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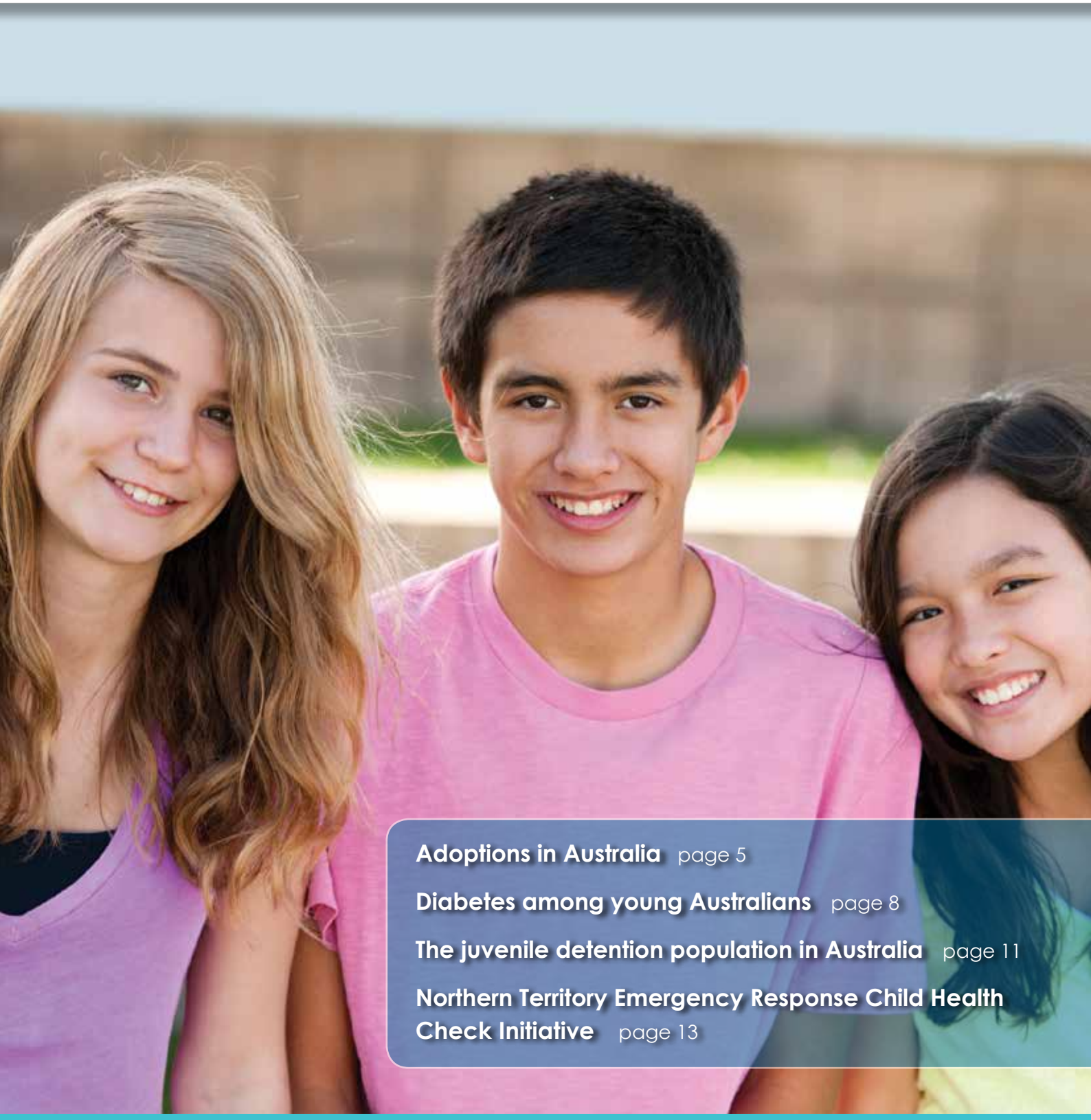

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Director David Kalisch

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From the Director

Welcome to the first *AIHW Access* for 2013. In this issue we are focusing on the health and welfare of children and young people in Australia. But before I move on to that topic, as well as to some reflections on the AIHW in 2013, I would like to add my congratulations to the many already sent to one of our own young staff, Kathleen Jackson.

Kathleen has been accepted into the PhD program in the Department of African and African-American Studies at Harvard University in the USA, a very prestigious achievement.

Kathleen has worked at AIHW as part of our Indigenous cadetship program, which provides part-time employment while also allowing Kathleen to complete her honours thesis at the University of Newcastle. By the time you read this, she will have finished her cadetship with us and will be on her way to enjoying some Boston spring sunshine. You can read more about Kathleen and her research interests on page 14.

In the meantime we are always keen to encourage more Indigenous students to join our Indigenous cadetship program. We benefit from the unique perspectives Indigenous cadets bring to our work, while they in turn gain valuable work experience as well as income support while completing university studies. If you are interested please email our human resources section at <hr@aihw.gov.au>.

Children and young people

Late last year I was interviewed for *International Innovation*, a web magazine based in Europe. The interview has been published in two parts, and is available at <http://www.research-europe.com/index.php/tag/australian-institute-of-health-and-welfare/>.

The questions were very wide-ranging, covering the Institute's role and governance mechanisms, as well our statistical methods and findings, and their relevance to Australians. One specific question asked of me was to outline key findings from our fourth *Young Australians: their health and wellbeing* report, and discuss how the findings had influenced Australian policy.

The number one finding is that overall, the majority of young Australians (12–24 years) experience good health and wellbeing. Over 90 per cent of young Australians rate their health as good, very good or excellent.

On the other hand, over one-third of Australia's young people are either overweight or obese, fewer than half meet recommended physical activity guidelines and very few consume the recommended amount of fruit and vegetables each day.

AIHW Director Mr David Kalisch (left) and Minister for Mental Health and Ageing, Hon Mark Butler at the Launch of the Australian Institute of Health and Welfare *Dementia Care in Hospitals Report*, 14 March 2013

Youth mortality rates have halved in the last 20 years, largely through fewer road accident deaths; most young people are achieving national minimum standards for literacy and numeracy; three-quarters of students remained in school to Year 12, and over half of all 15–24 year olds were studying for a qualification. Also on the plus side, young people report strong support networks, which are associated with better physical and mental health.

The results overall are very encouraging, but with potential for further improvement. For example, rates of insulin-treated diabetes in young people have risen by more than 40 per cent over the last decade. Rising rates of sexually transmissible infections are a concern, particularly chlamydia, as are mental health issues, with many young people reporting anxiety or substance-use disorders or depression. Young people in remote areas have higher death rates and poorer educational outcomes, while Aboriginal and Torres Strait Islander young people are more likely to be disadvantaged across most measures of health and welfare.

We believe our reports on children and young people have had a positive influence on policy. There are several initiatives being considered by governments to tackle childhood and youth obesity problems, including healthy eating campaigns, after-school physical activity programs and more exercise within school time. There are also activities under way to control the advertising of energy-dense foods to children and the availability of sugary drinks in school canteens. There are also several improvements to mental health policy in progress, to limit or reverse the disproportionate effects of mental illness on young people. These include headspace youth mental health centres and new early psychosis youth centres.

The AIHW in 2013

Earlier this year *Public Administration Today* magazine gave me the opportunity to set out some of my thoughts about AIHW and how we are placed in 2013. Here is a very much abridged version of what I said.

The AIHW has very extensive and ever-expanding data holdings across the health, community services and housing sectors.

We have shown that there is great value in drawing together understandings across the health and welfare sectors, and we are unique in our ability to do this. For example we can analyse trends in particular diseases coupled with hospital performance, disability, ageing, drug and alcohol use, social housing, and the resourcing of these sectors. These interrelationships, essential for well-designed policy and services, can be missed in narrowly focused information reporting.

While the AIHW is formally a Commonwealth Government statutory agency, our Commonwealth Authorities and Companies Act status, our 15-member management board, and extensive engagement with all governments and non-government health and welfare sector agencies, mean we truly operate as an independent national organisation.

We are required to be more entrepreneurial than many other government agencies. Our guaranteed appropriation is less than $16 million a year, and our external fee-for- service contracts, which currently total around $35 million a year, are not guaranteed—this places extraordinary challenges on us to make sure we deliver what our clients want in a reasonable time, to a high standard, at a value for money price.

The AIHW has a lean, efficient corporate infrastructure, with skilled and experienced staff. While this approach is ideal in all organisations that draw taxpayer funding, it is particularly relevant to us, given the extent to which we must compete for, and largely rely on, additional external funding.

Consistent with many other public service organisations, changes in our operating environment and developments in technology mean that we need to keep reforming ourselves. The 24/7 media and political cycle in particular has challenges for information providers such as the AIHW. The pressure for immediacy is at odds with the thorough processes of data collection, aggregation, supply, validation, analysis and dissemination.

Most important is the establishment and ongoing improvement of national data standards. AIHW's effort over decades means we now have quite reasonable comparability of information across jurisdictions across the health and welfare sectors—but there is always more to be done.

For example, last year the AIHW worked with the Royal Australasian College of Surgeons and many other key stakeholders, including all governments, to develop a more robust approach to urgency categorisation for elective surgery. At a minimum, this is critical for consistent COAG national reporting.

The AIHW has considerable professional expertise in data collation and data quality assurance. This includes identifying potential errors in supplied data, such as occurred in 2012 with emergency department information from the ACT.

AIHW is placing greater attention to improving the timeliness of our work while maintaining and if possible improving quality. We have developed a software program, Validata™, which automatically applies a large set of validation rules across supplied data. But rather than keep it to ourselves we are making this program available to our data suppliers in order to improve quality across the whole data supply chain, rather than only at the final point of national supply.

We have developed and adopted technologies that better enable us to analyse and present information in newer and smarter ways. And we are currently halfway through a two-year concentrated business transformation process to better manage our continually large number of complex projects and to enable staff to work across a range of different activities.

Overall, in 2013 we aim to deliver better quality services in reduced timeframes, constrain the cost of standard AIHW services to our external funders, and enable skilled AIHW staff to devote more attention to higher value-added analyses.

David Kalisch
Director (CEO), AIHW

Adoptions in Australia 2011–12

When a child is unable to live with their birth family, adoption can provide a permanent home and family. When an adoption occurs, rights and responsibilities for the child are transferred from the birth parents to the adoptive parents, and the legal rights of the adopted child become the same as they would be if the child had been born to the adoptive parents.

This publication presents the latest statistics and related information on most aspects of adoptions in Australia, including characteristics of adopted children, adoptive families and birth mothers. For the first time, the report also contains information on processing times for intercountry adoptions.

What are the different types of adoptions?

Intercountry adoptions involve children from countries other than Australia, who are legally able to be placed for adoption, but who generally have had no previous contact with the adoptive parents.

Local adoptions involve children who were born or permanently living in Australia before the adoption, who are legally able to be placed for adoption, but who generally have had no previous contact or relationship with the adoptive parents.

Known adoptions are similar to local adoptions, but involve children who have a pre-existing relationship with the adoptive parent(s) and who are generally not able to be adopted by anyone other than the adoptive parent(s). A known child adoption could involve, for example, a step-parent or foster parent.

Falling numbers

There were 333 finalised adoptions in Australia in 2011–12, which was the lowest annual number on record.

'For the first time since 1998–99, we saw more Australian children adopted than children from overseas—184 from Australia and 149 from overseas', said Mr Tim Beard, Head of the AIHW's Child Welfare and Prisoner Health Unit.

While the long-term fall in adoptions overall is primarily due to continuing falls in the number of Australian children adopted (an 84% decline from 1987–88 to 2011–12), the number of intercountry adoptions has also been falling in recent years.

The 2011–12 figure of 149 overseas adoptions continued a 7-year pattern of decline.

A changing society

A range of factors may be responsible for the falling number of adoptions in Australia.

'In part, the long-term decline can be attributed to legislative changes, such as what are called "alternative legal orders" that transfer guardianship and custody of a child to a person other than the parent—usually a relative or carer with whom the child is already living', Mr Beard said. These often replace the need for adoption.

'In Victoria, for example, these orders are called permanent care orders. In some other States and Territories they are known as guardianship orders to a third party.'

Broader social trends and changing community attitudes have also affected adoption numbers. For example, over the last few decades, there has been increasing social acceptance of raising children outside registered marriage, with increased levels of support available to single parents.

Other changes, such as declining fertility rates, wider availability of effective birth control methods and the emergence of family planning centres, are also thought to have contributed to the drop in the number of children available for adoption in Australia.

'For intercountry adoptions, numbers have been falling largely due to economic, legislative and social changes that allow children to remain with their birth families or be adopted within their home country', Mr Beard said.

Characteristics of the children

Most children adopted from overseas in 2011–12 (79%) were aged under 5, and 23% were infants aged under 12 months. In previous years the proportion of finalised adoptions involving infants was higher, reaching a peak of 47% of intercountry adoptions in 2005–06.

The majority of intercountry adoptions in 2011–12 involved only one child, although 18 children were adopted at the same time as at least some of their siblings, by the same adoptive family in each particular case.

Boys and girls were adopted from overseas in roughly equal proportions—52% and 48% respectively. Most intercountry adoptions (86%) involved children from Asia, with a further 12% involving children from Africa, and 2% from South/Central America.

The most common countries of origin were the Philippines (29 adoptions, or 19% of the total), South Korea (26 adoptions, 17%), China (24 adoptions, 16%) and Taiwan (22 adoptions, 15%).

For local adoptions, almost all (96%) involved children aged under 5, and absolutely all children were under 10.

'Locally adopted children tend to be younger than those adopted from other countries', Mr Beard said.

'In 2011–12, 36% of local adoptions involved infants aged under 12 months, compared with 23% for intercountry adoptions.'

'Among local adoptions, all were for single children except for one case where two siblings were adopted at the same time by the same family', Mr Beard said.

For known child adoptions, the children tend to be much older. Half of the known child adoptions finalised in 2011–12 (53%) were for children aged 10 and over, and only 16% involved children under 5.

'This reflects legal requirements applying to the age of known children, and the length of time the prospective parent or parents need to have had a relationship with that child. The additional time often involved in the forming of step-families is also likely to contribute', Mr Beard said.

What do we know about the birth parents?

Limited statistical information is available on the families of children adopted from overseas, but some information is available about the birth mothers of children adopted in Australia.

'Australian birth mothers of children who had their local adoptions finalised in 2011–12 tended to be younger than other mothers, with a median age of 22—nine years less than the median age of all mothers', Mr Beard said.

Most locally-adopted children (78%) had birth mothers aged under 30, and 62% had birth mothers aged under 25.

Most birth mothers (85%) were not in a registered marriage.

Almost all local adoptions finalised in 2011–12 (95%) were 'open', in that all parties were happy to allow a degree of contact or information exchange to occur between birth and adoptive families.

What about the adoptive families?

Adoptive parents tend to be older than biological parents due largely to eligibility requirements. More than two-thirds (70%) of intercountry adoptive parents were aged 40 and over in 2011–12. For local adoptions, 39% of adoptive parents were aged 40 and over.

Nearly all adoptive parents were in a registered marriage for both intercountry and local adoptions—92% and 95% respectively.

More than one-third (36%) of families who adopted a child from overseas had no other children in their families. Coincidentally, 36% of adoptive families had other adopted children only. About 19% had other biological children, and 9% had both biological and adopted children.

For local adoptions, most children were adopted into families with no other children (61% of cases). One-quarter (25%) of the adoptive families had adopted children only, and a further 11% had biological children only. About 3% had both.

How long does it take to adopt a child from overseas?

'This year, for the first time, we have been able to report on processing times for intercountry adoptions', Mr Beard said.

'This allows us to give a more complete picture of the intercountry adoption process, which in Australia is administered by the Commonwealth Attorney-General's Department.'

For children placed with their adoptive parents in 2011–12, the median length of time from when an Australian applicant, that is the adoptive parent(s), became an official client of the department to when a child was placed with them, was 56 months. The range was from a median of 32 months for a child from Taiwan to 79 months for a child from China.

The overall median length of time from approval of an applicant in Australia to placement of a child has risen steadily in the last few years, from 37 months in 2007–08 to the 56 months in 2011–12 mentioned earlier.

'The longest period in the process, for most countries, occurs between receipt of an applicant's file in the intended country and the date a child is allocated', Mr Beard explained.

'The main exceptions are Taiwan, where the initial approval of an applicant was the longest part of the process, and South Korea where the time between allocation and placement was longest.'

The time taken by countries of origin to allocate children after receiving files from Australia rose from a median of 19 months in 2007–08 to 30 months in 2011–12.

Download *Adoptions in Australia 2011–12* at <http://bit.ly/CWS042>.

Further information
Communications, Media and Marketing Unit
Phone: (02) 6244 1032
Email: info@aihw.gov.au

Diabetes among young Australians

Young people face many physical, social and psychological changes as they mature and begin to take responsibility for their own health. This experience can be particularly challenging for a young person with a chronic disease like diabetes.

Diabetes among young Australians is the first report from the National Centre for Monitoring Diabetes, based at the AIHW, to explore the experiences of young people (aged 0 to 30) living with diabetes. It shows how young people are managing the condition, their use of health services and the diabetes-related health problems they face.

How many young people have diabetes?

Diabetes affects a considerable number of young people. In 2010, there were about 31,300 people aged 0–30 with diabetes in Australia. Most had Type 1 diabetes (79%), while the remainder (21%) had Type 2 diabetes. Estimates on the number of young people with diabetes come from registrations with the National Diabetes Service Scheme (NDSS). The NDSS is an Australian government program that provides access to subsidised products such as syringes, needles, consumables for insulin infusion pumps, and blood and urine testing strips for people with diabetes.

How do young people manage their diabetes?

People with Type 1 diabetes require intensive treatment with insulin, a hormone that controls glucose levels in the blood. Treatment is highly individualised and needs to take into account factors such as body weight, food intake and exercise. Self-monitoring of glucose levels, achieved with a blood glucose monitoring device and blood glucose test strips, is an essential part of diabetes management.

What is diabetes?

Diabetes mellitus (diabetes) is a chronic condition marked by high levels of glucose (sugar) in the blood. The condition is caused by the inability to produce insulin (a hormone produced by the pancreas which controls blood glucose levels), or the body cannot use insulin effectively, or both (World Health Organization 2006).

Type 1 diabetes is an auto-immune condition that usually first manifests in children or young people, although it can start at any age. It is marked by the inability to produce any insulin and those affected need insulin replacement for survival. Across all ages it accounts for only about 10% of all diabetes cases, but in children and young adults Type 1 diabetes is the more common form.

Type 2 diabetes is the more common form of diabetes overall, and across all age groups it accounts for about 85% to 90% of cases. It is most common in people aged 50 and over, and is uncommon in young adults, although it may be increasing in this population. People with Type 2 diabetes produce insulin but may not produce enough of it, or cannot use it effectively.

The report shows that young people aged 0–11 are the highest users of products such as blood glucose test strips, urine testing strips, needles and insulin reservoirs.

'The higher level of blood glucose monitoring in this age group may be attributed to the high level of parental involvement in the child's diabetes care at this age', said report co-author Susana Senes. 'This involvement drops as the person aged 12-18 manages this task more and spends an increasing amount of time away from the family's direct care.'

People aged 19-24 were the lowest purchasers of blood glucose test strips, but they bought other products such as needles, reservoirs and urine test strips at a similar rate to people aged 25-30.

'Of concern is the finding that people aged 19-24 bought blood glucose test strips at lower rates than other age groups, which suggests they are not managing their diabetes as well as others', Ms Senes also observed.

Use of insulin pumps, a method of continuous insulin delivery used as an alternative to multiple daily injections, was also more common among people aged 18 and under.

'Possible reasons for this are the subsidies available for eligible people under 18 to buy a pump, ease of use at school and greater availability of staff resources for initiating pump therapy in paediatric centres', Ms Senes said.

Use of health care services

Younger people with Type 1 diabetes are typically supported in their management of the disease by a multi-disciplinary team based in a diabetes centre.

Diabetes centres are specialist centres that bring together a range of health care providers to care for people with diabetes.

Research has shown that young people with diabetes who attend a diabetes centre have better health outcomes than young people who only visit a GP or who receive no health care at all.

Increased rates of diabetes-related morbidity, poorer wellbeing and the earlier onset of diabetes-related complications have been consistently observed in young people who do not attend diabetes centres.

Hospital admissions

For young people with Type 1 diabetes, hospital care is often needed at the time of diagnosis and the commencement of insulin pump therapy.

For all types of diabetes, admission to hospital may also be needed during episodes of acute complications such as ketoacidosis (a condition caused by insufficient insulin that is characterised by very high blood glucose levels) and hypoglycaemia (low blood glucose).

Children aged 0–11 with diabetes had the highest rate of presentations to emergency departments. However, when young people aged 12–18 and 19–24 did present to emergency, a greater proportion needed more urgent medical attention than was observed in other age groups.

People under 25 were hospitalised more often than those aged 25–30 for acute diabetes-related complications, such as ketoacidosis.

'The number of hospitalisations for ketoacidosis among people aged 0–24 increased over the period 2002–03 to 2009–10. These hospitalisations were associated with the presence of acute illnesses and a history of non-compliance with medical treatment, especially among people aged 12–24', Ms Senes said.

Insulin pumps

Complications of diabetes and mortality

Diabetes is associated with a range of potential complications. 'Of real concern is that some serious but preventable long-term complications of diabetes are already evident in some people aged 19–30, including nerve damage, foot ulcers, eye and kidney disease', Ms Senes said.

Mortality data provides another insight into the health experiences of young people with diabetes.

Diabetes was the underlying cause of death of 88 people aged 0–30, and an associated cause of death for a further 76 in 2001–07.

'The number of deaths increased with age, and more than half (53%) occurred in the 25–30 age group. This finding is supported by research in England into the mortality of people with diabetes aged 0–40, which found that most of the observed deaths (88%) occurred between the ages of 20 and 39', Ms Senes said.

'In our study, many of the deaths where diabetes was the underlying cause of death were related to either diseases associated with diabetes (cardiovascular- or kidney-related) or to misadventure.'

The healthcare transition

Young people with diabetes can have difficulty making the transition from paediatric to adult diabetes centres, and can experience poor health outcomes as a result.

'The management of diabetes is a complex task. To develop good habits of self-care, expert knowledge and much support is required', Ms Senes said.

'For children, this support is provided by their parents or carers, as well as staff at paediatric diabetes centres. As they grow older people have to learn how to manage the disease for themselves and to develop their own habits of self-care.'

This change in approach as children become adults is underlined by the many differences in culture between paediatric and adult health care settings.

'The major difference between the two settings is in the expected roles of the patient. In the paediatric system the patient is more likely to be part of a family team, whereas in the adult setting the patient is expected to be informed and autonomous', Ms Senes said.

A recent survey of Australian diabetes centres showed that 1 in 5 people with diabetes aged 19–24 attended a paediatric clinic, but all people in the 25–30 age group were attending adult clinics.

A survey conducted by Diabetes Australia of young people with diabetes found that the major barriers to care for young adults were long waiting lists to see a specialist or general practitioner of their choice, getting time off work or study to attend an appointment, lack of transport, and the cost of care.

'The consequences of non-attendance can be serious, and several transition programs have been established to increase engagement of young adults with the health care system', Ms Senes said.

Risks of non-engagement include acute morbidity requiring hospitalisation, and earlier onset of chronic complications such as loss of eye-sight, reduced kidney function, and peripheral nerve damage.

Download *Diabetes among young Australians* at <http://bit.ly/CVD059>.

Further information
Communications, Media and Marketing Unit
Phone: (02) 6244 1032
Email: info@aihw.gov.au

The juvenile detention population in Australia

The AIHW's *Juvenile detention population in Australia 2012* report is the second in an annual series that focuses on trends in the numbers and rates of young people in detention in Australia.

The report covers quarterly trends from June 2008 to June 2012 and was compiled using the AIHW's 2010–11 Juvenile Justice National Minimum Data Set, supplemented with additional data on the number of young people in detention at midnight at the end of each month between July 2011 and June 2012.

In Australia, youth justice (also known as juvenile justice) is the responsibility of the state and territory governments, and each has its own legislation, policies and practices. Young people who have committed or allegedly committed an offence may be supervised by state and territory youth justice agencies, either in the community or in detention.

Only a small proportion (14%) of young people under youth justice supervision were in detention on an average day in 2010–11. Legislation in all Australian jurisdictions is based on the principle that detention is a last resort, and should be used for the shortest appropriate amount of time.

Few young people are in detention in Australia, and numbers are stable.

There were 1,024 young people in detention on an average night in the June quarter of 2012, or about 1 in every 3,000 young people aged 10–17.

More than half (53%)of the young people in detention were Indigenous, and most (91%) were boys or young men. Just over half (52%) were unsentenced—that is, awaiting the outcome of their court matter or sentencing.

The numbers of young people in detention remained quite stable over the 4-year period to the June quarter 2012. Similarly, there was little change in the number and proportion of young people in detention who were unsentenced over the 4-year period.

Indigenous over-representation has increased, particularly in unsentenced detention.

Although Indigenous young people only make up about 5% of the Australian population, 53% of those in detention on an average night in the June quarter 2012 were Indigenous (544 young people). The rate of Indigenous young people aged 10–17 in detention during this period was 4.60 per 1,000 relevant population, compared with only 0.15 per 1,000 for non-Indigenous people.

This meant that Indigenous young people were 31 times as likely as non-Indigenous young people to be in detention on an average night, up from 27 times in the June quarter 2008.

The level of Indigenous over-representation in unsentenced detention increased over the 4-year period (from 24 to 31 times), but decreased slightly for sentenced detention (from 32 to 30 times).

Download *Juvenile detention population in Australia 2012* at <http://bit.ly/AUS170>.

Further information
Communications, Media and Marketing Unit
Phone: (02) 6244 1032
Email: info@aihw.gov.au

People behind the stats
The Child Welfare and Prisoner Health Unit

(From left to right): Jenna Pickles, Kirsten Morgan, Georgie Jepsen, Arianne Schlumpp, Kristy Raithel, Sam Chambers, Tim Beard, Rhiannon Kelly and Ingrid Johnston (Not in picture: Nicole Hunter)

Who we are

The Child Welfare and Prisoner Health Unit is part of the Continuing and Specialised Care Group at the AIHW.

Our team, led by Tim Beard, is a diverse group with a variety of backgrounds and experience, including statistics, epidemiology, psychology, education, health sciences and clinical practice.

What we do

We collect and report on data covering four main subject areas—child protection, adoptions, youth justice and prisoner health. We produce regular reports on a range of topics including:

- Child protection Australia (annually, since 1996–97)
- Adoptions Australia (annually, since 1990–91)
- Juvenile justice in Australia (annually, since 2000–01)
- The health of Australia's prisoners (since 2009).

Our unit also produces reports and bulletins on special focus topics, including recent bulletins on Indigenous young people in the juvenile justice system and The mental health of prison entrants in Australia.

In addition to reports, we regularly undertake projects aimed at either improving existing data collections or developing new measures to fill specific data gaps. Recent examples include outcome indicators for prisoners being discharged, and a new module to measure educational outcomes for children in the child protection system.

Why we do it

We are confident that governments and the community use the statistics and related information that we produce to make better decisions on policies and programs that make a positive difference to the lives of some of the most vulnerable people in Australian society.

Did you know?

- **More than 7,000 young people were under youth justice supervision on an average day in 2010–11, or 1 in every 386 young people.**
- **There were only 333 finalised adoptions in 2011–12—the lowest annual number on record. For the first time since 1998–99, more Australian children (184) were adopted than children from overseas (149).**
- **In 2010 two-thirds of prison entrants reported illicit drug use in the previous 12 months, and 83% were current smokers.**
- **In 2011–12, almost 38,000 children were the subject of a substantiated child protection notification, or 1 in every 135 children.**

What lies ahead

In addition to our regular work, our team has been busy recently on several projects that will either enhance the national data we collect, or improve how we communicate with all of our audiences. For example:

- We will be introducing a new child protection data collection later in 2013 that focuses on children (through child-level unit records) rather than services.
- From 2013 the *Youth justice in Australia report* (formerly Juvenile justice in Australia) will be summarised in a bulletin with accompanying online fact sheets, which will give readers easier access to the key points.
- In response to regular requests, we will be providing easy online access to adoptions trend data.

Snapshot

Northern Territory Emergency Response Child Health Check Initiative

The AIHW has released the *Northern Territory Emergency Response Child Health Check Initiative—follow-up services for oral and ear health: final report 2007–2012*.

The report presents information on the dental, audiology and ear, nose and throat (ENT) services funded throughout the course of the Child Health Check Initiative Closing the Gap program.

Although open to all Indigenous children under 16 years of age living in prescribed communities, this program specifically targeted those Indigenous children who received referrals from Child Health Checks.

Dental, audiology and ENT services

'Over the course of the whole program, around 17,200 dental services were received by 9,300 children and 9,200 audiology services were received by 5,700 children', said Dr Fadwa Al-Yaman.

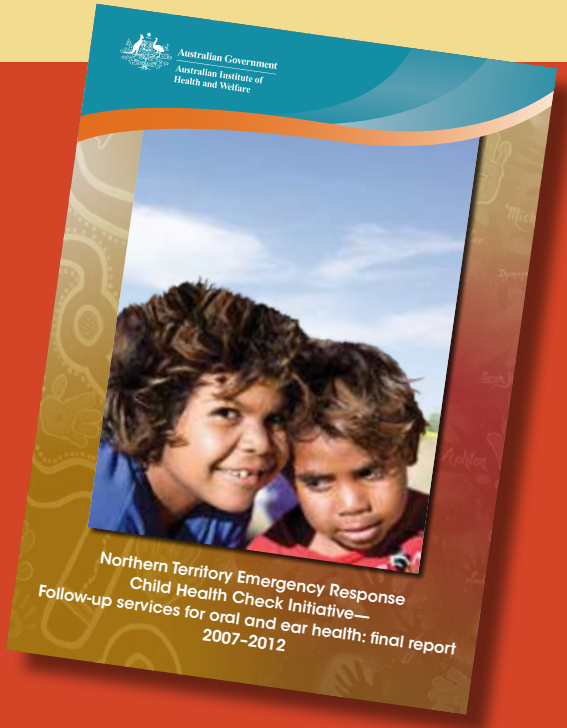
A further 3,800 ENT consultations were provided to over 2,600 children by the conclusion of the ENT component of the program in December 2010. Between 1 July 2009 and 31 December 2010, 291 ENT surgeries were performed on 283 children.

Child Health Check (CHC) referral follow-up services

At 30 June 2012, the majority of children who were on active CHC referral lists received follow-up services. The follow-up rates were 94% for dental referrals, nearly 100% for audiology referrals and 97% for ENT referrals.

The most significant oral health problem among children who received an oral health service was untreated caries (decay).

Around one-half of the children who had an audiological assessment were diagnosed with hearing loss and around one-third were diagnosed with some degree of hearing impairment based on their better ear. At least one type of middle ear condition was diagnosed in around two-thirds of children who received an audiology or ENT service.



Improvements in oral and ear health at the end of program

'The good news is there have been improvements', Dr Al-Yaman said.

'For children who had more than one course of dental care, the overall prevalence for children with at least one oral health problem fell by 12 percentage points.'

'Among children who had two or more audiology checks, the prevalence of hearing loss fell by 10 percentage points. About 60% of children who were diagnosed with hearing impairment at their first check showed some degree of improvement at their last audiology check. The prevalence of middle ear conditions fell by 21 percentage points among children who received two or more audiology/ENT services.'

Download the report at <http://bit.ly/nt-resp>.

Further information
Communications, Media and Marketing Unit
Phone: (02) 6244 1032
Email: info@aihw.gov.au


Kathleen Jackson

Opportunity of a lifetime

Indigenous cadet off to study at Harvard

One of the AIHW's brightest and youngest staff members is about to embark on the academic journey of a lifetime at Harvard University in the USA.

AIHW Indigenous cadet, Kathleen Jackson, was thrilled to find out earlier this year that she had been accepted into the PhD program in the Department of African and African American Studies.

Her acceptance into the program means she can continue her research into the little-known phenomenon of 'racial passing'—research that was sparked by her own family's experiences.

Ms Jackson describes racial passing as a situation where a person of a particular ethnic or racial background pretends to be of a different racial or ethnic background.

'Racial passing occurs for a variety of different reasons, but it's usually done for economic benefits, like getting a job, and it typically happens in racially hostile environments', Ms Jackson says.

'In Australia it was happening during the protectionist and assimilation period when people would pass as white or of a different kind of background to protect their children against being removed.'

Ms Jackson says her interest in racial passing was intensified after discovering her great-grandfather had 'passed' and seeing the consequences the experience has had on her family.

'He denied his Indigenous heritage to protect his family and avoid the stigma of being an Aboriginal man', Ms Jackson said.

'Growing up, we were never allowed to talk about it, but then this whole racial identity dilemma came out after he died.'

Ms Jackson says luckily her mother was eventually able to tell them about the family's Indigenous heritage, but that even until recently the 'racial passing' of her great-grandfather was 'a known unspeakable fact'.

'He was a shearer and had spent some time over in New Zealand working, so had some knowledge of New Zealand, so he pretended to be Maori', Ms Jackson said.

The Indigenous Cadet Program at the AIHW

The AIHW's Indigenous Cadet Program, subsidised by the Department of Education, Employment and Workplace Relations, provides financial assistance for cadets completing their tertiary studies while also offering a 12-week work placement at the AIHW.

In recent years cadets have gained valuable employment experience working on AIHW Indigenous health and welfare projects such as the online Closing the Gap Clearinghouse, and the Healthy for Life project.

For more information about the program visit <www.deewr.gov.au/ics>, or email <hr@aihw.gov.au>.

'As a result, we lost touch with Indigenous culture for quite a while there and it still causes ructions within our family.'

Ms Jackson's research on the topic so far has led her to believe that racial passing has had a significant impact on Australian history.

From a recent trip with a cohort of fellow Indigenous students, she estimates that at least three-quarters have a family member who has 'passed'.

The opportunity to complete her PhD on the topic at Harvard will allow her to gain some valuable insight, and have access to an abundance of resources.

'What I hope to do is use the African American history as a jump off point because, while the research there hasn't been extensive, there's been a lot more done in the US than anywhere else', Ms Jackson said.

The AIHW Reconciliation Action Plan

The AIHW's Reconciliation Action Plan (RAP) sets out goals to attract more Indigenous people to work at the Institute, including:

- Using culturally sensitive recruiting strategies when advertising positions and when interviewing
- Promoting the AIHW as an employer of choice among universities and education institutions
- Encouraging Indigenous students to work with the AIHW
- Maintaining the Indigenous temporary employment register
- Benefiting from the Australian Public Service Commission Indigenous Employment Program.

The RAP declares that all AIHW units will work together toward achieving the APS wide target of 2.7% Indigenous staff by 2015.

For more information about the RAP visit <http://bit.ly/RAP_12-13>.

Indigenous applied epidemiology students at AIHW

In addition to Indigenous cadetships, AIHW also has a longstanding commitment to supporting Indigenous students undertaking Masters of Applied Epidemiology studies.

In recent years we have provided placements to a number of Indigenous students including Kyle Turner, who is now completing his PhD in public health at Oxford University in the UK, and Ray Lovett, currently an Indigenous Visiting Research Fellow at the Australian Institute of Aboriginal and Torres Strait Islander Studies, at the Australian National University (ANU) and also completing his PhD in Epidemiology at the ANU.

For more information about the program visit <www.deewr.gov.au/ics> or email <hr@aihw.gov.au>.

'It's going to be a transnational study, which means it looks at the concept across borders. So I'm going to be looking at how passing occurred within African American populations in contrast to Aboriginal Australia.'

Ms Jackson began working at the AIHW in 2009, as part of the Australian Public Service Indigenous Cadetship Program, which helps Indigenous students work part-time while they continue their university studies.

Studying a Bachelor of Arts and Law when she first heard about the cadetship, she decided it was too good an opportunity to pass up.

'I was really excited by the projects and the variety of work here and because it is so far-reaching, and I was particularly interested in the welfare side of things, like detention and prison rates', she said.

Ms Jackson says even though she was 'terrible at maths', working on Indigenous projects at the Institute opened up a whole new world for her.

'I was really motivated a lot by my own Indigenous identity and my desire to do something for my community.

'Working on things like the Closing the Gap Clearinghouse project allowed me to get involved in the quality assessments, so I got to read literally hundreds of journals and reports about programs for Indigenous people. It was just such an eye-opener about what was out there and improved my knowledge of the field so much.'

REPORT Profiles

Child protection Australia 2011–12

Child protection Australia 2011–12 is the AIHW's 16th annual comprehensive report on child protection. It provides detailed statistical information on state and territory child protection and support services, and some of the characteristics of the children receiving these services.

Substantiated child abuse and neglect has increased

Over the past 12 months, the number of children who were the subject of substantiations increased from 31,527 to 37,781 (6.1 to 7.4 per 1,000 children). This increase was found across most jurisdictions and could be influenced by a range of factors including legislative changes, enhanced public awareness and inquiries into child protection processes, along with increases in abuse and neglect. This is a reversal of the previous downward trend where the rate of children who were the subject of substantiations decreased from 6.5 per 1,000 children in 2007–08 to 6.1 in 2011–12.

Very young children are most likely to be the subject of substantiated abuse and neglect

In 2011–12, children aged under 1 year were most likely to be the subject of a substantiation (13.2 per 1,000 children) and those aged 15–17 were least likely (3.2 per 1,000 children). Over the past 12 months, the rate of children aged under 1 year who were the subject of a substantiation increased from 12.0 to 13.2 per 1,000 children.

The number of children admitted to and discharged from care and protection orders has increased

Over the past 12 months, the number of children discharged from orders increased by 27%—from 7,480 in 2010–11 to 9,478 in 2011–12. This compares with a smaller (3%) increase in the number of children admitted to orders over the same period—from 13,830 to 14,191. Of these, about two-fifths (39%) had previously been admitted to an order. Almost half (45%) of children admitted to orders were aged under 5.

The majority of children in out-of-home care were placed for more than a year

At 30 June 2012, there were 39,621 children in out-of-home care (a rate of 7.7 per 1,000 children). This rate was an increase from 2011 when 7.3 per 1,000 children were in out-of-home care at 30 June. In 2012, almost 1 in 5 (19%) children had been in their current placement for less than 1 year. Almost one-third (30%) had been in a continuous placement for between 2 and 5 years, while a further 38% had been in a continuous placement for 5 years or more. Most (90%) children in out-of-home care were on care and protection orders.

More than half of foster carer households had multiple foster children

During 2011–12, there were 11,664 foster carer households and more than 12,278 relative/kinship households that had 1 or more children placed with them. At 30 June 2012, 49% of foster carer households with a placement had 1 child placed with them; 46% had between 2 and4 foster children and 4% had 5 or more.

Aboriginal and Torres Strait Islander children continue to be over-represented

In 2011–12, Aboriginal and Torres Strait Islander children were almost 8 times as likely to be the subject of substantiated child abuse and neglect as non-Indigenous children (rates of 41.9 and 5.4 per 1,000 children, respectively).

Serious childhood community injury in New South Wales 2009–10

This report provides summary data on hospitalised injury in New South Wales children and young people (0–17) for the period 1 July 2009 to 30 June 2010. It also provides information on trends in injury between 1 July 1999 and 30 June 2010.

More than 23,000 children and young people (0–17) were hospitalised in 2009–10 as a result of an injury. Roughly equal numbers of boys and girls were hospitalised under the age of 5. There were more boys hospitalised than girls aged 5–14.A total of 31 children died in hospital over this period as a result of injury, mainly transport-related.

The age-standardised injury rate of children and young people was just over 1,460 per 100,000 population. The rate of injury for males was 1,864 per 100,000 population and increased with age. In contrast, the rate of injury in females was 1,036 per 100,000. Similar rates were observed in the different age groups.

Causes of injury

Falls were the most commonly reported cause of hospitalised injury (39% of cases). Transport injuries were also common (14%). The most frequent cause of hospitalised falls involved playground equipment.

Age differences

Falls in the home were a frequent cause of injury for children aged 4 and under. Injury associated with burns, accidental poisoning by pharmaceuticals and drowning were also much more common in very young children. Transport injuries accounted for 20% of hospitalisations in young people aged 15–17. While pedal cycles were the most commonly reported cause of hospitalised transport injury for children aged 0–14, motorcycle rider injuries were more common in young people aged 15–17.

Sex differences

Males were more likely to be hospitalised because of transport accidents, falls and assault while females were more likely to be hospitalised for intentional self-harm injuries.

Trends over time

Significant declines in hospitalised injury since 1999 were seen in rates for poisoning by pharmaceuticals (average 6% decline per year) and poisoning by other substances (4% decline per year). Smaller but significant declines were also noted for drowning (3%), transport injuries (2%) and assault (2%).

Further information
Communications, Media and Marketing Unit
Phone: (02) 6244 1032
Email: info@aihw.gov.au

In the pipeline...

Projects

AUGUST 2013

- *Australia's welfare 2013* report launch and workshops

Events

MAY 2013

- Report on Government Services Steering Committee
- Research and Evaluation Data Working Group
- National Health Information Standards and Statistics Committee meeting
- AIHW Ethics Committee meeting

JUNE 2013

- AIHW Audit and Finance meeting
- AIHW Board meeting

Upcoming publications

- May—*Obesity and injury in the National Hospital Morbidity Database*
- May—*National social housing survey 2012: a summary of national results*
- May—*A snapshot of osteoarthritis* (web)
- May—*A snapshot of rheumatoid arthritis*
- May—*Oral health and dental care in Australia: Key Facts and Figures 2012 update*
- May—*Cervical screening in Australia 2010–11*
- August—*Australia's Welfare 2013*

Coming soon in August

Australia's welfare 2013

Australia's welfare 2013 will be the 11th edition of the AIHW's biennial report on statistics and related information about Australia's welfare services. It is the most comprehensive and authoritative source of national information on welfare services in Australia.

Topics will include:

- Children and young people
- People with disability
- Older people
- Homelessness
- Housing assistance
- Informal carers
- Community services workforce
- Welfare expenditure
- Indicators of Australia's welfare.

new releases

Alcohol and other drug treatment services in Australia 2010–11: state and territory findings

This report provides information on treatment episodes provided by publicly funded alcohol and other drug treatment services that are available to people seeking treatment for their own drug use and people seeking assistance for someone else's drug use.

About 700 agencies provide treatment for alcohol and other drug issues in Australia, and three-quarters of these agencies are in New South Wales, Victoria and Queensland. Most of the closed episodes provided in 2010–11 were for clients receiving treatment for their own drug use, and alcohol was the most common principal drug of concern in most states and territories. Counselling was the most common main treatment type in New South Wales, Victoria, Western Australia, South Australia and Tasmania, and was the second most common main treatment in the remaining state and territories.

Published: 21 March 2013.

Dementia care in hospitals: costs and strategies

This report estimates the cost of caring for people with dementia in New South Wales hospitals, and presents strategies and practices being implemented in Australia and internationally that might improve outcomes for people with dementia and reduce care costs. The average cost of hospital care for people with dementia was generally higher than for people without dementia ($7,720 compared with $5,010 per episode). The total cost of hospital care for these patients was estimated to be $462.9 million, of which around $162.5 million may be associated with dementia.

Published: 14 March 2013.

Cancer screening programs in Australia

This web update contains the release of the latest national participation data for Australia's breast cancer and cervical screening programs for 2010 and 2011.

BreastScreen Australia aims to reduce illness and death resulting from breast cancer by screening to detect cases of unsuspected breast cancer in women, enabling intervention at an early stage. Finding breast cancer early often means that the cancer is small, which is associated with increased treatment options and improved survival.

The web update includes the latest participation data for the National Cervical Screening Program, which aims to reduce illness and death resulting from cervical cancer in Australia.

The web update includes information on the National Bowel Cancer Screening Program the program began providing free bowel screening to people turning 55 and 65 years. In July 2008 this was extended to all Australians turning 50, 55 and 65 years of age.

The web update can be found at: <http://www.aihw.gov.au/cancer/screening/>

Published: 13 March 2013.

National core maternity indicators

This is the first report of 10 national core maternity indicators for monitoring the quality of maternity care in Australia. National rates have decreased for smoking in pregnancy, episiotomy among women having their first baby and giving birth vaginally, and the proportion of babies born weighing less than 2,750 grams at or after 40 weeks. Rates have increased for some indicators, including induction of labour, caesarean section and instrumental vaginal birth.

Published: 7 March 2013.

Healthy for life: results for July 2007–June 2011

This is the first publicly-released *Healthy for life* report since data collection and reporting began in 2007. Healthy for Life is an Australian Government program, announced in the 2005–06 Budget, which provides funds to improve the health of Aboriginal and Torres Strait Islander mothers, babies and children.

The average birthweight of babies at Healthy for Life services increased from 3,015 to 3,131 grams between the reporting periods ending in June 2008 and June 2011. Over the same period, the proportion of clients who had health assessments increased from 11.7% to 15.2% for those aged 15–54 and from 14.7% to 20.7% for those aged 55 and over. For clients aged 0–14, the proportion who had health assessments decreased slightly from 15.9% to 13.8%.

Published: 1 March 2013.

Australian hospital statistics: National emergency access and elective surgery targets 2012

This report presents 2012 data for performance indicators related to emergency department lengths of stay of 4 hours or less and lengths of time spent waiting for elective surgery, specified in the National Partnership Agreement on Improving Public Hospital Services. These data are provided to the COAG Reform Council for them to determine state and territory performance against the agreed targets.

Published: 28 February 2013.

Development of a prototype Australian mental health intervention classification: a working paper

The prototype Mental Health Intervention Classification (MHIC) has been developed so that information on mental health interventions can be collected using a standard classification scheme. Adoption of the prototype will enable nationally comparable and consistent reporting of trends, patterns and best practice in the provision of mental health services.

Published: 19 February 2013.

A snapshot of juvenile arthritis

This publication brings together the latest information on juvenile arthritis, a relatively uncommon condition affecting less than 1% of Australian children. Available data show that Australian Government subsidies for new classes of treatment medications have continually increased since their introduction in 2002–03 and hospitalisation rates for girls with juvenile arthritis rose in the 10 years to 2009–10. The reasons for the latter are not yet clear.

Published: 25 January 2013.

Dental workforce 2011

The number of dental practitioners registered in Australia in 2011 was 18,803, of whom 14,179 were dentists. The supply of employed dentists increased from 50.9 to 56.1 full-time equivalent practitioners per 100,000 population between 2006 and 2011, which reflected a 22.4% increase in dentists. The gender balance continued to shift, with women making up 35.6% of dentists in 2011 compared with 29.0% in 2006. The average hours worked each week by dentists decreased slightly from 38.5 to 37.4.

Published: 24 January 2013.

Medical workforce 2011

The supply of employed medical practitioners in Australia increased from 344.6 to 381.4 full-time equivalent practitioners per 100,000 population between 2007 and 2011, which reflected a 10.7% rise in practitioner numbers. The gender balance continued to shift, with women making up 37.6% of practitioners in 2011 compared with 34% in 2007. Specialists-in-training in the public sector worked the most average hours per week (47.6) while general practitioners in the public sector worked the least (20.5).

Published: 23 January 2013.

Any enquiries about or comments on this publication should be directed to:

Communications, Media and Marketing Unit
Australian Institute of Health and Welfare
GPO Box 570 Canberra ACT 2601

Phone (02) 6244 1028
Email info@aihw.gov.au
www.aihw.gov.au
Follow us on Twitter: @aihw