Growing up in the Territory

Parent Survey

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Minister’s foreword

Caring for our children – keeping them safe and healthy and making sure they have the best possible start in life – is one of our greatest responsibilities as family and community members and as a Government. If we as adults don’t get this right, not only do today’s children miss out on a healthy, secure and nurturing childhood, but the future wellbeing of the Territory is diminished.

Many people are involved in meeting this challenge, from family members, carers, sport and recreation organisations and schools to health, community, policing, housing, urban planning and environmental protection services.

Information about children’s health and wellbeing can help all involved to be aware of how well children are doing and ensure that the conditions in which they are thriving are understood and maintained. It also assists in focusing attention on those children and circumstances that need greatest attention and in monitoring improvements over time.

This report, Growing up in the Territory: Parent Survey, provides an invaluable picture of young children in the Northern Territory. It is the first time that a snapshot has been taken in this way of various aspects of Territory Children’s health and wellbeing and it represents a further step in improving the availability of information to guide action in their interests.

Thank you to the parents who contributed to this report by participating in the telephone survey. I commend the report as a resource to all involved in supporting the wellbeing and development of our Territory children.

The Honourable Delia Lawrie MLA
Minister for Family and Community Services
Acknowledgments

This project was undertaken for the Family and Children’s Services Branch of the Department of the Health and Community Services, with the support of the Department of Employment, Education and Training. The project team gratefully acknowledge the contribution of the many officers in both Departments. These contributions included both formal and informal advice by members of the Management Committee and the Reference Committee, as well as the much wider support provided by school principals and teachers. Of special mention are the efforts of Anthony Burton and Helen Crawford from the Family and Children’s Services Branch, and Ken Davies and Alyson Brown from the Department of Employment, Education and Training.

There were two types of questionnaires used within the project. The first type was the parent and carer telephone questionnaire, the results of which are reported in this publication. The second type were the school questionnaires, for which results will be provided in subsequent publications. All of the questionnaires used in this project were based on previous developments by Stephen Zubrick and Sven Silburn from the Telethon Institute of Child Health Research, with the cooperation of Alison Daly in the Department of Health in Western Australia. The project team thank Stephen, Sven and Alison for their advice and for their approval to use the survey questionnaires.

The telephone interviews for the project were undertaken by the interview staff at the Survey Research Centre, University of Western Australia. The project team thank the SRC staff for their diligence and cooperation.

Finally and most importantly the project team acknowledge and thank the parents and carers of Territory children, who participated in the project. Firstly by giving their time and sharing their knowledge during the telephone interviews, and secondly for their agreement for the subsequent collection of information from their children’s schools and for confidential linkage of the survey information to departmental datasets.
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Summary

Children are important for the Northern Territory, and there are a wide range of both general and specialised community services to support their wellbeing and development. To be most effective, the services require knowledge of the needs of children and of the major influences on their development. To date, the majority of information on the health and wellbeing of Northern Territory children has come from data collected at the point of contact with service delivery outlets. While this information is important it neither provides a comprehensive picture of the needs of all children, nor does it provide contextual information about the determinants of their health and development. This report fills part of that gap in knowledge, by providing prevalence estimates for common conditions as well as information about families, parents, schools and communities which form the settings for a child’s growth and maturation. The report contains separate chapters on children, families and schools and communities, but when reading these chapters it is important to recognise that these elements are not independent but interrelated.

The Parent Survey was conducted in August 2004, through Computer Assisted Telephone Interviewing (CATI). The respondents were the parents and carers of children aged from 0 to 12 years. The Parent Survey forms the first part of a wider project that also included a survey of teachers and principals (School Survey) and will link in the future, with routinely collected service datasets.

Almost two thousand children from all over the Northern Territory participated in the survey. The CATI process was chosen to generate valid information on many issues relevant to non-Indigenous children (n=1775) in a cost-effective manner. A sample of Indigenous children (n=221) was included in the survey, but the CATI methodology was not useful for generating a representative sample of all Indigenous children, because phone ownership in this population is so low. The Indigenous children who did participate were presumed to represent a group with relative socioeconomic advantage. The information about non-Indigenous children is presented in the early chapters, with a section on Indigenous children towards the end of the report.
Non-Indigenous children

Development and Health

Most children were reported to have good health, although the report does highlight some children who carry a higher burden of difficulty than the average.

Development

The three major developmental indicators described in this survey were birthweight, breastfeeding rates and active or passive smoking during pregnancy.

- The average birthweight for all children in the survey was 3321 grams. Of the whole sample, 9.1% of children were reported to be of low birthweight (<2500 grams).
- Rates of breastfeeding, while high in the initial phase (91.6%) dropped to just over half (53.3%) by the time children were six months of age. This rate was well below the national recommendation of 80% or more children still being breastfed at six months of age.
- Passive smoking is an independent risk factor for low birthweight and active smoking is associated with increased rates of miscarriage, stillbirth, prematurity, low birthweight and perinatal death. During the gestational period, almost a quarter of children (23.5%) had at least one parent or carer who smoked.

Health

The major indicators of child health reported were general health, mental health, asthma, attention deficit hyperactivity disorder and disability.

- Most children in the survey (85.1%) were described as having excellent or very good health although there was a sub-group whose health was reported to be fair or poor (3.3%).
- This survey found that the prevalence of mental health problems rose with increasing age of children and overall, was 7.9%. The proportion of all children who had received treatment for a mental health problem was 4.8%.
- The percentage of children diagnosed with asthma increased with age and overall, was 16.7%.
- The percentage of children diagnosed with Attention Deficit Hyperactivity Disorder increased with age and overall, was 2.9%.
- Children with a disability represent a vulnerable group with special needs for nurture and support. The families of these children also need support in psychosocial and practical ways, including the provision of economically and physically accessible services. Around nine percent (9.1%) of children in this survey were reported to have a disability, long term illness or pain that put a burden on the carer or family. This compares with a national prevalence of disability of 7.6% of 0 to 14 year old children.
Injury

Injury is the major cause of death in children aged from 1 to 14 years. Many injuries are preventable and therefore provide a focus for intervention.

- The most common form of injury (that required the attention of a health professional) in this survey fell into the category of ‘other injury’ (11.8%).
- Broken bones affected 2.9% of children in the year preceding the survey and the incidence increased with increasing age.
- The proportion of children that had experienced at least one injury in the year preceding the survey was 15.1%.

Risk and protective factors

Risk and protective factors have the potential to mediate the effect of upstream factors on health outcomes. Many factors are amenable to intervention and risk can be lowered for an individual through changes in behaviour. This survey revealed that Northern Territory non-Indigenous children were at risk or protected by their behaviour in similar proportions to their national counterparts. The risk and protective indicators reported here were body mass index (BMI), physical activity, television watching, nutrition and sun exposure.

- Of all children, 22.6% were described as either overweight (14.0%) or obese (8.6%). A notable proportion (12.4%) of children were described as underweight.
- Around two thirds of primary school aged children (63.0%) participated in moderate exercise (for half an hour a day) and about half (48.8%) participated in vigorous exercise (for 20 minutes a day) on at least five days in the week preceding the survey.
- Just over 10% of primary school aged children did not join in any physical activity at all during the week.
- The proportion of children who spent at least 14 hours a week (two hours a day or more) being entertained by electronic media rose dramatically with age from 12.4% of 0 to 4 year old children to 21.3% of 5 to 8 year old children and 33.7% of 9 to 12 year old children.
- Many primary school aged children were eating enough fruit (82.2%) but fewer were eating enough vegetables (29.3%), according to the national dietary guidelines for children.
- Almost three quarters (73.1%) of primary school aged children had been sunburned at least once in the previous year.
Family environment

The role of family in the life of children was explored through an examination of family structure, the health of parents, socioeconomic position and some aspects of family interaction.

Structure and size

• Altogether, 82.3% of children lived in an intact family, 10.8% lived in a one-parent family, 5.8% lived in a step or blended family and 1.1% lived in another type of family.

• The older the children in the survey, the less likely they were to live in an intact family. There was a corresponding increase in their likelihood of living in a step or blended family or a one-parent family.

• The most common household size was four people (40.1%).

• Of those children who lived apart from one of their biological parents, 40% saw them at least once a week but 29.0% never saw them.

Parents

Health

• Although many parents described their health as excellent or very good (61.8%), 4% of parents or carers described their health as poor or very poor.

• Almost 20% of parents (19.4%) had been treated for a mental health problem.

• Around 90% of the houses in this survey (89.9%) were described as smoke free.

Socioeconomic indicators

• Over half of parents (55.2%) had completed a post-secondary qualification at an institute of tertiary and further education (24.9%) or at a university (30.3%).

• Nearly three quarters (71.6%) of all respondents were in paid employment

• 17% of households (17.1%) had a total annual income of $40,000 or less.

• Around one fifth of households (21.2%) spent more money than they received or had just enough to get through to the next payday.

Family interaction

Family functioning

• A composite scale of family functioning was generated from four variables exploring issues of getting on together, planning activities, discussing fears and concerns and decision making. Of all families, 87.6% were described as functioning adequately and 12.4% were functioning poorly.

Discipline of children

• Almost two thirds of parents (61.2%) asked their children to stop always or often, when they were breaking the rules.

• Over half of parents (59.1%) were always or often able to calmly discuss the problem with their child and describe alternative, acceptable ways of behaving.

• Just over a quarter of parents (26.4%) reported that they rarely or never raised their voice with their child in response to inappropriate behaviour.

• Most parents (82%) rarely or never used physical punishment.

• Just over a quarter of parents (26.2%) always or often, and a third (33.4%) sometimes took away a child's privileges or put the child in their room.
**Schools and communities**

Some aspects of schools and communities were investigated for markers of social interaction and academic achievement.

**Education**

- Most children (86.7%) looked forward to going to school each day.
- Around three quarters of children (75.3%) were described as doing well or very well at school and at the other end of the spectrum 4% of children were described as doing poorly or very poorly at school.
- More girls (90%) than boys (83.6%) often or almost always looked forward to going to school and more girls (78.2%) than boys (72.8%) were described as performing well or very well at school.
- A notable group of children (7%) were absent from school for more than 10% of potential school days (four weeks or more) in the year preceding the survey. This would cause some disruption to the process of learning.
- Social and academic disruption may also come from the high mobility observed for some Northern Territory families. Less than half of children (44.3%) aged from 9 to 12 years had spent their entire primary school education at the same school.

**Friends**

- While most children have friends, 2.2% of all children from 4 to 12 years of age were reported to not have either a special friend or a group of friends nor belong to any group or association.

**Bullying**

- Bullying was common in children aged from 4 to 12 years, with respondents reporting that nearly half (48.1%) of children had been bullied in the previous 12 months and 17.1% of children had bullied other children.

**Services for children**

**Health services**

- The health services most frequently used by children were dental services (82.8% of children aged five or more years) and primary health care services (81.8% of all children).
- Over a quarter of children (27%) had used hospital based services.
- Very few children (2.3%) had used a mental health service and 14.4% had used an allied health service.

**Childcare**

- Over a quarter (27.7%) of all non-Indigenous children in this survey were recipients of formal care in the week before the survey and over a third (36.4%) received informal care from family and friends.
Indigenous children

The Indigenous children in this survey were not representative of all Northern Territory Indigenous children, however through the proxy measure of phone ownership, they do represent children from Indigenous households of relative socioeconomic advantage. Despite this relative advantage, this sample of Indigenous children consistently fell behind their non-Indigenous counterparts in the measured determinants of health and this was reflected in health outcome measures.

- The most striking shortfall was for socioeconomic status where 18.7% fewer Indigenous parents or carers had a post-secondary qualification, 12.1% fewer Indigenous parents were in paid employment and 31.3% more Indigenous households had an income of $40,000 or less.

- On traditional measures of risk, such as physical activity, television watching, eating fruit and vegetables and takeaway food, Indigenous children did not differ markedly from non-Indigenous children.

- However, on health outcome measures such as obesity and overweight (2.6% more), underweight (3.4% more), any injury in the last 12 months (8.2% more) and mental health problems (4.8% more), Indigenous children were bearing a greater burden of suffering.

- The families of Indigenous children were also more vulnerable, with higher percentages of one-parent families (13.4% more), step or blended families (5.6% more) and other types of families, including grandparent families (7.6% more).

- Consistent with greater poverty and sickness, rates of participation and levels of performance in education for Indigenous children were also lower. Almost 15% fewer Indigenous children belonged to a group or association and 7% more Indigenous children missed four or more weeks of school. 6.7% fewer Indigenous children were described as doing very well or well at school.

In conclusion

This survey has generated information on children, families, schools and communities. These different perspectives of children’s lives provide a variety of measures that can inform the development of appropriate policies and services. Many of the same measure can also be used as a benchmark for monitoring the effectiveness of intervention programs and of more general changes in the health and development of Northern Territory children.
Introduction

Children are a valued group in contemporary Australian society and their health, happiness and social development are regarded as important. The significance of the antenatal period, infancy and childhood are emphasised in life-course research, which has identified that many problems of adult life have their foundations in childhood. The early nurture and support of children can have profound effects on competence and resilience in later life. Investment in the health and wellbeing of children is not only a social obligation but is also a cost-effective strategy that benefits both the individual child and strengthens the social and economic resources of future Australia.\(^1,2\) An understanding of individual and environmental influences on children is necessary in order to put systems and structures in place that support children, parents and their communities.

Ecological models of child development place children with their innate biology, in the context of their social environment. Two common models, are those proposed by Zubrick et al. and included in the national *Indicators of Social and Family Functioning* and the model used by Nicholson and Sanson in the Longitudinal Study of Australian Children.\(^3,4\) The Zubrick model places the child in the centre of the major influences of family, school and neighbourhood. This grouping is placed within the wider environment, which includes health care services, government policies and general economic and social conditions (Figure 1). The child is born with physical attributes that are genetically unique, but which have already been influenced by environmental factors in utero.

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**Figure 1** Children and their environments: influences beyond the individual

Source: \(^3\) After Zubrick et al. 2000. *Indicators of social and family functioning*. Department of Family and Community Services, Canberra
The primary influence on the young infant is the family, who provide physical, social, intellectual and spiritual nurture. As the child grows, they increasingly interact with and are influenced by their neighbourhood and school.

Families, neighbourhoods and schools are situated in a wider social, economic and cultural setting, which in turn may be affected by national government policies and wider global influences. An example of this would be a decline in the international demand for primary products such as wool or sugar. In the absence of national protectionist policies, primary producers, their families and their communities would feel the impact. Communities would not be able to support local schools, either financially or emotionally to the same extent as more economically robust communities.

Families would expend their limited resources on daily survival. Within the family, parents may experience poor mental or physical health, which in turn would influence their ability to care for their children. The web of interaction that began at the perimeter with an international market force would eventually affect the health and wellbeing of an individual child.

The model of Nicholson and Sanson recognises similar influences, with a focus on the various levels of interaction, as well as the duration of influence from conception to adulthood (Figure 2). In this model, family and friends form the closest links to children, with schools, neighbourhoods and communities forming the next level of interaction. These settings operate in turn, within the influence of the wider socio-economic, physical and political environment.  

Figure 2 ► Ecological model of health across the life-course


Global forces that may affect economic policies (such as free trade) or social policies (such as childcare for working men and women) also influence our national policy framework.

Early intervention and prevention strategies aimed at contextual factors have become a priority for action in Australia. The persistent and increasing gap between the rich and poor and the associated gap in health and educational outcomes points to the need for society level interventions. Traditionally, government departments of education, community services and health have focused on providing services for individuals. Emerging evidence points to the importance of placing individuals in their contexts and the importance of programs that address the needs of groups, as well as individuals.

In order to maximise the care of our younger population, information is needed to direct planning and to monitor and evaluate programs. To date, the majority of information on the health and wellbeing of Northern Territory children has come from data collected at the point of contact with service delivery outlets. This type of information is unable to describe positive aspects of the health and wellbeing of children and provides limited contextual information about the determinants of health. It is also a poor proxy measure for need in the community. This report describes the results of the 2004 population survey of the health and wellbeing of Northern Territory children. The survey was specifically designed not only to collect benchmark information on key health measures, but also the contextual information about families, parents, schools and communities that is so critical to the lives of children and which provides the settings for child growth and maturation. The report follows the general outline of the Zubrick et al. model, but while the separate chapters report on children, families and schools and communities, it is important to recognise that these elements are not independent but interactive. The information is collected to provide evidence about the health and wellbeing of Northern Territory children and to provide a base on which to build future policy and service planning in the Northern Territory. The information also provides a reference point for changes in key areas of interest and intervention.

Importantly, this survey should be seen in the context of a broader strategy to collect information on the Northern Territory population. A significant limitation of the methods was that it provided an unrepresentative sample of Indigenous children and particularly under represented Indigenous children from remote communities. A separate survey, the National Aboriginal and Torres Strait Islander Health Survey, is currently being conducted by the Australian Bureau of Statistics and the first results are expected to be published in February 2006. The combination of material from the two surveys will provide comprehensive information for all Northern Territory children.
About the survey

The Northern Territory Child Health and Wellbeing Survey was a joint project of the Northern Territory Departments of Health and Community Services and Employment, Education and Training. It was an innovative project, developed in response to a need for holistic information on the health and wellbeing of children in the Northern Territory. The aims of the project were:

- to assess the health and wellbeing of children in the Northern Territory using a valid, reliable and standardised instrument and
- to develop a mechanism to link population health survey data to routinely collected health service and education data.

A Management Committee and a Working Group were established to oversee and realise the project. The Department of Health and Community Services chaired these groups and lists of members are contained in Appendix A.

The project had three components. The first component, the Parent Survey, collected information from parents and carers about the health, school and family environment of children from 0 to 12 years of age. The results of the Parent Survey are described in this report and cover general information about children, their health, developmental factors, risk and protective factors, social wellbeing, attitudes to school and academic performance, use of children’s services as well as information on family structure and functioning. The Parent Survey (involving 2000 children) was conducted during August 2004. The parent questionnaire is included as Appendix C in this report.

The second component, the School Survey, collected education and wellbeing information from teachers and principals about a subset of children from the Parent Survey. With parental permission, paper questionnaires were sent out to schools across the Northern Territory and principals and teachers were asked to complete one questionnaire each on the study child. Principals were also asked to complete a further questionnaire that provided school level information on students, staffing, resources and the socioeconomic environment of the school community. These questionnaires collectively referred to as the School Survey, covered information on the social and emotional wellbeing of children, academic performance, school attendance and the use of support services. The School Survey was conducted during the fourth term of 2004. This information will be included in a later report.

The third component of the project involves data linkage and, with parental permission, connects parent and schools information with health and education department data relating to participating children. Departmental records include history at birth, immunisation, hospital admissions, attendance at health centres, school attendance and academic performance. This information will also be included in a later report.

Survey method

The Parent Survey was a cross-sectional population-based survey using Computer-Assisted Telephone Interviewing (CATI). This methodology has also been used for child health surveys in New South Wales, Queensland, South Australia and Western Australia. It has been shown to generate representative samples and information that is as reliable as face-to-face population survey methods.7

Sample selection

The survey was designed to obtain completed interviews from the parents or carers of 2000 children from 0 to 12 years of age, across the Northern Territory. The sample was stratified, with a target of 1000 children from the Darwin metropolitan area (urban) and 1000 from the
remainder of the Northern Territory (rural). Households with children aged 12 years and under were randomly selected from all households listed in the Northern Territory electronic white pages.

Upon establishing that at least one child in the target population resided in the household, interviewers invited the parent or carer who was most knowledgeable about the child, to participate in the survey. When two or more children in the target age range lived in the household, one child was selected by the proximity of their birthday to a randomly selected month of the year. After agreeing to participate, parents or carers were asked a series of questions over the telephone.

Parents or carers of children attending school were also asked for permission to contact their child’s teacher and school principal. Parental consent was received for 89% of the eligible sample and the survey team forwarded copies of paper based questionnaires to the teachers and principals of participating children. Permission was also sought to approve the linkage of data from the Parent and School Surveys with routinely collected data in Northern Territory Government health and education databases. A high percentage (91%) of parents agreed to data linkage.

**Introductory letter and publicity**

Introductory letters (Appendix B) and pamphlets were sent to selected households before the interview, informing them of the survey. Householders were advised that they would be contacted by an interviewer during August 2004 and asked to participate in the survey.

Information pamphlets were also distributed to pre-schools and primary schools across the Northern Territory. A toll free telephone number was set up so that householders, teachers and principals could contact the Department of Health and Community Services with any queries regarding the survey. Notices about the survey were placed in all major Northern Territory newspapers and media releases were issued.

**Geographic region**

Postcodes listed with addresses in the electronic white pages were used to define the two geographic regions used in this survey: the Darwin Urban and Northern Territory Balance statistical divisions. For this survey, the Darwin area was classified as urban and other areas of the Northern Territory (including Alice Springs, Tennant Creek, Katherine and Nhulunbuy) were classified as rural. Stratification of the sample and relative over sampling of the Northern Territory Balance division generated representative samples that allowed regional comparisons to be made.

**Questionnaires**

The questionnaire used in the Parent Survey was primarily based on the Western Australian Child Health Survey developed by the Western Australian Department of Health and the Telethon Institute for Child Health Research. The questionnaires used in the School Survey were modelled on the Western Australian Aboriginal Child Health Survey.

**Pilot testing**

A pilot survey of 50 parent interviews was carried out in July 2004 under the supervision of the Department of Health and Community Services Survey Manager. The parent questionnaire was modified in response to minor issues raised during the pilot. The Department of Employment, Education and Training trialled processes associated with administering the school questionnaires at the same time.

**Data collection**

The Survey Research Centre, University of Western Australia was contracted to select the sample and undertake the parent interviews.
Qualified CATI practitioners conducted the interviews following a strict protocol under the supervision of senior staff. There was regular contact between the Department of Health and Community Services Survey Manager and the Survey Research Centre throughout the survey period.

Parent interviews were conducted during the weekdays and weekends with up to six call-backs made to establish contact and complete interviews. If a person could not be interviewed immediately, interviews were rescheduled to a more suitable time. Parents and carers were offered the use of a professional interpreter if required and 10 respondents chose this option. As a quality control measure, 20% of interviews were monitored.

A total of almost 25,000 telephone numbers were selected. Unused and disconnected numbers were then excluded. Of the remaining 11,967 potential households, 6983 had no child less than 13 years of age and 718 numbers were excluded here for other reasons (Figure 3). The remaining 4266 households were eligible families with a child from 0 to 12 years of age. 864 respondents in this group refused to participate in the survey and 1402 respondents were unable to participate for other reasons. These included no response after six telephone calls, no answer to the telephone, the telephone number was engaged, the respondent was unable to answer because of hearing loss, illness or language problems or a soft appointment was made after the end of the project. This left a sample of 2000 respondents who completed the survey.

Figure 3 ► Hierarchy of phone number selection

- 24,924 telephone numbers selected
- 12,956 unused and disconnected numbers deleted

- 11,967 potential households with a phone
- 6983 households with no child under 13 years were excluded
- 685 business, dead or killed numbers were excluded
- 33 households were excluded when survey quota was full

- 4266 eligible families (with a child aged from 0-12 years)

- 864 (20.2%) respondents refused to participate
- 1402 (32.9%) respondents were unable to participate for other reasons, including no response after six calls, no answer, number engaged, respondent was unable to answer because of hearing loss, illness or language problems or a soft appointment was made after the end of the project
- 2000 (46.9%) respondents completed interviews
The response rate was 46.9% of the initial eligible sample and the participation rate was 68.4% of the initial eligible sample that were contactable (Table 1).

**Data analysis**

There was a total of 2000 interviews completed. Three children were found to have duplicate entries, with independent responses by two parents or carers and one entry was collected for a child outside the target age range. Therefore four entries were excluded from analysis, providing a total sample of 1996 children.

Data for non-Indigenous and Indigenous children were weighted separately to account for differences between the sample and the population. The weighting was by the number of children in the household, age and sex of the child, area of residence and the number of separate telephone lines in the household, all of which affected the probability of a participating child being selected. Population estimates for Northern Territory children aged from 0 to 12 years were derived from the 2001 Census conducted by the Australian Bureau of Statistics.

For most analysis the data was grouped into three age groups: 0 to 4 years covering the pre-school period, 5 to 8 years encompassing early childhood and 9 to 12 years for the upper primary school period.

Data was analysed using STATA 8 statistical software. Confidence intervals (95%) were estimated for all analyses and these intervals are provided in tables and selected graphs.

**Table 1 ► Response and participation rate**

<table>
<thead>
<tr>
<th>Details of Sample</th>
<th>Number</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Initial eligible sample with a child aged from 0-12 years</td>
<td>4266</td>
<td>100.0</td>
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<tr>
<td>Respondents refused to participate</td>
<td>864</td>
<td>20.3</td>
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<tr>
<td>No response after 6 calls</td>
<td>952</td>
<td>22.3</td>
</tr>
<tr>
<td>No answer</td>
<td>323</td>
<td>7.6</td>
</tr>
<tr>
<td>Number engaged</td>
<td>2</td>
<td>0.0</td>
</tr>
<tr>
<td>Soft appointment made after the end of the project</td>
<td>67</td>
<td>1.6</td>
</tr>
<tr>
<td>Respondent unable to answer because of hearing loss</td>
<td>25</td>
<td>0.6</td>
</tr>
<tr>
<td>Respondent unable to speak English</td>
<td>32</td>
<td>0.8</td>
</tr>
<tr>
<td>Refused to reveal age of child</td>
<td>1</td>
<td>0.0</td>
</tr>
<tr>
<td>Completed interviews</td>
<td>2000</td>
<td>46.9</td>
</tr>
</tbody>
</table>

**Response rate**

\[
\text{Response rate} = \frac{2000}{4266} = 46.9\%
\]

**Participation rate**

\[
\text{Participation rate} = \frac{2000}{(4266 - (952 + 323 + 2 + 67))} = 68.4\%
\]
Limitations of the survey

The use of low-cost computer assisted telephone interviewing for this first survey of child health and wellbeing yielded a sample that was representative of Northern Territory non-Indigenous children. Indigenous children, who comprise 40% of children aged from 0 to 12 years, were significantly under-represented. Only 1.5% of Indigenous Territorians in remote areas have a fixed telephone service. This compares with 96.8% of all households in Australia.\(^9\) When using this report its primary relevance to non-Indigenous Northern Territory children (60%) should be kept in mind. Responses for Indigenous children are presented in a separate chapter.

Information about the health and wellbeing of Northern Territory Indigenous children from 0 to 15 years will emerge from the Australian Bureau of Statistics National Aboriginal and Torres Strait Islander Health Survey 2004-05. This survey will include approximately 1500 people from the Northern Territory, half of whom are children. The first results should be released by February 2006. In addition, the Australian Government’s Department of Family and Community Services is conducting the Longitudinal Study of Indigenous Children, which will generate further information on Northern Territory Indigenous children.

As the data in this survey was reported in an interview situation, some issues of a sensitive nature may have been subject to reporting bias. Examples include the weight of the child, mental health problems, family functioning and the discipline of the child. There was evidence in the results of some confusion between imperial and metric measurements of birthweight. Of the responses, 20% were coded in imperial units with the balance recorded in metric units. Three children had a recorded birthweight of less than 500 grams and these observations were recoded as unknown. Five children had a recorded birthweight of 6 kilograms or more. As this was considered statistically unlikely, their observations were also recoded as unknown.

Interview responses on certain issues, such as general and mental health may yield different results because of different interview methods.\(^{10}\) Direct comparisons between different population surveys should only be made with caution.
Children

Participants

The parents and carers of a random sample of 1775 non-Indigenous children in the Northern Territory were interviewed in August 2004. Children were aged from 0 to 12 years and after weighting the data, 7% to 8% of the children were in each of the 13 age categories. For most of the elements of the survey, the age categories were then aggregated into the three age groups: 0 to 4 years, 5 to 8 years and 9 to 12 years (Table 2).

In the weighted sample, 51.5% of children were male and 48.5% were female. This result is consistent with the Northern Territory 2001 Census estimates of non-Indigenous children where 51.9% were male and 48.1% were female. More children in the weighted sample were from the Darwin area (67.7%), which included Darwin City, Palmerston-East Arm and Litchfield Shire, than from other areas of the Northern Territory (32.3%). This is consistent with the distribution of the non-Indigenous population, which is clustered in and around Darwin. While it is recognised that many children, particularly in the outer Darwin area, live a rural lifestyle they also have greater access to the services and facilities available in Darwin than children elsewhere in the Northern Territory. As a result, in this report the children from the Darwin area are collectively referred to as ‘urban’ and the remainder as ‘rural’.

Almost all of the children (95.8%) were born in Australia, with the remaining 4.2% born overseas.

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Actual sample</th>
<th>Weighted sample</th>
<th>Percent (weighted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>686</td>
<td>703</td>
<td>39.5</td>
</tr>
<tr>
<td>5-8</td>
<td>504</td>
<td>550</td>
<td>31.0</td>
</tr>
<tr>
<td>9-12</td>
<td>585</td>
<td>523</td>
<td>29.5</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>942</td>
<td>915</td>
<td>51.5</td>
</tr>
<tr>
<td>Female</td>
<td>833</td>
<td>861</td>
<td>48.5</td>
</tr>
<tr>
<td>Area of residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban (Darwin, Palmerston, Litchfield)</td>
<td>916</td>
<td>1201</td>
<td>67.7</td>
</tr>
<tr>
<td>Rural</td>
<td>859</td>
<td>574</td>
<td>32.3</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>1775</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Development

Key Points

- A high proportion of children (91.6%) were breastfed for some time and just over half of these children (53.3%) were still being breastfed at 6 months.
- During the gestational period, almost a quarter of children had at least one parent or carer who smoked.
- Developmental delay was more commonly reported for male children (7.1%) than female children (4.6%).
- Delayed speech was more commonly reported for male children (18.2%) than female children (10.1%).

Many factors combine to give children a robust start to life. The four factors of birthweight, breastfeeding, introduction of solid foods and exposure to smoking during pregnancy provide an indication of risk and outlook for children. They are not deterministic, but may affect a child’s progress through the early years. Respondents were also asked if the child had been described as having developmental delay and whether they thought that their child was late in starting to talk.

Birthweight

Parents and carers were asked how much the child weighed at birth. Reported birthweight ranged from 600 to 5897 grams for all children. The average birthweight for girls was 3219 grams and for boys 3418 grams. A weight greater than 2500 grams is regarded medically as normal, while a weight below 2500 grams is considered to be a low birthweight and is associated with increased risk for a range of conditions. The proportion of children who were...
reported to be of low birthweight (less than 2500 grams) was 10.2% of 0 to 4 year old children, 9.9% of 5 to 8 year old children and 8.4% of 9 to 12 year old children. In 2002, the prevalence of low birthweight measured for all Northern Territory non-Indigenous babies was 5.8%. This was less than the prevalence reported here, which may be affected by random recall bias. There was also uncertainty by some respondents when distinguishing birthweight in either imperial or metric units.

Breastfeeding
A high proportion of children (91.6%) were breastfed for some time. Of all children, 70.3% were still being breastfed at 3 months, 53.3% at 6 months and 25.4% at 12 months (Figure 4). The number of children who were breastfed after twelve months steadily decreased to less than 5.6% at two years of age.

Introduction of solid food
National dietary guidelines recommend the introduction of additional solid and liquid food to babies from six months of age. Solid food was introduced to 4.5% of children in this survey by the age of 2 months, 16.5% of children by the age of 3 months, 87% of children by the age of 6 months and 99.4% of children by the age of 12 months (Figure 5).

Breastfeeding
The World Health Organisation recommends exclusive breastfeeding up to six months of age. These recommendations are consistent with the Australian guidelines, which aim to have greater than 90% of infants breastfeeding at discharge from hospital and more than 80% of infants breastfeeding when the infant is 3 and 6 months of age. The target was achieved by the children in this survey for the initial uptake of breastfeeding, but the continuity of breastfeeding declined at higher than the recommended rate.
Smoking during pregnancy

Smoking during pregnancy is known to affect the foetus and is causally associated with low birthweight and poor neonatal outcomes. Respondents were asked if they or their partner smoked during pregnancy. The question did not distinguish between the smoking of either the mother or her partner. During the gestational period almost a quarter of children in each age group had at least one parent or carer who smoked (Table 3). For children aged 0 to 4 years, 21.7% of mothers or partners smoked during pregnancy. For children aged 5 to 8 years, 24.4% of mothers or partners smoked and for children aged 9 to 12 years, 25.0% of mothers or partners smoked during pregnancy. While these results are not statistically different, the difference between the three age groups is consistent with a decline in gestational smoking exposure over the last decade.

Table 3 ► Non-Indigenous children whose parent or partner smoked during pregnancy

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>152</td>
<td>21.7</td>
<td>(17.9—25.5)</td>
</tr>
<tr>
<td>No</td>
<td>546</td>
<td>77.8</td>
<td>(73.9—81.6)</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
<td>0.5</td>
<td>(0.0—1.1)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>134</td>
<td>24.4</td>
<td>(19.8—29.0)</td>
</tr>
<tr>
<td>No</td>
<td>413</td>
<td>75.1</td>
<td>(70.5—79.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>0.5</td>
<td>(-0.1—1.0)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>131</td>
<td>25.1</td>
<td>(20.8—29.2)</td>
</tr>
<tr>
<td>No</td>
<td>390</td>
<td>74.6</td>
<td>(70.4—78.8)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>0.3</td>
<td>(-0.1—0.8)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Smoking during pregnancy

Smoking during pregnancy is associated with many adverse outcomes for both mother and baby. Smoking may make it more difficult to conceive in the first place. During pregnancy the likelihood of ectopic pregnancy, miscarriage and placental problems is elevated. For the baby, maternal smoking raises the chances of premature birth, perinatal death and a low birthweight. Stopping smoking during pregnancy can help reduce rates of preterm birth and increase the potential birthweight of babies. The Northern Territory has the highest reported rate of smoking during pregnancy (26.3%) in Australia, which is higher than the rate reported here. This represents an area for significant population health improvement through the application of both individual and population level tobacco-control strategies.
Developmental delay

Developmental delay was more frequently reported by parents of 9 to 12 year old children (8.8%) than those of 5 to 8 year old children (6.3%) or 0 to 4 year old children (3.5%) (Table 4). This result is consistent with problems being more likely to be identified as a child increases in age. Developmental delay was more commonly reported for boys (7.1%) than girls (4.6%).

Delayed speech

Nearly one fifth (17.8%) of children aged from 2 to 4 years were described as being late in starting to talk. About half (8.9%) of children with speech problems were thought by parents to need speech pathology services for their problem. Lower proportions of the older age groups of children (13.6% of 5 to 8 year old children and 12.3% of 9 to 12 year old children) were described as late in starting to talk and 8.8% and 6.3% of these groups respectively, were thought to require professional help (Figure 6). Delayed speech was more commonly reported for boys (18.2%) than girls (10.1%) and 9.4% of boys and 6.3% of girls were thought to require speech pathology services for their problem.

Table 4  Developmental delay in non-Indigenous children

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25</td>
<td>3.5</td>
<td>(1.8—5.1)</td>
</tr>
<tr>
<td>No</td>
<td>673</td>
<td>95.8</td>
<td>(93.9—97.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
<td>0.6</td>
<td>(-0.3—1.5)</td>
</tr>
<tr>
<td>Refused</td>
<td>1</td>
<td>0.1</td>
<td>(-0.1—0.3)</td>
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<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35</td>
<td>6.3</td>
<td>(3.7—8.9)</td>
</tr>
<tr>
<td>No</td>
<td>515</td>
<td>93.7</td>
<td>(91.1—96.3)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>46</td>
<td>8.8</td>
<td>(5.9—11.6)</td>
</tr>
<tr>
<td>No</td>
<td>477</td>
<td>91.2</td>
<td>(88.4—94.1)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Health

Key Points

- The proportion of children described as having fair or poor health fell after children reached school age.
- Of all children, 7.9% were thought to have problems with emotions, concentration, behaviour or getting on with people. The proportion of all children who had received treatment for a mental health problem was 4.8%.
- Mental health problems were reported for more boys (9.6%) than girls (6.1%).
- The prevalence of asthma increased with age and for all children was 16.7%.
- 3% of children were reported to have had a diagnosis of Attention Deficit Hyperactivity Disorder and three quarters of these were boys.

- Of all children, 9.1% were described as having a disability, long-term illness or pain that put a burden on the carer or family.

In this survey, respondents reported general health status on behalf of their children. Respondents were also asked about the mental health of their child, the presence of selected common disorders (asthma, attention deficit hyperactivity disorder and musculoskeletal problems) and whether their child had a disability. Mental health, asthma and injury prevention are national health priority areas and this survey provides the first available prevalence data specific to Northern Territory non-Indigenous children. This information will assist both the monitoring of prevalence in the Northern Territory population and the evaluation of interventions relating to these areas.

Figure 6 ► Delayed speech in non-Indigenous children

![Graph showing delayed speech in non-Indigenous children]
**General health**

A high proportion of children were described as having excellent or very good health (83.2% of children from 0 to 4 years of age, 87% of children from 5 to 8 years of age and 85.2% of children from 9 to 12 years of age). Approximately 10% in each group of children were described as having good health (12.3%, 10.5% and 12.1% from youngest to oldest age group). The proportion of children described as having fair or poor health fell after children reached school age (4.3%, 2.4% and 2.8% from youngest to oldest age group) (Figure 7).

A lower proportion of boys (96.3%) were described as having excellent, very good or good health compared with girls (97.3%) and at the other end of the scale a higher proportion of boys (3.7%) were described as having fair or poor health compared with girls (2.8%).

**Mental health**

Respondents for children aged at least one year were asked three questions about the social and emotional wellbeing of their child. These questions related to the presence of trouble with emotions, concentration, behaviour or getting on with people, whether the child was thought to need special help for these troubles and whether the child had ever been treated for an emotional or mental health problem.

The percentage of mental health problems (‘quite a lot’ or ‘very much’) was higher in the two older age groups of children (4.5%, 10.3% and 9.0% from youngest to oldest age group). The proportion of all children with any level of emotional problem (‘only a little’, ‘quite a lot’ or ‘very much’), who were thought to need special help for their problem rose sharply with the increasing age of children (3.2%, 8.5% and 9.0% from youngest to oldest age group) (Figure 7).
11.5% from youngest to oldest age group). Older children were more likely to have received treatment for a mental health problem (1.6%, 4.6% and 8.7% from youngest to oldest age group) (Figure 8).

Mental health problems were reported for more boys (9.6%) than girls (6.1%) and more boys (5.8%) than girls (3.8%) had received treatment for their problems. In each age group, more boys than girls had been treated (boys: girls, 2%: 1.3%, 6.7%: 2.4% and 9.0%: 8.3% from youngest to oldest age group).

**Mental health**

The *National Survey of Mental Health and Well-being* conducted in 1998, found a prevalence of mental health problems among children aged from 4 to 17 years of 14%. The results of the national survey and this Northern Territory survey highlight some areas for specific comment. Firstly, while the age groups of the two surveys differ, it does appear that the reporting of mental health problems by parents and carers in the Northern Territory survey is below the national average. This may reflect a true difference, or be due to under-reporting in an interview situation, or reflect a lack of awareness by parent and carers of symptoms of mental health problems. Secondly, treatment for mental health problems in the Northern Territory is consistent with the national survey, with only one in four young people with a mental health problem having received professional care. The presence of problem behaviours in childhood may be a predictor for antisocial behaviour in adolescence and the recognition of difficulties and early intervention may reduce subsequent problems.
Common disorders

Asthma

The prevalence of asthma has been rising in Australia over the last 20 years and has been reported as a long-term diagnosis for 13% of all Australian children aged from 0 to 14 years. Asthma is a major contributor to the burden of disease in children and also has a significant effect on school attendance and the use of health care services.\textsuperscript{13,21,22}

In this survey, asthma had been diagnosed in 16.7% of all children. The rate increased with age and was 9.2% of 0 to 4 year old children, 16.0% of 5 to 8 year old children and 27.6% of 9 to 12 year old children. Of these children, the proportion that had experienced symptoms in the previous 12 months was highest in the youngest age group (76.9%, 58.7% and 47.8% from youngest to oldest age group). The proportion of the affected group that had been treated for asthma in the 12 months preceding the survey was also highest for the youngest children (72.8%, 58.5% and 51.5% from youngest to oldest age group). However, the total numbers of children experiencing symptoms and receiving treatment was higher for older children (Figure 9). More boys (19.0%) than girls (14.3%) had been diagnosed with asthma.

Figure 9 ► Asthma in non-Indigenous children

- Asthma ever diagnosed
- Asthma symptoms during last year
- Asthma treatment during last year
Attention Deficit Hyperactivity Disorder

Respondents were asked if a doctor had ever diagnosed Attention Deficit Hyperactivity Disorder (ADHD) in their child. The reported prevalence of Attention Deficit Hyperactivity Disorder rose with increasing age of children (0.6%, 1.9% and 6.0% from youngest to oldest age group) (Table 5). Of the children affected 75% were boys and 25% were girls. These reported rates of diagnosed ADHD were well below the national prevalence of ADHD in children aged 6 to 12 years, which is 19.3% for males and 8.8% for females.  

Musculo-skeletal problems

A problem with coordination and clumsiness was documented for 3.3% of 2 to 4 year old children, 6.7% of 5 to 8 year old children and 8.1% of 9 to 12 year old children. The condition was more common in boys (6.5%) than girls (5.0%). A small proportion of children were noted to have a problem with deformity and stiffness (3.3%, 1.8% and 3.2% from youngest to oldest age group).

Table 5  ►  Attention Deficit Hyperactivity Disorder in non-Indigenous children

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Attention Deficit Hyperactivity Disorder</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-4</td>
<td>Yes</td>
<td>2</td>
<td>0.6</td>
<td>(-0.3—1.4)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>413</td>
<td>99.4</td>
<td>(98.6—100.3)</td>
</tr>
<tr>
<td>5-8</td>
<td>Yes</td>
<td>10</td>
<td>1.9</td>
<td>(0.2—3.6)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>539</td>
<td>98.1</td>
<td>(96.4—99.8)</td>
</tr>
<tr>
<td>9-12</td>
<td>Yes</td>
<td>31</td>
<td>6.0</td>
<td>(3.6—8.4)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>492</td>
<td>94.0</td>
<td>(91.6—96.4)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>1488</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Disability

A disability, long-term illness or pain that put a burden on the carer or family was reported for 6.9% of 0 to 4 year old children, 10.3% of 5 to 8 year old children and 10.6% of 9 to 12 year old children (Table 6). If the child had a disability that was described as putting a burden on the carer or family, the burden was described as ‘fairly big’, ‘big’ or ‘very big’ for 51.3% of families of 0 to 4 year old children, 40.4% of families of 5 to 8 year old children and 56.1% of families of 9 to 12 year old children.

Table 6  ► Disability in non-Indigenous children

<table>
<thead>
<tr>
<th>Disability</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>49</td>
<td>6.9</td>
<td>(4.5—9.4)</td>
</tr>
<tr>
<td>No</td>
<td>651</td>
<td>92.7</td>
<td>(90.2—95.2)</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>0.4</td>
<td>(-0.1—0.9)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>57</td>
<td>10.3</td>
<td>(7.0—13.7)</td>
</tr>
<tr>
<td>No</td>
<td>493</td>
<td>89.7</td>
<td>(86.3—93.0)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>55</td>
<td>10.6</td>
<td>(7.7—13.5)</td>
</tr>
<tr>
<td>No</td>
<td>468</td>
<td>89.4</td>
<td>(86.5—92.3)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Injury

**Key Points**

- The incidence of broken bones increased with age and was 6.4% for children aged from 9 to 12 years.
- Most poisonings occurred in younger children, aged from 0 to 4 years.
- Injuries were more common for boys (16.3%) than girls (13.8%).
- Injuries were more common for rural (16.1%) than urban children (14.5%).

Injury statistics are a key indicator of the safety and security of children. Injury is the major cause of death for children aged 1 to 14 years and includes motor vehicle accidents, drowning and assault or intentional harm. It is one of the national health priority areas. Parents in this survey were asked whether in the previous 12 months, their child had had any broken bones, a head injury that made them unconscious, a stay in hospital because of an accidental burn or accidental poisoning or any other injury that was serious enough to require treatment by a health professional (Table 7).

**Table 7: Injury of non-Indigenous children**

<table>
<thead>
<tr>
<th>Type of injury</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 Broken bones</td>
<td>6</td>
<td>0.9</td>
<td>(-0.1—1.8)</td>
</tr>
<tr>
<td>0-4 Head injury</td>
<td>6</td>
<td>0.8</td>
<td>(0.0—1.7)</td>
</tr>
<tr>
<td>0-4 Burn</td>
<td>1</td>
<td>0.2</td>
<td>(-0.1—0.4)</td>
</tr>
<tr>
<td>0-4 Poison</td>
<td>4</td>
<td>0.6</td>
<td>(-0.1—1.2)</td>
</tr>
<tr>
<td>0-4 Other injury</td>
<td>62</td>
<td>8.8</td>
<td>(6.2—11.5)</td>
</tr>
<tr>
<td>0-4 At least one injury</td>
<td>77</td>
<td>11.0</td>
<td>(8.0—13.9)</td>
</tr>
<tr>
<td>5-8 Broken bones</td>
<td>12</td>
<td>2.2</td>
<td>(0.9—3.4)</td>
</tr>
<tr>
<td>5-8 Head injury</td>
<td>11</td>
<td>1.9</td>
<td>(0.6—3.2)</td>
</tr>
<tr>
<td>5-8 Burn</td>
<td>0</td>
<td>0.1</td>
<td>(-0.1—0.2)</td>
</tr>
<tr>
<td>5-8 Poison</td>
<td>1</td>
<td>0.2</td>
<td>(-0.2—0.6)</td>
</tr>
<tr>
<td>5-8 Other injury</td>
<td>81</td>
<td>14.7</td>
<td>(10.9—18.5)</td>
</tr>
<tr>
<td>5-8 At least one injury</td>
<td>96</td>
<td>17.4</td>
<td>(13.4—21.4)</td>
</tr>
<tr>
<td>9-12 Broken bones</td>
<td>33</td>
<td>6.4</td>
<td>(4.2—8.6)</td>
</tr>
<tr>
<td>9-12 Head injury</td>
<td>7</td>
<td>1.3</td>
<td>(0.4—2.2)</td>
</tr>
<tr>
<td>9-12 Burn</td>
<td>1</td>
<td>0.2</td>
<td>(-0.1—0.4)</td>
</tr>
<tr>
<td>9-12 Poison</td>
<td>1</td>
<td>0.1</td>
<td>(-0.1—0.3)</td>
</tr>
<tr>
<td>9-12 Other injury</td>
<td>66</td>
<td>12.6</td>
<td>(9.5—15.7)</td>
</tr>
<tr>
<td>9-12 At least one injury</td>
<td>95</td>
<td>18.1</td>
<td>(14.5—21.6)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
**Broken bones**

The incidence of broken bones increased with age (0.9%, 2.2% and 6.4% from youngest to oldest age group). Broken bones were more commonly reported for boys (3.4%) than girls (2.3%).

**Head injury**

In the 12 months preceding the survey 0.8% of 0 to 4 year old children, 1.9% of 5 to 8 year old children and 1.3% of 9 to 12 year old children suffered a head injury that made them lose consciousness. Head injury was more commonly described in boys (1.6%) than girls (1.0%).

**Burns**

In the 12 months preceding the survey 0.2% of 0 to 4 year old children, 0.1% of 5 to 8 year old children and 0.2% of 9 to 12 year old children were hospitalised because of an accidental burn. Burns were more common in boys (0.2%) than girls (0.1%).

**Poisoning**

Poisoning was more common in younger children (0.6%, 0.2% and 0.1% from youngest to oldest age group). Poisoning occurred in 0.4% of boys and 0.3% of girls.

**Other injury**

‘Any other injury’ was more commonly described in school-aged children (8.8%, 14.7% and 12.6% from youngest to oldest age group). Any other type of injury was more common for boys (12.4%) than girls (11.1%).

**All injuries**

Overall, 16.3% of boys and 13.8% of girls suffered at least one significant injury in the year preceding the survey. The occurrence of at least one injury was more common for rural children (16.1%) than urban children (14.5%).

**Injury**

Injury and poisoning are the most common cause of death in children aged from 1 to 14 years in Australia and the fourth most common cause of death in infants less than one year old. They are also a frequent reason for the hospitalisation of children and infants.

Falls have been reported as the most common type of injury in Australian children. This is reflected in this survey by the rates of other injuries and broken bones. Injuries have been reported as more common in boys and more prevalent in rural areas, which is consistent with this Northern Territory survey. Children who are socio-economically disadvantaged are more likely to be injured and to die from their injuries.
Risk and protective factors

Key Points

• Around one quarter of all children (22.6%) were overweight or obese.

• On at least five days in the week before the survey, around two thirds (63.0%) of 5 to 12 year old children participated in moderate exercise and around half (48.8%) participated in vigorous exercise.

• The proportion of children who spent at least 14 hours each week (two hours a day or more) being entertained by electronic media rose dramatically with age from 12.4% of 0 to 4 year old children to 21.3% of 5 to 8 year old children and 33.7% of 9 to 12 year old children.

• Many primary school aged children were eating enough fruit (82.2%) but fewer were eating enough vegetables (29.3%), according to the national dietary guidelines for children.

• 10 to 15% of primary school-aged children were often not protected from the sun and around three quarters (73.1%) had been sunburned at least once in the previous year.

A range of individual behavioural factors was included in the survey. These factors have significant effects on an individual’s health in childhood and/or adulthood. A healthy weight for example, is influenced by physical activity and nutrition. These factors may also have implications for mental health and the development of chronic diseases. A summary of the findings is included in the figure below showing the percentage of children who reach specified national targets for each particular factor (Figure 10). A fuller explanation of each factor is included in the relevant section of this chapter.

Figure 10  ► Risk and protective factors for non-Indigenous children

- Always use sun protection
- Participates in physical activity five sessions or more per week*
- Eats recommended serves of fruit
- Eats recommended serves of vegetables
- Watches TV less than two hours per day
- Not overweight or obese

* One session equals 30 minutes of moderate activity or 20 minutes of vigorous activity
**Weight and height**

Respondents were asked to report the height and weight of their child. Body Mass Index (BMI) is a measure that combines height and weight to give a single numeric score for the body of an individual. To define overweight or obesity in children, BMI was compared to reference charts that are specific to the age and sex of the child.\(^{23}\) In childhood, BMI usually falls during the preschool years and then rises into adolescence.\(^{24}\)

More boys (24.1%) than girls (21.1%) were overweight or obese. The prevalence of overweight and obesity fell with increasing age of children (28.8% of 21 months to 4 year old children, 21.8% of 5 to 8 year old children and 19.1% of 9 to 12 year old children) (Figure 11).

The proportion of children described as underweight fell with increasing age of children (18.4% of 21 months to 4 year old children, 14.5% of 5 to 8 year old children and 4.6% of 9 to 12 year old children). More girls (13.5%) were described as underweight than boys (11.3%).

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**Figure 11 ► Body mass index of non-Indigenous children**

* Body Mass Index (BMI) was calculated from 21 months of age, using the following formula. BMI = weight (kg) / height (m)^2.\(^{23}\)
Overweight and obesity

The accuracy of parental recall of the height and weight of children has been reported as unreliable and the Body Mass Index (BMI) calculated from the figures in this report therefore need to be considered cautiously and may not be a reliable representation of the true prevalence of overweight and obesity among Northern Territory non-Indigenous children. Despite this, the prevalence of obesity and overweight recorded (24.1% of boys and 21.1% of girls) is consistent with the national trend, which saw a doubling of the rates of these problems in Australian children and adolescents from 1985 to 1997. In 1997, the prevalence of overweight and obesity in primary school-aged children in New South Wales and Victoria was reported to be between 20 and 25%.

Physical activity

Physical activity is beneficial for growth and development, fitness, skills development, mental wellbeing, maintaining a normal weight and social interaction with peers. Respondents to this survey were asked questions about physical activity if their child was four years of age or older. Responses related to exercise during the week preceding the survey.

Vigorous exercise

Vigorous exercise was defined as participation in a physical activity for at least 20 minutes a day that resulted in sweating and breathing hard. Sports such as basketball, soccer, football, running, swimming laps, fast cycling or netball qualify within this category.

In general, participation in vigorous exercise rose with increasing age of children. The proportion of children who did not participate in any vigorous activity in the week preceding the

Figure 12  Vigorous exercise during the week before the survey, non-Indigenous children

![Graph showing the percentage of non-Indigenous children engaging in vigorous exercise by age group (4 years, 5-8 years, 9-12 years)]
survey, fell from 32.4% of 4 year old children to 8.7% of 5 to 8 year old children and 5.8% of 9 to 12 year old children. Some children participated in vigorous exercise on only one or two days (13.8%, 20.4% and 17.9% from youngest to oldest age group). However, with increasing age there were increasing proportions of children who participated in three to four days (15.8%, 21.3% and 22.2% from youngest to oldest age group) and five to seven days of vigorous exercise (36.4%, 47.5% and 52.8% from youngest to oldest age group) (Figure 12).

More boys (52.8%) than girls (44.1%) achieved at least five days of vigorous exercise in the week before the survey. Slightly more girls (10.6%) than boys (9.6%) did not undertake any vigorous exercise in the preceding week.

Moderate exercise

Moderate exercise was defined as participation in a physical activity for at least 30 minutes a day that did not result in sweating or breathing hard. Activities such as fast walking, slow cycling, rollerblading or skate boarding fulfilled the requirements for this category.

Some children in each age group did not participate in any moderate exercise in the week preceding the survey (7.8%, 10.7% and 10.0% from youngest to oldest age group). Similar proportions of children participated in one to two days of moderate exercise (13.8%, 13.3% and 14.1% from youngest to oldest age group) and three to four days of moderate exercise (10.8%, 10.2% and 13.5% from youngest to oldest age group). Around two thirds of children in each age group participated in moderate exercise on at least five days of the week preceding the survey (67.6%, 64.4% and 60.4% from youngest to oldest age group) (Figure 13).
More boys (12.5%) than girls (7.5%) did not undertake any moderate exercise in the week preceding the survey. About the same proportion of boys (62.8%) and girls (63.2%) achieved at least five days of moderate exercise in the week preceding the survey.

Television watching
Watching television has a direct effect on the mental state of children and an indirect effect on their fitness and weight through enforced inactivity in front of the screen. Respondents were asked how many hours each week their child spent watching television or videos or playing video or computer games.

Over a quarter (26.8%) of 0 to 4 year old children did not watch television, videos or play video or computer games. The proportion of children who did not participate in screen activities dropped to 1.6% of 5 to 8 year old children and 0.6% of 9 to 12 year old children. At the other end of the scale, the proportion of children who spent at least 14 hours each week being entertained in front of a screen rose dramatically with age (12.4%, 21.3% and 33.7% from youngest to oldest age group).

The proportion of children who spent a modest amount of time with electronic media each week (one to seven hours) fell with increasing age of children (41.1%, 37.9% and 28.9% from youngest to oldest age group). The proportion of children who spent from eight to 14 hours with electronic media each week rose for school-aged children (19.1%, 39.2% and 36.6% from youngest to oldest age group) (Figure 14).
Television watching

National guidelines state that ‘children should not spend more than two hours a day using electronic media for entertainment (eg computer games, TV, internet), particularly during daylight hours’.\(^2\) One fifth of 5 to 8 year old children (19.1%) and one third of 9 to 12 year old children (36.6%) in this survey, exceeded this recommendation.

Electronic media have the potential to affect the health of young children in a variety of ways. Children can benefit from their interactions with media if content and time are supervised, if they have skills to discern different genres and their implications and if they have involvement in a wide range of other recreational and learning activities. Children at risk from interaction with electronic media are those who have less supervision, who suffer the effects of prolonged inactivity on weight and fitness, whose families are not functioning well, who are younger or who have intellectual, emotional, learning or other developmental problems.\(^2\) The association between the portrayal of violence in electronic media and aggressive behaviour has also been recognised.\(^2\) Other associated issues include education and learning, advertising of food, alcohol, fashion, pharmaceuticals and entertainment, the reinforcement of social stereotypes and messages about suicide and other mental health problems.\(^2\)\(^3\)

Figure 14 – Television watching each week by non-Indigenous children

[Graph showing television watching by age group]

No TV   1-3 hrs   4-7 hrs   8-14 hrs   14 hrs or more

0-4 years

5-8 years

9-12 years
Nutrition

Along with physical activity, consumption of a wide variety of healthy foods is essential for the growth and development of children (Table 8). Vegetables, fruit and cereals make up around three quarters of daily nutritional requirements. Respondents were asked about the quantities and types of food and drink that their child usually consumed each day. The questions related to fruit, vegetables, milk, takeaway food and soft drinks.

Fruit

The majority of children of all age groups ate at least one serve of fruit each day (94.8% of 1 to 4 year old children, 87.6% of 5 to 8 year old children, 87.7% of 9 to 12 year old children) (Figure 15).

The national dietary guidelines for children recommend at least one serve of fruit each day for children aged from 4 to 11 years. Most children aged from 4 to 11 met these guidelines. For children aged 12, the recommended fruit intake rises to three serves of fruit each day. This revised level was only met by one quarter (23.7%) of the 12 year old children in the survey.

Table 8 ► Recommended serves for children and adolescents in Australia

<table>
<thead>
<tr>
<th>Age group</th>
<th>Vegetables</th>
<th>Fruit</th>
<th>Milk</th>
<th>Extra Foods</th>
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<td>4-7 years</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1-2</td>
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<tr>
<td>8-11 years</td>
<td>3</td>
<td>1</td>
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<td>1-2</td>
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<tr>
<td>12 years</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1-3</td>
</tr>
</tbody>
</table>

Serving size

Vegetables: ½ cup cooked veg, 1 cup of salad; Fruit: 1 medium piece, 2 small pieces, 1 cup of diced fruit, 1 tablespoon dried fruit; Milk: 250ml cup of milk, 40g (2 slices) of cheese, 200g carton of yoghurt; Extra Foods: 1 can soft drink, 2 cups cordial, 1 slice pizza (2 serves), 1 meat pie/pasty (3 serves)

Vegetables

Across all age groups the majority of children were consuming one to two serves of vegetables each day (86.2%, 86.1% and 88.4% from the youngest to oldest age group) (Figure 16), however within these groups only a small proportion were consuming more than one to two serves.

The national dietary guidelines for children recommend at least two serves of vegetables each day for 4 to 7 year old children and at least three serves each day for 8 to 12 year old children. While children were consuming some vegetables, only 29.3% of children aged 4 to 12 years reached the recommended amount of vegetables. This included 40.1% of 4 to 7 year old children, 17.7% of 8 to 11 year old children and 29.4% of 12 year old children.
Fruit and vegetables

This survey has shown that many Northern Territory non-Indigenous children were not eating enough fruit and an even greater proportion were not eating enough vegetables. The low level of vegetable consumption is consistent with national indicators that have previously highlighted the inadequacy of vegetable consumption by children.

In 2004, the Federal government announced a new initiative, Building a Healthy Active Australia. This program aims to improve the eating habits and physical activity levels of Australian children. The Go for 2 & 5 Campaign was introduced in April 2005 and is aimed at the parents and carers of children aged from 0 to 17 years. The objectives of this campaign are to:

- Raise awareness of the need to eat 2 serves of fruit and 5 serves of vegetables each day as part of a healthy diet
- Increase the proportion of Australian adults and children who eat the recommended serves of fruit and vegetables each day

By fulfilling these objectives, it is hoped that Australia might improve the general health of its younger citizens, improve their levels of immunity and diminish the impending epidemic of obesity.21

Figure 16 ► Vegetable consumption each day by non-Indigenous children

![Bar chart showing vegetable consumption by age group](chart.png)
Milk

Full fat milks are recommended for children under 2 years of age because of their higher energy requirements. However, older children do not need the additional fat in their diet. Participants in this survey were asked the type of milk usually consumed by their child, if the child was over 1 year of age.

The proportion of children who usually drank full fat milk remained relatively high although there was a decrease with increasing age (88.6% of 1 year old children, 87.9% of 2 to 4 year old children, 83.0% of 5 to 8 year old children and 75.2% of 9 to 12 year old children). Only one fifth (20.2%) of 9 to 12 year old children drank low fat or skim milk. Fewer than 2% of children from 1 to 8 years of age did not drink milk and this proportion rose to 3.4% of 9 to 12 year old children (Figure 17).

Soft drinks

This survey asked respondents how much soft drink their child usually consumed. Nearly two thirds (62.3%) of 0 to 4 year old children drank less than one soft drink per week. This percentage dropped for 5 to 8 year old children (27.8%) and 9 to 12 year old children (22.0%). The consumption of one to seven soft drinks per week increased steadily with increasing age group (23.0%, 42.6% and 49.8%). The proportion of children who drank more than seven soft drinks each week was higher for children of school age (14.2%, 29.7% and 27.6% from youngest to oldest age group).

Figure 17 ► Type of milk usually consumed by non-Indigenous children
Other drinks
Respondents were asked if their child had consumed a variety of drinks in the 24 hours preceding the survey. Water had been consumed by 94.3% of children. Almost a third of children (29.3%) had drunk cordial or other sweetened or flavoured water. Over one half (55.8%) had drunk fruit juice. Nearly one fifth (18.5%) had consumed soft drink or sports drink. Almost a quarter (22.7%) had drunk another form of flavoured milk and a further 1.7% had drunk iced coffee.

Takeaway food from large franchises
This survey asked respondents how much fast food from large franchises was usually consumed during a week. There are no national recommendations relating to the optimal consumption of fast food. The proportion of children consuming fast food once or fewer times each week was constant throughout the age groups (90.1% of 1 to 4 year old children, 89.8% of 5 to 8 year old children and 89.1% of 9 to 12 year old children). This was also the case for children consuming fast food two or more times each week (9.9%, 10.1% and 10.8% from youngest to oldest age group) (Figure 18). The proportion of boys (89.3%) consuming one takeaway meal or less each week was similar to the proportion of girls (90.1%). This question did include fast food from other outlets such as local shops or the school canteen and therefore under-represents the true level of takeaway food consumed by children.
**Exposure to the sun**

As Northern Territory non-Indigenous children grow older their exposure to the sun increases. The proportion of children who were sunburned at least once in the past year increased with increasing age (37.3%, 69.5% and 76.6% from youngest to oldest age group). The proportion of children who were never sunburned in the year preceding the survey fell markedly as children reached school age (62.5% of 0 to 4 year old children, 29.0% of 5 to 8 year old children and 22.6% of 9 to 12 year old children).

The number of children going out into the sunlight with the protection of a hat, sunscreen or covering clothing, always or most of the time, was highest in the early years (92.3%, 89.3% and 85% from youngest to oldest age group) (Figure 19).

**Figure 19**  ► Sun protection (hat, sunscreen, covering clothing) for non-Indigenous children

![Graph showing sun protection by age group](image-url)
Exposure to the sun

Skin cancer contributes substantial morbidity and health care cost to Australia, where it accounts for 80% of newly diagnosed cancers each year. It is not a problem that directly affects children but exposure to too much ultraviolet radiation in childhood is linked to the development of skin cancer in later life. Although mortality from skin cancer is decreasing with the increase in early detection and treatment, prevention is still better than cure.

The tropical, sub-tropical and arid climates of the Northern Territory all lend themselves to many hours of sunshine; Darwin is Australia’s sunniest capital city with an average of 8.5 hours of sunshine a day. In Alice Springs, on average, one third of each year is completely cloudless.

Launched in 1998, SunSmart Schools is a national strategy to teach sun protection behaviours to children. It encourages schools to: have a written policy on sun protection, teach students at all levels about sun protection, be working to increase shaded areas, endorse the wearing of broad-brimmed or legionnaire style hats and schedule outdoor activities at times of the day when ultraviolet radiation is low.

In this survey, 10 to 15% of primary school aged children were often not protected from the sun and around three quarters had been sunburned at least once in the previous year. This exposure increases the risk of developing skin cancer in later life.
Family environment

Structure and size

Key Points

• Altogether, 82.3% of children lived in an intact family, 10.8% lived in a one-parent family, 5.8% lived in a step or blended family and 1.1% lived in another type of family.

• The older the children in this survey, the less likely they were to live in an intact family. There was a corresponding increase in their likelihood of living in a step or blended family or a one-parent family.

• Most children live in families with two children under the age of 16 years (43.5%).

• The most common household size in this survey was four people (40.1%).

• Of those children who lived apart from one of their biological parents, 40.0% saw them at least once a week but 29.0% never saw them.

Contemporary families vary greatly in structure. This survey used broad statistical classifications to both describe different family types and to provide a method for grouping characteristics that may be common to particular family types. A ‘couple’ family may or may not have children and includes same sex couples. An ‘intact’ family is a couple family that contains at least one child who is the biological, adopted or foster child of both members of the couple. A ‘step’ family is a couple family that contains at least one child who is the stepchild of either member of the couple. A ‘blended’ family is a couple family that contains at least one child who is the stepchild of either member of the couple and at least one child who is the biological child of both members of the couple. A ‘one-parent family’ is a lone parent family that contains at least one child. In addition to family structure, this survey also examined numbers of children less than 16 years of age living in households and the total number of persons in each household.
Structure

The older the age of children in this survey, the less likely they were to live in an intact family. Of 0 to 4 year old children, 89.1% lived in an intact family, compared with 82.9% of 5 to 8 year old children and 72.5% of 9 to 12 year old children. There was a corresponding increase in the likelihood of living in a step or blended family or a one-parent family. The proportion of 0 to 4 year old children living in step or blended families was only 2.0%. The proportion rose to 6.6% of 5 to 8 year old children and 10.1% of 9 to 12 year old children. Almost the same percentage of 0 to 4 year old children (8.7%) and 5 to 8 year old children (9.1%) lived in one-parent families. The percentage rose to 15.5% of 9 to 12 year old children. A small proportion of children (less than 2%) lived in other types of family (Figure 20).

Figure 20  Family structure (non-Indigenous children)
**Size**

**Number of children**

Parents and carers were asked how many children under the age of 16 years lived in the household. Most Northern Territory non-Indigenous children aged from 0 to 12 years live in families with two children under the age of 16 years. Around a quarter of children under 5 years of age and about 10% of children 5 years of age or more live in families of just one child at the time of the survey. 20% of children under 5 years of age and around 30% of children 5 years of age or more live in families of three children. Approximately 10% of families have four children under the age of 16 years. Less than 6% of families have five or more children (Figure 21).

**Figure 21** ► Number of children in the household under sixteen years of age (non-Indigenous children)
Total household size

The most common household size in this survey was four people, represented by 40.9% of 0 to 4 year old children, 42.8% of 5 to 8 year old children and 36.2% of 9 to 12 year old children. The second most common size for older children was households of five people, represented by 31.4% of 5 to 8 year old children and 31.3% of 9 to 12 year old children. For 0 to 4 year old children, households of three people (24.7%) were the second most common. Around 10% of 5 to 8 year old children (9.7%) and 9 to 12 year old children (11.5%) lived in households of three people. Families with younger children are more likely to be incomplete when the survey was undertaken.

As children grew older their increased likelihood of having younger siblings was reflected in increasing household size. The number of households of six or more people rose steadily from 11.7% of 0 to 4 year old children to 13.2% of 5 to 8 year old children and 18.2% of 9 to 12 year old children. Less than 3% of all age groups of children live in households of only two people (Table 9).

Table 9 ► Household size (non-Indigenous children)

<table>
<thead>
<tr>
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<th>Number</th>
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<td>100.0</td>
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</table>
Contact with non-custodial parents

Respondents were asked how often children who lived apart from one of their biological parents saw the other parent. Patterns of contact with non-custodial parents showed two distinct trends. Some children saw their non-custodial parent at least once a week (41%, 31% and 47% from youngest to oldest age group). However the proportion of children who saw their non-custodial parent less than once a week rose with age (12%, 24% and 45% from youngest to oldest age group). Similarly, the proportion of children who never saw their non-custodial parent increased with age (19%, 27% and 39% from youngest to oldest age group)(Table 10).

Table 10  Contact with non-custodial parent by non-Indigenous children

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>19</td>
<td>25.2</td>
<td>(13.2—37.2)</td>
</tr>
<tr>
<td>Less than once a week</td>
<td>12</td>
<td>16.7</td>
<td>(5.6—27.7)</td>
</tr>
<tr>
<td>1-2 times a week</td>
<td>17</td>
<td>22.1</td>
<td>(8.6—35.7)</td>
</tr>
<tr>
<td>More than twice a week</td>
<td>24</td>
<td>31.5</td>
<td>(17.1—45.9)</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>4.5</td>
<td>(-2.4—11.4)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>27</td>
<td>31.1</td>
<td>(17.8—44.4)</td>
</tr>
<tr>
<td>Less than once a week</td>
<td>24</td>
<td>28.2</td>
<td>(16.8—39.7)</td>
</tr>
<tr>
<td>1-2 times a week</td>
<td>11</td>
<td>12.9</td>
<td>(3.1—22.8)</td>
</tr>
<tr>
<td>More than twice a week</td>
<td>20</td>
<td>22.9</td>
<td>(12.1—33.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
<td>4.9</td>
<td>(-0.9—10.6)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>39</td>
<td>28.7</td>
<td>(19.6—37.9)</td>
</tr>
<tr>
<td>Less than once a week</td>
<td>45</td>
<td>33.9</td>
<td>(24.5—43.2)</td>
</tr>
<tr>
<td>1-2 times a week</td>
<td>20</td>
<td>14.9</td>
<td>(7.4—22.3)</td>
</tr>
<tr>
<td>More than twice a week</td>
<td>27</td>
<td>20.2</td>
<td>(12.8—27.6)</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>2.3</td>
<td>(-0.4—5.1)</td>
</tr>
<tr>
<td>Total</td>
<td>295</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Family structure and size

Most Northern Territory non-Indigenous children (82.3%) live in families with their biological (or adoptive) parents. The balance of children live in one-parent families (10.8%), step or blended families (5.8%) or other family types (1.1%). The proportion of intact families decreased with age of children and the proportion of step or blended families and one-parent families increased with the age of children. Some studies emphasise the role of family structure as a risk factor for mental health problems and aggressive or antisocial behaviour. However, other factors such as grief and loss, parenting style, skills and conflict may be equally, if not more important to the health and wellbeing outcomes of children. Childhood stressors seem to also have a cumulative effect, while protective factors can promote resilience and modify the effect of stressors.
Parents

Key Points

- Over three quarters of the respondents in this survey (79.8%) were mothers of the children.
- Of parents or carers, 4% described their health as poor or very poor.
- Almost 20% of parents (19.4%) had been treated for a mental health problem.
- Around 90% of the houses in this survey (89.9%) were described as smoke free.
- Alcohol misuse was reported to be a problem in only 1.9% of households.
- Fewer than 10% of parents reported often or always feeling a lack of control of life in general (7.4%), their personal life (5.8%), their finances (9%) or their work life (4.4%).
- Over half of parents (55.2%) had completed a post-secondary qualification at an institute of tertiary and further education (24.9%) or at a university (30.3%).

Respondents

Respondents were asked about their relationship to the child. The principal respondents to the survey were mothers of the children (79.8%), followed by fathers (19.3%) with 0.5% of respondents being another relative of the child and 0.4% of respondents not related to the child (Table 11).

Country of birth

Around three quarters of respondents (75.9%) were born in Australia with the remaining 24.1% being born overseas. Of their partners, 74.7% were born in Australia and 25.3% were born overseas.

Table 11 ► Relationship of respondent to non-Indigenous child

<table>
<thead>
<tr>
<th>Relationship of respondent to child</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>1417</td>
<td>79.8</td>
</tr>
<tr>
<td>Father</td>
<td>342</td>
<td>19.3</td>
</tr>
<tr>
<td>Other relative</td>
<td>9</td>
<td>0.5</td>
</tr>
<tr>
<td>Not related to child</td>
<td>7</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
</tr>
</tbody>
</table>
General health

Respondents were asked how they would rate their health in the month preceding the survey. Almost two thirds of parents and carers of children in all age groups described their health as excellent or very good. Another third reported their health to be good or fair and fewer than 5% described their health as poor or very poor (Figure 22).

There was no significant difference in general health between respondents for boys and respondents for girls.

Figure 22  General health status of parents (non-Indigenous children)
Mental health

Parents and carers were asked if they had ever been treated for an emotional or mental health problem and 19.4% stated that they had. A higher proportion of parents of 9 to 12 year old children (24.1%) had been treated, than parents of younger children (18.0% of parents of 0 to 4 year old children and 16.7% of parents of 5 to 8 year old children) (Table 12). More parents of boys (20.6%) than girls (18.0%) had been treated for a mental health problem.

<table>
<thead>
<tr>
<th>Parent ever treated for mental health problem</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>126</td>
<td>18.0</td>
<td>(14.5—21.4)</td>
</tr>
<tr>
<td>No</td>
<td>576</td>
<td>82.0</td>
<td>(78.6—85.5)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>92</td>
<td>16.7</td>
<td>(12.9—20.4)</td>
</tr>
<tr>
<td>No</td>
<td>458</td>
<td>83.3</td>
<td>(79.6—87.1)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>126</td>
<td>24.1</td>
<td>(19.9—28.3)</td>
</tr>
<tr>
<td>No</td>
<td>395</td>
<td>75.5</td>
<td>(71.3—79.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>0.3</td>
<td>(-0.2—0.8)</td>
</tr>
<tr>
<td>Refused</td>
<td>0</td>
<td>0.1</td>
<td>(-0.1—0.2)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Risk factors

Smoking

Around 90% of the houses in this survey were described as smoke free. This included houses where smoking is allowed outside only. The proportion of people who occasionally smoked in the house rose with increasing age of children (4.7%, 6.8% and 6.6% from youngest to oldest age group). The reported pattern was similar for people frequently smoking in the house, with the proportions being 2.7%, 5.4% and 5.1%, respectively (Figure 23). These rates are significantly less than those reported in the Northern Territory Health and Wellbeing Survey of adults, where the rate of smoking inside the home by the respondent or another household member was 22.7%. This suggests significant moderation of smoking habits in those households with children compared to those households reported in the adult survey, most of which did not have children.

Figure 23 ► Smoking inside the homes of non-Indigenous children

- Smoking free
- Occasionally smoking
- Frequently smoking

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

0-4 years 5-8 years 9-12 years

Health Gains Planning 55
Alcohol misuse

A very low percentage (1.9%) of parents and carers reported that alcohol caused a problem in their household, with 98.1% reporting that alcohol did not cause a problem (Table 13). In the Northern Territory Health and Wellbeing Survey of adults, the proportion of respondents who drank alcohol at high or very high risk levels was reported to be 2.6%, with an additional 8.9% of respondents drinking at a level of intermediate risk. The difference between the two surveys which used different measures of the impact of alcohol suggest either a difference in drinking behaviour in households with children, or lack of recognition by respondents of the significant impact of drinking at high risk levels.

Table 13 ► Alcohol causes a problem in the household (non-Indigenous children)

<table>
<thead>
<tr>
<th>Household problems caused by alcohol</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>1.5</td>
<td>(0.3—2.6)</td>
</tr>
<tr>
<td>No</td>
<td>692</td>
<td>98.5</td>
<td>(97.4—99.7)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>1.6</td>
<td>(0.1—3.2)</td>
</tr>
<tr>
<td>No</td>
<td>541</td>
<td>98.4</td>
<td>(96.8—99.9)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>2.7</td>
<td>(1.1—4.3)</td>
</tr>
<tr>
<td>No</td>
<td>509</td>
<td>97.3</td>
<td>(95.7—98.9)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
**Sense of control**

Parents and carers were asked five questions about how much control they felt they had over life in general, their personal life, their financial situation, their work life and with job security, during the four weeks preceding the survey.

![Figure 24](image.png)  
**Respondent’s lack of control over life in general (non-Indigenous children)**

<table>
<thead>
<tr>
<th></th>
<th>0-4 years</th>
<th>5-8 years</th>
<th>9-12 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>50%</td>
<td>45%</td>
<td>50%</td>
</tr>
<tr>
<td>Rarely</td>
<td>25%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>15%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Often</td>
<td>5%</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>Always</td>
<td>0%</td>
<td>5%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Control of life

Around 70% of parents and carers never or rarely felt a lack of control over their lives in general. About 20% sometimes felt a lack of control over their lives in general. For 0 to 4 year old children, 5.9% of parents felt a lack of control often or always, whereas this was experienced by 10.2% of parents of 5 to 8 year old children and 6.6% of parents of 9 to 12 year old children (Figure 24). There was virtually no difference between the parents of girls (7.5%) and boys (7.4%) who often or always felt a lack of control over their life in general.

Similar results were recorded for a lack of control of personal life, with around 80% of all parents never or rarely feeling a lack of control over their personal lives and around 5% often or always feeling a lack of control of their personal life (Table 14). More parents of boys (6.2%) than girls (5.4%) often or always felt a lack of control over their personal lives. There were no marked trends observed in relation to the age of the child.

Table 14 ► Respondent’s lack of control of personal life (non-Indigenous children)

<table>
<thead>
<tr>
<th>Parent’s lack of control of personal life</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>359</td>
<td>51.1</td>
<td>(46.6—55.5)</td>
</tr>
<tr>
<td>Rarely</td>
<td>170</td>
<td>24.1</td>
<td>(20.4—27.9)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>130</td>
<td>18.5</td>
<td>(14.9—22.2)</td>
</tr>
<tr>
<td>Often</td>
<td>33</td>
<td>4.7</td>
<td>(2.6—6.7)</td>
</tr>
<tr>
<td>Always</td>
<td>11</td>
<td>1.6</td>
<td>(0.4—2.8)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>307</td>
<td>55.9</td>
<td>(50.7—61.0)</td>
</tr>
<tr>
<td>Rarely</td>
<td>134</td>
<td>24.3</td>
<td>(20.0—28.6)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>79</td>
<td>14.4</td>
<td>(10.7—18.1)</td>
</tr>
<tr>
<td>Often</td>
<td>19</td>
<td>3.4</td>
<td>(1.8—5.1)</td>
</tr>
<tr>
<td>Always</td>
<td>10</td>
<td>1.9</td>
<td>(0.2—3.5)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.2</td>
<td>(-0.2—0.6)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>294</td>
<td>56.2</td>
<td>(50.7—61.0)</td>
</tr>
<tr>
<td>Rarely</td>
<td>120</td>
<td>22.9</td>
<td>(19.1—26.8)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>78</td>
<td>14.8</td>
<td>(10.7—18.1)</td>
</tr>
<tr>
<td>Often</td>
<td>19</td>
<td>3.7</td>
<td>(1.8—5.1)</td>
</tr>
<tr>
<td>Always</td>
<td>11</td>
<td>2.2</td>
<td>(0.2—3.5)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.2</td>
<td>(-0.1—0.2)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
Control of financial situation

Of respondents, 9% often or always and 19.9% sometimes felt a lack of control of their financial situation (Table 15).

Control of work life and job security

In terms of employment, 4.4% of respondents always or often felt a lack of control over their work life. In the separate question on job security, 3.1% always or often felt a lack of control of their job security (Table 16). These proportions were lower than the proportions of parents and carers (at least 5%) who always or often felt a lack of control of their life in general, their personal life or their financial situation.

Table 15 ► Respondent’s lack of control of financial situation (non-Indigenous children)

<table>
<thead>
<tr>
<th>Parent’s lack control of financial situation</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>900</td>
<td>50.7</td>
<td>(47.9—53.5)</td>
</tr>
<tr>
<td>Rarely</td>
<td>361</td>
<td>20.4</td>
<td>(18.1—22.6)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>353</td>
<td>19.9</td>
<td>(17.6—22.1)</td>
</tr>
<tr>
<td>Often</td>
<td>94</td>
<td>5.3</td>
<td>(4.1—6.5)</td>
</tr>
<tr>
<td>Always</td>
<td>66</td>
<td>3.7</td>
<td>(2.6—4.9)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>1</td>
<td>0.1</td>
<td>(-0.1—0.2)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 16 ► Respondent’s lack of control with job security (non-Indigenous children)

<table>
<thead>
<tr>
<th>Parent’s lack control with job security</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1108</td>
<td>62.4</td>
<td>(59.7—65.1)</td>
</tr>
<tr>
<td>Rarely</td>
<td>147</td>
<td>8.3</td>
<td>(6.8—9.8)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>83</td>
<td>4.7</td>
<td>(3.5—5.8)</td>
</tr>
<tr>
<td>Often</td>
<td>34</td>
<td>1.9</td>
<td>(1.2—2.7)</td>
</tr>
<tr>
<td>Always</td>
<td>21</td>
<td>1.2</td>
<td>(0.5—1.9)</td>
</tr>
<tr>
<td>Unknown</td>
<td>382</td>
<td>21.5</td>
<td>(19.1—23.9)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
**Socioeconomic indicators**

**Education**

Education was the first of three indicators of socioeconomic status collected in this survey; the others were employment status and income. Education of parents is directly associated with individual health status and indirectly with the health status of children. Although it is the most stable indicator of socioeconomic status it does not supply a lot of associated information.

Survey respondents were asked to state the highest level of education that they had achieved and whether they were currently studying. Only the parents or carers of 9 to 12 year old children contained a group of people (0.2%) who had not completed primary school. 1% or less of parents in each of the three age groups had completed primary school. Around 40% of parents in each age group had completed Year 10 or Year 12 of secondary school. Between 50% and 60% of parents in each age group had completed a post-secondary qualification at an institute of tertiary and further education (TAFE) or at university, with university qualifications outnumbering TAFE qualifications (Figure 25). Of all parents, 18.3% were currently studying.

---

**Figure 25 ► Education of the respondents (non-Indigenous children)**

![Education Graph]

- **0-4 years**
- **5-8 years**
- **9-12 years**

Growing up in the Territory Parent Survey
Employment

Employment was the second indicator of socioeconomic status measured in this survey. Although a less stable measure of socioeconomic status than education, it provides some estimate of social status implicit in occupational categories. Consideration of the hours worked and tenure need to be taken into account when interpreting employment information.

Respondents to this survey were asked about their current employment status, the number of hours worked per week, whether they were looking for work and the same questions in relation to their partner. Overall 71.6% of all respondents were in paid employment. Participation in paid employment increased with increasing age of children. Of 0 to 4 year old children, 64.0% of parents or carers were in paid employment compared with 72.3% of parents of 5 to 8 year old children and 82.1% of parents of 9 to 12 year old children. Correspondingly, 33.4% of parents of 0 to 4 year old children were involved in home duties as their primary occupation, which fell to 24.1% of parents of 5 to 8 year old children and 13.5% of parents of 9 to 12 year old children (Figure 26).

Involvement of parents and carers in full time paid employment increased with increasing age of children (34.8%, 40.2% and 45.4% from youngest to oldest age group). Many parents also worked part time, from 20 to 39 hours a week (40.5%, 44.7% and 43.5% from youngest to oldest age group). The proportion of parents working from one to nine hours per week fell with increasing age of the children (22.9%, 15.1% and 11.1% from youngest to oldest age group).

Figure 26 ► Employment status of the respondents (non-Indigenous children)
The proportion of respondents who considered themselves to be unemployed was fairly low (0.5%, 0.5% and 2.3% from youngest to oldest age group). However, the number of respondents who were looking for work rose with increasing age of children (5.4%, 8.9% and 9.4% from youngest to oldest age group).

Most respondents (88.2%) provided additional responses on behalf of a partner. 91.7% of partners were reported to be in paid employment, 5.8% involved in home duties and 1.2% unemployed. 6% of partners were reported to be looking for paid employment. Just over three quarters of partners (76.3%) in paid employment worked full time, 19.7% worked from 20 to 39 hours per week and 2.4% worked from one to 19 hours per week.

Household income

Household income is the most labile of the socioeconomic indicators collected in this survey. It may also be misleading if the number of persons in the household who are dependent on that income, are not concurrently considered. However, it can give a robust indication of levels of household poverty, which has profound impacts on health and education. This survey asked parents or carers to place their household income from all sources over the last 12 months in one of several categories ranging from ‘under $20,000’ to ‘more than $100,000’.

A small proportion of households were described as having an annual income of less than $20,000 (4%, 3.6% and 6.2% from youngest to oldest age group). A greater proportion of households had a total annual income from $20,000 to $40,000 (11.3%, 12.1% and 14.5% from youngest to oldest age group). Most households had an annual income between $40,000 and $100,000 (69.5%, 63.8% and 53.6% from youngest to oldest age group). The proportion of households with an annual income

**Figure 27** Household income (non-Indigenous children)
greater than $100,000 rose with increasing age of children (11.1%, 17.1% and 21.9% from youngest to oldest age group) (Figure 27). 2% or fewer parents in each age group category refused to answer this question.

In a marked proportion of households, the money situation was described in vulnerable terms. These included ‘spending more money than we get’ and ‘having just enough money to get us through to the next pay day’. People included in these categories were 23.0% of the parents and carers of 0 to 4 year old children, 19.2% of the parents of 5 to 8 year old children and 20.6% of the parents of 9 to 12 year old children. Over a third of households (38.1%, 36.4% and 36.6% from youngest to oldest age group), described themselves as ‘having some money left over, but just spending it’ or ‘managing to save a bit every now and then’. Other households described themselves as ‘managing to save a bit regularly’ or ‘managing to save a lot’ (38.2%, 44.1% and 42.1% from youngest to oldest age group).

**Socioeconomic indicators**

The survey group of parents and carers had a robust level of education with over half of respondents having had vocational training or having completed higher education courses and around 40% having completed at least the Year 10 level of secondary education. Participation in paid employment was also fairly high, including 72% of respondents and 92% of partners. The rate of unemployment among respondents was reported to be relatively low (less than 3%) and was not concordant with the rates of seeking employment (almost 10% of respondents and 6% of partners). Quite a large group of respondents (17%) reported a household income of $40,000 or less. Around 20% of households were described as not having or barely having enough money to live on. Households where parents are unemployed and household income is low are particularly vulnerable to poverty. The poverty line for households of four people where the head is employed was around $30,000 per annum in 2004. For households of four people where the head is not in the labour force the poverty line was around $27,000 per annum. As the number of children in a family increases, the effects of low income and unemployment increase.

Government policies that address the needs of people living in poverty are required at many levels and across different sectors. The maintenance and improvement of our social security system is essential to protect children living in poverty. Opportunities for parents and carers to participate in the market economy through training programs targeted at those who lack skills and the long term unemployed would promote a more inclusive society. Community support systems such as universal health care, affordable education and the provision of housing all contribute to a sufficient standard of living for those at risk.
Family interaction

Key Points

Family functioning
- Overall, 87.6% of families were functioning adequately and 12.4% were functioning poorly.
- Most families (97.5%) were reported to get on well with each other.
- One fifth of families (20.8%) found that planning family activities was usually difficult.
- Of all families, 7% avoided discussing fears and concerns openly.
- Making decisions was usually a problem due to misunderstanding for 7.8% of families.

Parenting style: discipline of children
- Almost two thirds of parents (61.2%) asked their children to stop always or often, when they were breaking the rules.
- Just over a quarter of parents (26.4%) reported that they rarely or never raised their voice with their child in response to inappropriate behaviour.
- Over half of parents (59.1%) were always or often able to calmly discuss a behaviour problem with their child and describe alternative, acceptable ways of behaving.
- Most parents (82.0%) rarely or never used physical punishment.

As mentioned in the Introduction, children grow and function in the centre of the major influences of family, school and neighbourhood. The role and functioning of the family within the community can vary greatly; the impact of this affects the development of a child and their future ability to function effectively within their families and communities.

Six hours of the average child’s weekday is spent at school and the balance is usually spent in childcare or at home. For younger children, many more hours are usually spent at home. Family functioning and parenting style (discipline of children) are important components of a child’s growth and development from infancy to the independence of adulthood.

Influencing factors may be considered on several levels (Figure 2, page 14). At the level of the child, positive family interaction, which embraces the child with safety and protection when vulnerable, can help children to mature into self-disciplined and self-motivated young adults. Resilience may provide skills for coping with hardship, periodic crisis and unpredictable change.

At the family level, parenting competence and support are required to create a functional environment. Traditional methods of parenting have undergone a rapid evolution; extended families are no longer the norm and hours spent by parents in paid employment are increasing. This creates new challenges.

Support for parents at a community level deserves consideration. Do we value our children, give precedence to their needs and provide support for their parents? Child friendly communities reflect concern for the physical and social needs of children, parent friendly communities will grapple with policies that support and educate parents in their contemporary situation.
Family functioning

In this survey respondents were asked several questions about their family relationships. These related to getting on together, planning family activities, having open discussion about fears and concerns and decision making as a family. The findings were considered both separately and together, in a composite score.

The most marked finding was that planning family activities was usually a problem for 20.8% of families. By 5 years of age, this survey found that around three quarters of children were involved in at least one sporting group, school group or social group. Over 9% of children over 5 years of age belonged to four or more groups. The proportion of parents who worked was also high with 72% of respondents and 92% of partners involved in some form of paid employment. It is not surprising with such a high level of commitment to both children’s activities and employment, that families found planning joint activities a difficult prospect.

Most families (97.5%) reported that they got on well together. 7% of families usually avoided discussing fears and concerns openly with each other. A similar proportion (7.8%) of families reported that making decisions was usually a problem due to misunderstanding of each other (Table 17).

Table 17 ► Family functioning (non-Indigenous children)

<table>
<thead>
<tr>
<th>Family interaction</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not get on well each other in the family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
<td>3</td>
<td>0.2</td>
<td>(0.0—0.4)</td>
</tr>
<tr>
<td>Agree</td>
<td>41</td>
<td>2.3</td>
<td>(1.4—3.2)</td>
</tr>
<tr>
<td>Disagree</td>
<td>509</td>
<td>28.6</td>
<td>(26.1—31.2)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1223</td>
<td>68.9</td>
<td>(66.3—71.5)</td>
</tr>
<tr>
<td>Planning family activity is usually difficult</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
<td>32</td>
<td>1.8</td>
<td>(1.1—2.5)</td>
</tr>
<tr>
<td>Agree</td>
<td>337</td>
<td>19.0</td>
<td>(16.7—21.2)</td>
</tr>
<tr>
<td>Disagree</td>
<td>755</td>
<td>42.5</td>
<td>(39.8—45.3)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>652</td>
<td>36.7</td>
<td>(34.1—39.4)</td>
</tr>
<tr>
<td>Usually avoid discussing fears and concerns openly with each other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
<td>14</td>
<td>0.8</td>
<td>(0.4—1.2)</td>
</tr>
<tr>
<td>Agree</td>
<td>110</td>
<td>6.2</td>
<td>(4.9—7.5)</td>
</tr>
<tr>
<td>Disagree</td>
<td>817</td>
<td>46.0</td>
<td>(43.2—48.8)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>833</td>
<td>46.9</td>
<td>(44.1—49.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>0.1</td>
<td>(0.0—0.3)</td>
</tr>
<tr>
<td>Making decisions is usually a problem in the family due to misunderstanding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
<td>8</td>
<td>0.4</td>
<td>(0.0—0.9)</td>
</tr>
<tr>
<td>Agree</td>
<td>132</td>
<td>7.4</td>
<td>(6.0—8.9)</td>
</tr>
<tr>
<td>Disagree</td>
<td>882</td>
<td>49.7</td>
<td>(46.9—52.4)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>753</td>
<td>42.4</td>
<td>(39.7—45.2)</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0.0</td>
<td>(0.0—0.1)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
A composite score for family functioning was generated from the four separate variables, to identify a proportion of families at greater risk of poor family function. Using this score, 87.6% of families were functioning adequately and 12.4% were functioning poorly. Given this finding, there appears to be an identified group of families with a need for education about communication and problem solving.

**Parenting style: discipline of children**

This survey explored seven discipline parameters. These questions were introduced by a statement that all children break rules and parents may respond in different ways. Respondents were asked how often they used a particular type of discipline when their child broke the rules or did things that they were not supposed to do. About 5% of respondents refused to answer the questions about the discipline of children. While this is understandable, given the personal nature of the questions being asked, it introduces a respondent bias to the results.

- Almost two thirds of children (61.2%) were always or often told to stop when breaking the rules, with a further 18.9% sometimes told to stop.
- Nearly one third (29.6%) of parents sometimes ignored inappropriate behaviour, 60.8% rarely or never ignored it.
- Just over a quarter of parents or carers (26.4%) never or rarely raised their voice to scold or yell at the child, while a similar proportion (22.8%) always or often did this. Nearly half of parents (45.5%) reported that they sometimes raised their voice at the child.
- Most parents (59.1%) reported that they were always or often able to calmly discuss the problem with their child, and a further 22.5% were sometimes able to do this. 6.0% of parents were rarely or never able to calmly discuss the problem.
- Alternative, acceptable behaviours were suggested always or often by 59.1% of parents, sometimes by 21.0% and rarely or never by 5.9%.
- A large majority of parents (82.0%) rarely or never used physical punishment for inappropriate behaviour, with 11.1% sometimes using this form of discipline. Only 1.2% of parents reported that they always or often used physical punishment.
- Just over a quarter of parents (26.2%) took away the child’s privileges or put them in their room in response to inappropriate behaviour. A third of parents (33.4%) sometimes did this and 30.5% of parents rarely or never did this.

Many of these discipline parameters may have been concurrently or consecutively used in dealing with inappropriate behaviour. Patterns of response may reflect the volatility or danger involved in a situation, and proceed from less to more rational when considered from the perspective of the observer. Again the results of this survey support the appropriateness of providing families with skills, encouragement and support for parenting in difficult situations. Delivery of these skills or the opportunity to acquire such skills could either be on a needs basis or through population level interventions.
### Table 18: Parenting style: discipline of non-Indigenous children

<table>
<thead>
<tr>
<th>Type of discipline</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tell him/her to stop</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>748</td>
<td>42.1</td>
<td>(39.4—44.9)</td>
</tr>
<tr>
<td>Often</td>
<td>499</td>
<td>28.1</td>
<td>(25.6—30.6)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>336</td>
<td>18.9</td>
<td>(16.7—21.1)</td>
</tr>
<tr>
<td>Rarely</td>
<td>85</td>
<td>4.8</td>
<td>(3.8—6.0)</td>
</tr>
<tr>
<td>Never</td>
<td>16</td>
<td>0.9</td>
<td>(0.4—1.4)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>91</td>
<td>5.1</td>
<td>(4.0—6.3)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>0.0</td>
<td>(0.0—0.1)</td>
</tr>
<tr>
<td>Ignore it, do nothing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>16</td>
<td>0.9</td>
<td>(0.3—1.5)</td>
</tr>
<tr>
<td>Often</td>
<td>55</td>
<td>3.1</td>
<td>(2.1—4.1)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>526</td>
<td>29.6</td>
<td>(27.0—32.2)</td>
</tr>
<tr>
<td>Rarely</td>
<td>611</td>
<td>34.4</td>
<td>(31.8—37.0)</td>
</tr>
<tr>
<td>Never</td>
<td>469</td>
<td>26.4</td>
<td>(24.0—28.9)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>93</td>
<td>5.2</td>
<td>(4.1—6.4)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4</td>
<td>0.2</td>
<td>(0.0—0.4)</td>
</tr>
<tr>
<td>Refused</td>
<td>2</td>
<td>0.1</td>
<td>(0.0—0.2)</td>
</tr>
<tr>
<td>Raise your voice, yell at him/her</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>60</td>
<td>3.4</td>
<td>(2.3—4.4)</td>
</tr>
<tr>
<td>Often</td>
<td>344</td>
<td>19.4</td>
<td>(17.1—21.6)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>807</td>
<td>45.5</td>
<td>(42.7—48.2)</td>
</tr>
<tr>
<td>Rarely</td>
<td>384</td>
<td>21.6</td>
<td>(19.4—23.9)</td>
</tr>
<tr>
<td>Never</td>
<td>87</td>
<td>4.9</td>
<td>(3.7—6.1)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>91</td>
<td>5.2</td>
<td>(4.0—6.3)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>0.1</td>
<td>(-0.1—0.3)</td>
</tr>
<tr>
<td>Calmly discuss the problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>281</td>
<td>15.8</td>
<td>(13.9—17.8)</td>
</tr>
<tr>
<td>Often</td>
<td>769</td>
<td>43.3</td>
<td>(40.5—46.1)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>400</td>
<td>22.5</td>
<td>(20.2—24.9)</td>
</tr>
<tr>
<td>Rarely</td>
<td>77</td>
<td>4.3</td>
<td>(3.2—5.5)</td>
</tr>
<tr>
<td>Never</td>
<td>33</td>
<td>1.8</td>
<td>(1.0—2.7)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>216</td>
<td>12.1</td>
<td>(10.5—13.8)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>0.0</td>
<td>(0.0—0.1)</td>
</tr>
<tr>
<td>Use physical punishment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>4</td>
<td>0.2</td>
<td>(-0.1—0.5)</td>
</tr>
<tr>
<td>Often</td>
<td>18</td>
<td>1.0</td>
<td>(0.4—1.6)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>198</td>
<td>11.1</td>
<td>(9.3—13.0)</td>
</tr>
<tr>
<td>Rarely</td>
<td>719</td>
<td>40.5</td>
<td>(37.8—43.3)</td>
</tr>
<tr>
<td>Never</td>
<td>736</td>
<td>41.5</td>
<td>(38.7—44.2)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>98</td>
<td>5.5</td>
<td>(4.4—6.7)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>0.0</td>
<td>(0.0—0.1)</td>
</tr>
<tr>
<td>Refused</td>
<td>1</td>
<td>0.0</td>
<td>(0.0—0.1)</td>
</tr>
</tbody>
</table>
### Table 18  ► Parenting style: discipline of non-Indigenous children (continued)

<table>
<thead>
<tr>
<th>Type of discipline</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe alternative ways of behaving that are acceptable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>368</td>
<td>20.7</td>
<td>(18.5—23.0)</td>
</tr>
<tr>
<td>Often</td>
<td>681</td>
<td>38.4</td>
<td>(35.6—41.1)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>373</td>
<td>21.0</td>
<td>(18.7—23.3)</td>
</tr>
<tr>
<td>Rarely</td>
<td>68</td>
<td>3.8</td>
<td>(2.7—5.0)</td>
</tr>
<tr>
<td>Never</td>
<td>37</td>
<td>2.1</td>
<td>(1.2—2.9)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>232</td>
<td>13.1</td>
<td>(11.3—14.9)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>13</td>
<td>0.7</td>
<td>(0.3—1.2)</td>
</tr>
<tr>
<td>Refused</td>
<td>3</td>
<td>0.2</td>
<td>(0.0—0.4)</td>
</tr>
<tr>
<td>Take away privileges or put in room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>106</td>
<td>6.0</td>
<td>(4.4—7.6)</td>
</tr>
<tr>
<td>Often</td>
<td>358</td>
<td>20.2</td>
<td>(17.1—21.6)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>592</td>
<td>33.4</td>
<td>(30.8—36.0)</td>
</tr>
<tr>
<td>Rarely</td>
<td>315</td>
<td>17.7</td>
<td>(15.6—19.8)</td>
</tr>
<tr>
<td>Never</td>
<td>228</td>
<td>12.8</td>
<td>(11.0—14.7)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>173</td>
<td>9.7</td>
<td>(8.2—11.3)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>0.0</td>
<td>(0.0—0.1)</td>
</tr>
<tr>
<td>Refused</td>
<td>3</td>
<td>0.1</td>
<td>(0.0—0.2)</td>
</tr>
</tbody>
</table>
Outside of the family, children over 5 years of age spend the majority of their time at school. Participation in the school community involves a spectrum of features from social interaction to learning tasks and assessments. These features influence both the current experience of being at school and developmental pathways to the future. Respondents to this survey, whose children were aged 4 or more years, were asked a variety of questions about their child at school, including the child’s enjoyment of school, school performance, attendance pattern and the number of schools attended.

**Key Points**

- Most children (86.7%) looked forward to going to school each day.
- More girls (90%) than boys (83.6%) often or almost always looked forward to going to school.
- Around three quarters of children (75.3%) were described as doing well or very well at school.
- More girls (78.2%) than boys (72.8%) were described as performing well or very well at school.
- Of children attending school, 4% were described as doing poorly or very poorly at school.
- Of children attending school, 7% were absent from school for more than 10% of potential school days (20 days or more) in the year preceding the survey.
- Of children aged from 9 to 12 years, less than half (44.3%) had spent their entire primary school years at the same school and nearly 10% (9.6%) had attended four or more schools.
Happy at school

Parents and carers were asked if their child looked forward to going to school each day. Most children (86.7%) looked forward to going to school. The proportion of children who often or almost always looked forward to going to school fell slightly with increasing age of children (88.6% of 4 year old children, 88.3% of 5 to 8 year old children and 84.6% of 9 to 12 year old children). The proportion of children who sometimes looked forward to going to school varied with age (7.6%, 6.6% and 10.9% from youngest to oldest age group). 4.9% of 5 to 8 year old children and 3.4% of 9 to 12 year old children almost never or rarely looked forward to going to school (Figure 28).

More girls (90%) than boys (83.6%) often or almost always looked forward to going to school. As a balance, more boys (11.1%) than girls (5.9%) sometimes looked forward to going to school and more boys (4.0%) than girls (3.7%) almost never or rarely looked forward to going to school.

Figure 28 ▶ Non-Indigenous children: looking forward to going to school

Growing up in the Territory Parent Survey
Parents and carers were asked to rate the overall academic performance of their child based on knowledge of their schoolwork and school reports. Around three quarters of children were described as doing well or very well at school (72.0%, 77.1% and 74.3% from youngest to oldest age group). Around a fifth of children were described as having an average performance (18.5%, 19.2% and 20.8% from youngest to oldest age group). The percentage that was described as doing poorly or very poorly at school rose in the oldest age group (3.5%, 3.3% and 4.8% from youngest to oldest age group) (Figure 29).

Girls outperformed boys, with more girls (78.2%) than boys (72.8%) described as performing well or very well at school. As a balance, more boys (20.7%) than girls (18.9%) were described as having an average performance and more than twice the proportion of boys (5.5%) than girls (2.4%) were described as doing poorly or very poorly at school.

![Figure 29](image-url)
School performance and gender

The reported educational performance of Northern Territory non-Indigenous boys in this survey is consistent with a national trend of declining educational performance by boys. Approximately 5% more girls than boys were described as performing well or very well at school. Boys were more likely to be described as having an average, poor or very poor performance at school. The poorer performance of boys was more marked at the top end of the achievement scale.

There are different ways of approaching a discussion on the change in comparative performance of boys and girls. Firstly, a single reported measure does not define the debate. Are we measuring the declining performance in literacy and English by boys, the improved general performance girls, or different ways of reporting educational attainment that have been instituted in recent years? Secondly, socioeconomic position is more strongly associated with educational performance than gender. Thirdly, there is a contemporary societal level discussion about the changing role of men. This societal perspective may feed directly into the education debate, focussing it on gender issues and gender-level action rather than on more ubiquitous platforms that may be applicable to both boys and girls in schools. These platforms include a differential emphasis on group or individual learning styles, the socioeconomic contexts of poor achievers, the increasing prevalence of mental health issues that affect both boys and girls and consideration of workforce and curriculum issues.

Having stated this, there is a need to acknowledge the different characteristics of boys and girls and the feminisation of the education system, its learning styles and curriculum over the last 10 years. The federal government has recognised this with its initiatives, Boys' Education Lighthouse Schools and Success for Boys. These two initiatives focus respectively on disadvantaged and at-risk boys, and building the evidence base for effective educational practices for boys. In the Northern Territory, 14 schools are currently participating in the Lighthouse Schools initiative. Other local, national and international programs that focus on the specific learning needs of boys have also been implemented in selected Northern Territory schools. Professional development activity to increase teacher awareness and training in relation to the education of boys has been in place for several years.

In summary, the key issue in the debate is that boys' educational performance relative to girls is declining. This is an educational and societal problem that may be framed in different ways. Educational interventions will probably engender most success when aimed at boys specifically and also at vulnerable groups within schools. Structural factors that form part of the debate are the gender of teachers, the content of the curriculum, current assessment practices, behaviour management policies and styles of teaching and learning that may benefit boys.
**Attendance patterns**

A Northern Territory primary school-aged child can spend 201 days at school each year.
Children who are absent for 10 to 19 days of school have missed more than 5% of total school days and children who are absent for 20 or more days, have missed more than 10% of total school days. Most children (91.7%) had some absences from school in the year preceding the survey. The proportion of children absent for one to nine days increased with increasing age of children (55.8%, 65.0% and 69.4% from youngest to oldest age group). There was a variable proportion of children absent for 10 to 19 days (13.8%, 20.6% and 16.9% from youngest to oldest age group). The proportion of children absent from school for 20 days or more decreased with increasing age of children (9.6%, 8.4% and 5.1% from youngest to oldest age group) (Figure 30).

Patterns of attendance were similar for boys and girls, with 74.8% of boys and 74.1% of girls spending less than 10 days absent from school.

![Figure 30](chart.png)

**Figure 30 ★ Number of days absent from school for non-Indigenous children**

- No days absent
- 1-9 days
- 10-19 days
- 20 days or more

![Bar chart showing attendance patterns by age group](chart.png)

Internals (complete).indd   73
30/03/2006   9:33:45 AM
**Number of schools attended**

Parents and carers were asked how many different schools their child had attended since starting primary school. The proportion of children who had spent their entire primary school education at the one school decreased markedly with increasing age of children (85.9%, 76.6% and 44.3% from youngest to oldest age group). In balance, the proportion of children who had attended two or three schools rose with increasing age of children (14.1%, 21.8% and 46.1% from youngest to oldest age group). Nearly 10% of 9 to 12 year old children (9.6%) had attended four or more different schools since starting primary school. This was a sharp rise from the 1.6% of 5 to 8 year old children who had attended four or more different schools (Figure 31).

Differences between boys and girls were minor compared with the age trend, with 36.2% of boys having attended two or more schools compared with 38.4% of girls.

---

**Figure 31**  ► **Number of schools attended by non-Indigenous children**

- 1 school
- 2 school
- 3 school
- 4 school
- 5 school
- 6 school or more

---

Growing up in the Territory Parent Survey
Friends

Key Points

- More than three quarters of children, from 4 to 12 years of age were reported to have a special friend and 90% had a group of friends.
- While most children have friends, 2.2% of all children from 4 to 12 years of age were reported to not have either a special friend or a group of friends nor belong to any group or association.

Friendship is an important aspect of human life. For children, primary socialisation begins in the context of family, with parents and siblings providing the earliest interactive experiences. After a child begins attending school, six to eight hours of their day will be spent outside the home. Learning to socialise with peers and to relate effectively to teachers and other staff becomes important, although the role of home life is still significant. Friendship brings positive benefits to children such as a sense of belonging. It can teach communication and problem solving skills and the appreciation of difference in others.

This survey contained three questions relating to friendship among children aged from 4 to 12 years. These investigated the presence of a special friend, a group of friends and membership of groups and associations.

A special friend

Around three quarters of Northern Territory non-Indigenous children, aged from 4 to 12 years had a special friend or a really close mate. The proportion of children with a special friend increased with the commencement of school, from 71.6% of 4 year old children to 78.1% of 5 to 8 year old children and 78.7% of 9 to 12 year old children (Table 19).

There was a minor gender difference, with 75.7% of boys and 79.7% of girls described as having a special friend. There was also a small regional difference, with 81.0% of rural children having a special friend compared with 76.0% of urban children.

Key Points

- More than three quarters of children, from 4 to 12 years of age were reported to have a special friend and 90% had a group of friends.
- While most children have friends, 2.2% of all children from 4 to 12 years of age were reported to not have either a special friend or a group of friends nor belong to any group or association.

Table 19 ► Non-Indigenous child has a special friend

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>97</td>
<td>71.6</td>
<td>(60.4—82.8)</td>
</tr>
<tr>
<td>No</td>
<td>38</td>
<td>28.4</td>
<td>(17.2—39.6)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>429</td>
<td>78.1</td>
<td>(73.7—82.5)</td>
</tr>
<tr>
<td>No</td>
<td>119</td>
<td>21.7</td>
<td>(17.4—26.0)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.2</td>
<td>(-0.2—0.7)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>412</td>
<td>78.7</td>
<td>(74.7—82.7)</td>
</tr>
<tr>
<td>No</td>
<td>111</td>
<td>21.1</td>
<td>(17.1—25.2)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.1</td>
<td>(-0.1—0.3)</td>
</tr>
<tr>
<td>Total</td>
<td>1208</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
A group of friends

Most of the children in the survey were reported to have a group of friends with whom to play or hang around. The most marked change was again associated with the commencement of school. 82.5% of 4 year old children had a group of friends compared with 92.6% of 5 to 8 year old children and 87.7% of 9 to 12 year old children (Table 20). There was little difference between the genders with 88.7% of boys and 89.9% of girls having a group of friends. Once more there was a higher proportion of rural children (91.3%) with a group of friends than urban children (88.4%).

Table 20 ► Non-Indigenous child has a group of friends

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>112</td>
<td>82.5</td>
<td>(73.2—91.9)</td>
</tr>
<tr>
<td>No</td>
<td>24</td>
<td>17.5</td>
<td>(8.1—26.8)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>509</td>
<td>92.6</td>
<td>(90.0—95.1)</td>
</tr>
<tr>
<td>No</td>
<td>39</td>
<td>7.1</td>
<td>(4.6—9.6)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>0.3</td>
<td>(-0.2—0.8)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>459</td>
<td>87.7</td>
<td>(84.5—90.0)</td>
</tr>
<tr>
<td>No</td>
<td>63</td>
<td>12.0</td>
<td>(8.8—15.1)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>0.4</td>
<td>(-0.1—0.8)</td>
</tr>
<tr>
<td>Total</td>
<td>1208</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Friends

About one fifth of Northern Territory non-Indigenous children of primary school age were reported to not have a special friend and around one tenth did not have a group of friends to play with.

The population of the Northern Territory is highly mobile. In 2003, 8.7% of the total population migrated into and 10.2% migrated out of the Territory. This mobility is reflected in the survey results showing that 14% of the boys and girls had attended three or more schools during their primary school years. Factors such as these may impact on the ability to make friends and present an opportunity for teaching activities focussed on building resilience and attaining skills for managing change.
**Participation in groups and associations**

Participation in groups and associations such as sporting groups, school groups and social groups is an important opportunity for both physical and social development. In this survey, the level of participation in groups increased with age. Of 4 year old children, 46% were participating in at least one group. Participation rose to 73.2% of 5 to 8 year old children and 83.3% of 9 to 12 year old children.

A proportion of children belonged to four or more groups. This proportion increased with age from 1.6% of 4 year old children to 9.0% of 5 to 8 year old children and 11.7% of 9 to 12 year old children (Figure 32).

More boys (76.1%) than girls (72.4%) belonged to at least one group or association. There was greater variation between the two regions. Rural children had a higher level of membership of at least one group (79.6%) or four or more groups (11.1%) than urban children for whom the proportions were 71.8% and 8.2%, respectively.

**Figure 32 ► Participation in groups and associations by non-Indigenous children**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Child does not belong to any group</th>
<th>Child belongs to 1-3 groups</th>
<th>Child belongs to 4 or more groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-8 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-12 years</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Bullying

Key Point
• Bullying was common in children aged from 4 to 12 years, with respondents reporting that nearly half (48.1%) of children had been bullied in the previous 12 months and 17.1% of children had bullied other children.

'Bullying involves a desire to hurt + hurtful action + power imbalance + (typically) repetition + an unjust use of power + evident enjoyment by the aggressor and a sense of being oppressed on the part of the victim' \(^4^9\). It may be of a physical, verbal or indirect nature. In this survey, bullying was described as being picked on, hit, kicked, threatened or ignored by other children. Respondents were asked whether their child had been bullied or had bullied other children in the 12 months preceding the survey.

Nearly half of respondents (48.1%) reported that their children had been bullied and 17.1% of children were reported to have bullied other children. The prevalence of bullying varied with age. 38.9% of 4 year old children had been bullied and 20.7% had bullied others. For 5 to 8 year old children the proportion being bullied had increased to 49.8% but the proportion that were bullying others had dropped to 16.0%. These proportions were similar in the 9 to 12 year old children with 48.6% being bullied and 17.4% acting as bullies (Figure 33).

There was a gender difference in reported bullying, with boys (52.4%) more likely than girls (43.4%) to have been bullied and boys (22.0%) also more likely than girls (11.9%) to bully others.

There was a regional difference in reported bullying. While the proportion of children who had been bullied was similar in the urban (49.2%) and rural (45.7%) regions, there was a greater and opposite difference in those who were reported to have acted as bullies in urban (15.1%) and rural (21.4%) regions.

Figure 33 ▶ Non-Indigenous children who had been bullied in the 12 months before the survey, by age and sex

Boys
Girls
Bullying

The high percentage (48.1%) of Northern Territory non-Indigenous children who were reported to have been bullied and the nearly one fifth (17.1%) of children who were reported to be perpetrators, makes this a theme of some consequence.

Bullying is an issue that involves the areas of child protection and discrimination. It is reported that bullying can have harmful effects on the self-esteem of children and can contribute to the development of further mental health problems in a considerable proportion of victimised children.\textsuperscript{51}

The National Safe Schools Framework, encourages schools to develop written policies to address bullying and harassment in schools, incorporating the whole school community from non-teaching staff and teachers through to parents, carers and the wider community.\textsuperscript{52}

Approaches to intervention are multi-pronged and aimed at professional development for staff, support and information for parents and carers and teaching children both to recognise and report bullying behaviour.

The Northern Territory Department of Employment, Education and Training provides a Behaviour Management Framework to schools, which supports the development of behaviour management policies on issues such as bullying. The Behaviour Management Team at Student Services works within the principles of the National Safe Schools Framework. From 2004, several School Wellbeing Advisors have been appointed to Northern Territory schools. Their role is to work with the whole school community to help children develop resilience through building positive relationships and using the principles of restorative justice. The Wellbeing Advisors also implement strategies that will nurture and support students and families who are experiencing difficulties. Their focus is on the whole school community including individuals with particular problems.\textsuperscript{53}
Services for children

Health services

Key Points
In the 12 months preceding the survey:

- Four out of every five children (81.8%) had used primary health care services
- Over a quarter of children (27.0%) had used hospital based services
- Four out of five children (82.8%) had used a dental service
- Very few children (2.3%) in the survey had used mental health services.

Health service utilisation is a common and important measure for health service management. However, if applied directly, it is of limited value when planning for the health service needs of a population. What is of greater value is an assessment of the expected service use in a population compared with the actual use. This assessment can be extended to subpopulations for whom the actual use provides an indication of those vulnerable groups that may be missing out on care. Health service utilisation also highlights the high users of services, which may be a group of children that need special attention. Respondents to this survey were asked about the use of a range of health services by their child, in the 12 months preceding the survey (Figure 34).

Figure 34 ► Use of health services by non-Indigenous children in the 12 months preceding the survey

- Primary health care
- Hospital services
- Allied health
- Dental
- Mental

Growing up in the Territory Parent Survey
Primary health care

Primary health care is the gateway of health care services, providing the first point of contact from which a health problem can either be managed entirely or a referral made to other services. In the Northern Territory, primary health care services include general practices, community health centres and community or district nursing services.

Three quarters of the children in this survey accessed primary health care services in the 12 months preceding the survey. The use of primary health care service declined with the increasing age of the child (91.4%, 79.9% and 71.4% from youngest to oldest age group). There was also some variation in the frequency of use of services over the 12 month period. Younger children had used services more frequently with 6.9% having used services between 12 and 24 occasions and a further 2.2% having used services on more than 24 occasions. These proportions were higher than the corresponding rates for 5 to 8 year olds (1.8% and 0.3%) and 9 to 12 year olds (1.6% and 0.1%). The comparisons are provided in Figure 35.

The reasons for not using primary health care services vary. While some children have more robust health and are reasonably judged not to need the service, there are also barriers to access to primary health care services including socioeconomic factors (like no money or no car), cultural factors (like no interpreters), workforce factors (such as no practitioners) and lack of knowledge of the available services.

Figure 35 ► Use of primary health care services by non-Indigenous children in the 12 months preceding the survey
Hospital based services

Hospital based services include hospital inpatient and outpatient care, as well as services provided through an Emergency Department. Hospital based services serve the needs of children with more serious illnesses. The majority of children in this survey had not been to hospital in the 12 months preceding the survey, (67.2%, 76.5% and 76.7% from youngest to oldest age group). Use of hospital services declined with increasing age of children. One fifth or less of children had one service event in a hospital (20.0%, 15.8% and 15.7% from youngest to oldest age group). A smaller proportion of children had two to four service events (11.0%, 7.0% and 6.2% from youngest to oldest age group) and a remaining group of children had five or more service events (1.7%, 0.7% and 1.4% from youngest to oldest age group) (Table 21).

Allied health services

Allied health services include those provided by a physiotherapist, occupational therapist, naturopath, podiatrist, dietician, speech pathologist, optometrist or audiologist. The proportion of children in the survey who used allied health services increased slightly with increasing age (9.2%, 10.0% and 10.9% from youngest to oldest age group). There was a subgroup of children who used allied health services five or more times in the 12 months preceding the survey (4.5%, 4.6% and 4.1%)

Table 21: Use of hospital services by non-Indigenous children in the 12 months preceding the survey

<table>
<thead>
<tr>
<th>Use of hospital services</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No service</td>
<td>472</td>
<td>67.2</td>
<td>(63.1—71.4)</td>
</tr>
<tr>
<td>1 services</td>
<td>140</td>
<td>20.0</td>
<td>(16.5—23.5)</td>
</tr>
<tr>
<td>2-4 services</td>
<td>77</td>
<td>11.0</td>
<td>(8.2—13.8)</td>
</tr>
<tr>
<td>5 services or more</td>
<td>12</td>
<td>1.7</td>
<td>(0.6—2.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.1</td>
<td>(-0.1—0.3)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No service</td>
<td>420</td>
<td>76.5</td>
<td>(72.2—80.8)</td>
</tr>
<tr>
<td>1 services</td>
<td>87</td>
<td>15.8</td>
<td>(12.2—19.4)</td>
</tr>
<tr>
<td>2-4 services</td>
<td>38</td>
<td>7.0</td>
<td>(4.3—9.6)</td>
</tr>
<tr>
<td>5 services or more</td>
<td>4</td>
<td>0.7</td>
<td>(-0.1—1.5)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No service</td>
<td>402</td>
<td>76.7</td>
<td>(72.8—80.7)</td>
</tr>
<tr>
<td>1 services</td>
<td>82</td>
<td>15.7</td>
<td>(12.2—19.2)</td>
</tr>
<tr>
<td>2-4 services</td>
<td>32</td>
<td>6.2</td>
<td>(4.2—8.2)</td>
</tr>
<tr>
<td>5 services or more</td>
<td>7</td>
<td>1.4</td>
<td>(0.3—2.4)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
from youngest to oldest age group). 9% of children in this survey were reported to have a disability and these children were probably represented among the more frequent users of allied health services.

Dental services

The three major factors involved in the maintenance of healthy teeth in children are regular dental care, fluoridation of the drinking water supply and nutrition. Primary teeth generally emerge from the age of 6 months and regular dental care is recommended from 2 years of age. In this survey 87.0% of 0 to 4 year old children had not used a dental service in the 12 months preceding the survey. Of concern is the 18.3% of 5 to 8 year old children and 16.1% of 9 to 12 year old children who had not used a dental service in the previous 12 months. Around half of children in these two age groups had received one dental service event (49.9% of 5 to 8 year old children and 48.8% of 9 to 12 year old children) and around one third had received two to four service events (29.2% of 5 to 8 year old children and 32.0% of 9 to 12 year old children). A small group of children had received five or more dental service events (2.2% of 5 to 8 year old children and 3.0% of 9 to 12 year old children) during the previous year (Table 22).

Table 22  Use of dental services by non-Indigenous children in the 12 months preceding the survey

<table>
<thead>
<tr>
<th>Use of dental services</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No service</td>
<td>611</td>
<td>87.0</td>
<td>(83.9—90.0)</td>
</tr>
<tr>
<td>1 services</td>
<td>70</td>
<td>10.0</td>
<td>(7.2—12.8)</td>
</tr>
<tr>
<td>2-4 services</td>
<td>22</td>
<td>3.1</td>
<td>(1.6—4.5)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No service</td>
<td>100</td>
<td>18.3</td>
<td>(14.2—22.4)</td>
</tr>
<tr>
<td>1 services</td>
<td>274</td>
<td>49.9</td>
<td>(44.7—55.2)</td>
</tr>
<tr>
<td>2-4 services</td>
<td>161</td>
<td>29.2</td>
<td>(24.5—33.9)</td>
</tr>
<tr>
<td>5 services or more</td>
<td>12</td>
<td>2.2</td>
<td>(0.7—3.6)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>0.4</td>
<td>(-0.1—1.0)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No service</td>
<td>84</td>
<td>16.1</td>
<td>(12.5—19.6)</td>
</tr>
<tr>
<td>1 services</td>
<td>255</td>
<td>48.8</td>
<td>(44.0—53.6)</td>
</tr>
<tr>
<td>2-4 services</td>
<td>167</td>
<td>32.0</td>
<td>(27.4—36.5)</td>
</tr>
<tr>
<td>5 services or more</td>
<td>16</td>
<td>3.0</td>
<td>(1.5—4.5)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.2</td>
<td>(-0.2—0.6)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
**Mental health services**

The survey asked specifically about services provided to the child by a psychiatrist, psychologist or counsellor during the twelve months preceding the survey. Of 0 to 4 year old children, 0.7% reported at least one mental health service event. The proportion rose for older groups with 2.6% of 5 to 8 year old children and 3.9% of 9 to 12 year old children reporting at least one mental health service event (Table 23).

The prevalence of mental health problems among Australian children aged from 4 to 17 years has been reported as 14%\(^2\) and elsewhere in this report the reported rate for Northern Territory non-Indigenous children aged from 1 to 12 is reported to be 7.9%. While not all of these problems require professional treatment, these results raise issues of community awareness, parent education and accessibility to mental health services for children.

---

**Table 23**: Use of mental health services by non-Indigenous children in the 12 months preceding the survey

<table>
<thead>
<tr>
<th>Use of mental health services</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No service</td>
<td>698</td>
<td>99.3</td>
<td>(98.5—100.2)</td>
</tr>
<tr>
<td>2 services or more</td>
<td>5</td>
<td>0.7</td>
<td>(-0.2—1.5)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No service</td>
<td>535</td>
<td>97.4</td>
<td>(95.8—98.9)</td>
</tr>
<tr>
<td>1 services</td>
<td>6</td>
<td>1.1</td>
<td>(0.0—2.3)</td>
</tr>
<tr>
<td>2 services or more</td>
<td>8</td>
<td>1.5</td>
<td>(0.4—2.6)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No service</td>
<td>503</td>
<td>96.1</td>
<td>(94.5—97.6)</td>
</tr>
<tr>
<td>1 services</td>
<td>8</td>
<td>1.5</td>
<td>(0.5—2.6)</td>
</tr>
<tr>
<td>2 services or more</td>
<td>13</td>
<td>2.4</td>
<td>(1.3—3.6)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Childcare

Key Points

• Over a quarter (27.7%) of all non-Indigenous children in this survey were recipients of formal care in the week before the survey and over a third (36.4%) received informal care from family and friends.

• The most common users of long day care and family day care were 0 to 4 year old children (20.1% and 17.6%, respectively).

• The largest users of outside school hours care were 5 to 8 year old children with 22.6% of this age group using this type of care in the week before the survey.

• The most frequent providers of informal care were grandparents, who cared for 40.6% of those children receiving informal care in the week before the survey.

• More urban children (32.0%) than rural children (18.8%) used formal childcare in the week before the survey. This was largely a result of the difference in use of outside school hours care.

The availability of childcare is a crucial issue for parents whose children are of preschool and primary school age. Childcare for very young children is usually needed throughout the day, while childcare for school-aged children is often required to bridge the gap between parents’ working hours and formal school hours.

Formal childcare is government regulated and takes place away from the child’s home. The main types of formal care are long day care, family day care, before and/or after school care, occasional care and preschool. Informal childcare is non-regulated and is arranged by a child’s parent/guardian, either in the child’s home or elsewhere. It covers care by brothers or sisters (including step siblings), care by grandparents, care by other relatives (including a parent living elsewhere) and care by other people such as friends, neighbours, nannies or babysitters. In this survey, all respondents were asked questions about the use of both formal and informal childcare services. These questions covered type of services used and time spent in childcare.
**Formal childcare**

There is a range of formal childcare services. Long day care services provide full or part-time care for children who do not yet attend school and may also provide care for limited numbers of primary school-aged children before and after school or during the school holidays. Family day care services provide registered childcare services within private homes. These services have the ability to be flexible in providing care for children of parents involved in extended working hours or shift work. Outside school hours care services provide care for school-aged children before and after school, during school holidays and on pupil free days. These services are most commonly used by younger primary school-aged children. These are the main types of formal or regulated childcare services, although there are others such as occasional care, vacation care and in-home care services.

Overall 27.7% of non-Indigenous children aged 0 to 12 participated in some form of formal childcare in the week before the survey. There was substantial variation of childcare use between the age groups. Children aged from 0 to 4 were the most common users with nearly half (44.3%) cared for in formal childcare in the week before the survey. This compared with a quarter (25.3%) of 5 to 8 year old children and 8.0% of 9 to 12 year old children. The largest users of formal childcare services were children who had not started school (Figure 36).

More urban children (32.0%) than rural children (18.8%) were cared for in formal childcare in the week before the survey. For those urban and rural children receiving formal childcare, similar proportions received between 1 and 19 hours of care (59.0% and 59.1% respectively), and 20 hours or more of childcare (41.0% and 40.9% respectively).

**Figure 36 ► Hours spent in formal childcare by non-Indigenous children * **

* Note: Responses for a total of 492 children.
Long day care
The greatest use of long day care services was by children aged from 0 to 4 years. In this group 20.1% of children had used a long day care facility in the week before the survey (Table 24). The use of long day care services was similar for urban (20.8%) and rural children (17.6%).

Family day care
The pattern of use of family day care services was similar to that for long day care services, with the largest group of users again being children aged from 0 to 4 years. Of these children, 17.6% had used family day care in the previous week. A small proportion of 5 to 8 year old children (2.3%) and 9 to 12 year old children (0.6%) had also used these services (Table 25). More urban (9%) than rural (5.6%) children had used family day care services.

### Table 24 ► Use of long day care by non-Indigenous children in the week before the survey

<table>
<thead>
<tr>
<th>Used long day care</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>123</td>
<td>20.1</td>
<td>(16.5—23.7)</td>
</tr>
<tr>
<td>No</td>
<td>489</td>
<td>79.9</td>
<td>(76.3—83.5)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>6.8</td>
<td>(-8.6—22.2)</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>93.2</td>
<td>(77.8—108.6)</td>
</tr>
<tr>
<td>Total</td>
<td>624</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

## Table 25 ► Use of family day care by non-Indigenous children in the week before the survey

<table>
<thead>
<tr>
<th>Use of family day care</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>124</td>
<td>17.6</td>
<td>(14.0—21.2)</td>
</tr>
<tr>
<td>No</td>
<td>579</td>
<td>82.4</td>
<td>(78.8—86.0)</td>
</tr>
<tr>
<td>5-8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>2.3</td>
<td>(1.0—3.7)</td>
</tr>
<tr>
<td>No</td>
<td>537</td>
<td>97.7</td>
<td>(96.3—99.0)</td>
</tr>
<tr>
<td>9-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>0.6</td>
<td>(0.0—1.3)</td>
</tr>
<tr>
<td>No</td>
<td>520</td>
<td>99.4</td>
<td>(98.7—100.0)</td>
</tr>
<tr>
<td>Total</td>
<td>1775</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Outside school hours care

The major users of outside school hours care were 5 to 8 year old children (22.6%), with a smaller proportion (7.2%) of 9 to 12 year old children using these services. A small proportion (11.5%) of 4 year old children, who had begun school, also used these services (Table 26). Of all formal childcare services, outside school hours care is the service for which there is the greatest difference in participation between urban and rural children, with 18.5% of the total urban sample using these services compared to 6.8% of the rural sample.

Any other type of formal childcare

Any other type of formal childcare service had been used by 7.2% of 0 to 4 year old children and 0.6% of 5 to 8 year old children in the week before the survey. Slightly more urban (3.5%) than rural (2.1%) children used any other type of formal childcare service.

Informal childcare

In addition to formal childcare services, which are subject to government regulations, there are informal arrangements in which people other than their parents or primary carers look after children. These may include both paid and unpaid arrangements with grandparents, other relatives or friends and may overlap with formal childcare arrangements. Individual children may receive both formal and informal childcare.

Of all children, 36.4% had been cared for by someone apart from their parent, primary carer, or the parent’s spouse or partner in the week before the survey. The proportion of children cared for by someone other than their primary carer decreased with increasing age of the child (40.9%, 34.1% and 32.5% from youngest to oldest age group).

For children who used informal childcare, grandparents were the most common providers of care for all age groups (45.3%, 41.1% and 32.6% from youngest to oldest age group),

Table 26 ► Use of outside school hours care by non-Indigenous children in the week before the survey

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Used outside school hours care</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>Yes</td>
<td>11</td>
<td>11.5</td>
<td>(3.0—20.1)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>81</td>
<td>88.5</td>
<td>(79.9—97.0)</td>
</tr>
<tr>
<td>5-8</td>
<td>Yes</td>
<td>122</td>
<td>22.6</td>
<td>(18.2—27.0)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>417</td>
<td>77.4</td>
<td>(73.0—81.8)</td>
</tr>
<tr>
<td>9-12</td>
<td>Yes</td>
<td>483</td>
<td>7.2</td>
<td>(4.5—9.9)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>37</td>
<td>92.8</td>
<td>(90.1—95.5)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1151</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
in the week preceding the survey. Following grandparents, family friends were the most common providers of care, giving care for similar proportions of children in each age group (27.6%, 23.2% and 24.2% from youngest to oldest age group). Other providers of care included other relatives, neighbours, the other parent and other people or organisations. A marked trend toward increasing levels of informal childcare with increasing age of the child was noted for care provided by siblings (3.2%, 14.4% and 18.0% from youngest to oldest age group). This may be due to older children in the survey requiring less complex care and also being more likely to have siblings capable of providing care (Figure 37).

Of those children who had used informal childcare, there was a range in total hours of care. About three quarters (73.9%) of these children received less than 10 hours of care in the week preceding the survey. At the other end of the scale, 5.8% of these children received 30 or more hours of care.

There was little difference between levels of informal childcare provided in urban and rural settings. Informal childcare was used by 36.7% of urban children compared to 35.5% of rural children, in the week before the survey. Patterns of care were similar in urban and rural regions, with about three quarters of children (73.4% urban, 74.5% rural) using informal care for less than 10 hours a week. There was a regional difference in the providers of informal childcare. Grandparents and other relatives were more likely to provide care in urban areas (43.4% and 11.4% of children using childcare) than in rural areas (35.0% and 9.8% of children using childcare). This difference was offset by an increased reliance on family friends and siblings in rural areas (23.5% and 9.9% urban, 29.7% and 11.3% rural) (Table 27).

Figure 37 ► Providers of informal childcare for non-Indigenous children in the week before the survey*

* Note: Responses for a total of 643 children
Childcare

Of all respondents in this survey, 71.6% were in paid employment and 91.7% of their partners were involved in paid employment. For these parents and carers, as well as non-employed parents and carers, the need for childcare may be significant. Over a quarter (27.7%) of all non-Indigenous children in this survey were recipients of formal care in the week before the survey and over a third (36.4%) received informal care from family and friends.

Table 27  Providers of informal childcare to non-Indigenous children in the week before the survey, by region

<table>
<thead>
<tr>
<th>Care from other people</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>146</td>
<td>43.4</td>
<td>(37.5—49.2)</td>
</tr>
<tr>
<td>Brother/Sister</td>
<td>33</td>
<td>9.9</td>
<td>(6.4—13.4)</td>
</tr>
<tr>
<td>Other parent living elsewhere</td>
<td>5</td>
<td>1.6</td>
<td>(0.3—2.9)</td>
</tr>
<tr>
<td>Other relative</td>
<td>38</td>
<td>11.4</td>
<td>(7.3—15.4)</td>
</tr>
<tr>
<td>Family friend</td>
<td>79</td>
<td>23.5</td>
<td>(18.3—28.6)</td>
</tr>
<tr>
<td>Neighbour</td>
<td>17</td>
<td>4.9</td>
<td>(2.2—7.7)</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>3.6</td>
<td>(1.5—5.6)</td>
</tr>
<tr>
<td>Other organisation</td>
<td>4</td>
<td>1.3</td>
<td>(0.2—2.4)</td>
</tr>
<tr>
<td>None of the above</td>
<td>2</td>
<td>0.5</td>
<td>(-0.3—1.2)</td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>107</td>
<td>35.0</td>
<td>(29.0—41.1)</td>
</tr>
<tr>
<td>Brother/Sister</td>
<td>35</td>
<td>11.3</td>
<td>(6.6—16.0)</td>
</tr>
<tr>
<td>Other parent living elsewhere</td>
<td>4</td>
<td>1.2</td>
<td>(0.2—2.2)</td>
</tr>
<tr>
<td>Other relative</td>
<td>30</td>
<td>9.8</td>
<td>(5.7—13.9)</td>
</tr>
<tr>
<td>Family friend</td>
<td>91</td>
<td>29.7</td>
<td>(24.1—35.4)</td>
</tr>
<tr>
<td>Neighbour</td>
<td>8</td>
<td>2.7</td>
<td>(0.8—4.7)</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>6.5</td>
<td>(3.2—9.9)</td>
</tr>
<tr>
<td>Other organisation</td>
<td>10</td>
<td>3.4</td>
<td>(1.1—5.6)</td>
</tr>
<tr>
<td>None of the above</td>
<td>1</td>
<td>0.3</td>
<td>(-0.3—0.9)</td>
</tr>
<tr>
<td>Total</td>
<td>642</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Issues relating to childcare include the availability of places in relation to demand, the allocation of scarce childcare places preferentially to working or non-working parents, the affordability of places, the needs of rural families, childcare places for disadvantaged groups of children and quality assurance in both the public and private childcare sectors.
Indigenous children

Key Points

- The sample of Indigenous children in this survey is not representative of all Indigenous children throughout the Northern Territory.

- The proportion of children reported to have been of low birthweight (less than 2500 grams at birth) was 11.4%.

- Although the initial percentage of mothers breastfeeding (91.3%) meets the national recommendations, the percentage when babies were 6 months old (55.0%) was well below the national recommendations.

- During the gestational period, 39.3% of Indigenous children had at least one parent or carer who smoked.

- While 12.7% of children were described as having trouble with emotions, concentration, behaviour or getting on with people, only 8.7% of children had received treatment for their problems.

- Almost a quarter (23.3%) of Indigenous children had some form of injury in the 12 months preceding the survey.

- One quarter (25.2%) of the Indigenous children were described as overweight or obese. Just over 15% (15.8%) were described as underweight.

- Just over half of the children (56.4%) were participating in physical activity for five sessions a week. Over two thirds (71.1%) of children were watching television for less than two hours a day. Quite a high proportion of children (83.1%) were eating the recommended amount of fruit each day and eating one or less fast food meals a week (84.0%). However, only just over a quarter of children (27.0%) were eating recommended amounts of vegetables. Under half of children (44.4%) always used sun protection.

Of the total unweighted sample of children, 221 (11.1%) were Indigenous. This compares with the proportion of all Indigenous children living in the Northern Territory, which is close to 40%. However, not only are Indigenous children underrepresented in total numbers but those who did participate were much more likely to come from urban areas, where Indigenous households were more likely to have a fixed telephone service than the rate of 1.5% for Indigenous Territorians living in remote areas. The sample of Indigenous children in this survey is clearly unrepresentative of all Indigenous children throughout the Northern Territory and results cannot therefore be generalised to that population. However, the sample is representative of Indigenous children in households which do have a telephone and who are arguably, more advantaged than children in households without telephones.
Although the Indigenous sample was not considered to be representative of all Indigenous children in the Northern Territory, it was weighted to control other factors that affected the likelihood of being included in the sample. These included the number of children in the household, age and sex of the child in the survey and the number of telephones in the household. The area of residence was also weighted because the rural area was over sampled to derive a representative non-Indigenous sample. While the weighting provided a technically more correct outcome, there was little difference between the weighted and unweighted results. Because of the relatively small sample of Indigenous children the results in this report are only provided for the aggregate sample of Indigenous children and not for any age or sex specific groupings.

Age, sex and area of residence

After weighting, the Indigenous children were distributed through the three age groups as follows; 38.1% were 0 to 4 year old children, 32.0% were 5 to 8 year old children and 29.8% were 9 to 12 year old children. There were more boys (52.4%) than girls (47.6%) (Table 28). More Indigenous children in the weighted sample were from the urban (56.2%) rather than the rural (43.8%) area, as was expected with the extremely low level of phone ownership in remote Indigenous communities. In this survey the ‘rural’ area included the large towns of Alice Springs, Tennant Creek, Katherine and Nhulunbuy and the ‘urban’ area included Darwin City, Palmerston-East Arm and Litchfield Shire.

Table 28 ► Age, sex and area of residence, Northern Territory Indigenous children with a phone, 2004

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>84</td>
<td>38.1</td>
</tr>
<tr>
<td>5-8</td>
<td>71</td>
<td>32.0</td>
</tr>
<tr>
<td>9-12</td>
<td>66</td>
<td>29.8</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>116</td>
<td>52.4</td>
</tr>
<tr>
<td>Female</td>
<td>105</td>
<td>47.6</td>
</tr>
<tr>
<td>Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>124</td>
<td>56.2</td>
</tr>
<tr>
<td>Rural</td>
<td>97</td>
<td>43.8</td>
</tr>
<tr>
<td>Total</td>
<td>221</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Development

Birthweight

Reported birthweight ranged from 640 grams to 5000 grams. The proportion of children reported to have been of low birthweight (less than 2500 grams at birth) was 11.4%. This was slightly lower than the recorded prevalence of low birthweight for all Indigenous babies (14%) born in the Northern Territory in 2002.\(^{12}\)

Breastfeeding

A high proportion of Indigenous children (91.3%) were breastfed for some time, with 55.0% still being breastfed at 6 months and 29.1% still being breastfed at 12 months (Figure 38). Although the initial percentage of mothers breastfeeding meets the national recommendations, the rate of drop-off is quite high, resulting a level of breastfeeding when babies are 6 months old that is well below the national recommendations (more than 80% still breastfeeding at 3 and 6 months).

Smoking during pregnancy

During the gestational period, 39.3% of Indigenous children had at least one parent or carer who smoked. This high rate of smoking was consistent with the reported rate for Northern Territory Indigenous mothers, which in 2002 was 28.1% in the third trimester of pregnancy.\(^{12}\)

Figure 38 ► Duration of breastfeeding for Indigenous children

![Graph showing duration of breastfeeding]
Health

General health
A high proportion of Indigenous children were reported to have excellent or very good general health (85.9%), 11.0% to have good health and 3.1% to have fair or poor health.

Mental health
The proportion of Indigenous children described as having trouble with emotions, concentration, behaviour or getting on with people was 12.7%. Treatment for these problems had been received by 8.7% of all Indigenous children (Figure 39).

Figure 39 ► Emotional or mental health problems of Indigenous children
Injury

In the 12 months preceding the survey, 23.3% of Indigenous children had an injury. Of these children, 5.7% had experienced a broken bone, 3.7% a head injury, 0.3% a burn, 2.4% a poisoning and 19.2% another form of injury (Figure 40).

Figure 40 ► Injury of Indigenous children
Risk and protective factors

In this survey, 25.2% of the Indigenous children were described as overweight or obese. Just over 15% (15.8%) were described as underweight. Just over half of the children (56.4%) were participating in physical activity for five sessions a week. Over two thirds (71.1%) of children were watching television for less than two hours a day. Quite a high proportion of children (83.1%) were eating the recommended amount of fruit each day and eating one or less fast food meals a week (84.0%). However, only just over a quarter of children (27.0%) were eating recommended amounts of vegetables. Under half of children (44.4%) always used sun protection (Figure 41).
Indigenous family environment

Key Points

• Over a half (55.7%) of Indigenous children lived in an intact family, a quarter (24.2%) lived in a one-parent family, 11.4% lived in a step or blended family and 8.7% in another type of family

• The most common household size was four people

• 7.8% of Indigenous families had five or more children less than 16 years of age

• 25.7% of parents had been treated for an emotional or mental health problem

• Half of the parents or carers of Indigenous children always, often or sometimes felt a lack of control over their financial situation

• 36.5% of parents or carers had a post-secondary qualification

• 59.5% of respondents were in paid employment

• Almost one half (48.4%) of households had an income of $40,000 or less
Structure and size

Over half of Indigenous children (55.7%) lived in an intact family, followed by almost a quarter (24.2%) who lived in a one-parent family. 11.4% of children lived in a step or blended family and 8.7% in another type of family.

The most common household size was four people (33.0%), followed by five people (21.2%), three people (20.3%) and six people (9.2%). Some households (6.7%) contained from eight to twelve people.

The most common number of children under 16 years of age in a household was two children (42.1%), followed by three children (20.8%), one child (20.0%) and four children (9.2%). Three families (0.9%) had from seven to nine children less than 16 years of age (Table 29).

Table 29 ▶ Household size and number of children under 16 years of age (Indigenous children)

<table>
<thead>
<tr>
<th>Family size</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 people</td>
<td>13</td>
<td>5.7</td>
<td>(3.1—8.4)</td>
</tr>
<tr>
<td>3 people</td>
<td>45</td>
<td>20.3</td>
<td>(13.1—27.5)</td>
</tr>
<tr>
<td>4 people</td>
<td>73</td>
<td>33.0</td>
<td>(24.7—41.3)</td>
</tr>
<tr>
<td>5 people</td>
<td>47</td>
<td>21.2</td>
<td>(14.1—28.4)</td>
</tr>
<tr>
<td>6 people</td>
<td>20</td>
<td>9.2</td>
<td>(4.5—13.9)</td>
</tr>
<tr>
<td>7 people</td>
<td>8</td>
<td>3.7</td>
<td>(0.3—7.1)</td>
</tr>
<tr>
<td>8 people</td>
<td>6</td>
<td>2.8</td>
<td>(-0.5—6.0)</td>
</tr>
<tr>
<td>9 people</td>
<td>1</td>
<td>0.4</td>
<td>(-0.4—1.1)</td>
</tr>
<tr>
<td>10 people</td>
<td>4</td>
<td>1.7</td>
<td>(-0.7—4.2)</td>
</tr>
<tr>
<td>12 people</td>
<td>1</td>
<td>0.6</td>
<td>(-0.6—1.9)</td>
</tr>
<tr>
<td>13 people</td>
<td>1</td>
<td>0.5</td>
<td>(-0.5—1.6)</td>
</tr>
<tr>
<td>15 people</td>
<td>2</td>
<td>0.7</td>
<td>(-0.3—1.7)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 child</td>
<td>44</td>
<td>20.0</td>
<td>(12.8—27.2)</td>
</tr>
<tr>
<td>2 children</td>
<td>93</td>
<td>42.1</td>
<td>(33.6—50.5)</td>
</tr>
<tr>
<td>3 children</td>
<td>46</td>
<td>20.8</td>
<td>(13.8—27.9)</td>
</tr>
<tr>
<td>4 children</td>
<td>20</td>
<td>9.2</td>
<td>(3.7—14.8)</td>
</tr>
<tr>
<td>5 children</td>
<td>10</td>
<td>4.6</td>
<td>(1.1—8.1)</td>
</tr>
<tr>
<td>6 children</td>
<td>5</td>
<td>2.3</td>
<td>(-0.9—5.5)</td>
</tr>
<tr>
<td>7 children</td>
<td>1</td>
<td>0.2</td>
<td>(-0.2—0.7)</td>
</tr>
<tr>
<td>8 children</td>
<td>1</td>
<td>0.4</td>
<td>(-0.4—1.3)</td>
</tr>
<tr>
<td>9 children</td>
<td>1</td>
<td>0.3</td>
<td>(-0.3—1.8)</td>
</tr>
<tr>
<td>Total</td>
<td>221</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Parents

General health

Just over half of respondents (55.8%) described their own general health as excellent or very good, 39.5% as good or fair and 4.7% as poor or very poor (Figure 42).

Mental health

Over a quarter of the parents or carers of Indigenous children in this survey (25.7%) had been treated for an emotional or mental health problem.

Risk factors

A very high proportion of respondents (81.5%) reported that their home was smoke free, while 18.5% reported that smoking occasionally or frequently occurred inside the house. Alcohol was reported to cause a problem in 4.1% of households (Table 30).

Figure 42 ► General health status of parents of Indigenous children

Table 30 ► Smoking and alcohol use by parents and carers of Indigenous children

<table>
<thead>
<tr>
<th>Smoking and alcohol use</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking in the home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoke free home</td>
<td>180</td>
<td>81.5</td>
<td>(74.9—88.1)</td>
</tr>
<tr>
<td>Occasionally smoking inside house</td>
<td>17</td>
<td>7.7</td>
<td>(3.6—11.8)</td>
</tr>
<tr>
<td>Frequently smoking inside house</td>
<td>24</td>
<td>10.8</td>
<td>(5.2—16.4)</td>
</tr>
<tr>
<td>Alcohol causes a problem in the home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>4.1</td>
<td>(1.4—6.8)</td>
</tr>
<tr>
<td>No</td>
<td>211</td>
<td>95.6</td>
<td>(92.8—98.4)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.2</td>
<td>(-0.2—0.7)</td>
</tr>
<tr>
<td>Total</td>
<td>221</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Sense of control

A notable minority of the parents or carers of Indigenous children reported that they often or always felt a lack of control over various areas of their life. These areas included life in general (7.6%), personal life (6.7%), finances (13.3%), control of work life (7.7%) and control of job security (5.9%). Once again a lack of control of financial situation had the most marked response (Figure 43).

Socioeconomic indicators

Education

A small proportion of respondents (6.0%) had only completed a primary school level of education or less. Around half of respondents (49.1%) had completed Year 10 or Year 12 of secondary school and 36.5% had a post-secondary qualification. More post-secondary qualifications were from a college of tertiary and further education (TAFE), than from a university.
Employment

Overall, 59.5% of respondents were in paid employment. Almost one third of respondents (33.5%) were involved in home duties. A small proportion (1.4%) reported that they were unemployed for less than one year, with a further 0.5% unemployed for more than one year.

Income

Almost one half of households had an income of less than $40,000 a year. This consisted of 20.2% with an annual income of less than $20,000 and 28.2% with an annual income from $20,000 to $40,000. Over a third (37.3%) of households had an income from $40,000 to $100,000 and 6.6% had an income of over $100,000 (Table 31).

Table 31  Socioeconomic indicators for Indigenous parents and carers

<table>
<thead>
<tr>
<th>Socioeconomic indicators</th>
<th>Number</th>
<th>Percent</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent’s education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some primary school</td>
<td>1</td>
<td>0.6</td>
<td>(-0.1—1.4)</td>
</tr>
<tr>
<td>Completed primary school</td>
<td>12</td>
<td>5.4</td>
<td>(1.5—9.3)</td>
</tr>
<tr>
<td>Completed Year 10</td>
<td>79</td>
<td>35.7</td>
<td>(27.1—44.3)</td>
</tr>
<tr>
<td>Completed Year 12</td>
<td>30</td>
<td>13.4</td>
<td>(7.4—19.4)</td>
</tr>
<tr>
<td>TAFE or Diploma</td>
<td>51</td>
<td>23.1</td>
<td>(16.0—30.2)</td>
</tr>
<tr>
<td>University degree</td>
<td>30</td>
<td>13.4</td>
<td>(8.1—18.8)</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>8.3</td>
<td>(3.8—12.9)</td>
</tr>
<tr>
<td>Household income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$20,000 or less</td>
<td>45</td>
<td>20.2</td>
<td>(13.7—26.7)</td>
</tr>
<tr>
<td>$20,000-$40,000</td>
<td>62</td>
<td>28.2</td>
<td>(20.1—36.2)</td>
</tr>
<tr>
<td>$40,000-$60,000</td>
<td>39</td>
<td>17.5</td>
<td>(10.7—24.4)</td>
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<td>$60,000-$80,000</td>
<td>32</td>
<td>14.5</td>
<td>(7.9—21.2)</td>
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<tr>
<td>$80,000-$100,000</td>
<td>12</td>
<td>5.3</td>
<td>(4.2—8.4)</td>
</tr>
<tr>
<td>More than $100,000</td>
<td>15</td>
<td>6.6</td>
<td>(3.0—10.2)</td>
</tr>
<tr>
<td>Unknown</td>
<td>14</td>
<td>6.3</td>
<td>(1.7—10.8)</td>
</tr>
<tr>
<td>Refused</td>
<td>3</td>
<td>1.5</td>
<td>(0.0—3.0)</td>
</tr>
<tr>
<td>Parent’s employment status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self employed</td>
<td>9</td>
<td>4.0</td>
<td>(1.3—6.8)</td>
</tr>
<tr>
<td>Employed for wages</td>
<td>123</td>
<td>55.5</td>
<td>(46.9—64.1)</td>
</tr>
<tr>
<td>Unemployed for less than one year</td>
<td>3</td>
<td>1.4</td>
<td>(0.0—2.8)</td>
</tr>
<tr>
<td>Unemployed for more than one year</td>
<td>1</td>
<td>0.5</td>
<td>(-0.5—1.6)</td>
</tr>
<tr>
<td>Home duty</td>
<td>74</td>
<td>33.5</td>
<td>(25.1—42.0)</td>
</tr>
<tr>
<td>Retired</td>
<td>2</td>
<td>0.8</td>
<td>(0.0—1.7)</td>
</tr>
<tr>
<td>Unable to work</td>
<td>2</td>
<td>1.1</td>
<td>(-0.1—2.3)</td>
</tr>
<tr>
<td>Student</td>
<td>2</td>
<td>1.0</td>
<td>(-0.2—2.2)</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>2.1</td>
<td>(-0.4—4.5)</td>
</tr>
<tr>
<td>Total</td>
<td>221</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Schools and communities for Indigenous children

Key Points

- Most Indigenous children had friends, but only 59.6% belonged to a group or association.
- 16.8% of Indigenous children had missed 20 or more days (four weeks or more) of school in the previous year.
- Almost half of Indigenous children (48.3%) had been bullied in the previous year and 18.9% had bullied others.

Education

Of Indigenous children, 81.0% almost always or often, 14.8% sometimes and 3.5% rarely or almost never looked forward to going to school.

The majority of Indigenous children (68.6%) were described as doing very well or well at school, 25.8% as having an average performance and 3.0% as doing poorly or very poorly.

Most Indigenous children had some absences from school in the year preceding the survey. Around half of children (55.8%) were absent for one to nine days, around one quarter (21.4%) for 10 to 19 days and 16.8% for 20 days or more.

Almost two thirds of Indigenous children (66.7%) had only attended one school since the beginning of primary school, 26.4% had attended two or three, 5.8% had attended four or five and 0.7% had attended six or more schools (Figure 44).

Figure 44 ► Number of schools attended by Indigenous children
**Friends**

Most Indigenous children had a special friend (82.5%) or a group of friends (88.3%) to play with. Over a half of Indigenous children (59.6%) belonged to at least one group or association (Figure 45). Very few children (0.3%) did not have any friends and were not members of any group or association.

**Bullying**

Almost half of Indigenous children had been bullied in the 12 months preceding the survey (48.3%) and 18.9% of children had bullied other children.

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**Figure 45**  
Friendship and participation in groups or associations by Indigenous children
Services for Indigenous children

Health services

Primary health care services were the most commonly accessed services; with 80.7% of Indigenous children having at least one primary health care visit in the 12 months preceding the survey. Over one third of children (35.6%) had used a hospital based service, 10.8% had used an allied health care service and 3.1% of children had used a mental health care service. Just over half of Indigenous children (52.5%) had used a dental service in the year preceding the survey (Figure 46).

Childcare

Of the Indigenous children in this survey, 29.7% had received formal childcare and 40.7% had received informal childcare, in the week before the survey. Around 40% (41.1%) of Indigenous children did not receive any childcare during that period.

Figure 46 ► Use of health services by Indigenous children
Commentary on Indigenous children

Although the Indigenous children in this survey were not considered to be a representative sample of all Northern Territory Indigenous children, it might be presumed that they were drawn from a group of relative socioeconomic advantage, through the proxy measure of phone ownership. In many of the parameters, the findings were similar to those for their non-Indigenous counterparts. Most Indigenous children are reported to be in excellent or very good general health and have a special friend or a group of friends. However, a persistent pattern of falling slightly behind non-Indigenous children in several significant areas may indicate a cumulative burden, even in this sample of children.

There are several developmental issues of importance. Although the reported average birthweight for Indigenous babies (3063 grams) was 71 grams less than the non-Indigenous babies (3134 grams), of greater importance is that the range of weights was lower. This information is consistent with other data sources, which have highlighted that improvement in birthweight is an area with the potential for significant health gain for Indigenous children.

Despite the high initial rate of breastfeeding for Indigenous women (91.3%), the rate at 6 months (55.0%) was more than 20% lower than national recommendations. Encouraging more mothers to continue breastfeeding throughout the first year of a baby’s life would be another area of potential benefit to children.

Smoking during pregnancy impedes foetal development and may result in prematurity, low birthweight and an increased chance of perinatal death. After birth, children of smokers have higher rates of respiratory infection and an increased chance of infant death. Harm could be avoided if smoking exposure was reduced. Well over a third of Indigenous children (and nearly a quarter of non-Indigenous children) had at least one parent or carer who smoked during the pregnancy.

Compared with non-Indigenous children (7.9%), the Indigenous children (12.7%) in this survey were reported to have more problems with emotions, behaviour and getting on with people. In a similar pattern, fewer Indigenous children with problems had received treatment (8.7%). The origin of a higher rate of reported mental health problems for Indigenous children is not clear. The result may be due to chance, but more plausibly is a result of the recognised complex of contextual factors that have a known impact on health and education. These include socioeconomic disadvantage, intergenerational trauma and its consequent effects and the health effects of racism.

The links between Indigeneity and poverty are indisputable. In this survey, nearly one half of Indigenous households (48.4%) had an annual income of less than $40,000, (20.2% less than $20,000) compared with 17.1% of non-Indigenous households (4.5% less than $20,000). Nearly 20% fewer Indigenous parents or carers had a post-secondary qualification compared with their non-Indigenous counterparts. Reported rates of unemployment were similar, but actual employment rates were 12.5% lower for Indigenous parents and carers. Flow on effects were observed in the reported health of parents and carers. 20% more Indigenous parents and carers reported a feeling of lack of control over their financial situation always, often or sometimes. Reports on general health status were similar, but 5% more Indigenous parents or carers had been treated for mental health problems. Reported risk behaviours (smoking and alcohol related harm) were also higher for Indigenous parents. The broad nature of these factors cannot be simply managed within the traditional scope of health and education policy, but requires...
macro-level commitment to address the antecedents of poverty and disadvantage. The indicators provided here demonstrate that this is a policy issue of significance.

As has been previously mentioned, injury and poisoning are the most common cause of death in children aged from 1 to 14 years. In this survey, almost a quarter of Indigenous children (23.3%) were reported to have had at least one significant injury in the year preceding the survey. This was 8.2% more than non-Indigenous children. Socioeconomic vulnerability often links to susceptibility through a variety of mechanisms. In relation to injury, the links may operate at a child (lack of supervision), family (perceived helplessness, family violence) or community level (lack of resources, alienation).

The family environment of Indigenous children in this survey contained more one-parent families (24.2% compared with 10.8% non-Indigenous families), more step or blended families (11.4% compared with 5.8% of non-Indigenous families) and a higher proportion of ‘other’ types of families (8.7% compared with 1.1% of non-Indigenous families). Other families would have included families where grandparents are providing the parent role. Both one-parent and grandparent families are known to have lower household incomes than other family types and these structures also imply situations of parental loss, which may vary in their severity and consequences, but are likely to have had a significant impact on children.

The most common household size for both Indigenous and non-Indigenous children was four people, but Indigenous families tended to have a greater number of children less than 16 years of age. Twice as many Indigenous families (7.8%) had five or more children compared with non-Indigenous families (3.5%). The combination of low income levels and high numbers of children compounds the strain on families and provides an equation for support through government programs.

Most Indigenous children look forward to going to school, however attendance levels for the Indigenous children in this survey were much lower than for their non-Indigenous associates. School performance was also reported to be at slightly lower levels. While similar proportions of Indigenous and non-Indigenous children had friends, participation in at least one group or association was much lower for Indigenous children (59.6% compared with 74.4% of non-Indigenous children). The proportion of Indigenous children who had been bullied (48.3%) was almost identical to the proportion of non-Indigenous children, as was the proportion of Indigenous children who had bullied others (18.9%). In summary, school attendance and performance appear to be problems for more Indigenous children.

Rates of primary health care, allied health and mental health service use for Indigenous and non-Indigenous children were similar in this survey. Use of hospital based services was higher for Indigenous children (35.6% compared with 27.0% of non-Indigenous children). Nearly one half of Indigenous children (52.5%) had not used a dental service in the year preceding the survey.

This survey has indicated on several levels, that even among this group of relatively advantaged Indigenous children, families are poorer and children are bearing a disproportionate and cumulative burden. This begins with the early developmental years and translates into health and educational discrepancies in later years.
Discussion

The increasing recognition of the broader context of health and wellbeing has resulted in a shift of emphasis for preventive activity from risk and protective behaviours to a multi-disciplinary approach, that incorporates biological and environmental factors. The Computer Assisted Telephone Interview (CATI) Survey of Child Health and Wellbeing provides a useful and relatively inexpensive mechanism for reporting the health of non-Indigenous children in the Northern Territory. For the first time Northern Territory policy makers and service providers have reliable information on both the prevalence of common conditions and also a measure of the underlying determinants of those conditions. Repeated surveys will provide cumulative data that will monitor the ongoing health and wellbeing of children and provide a basis for assessment of the effectiveness of population level interventions. For Indigenous children, this survey has produced a useful sample. However, the group is unrepresentative and the data cannot be used either for standard measures of the health of Indigenous children or for the ongoing monitoring of this group. Other surveys are needed and one of the most immediate sources of such information will be the Australian Bureau of Statistics, National Aboriginal and Torres Strait Islander Health Survey. The first release of information from that survey is planned for early 2006. At that time the Northern Territory will have comprehensive information on the health and wellbeing of all Northern Territory children.

Key indicators of health, development and wellbeing

Nationally, child health indicators have been organised into groups that cover traditional measures of health (mortality and morbidity) as well as development, adversity, safety, learning and families and communities. The results of this survey will be grouped into these categories for discussion, indicating the broad spectrum planning that is needed for all children and for programs for children with special needs. This approach also allows national and state/territory data comparisons.

How healthy are Northern Territory non-Indigenous children?

The common disorders among Northern Territory non-Indigenous children measured in this survey were the prevalence of asthma (17%), disability (9%) and mental health problems (8%). Asthma and disability had a higher prevalence among Northern Territory children than among children nationally (13% and 8%, respectively). Mental health problems were less frequently reported in the Northern Territory (8% compared with 14% nationally). It seems unlikely that the actual occurrence of mental health problems in the Northern Territory is almost half of the national rate. Other explanations for the relatively low reported prevalence need to be considered, including a lack of recognition of problems or the reluctance to disclose the presence of problems. The prevalence of attention deficit hyperactivity disorder among children aged from 5 to 12 years was reported to be 4%. These children form a subset of all children with mental health problems, leaving a small reported percentage for all other mental health problems. In parallel with the low prevalence of reported mental health conditions, only 5% of all children had used a mental health service in the year preceding the survey.
How well are we promoting healthy child development?

Rates of breastfeeding among children in the survey were initially high, but dropped off at a rate much greater than recommended. At 6 months, instead of 80% or more of children being breastfed, the rate was only 53.3%. This is an area where health promotion messages and structural reforms such as workplace based childcare and child friendly return to work practices would be helpful.

Immunisation rates and dental health were not assessed by the survey, although it was noted that 17% of children over 5 years of age had not used a dental service in the preceding year.

What factors can affect children adversely

Low birthweight has been shown to adversely affect both child (increased rates of hospitalisation and death) and adult (increased rates of coronary heart disease and Type 2 diabetes) health outcomes. The information obtained from this survey (9.6% of children were reported to be of low birthweight) was higher than recorded low birthweight in the Northern Territory in 2002 (5.8%).12 The national percentage of children born with low birthweight is about 6%.18 It appears that there may have been some miscommunication between the respondent and the interviewer in this survey, about imperial and metric measurements of birthweight.

The proportion of Australian children who are obese is reported to be increasing annually by around 1%. Avoiding obesity is important for mobility, psychosocial health and to reduce the risk of heart disease, respiratory disease and metabolic disorders.18 Northern Territory non-Indigenous children in this survey reported rates of obesity well above the national averages from 1995,18 but which may be consistent with current national levels. 9% of Northern Territory girls were reported to be obese compared with the 1995 level of 6% nationally. 8% of Northern Territory boys were reported to be obese compared with 4% nationally.18 While these differences from national figures may arise from comparing new with older figures, the local implications are clear. As rates of obesity among children in the Northern Territory approach 10%, environmental and structural interventions are needed to both reduce the extent and consequences of this impending epidemic. Effective interventions address the spectrum of action, from bans on food advertising and legislation covering food placement in supermarkets, to compulsory physical education and health programs in schools. A higher proportion of children in this survey were also reported to be underweight (11% of boys and 14% of girls) compared with their national counterparts (7% of boys and 4% of girls).18 These children also carry increased health risk. The high prevalence of both underweight and overweight children in the Northern Territory indicates that comprehensive programs, which encourage the maintenance of healthy weight, are needed. These programs will bring physical and social benefits to all children.

Smoking has been identified as ‘the most important known modifiable risk factor for low birthweight and infant mortality’.18 In this survey the rate of reported smoking by the child’s mother or partner during pregnancy was 23.5%, which is well above the national average of 18.0%. The prevalence of smoking inside the home was reported to be 10.1% in this survey, but has been shown in another Northern Territory report to be as high as 22.7% in all households.30 This is not dramatically different from the national prevalence of 19.7%.18 With the known adverse effects of environmental tobacco smoke on particularly the respiratory health of children, this also remains an area for active intervention with recognisable potential health gain.
How safe and secure are our children?

Safety is one of the basic human needs for good psychosocial health. Injury is the major contributor to death of children from 1 to 14 years of age. In this survey the reported rate of at least one significant injury in the preceding year for non-Indigenous children was 15.1% and for Indigenous children was 23.3%. Many causes of injury are amenable to public health interventions. Successful interventions range from parent education and support, to safety legislation covering the built environment, products, motor vehicles, roads and child protection. Intervention to prevent injury is specific to the developmental age of risk with, for example, poisonings being more common at younger ages and broken bones at older ages. Surveillance data can provide evaluative information on the effectiveness of preventive measures.

What kind of families do our children live in?

Family function was measured in this survey by a range of variables exploring interaction and the discipline of children. While most families got on well together, around 7% of families found that they avoided discussing their fears and concerns together and that decision-making was difficult because of misunderstanding. The world of the child is dominated by family and community influences. When the family interaction is poor, the emotional needs of the child are less likely to be met.

More than half of parents reported using generally accepted approaches to the discipline of their child most of the time. There appears to be a substantial minority however, who may need support and education to build constructive relationships with their child or children. This may be a particular need in the Northern Territory, where the extended family often live in another part of Australia and are not on hand to provide advice and assistance.

Economic security within a family is essential to provide for the basic needs of the child including food, shelter and education. It may be argued that in a country like Australia, the ability to provide for expectations (such as school excursions, sporting club memberships) is also important in terms of participation and inclusion in the wider community. The most vulnerable families economically are those where no parent is employed. In this survey, 1% of respondents and 1% of their partners described themselves as unemployed. However, 8% of respondents and 6% of their partners were actively looking for work. 17% of households had a total annual income of $40,000 or less, with 5% having less than $20,000. These families are the most vulnerable to economic hardship. The lived experience of this was reflected by the 9% of respondents who often or always and the further 20% who sometimes felt a lack of control of their financial situation. An additional 21% of households had an income between $40,000 and $60,000. Depending on the number of children and total household size, these families may also be subject to significant financial pressures.

Children are dependent on their parents. If the health of parents is compromised, the security of children may also be compromised. In this survey while many parents described their general health as excellent or very good, 4% described their health as poor or very poor. Almost 20% of parents had been treated for a mental health problem (reflecting the prevalence of mental health problems nationally). Families where one or both parents are struggling with health or disability issues may need emergency and often long-term assistance.
What is their educational experience like?

Nationally, the inclusion of educational information in health reports is a relatively new, but increasingly important part of creating the whole picture of a biologically and socially resilient child. This survey looked at attitudes to school, which were found to be largely positive, performance, which showed that girls outperformed boys, especially at the upper end of the spectrum, and absenteeism and mobility. There was an at-risk group of children (7%) who missed four weeks or more of the preceding school year. A perhaps unique attribute of Northern Territory non-Indigenous children was the high level of mobility noted, with less than half of 9 to 12 year old children (44.3%) having spent their entire primary school education at the same school. The report highlights a range of education challenges, some at a national level (such as encouraging the participation of boys in appropriate education) and others of specific relevance to the Northern Territory such as encouraging adaptive behaviour in a highly mobile community.

This survey also examined friendships and bullying behaviour. The great majority of children were reported to have friends and to be part of their peer group but there was a small group of children (2.2%) who were reported to have no friends and to not be participating in any groups or associations. Nearly half of all children had been bullied. This highlights the importance of national and regional initiatives that address the social and emotional development of our children.

Groups with special needs

Children with a disability

Around 9% of the children in this survey reported having a disability or long term illness that put a burden on the carer or family. The spectrum of need of these children may cover a variety of other areas that were also investigated. On a personal level there may be issues relating to friends, participation and bullying that are of particular relevance. These children may appear in the morbidity figures for asthma or mental health problems. These may also be comorbidities. The level of primary health care, hospital based services and allied health care services use is likely to be higher for children with a disability. This in turn may be a stressor on the financial and emotional resources of families.

Boys

From this survey boys have emerged as a group that falls slightly behind on many parameters. Often the effects are almost unnoticeable individually, but taken together they paint a picture of cumulative burden that may be affecting both the physical and mental health of our male children. In the area of development, more boys were described as having delay in general (2.5% more) and delayed speech (8.1% more). On many health parameters they carried a greater burden. These included 3.5% more mental health problems, 1.5% more attention deficit hyperactivity disorder, 4.6% more asthma and 2.5% more injuries during the preceding year. Slightly fewer boys were described as doing well (4.6% more) looked forward to going to school than boys who performed better academically once they were there (6.4% more). More girls (6.4% more) looked forward to going to school than boys who performed better academically once they were there (4.6% more). More girls were described as doing well (6.4% more) looked forward to going to school than boys who performed better academically once they were there (4.6% more). More girls were described as doing well (6.4% more) looked forward to going to school than boys who performed better academically once they were there (4.6% more). More girls were described as doing well (6.4% more) looked forward to going to school than boys who performed better academically once they were there (4.6% more). More girls were described as doing well (6.4% more) looked forward to going to school than boys who performed better academically once they were there (4.6% more). More girls were described as doing well (6.4% more) looked forward to going to school than boys who performed better academically once they were there (4.6% more). More girls were described as doing well (6.4% more) looked forward to going to school than boys who performed better academically once they were there (4.6% more).
outcomes for Northern Territory boys and girls will be available from a future report on the social and emotional wellbeing of Northern Territory children.

It is difficult to find clear measures of the impact of this identified burden on boys. In both education and health, the effects may be showing up in the next age group of young people aged from 12 to 24 years. In the year 2000, more 19 year old women than 19 year old men had either completed Year 12 at high school or had attained a post-secondary qualification. The societal impact of this differential participation may not yet be visible in employment profiles, but may emerge in the future.

Death rates for young men aged from 12 to 24 years are about three times those of young women. The death rate from injury in the Northern Territory from 1991 to 2000, for males from 15 to 19 years of age was 104 per 100,000 compared with a rate of 35 for females. Nationally, a similar trend can be observed. Among young men from 12 to 24 years of age, injury (including suicide) and poisoning were the most common cause of death. The death rate for injury and poisoning for young men in this category was 52.2 per 100,000 compared with 14.7 per 100,000 for young women. These observations fit into a societal picture of declining resilience and self esteem among boys.

The special needs of boys have more recently been recognised in the education system, but perhaps their relevance to the health system has not been so clearly delineated. This survey provides a sketch of what is a wider phenomenon that calls for healthy action at the do-able margins.

**Poor children**

The most profound influence on children in this survey is probably that of poverty. Poor children as a group tend to be sicker, to live in poorer circumstances, have fewer opportunities to participate and to suffer poor educational outcomes. Poor people lack the power (financially, politically and often emotionally) to act on their circumstances. These are our most vulnerable citizens for whom the provision of universal education and health systems is fundamental. Targeted interventions provide supplementary layers of support, rather than replacing universal provisions. These programs can aim to alleviate individual suffering (such as disability support programs), empower parents who lack knowledge (such as parenting programs) or foster child friendly communities (such as building and running swimming pools in remote communities). Evidence indicates that early intervention is not only indicative of a humane society, but is cost-effective in terms of participation in employment and avoidance of the criminal justice system.

The Indigenous children in this survey highlight the comparative burden of economic disadvantage carried by this group. Indigenous households were 2.8 times as likely to have a household income of $40,000 or less and 4.5 times as likely to have a household income of less than $20,000. They form a subgroup of poor children for whom targeted programs may be especially important.
In conclusion

This survey has generated information on children, families and schools and communities. These three levels provide different indicators that can be used both immediately and in combination with future surveys to provide comparative statistics.

- For children, there are indicators of development (such as low birthweight), health (such as prevalence of asthma) and injury (such as incidence of any injury). The ongoing monitoring of risk and protective factors may also be possible (such as BMI, levels of physical activity and sun protection).

- At the level of the family, aggregate indicators highlight vulnerable groups (such as one-parent families, large families, families where the parents or carers have health problems and families living in poverty).

- For schools and communities, indicators are provided that reflect the individual experience of the child (such as performance and absenteeism) and their social experience (such as having friends and participating in groups). Service level indicators can assist in future planning for the general population, for children and for groups with special needs (such as service use data, hours and type of childcare).
Glossary

Bullying
Bullying involves a desire to hurt + hurtful action + power imbalance + (typically) repetition + an unjust use of power + evident enjoyment by the aggressor and a sense of being oppressed on the part of the victim.49

BMI
Body Mass Index (BMI) can be calculated from the age of 21 months, using the following formula. BMI = weight (kg) / Height (m)².

CATI
Computer Assisted Telephone Interviewing.

Childcare
formal care
Regulated care away from the child’s home. The main types of formal care include before and/or after school care, long day care, family day care, occasional care and preschool.

informal care
Non-regulated care, arranged by a child’s parent/guardian, either in the child’s home or elsewhere. It comprises care by brothers or sisters (including step siblings), care by grandparents, care by other relatives (including a parent living elsewhere), care by other people such as friends, neighbours, nannies or babysitters.

Ecological
Describing the relationships between people and their environments.

Exercise
moderate
Participation in a physical activity for at least 30 minutes a day that does not result in sweating or breathing hard (fast walking, slow cycling, rollerblading or skate boarding).

vigorous
Participation in a physical activity for at least 20 minutes a day that results in sweating or breathing hard (basketball, football, running, swimming laps, fast cycling or netball).

Family structure
blended family
A couple family containing two or more children, of whom at least one is the natural child of both members of the couple and at least one is the stepchild of either member of the couple.

intact family
A couple family containing at least one child who is the natural or foster child of both members of the couple and no child who is the stepchild of either member of the couple.

one-parent family
A family consisting of a lone parent with at least one dependent or non-dependent child (regardless of age) who is usually resident at the household. The family may also include any number of other dependent children, non-dependent children and other related individuals.

step family
A couple family containing one or more children, at least one of whom is the stepchild of either member of the couple and none of whom is the natural or foster child of both members of the couple.
Indigenous
An Indigenous person is one who:

• is a descendant of an Indigenous inhabitant of Australia,
• identifies as Indigenous,
• and is recognised as Indigenous by members of the community in which she or he lives.

Lifecourse
The human lifespan considered from the antenatal period through until death.

Mental health problem
A mental health problem interferes with a person’s cognitive, emotional or social abilities, but to a lesser extent than a mental disorder. Mental health problems are more common mental complaints and include the mental ill health temporarily experienced as a reaction to life stressors. Mental health problems are less severe and of shorter duration than mental disorders, but may develop into mental disorders. The distinction between mental health problems and mental disorders is not well defined and is made on the basis of the severity and duration of the symptoms.58

Parent Survey
A survey made up of responses from parents or carers on behalf of a Northern Territory child aged from 0 to 12 years.

Resilience
Resilience describes the ability to adjust individually and socially despite adverse life circumstances.

Respondent
The person who answered the survey questions on behalf of the child.

Schools Survey
A survey made up of responses from teachers or principals relating to a subset of school-aged children from the Parent Survey.
References


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Appendix A - Committees

Management Committee

<table>
<thead>
<tr>
<th>Member</th>
<th>Affiliation</th>
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<tbody>
<tr>
<td>Alyson Brown</td>
<td>Department of Employment, Education and Training (DEET)</td>
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<tr>
<td>Anthony Burton</td>
<td>Department of Health and Community Services (DHCS)</td>
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<td>Helen Crawford</td>
<td>DHCS</td>
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<tr>
<td>Ken Davies</td>
<td>DEET</td>
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<tr>
<td>Steven Guthridge (Chair)</td>
<td>DHCS</td>
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<td>Mary-Anne Measey</td>
<td>DHCS</td>
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Technical Reference Group

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<th>Member</th>
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<tr>
<td>Alyson Brown</td>
<td>Department of Employment, Education and Training (DEET)</td>
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<tr>
<td>Toby Clifford</td>
<td>Department of Health and Community Services (DHCS)</td>
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<tr>
<td>Jenny Coccetti</td>
<td>Northern Territory Treasury</td>
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<tr>
<td>Helen Crawford</td>
<td>DHCS</td>
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<td>Ken Davies</td>
<td>DEET</td>
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<td>Keith Edwards</td>
<td>DHCS</td>
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<td>Steven Guthridge (Chair)</td>
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<td>Vivienne Hobson</td>
<td>DHCS</td>
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<td>Mary-Anne Measey</td>
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<td>Barbara Paterson</td>
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<td>Garry Scapin</td>
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<tr>
<td>Lorelei White</td>
<td>DEET</td>
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<td>Annie Villeseche</td>
<td>DHCS</td>
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Appendix B - Introductory letter

The Householder
Address line 2
Address line 3

Dear Householder

The health and development of children in the Northern Territory is of great importance. The NT departments with responsibility for health, community services and education are working together to provide the types of services that best meet the needs of NT children. We are seeking your support in planning these services. Your household has been randomly selected to participate in a Northern Territory survey, which will collect information on children’s health and wellbeing and the important things that influence children’s development. This is the first time that this type of information has been collected about Northern Territory children.

During August, an interviewer may telephone your household and ask to speak to the parent or principal carer of a child aged from birth to 12 years of age. If there are no eligible children living in the household, then your household will not need to participate in the survey. If there is more than one eligible child then the interviewer will assist in selecting one child. The interviewer may either continue the interview or can arrange to phone back at a time more convenient for you. The interview will take about 20 to 25 minutes and all of the information collected will be confidential.

The enclosed brochure outlines details of the survey and provides an overview of the type of information that will be asked. The brochure also contains a phone number for contacting the ethics committee, which has approved this project. If you would like additional information about the survey then please phone our survey team on freecall number 1800 264 090 between 8:00am and 4:30pm Monday to Friday.

Participation in the survey is voluntary and if you do not want to take part please tell the interviewer. A high level of participation, however, is very important and will make the survey as accurate as possible. We would like to encourage your participation and appreciate your support.

Kind regards,

Robert Griew
Chief Executive Officer
Department of Health and Community Services

Peter Plummer
Chief Executive
Department of Employment, Education and Training
Appendix C - Telephone questionnaire

Introduction 1
Hello. My name is...... from the Survey Research Centre at the University of Western Australia. We are conducting a survey on behalf of the NT Departments of Health, Community Services and Employment, Education and Training about the health and wellbeing of the children in the NT. The survey is used to help improve health care services such as hospitals and clinics and other services for children and families in the NT and to let us know about current health issues.

Q   We recently sent you a letter telling you about the survey. Have you received the letter we sent you? [If no, give basic explanation] (Single response)
      1 Yes  2 No  998 Don’t know

Basic explanation
The letter invited you to take part in an important health survey being conducted by the Department of Health. It was sent to your household to let you know that we would be contacting you by phone.

Your responses will form part of a picture of your local community. The results of the survey will be used to help us keep track of the health of children in the NT. That way we can better plan and develop health services to meet local needs.

Q   Do you have any children under the age of thirteen?
      1 Yes  2 No (terminate interview)  998 Don’t know (terminate interview)

Q   How many children under that age do you have? Number:
      98 Don’t know  99 Refused

Determine the age required as per the random assignment.
If respondent not the one who will be doing the interview, repeat Introduction 1 and add Introduction 2.
Introduction 2

I can assure you that information given will remain confidential. The answers from all people interviewed will be gathered together and presented in a report. No individual answers will be passed on.

Q  Do you have any children under the age of thirteen?
Yes [ ]   No [ ] (terminate interview)   998 Don’t know

Q  How many children under that age do you have?
998 Don’t know   999 Refused

Q  We would like to speak about the child whose birthday is in (random month) or closest to it. (If in same month then random selected based on younger/older). As some of the questions relate to certain groups of children only, we need to know how old this child is. (Single response, code refused as 999)
1 Enter age in years   OR   2 Enter age in months
If refused terminate interview.

Q  Because we are going to ask lots of questions about your child, would you mind telling me your child’s first name so that we can use this during the interview? (Single response)
Enter name:

Q  Child’s gender? (Ask if necessary, single response)
1 Male   2 Female

Use first name of child throughout the questionnaire where [child] appears

Q  What is your relationship to [child]? (Single response)
1 Mother   2 Father   3 Other relative   4 Other
General health

These first few questions ask about [child]'s health.

A1. In general, how would you say your child’s health is: (Read options, single response)
   1 Excellent  2 Very good  3 Good  4 Fair  5 Poor
   998 Don’t know  999 Refused

A2. Does [child] have any disability, long term illness or pain that puts a burden on you or the family as a whole? (Single response code refused as 999)
   1 Yes  2 No  998 Unsure  999 Refused

A3. How much of a burden is this, would you say it’s: (Single response, read options)
   1 Not much of a burden at all  2 A little burden  3 A fairly big burden
   4 A big burden  5 A very big burden  998 Unsure  999 Refused

Comorbidity

Now I’m going to ask you about health conditions that some children have.

Has a doctor ever told you that [child] has: (Read options)

B1. Ask age 2+ only Attention Deficit Hyperactivity Disorder (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

B2. A problem with coordination and clumsiness (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

B3. Deformity and stiffness (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

B4. Developmental delay (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

B5. Have you ever been told by a doctor or nurse that [child] has asthma? (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused
B6. In the last twelve months, has [child] had symptoms of asthma? (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

B7. In the last twelve months, has [child] taken treatment for asthma? (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

Thinking about the last twelve months, has [child] had: (Read options)

B8. Broken bones? (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

B9. A head injury that made him/her unconscious? (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

B10. A stay in hospital because of an accidental burn? (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

B11. A stay in hospital because of an accidental poisoning? (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

B12. Any other injury serious enough to require treatment by a health professional? (Single response)
   1 Yes  2 No  998 Don’t Know  999 Refused

How many times in the last 12 months, has [child] used these health services?
(Code none as 0, can’t remember and don’t know as 998 and refused as 999)

B13. Primary health care e.g. general practitioner, community health centre, community or district nurses
   Enter number _______

B14. Hospital based services e.g. accident & emergency department
   Enter number _______

B15. Allied health services e.g. physiotherapist, chiropractor, acupuncturist, naturopath, osteopath, podiatrist
   Enter number _______
**B16. Dental services**
Enter number ______

**B17. A mental health service e.g. psychiatrist, psychologist or counsellor**
Enter number ______

**Child development**

Now I would like to ask you some more general questions about [child]’s development.

**C1. How much did child weigh when s/he was born?** (Single response, code don’t know/can’t remember as 998 and refused as 999 in first field and Go to C3)

___ lbs ___ oz OR ___ kg ___ grams

**C2. Can you remember if anyone said [child] was a low birthweight baby?** (Single response)
1 Yes 2 No 998 Don’t Know 999 Refused

**C3. If [child] was breastfed, how long was s/he breastfed for?** (Single response. Code didn’t breastfeed as 0 days, can’t remember as 998 and refused as 999. If the child is still breastfeeding code as 997)

____ days ____ weeks ____ months

**C4. At what age did you first introduce water or liquids other than formula to [child]?** (Note: This does not include formula. Single response, code can’t remember as 998 and refused as 999. If the child hasn’t had any liquids, code as 0 in the first field)

____ days ____ weeks ____ months

**C5. At what age did you first introduce foods other than liquids to [child]?** (Single response, code can’t remember as 998 and refused as 999. If the child hasn’t had any solid food, code as 0 in the first field)

____ days ____ weeks ____ months

**C6. Ask age 2+ only Do you think [child] was late in starting to talk?** (Single response)
1 Yes 2 No 998 Don’t know 999 Refused

**C7. Ask age 2+ only Do you think [child] needs professional help (speech therapy) with his/her speech?** (Single response)
1 Yes 2 No 998 Don’t know 999 Refused
Risk Factors – Physical Activity

D1. Ask age 4+ only. On how many of the past 7 days did [child] exercise or participate in physical activity for at least 20 minutes that made them sweat and breathe hard, such as basketball, soccer, football, running, swimming laps, fast bicycling or netball? (Single response. Code didn’t do any of these activities as 0, code don’t know as 998 and refused as 999)
   Days __

D2. Ask age 4+ only. On how many of the past 7 days did [child] participate in physical activity for at least 30 minutes that did not make them sweat or breathe hard, such as fast walking, slow bicycling, rollerblading or skate boarding? (Single response, code didn’t do any of these activities as 0, code don’t know as 998 and refused as 999)
   Days __

D3. How many hours per week does [child] spend watching TV, videos or playing video or computer games? (Single response, code didn’t watch any tv as 0, code don’t know as 998 and refused as 999)
   Hours __

Risk Factors

D4. What is [child]’s height without shoes? (Single response, code don’t know/unsure as 998 and refused as 999 in first field)
   Centimetres ___ OR Feet ___ Inches ___

D5. What is [child]’s weight? (Single response, code don’t know/unsure as 998 and refused as 999 in first field)
   Kilograms (Kg) ___ OR Stones ____ Pounds ___
The next questions are about lifestyle

D6. Does alcohol cause problems in your household? (Single response)
   1 Yes  2 No  998 Don't know/Unsure  999 Refused

D7. Which of the following best describes your home situation? (Single response, read options)
   1 My home is smoke free (includes smoking is allowed outside only)
   2 People occasionally smoke in the house
   3 People frequently smoke in the house
   998 Unsure  999 Refused

D8. When you/your partner were pregnant with this child, did you/your partner smoke? (Single response)
   1 Yes  2 No  998 Unsure/Can't remember  999 Refused

D9. How many times did [child] get sunburned in the last 12 months (even just their nose or shoulders)? (Single response, code don't know/unsure as 998 and refused as 999 in first field)
   Enter number of times ________

D10. Do you check to see if [child] is adequately protected before going out into the sunlight? That is, does s/he wear a hat, use sunscreen and keep covered? Would you say: (Single response)
    1 Always  2 Most of the time  3 Sometimes  4 Rarely  5 Never
    998 Unsure/Can’t Remember  999 Refused

Now to some questions about food

D11. Ask age 1+ only. How many serves of vegetables does [child] usually eat each day? A serve of vegetables is equal to half cup of cooked vegetables or 1 cup of salad. (Single response, code none 0 and less than one a day as 991, unsure/don’t know as 998 and refused as 999)
    Enter number ________

D12. Ask age 1+ only. How many serves of fruit does [child] usually eat each day? A serve of fruit is equal to one medium piece, two small pieces of fruit or one cup of diced or 1 tablespoon of dried fruit. (Single response, code none 0 and less than one a day as 991, unsure/don’t know as 998 and refused as 999)
    Enter number ________
**D13. Ask age 1+ only. What type of milk does [child] usually drink?** (Single response, prompt if necessary)

1. Full fat or whole milk of any kind, including soya
2. Low / reduced fat milk of any kind, including soya
3. Skim milk, that is milk with no fat content at all
4. Other
5. Don’t use milk

998 Can’t Remember/Unsure/Don’t Know 999 Refused

**D14. Ask age 1+ only How many times a week on average, does [child] have meals or snacks such as burgers, pizza, chicken or chips from places like McDonalds, Hungry Jacks, Pizza Hut or Red Rooster?** (Single response, code none 0 and less than once a week as 991, unsure/don’t know as 998 and refused as 999)

Enter number ________

**D15. How many cups of soft drink, cordials or sports drink, such as lemonade or Gatorade does [child] usually drink in a day?** (1 cup=250ml. One can of soft drink=1½ cups. One 500ml bottle of GATORADE=2 cups)

1. ___ cups per day 2. ___ cups per week 3. Doesn’t drink soft drink

998 Don’t know 999 Refused

**D16. I would like you to tell me if he/she has been fed any of these things since this time yesterday?** (Interviewer: read out each option in turn. Single response, code no as 0, yes as 1, unsure/don’t know as 998 and refused as 999)

1. Plain water
2. Cordial or other sweetened or flavoured water
3. Fruit juice
4. Fizzy soft drink and sports drink
5. Iced coffee
6. Other flavoured milk
Mental health

The next few questions are about [child]'s social and emotional wellbeing

E1. Ask 1+ only. Overall, does [child] have trouble with emotions, concentration, behaviour or getting on with people? Would you say: (Single response, read options)
   1 No
   2 Only a little
   3 Quite a lot
   4 Very much
   998 Unsure/Can’t remember
   999 Refused

E2. Ask 1+ only. Do you think [child] needs special help for this? (Single response)
   1 Yes  2 No  998 Unsure/Can’t remember  999 Refused

E3. Ask 1+ only. Has [child] ever been treated for an emotional or mental health problem? (Single response)
   1 Yes  2 No  998 Don’t know/Unsure/Can’t remember  999 Refused

E4. Ask 4+ only. Thinking about the previous 12 months, can you tell me about how many days [child] has been away from school for any reason? (Single response. Don’t include official holidays. Code no days as 0, can’t remember/don’t know as 998, refused as 999 and doesn’t attend school as 995. If code is 995 - Go To E8)
   Days ________

E5. Ask 4+ only. Based on your knowledge of his/her school work, including his/her school reports, how is s/he doing in school overall? Would you say it was overall: (Single response, read options, code don’t know as 998 and refused as 999)
   1 Very Well  2 Well  3 Average  4 Poorly  5 Very Poorly  
   998 Don’t know  999 Refused

E6. Ask 4+ only. Does s/he look forward to going to school each day? Would you say: (Single response, read options, code don’t know as 998 and refused as 999)
   1 Almost Never  2 Rarely  3 Sometimes  4 Often
   5 Almost Always  995 Not applicable  998 Don’t know  999 Refused
E7. Ask 4+ only. Since starting primary school, how many different schools has [child] attended? (Include current school) (Code none as 0, can’t remember/unsure as 998 and refused as 999)
Enter number ________

The next questions are about bullying. Bullying is when someone is picked on, hit, kicked, threatened or ignored by other children.

E8. Ask 4+ only. In the last 12 months has [child] been bullied?

1 Yes 2 No 998 Unsure/Can’t remember 999 Refused

E9. Ask 4+ only. In the last 12 months has [child] bullied other kids?

1 Yes 2 No 998 Unsure/Can’t remember 999 Refused

E10. Ask age 4+ only. Does [child] have a special friend or a really close mate?

1 Yes 2 No 998 Unsure/Can’t remember 999 Refused

E11. Ask age 4+ only. Does [child] have a group of friends to play with or hang around with?

1 Yes 2 No 998 Unsure/Can’t remember 999 Refused

E12. Ask age 4+ only. How many groups/associations does your child belong to? Include sporting groups, school groups, social groups etc…
Enter number ________ 998 Unsure/Can’t remember 999 Refused
These questions are about your family. By having a better description of how families function and the nature of their social circumstances, improvements can be made in a variety of health and community services. This information will also allow a better understanding of how families and communities change over time.

F1. How would you best describe your family structure? Please listen to the options and then tell me which one is the closest to your family situation. (Single response, read options, code don’t know/unsure as 998 and refused as 999)
   1 A family with a child or children living with both biological or adoptive parents Go to F3
   2 A step or blended family
   3 A sole parent family
   4 Other Go to F3
   5 A couple with no dependent children Go to F3
   998 Unsure/Don’t Know Go to F3  999 Refused Go to F3

F2. How often would [child] see their other biological parent during a usual month? (Single response, code as 0 for never, 444 if child doesn’t have another parent or parent dead, 991 if child sees other parent less frequently than once a month, 998 don’t know/unsure/can’t remember and refused as 999)
   Times ________

Below are statements about families and family relationships. Please rate how much you agree or disagree with the following statements.

F3. We usually don’t get on well together. (Single response, read options)
   1 Strongly agree  2 Agree  3 Disagree  4 Strongly disagree  999 Refused

F4. Planning family activities is usually difficult. (Single response, read options)
   1 Strongly agree  2 Agree  3 Disagree  4 Strongly disagree  999 Refused

F5. We usually avoid discussing our fears and concerns openly with each other. (Single response, read options)
   1 Strongly agree  2 Agree  3 Disagree  4 Strongly disagree  999 Refused

F6. Making decisions is usually a problem in our family because we misunderstand each other. (Single response, read options)
   1 Strongly agree  2 Agree  3 Disagree  4 Strongly disagree  999 Refused
F7. *Just about all children break the rules or do things that they are not supposed to. Also, parents react in different ways. Please tell me how often you do each of the following when [child] breaks the rules or does things that s/he is not supposed to.*

*How often do you:*  
- Always  
- Often  
- Sometimes  
- Rarely  
- Never  
- Not applicable  
- Don’t know  
- Refused

A Tell him/her to stop?  
B Ignore it, do nothing?  
C Raise your voice, scold or yell at him/her?  
D Calmly discuss the problem?  
E Use physical punishment?  
F Describe alternative ways of behaving that are acceptable?  
G Take away privileges or put in room?

The next few questions are about your use of formal and/or informal childcare last week.

F8. **Last week, did [child] attend:**  
   1 A before or after-school care program?  
   2 A long day care centre?  
   3 Family Day care?  
   4 Any other formal childcare service? (a service that is funded or regulated by Government?)  
   5 None of the above? **Go to F10**

F9. **How many hours did [child] attend this/these services in this week (in total)**  
   Hours __________ Don’t know 998 Refused 999

F10. **Apart from yourself and your spouse/partner did anyone else look after [child] last week?**  
   1 Yes  
   2 No **Go to G1**
   998 Don’t know **Go to G1**  
   999 Refused **Go to G1**
F11. **Who provided this care.**

**Relatives:**
1. Child’s grandmother/grandfather
2. Child’s brother/sister (or step-brother/sister)
3. Child’s other parent living elsewhere
4. Child’s other relative

**Other people:**
5. Family friend
6. Neighbour
7. Other

**Other arrangements:**
8. Other organisation
9. Child looked after self
10. No/none of the above

F12. **For about how many hours was [child] looked after by ... last week?**

Hours ________  Don’t know 998  Refused 999
Social characteristics

Now to finish off with some general questions. The first two questions are about your child.

G1. Was [child] born in Australia? (Single response)
   1 Yes   2 No Go to G3
   998 Don’t Know/Unsure/Can’t Remember Go to H1  999 Refused Go to H1

G2. Is [child] of Aboriginal or Torres Strait Islander origin? (Single response)
   1 Yes Go to H1   2 No Go to H1
   998 Don’t Know/Unsure/Can’t Remember Go to H1  999 Refused Go to H1

G3. Where was your child born? Was it:
   1 United Kingdom including Scotland and Wales Go to H1
   2 Ireland Go to H1
   3 New Zealand Go to H1
   4 North America (includes Canada and the US) Go to H1
   5 Central or South America Go to H1
   6 South Africa Go to H1
   7 Other African country Go to H1
   8 Eastern Europe Go to H1
   9 Western Europe Go to H1
   10 Middle Eastern country including Saudi Arabia, Bahrain, Kuwait, Iran, Iraq, Yemen, Israel, Jordan etc) Go to H1
   11 Vietnam Go to H1
   12 Thailand Go to H1
   13 Indonesia Go to H1
   14 China Go to H1
   15 India Go to H1
   16 Philippines Go to H1
   17 Other

G3a. What other country was that?

___________________
The next questions are about you

H1. Were you born in Australia? (Single response)
   1 Yes   2 No Go To H3
   998 Don’t Know/Unsure/Can’t Remember Go To H4  999 Refused Go To H4

H2. Are you of Aboriginal or Torres Strait Islander origin? (Single response)
   1 Yes Go To H4   2 No Go To H4
   998 Don’t Know/Unsure/Can’t Remember Go To H4  999 Refused Go To H4

H3. Where were you born? Was it:
   1 United Kingdom including Scotland and Wales Go To H4
   2 Ireland Go To H4
   3 New Zealand Go To H4
   4 North America (includes Canada and the US) Go To H4
   5 Central or South America Go To H4
   6 South Africa Go To H4
   7 Other African country Go To H4
   8 Eastern Europe Go To H4
   9 Western Europe Go To H4
   10 Middle Eastern country including Saudi Arabia, Bahrain, Kuwait, Iran, Iraq, Yemen, Israel, Jordan etc) Go To H4
   11 Vietnam Go To H4
   12 Thailand Go To H4
   13 Indonesia Go To H4
   14 China Go To H4
   15 India Go To H4
   16 Philippines Go To H4
   17 Other

H3a. What other country was that?

   ______________________

H4. Overall, how would you rate your health during the past 4 weeks? (Read options, single response)
   1 Excellent   2 Very good   3 Good   4 Fair   5 Poor   6 Very poor
   998 Don’t know/Can’t remember  999 Refused
H5. Have you ever been treated for an emotional or mental health problem? (Single response)
   1 Yes  2 No  998 Don’t Know/Unsure/Can’t Remember  999 Refused

H6. During the past four weeks how much of the time did you feel a lack of control over your life in general: (Read options, single response)
   1 Never  2 Rarely  3 Sometimes  4 Often  5 Always
   996 Not applicable  998 Don’t know  999 Refused

H7. During the past four weeks how much of the time did you feel a lack of control with your financial situation: (Read options, single response)
   1 Never  2 Rarely  3 Sometimes  4 Often  5 Always
   996 Not applicable  998 Don’t know  999 Refused

H8. During the past four weeks how much of the time did you feel a lack of control with your personal life: (Read options, single response)
   1 Never  2 Rarely  3 Sometimes  4 Often  5 Always
   996 Not applicable  998 Don’t know  999 Refused

H9. During the past four weeks how much of the time did you feel a lack of control with your job security: (Read options, single response)
   1 Never  2 Rarely  3 Sometimes  4 Often  5 Always
   996 Not applicable  998 Don’t know  999 Refused

H10. During the past four weeks how much of the time did you feel a lack of control with your work life (paid or voluntary): (Read options, single response)
    1 Never  2 Rarely  3 Sometimes  4 Often  5 Always
    996 Not applicable  998 Don’t know  999 Refused

H11. During the past four weeks how much of the time did you feel a lack of control with your health: (Read options, single response)
    1 Never  2 Rarely  3 Sometimes  4 Often  5 Always
    996 Not applicable  998 Don’t know  999 Refused
H12. What is the highest level of education you have completed? (Single response. Interviewer note: Prompt if necessary)
   1. Never attended school
   2. Some Primary school
   3. Completed Primary school
   4. Completed Year 10
   5. Completed Year 12
   6. TAFE or Trade Certificate or Diploma
   7. University or other tertiary degree including post graduate degrees
   8. Other
   9.98 Don’t know
   9.99 Refused

H12a. Please describe education – other

H13. Are you currently studying? (Single response)
   1. Yes
   2. No
   9.98 Don’t Know/Unsure/Can’t Remember
   9.99 Refused

H14. Which ONE of the following best describes your current employment status? Are you:
   (Single response, read options)
   1. Self employed
   2. Employed for wages, salary or payment in kind
   3. Unemployed for less than one year
   4. Unemployed for more than one year
   5. Engaged in home duties
   6. Retired
   7. Unable to work
   8. A student
   9. Other
   9.98 Don’t Know/Unsure/Can’t Remember
   9.99 Refused

H15. If you are in paid employment whether for yourself or others, how many hours per week do you work? (If asked, it is the total number of hours put in rather than the hours paid for. Code none as 0, can’t remember as 998 and refused as 999)
   Hours per week ______

Growing up in the Territory Parent Survey
H16. Are you looking for employment? (Single response)
1 Yes 2 No 998 Don’t Know/Unsure/Can’t Remember 999 Refused

H17. Which best describes your household money situation? (Read options, single response)
1 I am / we are spending more money than I / we get
2 I / we have just enough money to get us through to the next pay day
3 There’s some money left over but I / we just spend it
4 I / we can save a bit every now and then
5 I / we can save a bit regularly
6 I / we can save a lot
998 Don’t Know/Unsure/Can’t Remember
999 Refused

H18. I would now like to ask you about your household’s income. We are interested in how income relates to health, lifestyle and access to health services. Before tax is taken out, which of the following ranges best describes your household’s income, from all sources, over the last 12 months? (Read options, single response)
1 Under $20,000
2 $20,000 - $40,000
3 $40,000 - $60,000
4 $60,000 - $80,000
5 $80,000 - $100,000
6 More than $100,000
998 Don’t Know/Unsure/Can’t Remember
999 Refused

H19. What is your postcode? (Single response, code refused as 9999, don’t know as 9998)
Enter postcode __________

H20. What town, suburb or community do you live in? (Single response, leave blank if refused; don’t know as 998)
Enter town/suburb __________________________

H21. How many children (including babies) under 16 years live in your household? (Single response, code none as 0, unsure as 998 and refused as 999)
Enter number _____
H22. **What is the total number of people who usually live in this household?** (Code none as 0, can’t remember/unsure as 998 and refused as 999)

Enter number __________

H23. **How many times have your family moved since [child] was born?** (Code none as 0, can’t remember/unsure as 998 and refused as 999)

Enter number __________

And now a few questions about your partner, if you have one.

I1. **So, first of all, do you share your home with a partner?** (Single response)

1 Yes  
2 No Go to J1

998 Don’t Know/Unsure/Can’t Remember Go to J1  
999 Refused Go to J1

I2. **Was your partner born in Australia?** (Single response)

1 Yes  
2 No Go to I4

998 Don’t Know/Unsure/Can’t Remember Go to I4  
999 Refused Go to I4

I3. **Is your partner of Aboriginal or Torres Strait Islander origin?** (Single response)

1 Yes  
2 No

998 Don’t Know/Unsure/Can’t Remember  
999 Refused

I4. **Which one of the following best describes your partner’s current employment status?** Is your partner:

1 Self employed Skip I6

2 Employed for wages, salary or payment in kind? Skip I6

3 Unemployed for less than one year? Go to I6

4 Unemployed for more than one year? Go to I6

5 Engaged in home duties? Go to J1

6 Retired? Go to J1

7 Unable to work? Go to J1

8 A student? Go to J1

9 Other Go to J1

998 Don’t Know/Unsure/Can’t Remember Go to J1

999 Refused Go to J1
I5. If your partner is in paid employment, either for themselves or others, how many hours per week does s/he work? (Single response. If asked, it is the total number of hours worked rather than the hours paid for. Code no hours as 0, don’t know as 998 and refused as 999)

Hours per week _________

I6. Is your partner looking for employment? (Single response)

1 Yes  2 No  998 Don’t Know/Unsure/Can’t Remember  999 Refused

That ends the main part of the interview, I just have a couple more questions to finish off

J1. How many listings do you have in the White Pages telephone book? (Code none as 0, can’t remember/unsure as 998 and refused as 999)

Enter number ______

J2. Part of this survey involves collecting information from teachers and principals. We would like your permission to contact your child’s teacher and principal. We will ask them to provide some information on your child at school and facilities offered by the school.
All information gathered will be confidential and will be put together into a report in the NT. Your child will never be identified individually.

If respondent is still concerned, read out Sheet A (Single Response)

1 Yes (If Yes, record full name of child, grade at school, name of teacher, name of school)
2 No (If permission is denied, thank the respondent)
3 Not applicable – Home schooled
998 Don’t know/Unsure/Can’t remember
999 Refused

Thank you. I just need to collect some details from you:

Child’s full name:
Grade at school:
Name of teacher:

J3. And finally, as you know, the Departments of Health and Education collect information on things like births, clinic and hospital visits and school assessments. We would like your permission to link the information from this survey with some of the health and education information we have about your child? The information will be put together into a report about all children in NT and your child will never be identified individually. (Single response)

1 Yes (If Yes, record full name if not already recorded plus date of birth of child.)
2 No (If permission is denied, thank the respondent and terminate the interview.)

J3a. May I ask [child]’s full name and date of birth?
First name:
Surname:
Date of birth: [dd/mm/yyyy]

Would you like me to give you the phone number for the Parenting Support Service?

If YES, The number for Parenting Support Service is 1300 30 1300

Interviewer use only – Did respondent require the number?

1 Yes – Number provided
2 No – Number not provided

That is the end of the interview.

Thank you for your time.
Just to remind you my name is … … From the Survey Research Centre at the University of Western Australia.

If you have any questions about this research you can telephone our office on 1800 799 100, or contact the Northern Territory Health Department on 1800 264 090.

Date of interview ________
Day of week interview undertaken ________
Time of day interview undertaken ________

**End interview re: no children in age group:**
Thank you very much, but for the purposes of this survey we need to speak to people with children under 13.

**End interview re: age refusal:**
As many of our questions are related to age groups, we will be unable to continue the survey, but thank you for your time.
Selected Health Gains Planning publications

**Mortality**


**Cancer**


Kinmonth TJN. *Cancer in the Northern Territory 1982*. NT Department of Health.


**Economics & Finance**


Beaver C, Zhao Y. *Investment Analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory*. Department of Health and Ageing, Australian Government: Canberra; 2004.


**Other Publications**


