ABS statistical local area (SLA).

These different business rules mean department-specific variables such as child protection cannot be compared across agencies, but also, even more general demographic identifiers cannot be used for direct comparison. Each area discussed below should therefore be considered a *discrete* area, not necessarily a comparable area.

The data have been obtained from a range of governmental departments, including Queensland Treasury, Queensland Health, Queensland Police Service, the Queensland School Curriculum Council, Education Queensland, Disability Services Queensland and the Department of Families[6].

These measures have been chosen for their direct relevance to the broad areas of health, education, victimisation and criminality, as identified in the previous section. They are not, however, reflective of all administrative data available in Queensland. For a more extended overview of administrative data available from Queensland agencies see Appendix A. It should be noted, however, that the variables outlined in Appendix A are *also* not an exhaustive list of all possible administrative data in Queensland, and many other internal sources of data exist within different agencies.

The data chosen for analyses in this report are included because they:
1. provide *broad* indicators of key areas recognised in the literature as important in understanding children and young people's well-being
2. are available on a state level

[6] Despite the breadth of the data analysed, it was not possible to include all sources of administrative data in Queensland.

3. are available and accessible (ie. in electronic format, and the publishing of the data did not contravene any agencies' statutory confidentiality provisions)
4. are capable of dis-aggregation (ie. by sex and/or Indigenous status)
5. allow for repeated comparisons on an annual basis, in terms of providing an annual report on the status of children and young people in Queensland.

The areas focused on in this section of the report are:

Health
- births
- mothers' demographics
- immunisation
- disabilities
- morbidity
- mortality

Access to housing
- clients
- services provided to families with children

Education and childcare
- reading
- number skills
- suspensions
- number in child care

Victimisation and criminality

Child protection
- child protection notifications
- protective orders
- protective orders by most serious type of harm

Police
- victims
- offenders

Juvenile Justice (Offenders)
- court appearances
- youth justice orders (supervised/unsupervised)

Given the different counting strategies of the different agencies, it must be recognised that different time periods have been used throughout this report. Where appropriate, data has been calculated in rates per 100 000 and has been dis-aggregated by sex and Indigenous status. In the majority of cases, the rates have been calculated using Projected Census data[7]. When this was not possible, 1996 Census data was used. This has been noted in the footnotes. Given the gap between the last Australian Census and the data used in this report, all rates described in this report should be considered *estimated rates*. Where possible, the data has also been dis-aggregated by geographical location. In the majority of cases, the age categories drawn on have been less than one year, 1 - 3 years, 4 - 6 years, 7 - 9 years, 10 - 12 years, 13 - 15 years and 16 - 18 years, except when this has not been appropriate.

[7] ABS Cat. No. 3201.0.

Queensland administrative data on children and young people

Health

Births

The birth rate is the first and most obvious factor to consider as an indicator of the state of children and young people in Queensland. As can be seen in Table 7, there was a total of 47 078 births in Queensland during 2000. There is a far higher likelihood of Indigenous children being born in remote and inaccessible regions than non-Indigenous children (14 per cent of Indigenous males and females are born in very remote areas compared with 1 per cent of non-Indigenous males and females). The vast majority of non-Indigenous children (71 per cent) are born in highly accessible areas (Table 7).

Table 7: Registered births, by Indigenous status, sex and remoteness Queensland 2000 (row per cent)

		Highly Accessible	Accessible	Moderately Accessible	Remote	Very Remote	Not Stated	Total number
Non Indigenous	Male	71	13	10	3	1	1	22 046
	Female	72	13	10	3	1	1	20 682
Indigenous	Male	39	21	16	9	14	0	1 607
	Female	39	20	17	10	14	1	1 584
Not stated	Male	68	13	13	5	1	1	553
	Female	68	13	12	3	2	1	606
Total births		69	14	11	4	2	1	47 078

Source: ABS, Births Queensland 2000, unpublished data.

Parental Demographics

As Table 8 shows, the majority of both Indigenous and non-Indigenous mothers are aged 20 - 29 years (58 per cent and 50 per cent respectively). However, Indigenous mothers are more likely to be aged under 19 years (19 per cent) and conversely, non-Indigenous mothers are more likely to be aged 30 - 39 years (43 per cent).

Table 8: Births by mothers' Indigenous status and age Queensland 2000 (row per cent)

	Unknown	19 and under	20-29	30-39	40-49	Total births (n)
Non Indigenous	0	5	50	43	2	42 728
Indigenous	0	19	58	22	1	3 191
Not stated	0	7	50	40	3	1 159
Total	0	6	50	42	2	47 078

Source: ABS, Births Queensland 2000, unpublished data.

In 2000, the largest proportion of Indigenous fathers were aged 20 - 29 years (47 per cent) while the largest proportion of non-Indigenous fathers were aged 30 - 39 years (49 per cent) (Table 9).

Table 9: Births by fathers' Indigenous status and age - Queensland 2000 (row per cent)

	Unknown	19 and under	20-29	30-39	40-49	50+	Total births (n)
Non Indigenous	4	2	35	49	9	1	**42,728**
Indigenous	13	8	47	27	5	1	**3,191**
Not stated	6	2	36	44	9	2	**1,159**
Total	4	2	36	47	9	1	**47,078**

Source: ABS, Births Queensland 2000, unpublished data

Birthweight

The next indicator of the state of children and young people in Queensland to consider is birthweight. It is argued that "infants of low birthweight (defined as those less than 2 500 grams) require a longer period of hospitalisation after birth than other babies and are at greater risk of developing significant disabilities" (ABS, 1999: 87). For our purposes we will look at children with birthweights in the significantly low category of less than 2 000 g (2 kg) and the extremely low category of less than 1 000g (1 kg).

It is interesting to note that low birthweight is said to be related to maternal characteristics including youth, having none or more than four children, and being Indigenous (ABS, 1999: 87). However, Queensland data for 1999 appears to show very little difference between Indigenous and non-Indigenous children in the extremely low birthweight category (one per cent of Indigenous females and males were born with an extremely low birthweight compared with one per cent of non-Indigenous females). There is also no difference between Indigenous and non-Indigenous children in the significantly low birthweight category (2 per cent of Indigenous and non-Indigenous male and female babies were born significantly underweight). Modest differences do emerge in the 2 to 3 kg category, with 21 per cent of Indigenous female babies and 15 per cent of Indigenous male babies born underweight, compared with 18 per cent of non-Indigenous female babies and 13 per cent of male non-Indigenous babies (Table 10).

Table 10: Registered births by Indigenous status and birth weight Queensland 1999 (row per cent)

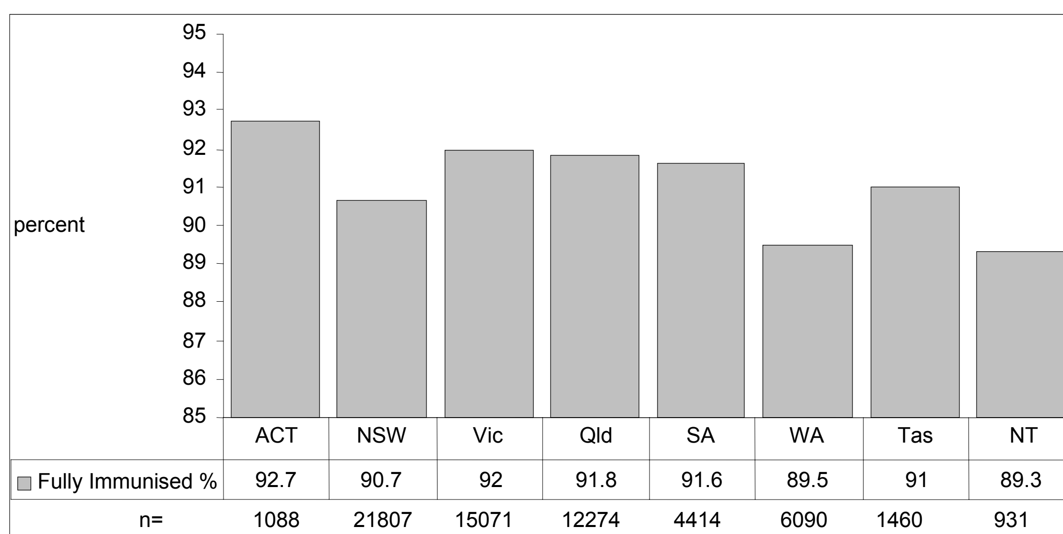
		<1kg	1-<2kg	2-<3kg	3-<4kg	4-<5kg	>5kg	not collected	Total number
Non Indigenous	**Male**	0	2	13	61	15	0	8	**21 743**
	Female	1	2	18	62	9	0	8	**20 495**
Indigenous	**Male**	1	2	15	50	10	0	21	**1 485**
	Female	1	2	21	50	6	0	19	**1 503**
Not stated	**Male**	1	2	14	53	13	1	17	**555**
	Female	1	1	19	55	7	0	17	**482**
	Total births	1	2	16	61	12	0	9	**46 263**

Source: ABS, Births Queensland 1999, unpublished data.
Indigenous status not identified n= 1037.

Immunisation

A range of vaccines is administered to children at different age-appropriate times (see Appendix B for a list of the NHMRC Australian Standard Vaccination Schedule 2000, 0 - 4 years). Most jurisdictions maintain quite a high level of immunisation, with Queensland having 12 274 children aged between 12 - 15 months assessed as fully immunised after receiving vaccines appropriate for their age group (Chart 1).

Chart 1: Percentage of children 12-<15 months of age assessed as fully immunised by jurisdiction (as at 30 June 2001)



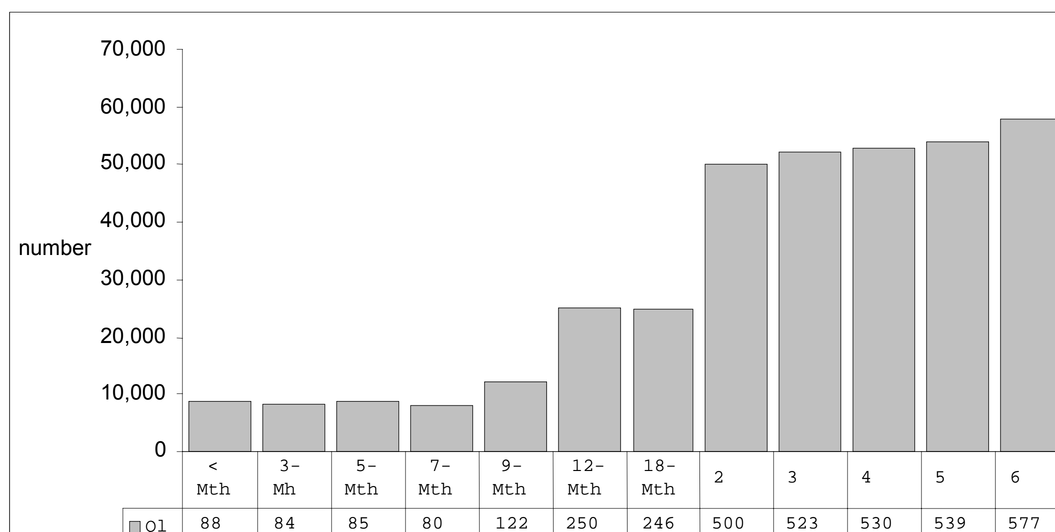
	ACT	NSW	Vic	Qld	SA	WA	Tas	NT
Fully Immunised %	92.7	90.7	92	91.8	91.6	89.5	91	89.3
n=	1088	21807	15071	12274	4414	6090	1460	931

Source: Australian Childhood Immunisation Register (Date of processing as at 30 September 2001).

Queensland had a total of 362,860 children aged six years and under registered on the Australian Childhood Immunisation Register (Chart 2)[8].

[8] It is also interesting to note that if we compare the Child Registration (Chart 2) to the ABS population figures we see that these figures are reasonably close to the total population of children and young people in QLD.

Chart 2: Child immunisation registration by age (under 7 years)- Queensland [9] (as at 30 Sept. 2001)



Source: Australian Childhood Immunisation Register (Date of processing as at 30 September 2001).
Unknown n=4
Total n=362 860

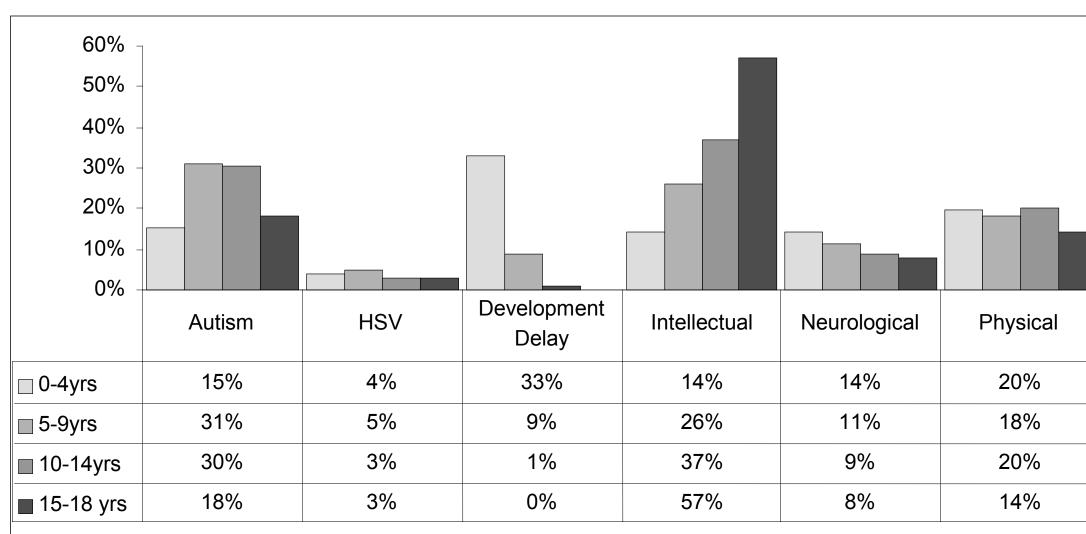
Disability

Developmental delays are the primary disability among those registered with Disability Services Queensland (DSQ), aged zero to four years (33 per cent) followed by physical disabilities (20 per cent). For those registered as having a disability aged five to nine years, autism is the most common primary disability recorded (31 per cent), followed by intellectual disability (26 per cent).

Thirty seven per cent of those aged 10 -14 years and registered with DSQ were registered as having an intellectual disability as their primary disability, and 30 per cent were registered as having autism as their primary disability. Fifty-seven per cent of those aged 15 -18 years were registered as having an intellectual disability as their primary disability (Chart 3).

[9] The data described in Chart 3 refers to those children and young people who were current clients, registered with Disability Services Queensland on the 21st of November, 2001.

Chart 3: Primary disability by age – Queensland 2001



	Autism	HSV	Development Delay	Intellectual	Neurological	Physical
0-4yrs	15%	4%	33%	14%	14%	20%
5-9yrs	31%	5%	9%	26%	11%	18%
10-14yrs	30%	3%	1%	37%	9%	20%
15-18 yrs	18%	3%	0%	57%	8%	14%

Source: Disability Services Queensland.
Note: due to small numbers some categories have been combined. HSV denotes hearing, speech and vision disabilities and includes those who are deaf or blind, or have hearing, speech and vision disabilities. Neurological includes Neurological disabilities and Acquired Brain Injuries. Psychiatric Disabilities have been excluded from the analyses, due to the very small numbers.

A second important observation to make about the number of young people with a disability is the higher number of young males registered as having a disability compared with young females. For all children and young people aged 18 years and under, males are roughly four times more likely to experience autism as their primary disability than females (n = 403 and 105 respectively). Males also experience all other primary disabilities in higher numbers than females (Table 11).

It is important to note here that the DSQ data base is not a random sample of the population with a disability. In Queensland, people with a disability represent around 20 per cent of the population (n=686 700) (sourced from ABS, Survey of Disability, Ageing and Carers 1998b) while the DSQ data base has over 8,000 registrations.

DSQ's data base may also include those with higher support needs and is representative of the general population's familiarity with DSQ's services. Nonetheless, the higher disability rates of males aged 0 -14 years has also been found in the ABS's (1998b) survey, indicating a need for more rigorous investigation of why young males are at greater risk of having a disability than young females.

Table 11: Primary disability by sex for young people aged 0 - 18 years registered with DSQ - Queensland 2001

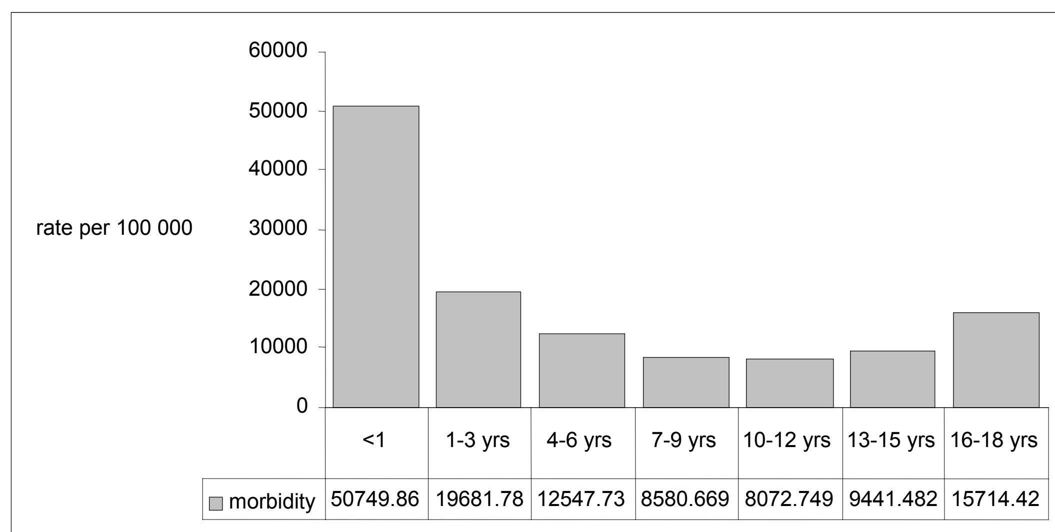
	Autism	HSV	Developmental delay	Intellectual	Neurological	Physical	Total
Female (n)	105	25	64	309	96	134	**733**
Male (n)	403	51	107	430	113	234	**1338**
Total (n)	508	76	171	739	209	368	**2071**

Source: Disability Services Queensland.
Note: due to small numbers some categories have been combined. HSV denotes Hearing, Speech and Vision disabilities and includes Deaf/Blind, Hearing, Speech and Vision. Neurological includes Neurological disabilities and Acquired Brain Injuries. Psychiatric Disabilities have also been excluded from the analyses, due to the small numbers.

Morbidity

Morbidity refers to all causes of illness for which children and young people may enter a hospital. For 2000/2001, estimated morbidity rates appear relatively stable in all age groups, with the single and dramatic exception of 'under ones', who are likely to enter hospital for a morbidity-related issue at a rate of 50 749.9 per 100 000. Morbidity steadily declines with age until adolescence, when it rises slightly for the 13 - 15 year olds age group (at a rate of 9 441.5 per 100 000) and then increases rapidly for those aged 16 -18 years at a rate of 15 714.4 per 100 000 (Chart 4).

Chart 4: Morbidity by age - Queensland 2000/2001 (rate per 100 000)



	<1	1-3 yrs	4-6 yrs	7-9 yrs	10-12 yrs	13-15 yrs	16-18 yrs
morbidity	50749.86	19681.78	12547.73	8580.669	8072.749	9441.482	15714.42

Source: Health Information Centre unpublished data.
(# Preliminary data obtained Dec, 01, subject to change)

Before considering the issue of morbidity in more detail, it is important to note that this report examines the top seven causes of morbidity for each group of interest. The top seven causes of morbidity were chosen on the basis of the *total number* of morbidity-related factors for which children and young people may enter hospital. The headings for causes of morbidity have been abbreviated from the original Principal Diagnosis definitions according to the ICD-10-AM Chapters. For a list of all Chapters, and full headings, see Appendix C.

Before examining the specific areas of interest in detail, it is useful to look at the patterns of morbidity, as indicated by the top seven Chapters for each group (Table 12). The top seven causes remain the same for all groups except Indigenous children and young people. For all other groups, the causes are respiratory, injury and poisoning, abnormal clinical laboratory findings, digestive diseases, infectious and parasitic diseases and other factors influencing health status. For Indigenous children and young people, the causes are slightly different, with pregnancy, childbirth and puerperium complications ranking in the top seven and factors influencing health status and contact with health services. Respiratory problems and injuries and poisoning are the top causes of morbidity-related illness for all groups of children and young people.

Table 12: Top seven causes of morbidity for children aged 0 - 18 according to number of episodes in hospital - Queensland 2000/2001

	All		Indigenous		Non Indigenous		Female		Male	
1	Injury, poisoning	22378	Diseases of the respiratory system	2260	Injury, poisoning	19553	Diseases of the respiratory system	9025	Injury, poisoning	14514
2	Diseases of the respiratory system	20973	Injury, poisoning	1573	Diseases of the respiratory system	17069	Injury, poisoning	7864	Diseases of the respiratory system	11948
3	Diseases of the digestive system	16086	Infectious and parasitic diseases	826	Diseases of the digestive system	13242	Diseases of the digestive system	7811	Diseases of the digestive system	8275
4	Factors influencing health status and contact with health services	10304	Diseases of the digestive system	735	Factors influencing health status and contact with health services	8891	Abnormal clinical and lab findings	4126	Factors influencing. health status and contact with health services	6259
5	Infectious and parasitic diseases	8672	Pregnancy, childbirth and the puerperium	701	Infectious and parasitic diseases	7303	Factors influencing health status and contact with health services	4045	Infectious and parasitic diseases	4642
6	Perinatal	8494	Abnormal clinical and lab findings	679	Perinatal	7119	Infectious and parasitic diseases	4030	Perinatal	4613
7	Abnormal clinical and lab findings	8164	Perinatal	662	Abnormal clinical and lab findings	6930	Perinatal	3880	Abnormal clinical and lab findings	4038

Source: Health Information Centre unpublished data.
(# Preliminary data obtained Dec, 01, subject to change)

If we examine the same table according to the rates per 100 000 it is evident that Indigenous children and young people are far more likely to experience a morbidity related factor. Indigenous children and young people experience diseases of the respiratory system at a rate of 3 919.5 per 100 000 compared with non-Indigenous children's experiences of respiratory diseases at a rate of 1 899.2 per 100 000. Males also have higher rates of morbidity than females, experiencing diseases of the respiratory system at a rate of 2 433.5 per 100 000 compared with females at 1 939.1 per 100 000.

Table 13: Top seven causes of morbidity for children aged 0 - 18 according to episodes in hospital - Queensland 2000/2001 (rate per 100 000)

	All		Indigenous		Not Indigenous		Female		Male	
1	Injury, poisoning	2339.8	Diseases of the respiratory system	3919.5	Injury, poisoning	2175.6	Diseases of the respiratory system	1939.1	Injury, poisoning	2956.1
2	Diseases of the respiratory system	2192.9	Injury, poisoning	2728.1	Diseases of the respiratory system	1899.2	Injury, poisoning	1689.6	Diseases of the respiratory system	2433.5
3	Diseases of the digestive system	1681.9	Certain infectious and parasitic diseases	1432.5	Diseases of the digestive system	1473.4	Diseases of the digestive system	1678.3	Diseases of the digestive system	1685.4
4	Factors influencing health status and contact with health services	1077.4	Diseases of the digestive system	1274.7	Factors influencing health status and contact with health services	989.3	Abnormal clinical and lab findings	886.5	Factors influencing health status and contact with health services	1274.8
5	Infectious and parasitic diseases	906.7	Pregnancy, childbirth and the puerperium	1215.7	Infectious and parasitic diseases	812.6	Factors influencing health status and contact with health services	869.1	Infectious and parasitic diseases	945.4
6	Perinatal	888.1	Abnormal clinical and lab findings	1177.6	Perinatal	792.1	Infectious and parasitic diseases	865.9	Perinatal	939.5
7	Abnormal clinical and lab findings	853.6	Perinatal	1148.1	Abnormal clinical and lab findings	771.1	Perinatal	833.6	Abnormal clinical and lab findings	822.4

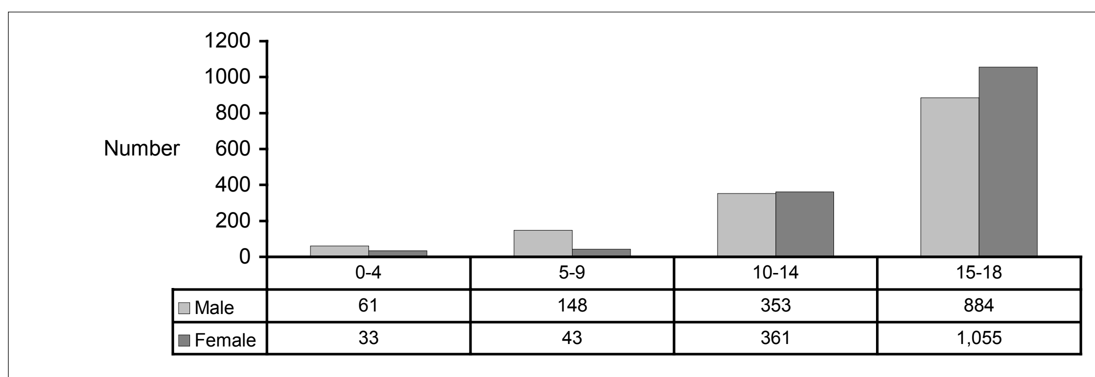
Source: Health Information Centre unpublished data.
(# Preliminary data obtained Dec, 01, subject to change)

Mental and Behavioural Disorders

The specific indicator of mental health, shows that as children grow into their teens, the number hospitalised due to mental illness increases (Chart 5). While hospitalisations for mental health are not one of the top seven causes of morbidity, it is still interesting to note that boys are more likely to suffer from mental illness than girls before the age of ten, after which the pattern reverses, although only marginally[10].

[10] Please note that the source of this data was hospital statistics (from both private and public hospitals). Children and young people being treated for mental health issues elsewhere (eg., Community Health, General Practitioners, private psychiatrists) or not being treated at all are therefore not included in this count.

Chart 5: Number of incidents requiring hospitalisation for mental health issues - Queensland 2000/01



Source: Health Information Centre unpublished data.
(# Preliminary data obtained Dec, 01, subject to change)

Mortality

The preceding morbidity data highlights the importance of the age category of less than one year. It is encouraging to see that the mortality rate in 2000 is lower than that of 1999 for all people aged 0 -18 years, dropping slightly from 55.6 to 54.4 per 100 000 between 1999 and 2000. However, for the high risk age of less than one year, the mortality rate rose from 580.7 per 100 000 to 627.8 per 100 000 (*see* Table 14).

Table 14: Mortality by age - Queensland (rate per 100 000)

	0 yrs	1-3 yrs	4-6 yrs	7-9 yrs	10-12 yrs	13-15 yrs	16-18 yrs	Total 0-18
1999	580.7	38.0	14.5	11.7	16.1	25.4	64.7	55.6
2000	627.8	29.2	16.4	13.5	12.4	20.8	56.0	54.4

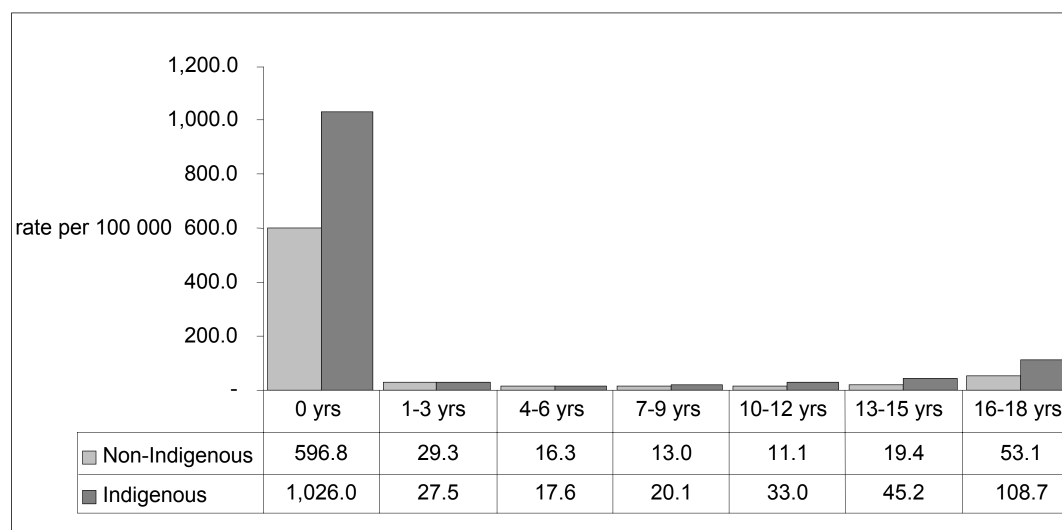
Source: ABS, Deaths Queensland 2000, unpublished data

Because of the very small numbers involved, each age group has not been collapsed by cause of mortality, but broad estimated mortality rates have been provided. Even so, caution should be exercised in interpreting the results.

Not surprisingly, the mortality rates of Indigenous infants outstrip the mortality rates of non-Indigenous infants, and the mortality rates for all Indigenous age groups remain higher than those of non-Indigenous groups (Chart 6). The greatest differences in 2000 are seen in the extremes of the age groups, with Indigenous children aged less than one year being nearly twice as likely to die as non-Indigenous children in the same age group (1026.0 compared with 596.8 per 100 000). Likewise, for those aged 16 - 18 years, Indigenous young people experienced a mortality rate of 108.7 per 100 000 compared with a mortality rate for non-Indigenous young people in the same age category of 53.1 per 100 000.

Countering this trend however, is the one to three year category, in which non-Indigenous children are actually more likely to die than Indigenous children (29.3 vs 27.3 per 100 000 respectively) (Chart 6).

Chart 6: Mortality by age and Indigenous status - Queensland 2000 (rate per 100 000)

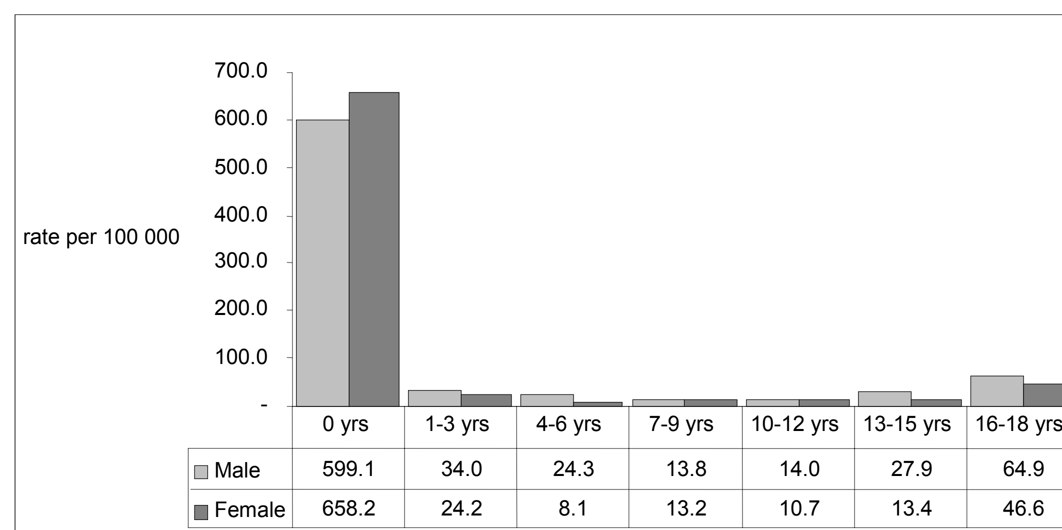


	0 yrs	1-3 yrs	4-6 yrs	7-9 yrs	10-12 yrs	13-15 yrs	16-18 yrs
Non-Indigenous	596.8	29.3	16.3	13.0	11.1	19.4	53.1
Indigenous	1,026.0	27.5	17.6	20.1	33.0	45.2	108.7

Source: ABS, Deaths Queensland 2000, unpublished data.

A different pattern is observed when we look at sex differences, with males being more likely to die in every age category except the less than one year category. Males have a mortality rate of 599.1 per 100 000 compared with females at 658.2 per 100 000 for this age group (Chart 7).

Chart 7: Mortality by age and sex - Queensland 2000 (rate per 100 000)



	0 yrs	1-3 yrs	4-6 yrs	7-9 yrs	10-12 yrs	13-15 yrs	16-18 yrs
Male	599.1	34.0	24.3	13.8	14.0	27.9	64.9
Female	658.2	24.2	8.1	13.2	10.7	13.4	46.6

Source: ABS, Deaths Queensland 2000, unpublished data

If we examine the causes of death for all aged 0 - 18 years, death due to external causes[11] (one of the most preventable causes of death) is the greatest cause of mortality for all groups except females (where it is second). This is followed by many of the causes most strongly associated with the deaths of those aged under one-year, ie. perinatal problems, deformation and clinical abnormalities. For males, diseases of the nervous

[11] External causes include: transport accidents, falls, exposure to mechanical forces, accidental drowning and submersion, other accidental threats to breathing, exposure to electric current, radiation, extreme ambient air temperature and pressure, exposure to smoke, fire and flames, exposure to venomous animals and plants, accidental poisoning, other external causes of accidental injury, intentional self-harm, assault, event of undetermined intent, complications of medical and surgical care and sequelae and supplementary factors.

system are the fifth highest cause of death, and for Indigenous children, diseases of the nervous, immune and respiratory system are all equal as the fifth highest cause of death (Table 15).

Again, it must be kept in mind that these rates per 100 000 have been calculated on the basis of very small actual numbers, so there is a need for caution when considering the implications of these data as mentioned earlier.

Table 15: Highest five causes of mortality for children aged 0-18 years - Queensland 2000 (rates per 100 000)

	1	2	3	4	5
Male	External 19.8	Perinatal 13.9	Deformation 8.9	Clinical Abnormality 4.4	Nervous system 3.6
Female	Perinatal 14.7	External 10.6	Deformation 10.0	Clinical Abnormality 5.5	Cancer 3.0
Non-Indigenous	External 14.4	Perinatal 13.5	Deformation 9.1	Clinical Abnormality 4.4	Cancer 3.1
Indigenous	External 29.1	Perinatal 25.8	Deformation 14.5	Clinical Abnormality 12.9	Respiratory/nervous system/immune system all equal at 3.2

Source: ABS, Deaths Queensland 2000, unpublished data.

One of the key indicators of concern in relation to young people and mortality is suicide. It can be seen that the rate of suicide for young people in Queensland was substantially lower than for other age groups, at 7.5 per 100 000 compared with 23.4 per 100 000 for the 20 - 39 age group. But although the rate is lower, it does not reduce the significance of the number of young people committing suicide. Young males are over twice as likely to commit suicide then young females, at a rate of 10.5 per 100 000 compared with 4.4 per 100 000 for females.

Table 16: Suicide for young people aged 19 years and under - Queensland 2000 (rates per 100 000)

	Males		Females		All persons	
Age Group	Number	Rate	Number	Rate	Number	Rate
10-19yr	28	10.5	11	4.4	39	7.5
20-39yr	196	36.7	54	10.1	250	23.4
40-59yr	132	28.0	35	7.6	167	17.9
60-79yr	52	23.5	15	6.4	67	14.7
80yr and over	13	37.3	5	-	18	18.9
All Ages	421	23.6	120	6.7	541	15.2

Source: Australian Institute for Suicide Research and Prevention, Griffith University.
Rates can not be calculated when the number of suicides is less than 10.

Access to housing

As previously noted, access to affordable housing is a key issue facing many disadvantaged families and young people at risk of homelessness. While data from SAAP (Supported Accommodation Assistance Program) is in no way representative of homelessness or general disadvantage, it is an indicator of the numbers of people requiring accommodation assistance.

Table 17 shows that young people are a relatively small proportion of SAAP clients, although young females appear more likely to require assistance and accommodation than young males. Females aged 0 - 19 years make up 12.5 per cent of SAAP's client base, compared with males at 9.4 per cent.

Table 17: SAAP clients by age - Queensland, 2000/2001

Age Group	% of total		Total number
	Male	Female	
<15 years	1.0	1.5	450
15-17 years	4.9	6.7	2050
18-19 years	3.5	4.3	1350
0-19 years	9.4	12.5	3850
>20	90.6	87.5	13750
Total			17600

Source: Adapted from SAAP National Data Collection Annual Report 2000-01 Queensland Supplementary Tables

It is important to remember that Table 17 only refers to individual clients. Many families with children may also require accommodation assistance.

Table 18 refers to services provided to SAAP clients. Please note that clients can receive multiple services, so percentages do not total 100. If we look at families with children, we can see that housing and accommodation and general support and advocacy (including assistance with legal issues, living skills, advice and information) are the two services required most by SAAP clients with children.

Interestingly, basic support and services (including meals, laundry and transport) are required far more by females with children (70.4 per cent) than by males with children (46.8 per cent) or couples with children (34.6 per cent). A similar pattern is also evident for counselling, which includes counselling about incest/sexual assault, domestic violence, family and relationships (Table 18).

Table 18: SAAP support periods: services provided to clients by client group - Queensland 2000/2001 (per cent)

	Client type		
Service type	Couple with children	Male with children	Female with children
Housing/accommodation	73.1	67.7	75.8
Financial/employment	50.7	53.5	51.1
Counselling	38.9	46.9	76.2
General support/advocacy	68.7	71.0	77.5
Specialist services	7.1	19.6	26.4
Basic support/services	34.6	46.8	70.4
None	2.1	8.7	1.3
Total (number)	1050.0	300.0	5350.0

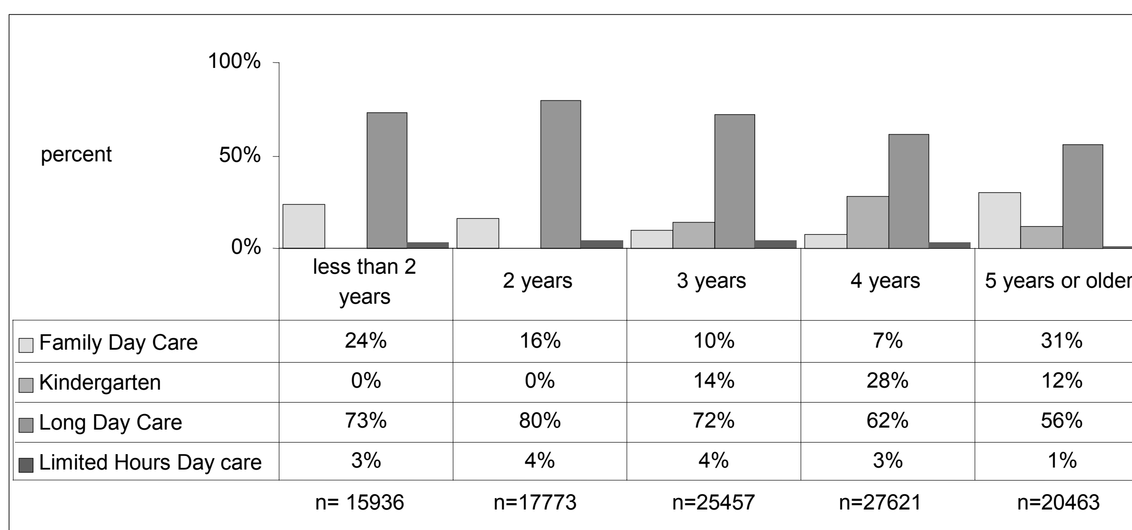
Source: Adapted from SAAP National Data Collection Annual Report 2000-01 Queensland Supplementary Tables

Education/childcare

In licensed child care services, the largest proportion of children across all age categories are placed in long day care. Eighty per cent of two-year-olds are placed in this type of child care.

Those aged five years and older (31 per cent) and those aged under two years (24 per cent) are placed in family day care next most often. A relatively small number of children are placed in limited hours day care (Chart 8).

Chart 8: Age category of children* attending licensed child care services by type of child care service[12] - Queensland 2000



	less than 2 years	2 years	3 years	4 years	5 years or older
Family Day Care	24%	16%	10%	7%	31%
Kindergarten	0%	0%	14%	28%	12%
Long Day Care	73%	80%	72%	62%	56%
Limited Hours Day care	3%	4%	4%	3%	1%
	n= 15936	n=17773	n=25457	n=27621	n=20463

Source Dept. of Families, Child Care Census 2000.
*Count of all children attending – includes part-time attendees and school aged children in after/before school or vacation care provided by licensed services.

Literacy and numeracy

Literacy and numeracy are two critical variables to be analysed when considering indicators of well-being. In Queensland, one source of data available on literacy and numeracy is the 2000 Queensland Years three, five and seven Testing Program. These tests were provided to a representative stratified random sample of approximately 10 per cent of Queensland Year three students and to all Year five and Year seven students of participating schools (QSCC, 2001: 1).

Insight into literacy levels in Queensland is obtained by assessing four separate aspects of literacy - reading, viewing, writing and spelling. Numeracy is assessed through the testing of number, measurement and data, and space. However, the adequacy of standardised pen and paper tests in gauging a student's competence in literacy and numeracy is highly contested in the education arena and the Queensland School Curriculum Council (QSCC) acknowledges that there are other important aspects of literacy and numeracy that cannot be tested in this way (QSCC, 2001: 3). For example, the tests assess student performances in Standard Australian English. This means that high literacy abilities in other languages, including Indigenous languages, may not be

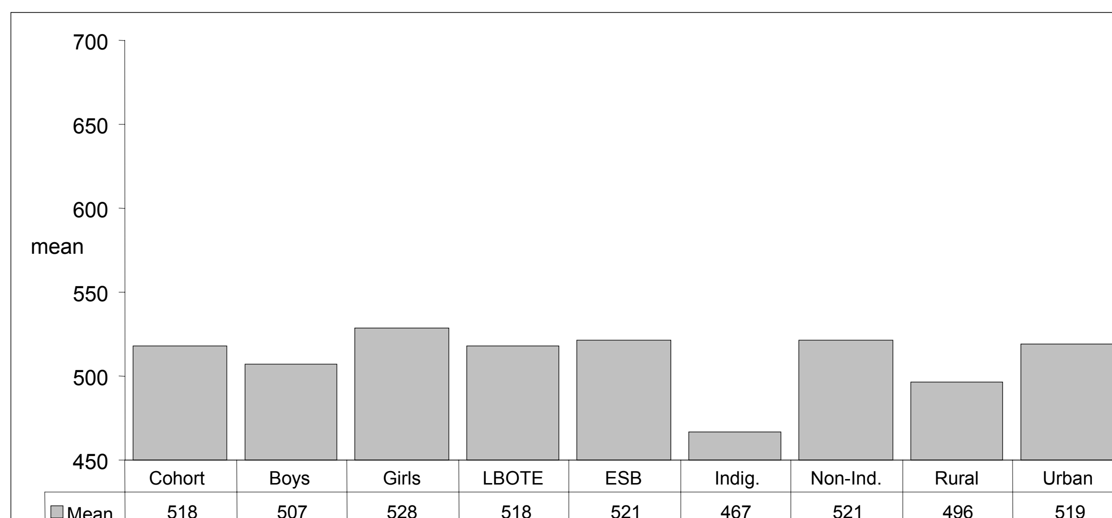
[12] Family Day Care schemes organise, co-ordinate and monitor family day care provided by carers in their homes. Kindergartens provide care for children three years and up to compulsory school age and operate for not more than six hours a day. Long day care centres provide care for more than 21 children at any time or operate for more than 20 hours in a week. Generally these centres operate for more than 10 hours a day and for more than 48 weeks a year. Limited hours care services provide care for up to 21 children and operate for not more than 20 hours a week. Limited hours care services do not provide care to any one child for more than 12 hours a week. For more information on the Childcare Census, see Department of Families, 2000.

captured, and other potentially valuable measures of literacy such as oracy and literacy skills relating to information technology are also not included (QSCC, 2001:3)[13]. In acknowledging the tests do not capture all aspects of literacy and numeracy, this report will consider only one aspect of each: *reading* as an aspect of literacy and *number* as an aspect of numeracy. These two strands have been chosen as being *indicative* of literacy and numeracy among Queensland students.

Reading Skills

The mean reading score for those in Year three in 2000 was 518. Females have slightly higher reading scores than males (means of 528 and 507 respectively with a difference of 21). Urban students have better reading scores than rural students, with reading scores of 519 and 496 respectively. For children in Year three, Indigenous children have a mean reading score of 467, in comparison to non-Indigenous children at 521 (a difference of 54). Interestingly, the mean score of students with a background other than English is similar to that of students with an English speaking background (Chart 9).

Chart 9: Mean reading score: Year 3 - Queensland 2000[14]



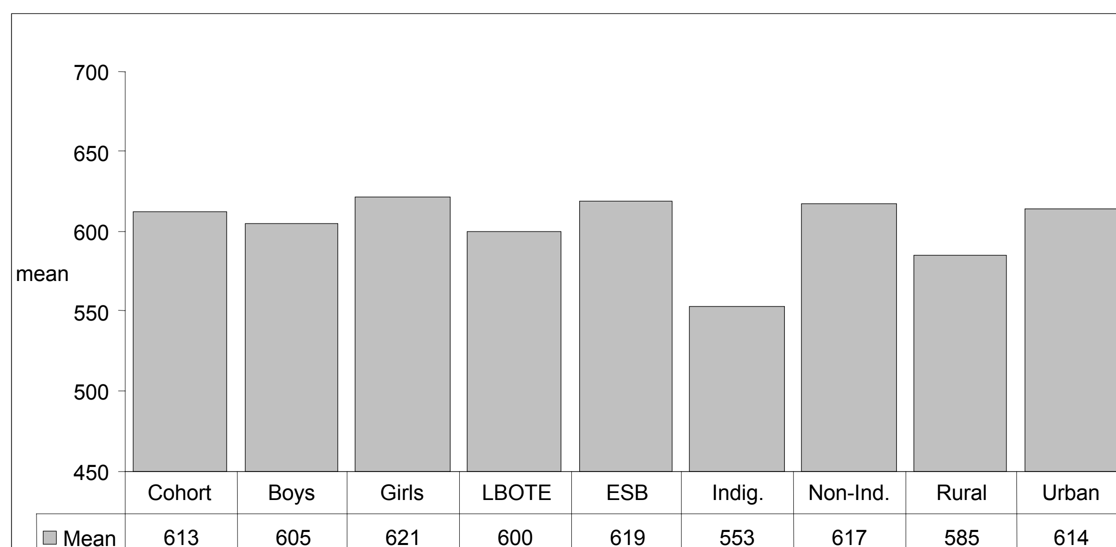
Source: Queensland School Curriculum Council

For children who were in Year five in 2000, the patterns are similar, although the disparities between groups have increased slightly. Indigenous children have a mean reading score of 553 compared with non-Indigenous children at 617, a difference of 64. Females have a mean reading score of 621 in comparison with males at 605, a difference of 16. Rural students score lower than urban students, with mean reading scores of 585 and 614 respectively, and students with a language background other than English have lower mean reading scores compared with students from an English speaking background (mean reading scores of 600 and 619 respectively) (Chart 10).

[13] For a detailed overview of all of the strands of literacy and numeracy scores in Queensland, see the Office of the Queensland School Curriculum Council (2001) 2000 Queensland, Statewide student performance in aspects of literacy and numeracy – Report to the Minister of Education.

[14] In the following education charts, all relevant variables have been collated in the one chart (i.e. Sex, Indigeneity, Rural and Urban status etc) for convenience. However, it is important to note that students in one group can also be members of other groups presented. In the following QSCC data, LBOTE indicates language background other than English and ESB indicates English speaking background.

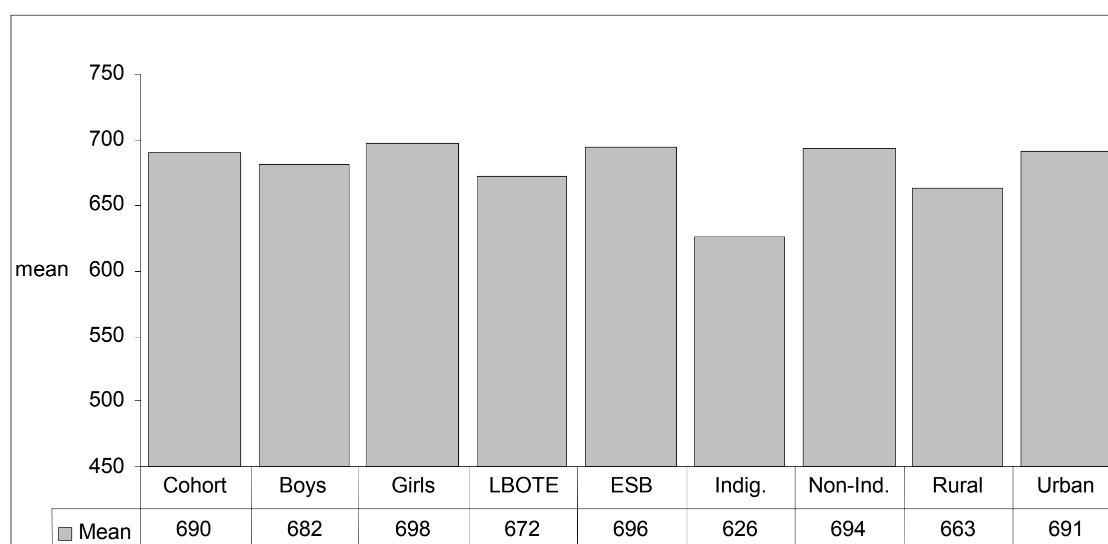
Chart 10: Mean Reading Score: Year 5 - Queensland 2000



Source: Queensland School Curriculum Council.

For students in Year seven in 2000, the same patterns are evident but with even wider disparities. Indigenous children have a mean reading score of 626 compared with non-Indigenous children at 694, a difference of 68. Females have a mean reading score of 698 in comparison with males at 682, a difference of 16 (Chart 11).

Chart 11: Mean Reading Score: Year 7 - Queensland 2000



Source: Queensland School Curriculum Council

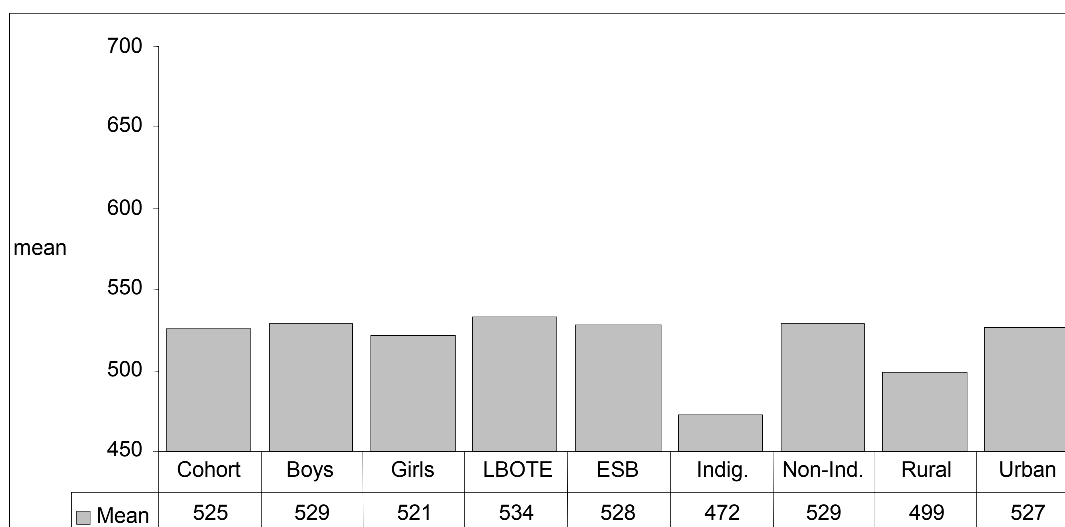
The preceding charts show there are distinct differences in reading scores at Year three, five and seven. The major concern is the indicators showing lower levels of literacy for Indigenous and rural children. In addition, the difference between the reading levels of Indigenous and non-Indigenous children appears to increase with age.

Number Skills

When we examine numeracy among year 3 students in 2000, or more specifically number skills, lower mean scores are again recorded for Indigenous children. Year three Indigenous students have a mean number score of 472 in comparison with non-

Indigenous children at 529, a difference of 57 - slightly more than the difference in reading at the same age. Males had slightly higher mean number scores than females (529 and 521 respectively). As with literacy skills, rural students had lower mean number scores than urban students, with mean number scores of 499 and 527 respectively (Chart 12).

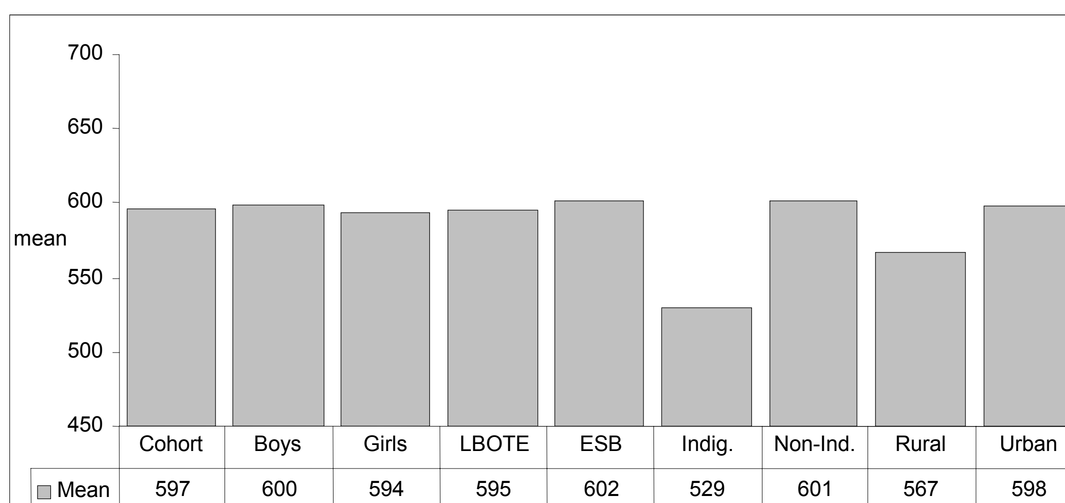
Chart 12: Mean Number Score: Year 3 - Queensland 2000



Source: Queensland School Curriculum Council

For those in Year five in 2000, the mean number score for Indigenous children was 529 compared with 601 for non-Indigenous children, a difference of 72. Males had slightly higher mean number scores than females, with mean scores of 600 and 594 respectively. Rural students had a mean number score of 567 in comparison with urban students at 598 (Chart 13).

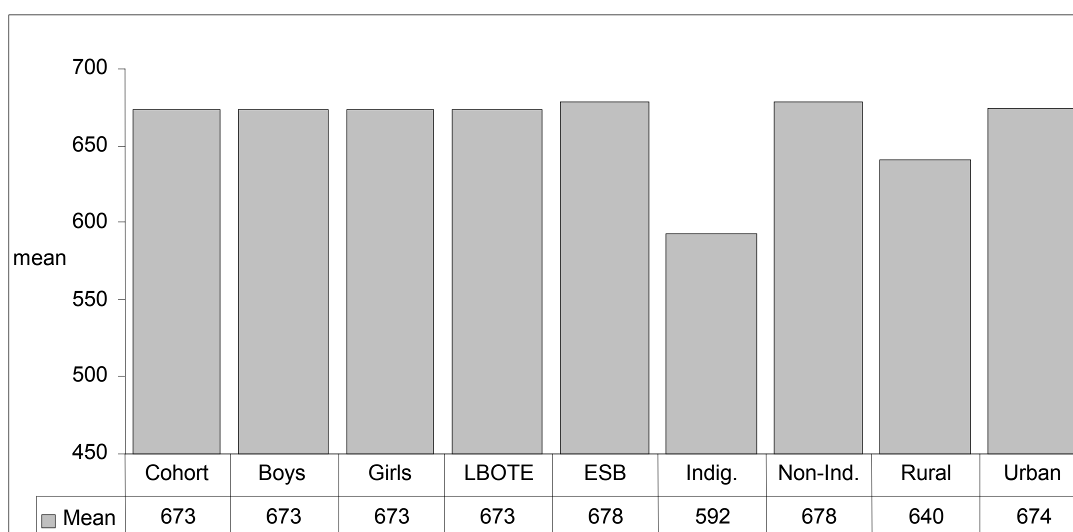
Chart 13: Mean Number Score: Year 5 - Queensland 2000



Source: Queensland School Curriculum Council

For those in Year seven in 2000, the disparity between Indigenous children and non-Indigenous children increased with age. Indigenous children had a mean number score of 592 compared with non-Indigenous students at 678 (a difference of 86). Females and males had mean scores of 673 respectively (Chart 14).

Chart 14: Mean Number Scores: Year 7 - Queensland 2000



Source: Queensland School Curriculum Council.

These aspects of literacy and numeracy data are extremely important. Indigenous children have lower mean scores in both reading and number skills in Year three, and these differences increase with age, particularly in regard to number skills, where there is a 57 point difference for students in Year three in 2000 compared with a 86 point difference for students in Year seven[15] . For males and females, the difference in mean scores decreases with age (Table 19).

Table 19: Difference in mean scores for literacy and numeracy by Indigenous status, rural/urban status and sex - Queensland 2000

		Year 3	Year 5	Year 7
Indigenous/non-Indigenous	Reading	54	64	68
	Numbers	57	72	86
Rural/Urban	Reading	23	29	28
	Numbers	28	31	34
Female/Male	Reading	21	16	16
	Numbers	-8	-6	0

Source: Queensland School Curriculum Council.

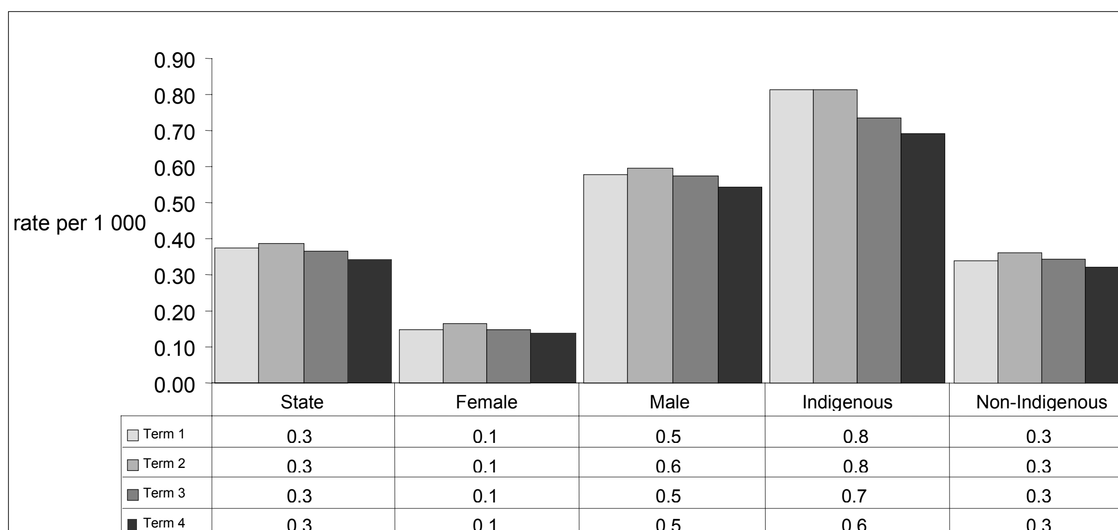
Disciplinary Absences

Student Disciplinary Absences are student absences from a state school as a result of suspensions, exclusions or cancellations of enrolment[16]. When we examine disciplinary absences, the 'danger' period for all children appears to be the second term, with a rate of 0.39 per 1 000 disciplinary absences per school day for state schools in term two in 2001. Females were less likely to experience disciplinary absences, at a rate of 0.15, 0.17, 0.15 and 0.14 per 1 000 for terms one, two, three and four respectively. Indigenous children had substantially more disciplinary absences than non-Indigenous children. In terms one and two of 2001, 0.81 per 1 000 Indigenous children were subject to a

[15] It is important to note that these students are different cohorts and so conclusions can not be drawn as to whether this trend is a cohort effect or a temporal effect.
[16] The following table refers only to Queensland State Schools. Suspension - prohibiting a student from attending an educational institution for a stated number of days. Exclusion - prohibiting a student from attending any number of or all state educational institutions for a period or permanently. Cancellation - prohibiting a student more than the age of compulsory attendance from attending that State educational institution whether for a period or permanently.

disciplinary absence, compared with 0.34 and 0.36 per 1 000 non-Indigenous children for the same time period. There was a sizeable drop in disciplinary absences for Indigenous children in term four, to 0.69 per 1 000 (Chart 15)[17].

Chart 15: Student disciplinary absences rates per 1000 students per school day by gender and Indigenous status - Queensland State School 2001



	State	Female	Male	Indigenous	Non-Indigenous
Term 1	0.3	0.1	0.5	0.8	0.3
Term 2	0.3	0.1	0.6	0.8	0.3
Term 3	0.3	0.1	0.5	0.7	0.3
Term 4	0.3	0.1	0.5	0.6	0.3

Source: Education Queensland, Performance Measurement and Review Branch (unpublished data).
The Student Disciplinary Absences comprise the total of short suspension (1-5 days), long suspension (6-20 days) exclusions and cancellations.
*The information is presented in terms of the average rate of SDAs per 1000 students per school day.

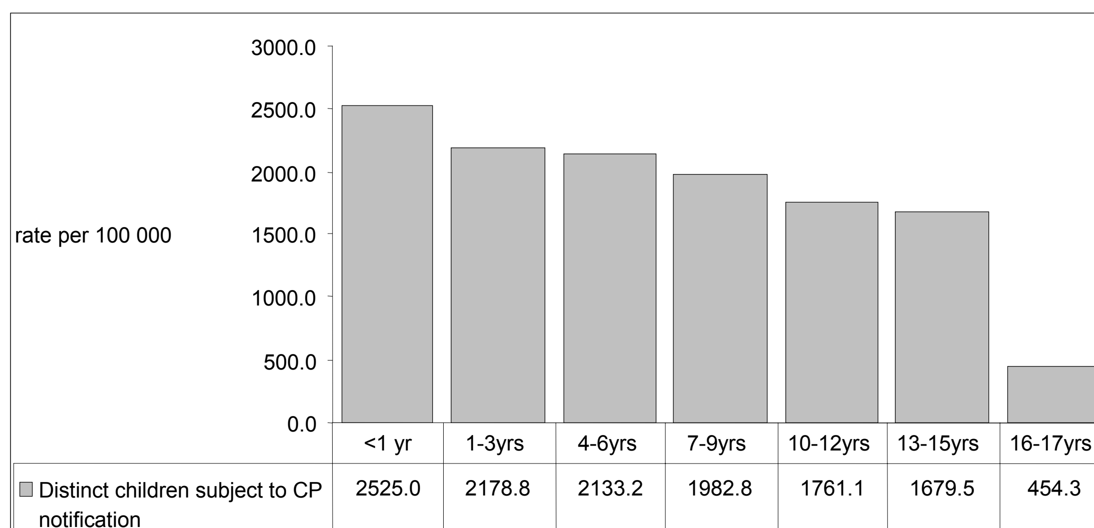
Victimisation and criminality

Child Protection

"A matter constitutes a child protection notification when information indicates that a child has been harmed or is at risk of harm and does not have a parent or other family member both willing and able to protect the child from harm" (Department of Families, 2001: 2). The following charts demonstrate that those aged under one year are most likely to be subject to a child protection notification (at an estimated rate of 2 525 per 100 000). This gradually decreases with age (Chart 16).

[17] As with the previous charts, all relevant variables have been collated in the one for the purpose of convenience. Students in one group can also be members of another of the groups presented.

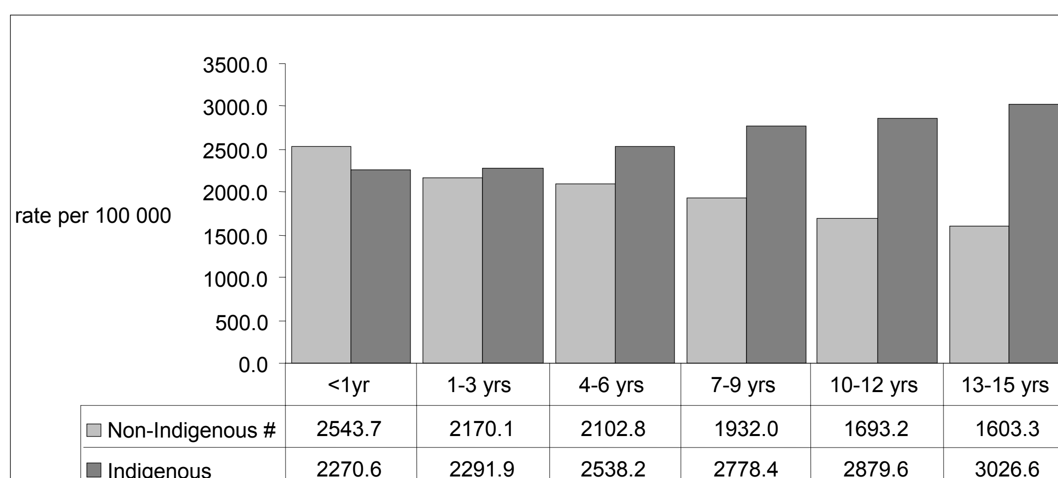
Chart 16: Distinct children subject to child protection notification - Queensland, 2000/2001 (rate per 100 000) [18]



Source: Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data.

What is less expected however, are the trends in Indigenous and non-Indigenous child protection notifications (Chart 17). Non-Indigenous children under one year are more likely to receive a child protection notification than Indigenous children under one year (2 543.7 in comparison with 2 270.6 per 100 000). But unlike previous trends, non-Indigenous children's notifications for child protection decrease with age, while Indigenous children and young people's notifications increase, from 2 270.6 per 100 000 aged less than one year to 3 026.6 per 100 000 aged 13 - 15 years.

Chart 17: Distinct children subject to child protection notification by Indigenous status - Queensland, 2000/2001 (rate per 100 000)

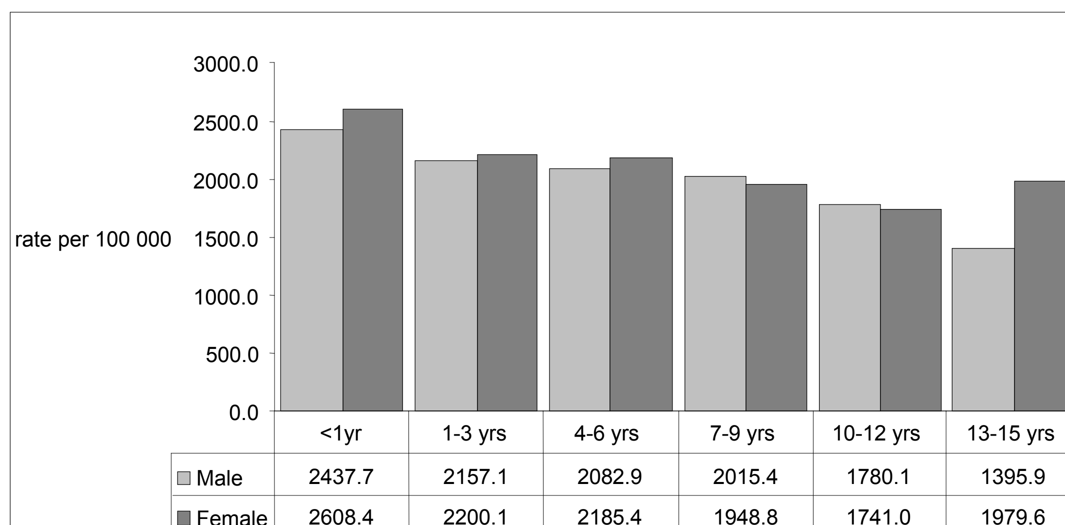


Source: Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data.
including non-Indigenous and those whose Indigenous status is unknown or not stated

The age most at risk is less than one year of age for both males and females (2 437.7 for males and 2 608.4 per 100 000 for females), which decreases with age (Chart 18). The only exception is females aged 13 - 15 years where a reasonably sharp increase can be seen to 1 979.6 per 100 000 child protection notifications, compared with boys of the same age, with 1 395.9 per 100 000 notifications.

[18] All 2000/2001 data from the Department of Families refers to 1 July 2000 to 30 June 2001

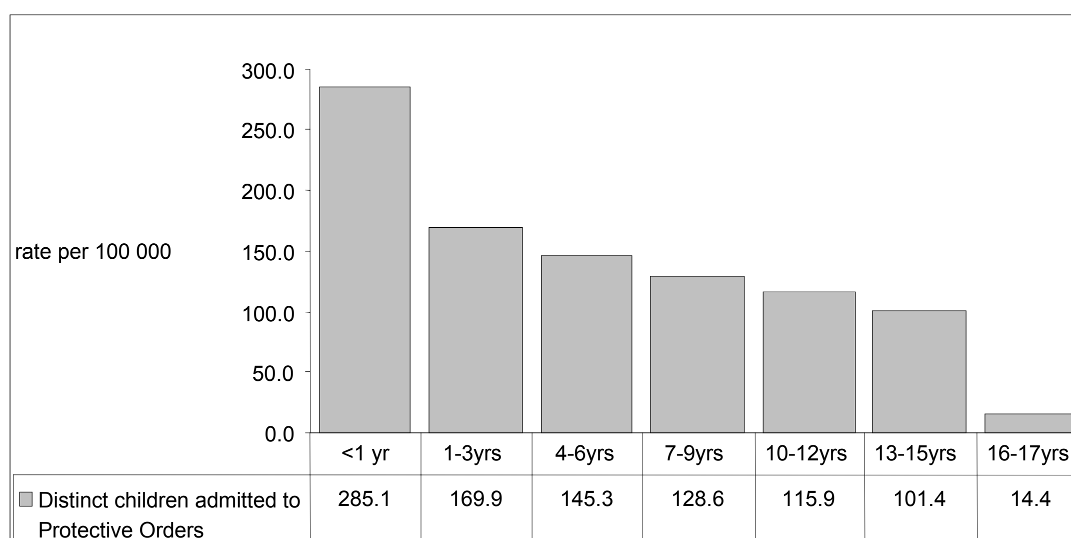
Chart 18: Distinct children subject to child protection notification by sex - Queensland 2000/2001 (rate per 100 000)



Source: Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data.

A child protection notification differs from a child protection order, which is a court order made under child protection legislation[19]. Again, children aged less than one are most likely to be admitted to a protective order at a rate of 285.1 per 100 000. There is a sharp drop in admissions to protective orders for children aged one to three years (169.9 per 100 000) which then decreases steadily with age (Chart 19).

Chart 19: Distinct children admitted to protective orders - Queensland 2000/2001 (rate per 100 000)



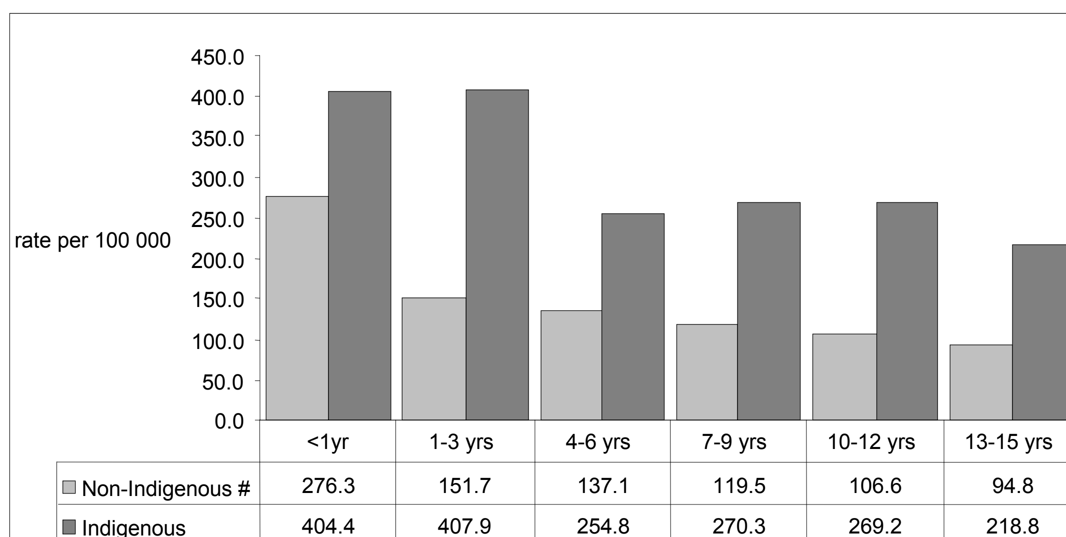
Source: Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data

If we dis-aggregate by age, it can be seen that Indigenous children, particularly under the age of three, were most likely to be admitted to protective orders in 2000/2001. There is little difference between Indigenous rates for those aged less than one year, and those aged one to three years, at 404.4 and 407.9 per 100 000 respectively. In contrast, there

[19] Admissions to orders are *new* orders made in the year, not including children currently on orders made in previous years, some of which may run until young people become 18 years of age.

is a sizeable decline for non-Indigenous children in the same age group, with 276.3 non-Indigenous children aged under one year and 151.7 per 100 000 non-Indigenous children aged one to three years being admitted to protective orders (Chart 20)[20].

Chart 20: Distinct children admitted to protective orders by Indigenous status - Queensland 2000/2001 (rate per 100 000)

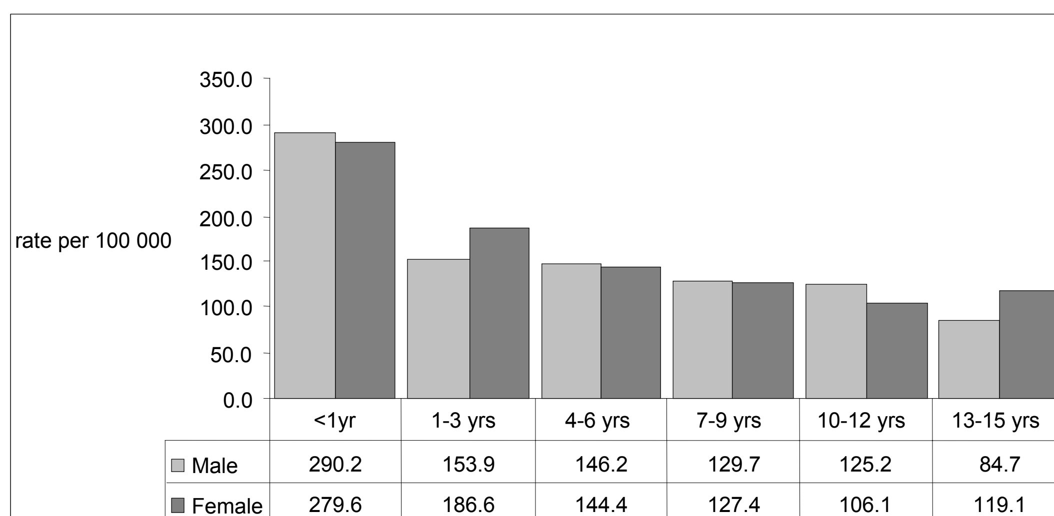


	<1yr	1-3 yrs	4-6 yrs	7-9 yrs	10-12 yrs	13-15 yrs
Non-Indigenous #	276.3	151.7	137.1	119.5	106.6	94.8
Indigenous	404.4	407.9	254.8	270.3	269.2	218.8

including non-Indigenous and those whose Indigenous status is unknown or not stated
Source: Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data

Males under the age of one year are slightly more likely to be admitted to protective orders than females of the same age, at 290.2 and 279.6 per 100 000 respectively in 2000/2001. This then changes for the one to three year age group, with females being more likely to be placed on orders than males at 186.6 in comparison with 153.9 per 100 000 (Chart 21).

Chart 21: Distinct children admitted to protective orders by sex - Queensland, 2000/2001 (rate per 100 000)



	<1yr	1-3 yrs	4-6 yrs	7-9 yrs	10-12 yrs	13-15 yrs
Male	290.2	153.9	146.2	129.7	125.2	84.7
Female	279.6	186.6	144.4	127.4	106.1	119.1

Source: Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data.

[20] The category of 16 to 17 years has been dropped from analyses due to the small numbers.

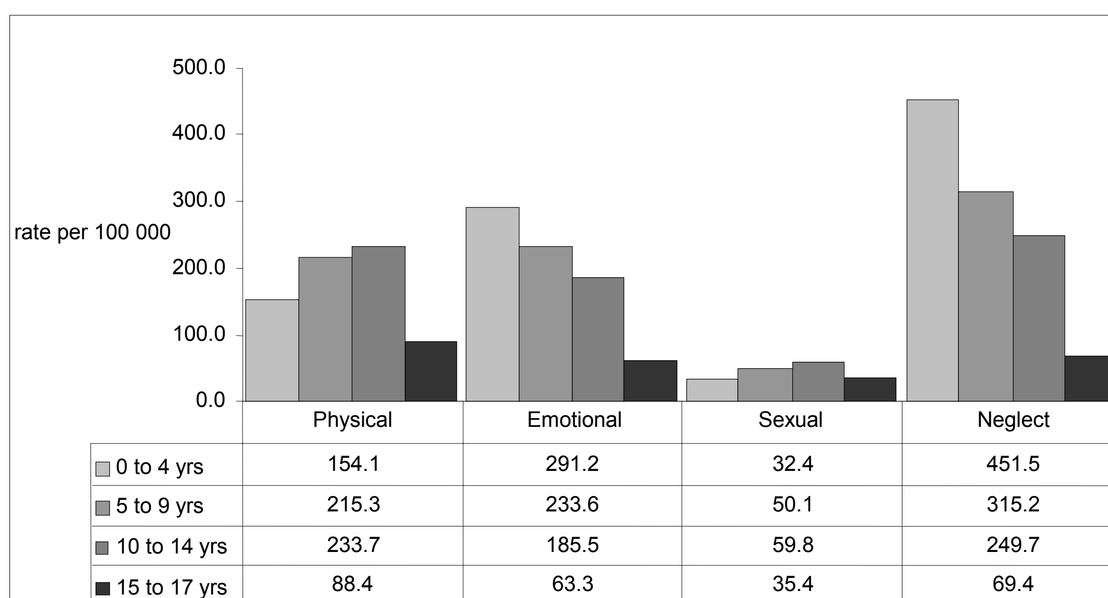
Protective orders by most serious type of harm

It is important to consider the types of harm to children and young people for which there are substantiated notifications. In the charts below, slightly different age categories are used to those used previously[21]. In the later charts the category of sexual harm has been excluded as the very small numbers involved allow the potential identification of individuals.

The charts below indicate quite different trends, according to age, for the different types of harm. For the category of neglect, those aged zero to four years are the most at risk, at a rate of 451 per 100 000, This decreases to 249.8 per 100 000 for 10 - 14 year olds (Chart 22). A similar trend is evident for emotional harm (although the numbers are lower) where zero to four year olds are most at risk at a rate of 291.2 per 100 000, decreasing to 185.5 for 10 - 14 year olds.

In contrast, the incidence of physical harm appears to increase with age. Zero to four year olds experience physical harm at a rate of 154.1 per 100 000 compared with 10 - 14 year olds, who experience physical harm at a rate of 233.7 per 100 000 (Chart 22). There appears to be a similar trend, increasing with age, for sexual harm, although the rates are so small they should be treated cautiously.

Chart 22: Distinct children subject to substantiated (including substantiated risk) notification, by age group by most serious type of harm substantiated - Queensland, 2000/2001 (rate per 100 000)



	Physical	Emotional	Sexual	Neglect
0 to 4 yrs	154.1	291.2	32.4	451.5
5 to 9 yrs	215.3	233.6	50.1	315.2
10 to 14 yrs	233.7	185.5	59.8	249.7
15 to 17 yrs	88.4	63.3	35.4	69.4

Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data.

Slightly different trends can be seen when we look at the same measures by Indigenous status (Chart 23). The increase in physical harm by age is substantial for Indigenous children. The estimated rate for Indigenous children more than doubles from 252.5 (for zero to four year olds) to 568.7 (for 10 - 14 year olds). Indigenous children appear to experience relatively stable rates of substantiated emotional harm notifications (413.8 per 100 000 for zero to four year olds and 411.2 per 100 000 for 10 - 14 year olds) while non-Indigenous children appear to experience a slight decrease in emotional harm over age.

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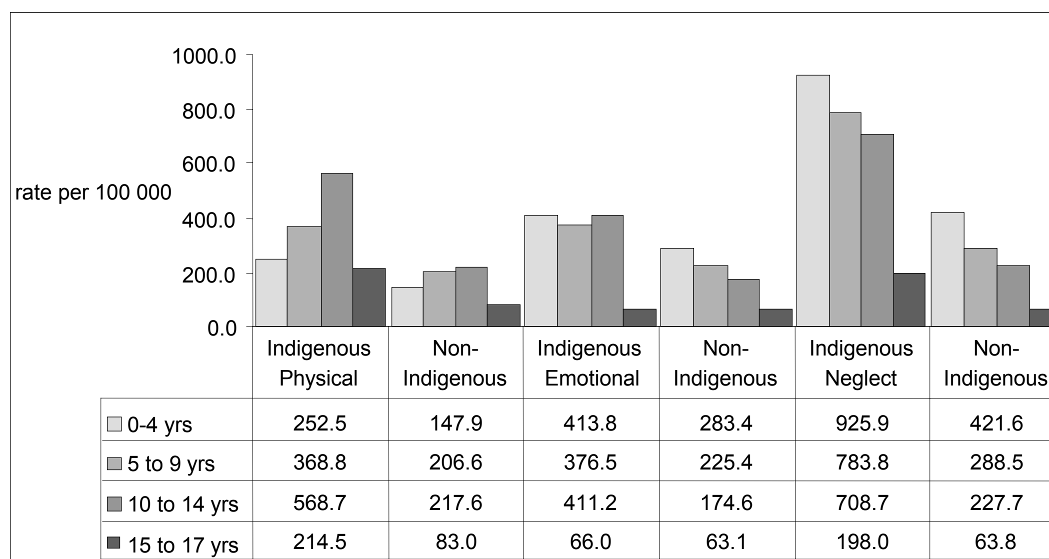
[21] The age categories are those supplied by the Department of Families. The rates for types of harm substantiated have been calculated using ABS, 1996 *Census of Population and Housing* population data.

For both groups, neglect is the most likely harm substantiated for zero to four year olds (925.9 per 100 000 for Indigenous children and 451.6 per 100 000 for non-Indigenous children).

Chart 23: Distinct children subject to substantiated (including substantiated risk) notification, Indigenous status by age group by most serious type of harm substantiated - Queensland 2000/2001 (rate per 100 000)

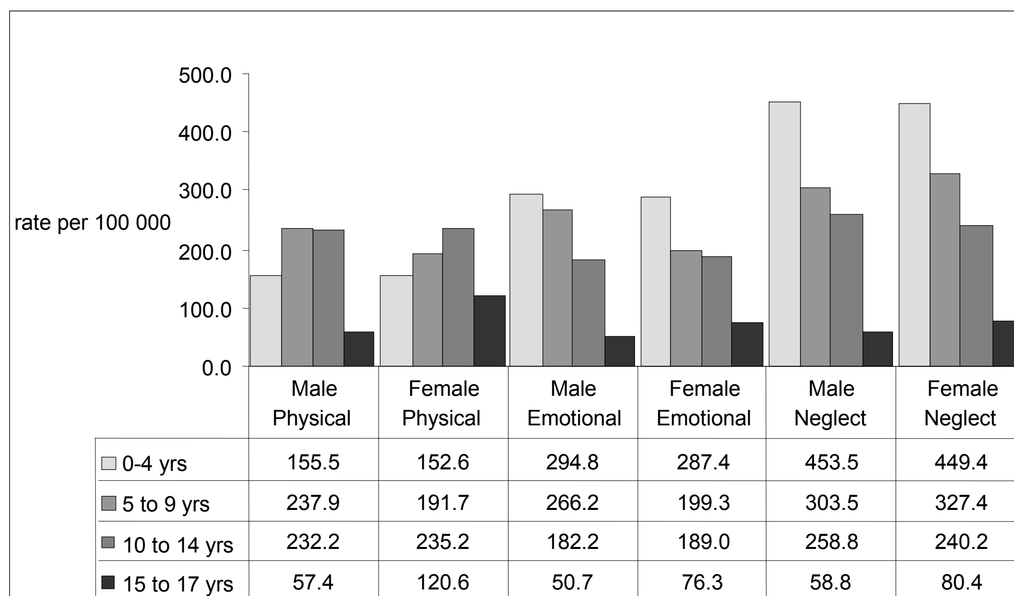


	Indigenous Physical	Non-Indigenous	Indigenous Emotional	Non-Indigenous	Indigenous Neglect	Non-Indigenous
0-4 yrs	252.5	147.9	413.8	283.4	925.9	421.6
5 to 9 yrs	368.8	206.6	376.5	225.4	783.8	288.5
10 to 14 yrs	568.7	217.6	411.2	174.6	708.7	227.7
15 to 17 yrs	214.5	83.0	66.0	63.1	198.0	63.8

Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data.

There are more similarities between females and males for types of harm substantiated (Chart 24), although males aged five to nine years are more likely to experience physical harm than females of the same age (220.6 vs 179.4 per 100 000). Males in this age group are also slightly more likely to experience emotional harm than females of the same age groups (237.9 vs 191.7 per 100 000). Particularly concerning is the fact that the usual substantial drop in harm for the 15 - 17 year old age group is not as strong for females aged 15 - 17 years. This group experience physical harm at a rate of 120.6 per 100 000.

Chart 24: Distinct children subject to substantiated (including substantiated risk) notification, sex by age group by most serious type of harm substantiated - Queensland, 2000/2001 (rate per 100 000)



	Male Physical	Female Physical	Male Emotional	Female Emotional	Male Neglect	Female Neglect
0-4 yrs	155.5	152.6	294.8	287.4	453.5	449.4
5 to 9 yrs	237.9	191.7	266.2	199.3	303.5	327.4
10 to 14 yrs	232.2	235.2	182.2	189.0	258.8	240.2
15 to 17 yrs	57.4	120.6	50.7	76.3	58.8	80.4

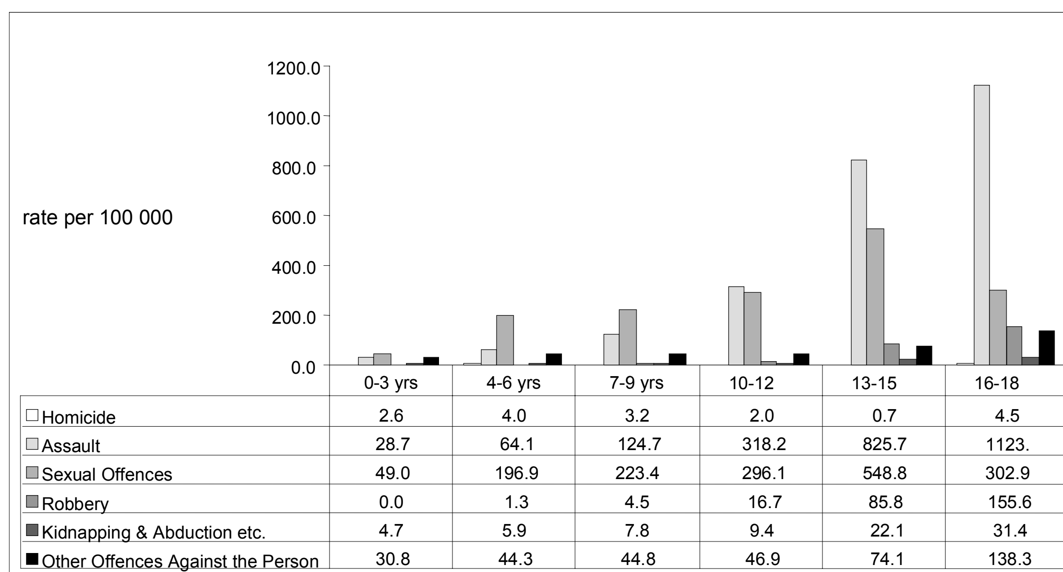
Source: Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data.

Police

Child protection data refers only to those children deemed 'at risk' by the Department of Families. Police victim data can also help ascertain the safety of Queensland's children and young people. For those aged zero to three years, 49.0 per 100 000 children have experienced a recorded offence for sexual assault. This peaks for those aged 13 - 15 years, at 548.8 per 100 000, before dropping again at 16 - 18 years to a rate of 302.9 per 100 000 (Chart 25).

However, experiencing a crime of assault increases steadily with age, starting at a rate of 28.7 per 100 000 for zero to three year olds and increasing to a rate of 1 123.7 per 100 000 for 16 - 18 year olds.

Chart 25: Offences against the person[22] by age - Queensland 2000/2001 (rate per 100 000)

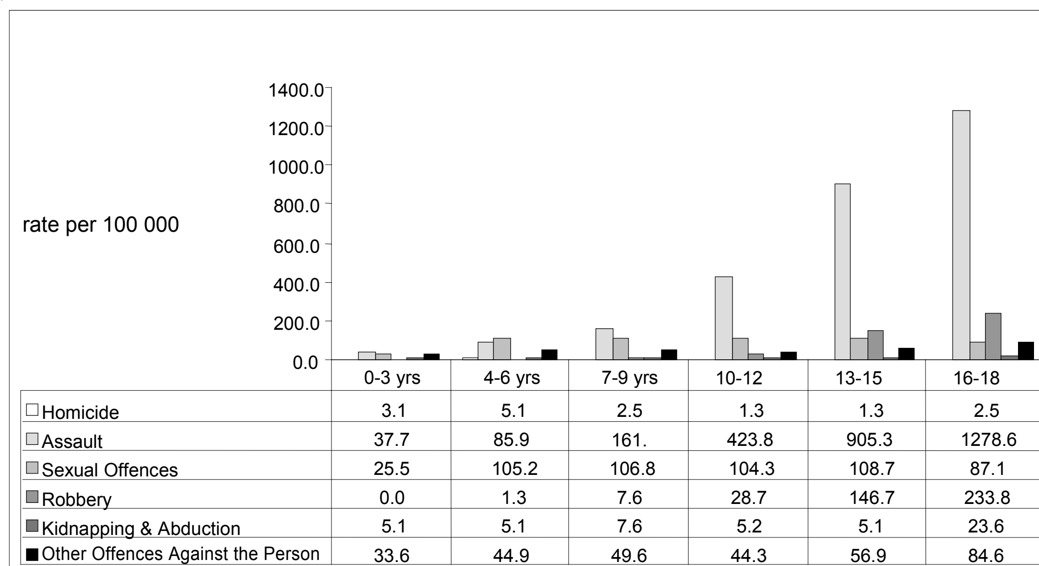


	0-3 yrs	4-6 yrs	7-9 yrs	10-12	13-15	16-18
Homicide	2.6	4.0	3.2	2.0	0.7	4.5
Assault	28.7	64.1	124.7	318.2	825.7	1123.
Sexual Offences	49.0	196.9	223.4	296.1	548.8	302.9
Robbery	0.0	1.3	4.5	16.7	85.8	155.6
Kidnapping & Abduction etc.	4.7	5.9	7.8	9.4	22.1	31.4
Other Offences Against the Person	30.8	44.3	44.8	46.9	74.1	138.3

Source: Queensland Police Service (QPS) unpublished data.

The previous patterns appear to be strongly associated with the sex of the victim. Young males experiencing an assault appear to be driving the earlier trend, with 1 278.6 per 100 000 16 - 18 year olds experiencing this offence. In contrast, all other offence categories are experienced under a rate of 150 per 100 000 (Chart 26).

Chart 26: Offences against the person for males by age - Queensland 2000/2001 (rate per 100 000)



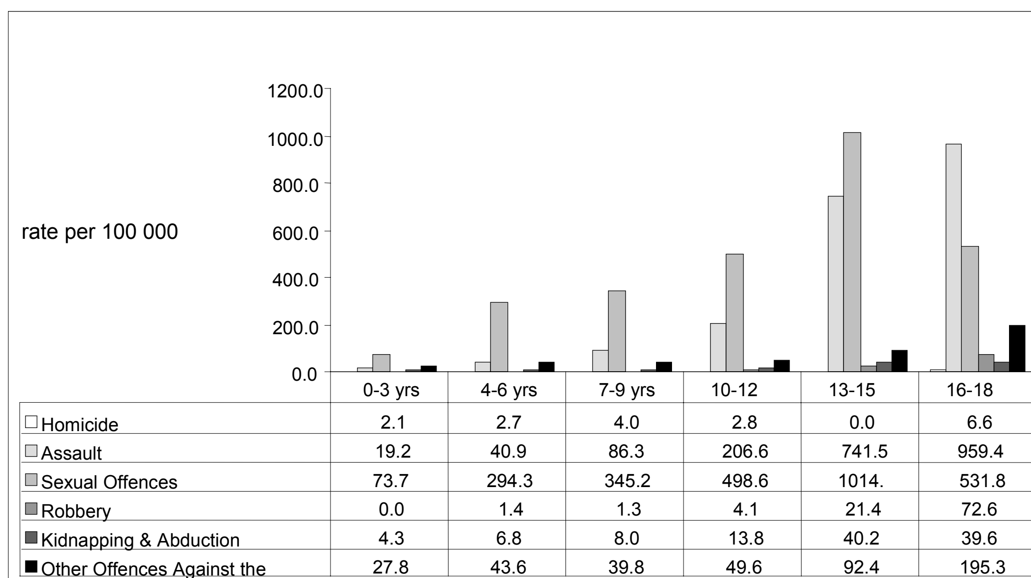
	0-3 yrs	4-6 yrs	7-9 yrs	10-12	13-15	16-18
Homicide	3.1	5.1	2.5	1.3	1.3	2.5
Assault	37.7	85.9	161.	423.8	905.3	1278.6
Sexual Offences	25.5	105.2	106.8	104.3	108.7	87.1
Robbery	0.0	1.3	7.6	28.7	146.7	233.8
Kidnapping & Abduction	5.1	5.1	7.6	5.2	5.1	23.6
Other Offences Against the Person	33.6	44.9	49.6	44.3	56.9	84.6

Source: QPS unpublished data.

Females experience a similar increase in assault over age, but at a lesser rate, peaking at 959.4 per 100 000 for 16 to 18 year olds. They are most likely to experience sexual assault at ages 13 - 15 years, at a rate of 1 014.6 per 100 000, which drops off reasonably sharply at age 16 - 18 to a rate of 531.8 per 100 000 (Chart 27).

[22] It needs to be remembered here that the rates of offences against the person reported here are only of those offences that have been reported to police, and hence do not represent rates of all victimisation.

Chart 27: Offences against the person for females by age - Queensland 2000/2001 (rate per 100 000)

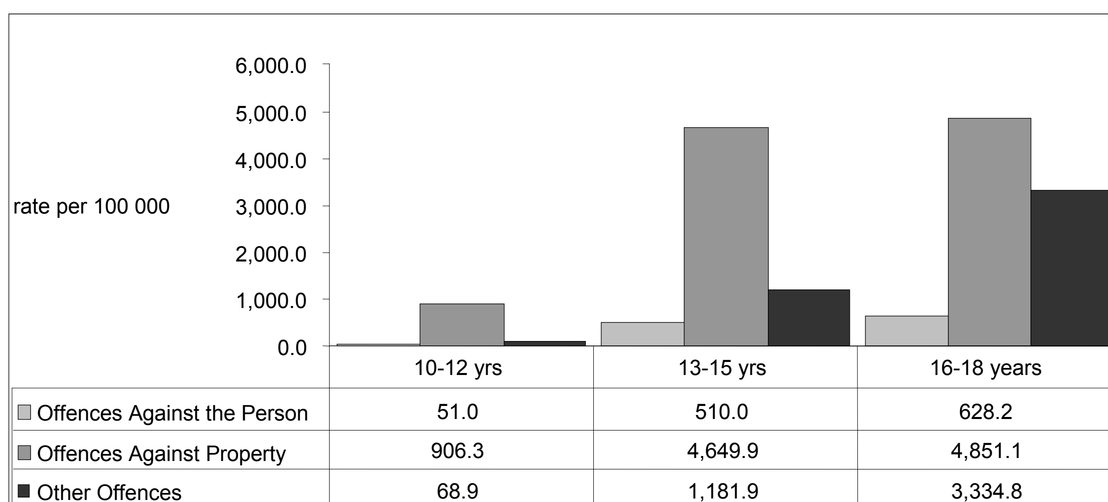


	0-3 yrs	4-6 yrs	7-9 yrs	10-12	13-15	16-18
Homicide	2.1	2.7	4.0	2.8	0.0	6.6
Assault	19.2	40.9	86.3	206.6	741.5	959.4
Sexual Offences	73.7	294.3	345.2	498.6	1014.	531.8
Robbery	0.0	1.4	1.3	4.1	21.4	72.6
Kidnapping & Abduction	4.3	6.8	8.0	13.8	40.2	39.6
Other Offences Against the	27.8	43.6	39.8	49.6	92.4	195.3

Source: QPS unpublished data.

If we examine offences committed by young people (obtained from police data)[23], predictable patterns arise. The most common offence category for females is property offences. All offences increase with age, although the really large increase occurs from 10 - 12 years to 13 - 15 years of age. For example, offences against the person are recorded at a rate of 51.0 per 100 000 for 10 - 12 year old females, jumping markedly to 510.0 per 100 000 for 13 - 15 year olds, and increasingly slightly again to 628.2 per 100 000 for 16 - 18 year olds (Chart 28).

Chart 28: Offences by females by age - Queensland 2000/2001 (rate per 100 000)



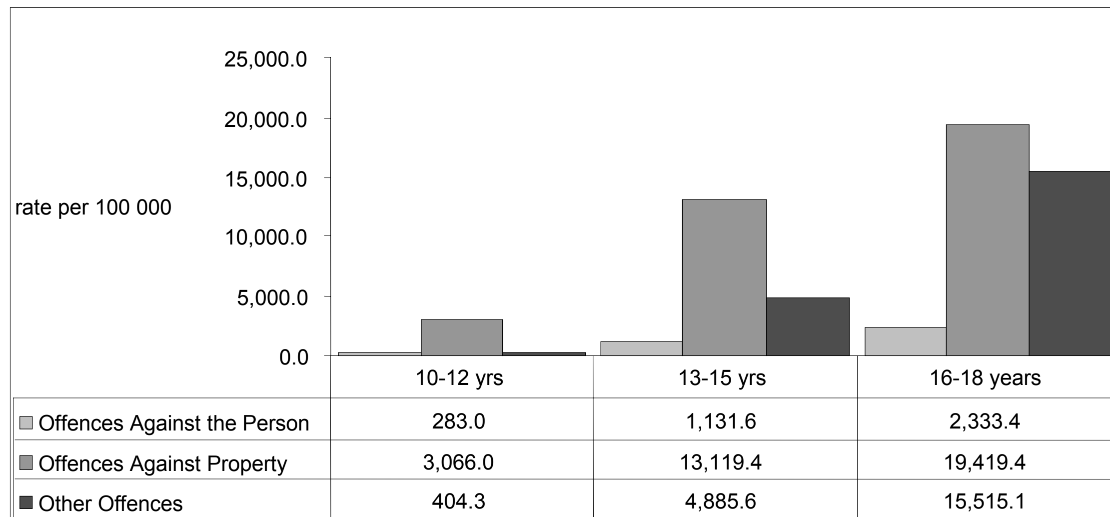
	10-12 yrs	13-15 yrs	16-18 years
Offences Against the Person	51.0	510.0	628.2
Offences Against Property	906.3	4,649.9	4,851.1
Other Offences	68.9	1,181.9	3,334.8

Source: QPS unpublished data

Offence patterns for males show far higher offence rates than those observed for females. Offences against property remain the most likely offence, being recorded at 19 419.4 per 100 000 for 15 - 18 year olds. As with females, all offences increase with age. The most evident increase is that from 10 - 12 years to 13 - 15 years (Chart 29).

[23] These figures do not equate to a unique offender count, rather they illustrate the number of offenders associated with each offence cleared per offence category.

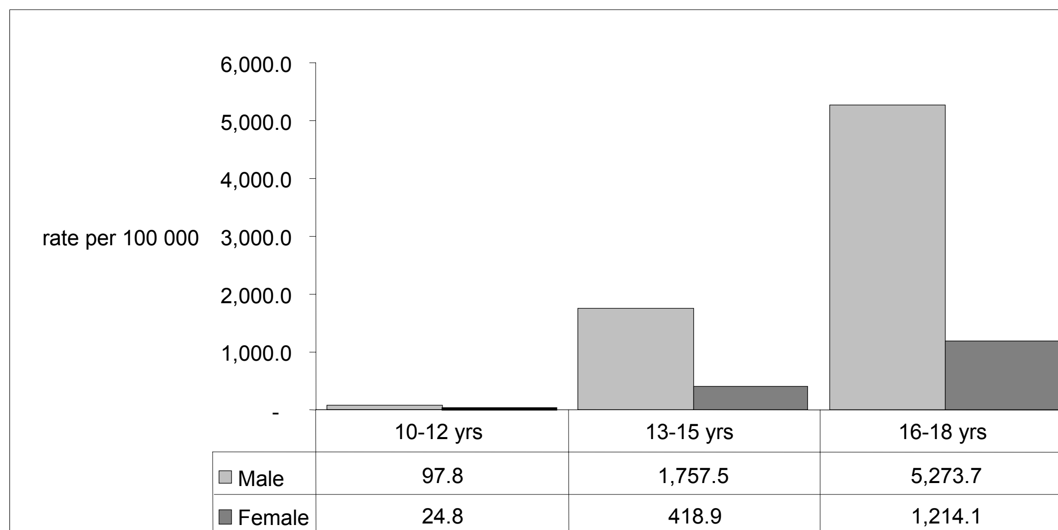
Chart 29: Offences by males by age - Queensland 2000/2001 (rate per 100 000)



Source: QPS unpublished data

Finally, if we examine one particular aspect of interest in offending behaviours - drug offences – it can be seen that males are substantially more likely to be recorded in police statistics for drug offences than are females. This is particularly evident for 16 - 18 year olds, where 5 273.7 per 100 000 males are recorded as committing drug offences, compared with 1 214.1 per 100 000 similar offences for females of the same age group.

Chart 30: Drug Offences by sex and age - Queensland 2000/2001 (rate per 100 000)



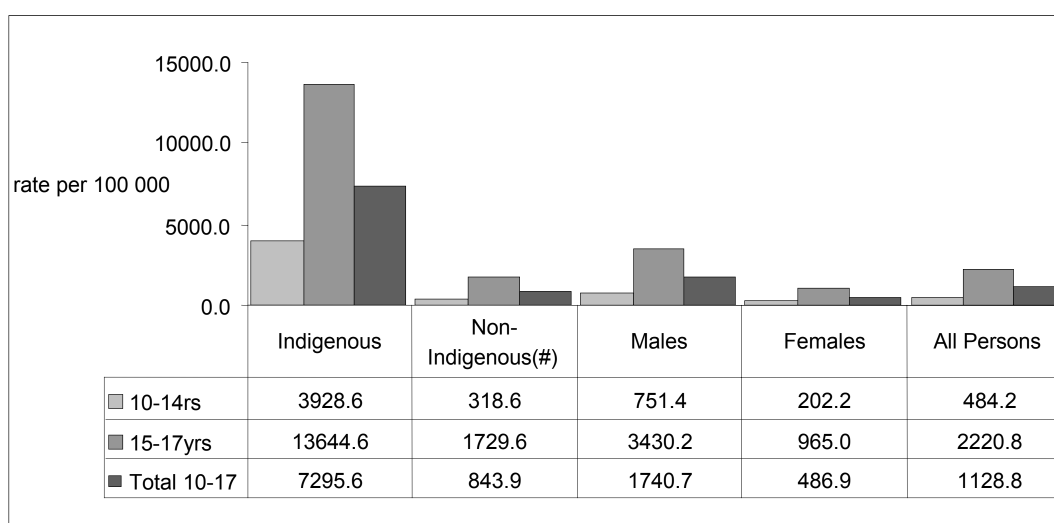
Source: QPS unpublished data.

Juvenile Justice (Offenders)

The final category of interest in this snapshot of children and young people in Queensland is young offenders[24]. Overall, 1128.8 per 100 000 young people aged 10 - 17 appeared in court in 2000/2001. Both males and Indigenous young people are over-represented, particularly in the 15 - 17 year category. Indigenous young people aged 15 - 17 are the most likely to appear in court, at a rate of 13 644.6 per 100 000 in comparison with non-Indigenous young people of the same age who appear in court at a rate of 1 729.6 per 100 000. However, the age-related increase is much greater for non-Indigenous young people, who are almost six times more likely to appear in court at 15 - 17 years of age, than from 10 - 14, compared with Indigenous young people, who experience a threefold increase in court appearances over the same age range (Chart 31).

Males are also significantly more likely than females to appear in court for offences, at a rate of 1740.7 per 100 000 for all 10 - 17 year olds. Females aged 10 - 17 years appeared in court at a rate of 486.9 per 100 000 in 2000/2001.

Chart 31: Distinct children appearing in court for offences, Indigenous status and sex by age of child at earliest appearance data in period - Queensland 2000/2001 (rate per 100 000)



	Indigenous	Non-Indigenous(#)	Males	Females	All Persons
10-14rs	3928.6	318.6	751.4	202.2	484.2
15-17yrs	13644.6	1729.6	3430.2	965.0	2220.8
Total 10-17	7295.6	843.9	1740.7	486.9	1128.8

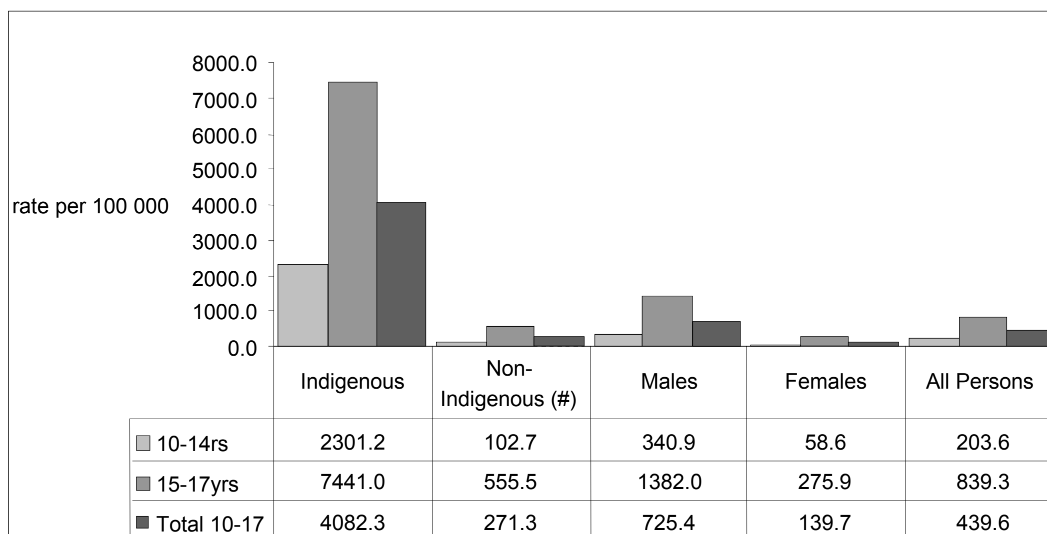
Including non-Indigenous and those whose Indigenous status is unknown or not stated.
Source: Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data.

Youth Justice Orders (supervised/unsupervised)

There are also interesting patterns evident for individuals on youth justice orders. In comparing supervised and unsupervised orders, it can be seen that all groups are more likely to end up on an unsupervised order. Indigenous young people are over-represented in both categories, with 2 301.2 per 100 000 Indigenous children aged 10 - 14 and 7 441.0 per 100 000 Indigenous children aged 15 - 17 being placed on a supervised youth justice order, compared with 102.7 and 555.5 per 100 000 non-Indigenous children respectively (Chart 32). Males are substantially more likely to be placed on a supervised order than females, who have an estimated rate of 1 382.0 vs 275.9 per 100 000 in the high risk age category of 15 - 17 year olds.

[24] The rates for the following juvenile justice data have been calculated using ABS, 1996 Census of Population and Housing population data.

Chart 32: Distinct children placed on supervised youth justice orders, age of child at earliest appearance date in period by Indigenous status and sex - Queensland 2000/2001 (rate per 100 000)

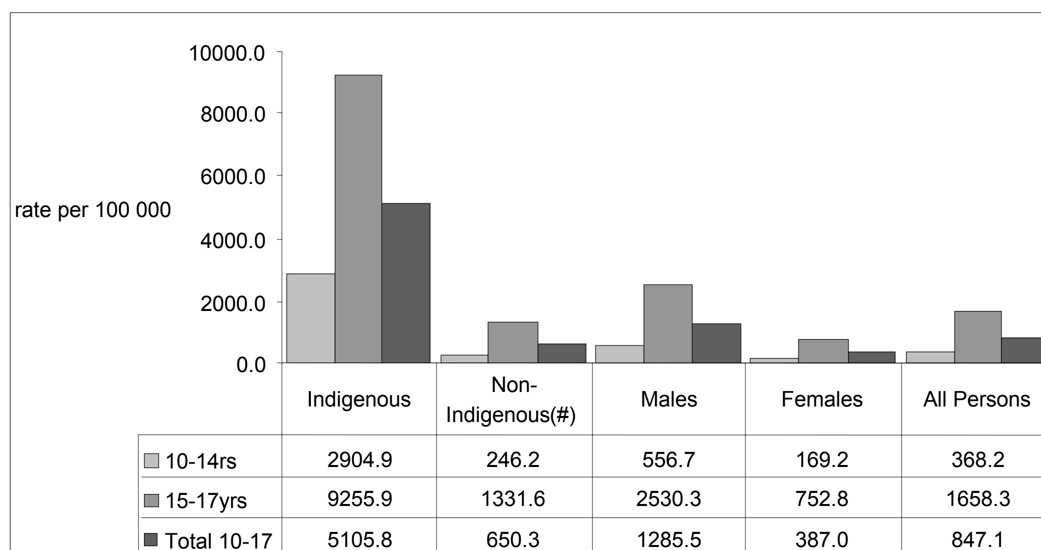


	Indigenous	Non-Indigenous (#)	Males	Females	All Persons
10-14rs	2301.2	102.7	340.9	58.6	203.6
15-17yrs	7441.0	555.5	1382.0	275.9	839.3
Total 10-17	4082.3	271.3	725.4	139.7	439.6

Including non-Indigenous and those whose Indigenous status is unknown or not stated.
Source: Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data.

For non-supervised youth justice orders, 2 904.9 per 100 000 Indigenous children aged 10 - 14 years were served with an unsupervised youth justice order, as were 9 255.9 per 100 000 Indigenous young people aged 15 - 17 years. Of all categories, the 15 to 17 year old age group is most at risk of being served an unsupervised youth justice order (Chart 33).

Chart 33: Distinct children placed on unsupervised youth justice orders, age of child at earliest appearance date in period by Indigenous status and sex - Queensland 2000/2001 (rate per 100 000)



	Indigenous	Non-Indigenous(#)	Males	Females	All Persons
10-14rs	2904.9	246.2	556.7	169.2	368.2
15-17yrs	9255.9	1331.6	2530.3	752.8	1658.3
Total 10-17	5105.8	650.3	1285.5	387.0	847.1

Including non-Indigenous and those whose Indigenous status is unknown or not stated.
Source: Department of Families, Statistical Services Unit, as at 9th September 2001 - unpublished data.

Key Findings

Health

- There were a total of 47 078 births in Queensland in 2000. There was a far higher likelihood of Indigenous children being born in remote and inaccessible regions than non-Indigenous children. The vast majority of non-Indigenous children (71 per cent) were born in highly accessible areas.

- The majority of both Indigenous and non-Indigenous mothers were aged 20 - 29 years. Indigenous mothers were more likely to be aged under 19 years. Conversely, non-Indigenous mothers were the most likely to be aged 30 - 39 years.

- The top five causes of morbidity for children aged 0 - 18 were respiratory diseases, injuries and poisoning, abnormal clinical laboratory findings, digestive diseases and infectious diseases.

- For Indigenous children and young people, pregnancy, childbirth and puerperium complications rank in the top seven causes of morbidity.

- The mortality rate in 2000 was lower than that in 1999 for all people aged 0 - 18 years. For this age group, the mortality rate in 2000 was 54.4 per 100 000 compared with 55.6 per 100 000 in 1999. However, for the high-risk age of less than one year, the mortality rate grew from 580.7 per 100 000 to 627.8 per 100 000 in this time period.

- The five highest causes of mortality for children aged 0 - 18 years were external causes, perinatal causes, deformation, clinical abnormalities and diseases of the nervous system.

- The rate of suicide for young people in Queensland was substantially lower than for other age groups at 7.5 per 100 000 compared with 20 - 39 year olds, who were most likely to commit suicide, at a rate of 23.4 per 100 000. Young males were more than twice as likely to commit suicide than young females, at a rate of 10.5 per 100 000 compared with 4.4 per 100 000.

Disabilities

- Developmental delays were the primary disability registered by those aged 0 - 4 years (33 per cent). For those registered as having a disability aged 5 - 9 years, autism was the most common primary disability recorded (31 per cent). For those aged 10 - 14 years, 37 per cent were registered as having an intellectual disability as their primary disability. For those aged 15 - 18 years, 57 per cent were registered as having an intellectual disability as their primary disability.

Access to Housing

- Young people were a relatively small proportion of SAAP (Supported Accommodation Assistance Program) clients. Young females appear more likely to require assistance and accommodation than young males.

Childcare and education

- In all age categories, the largest number of children placed in licensed child care services were placed in long day care.

- A concerning trend can be seen in relation to Indigenous students' literacy and numeracy rates. Indigenous children in Year three recorded lower mean scores in both reading and number skills than non-Indigenous students, and the gap between Indigenous and non-Indigenous children increased when the performance of students in Years three, five and seven were compared in 2000.

- The largest sex difference could be seen in regard to reading. Females scored higher than males on this measure.

Victimisation

- Children under one year of age were most likely to be subject to a child protection notification and were most likely to be admitted to a child protection order.

- There were quite different trends according to age in terms of the types of harm children experience. Those aged zero to four years were the most at risk of neglect. A similar trend (although the number affected was lower) was evident for emotional harm. In contrast, the number of children or young people subject to physical harm appears to increase with age. There appears to be a similar trend, increasing with age, for sexual harm, although the numbers were so small they should be interpreted with caution.

- Police victim data indicated that the rate of sexual offences against children and young people was comparatively high, peaking for those aged 13 - 15 years before dropping again at age 16 - 18 years. However, the risk of experiencing a crime of assault increases steadily with age. Young males were more likely to be assaulted, while young females were more likely to experience a sexual offence.

Criminality

- The most common offence category for both females and males seen in police data, were property offences. All offences increased with age.

- Of children appearing in court, both males and Indigenous young people were over-represented, particularly in the 15 - 17 year category.

- Unsupervised orders were the most common youth justice order. Indigenous young people were over-represented in both supervised and unsupervised orders. Males were substantially more likely to be placed on a supervised order than females.

Summary

These findings provide a useful snap shot of children and young people in Queensland. However, in many ways they create more questions than they answer. For example, while there appears to be an increasing gap between Indigenous and non-Indigenous students' numeracy and literacy scores as they progress through the education system, we do not know why this is occurring. Is this trend connected to Indigenous students' higher likelihood of receiving disciplinary action, or is it connected to their higher rates of morbidity? We could also speculate about whether the trend results from background factors, such as Indigenous children's higher likelihood of receiving child protection placement. Are higher scores for those who were younger in 2000 merely a cohort effect, reflecting the success of newly implemented programs? Finally, as seems more likely, does this trend result from an interaction of all these factors? Similar questions arise about other agencies' data. The answers to these queries should provide the basis for the way in which we make our services most effective. However, at present, we are unable to answer them in a way that can inform policy and practice. These types of research, policy and practice issues are addressed in the conclusion of this report.

Conclusion

> *Knowing the status of various groups of children is important for both policy planning and implementation. Knowing the status of disadvantaged groups will help in developing policies and ideas to promote their well-being, and knowing the status of those children who are doing well will enable us to enrich our knowledge regarding what works in giving children better lives*
> (Ben-Arieh, 2001: 7).

Introduction

The data presented in the preceding section provides an overview of the general health, education, victimisation and criminality levels of children and young people in Queensland. Unfortunately, as noted earlier, these findings are only indicative, as none of the various administrative data systems are directly compatible with each other, and much (if not most) of the data are collected for operational purposes rather than to provide the basis for any more general measures of well-being. What does this mean for future decision-making, as agencies move towards evidence-based policy and practice?

Policy implications

The rhetoric surrounding much current Australian policy echoes that of the United Kingdom. Initiatives are designed to promote individual and social responsibility, access to educational training and employment opportunities, to improve recreational opportunities and to tackle problems faced by young people such as homelessness and drugs (Muncie, 1999: 246). In Australia, Ross Homel and his colleagues have achieved a great deal by promoting the implementation of evidence-based programs that reduce the likelihood of young people becoming chronic offenders (*see* National Crime Prevention, 1999). Most recently, the creation of the *National Investment For The Early Years* (NIFTeY) and the *Australian Research Alliance for Children and Youth* (ARAFCAY) represents a national level commitment to better researching and supporting early intervention to improve the well-being of children and young people.

In Queensland, there has been a variety of initiatives aimed at early intervention. These include specific Queensland Government policies such as *Putting Families First* (Queensland Government, 2000) which includes, among other priorities:

- a commitment to improving our understanding of the early years
- increased community-based family support services including expanded services for Aboriginal and Torres Strait Islanders and children with a disability
- community-based services providing prevention, early intervention, advocacy, family support and placement services, and
- support services for families with newborn babies.

Queensland Government early intervention and prevention initiatives also include home visiting and providing practical assistance to disadvantaged parents to potentially reduce the risk of children suffering child abuse. Educational materials have also been provided to at-risk groups which address issues such as child development, health, nutrition, safety and effective parenting.

The early years are also being considered in other arenas such as crime prevention, where early childhood and parent support initiatives provide assistance to parents and families to overcome behavioural and developmental problems for children (Taskforce on Crime Prevention, 1998).

Queensland Health has been involved in running a number of Positive Parenting Programs (Triple P) developed by the Parenting and Family Support Centre at the University of Queensland. It has also established a Young Parents Support Program and

an Indigenous Parenting Support Program as a part of its Early Intervention Parenting Support Initiative. In addition, the department is engaged in an Early Intervention for Safe and Healthy Families Initiative (EISHFI) which integrates the Family CARE Nurse Home Visiting Program (a home visiting program for families with newborn babies at risk of poor health and social outcomes) with its Domestic Violence Initiative (DVI).

PeakCare has also sponsored an Early Intervention Project to coordinate and integrate early intervention services for children, young people and families. In addition, the Department of Families runs several projects intended to assist disadvantaged young people in Queensland, such as the *Which Way You Mob* project designed to help Indigenous young people in rural and remote areas.

However, for these emerging programs to lead to practical outcomes, we need to improve our understanding of what is actually occurring in the real world. At present, this is a difficult exercise if the only data available are from agency-specific administrative data sets.

To genuinely improve policy, we must improve the core data we draw on. With this in mind, there are two different, although related, aspects to consider:

- **comparable data, and**
- **appropriate data.**

Comparable administrative data

Recently, the Federal Department of Family and Community Services (Zubrick et al, 2000) released a report examining indicators of social and family functioning. The report calls for:

> *a set of social and family functioning indicators be selected on the basis of their capacity to measure risk exposures known to be on the causal pathways of poor health, educational, social and criminological outcomes. These indicators should be included in the regular social and health survey publications of key government agencies on children, young people and their families. Population health researchers should also be encouraged to incorporate these indicators into research designs* (Zubrick et al, 2000: xi)

While an admirable suggestion, our ability to put it into practice is limited by the data sources available in each jurisdiction. There is a more pressing need to make better use of the data we already have, while setting in train processes to improve data sources in the future. The data presented in this report strongly suggests that there are young people in need who are not being responded to by social services as effectively as we would wish. While the data we have is less than ideal, it still reveals service gaps that must be addressed as a matter of urgency. This in turn suggests we need to improve our ability to deliver services where they will be most useful. As resources are finite, we must ensure efficiency and effectiveness in spending public money.

We know there are some demographically well defined groups of people using multiple government services at far higher levels than other groups. The data presented in this report demonstrates that Indigenous children and young people appear to be disadvantaged in terms of every administrative data set drawn on. Indigenous children and young people have a higher mortality rate in hospitals, have lower literacy and numeracy scores aged five - 12 years, have a higher suspension rate aged up to 16 years, and are more likely to end up on a youth justice order aged 14 - 17 years than other groups of children and young people.

If it emerges that children and young people are accessing multiple services, this is not necessarily inappropriate. Many current government policies are structured around whole-of-government and multi-agency approaches. If there are specific groups being counted consistently in all administrative data sets, this may indicate services are working. In the absence of sound empirical data, there is no way of knowing whether

these young people are the same group travelling through government services, whether they are different groups of young people who need different resources, and whether our 'care' is actually assisting them (Ogilvie, 2001).

It is essential then, that Queensland services which assist children and young people in various ways, begin to seriously examine the nature of their data and the possibility of ensuring comparability across programs. As noted previously, this is not a new exercise, with the Office of the Premier and Cabinet actively pursuing greater coordination of administrative data as part of an increasing interest in whole-of-government strategies.

Queensland Health, for example, is currently clarifying its own 'key indicators' of child health across its different branches. In the area of criminality in particular, great attention has been placed on the importance of comparable data, with initiatives such as the Integrated Justice Information Strategy (IJIS) considering the feasibility of common person and case identifiers which would allow tracking of people and cases through the criminal justice system. The implementation of such integrated services would ensure that integrated, complete, accurate and timely information is provided to appropriate criminal justice agencies. It will also enable shared knowledge, improved decision-making, and better outcomes for the community. Further, it will minimise duplication of process and provide seamless management of young people and adults through the criminal justice system.

At the Commonwealth level, a recent *Report for the National Community Services Information Management Group* provided a detailed overview of the potential for statistical data linkage in Community Services data collections, noting that the benefits include:

- identification of any gaps or overlaps in service provision between programs (or across agencies)
- identification of the progression pathway of client groups through community services programs
- ability to look at the range of government programs offered by different agencies from the client's point of view, and
- ability to assess the (intended or unintended) impacts of one program on another (Statistical Linkage Key Working Group, 2002: 7).

However, in general, few of the various projects associated with data coordination have met with any great success to date. This may be because they focussed primarily on the issue of *data linkage*, without first clarifying the issue of *data complementarity*. While linking data may be an extremely beneficial exercise for a variety of systems so we better understand whether the services they are providing are actually working, it is impossible to initiate such a plan without first ensuring the data collected are actually compatible.

The current absence of coordinated administrative data systems means policy options cannot be effectively evaluated in cost benefit terms because agency outputs cannot be measured with validity or reliability. Performance measurement/output indicators must be capable of aggregation so government as a whole can judge performance and the performance of individual agencies with respect to each other. More specifically, *comparable* measures are required to ensure that children's well-being is being sponsored by all the agencies responsible for their care. Few dispute the need to start integrating data systems across agencies where relevant, but first there is a need to ensure a degree of comparability between data systems, such as common use of the same definitions, measures and/or variables. It is critical to note that achieving data compatibility by having common business rules is a *vastly* cheaper exercise than achieving an over-arching integrated common data system. In any case, this would succeed or fail on the basis of how extensively it links diverse data sources unified by an adherence to common business rules.

It is also critical to recognise that this recommendation is not simply a desire for more rigorous data. It is recognised that governmental data sets are precisely that, and are developed for a variety of reasons relating to the core business of agencies. However, acknowledging this does not alter the fact that at present, we have only minimal

information to help us answer even the basic accountability question – how well are we contributing to the well-being of children and young people in Queensland?

Appropriate data

There is also a need to begin collecting *appropriate* data on children and young people's well-being to more effectively *sponsor* children and young people. We need state level information on issues such as children's social competence and social skills, their attachment to their family, their capacity for empathy, and their sense of belonging to a community, to more fully measure children and young people's well-being in Queensland.

In many ways Australia is making substantial progress on this issue. The Longitudinal Survey of Australian Children represents a welcome acknowledgment of the importance of having national level data on children in Australia. Unfortunately, it is unlikely to allow jurisdictional level analyses of children and young people's well-being in states other than New South Wales and Victoria[25].

Nonetheless, initiatives such as the Longitudinal Survey of Australian Children are of enormous value, especially if used in a similar way to initiatives in Canada. Canadian children and young people projects include their National Longitudinal Survey of Children and Young People, which is particularly powerful, as it allows analyses at both the *national* and the *provincial* levels. Other projects include the mapping of community resources, including the types of programs available and the physical environment of communities, together with data from their Early Development Instrument (EDI) (*see* Connor, 2001). This means the data resulting has enough depth to be used as building blocks for policy and practice, which serve to improve children's lives, and allow for the continual monitoring of the welfare of Canada's children and young people, and so the ongoing evaluation of Canada's services. Instruments such as the EDI and the National Longitudinal Survey of Canadian Youth (NLSCY) allow for investigations far broader than for example, literacy and numeracy, as they focus on issues such as:

- physical health and well-being
- social competence
- emotional maturity
- language and cognitive development
- communication skills and general knowledge (Janus and Offord, 2000).

This allows for the examination of community supports, parenting style, and barriers to effective resource use (the NLSCY) as well as children's health, social competence, emotional maturity, communication skills and their overall well-being (the EDI).

It is this kind of information is coming to the fore in evidence-based approaches. This term provides a convenient label for a wide range of initiatives explicitly based on the scrutiny and analysis of quantitative data. The interest in evidence-based approaches demonstrates concern about reliability, validity and accountability of services and the most effective use of public money. The growing prevalence of evidence-based approaches can be seen as the coming together of the fiscal concerns of Queensland Treasury, the research rigour concerns of social scientists and the desire of practitioners to achieve the best possible outcome for their clients.

[25] At the time of writing, the Queensland sample size was estimated to be slightly too small to be capable of providing statistically valid Queensland estimates. If so, the data available from the LSAC is more likely to provide useful *indicators*, rather than useful *evidence,* of the state of children and young people in Queensland.

Summary

There is now a well-established body of research indicating that the early years in particular, and childhood and adolescence more generally, are critical years. At these stages, negative or positive factors can produce negative or positive developmental pathways. There is also increasing evidence that early interventions can help mitigate or 'sponsor' these effects. It is surprising, then, that such a basic exercise as collating a 'state of the state' report on Queensland's children and young people proved to be a difficult project.

The importance of this exercise is high, as:

> *knowing more about children's well-being will also enable us to compare the status of children across different time periods and in different locations. Such comparisons are essential if we want to evaluate the policies that are under our control in order to discern whether they are helping children to do better or are contributing or failing to prevent negative consequences for children* (Ben-Arieh, 2001: 9).

The issues that we return to, however, are those raised at the beginning of this report, i.e.:

a) what are our key indicators, and
b) how well does our current data allow us to measure indicators of well-being?

As we know, sustainable social development must begin by establishing what are compulsory 'needs' for sponsoring people's well-being and what are sought-after 'wants' to *better* sponsor people's well-being (*see* Osberg, 1992).

Unfortunately,

> *To do this while keeping children at the centre of inquiry requires an understanding of popular assumptions and values held about children, the labour market participation of parents, and the relationship between families and the state. Reliable access to this kind of information is limited, however, by the kinds of data collected* (Stroik and Jensen, 1999:41).

To fulfil these requirements, we need the building blocks of good policy and practice to promote children and young people's well-being. This means we need data that are comparable, appropriate, accurate and comprehensive. Without such data we cannot ever really know the level of well-being of children and young people in Queensland, and we cannot really know what to do to preserve and enhance the health, safety and happiness of tomorrow's adults.

Whenever we use units of administrative data, we are dealing with individual aspects of a larger picture made up of multiple factors which interact in complex and ever changing ways. Administrative data does not usually provide the fine-grained detail needed to examine concepts such as 'well-being'. Administrative data does however allow us to take a snapshot of basic mortality, morbidity, education, victimisation and criminality rates in Queensland. While such data do not let us know if Queensland's children are receiving high emotional support from, for example, their families, it does tell us the critical areas where we are succeeding, and/or failing, in our responsibilities to their basic welfare.

As noted at the beginning of this report, when we talk about child development, we are talking about the development of the whole child – physical, social, emotional and cognitive. It is important, then, that whatever the specific issue we are focussing on - education, crime, victimisation, health or some other aspect – it must be recognised as just one of many intersecting and interacting factors. Sometimes this results in risk accumulation and sometimes in resilience enhancement, depending on the precise

nature of the mix at the time. Getting the mix right for optimal well-being means agencies that work with children and young people need to work with other agencies who can help them enhance children's development in areas other than their own specific priority.

> *Investments in children will be most successful when efforts are co-ordinated, when providers work in partnership, when their efforts are comprehensive, and when the child is treated as a whole person who is developing in the context of his or her family and community* (Danziger and Waldfogel, 2000:14).

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Appendix A

Below is a list of the much of the current data available on children and young people across Queensland administrative data bases. This is *not* an exhaustive list of all the information available from Queensland agencies (nor is it a complete list of all departmental databases). It is intended as a guide to what statistical information is routinely collected and is accessible from various departments.

Health
All episodes of care from public and private hospitals (including psychiatric institutions) in Queensland.
Major data items available:
Illness/injury
Diagnosis
External Cause
Procedures
Length of Stay
Separation Status
Patient Classification
Insurance Status
Demographic Details
Indigenous Status
Country of Birth
Mortality data (sourced from death certificates)
Major data items include:
Underlying cause of death
Patient demographics
External Cause
Usual Residence
Injury data
Type of Injury
Demographics (Age, Sex, Indigeneity)
External Cause (ie falls)
Location (ie bedroom)
Nature and Body location of Injury (ie sprain and ankle)
Main Injury Factor (ie drugs/chemicals)
Severity
Perinatal Data
Provides information on neonatal morbidity and congenital abnormalities
Major data items include:
Antenatal history
Labour and delivery details
Outcomes of confinements
Congenital abnormalities
Mothers demographics
Cancer Registry
collects all Cancer related inpatient episodes, histo-pathology results and deaths in Queensland
Cancer site
Cancer morphology
Date and Cause of Death
Demographic details (includes ethnicity)
Occupation

Education
Student statistics
How many students attend State Schools?
Who are the students attending State Schools?
Where are students attending State Schools located?
In which learning areas do students participate?
Which students participate in vocational learning programs?
How well are students achieving?
Which students receive additional learning support?
School Statistics
How many State Schools is Education Queensland responsible for, and where are they located?
What are the broad characteristics of Education Queensland schools?
How are Education Queensland schools organised and managed?
How satisfied are students with State Schools?
How satisfied are parents with State Schools?
How satisfied are School Staff with State Schools as a workplace?
System statistics
What proportion of students attend government and non-government schools?
What proportion of State School students continue through the Year Levels?
What are the characteristics of Education Queensland's workplace?
Youth Justice
Children appearing in court for offences and offence related matters (ie. breaches, appeals, sentence reviews etc.)
Details of types of offences heard in court
Outcomes to finalised court appearances
Children admitted to supervised youth justice orders (including types of orders)
Children on supervised youth justice orders (including types of orders)
Young people in detention (including reasons for being detained)
Watchhouses (young people held in watchhouses)
Community Conferencing (young people involved in community conferences)
Conditional Bail (young people given conditional bail by the courts)
Child Protection
Child protection notifications
Category of abuse or neglect notified/substantiated (eg. physical abuse, emotional abuse, sexual abuse, neglect)
Court hearings for protective matters
Children on protective orders (including types of orders)
The above information is available by the child’s age, sex and Indigenous status.
Adoptions
Includes the following information/counts:
Children adopted
Applications for identifying information
Child Care
Proportion of child care services providing non standard hours of service by service type
Proportion of target groups using services relative to their population proportions
Children using State government funded and/or provided formal child care services Children attending preschool
State government recurrent expenditure for child care services
State government administrative expenditure as a proportion of total government expenditure for child care services
Number of serious injuries sustained government funded and/or provided service or

family day care providers, by service type
Substantiated complaints per government funded and/or provided service or family day care providers, by service type
Total staff in State government funded and/or provided child care services
Qualifications and experience of primary contact staff in State funded services
Average hours of attendance by service type
State funded and/or provided services by service type
Places available by service type
Total services by management type
Total family daycare providers
Supported Accommodation Assistance Program (SAAP)
Source of referral/information
Person(s) receiving assistance
Labour force status before and after support period
Main income source before and after support period
Student status before and after support period
Presenting reasons for seeking assistance
Main presenting reason for seeking assistance
Current period of unsafe, insecure or inadequate housing (ie homelessness)
Location before the period of unsafe, insecure or inadequate housing in Q14
Type of housing/accommodation immediately before and after this support period
Who was the client living with immediately before and after this support period
Was the client the subject of a legal order or legal processes before or after support
Has a case management/support plan been agreed to by the end of the support period
To what extent have the client's case management goals been achieved by the end of the support period
Was SAAP/CAP accommodation provided
Support to client
Does this client have children reported on this form or another form for this period of support
Child – Alpha code
Country of birth of the child(ren)
Number of homes the child(ren) has lived in during the past year
Age of child(ren)
Gender of child(ren)
Support to child(ren)
Disability Services Queensland
Basic Demographics (Age, sex, residential address)
Country of Birth
Indigenous self-identifier *(note includes South Sea Islander, and distinguishes between Aboriginal and Torres Strait islander)*
Language used at home
Primary Disability
Secondary Disabilities
Living arrangements (who do they live with)
Details of primary carer (including demographic – age, indigenous etc)
Details of Supports
Level of support needed (low, medium etc)
Continuity of support needed (ongoing, occasional etc)
Type of support needed (household, bathing)
Support required for carers (respite, accessing services etc)
Need for Participation in Community life (social contacts, transport etc)
Need for Professional services (assessment, therapy etc)
Need for Other services (housing, equipment etc)

Appendix B

NHMRC Australian Standard Vaccination Schedule 2000 (0 - 4 years)

AGE	VACCINE	
Birth	hepB	
2 months	OPTION 1	OPTION 2
	DTPa-hepB	DTPa
	Hib	Hib-hepB
	OPV	OPV
4 months	DTPa-hepB	DTPa
	Hib	Hib-hepB
	OPV	OPV
6 months	DTPa-hepB	DTPa
	OPV	OPV
12 months	Hib	MMR
	MMR	Hib-hepB
18 months	DTPa	
4 years	DTPa	
	MMR	
	OPV	

NOTE:

The NHMRC 2000 Schedule introduces two options at 2, 4, 6 and 12 months of age, each of which involves the use of a new combination vaccine.

Schedule options 1 and 2 may be interchanged with regard to their hepatitis B and Hib components.

Hepatitis B vaccine should be given to all infants at birth and should not be delayed beyond 7 days.

Wherever possible, the same brand of DTPa should be used at 2, 4 and 6 months.

Appendix C

Principal Diagnosis Definitions

Principal Diagnosis
Chapter 1 - Certain infectious & parasitic diseases (A00-B99)
Chapter 2 - Neoplasms (C00-D48)
Chapter 3 - Diseases of blood & blood-forming organs & disorders of immune mechanisms (D50-D89)
Chapter 4 - Endocrine, nutritional & metabolic diseases (E00-E90)
Chapter 5 - Mental, behavioural disorders (F00-F99)
Chapter 6 - Diseases of the nervous system (G00-G99)
Chapter 7 - Diseases of the eye & adnexa (H00-H59)
Chapter 8 - Diseases of the ear & mastoid process (H60-H95)
Chapter 9 - Diseases of the circulatory system (I00-I99)
Chapter 10 - Diseases of the respiratory system (J00-J99)
Chapter 11 - Diseases of the digestive system (K00-K93)
Chapter 12 - Diseases of the skin & subcutaneous tissue (L00-L99)
Chapter 13 - Diseases of the musculoskeletal system & connective tissue (M00-M99)
Chapter 14 - Diseases of the genitourinary system (N00-N99)
Chapter 15 - Pregnancy, childbirth & the puerperium (O00-O99)
Chapter 16 - Certain conditions originating in the perinatal period (P00-P96)
Chapter 17 - Congenital malformations, deformations & chromosomal abnormalities (Q00-Q99)
Chapter 18 - Symptoms, signs & abnormal clinical & lab findings, nec (R00-R99)
Chapter 19 - Injury, poisoning & other consequences of external causes (S00-T98)
Chapter 21 - Factors influencing health status & contact w. health services (Z00-Z99)

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