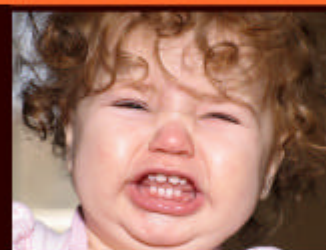


F a m i l i e s

a t R i s k :



the effects of chronic
and multiple disadvantage



F a m i l i e s a t R i s k :

*the effects of chronic
and multiple disadvantage*



Contents

List of Tables	3
List of Figures.....	3
Project Team Members	4
Project Website.....	4
Executive Summary of Policy and Service Implications	5
1. <i>Life chances – social inclusion.....</i>	5
Gender and Young Parents.....	5
Education	6
Employment and income	6
Aboriginal Families	6
2. <i>Living environments - housing and residential mobility</i>	6
3. <i>Living environments – neighbourhoods and social cohesion.....</i>	6
4. <i>Mental and emotional health and well-being.....</i>	7
5. <i>Support for parenting.....</i>	7
6. <i>Childcare</i>	7
7. <i>Service planning and provision</i>	8
8. <i>Intersectoral action</i>	8
9. <i>Role of the health system.....</i>	9
Introduction	10
Project description	10
Research approach	11
Research limitations	11
What factors determine the health and well-being of families with young children?	13
Inequalities and Disabling Environments - a profile of study participants.....	18
Gender.....	18
Family/household form	18
Age at becoming a parent for the first time	18
Employment and Income.....	18
Education	19
Ethnicity	19
Aboriginality	19
Living environments – housing, mobility and transport.....	20
Living environments - neighbourhoods and social cohesion.....	22
Informal Social Control	22
Social Cohesion	23
Neighbourhood Safety, Trust, and Social Connectedness	23
Crime and disorder in the neighbourhoods	25
Parents and Parenting	28
Parent reports of their own and their children’s health and well-being.....	28
Parent Self-Reported Health Status	28
Stressful Life Events	28
Parent mental health.....	30
Parent Confidence and Satisfaction	31
Parent reports of Children’s Health.....	32
Relationship between Parent Reports of Children’s Health and Parental Self-Efficacy.....	34
Spatial Distribution of Child Health Problems/Concerns	34
Parenting in Your Own Words.....	36
The rewards and challenges of parenting.....	36
Expectations of my children’s future.....	39
Your resources for parenting?.....	40
Fathers	45
Teenage Parents	47
Aboriginal Parents	47
Support and Service Use	49
Informal support	49
Childcare services.....	51
Use of Formal Services for help with child problems/concerns	52
Some observations about help-seeking	52
Services working together.....	53
Schools as a source of support.....	54
What are helpful services for women with young children?	54
The ways women are viewed.....	54
The ways ‘problems’ are viewed.....	55
The relationship between the service/service-provider and women	55

Policy and Service implications	59
1. <i>Life chances – social inclusion</i>	60
Gender and Young Parents.....	60
Education	61
Employment and income	61
Aboriginal Families	61
2. <i>Living environments - housing and residential mobility</i>	62
3. <i>Living environments – neighbourhoods and social cohesion</i>	63
4. <i>Mental and emotional health and well-being</i>	63
5. <i>Support for parenting</i>	64
6. <i>Childcare</i>	65
7. <i>Service planning and provision</i>	65
8. <i>Intersectoral action</i>	67
9. <i>Role of the health system</i>	67
References	68
Appendices	72
Appendix A: <i>Project Aims</i>	72
Appendix B: <i>Collection Districts included in the Families at Risk study</i>	73
Appendix C: <i>Maps of Collection Districts included in the study</i>	74
Appendix D: <i>Case Studies illustrating helpful service responses</i>	76

List of Tables

<i>Table 1: Mobility of Families in Interview One Sample</i>	20
<i>Table 2: Neighbourhood Informal Social Control</i>	23
<i>Table 3: Neighbourhood Social Cohesion</i>	23
<i>Table 4: Perceptions of Neighbourhood Safety, Trust and Social Connectedness (Mean Scores for Suburbs)</i>	25
<i>Table 5: Crime Statistics for the Neighbourhoods – Type of Offences</i>	26
<i>Table 6: Self Reported Health Status, SA, Australia & Families at Risk Study</i>	28
<i>Table 7: Stressful Life Events</i>	30
<i>Table 8: Have any of your children (0-7 yrs) been diagnosed with an ongoing physical, developmental or emotional/behavioural problem or have a problem you are concerned about?</i>	32
<i>Table 9: Percentage of children with significant problems</i>	34
<i>Table 10: What Fathers do when things get too much</i>	46
<i>Table 11: Fathers' Preferred Mode(s) of Service Delivery</i>	46
<i>Table 12: Fathers' Ways of Finding Out About Services</i>	46
<i>Table 13: Help-seeking related to Child Health Problems / Concerns</i>	49
<i>Table 14: Sources of Financial Help utilised in the last 12 Months</i>	50
<i>Table 15: Sources and domains of support upon which at least 25% of participants rely</i> ----	51
<i>Table 16: Sources of childcare/babysitting utilised in the past 12 months</i>	52

List of Figures

<i>Figure 1: Effects and Modifiers of Parenting in Situations of Multiple Disadvantage</i>	17
<i>Figure 2: Distribution of GHQ12 Symptom Scores</i>	31
<i>Figure 3: Distribution of PEDS significant problem scores</i>	33

Project Team Members

This was a collaborative project between:

- *The Flinders University* (Rosalind Murray-Harvey, Phillip Slee, Stephanie Jarrett, Judith Saebel, Miranda Roe, Robin Fogarty, Teresa Hayton, Carmel Travers);
- *The University of South Australia* (Helen Cameron, Anne Bolst, Kate Martin, Paula van Gelder);
- *The Department of Human Services*¹ (Tony Woollacott, Julia Cranney, Andrew Stanley, Krystyna Slowinski, Sally Castell-McGregor, Julie Francis, Jennifer Schaffer, Bianca Barbaro); and
- *The Women's and Children's Hospital* (Peter Baghurst, Georgia Antonio).

Project Website

The *Families at Risk* website includes information on the project methodology, sample characteristics of the interview respondents, abstracts of papers written during the course of the project and presentations from the Service Provider Forums conducted. It can be viewed at:

<http://ehlt.flinders.edu.au/education/FamilyNeeds/index.htm>.

¹ The Department of Human Services was split into the Department of Health and the Department for Families and Communities in July 2004.

Executive Summary of Policy and Service Implications

The *Families at Risk* study has produced local evidence drawing attention to the strengths and challenges for parents living in situations of chronic and multiple disadvantage with children aged 0 to 7 years. Life for the majority of these parents and young children is under-resourced, stressful and isolated, and interventions are required that open up pathways out of disadvantaged life situations.

The findings of the *Families at Risk* study affirm key aspects of the South Australian Government's *Generational Health Review*, as well as recent state, federal and international policy frameworks to promote health and well-being in the 'early years'.

To achieve improved outcomes for families at risk a paradigm shift is required so that unequal outcomes for families and children are seen as social injustices, rather than as products of individual dysfunction or deficit. To effectively redress inequalities service responses should:

- be universal and comprehensive
- be holistic by responding to the barriers and opportunities to health and well-being
- focus on prevention, early intervention and social connection
- build capacity in the most disadvantaged localities and populations
- entail continuous and coordinated commitment in all sectors and at all levels.

Policy and service implications drawn from the *Families at Risk* study relate to the following headings:

1. Life chances - social inclusion
2. Living environments – housing and residential mobility
3. Living environments – neighbourhoods and social cohesion
4. Mental and emotional health and well-being
5. Support for parenting
6. Childcare
7. Service planning and provision
8. Intersectoral action
9. Role of the health system

1. Life chances – social inclusion

Gender and Young Parents

Women (particularly *young* women) and children are most vulnerable to poverty and other forms of disadvantage. In the *Families at Risk* study population, women are primarily responsible for the care of children. Age at first becoming a parent is strongly associated with children's health and well-being issues/outcomes. There is a need to:

- apply a 'gender' and a 'youth' lens to parent support issues and to policy and service development
- implement strategies that reduce women's/young women's poverty
- increase public resources and opportunities for mothers (and particularly young mothers) of young children to receive support and recognition
- provide advocacy and support for women/young women to negotiate service systems.

Whilst the number of fathers participating in the study was small the indications are that their service use is different from mothers. It is clear that more research in relation to the experiences and service support needs of fathers is needed.

Education

The study adds to evidence linking poor(er) health and well-being outcomes to low levels of educational attainment. The study findings affirm:

- the emphasis of education and social inclusion policies on school retention and participation in further education
- the current emphasis in pre-school and school settings on health and well-being education
- the potential of early childhood centres and schools as settings for parent/family and community support and participation.

Employment and income

The study adds to evidence linking a wide range of health and well-being outcomes to unemployment and low income. The study findings affirm the need for investment in a range of anti-poverty strategies.

Aboriginal Families

Whilst the study had no specific focus on Aboriginal families, and the actual numbers of Aboriginal families who participated may be too small to draw reliable conclusions, the findings confirm what is already known about risk factors and poor(er) outcomes for Aboriginal families. The findings affirm the need:

- for leadership across government
- for population and context specific service and program responses that support community capacity
- to build on existing initiatives through consultation with Indigenous populations and human service agencies (all sectors and all levels).

2. Living environments - housing and residential mobility

Living conditions, in terms of both housing and neighbourhood characteristics, are a major determinant of health and well-being. For the *Families at Risk* study population, choice of housing is largely limited by affordability and location of public housing stock as well as their vulnerability (to domestic violence and other unsafe situations). The study findings support some of the current thinking related to the future development of public housing, in particular:

- Addressing issues of availability and affordability of housing, in particular for young mothers
- Avoiding the concentration of public housing stock in particular localities
- Addressing the current problems of concentration through strategies that address the broad social determinants of health and well-being, including local employment, neighbourhood development, education and childcare opportunities, and so on.

3. Living environments – neighbourhoods and social cohesion

Social isolation, and the lack of safe and supportive environments for parents and young children, requires focus in terms of policy and innovation in service provision. Overall, an increase in resources devoted to crime prevention and neighbourhood community development, would enable them to become healthier communities that better meet the needs of their members. Possible strategies include:

- Create safe, attractive physical environments – including parks, playgrounds, streets and buildings
- Subsidize programs and provide transport to encourage children to participate in sport and recreational activities
- Develop comprehensive community based initiatives that connect residents in communal activities
- Provide opportunities, particularly for women, to learn advocacy and leadership skills that they could apply towards community development initiatives.

4. Mental and emotional health and well-being

The *Families at Risk* study findings add to the evidence of the associations between chronic and multiple disadvantage, stressful life events, and people's mental and emotional health. "Upstream" policies and strategies that address the social determinants of health and well-being as well as interventions that foster resiliency in children, families and communities are keys to improving mental and emotional health and well-being. Examples of strategies that can contribute to improved outcomes include:

- Inclusion and participation in social programs such as early childhood education and childcare, employment, housing, community and neighbourhood development
- Population-based parent support and early childhood development programs such as nurse home visiting, community midwifery, parent support networks, enriched centre-based childcare and pre-school programs, and school-based health promotion programs
- Policy and strategy development to protect and improve the safety of women and children.

5. Support for parenting

The findings highlight many of the stressors and challenges of parenting in contexts of multiple disadvantage. Many of the parents displayed considerable hope, commitment and achievements in the face of coping with such challenges. Services should focus greater attention on building and maintaining supportive structures and practices - such as access to safe, adequate housing, recreation and play, adequate income, practical support, education, childcare, health services, community networks and opportunities for friendship - than on individual deficit in skill, lifestyle, behaviour or responsibility.

There is a need for a different way of thinking/speaking about parental 'responsibility'. It is recommended that:

- Services/programs recognise and respect the strengths and resourcefulness of parents/mothers
- Service providers be trained and encouraged to acknowledge parents' efforts to raise their children well and acknowledge gender inequalities in power and responsibility
- Services apply a 'gender lens' and support the relationship between parent/mother and child(ren) by providing a parent/woman-centred response
- Appropriate service provision allows for more opportunities for parents to take time out for themselves while their children are safely cared for.

6. Childcare

To achieve increased use of community-based childcare services need to be flexible, affordable, conveniently located and accessible (in terms of hours, cultural sensitivity,

suitability for children with differing abilities, etc.), and meet parents' standards. More research is needed in relation to the barriers and what would support the use of formal childcare services by families with young children living in situations of chronic and multiple disadvantage.

7. Service planning and provision

Not one causal factor

Definitions or categories of service and eligibility requirements most often reflect professional and administrative needs and ways of thinking and organising, and may not reflect parents' lived experiences. In this way, according to parent reports, services can be unhelpful.

Findings from the study support a change of thinking, away from the dominance of 'boundary driven', professionally defined services focused on particular problems. Service organisations need to open their 'borders' and develop links, exchanges and dialogue with other sectors/agencies as well service users. To achieve this the focus should be on:

- flexible structures and competent collaborative practices
- universal and comprehensive provision of supports for families with young children, with 'additional needs' provision linked to universal programs (eg. nurse home visiting, early childhood education, schools)
- fitting the service to the person not the person to the service.

Multiple service use

Many parents living in situations of multiple disadvantage, and in particular, parents with multiple concerns regarding their child(ren)'s health and well-being, have a great deal of interaction with 'the system' (illness care, education, welfare, housing, social security, justice, etc.). Difficulties with this interaction, as reported by parents, include: difficulty getting access to services and/or individual providers; lack of continuity in providers; inconsistent information; disrespect; feeling judged or blamed; and a general lack of response to their concerns and needs. These services need to be adequately staffed by individuals who are appropriately trained, capable of responding to people's needs and able to demonstrate understanding of and respect for service users.

Enabling participation

Policy makers and services need to find ways to listen to parents' experiences, connect them to each other, and build on and use their strengths. To enable participation there is a need for services to:

- be locally based and locally responsive, include as much participation and control by service users as is feasible, and be accountable to the communities in which they operate and/or the population groups they serve
- Implement strategies to eliminate barriers to people participating in policy, program and service development
- Develop innovative strategies to obtain parents' input into policy and program development
- Foster and develop supportive networks so that parents' stories can be told, common issues and priorities can be identified, and agendas for action can be developed.

8. Intersectoral action

There is growing recognition that employment, social supports, physical environments and education have all been linked with the health outcomes of

communities, as illustrated by Figure 1 (page 17). Addressing these social determinants of health involves many areas which fall outside the jurisdiction of health and welfare departments. It is vital that all sectors are engaged in strong partnerships and collaborative work on a range of policy inputs and services to address the social determinants of health and subsequent inequalities, and to solve issues where the solutions fall across multiple sectors.

9. Role of the health system

The health system can play an important role by:

- raising awareness of the social determinants of health, assessing the health impacts of policies, and advocating for health promoting policies and programs in other sectors (such as schools, workplaces, early childhood centres);
- engaging with communities and other partners in ways that integrate and strengthen action and build capacity for future action;
- co-ordinating health planning activities to address the social determinants of health;
- developing health organisation capacity, including workforce development and research.

Introduction

Project description

Families at Risk: the effects of chronic and multiple disadvantage is an Australian Research Council (ARC) *Linkages* (previously named SPIRT) funded project, a collaboration between the Flinders University, The University of South Australia, the Department of Human Services, and the Women's and Children's Hospital. The project team comprised research workers from each of these organisations as well as a doctoral research student funded by an Australian Postgraduate Award (Industry) and supported by all the research partners. The doctoral research component of the project was designed to specifically focus on implications of the research findings for family support services. In addition, a reference group provided oversight to the project team.

The project is a study of 500 families² with young children aged 0 to 7 residing in the lowest socio-economic status Census collection districts of Metropolitan Adelaide. Parents³ in these areas were invited to undertake one or two interviews consisting of both quantitative and qualitative questions about parenting, their neighbourhood, and sources of formal and informal help. The original aims of the project are specified in Appendix A.

Ethics clearance for the study was obtained from Flinders University Social and Behavioural Research Ethics (SBREC) committee and The Women's and Children's Hospital Research Ethics committee. In addition, ethics advice was also sought from Yunggorrendi.⁴ Throughout the course of the study the research team met regularly with a community consultation committee.

The target population of the *Families at Risk* Project were families with young children (0-7 years) living in highly disadvantaged circumstances. Hence, Adelaide census collection districts (CDs) were selected on the basis of very low Australian Bureau of Statistics (ABS) SEIFA Index of Relative Socio-Economic Disadvantage scores (Census 1996) and with a high percentage (around 20-35%) of families with young children. The final sample consisted of 17 outer northern Adelaide CDs, six inner north-west CDs, and four outer southern CDs (Appendices B and C). These 27 Collection Districts represent some of the most disadvantaged neighbourhoods in Australia, all falling within the bottom 1.5 per cent of all CDs in Australia ranked according to the SEIFA disadvantage index.

To ensure that the target number of around 500 families were enlisted for the project from the selected areas, contact was made with as many eligible⁵ families as

² The term 'families' is used in the broadest sense to encompass the range of different family and household formations we encountered. The primary care-giver of the young children in each family was the interview participant.

³ Use of the term 'parents' is somewhat misleading in that 92% of participants were mothers (half of the interview population were sole mothers). Following this, the doctoral component of the project explicitly applies a gender lens to the issues of parenting in situations of multiple disadvantage.

⁴ Yunggorrendi, the First Nations Centre for Higher Education and Research at Flinders University, is a learning centre which supports the access of Aboriginal and Torres Strait Islander people into tertiary study and establishes an environment where the history and culture of Indigenous Australians is respected and valued.

⁵ 'Eligible' families were those with children 0-7, regardless of their actual socio-economic circumstances.

possible within each CD. The project was conducted in two stages. Stage One involved contacting, inviting and interviewing families in the 27 Collection Districts. This resulted in door knocking 5137 houses, 915 of which were identified as eligible families for the purpose of the study (18%⁶ of total households). Of this number, 500 families completed Interview One (10% of total households in the area, and 55% of families deemed eligible). A second round of interviews (Interview Two) were conducted in the second stage, which selected a random sample of 206 families from the original 500 families who participated in Interview One.

Interview One focussed on questions about parental sources of help and advice, financial resources, how the participants felt about parenting including feelings of satisfaction, as well as a range of demographic variables. Interview Two looked at stressful events in the parent's life, aspects surrounding location, mobility and neighbourhood, service use, and concerns about children and parents' health.

Research approach

The research involving 'at risk' families aimed to be ground-breaking in examining multiple concepts such as social determinants of health and well-being, individual (parent and child) functioning, social support and cohesion, and service use. The research partners shared a commitment to research that would affirm the capacity and strengths of many parents and enable practitioners to "look beyond traditional theoretical frames" and to "discern the value and strength of families" (Slee & Shute 2003). The project aimed to "identify what families are doing right" and to reveal the "unique functionality" and "unique coping strategies" of some families (Cameron et al. 2000). Despite the considerable constraints of socio-economic context, some families are more resilient than others, and the things for which they are considered 'at risk' from, do not eventuate. Following this, key questions informing the research at the outset included:

- *What are the keys to resilience?*
- *How do protective factors and processes work in the lives of families with young children identified as being at risk?*
- *How do services best support parents and enhance resiliency?*

This last question represents the focus of the PhD component of the project, which consists of a small qualitative study exploring the knowledge and experiences of service providers and mothers of young children living in situations of multiple disadvantage. The focus of the research includes midwifery, child health, parenting support, housing support, community development and counselling service relationships that mothers had experienced as helpful. Fifteen, two-hour semi-structured interviews, involving the researcher, a service provider and her client were recorded, transcribed and their content analysed. The data from these interviews enabled the addition of 'rich' description to various aspects of the larger study.

Research limitations

While the researchers endeavoured to recruit 'hard-to-reach' families (eg. caravan park dwellers, non-English speaking parents) to participate in the study, but these attempts were not successful due to a number of reasons including the high mobility associated with these families, language barriers and lack of sufficient research resources.

A limitation of the study is that no direct questions were asked about violence and abuse, or drug and alcohol use, and their impacts on the health and well-being of

⁶ Percentages have been rounded when cited in text to improve readability.

parents and children. The decision to exclude these was based on a concern not to alienate participants in the face-to-face interview with a field researcher who would be unknown to them. However, issues of child abuse, family conflict and intimate partner violence were raised by some parents and, along with drug and alcohol use, were significant themes in the research conversations that informed the doctoral component of the project.

Another limitation of the study is that whilst the proportion of families interviewed who had Aboriginal parents or children was relatively high (13%), the actual numbers of this population group may be insufficient to draw reliable conclusions. Although the study recognises that none of the field researchers were of Aboriginal descent, the principal field researcher came from a strong background in researching family issues with Aboriginal people.

What factors determine the health and well-being of families with young children?

In the broadest sense, health and well-being is a resource for individuals and families, supporting their capacity to adapt to, respond to, or control life's challenges and changes. Health and well-being are the result of multiple and interwoven determinants ranging from individual factors (biological, genetic, behavioural) to local resources and opportunities for health and well-being, to society-wide factors (environmental, cultural, socio-economic). That said, there is a wealth of evidence from Australia and other countries that supports the notion that the socio-economic circumstances of families with young children are more important to their health and well-being status than their parenting, health behaviours, lifestyles or their access to services (Hertzman 2002; Turrell et al. 1999; Marmot & Wilkinson 1999; Keating & Hertzman 1999).

In this 'social determinants of health' framework, health inequalities, social isolation and exclusion are understood as social injustices, rather than as products of individual dysfunction or deficit. Factors such as education, employment, occupation and living/working conditions, income, housing and area of residence are the most fundamental determinants of health and well-being in that they interact with each other to determine the extent to which parents possess the physical, social, personal and other resources to cope with their environments and identify and achieve their aspirations for themselves and their children (see Figure 1, page 17).

In terms of the health of whole populations, it is well known that disparities – the size of the gap in social and economic status between groups within a given population – greatly affect the health status of the whole population. The larger the gap, the lower the health status of the overall population (Wilkinson & Marmot 1998).

The Solid Facts, a publication of the World Health Organization (2003), identifies from many thousands of research reports, ten important social determinants where action can be taken to reduce inequalities and improve health and well-being. The summary table below illustrates the coincidence between our research sample population and these 'solid facts'.

'The Solid Facts' WHO (2003)	Key findings of the 'Families at Risk' project
<p>1. The social gradient - people at each level of the 'social ladder' experience poorer health status than those immediately above them. This <i>relative</i> inequality has disabling/disadvantaging effects.</p>	<p>In comparison with Metropolitan Adelaide, the research sample population are significantly disadvantaged in every measured factor, with the exception of the proportion of the research population born outside Australia and speaking a language other than English at home.</p>
<p>2. Stress – continuing stressful psychological and social circumstances increase the chances of poor mental health and premature death.</p>	<p>Approximately 50% of the participants are sole parents. 38% of participants are the sole adult in their household. Sole fathers are more likely to live alone with their children than sole mothers.</p> <p>In 40% of the households there are 3 or more children. 17% of the total sample have 4 or more (up to 10) children.</p> <p>High levels of poor mental health – 53% of parents were likely to have one or more mental health conditions.</p> <p>High rates of local crime and social disorder</p> <p>High frequency of stressful life events</p>
<p>3. Early life – the foundations of adult health are laid before birth and in early childhood.</p>	<p>There is overwhelming evidence of the association between parental disadvantage (nearly all the study participants) and adverse outcomes for children.</p>
<p>4. Poverty & Social exclusion – relative poverty denies people access to quality housing, education, transport and other factors vital to full participation in the life of society.</p>	<p>Low income - 74% of households in the study rely on income support from the government.</p> <p>92% of research participants are mothers – women and children are particularly vulnerable to the effects of social inequalities.</p> <p>In 64% of the households there is no wage earner.</p> <p>70% of research participants describe their household income as 'just enough' or 'not enough' to live on.</p> <p>Housing: 56% of participant households rent public housing. One-quarter rent privately. Most commonly participants believe they had little or no housing choice.</p> <p>Residential mobility: 81% of participants had moved house in the past 5 years. Nearly half of the total study population had moved between 3 and 10 times in this period.</p>

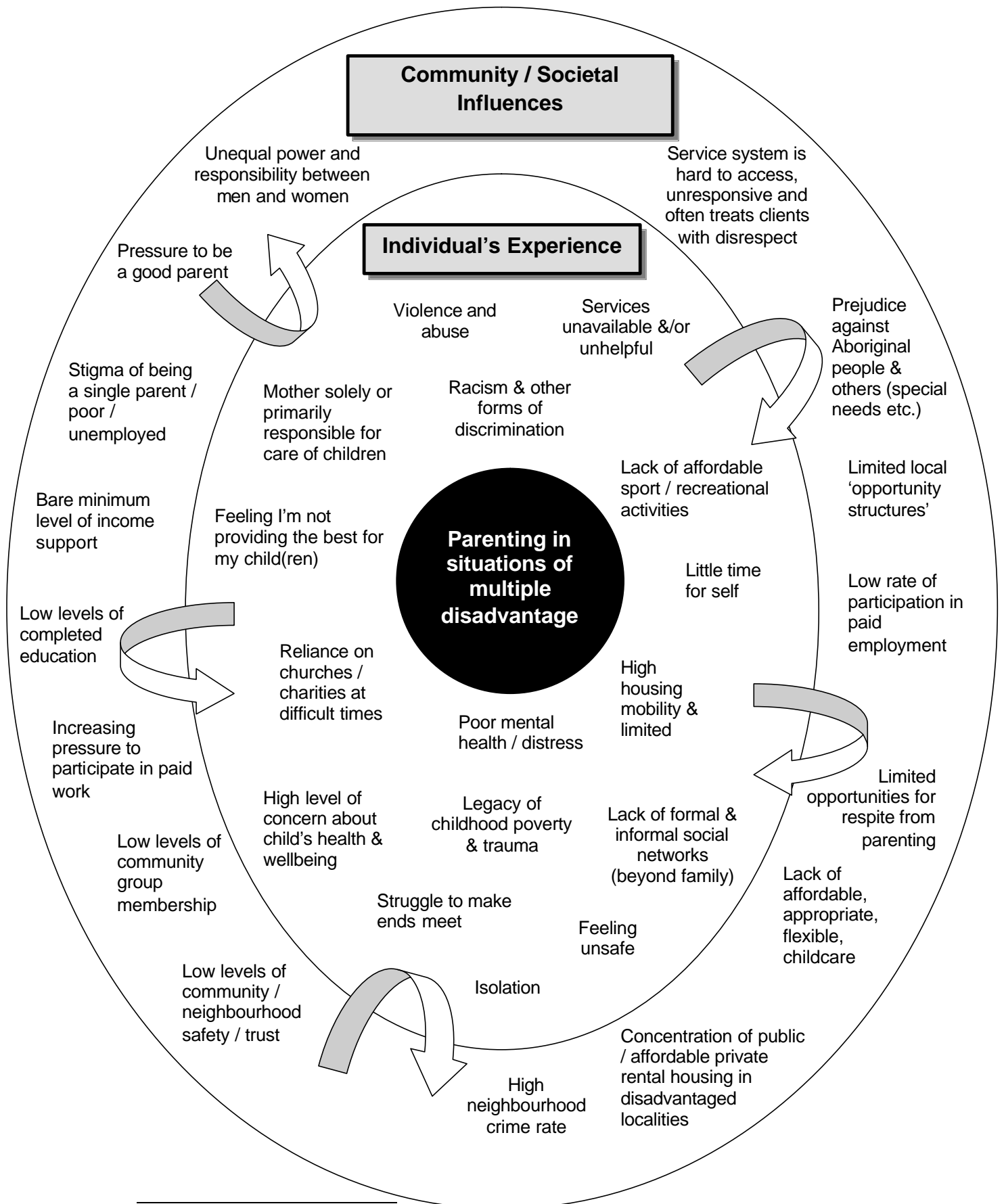
	Young parents – 47% of the sample population were less than 20 years old when first becoming a parent. (Women, particularly young women, are most vulnerable to poverty & other forms of disadvantage).
5. Working conditions	Very few employed people in the study (less than 15%)
6. Unemployment – job insecurity and unemployment have negative health effects linked to the psychological and financial consequences they bring.	Nearly 90% of research participants have no participation in paid work. The remainder (approx. 12%) are engaged in part-time paid work. Nearly three-quarters (73%) of research participants had less than 12 years of completed education. 2% of the total sample population are currently ‘ students ’.
7. Social support and social cohesion – positive health effects of emotional and practical support, feeling valued and belonging. Similarly, trust, mutual obligation and respect in neighbourhoods, communities and wider society.	Participants rely primarily on their own family (particularly their own mother) for help and advice. Participants perceive low to very low levels of safety and trust within their local area and limited confidence that others in their neighbourhoods would intervene to protect or uphold social order. Participants have a higher level of trust regarding the extent to which neighbours can be relied on to ‘keep an eye out for children’. Participants report no or very low levels of community group membership.
8. Addiction	Not studied
9. Food	Not studied
10. Transport – Cycling, walking and use of public transport promote health. Social isolation and lack of community interaction are strongly associated with poorer health.	37% of households did not own/have use of a car when needed.

It is certainly a challenge to conceptualise and report in ways that reveal the complex interrelationships between the social determinants of health and wellbeing. Figure 1 below, is an attempt to illustrate the consequences of parenting in situations of multiple disadvantage as well as factors at the community and societal level that make these effects better or worse.

Various aspects of the experiences of parent participants identified through the *Families at Risk* research interviews and supported by evidence from relevant research literature, appear in the inner circle. In the outer circle some important societal and social policy contexts that influence (and are influenced by) parenting in situations of multiple disadvantage are listed. The experiences and factors *within* each circle and *between* the two circles (and the even broader political, global, environmental and temporal base or background upon or within which the two circles exist) are linked in ways that are interwoven and multi-directional as broadly indicated in Figure 1 by the curved arrows.

The 'stories' of mothers and their children in Appendix D provides a different but complementary illustration of the interplay of these factors in their lives.

Figure 1: Effects and Modifiers of Parenting in Situations of Multiple Disadvantage⁷



⁷ Developed after a similar model in Green (2004).

Inequalities and Disabling Environments - a profile of study participants

The range of variables presented in this section illustrates the complex picture of disadvantage in the lives of the families involved in the study compared to the Metropolitan Adelaide and South Australian populations.

Gender

The majority (92%, or 459 of the 500 parents interviewed) were women while only 8% (41) were men. The early childhood literature shows that women and children are particularly vulnerable to inequality, both in the antenatal period and throughout the early years of life. It also highlights that inequalities have lasting and widespread impacts on health and well-being throughout life. For many mothers, social isolation, the inequitable distribution of parenting and family support responsibilities, violence and abuse, and the expectation that women's needs will always come last (after children, men and family), have the ability to seriously limit their, and their children's, access to information, opportunities and choice.

Family/household form

Throughout Australia, single parent families generally experience lower socio-economic status than two-parent families, have poorer health and are major users of public health services (Glover & Tennant 1999). Almost half of those who participated in the study were sole parents (47%). In comparison, single parents made up 16.6% of all families in Metropolitan Adelaide and around 27% of all families with children (ABS 2001).

Sixty-two per cent of study participants lived in multiple-adult households (2 to 6 adults) with their adult children, adult friends, their own parents or boarders for example. Sole fathers were more likely to live alone with their children than sole mothers. Half of the fathers (20 of the 41) involved in the study were the only adults in their household.

The number of children per household in the study sample was greater than the average for South Australia. Seventy-one per cent of households had 2 or more children, 40% of households had 3 or more children, and 17% of the total number of households had 4 or more children (with up to 10 children). Approximately 29% of households had only one child. South Australian 2001 figures vary quite considerably, with 73% of households having no children, 12% of households having one child and only 15% of households having 2 or more children.

Age at becoming a parent for the first time

The most common age for first becoming a parent in the *Families at Risk* study was 18 years. Among the mothers participating in Interview One, 46.6% had their first child before the age of 20. This compares with 10% of mothers in Metropolitan Adelaide who had their first child before the age of 20 (Pregnancy Outcome Unit data, 2001).

Employment and Income

As the major source of income for most Australian households, employment provides opportunities to utilise and develop skills and to expand social networks. In addition, employment enhances a sense of personal self-worth and attachment to the broader

community. As a result, unemployment can affect individuals and their families on financial, personal and social levels (ABS 2004:51).

Of the children from the 500 households participating in Interview One, 64% were living in a household where there was no wage earner. This is a dramatic comparison to the 19% of children under the age of 15 years in SA living in households where no parent was employed (ABS 2004). For 74% of households in the study, the main source of income was some kind of government income support payment. This compares with 35% of households in South Australia whose principal source of household income was Government pensions and allowances, and 34% in Metropolitan Adelaide in 2000-01 (ABS 2003).

Almost 90% of study participants had no participation in paid work. Less than 10% of study participants were engaged in part-time paid work for up to 30 hours per week and 3% for more than 30 hours (up to 45 hours). More than three-quarters (78%) of participants nominated 'home duties' as their major occupation. Two percent were engaged in education, nominating 'student' as their major occupation.

The majority of participants (50%) regarded their household income as *just enough*, while 24% stated they usually had *some left over*, and 21% had *not enough*. A low 5% regarded their household income as *plenty of money*.

The evidence shows that people with a higher income generally enjoy better health and longer lives than people with a lower income. It is likely that the important determining factors are not only material conditions but also the social advantages (for example, community associations, car ownership, participation in education) attached to those conditions (Hetzl et al. 2004).

Education

Although 'Education' doesn't appear with its own heading in *The Solid Facts* report, our findings correlate with Australian and international research that points to the association between educational attainment and a range of life chances, justice outcomes, physical, mental and emotional health and parenting effectiveness. Educational attainment is steeply graded according to socio-economic position, with health and well-being improving with increasing levels of educational attainment (Hetzl et al. 2004). The link between education and having the capacity to adapt to, respond to and control many aspects of life is particularly significant to parenting. A large proportion of participants (73%) had less than 12 years of completed education, compared to a lesser figure of 52% of the population in the Metropolitan Adelaide area. Only two per cent of the participants were studying, which is significant in the context of the policy emphasis on education as a route to employment.

Ethnicity

Eighty-nine per cent of participants were born in Australia, compared to the 72% of the Metropolitan Adelaide population who were Australian-born. English was the major language spoken in over 95% of homes. This paints the picture of a particularly non-diverse population in terms of ethnicity.

Aboriginality

Families with Aboriginal children represent 11% of the study participants. There was a significant group of Aboriginal children in families with non-Aboriginal parents and when households with both Aboriginal and non-Aboriginal children in the same family were included this figure rose to 13%.

There was a higher prevalence of teenage parenthood amongst Aboriginal parents in the study, with 72% reporting having their first child as teenagers. Over half of Aboriginal parents (55%) were sole parents. Parents with Aboriginal children had lower school attainment and education levels, with only one Aboriginal parent reporting to have completed year 12 or higher. The Aboriginal parents interviewed were also found to shift more frequently with the average being 4.8 shifts over the last five years.

Living environments – housing, mobility and transport

Of the 206 parents involved in Interview Two, 37% did not have access to a car when needed. In 2001 however, only 11% of households in Metropolitan Adelaide did not own a car. With increasing distance from the city centre, vehicle ownership becomes more important. Without a vehicle, parents are reliant on public transport to access both local services and those located within the city centre.

Children benefit from settling into a community, which brings a stability of friendships and schooling. Families in this study are highly mobile for a range of push-pull reasons, including low income (which often leads to an inability to buy a home), changes in family relationships, safety issues, and possibly the young age of many of these parents.

Only 17% of families were buying or owned their own home. Most families were renting their homes from the South Australian Housing Trust (56%, compared to 8% of households in Metropolitan Adelaide), whilst 25% were in private rental accommodation (17% in Metropolitan Adelaide), and 3% were boarders.

More than 80% of the study participants had moved house in the past five years. More than half had moved three or more times during the last five years, while less than a third of participants had lived in their area for more than five years (Table 1).

Table 1: Mobility of Families in Interview One Sample

Characteristic	
Time (yrs) living in the area	(N = 499)
= 1 year	170 (34%)
>1 year and = 5 years	176 (35%)
> 5 and = 10 years	81 (16%)
Over 10 (up to 38) years	72 (14%)
Times the parent (the family) moved during the last five years (N = 489)	
0 times	95 (19%)
1-2 times	137 (28%)
3-10 times	236 (48%)
11-20 times	15 (3%)
21+ times	6 (1%)

A number of questions in Interview Two explored issues around family mobility and housing conditions. Specifically, participants were asked about:

- the reasons for living in the current location
- reasons for moving in the last five years
- the degree of choice they had when they had been looking for a place to live, and

- the effect of their current place/area of residence on various aspects of their lives, including their children's health and wellbeing.

No Choice and High Dissatisfaction

Of the 206 participants in the study, 143 or around 70% of those interviewed perceived they had no choice about their current housing circumstances for a range of reasons. In this group some had more than one area of compulsion about their current housing so the figures quoted in the following do not represent discrete groups as some residents moved for more than one of the reasons.

For 68 participants their sense of no choice was related to housing allocation and availability. For a large number of these, the housing authority allocated the house to their family and the participants saw they had no right of refusal as this might mean they would be dropped off the housing list. Others in this 'no choice' grouping were without access to public housing but also felt pressure to accept a less than satisfactory private rental contract, believing nothing else was available within their price range. A small number of participants (6) had moved to their current location because of emergency circumstances such as living with young children in small caravans or in one case a car, or because of medical problems.

For 18 participants, the move to the area was because of a larger house becoming available (mostly public housing) where their family could be better accommodated. The need for a larger house was often the result of another child being born, or changed family circumstances, resulting in additional children in the household (eg. the children moving from living with dad to mum or vice versa). Although many of these participants were happy to have the larger house and appreciated the bigger yard for the children to play in, they too felt there was no choice about the area or suburb in which this larger house was offered.

For another 16 participants their current living circumstances were the result of being moved or moving away from circumstances where there was danger or trouble - including domestic violence, community violence, trouble with neighbours and desire to get as far away as possible from ex-partners or other family members.

A reasonably large number, (40 participants including some in the other "no choice" categories above) felt their choice of a place to live was severely curtailed by not being able to afford private rental housing and that the housing authority rent was all they could afford. These families felt stuck in the poorer, less salubrious suburbs where rental rates were cheaper or where the public housing stock was located. Several parents expressed the desire to live elsewhere, but recognised that housing choice was limited by their finances.

Choice and Some Satisfaction

A smaller number (63 or around 30%) were reasonably well satisfied with their living location. These people cited three primary reasons for satisfaction with some citing more than one of the following reasons;

- Growing up in the same area, having lived there for a long time and having familiarity with the area was one set of positive reasons mentioned by 10 participants. These people expressed a sense of loyalty to the area they live in.
- A somewhat larger group (27 or around 12%) felt they had little choice of housing originally but have come to like where they live now, describing it as 'a nice area' or having 'community spirit'. Several in this group described their

- residential setting as 'quiet' and 'peaceful' and themselves as 'lucky' to get a house in what they now see as a good area.
- Forty-one participants expressed satisfaction with their current place of residence because they are close to work settings, near children's schools, playgrounds and child care facilities, are able to walk to shopping centres and because they live close to public transport (train stations and bus routes). For this group, convenience issues were cited as most important in terms of satisfaction with living location.

Living environments - neighbourhoods and social cohesion

Better health and well-being are associated with access to support from families, friends, neighbourhoods and communities. Influencing factors include community and cultural values and beliefs, trust and social connectedness, housing mobility and neighbourhood characteristics. The *Families at Risk* study examined perceptions of neighbourhood safety, feelings of trust in others, and civic engagement levels, in the context of statistics on the incidence of crime and social disruption according to offences recorded by police.

Collective efficacy is a term referring to how people think about their community and is measured through two related areas (Sampson, Raudenbush & Earls 1997:919). One is termed 'informal social control', which measures beliefs about the likelihood of people taking responsibility for managing socially damaging events in the neighbourhood. The second area, termed 'social cohesion', measures the sense of connection and agreement between people living in the neighbourhood.

Informal Social Control

Six hypothetical scenarios about a range of socially disordering occurrences in the neighbourhood were used in the study to measure 'informal social control'. For each scenario, participants were asked to say how likely others were to intervene on a five point scale – with 'very likely' scoring 1, through to 'very unlikely' scoring 5.

Overall, the findings were that in most scenarios participants had limited or uncertain/non-committal expectations that people in their neighbourhood would intervene in the face of social disorder. In only one scenario, 'young people harassing an older person', participants' beliefs that people would intervene outweighed their negative or 'don't know' (neither likely nor unlikely) expectations.

Table 2: Neighbourhood Informal Social Control

Scenario	People are likely or very likely to intervene	People are unlikely or very unlikely to intervene	Neither likely nor unlikely
Children skipping school and hanging around your street corners or local shopping centre	30.6%	51%	18.4%
Young people spray painting graffiti on local buildings	42.7%	38.4%	18.9%
Young people harassing an older person in the street	56.3%	22.3%	29.1%
Young men fighting in a local street	24.2%	56.8%	18.9%
Drug deals going down in view of people in the neighbourhood	32.5%	48.6%	18.9%
The local childcare centre threatening to close due to budget cuts	48%	17.9%	34%

Social Cohesion

Social cohesion refers to the sense of connection and agreement between people living in a neighbourhood. Participants were asked to declare to what extent they believed others in their neighbourhood could be counted on in terms of shared values, helping each other out and other related variables. For each scenario participants were asked to indicate their agreement on a five-point scale ranging from a definite agreement to a definite disagreement.

Table 3: Neighbourhood Social Cohesion

Scenario question	Score				
	1 Definitely agree %	2 Agree %	3 Neither agree or disagree %	4 Disagree %	5 Definitely disagree %
People are willing to help others	18.4	43.7	21.4	11.2	5.3
This is a close-knit neighbourhood	12.6	21.4	26.1	28.3	11.7
People in this neighbourhood can be trusted	7.8	16.5	31.1	24.8	19.5
People here generally <i>don't</i> get along with each other	6.8	19.4	32.0	34.0	7.8
People here <i>do not</i> share same values	14.6	28.6	33.5	20.9	2.4

In summary, participants perceived low levels of trust, shared values and connection in their communities, but believed that people were willing to help others in their neighbourhood if needed. Overall the findings revealed clustering on most variables around the 'neither agree nor disagree', the point of non-commitment. This cautious stance is most obvious on the questions about shared values, mutual trust and people getting along with one another.

Neighbourhood Safety, Trust, and Social Connectedness

Included in Interview Two were questions about safety, trust, community membership, and watching out for children. Perceptions of safety were measured on

a four-point scale, with scores of less than two (somewhat safe), indicating low to very low levels feelings of safety and scores of three or higher indicating feelings of being safe. Results indicate that participants experience a low sense of safety with no scores in any of the neighbourhoods studied reaching the safe level of three. This indicates a prevailing unease about safety within neighbourhoods.

Parents were asked two questions about trust. The first asked about how many of their neighbours they trusted, and the second, to what extent neighbours could be relied on to 'keep an eye out for the children'. In relation to the first trust question scores were clustered around 2 (on a scale of 1 – 4) indicating perceptions of there being few people in the neighbourhoods to trust. The link between perceptions of safety and levels of trust in the neighbourhoods is an inevitable one. Although there are differences in scores between areas, indicating a range of perceptions about trust and safety, no neighbourhood had average scores indicating participants felt safe, or experienced high levels of trust in others. Safety scores range between 1.6 and 2.4 and trust scores between 1.8 and 2.7. However, even the higher scores here reflect limited perceptions of safety and trust in others.

Scores on the second 'trust' question - about the extent to which they and others in the neighbourhood can be expected to 'keep an eye out for children' - neighbourhood scores ranged between 2.0 and 2.4. Whilst these scores indicate a low level of trust, the relative consistency between neighbourhoods may indicate a generalised expectation of trust when children are concerned. It is acknowledged that trust is a complex phenomenon and is related to other variables within the individuals and families, as well as within the neighbourhoods.

There is evidence to suggest that neighbourhoods with stable populations are more likely to share a sense of communal trust and support (Walklate 2001; Irwin 2001). In contrast, the *Families at Risk* study population is highly mobile, a factor that may contribute to limited connection between participants, their neighbours and local communities.

Further insight into levels of community engagement comes from the number of community groups to which participants say they belong. Table 3 below reveals low levels of community group membership. A score of 1 on the scale indicates membership in *no* community groups and the mean scores (1.3 – 1.8) show that participants ranged between the 'none' and 'very few' categories of community group membership. Poverty, gender inequalities, unemployment, insecure housing, sole parenthood, issues of ethnicity, race and discrimination, and their multiple effects are contributing factors to this social isolation.

Table 4: Perceptions of Neighbourhood Safety, Trust and Social Connectedness (Mean Scores for Suburbs)

Metropolitan area	Number of families interviewed (N = 500)	Safety* (N = 500)	Trust* (N = 493)	Community group memberships (N = 500)*	Watch out for children* (N = 473)	No. of adults** (N = 500)
Northern area 1	27	1.7	2.0	1.3	2.0	1.7
Northern area 2	121	1.9	2.2	1.6	2.1	1.7
Northern area 3	47	2.1	2.1	1.6	2.1	1.8
Northern area 4	81	1.9	2.1	1.6	2.2	1.7
Northern area 5	93	2.0	2.1	1.4	2.3	1.9
Inner West area 1	27	1.7	2.2	1.5	2.1	1.5
Inner West area 2	21	1.6	2.1	1.7	2.3	2.0
Coastal West	14	2.4	2.2	1.6	2.3	1.4
Southern area 1	32	2.2	2.7	1.8	2.3	1.7
Southern area 2	23	2.1	2.1	1.5	2.2	1.7
Southern area 2	14	2.1	1.8	1.8	2.4	1.5
Entire sample	500	1.9	2.1	1.6	2.2	1.7

Note - *Questions on Safety, Trust, Community Membership, and Watching out for Children were all measured on a 4-point scale. Higher scores indicate more positive outcomes.

**Figures on number of adults in house are from demographic data collection, and represent average numbers of adults in the house at the point of data collection in 2002.

Crime and disorder in the neighbourhoods

It is acknowledged that perceptions of safety are not the same as actual safety. However, there appears to be a correlation with regard to perceptions of trust and safety in the areas studied and actual crime statistics. The figures on reported crime shown in the table below indicate some basis of concern for these families.

Table 5: Crime Statistics for the Neighbourhoods – Type of Offences

Area	Against person	Sexual Crime	Robbery/ Extortion	Property Crime	Against Good order ⁸	Drugs	Total offences	Area Pop	Offences for area 1,000 pop
Northern area 1	80	5	6	633	66	13	803	977	2002*
Northern area 2	125	15	5	533	22	17	717	3229	350
Northern area 3	10	2	0	55	8	3	78	300	267
Northern area 4	59	8	4	376	71	9	527	2316	269
Northern area 5	38	19	0	166	31	7	261	1587	290
Inner West area 1	46	5	2	115	26	6	200	744	460
Inner West area 2	25	0	2	160	28	10	225	723	412
Coastal West	8	2	0	40	15	1	66	556	127
Southern area 1	30	4	4	120	35	0	193	447	497
Southern area 2	13	2	0	58	14	2	89	505	204
Southern area 3	149	9	20	1030	242	13	1463	1046	2700*

* In Column 10, figures marked with an asterisk indicate areas with crime rates presumed to be inflated by the presence of a shopping centre, transport centre or other major commercial venue, where crime features more frequently.

⁸ For example breaching an order, resisting and hindering police, disorderly and offensive behaviour

Source: Office of Crime Statistics Research, 2000

These crime statistics show that most of the neighbourhoods included in the project recorded crime rates higher than the average rate of 196 offences per 1,000 population for Metropolitan Adelaide (Office of Crime Statistics Research 2000). Only one area had a rate below that of the Adelaide metropolitan area (Coastal West), whereas several have crime rates more than double the metropolitan rate (Inner West area 1 and 2, and Southern area 1). Two of the areas (Northern area 1 and Southern area 3) have rates over ten times higher than the overall metropolitan rate. The very high rates for Northern area 1 and Southern area 3 are a product of these neighbourhoods containing, or abutting, large commercial and entertainment centres and/or large transport stations where crime features more frequently. These centres produce crime in the form of more prevalent car theft, drug trading, sexual offences and personal attacks and robberies. This is not to dismiss the impact on families living in or around these centres, as the crime spills into their lives even if it is not originating within their residential area.

In summary, it is evident that there is a statistical basis for participants' concerns for their own and their children's safety. It is likely that reported crime rates, perceived levels of safety and trust, collective efficacy, and community group membership sit within a circular loop, each feeding from and into the others. It is also important to note the strongly gendered aspects of crime and safety.

Highlights: Inequalities and disabling environments

The study sample is a highly disadvantaged group of families characterised by being predominantly young Australian born female sole parents, not in the workforce, reliant on Government assistance, living in rented housing, residentially mobile and having low levels of formal education.

- Almost half (47%) of families were of single-parent status with the majority (71%) having two or more children
- 47% became parents for the first time at 19 years old or younger
- Most families were renting their homes from the SAHT (56%) while 25% were in private rental accommodation
- 34% had lived in their current area for less than 1 year and 69% for less than 5 years
- A large proportion of participants (73%) had less than 12 years of completed education
- Almost 90% of study participants had no participation in paid work, with the main source of income being Government assistance (74%)
- 37% did not have access to a car
- 89% of parents interviewed were born in Australia
- 95% cited English as the main language spoken at home
- 7% of parents interviewed identified as being of ATSI origin with 11% of children being identified as of ATSI origin
- Participants perceive low levels of trust, shared values and connection but believe that people are willing to help others in their neighbourhood if needed
- Low levels of community group membership were revealed.
- A correlation was found with regards to the perceptions of trust and safety in the areas studied and actual crime statistics, with most of the neighbourhoods recording crime rates higher than the average rate for Metropolitan Adelaide

Parents and Parenting

Although the term 'parent' is used throughout this section the data is derived primarily from interviews with mothers (459 mothers and 41 fathers in Interview One), almost half of whom are sole parents.

Parent reports of their own and their children's health and well-being

Having identified in the previous section a range of social determinants of the health and wellbeing of families and young children, the research data can also shed light on aspects of parents' health and well-being and their concerns about their children. These areas include:

- Parent self-reported health status
- Stressful life events
- Parent mental health
- Parent confidence and satisfaction
- Parent reports of children's health and well-being

Parent Self-Reported Health Status

Self-reported health status refers to a person's perception of their general health and well being. This self-reporting measure was used in the study to give measures on a 5 point scale of parents' perceptions of their health, with responses ranging from excellent to poor.

In the table below, the *Families at Risk* study findings are shown alongside comparable measures of self reported health status of the South Australian and Australian populations.

Table 6: Self Reported Health Status, SA, Australia & Families at Risk Study

Self-Assessed Health Status	No. of Responses in Families at Risk study	Families at Risk Study %	SA %	Australia %
Excellent	18	8.8%	16.1%	18.9%
Very Good	63	30.7%	34.2%	32.8%
Good	74	36.1%	29.8%	30.2%
Fair	44	21.5%	15.5%	13.3%
Poor	6	2.9%	4.5%	4.8%
Total Responses	205			

Source of SA and Australian figures: ABS, National Health Survey, 2001

The proportion of study participants rating their health as 'excellent' or 'very good' (40%) is less than for the South Australian population of adults over 15 years (50%) and the Australian population (52%). The proportion of the study population rating their health as 'fair' or 'poor' was 24% compared with the SA (20%) and national (18%) populations.

Stressful Life Events

The 22-item Life Events Survey (Murray-Harvey & Slee 1998) was used to measure parents' perceptions of stressful life events occurring within their families. Parents indicated through a 'yes' or 'no' format whether their family had experienced any one or more of the 22 items in the last years, such as 'Another child has been born into

the family' or 'Parents have divorced'. For 'yes' responses, a score on a 3-point scale was given to indicate how stressful the event was for adults in the family (3=stressful, 2=somewhat stressful' and 1=not stressful).

As can be seen from Table 7 the most frequently occurring stressful life events were: another child being born into the family; used social welfare; parents unemployed; greater financial worries and discipline problems with children. When questioned regarding the level of stress of all the nominated events, the most stressful were; serious illness in the family, family member robbed, discipline problems, parent accident and increased family conflict.

Compared with a 2004 South Australian study (Avery, et al. 2004) that reported on 4572 responses to a range of similar psychosocial events to that assessed in the *Families at Risk* study, a number of interesting comparisons emerged. In all, 11 out of the 22 items generally overlapped between the two studies. These included the items on unemployment, death of some-one close, discrimination, moving house, robbery, marriage breakdown, birth of a child, financial stress, family counselling, new job, and serious illness in the family. Allowing for the fact that in the 2004 study the sample was drawn from a random sample of South Australians and there was some variation in the wording of the stressful life events some interesting comparisons can be made. As can be seen from Table 7, the participants in the *Families at Risk* study reported three times or more the frequency of the occurrence of these psychosocial events in their lives for all items with the exception of 'new job'. This pattern suggests that those interviewed in the Families at Risk study represent a group who are subject to a significant level of psychosocial stress. The impact of multiple stressors on individuals and families is well documented and is illustrated in Figure 1 (Slee 2002).

Table 7: Stressful Life Events

Stressful Life Event	Families at Risk Study - responses (number)	Families at Risk Study responses (%)	SA Study responses (%)
Another child born into family	134	65	3
Family moved several times	71	35	8
Increased intra-familial conflict	74	36	
Child hospitalised	84	41	
Death in family	92	45	20
Greater financial worries	107	52	5
Parent had an accident	26	13	
Parents separated	71	35	
Parent unemployed	120	58	5
Parents divorced	12	6	3
Home broken into	40	19	4
Family counselling	31	15	5
Others moved into home	58	28	
Parent away frequently	35	17	
Less marital harmony	44	21	
Family member robbed	21	10	
Child psychological counselling	34	17	
Parents changed jobs	58	28	12
Used social welfare	125	61	
Serious illness in family	60	29	8
Discipline problems	106	52	
Ethnic discrimination	19	9	4
Total number interviewed	206		

Note -Multiple responses per parent were possible.

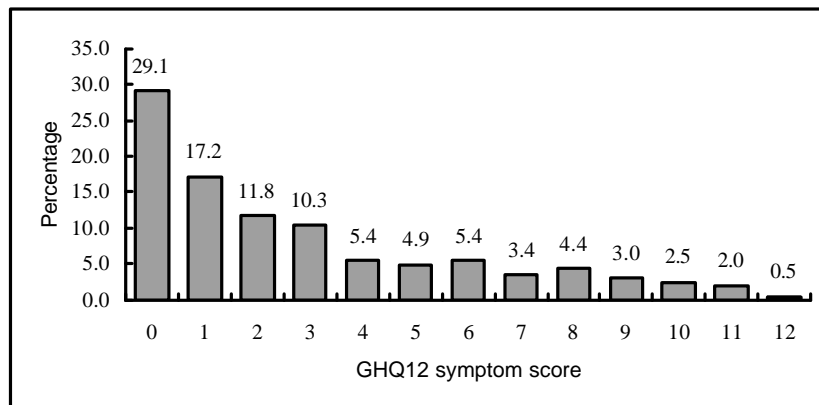
Parent mental health

Information about parents' perceptions of their mental health was gathered in Interview Two, using the 12-item General Health Questionnaire (Goldberg & Williams 1988). The General Health Questionnaire (GHQ) is a measure of current mental health. The self-report questionnaire is one of the principle tools used to measure non-psychotic mental illness in the community and in general practice. The scale asks whether the participant has experienced a particular symptom or behaviour recently. Each item is rated on a four-point scale (*less than usual, no more than usual, rather more than usual, or much more than usual*). When using the GHQ-12 it gives a total score of 36 or 12 based on the selected scoring methods.

Using the 1/2 cut-off point⁸, the results in Figure 2 suggest that among parents participating in Interview two, 109 (53.7%) of the parents were likely to have one or more mental disorders. This compares to the prevalence rate of 14% of adults in South Australia who have a mental health condition using the same cut-off score (Dal Grande et al. 1999). Caution needs to be taken when comparing the figures from these two studies, as the population groups are not directly comparable. The *Families at Risk* study looked specifically at parents with young children, while the latter was a sample representing the total South Australian population over 15 years.

⁸ The raw GHQ scores (i.e., individual item scores ranging from 0 to 3) are first recoded (0,1 = 0, 2,3 = 1). The GHQ12 symptom scores are the sum of the 12 recoded scores; they can thus range from 0 to 12. Using the cut-off point of 1/2 means that anyone with a symptom score between 2 and 12 is likely to have some mental disorder(s). If the 2/3 threshold is employed, the clinical scores lie between 3 and 12.

Figure 2: Distribution of GHQ12 Symptom Scores



When the threshold was raised to 2/3 (ie. anyone with a symptom score between 3 and 12 is likely to have some mental disorder(s)), the prevalence rate dropped to 42%, compared to 12% in the Andrews et al. study (1999). The symptom scores can also be recoded as 0,1 = low or no disturbance, 2,3 = mild to moderate disturbance, and 4 or higher = high or severe disturbance (Dal Grande et al. 1999, p. 56). When this classification method was applied to the current data, it emerged that 94 (46%) parents had no or low mental disturbances, 45 (22%) parents suffered from some kind of mild disturbance, and 64 (32%) parents had high or severe mental problems.

Parent Confidence and Satisfaction

In Interview One, participants were asked to assess their parenting skills, confidence and satisfaction⁹. Whilst the results indicate that these parents are a strong and positive resource for their children it is also likely that participants' self-assessments were influenced by contextual factors. Given strong societal pressure to be a 'good parent' and the threat of children being 'taken away' from 'bad parents', as well as the context of being interviewed by someone from the University who they were meeting for the first time, it is perhaps not surprising that generally, parents described themselves as skilled, confident and satisfied.

- 94% of parents described themselves as being "a good parent" all or most of the time.
- 85% assessed the statement "I've not much confidence as a parent" as completely false or mainly false. This result is consistent with a later, general question about parenting confidence in which 39% rated themselves as "very confident" and 46% as "confident" with the remaining 15% feeling "less confident" or "far less confident".
- Less than 6% of parents felt unable to work out "normal parenting problems" all or most of the time.
- 69% assessed the statement "Parenting duties are depressing" as completely false or mainly false. Another 13% (65) of parents said they felt "uncertain" whether this statement was true or false.
- 95% of parents felt confident or mostly confident to "teach their children new things", while 88% assessed the statement "I have knowledge to teach my kids" as completely true or mainly true.
- 67% of parents described the statement "I'm doing a good job of caring for my kids" as completely true and 30% as mainly true. Almost 3% (14)

⁹ Using the Parental Self-Report Inventory (Umberson 1992) plus a general question about their level of satisfaction with being a parent.

parents felt uncertain and 2 parents assessed the statement as mainly false.

Finally, in a general question asking participants to rate their satisfaction with being a parent/caregiver, 63% felt a “great deal of satisfaction”; 33% - “quite a bit”; 4% (18 parents) – “a little”; and 0.2% (1 parent) – “not at all”.

The findings from the present study should be considered in relation to the detail presented in Figure 1, which highlights the various pressures bearing on parents raising young children in environments of multiple disadvantage. One way of understanding the present findings is in relation to the psychological significance of being a successful parent in an environment of multiple and chronic disadvantage for one's esteem and self-worth.

Parent reports of Children's Health

In Interview One, participants responded to questions regarding whether their child had been diagnosed, or whether they had an ongoing concern about their child related to one of three health domains: physical, developmental or emotional/behavioural development. The frequency of parent reported problems or concerns are presented in Table 8.

Table 8: Have any of your children (0-7 yrs) been diagnosed with an ongoing physical, developmental or emotional/behavioural problem or have a problem you are concerned about?

	Physical	Developmental	Emotional/Behavioural
'No'	59% (294)	80% (402)	78% (388)
'Yes'	41% (206)	20% (98)	22% (112)
Total	500	500	500

From Table 8 it can be seen that 41% of parents report a diagnosed problem or concern regarding the physical health of their child (ren), 20% report a developmental concern and 22% a problem/concern regarding the emotional/behavioural health of their child(ren). More data was collected from participants in Interview Two using the authorised Australian version of the Parents' Evaluation of Developmental Status (PEDS) questionnaire¹⁰, a quick method of assessing the child's health and developmental status.

The questionnaire consists of a series of questions centred on 10 potential areas of concern:-

¹⁰ Developed by Frances Glascoe and tailored for Australia by Frank Oberklaid (Wright & Oberklaid, 2003). The instrument was originally developed as a tool for rapid screening in, for example, a doctor's surgery or a community health service. It endeavours to count the carer's “significant concerns” about the target child's health and developmental status – and then provides a simple decision tool for choosing appropriate care-paths depending on whether the number of significant concerns is =2, 1, or zero.

	Area of concern	Question
1	Global/Cognitive	Please list any concerns about your child's learning, development and behaviour.
2	Expressive Language and Articulation	Do you have any concerns about how your child talks and makes speech sounds?
3	Receptive Language	Do you have any concerns about how your child understands what you say?
4	Fine Motor	Do you have any concerns about how your child uses his or her hands and fingers to do things?
5	Gross Motor	Do you have any concerns about how your child uses his or her arms and legs?
6	Behaviour	Do you have any concerns about how your child behaves?
7	Social-emotional	Do you have any concerns about how your child gets along with others?
8	Self-help	Do you have any concerns about how your child is learning to do things for himself/herself?
9	School	Do you have any concerns about how your child is learning preschool or school skills?
10	Other	Please list any other concerns.

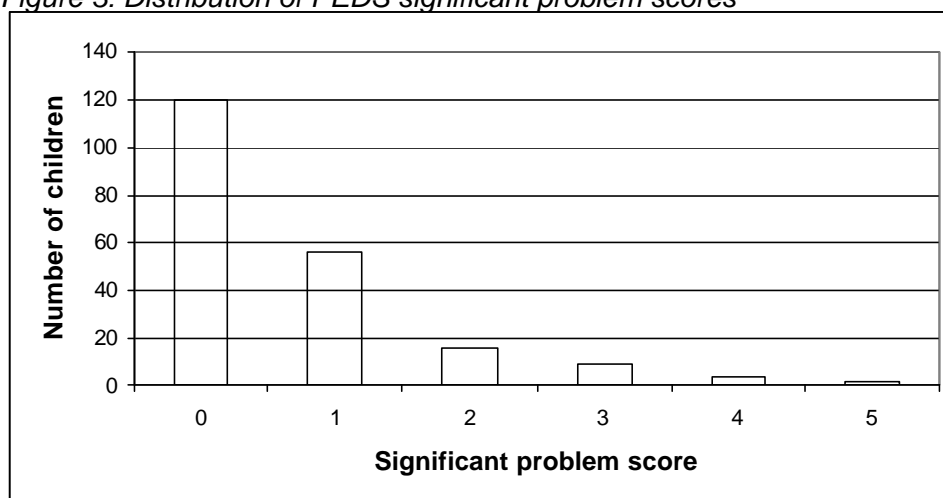
In response to each question, the participant was asked to circle one of: 'No', 'Yes', or 'A little'; with space for open-ended comments.

The instrument distinguishes between problems that, in a paediatrician's expert opinion are a 'significant' concern, given the age of the child, and those that are not (see table).

Age	Items considered to constitute a 'significant' concern
< 18 months	1,2,7,10
18 – 35 months	1,2,3,10
36 – 53 months	1,2,3,5,10
54 – 96 months	1,2,3,4,5,9,10

The distribution of significant problem scores is shown in Figure 3.

Figure 3: Distribution of PEDS significant problem scores



Only two other studies are available in Australian settings, one conducted in Melbourne and the other in Wodonga, Victoria (see Table 9). From the results it is apparent that while the families in this study reported substantially more significant problems than a similar study in Melbourne, they had only marginally more significant concerns for their children than the parents of children in Wodonga, Victoria (Armstrong & Goldfield 2004; Coghlan, Kiing & Wake 2003).

Table 9: Percentage of children with significant problems

Significant problems	Study site		
	Melbourne	Wodonga	Adelaide
0	72.1	62.3	58.3
1	18.7	24.1	27.2
=2	9.2	13.6	14.6

Relationship between Parent Reports of Children's Health and Parental Self-Efficacy¹¹

As could be reasonably expected, a high PEDs score was inversely related to self-efficacy: that is the higher the PEDs score, the lower the self-efficacy score. The total PEDs problem score added across all children within the family bore the strongest relationship with self-efficacy, reflecting the challenges of caring for multiple children and their health and well-being concerns.

An exploration of the relationship between parent self-efficacy and parent's age and weekly income generated the following observations:

- Self-efficacy appears to increase with age (0.11 – 0.12 per age-year) and this relationship is not confounded with variation in income or PEDs problems.
- Self-efficacy increases with income – and this trend becomes stronger when age and PEDs problems are taken into account.
- Self-efficacy decreases with increasing PEDs problems – and the decrease is 'sharper' when age and weekly income are taken into account.

These findings are significant given the young age at which individuals in the study sample became parents (almost half became parents before the age of 20) and the generally low income levels (three quarters of the sample population relied on government income support). However, the ability of these three variables to predict self-efficacy, while statistically significant is still modest. They can explain at best around 10.5% of all the variation in self-efficacy.

Spatial Distribution of Child Health Problems/Concerns

To facilitate the description of the spatial distribution of physical, developmental and behavioural problems across the 27 Census Collection Districts (CDs) sampled, prevalence rates for each problem type were mapped using location quotients (LQ)¹².

¹¹ In stage Two of the study the Generalized Self-efficacy Scale (10 items scored on a 1-4 scale) was administered with 186 participants. (Jerulsaem & Schwarzer 1992).

¹² Following a procedure outlined by LeClair, the location quotient "...measures the relative concentration of a particular phenomenon in a real unit with respect to the mean for the region as a whole" (2001:282).

Inspection of the LQ distributions highlighted a number of points.

- There are marked variations in prevalence rates in CDs across the northern, central and southern Metropolitan Adelaide geographic regions from which the study sample was drawn (see Appendices B and C).
- The widest variation occurred in relation to parent's perceptions and concerns regarding their children's emotional/behavioural problems. There was less variation in physical and developmental problems across CDs.
- Both the southern and northern geographic regions have a number of CDs with relatively high concentrations of diagnosed or identified problems for children, while such variation is not apparent in the central region.
- The central region contained CD's with the lowest location quotients across all domains.
- In both the southern and northern regions there were some CDs in which the prevalence rates for developmental and behavioural problems were higher than for physical problems.

Further analysis of the associations between child health problems/concerns and a range of socio-economic factors – receipt of a government pension/benefit, level of completed education, public housing tenancy, family mobility, marital status and financial well-being – revealed that low level of completed education and financial hardship are significantly linked with poor child health outcomes. More specifically:

- The higher the percentage of parents with less than nine years of completed education, the higher the percentage of families reporting problems/concerns for their children in the physical domain, and the higher the percentage of families with problems/concerns in at least one domain.
- The higher the percentage of families that “cannot make ends meet”, the higher the percentage of families with children reported as having developmental problems/concerns.
- Compared to families that can “make ends meet”, for families who cannot do so, the odds of having problems or concerns in physical, developmental, or at least one domain are almost double.
- The odds of reporting concerns in the emotional/behavioural domain are almost twice as high for sole parent families than for families with two parents.

Research in the Netherlands (Schneider et al. 2003) indicates that children's behavioural problems were associated with neighbourhood disadvantage over and above the effect of family socio-economic status. The evidence from the *Families at Risk* study does not fully support these findings in that the LQ analysis shows that variability amongst children's behavioural problems was least in the most significantly disadvantaged CDs. This would suggest that other factors are at work. The links found in this study between parental concerns regarding the health of their children and low level of completed education and financial hardship supports a socio-economic explanation for the uneven spatial distribution for emotional/behavioural problems¹³.

¹³ There is a wealth of research from Australia and other countries linking socio-economic disadvantage with childhood behaviour problems (Bor et al. 1997; McLoyd 1998; Leventhal & Brooks-Gunn 2000; Boyle & Lipman 2002; Schneiders et al. 2003; Rutter, 2003).

Another facet of this social determinants explanation relates to the possible uneven spatial distribution of services available for parents in the geographic areas studied. It may be that parents have greater access to general practitioners and medical specialists than to psychological services. It is also likely that there is variability in the distribution of services across regions.

In summary, the findings in this study resonate with Pickett & Pearl's observation that:

“The neighbourhoods in which people live may influence health, operating through such mechanisms as: the availability and accessibility of health services; infrastructure deprivation (lack of parks, stores selling healthy foods at affordable prices, etc); the prevalence of prevailing attitudes towards health and health related behaviours; and stress and a lack of social support” (2001, p. 111).

Parenting in Your Own Words

In addition to parent reports about their own and their children's health and wellbeing, we were interested in questions of what life is like for parents – how do parents talk about their experiences, challenges and their resources for parenting? What do the perspectives of parents, their own definitions of what parents and children need, add to concepts and evidence from psychology, medical, and social sciences? The qualitative data from Interview One and the doctoral research component of the project have been drawn together under the following headings:

- The rewards and challenges of parenting
- Expectations of my children's future
- Your resources for parenting?

This section adds to the picture provided by the quantitative data of the experiences and needs of parents with young children who live in situations of chronic and complex disadvantage. It highlights their commitment to achieve the best for their children and confirms the impact of social determinants on health and well-being outcomes for both parents and children. The qualitative data from the 500 interviews in Interview One have been drawn together from the short notes on the interview schedule made by the field researcher. Each participant responded to the following open-ended questions about their experiences of the rewards and challenges of parenting and about their resources for parenting. This relatively 'thin' qualitative data is supplemented by 'thicker' descriptions from the in-depth research conversations with mothers and service providers in the doctoral research component of the project.

Questions relating to *the rewards and challenges of parenting* were:

- What are the good things in an average week of your life as a parent or caregiver in this family?
- What are the more difficult things in an average week of your life as a parent or caregiver in this family?
- What are the everyday demands in an average week of your life as a parent or caregiver in this family?

The rewards and challenges of parenting

It appears from the data that the experiences of parents in at risk families are not different from the experiences of parents generally – their love of and commitment to their children, doing the work of caring for children, worries about children's health and development, challenges of managing children's behaviour, maintaining their personal health and well-being, and developing their own sense of identity and

purpose. The following sub-headings emerged from a content analysis of participants' responses to the open-ended interview questions.

“The joy and the responsibility of being a parent”

Many participants describe the expressions of love and seeing their children happy, healthy, growing and accomplishing things as rewarding and joyful. Spending time together with their children, enjoying each other and laughing and having fun, are highlighted by parents as 'good things' in their lives. Participants spoke of the pleasure and pride they feel in their children, the joy of waking up to them in the morning and of being a family together. The commitment of parents to their children and to wanting the best for them shines out from the experience of the interviews (commented on by the field researchers) and from the analyses of the qualitative data. One theme arising from the data is the anxiety and self-criticism participants report related to knowing what to do to best help their children, and being a “good mother”.

Another aspect of parent commitment and responsibility was expressed in the idea held by numerous participants that it is a mother's responsibility to look after her own children - *“...it's not anyone else's burden to look after my kids”*. For some participants in this study this belief underpins their low level use of formal childcare services and contributes to their need (sometimes desperate) for 'time out' from caring for their children. Getting enough sleep and having enough time to be able to meet their children's and family's needs are challenges for many participants.

“The hard work of caring for children”

Participants describe one of their main challenges as the hard and constant demands of housework and parenting work. Cleaning, cooking, washing, shopping, worrying about and paying the bills, home maintenance, getting kids organised, establishing and maintaining routines and meeting children's multiple needs (physical, material, emotional, developmental, entertainment) are the tasks most commonly listed by participants as demanding. This work is particularly demanding for the many that parent alone. Whilst this work is described by some participants as routine and never-ending, some also talked about meeting the challenges of constant change –

“Everyone's going to have issues that come and go - all different issues. Things are so up and down all the time. Lots of things one day, and the next day it could be something else...”

Full-time care for children is exhausting and at times overwhelming but many participants, particularly those without partners or family support, report they struggle to find alternative sources of care. Whilst the benefits of childcare for children and parents are recognised, some participants point to the challenges of finding appropriate childcare. That is, childcare with which the mother feels comfortable and that is liked by the child, easy to access, flexible and affordable. The benefits of time out from caring for their children experienced by participants include: catching up on sleep; the opportunity to calm down and deal with frustration; getting some time for self-care; time to talk with other adults; getting out of the house; and the opportunity to connect with community groups, services and programs.

“Access to basic resources for living”

Participants stress the need for financial resources to feed, clothe and entertain children and pay the household bills. Many participating families report their financial resources as enough for basic needs but insufficient for unexpected or difficult times such as moving house, purchasing furniture or white goods, or for children's entertainment, sport or recreation. Appropriate, safe and secure housing is

fundamental but difficult to find, especially in some geographic areas and for some participants, particularly young mothers. Transport to enable access to resources and services for both parents and children is another basic need. In some geographic areas general medical practices that bulk-bill are scarce, limiting access for some to basic medical care. Participants need and value practical help with the housework, providing meals, transport and other work of caring for children. This assistance is particularly important for sole parents, young parents and working mothers and at difficult times or life transitions, for example when a baby is newborn or when the parent is ill.

Participants express concern about the likely detrimental effects for their young children of unsafe neighbourhood environments, a lack of community resources and local 'opportunity structures' as well as barriers to accessing services.

“Communicating with children and managing their behaviour”

The primary concerns of participants relate to the emotional and behavioural health and well-being of their children. Managing children's behaviour is the aspect of parenting most frequently talked about. The joy when children do as they're told, help out at home and get on well with their siblings is well known to parents. More often however, participants talk about “discipline” - the challenges of managing their children's bad behaviour. Issues commonly raised include:

- How to discipline without smacking and without yelling? How to remain calm and patient?
- The intense frustration of telling a child over and over again to do something and not being listened to.
- The challenge to control children rather than be controlled by them (stories about children's shopping centre tantrums and poorly disciplined children they know were frequently told).
- The desire to build open and honest communication so that your children will tell you “anything” was frequently mentioned by mothers (especially those who had experienced abuse as children).
- What is it realistic to expect and how best to support a 'challenged' child (for example, children who have a disability, developmental delay or who have been subjected to abuse)? For example, distinguishing between 'bad' behaviour that might be part of the disability or the effects of abuse and “simply bad behaviour”.
- The challenge and anxiety related to keeping school-age children “on the straight and narrow” (truancy, window smashing, theft).

“Joy and worry about children's health and development”

The joy participants feel at seeing their children happy, healthy, growing and accomplishing things has already been highlighted. On the flip-side participants talk about the challenges of getting used to the demands of a new baby (especially when the baby is ill or premature), their worry when their children are ill and that they sometimes feel anxious about their children's development (including, speech development, crawling and walking at appropriate ages) and behaviour. Some participants point to the demands of getting children ready for school each day and the challenges of managing school issues when they arise (see *Schools as a source of Support*).

“My own health and well-being”

For some participants, one of the main challenges of parenting relates to their personal health and well-being. A 'shadow-side' of their commitment to their children is that their own needs generally come after their children's and those of other family

members. They point to the negative influences on health and well-being of insufficient sleep / rest, lack of time for self, continuing worry and stress, caring for other family members as well as children, family conflict, violence and abuse, as well as the detrimental effects of social isolation and lack of support and appreciation. Some participants point to the positive effects for women of developing an identity and purpose in addition to that of 'mother', for example through participation in paid work, study or community groups.

“The effects of family history”

The effects of a parent's own history are reflected in outcomes for children. One example is the relationship between the age at which the participant left school and their children's attitudes to school. The greater the number of years educated, the more likely the parents interviewed reported their child as 'loving school'. Twenty-five per cent of participants who left school aged 12-14 report their children as 'loving school', compared with around 40% of those who left at 15-17 years, and 90% of those whose school leaving age was 18-19 years. Participants express their general concern about the effects on their children of current and past stressful environments, life events and experiences.

From the in-depth research conversations with mothers and their service providers that were part of the doctoral research component of the study, the influence of family background and upbringing on personal resources for parenting emerges as a key theme. Some mothers describe their upbringing as education about how not to parent and others identify their “shit background” (including poverty, abuse and estrangement from their parents) as motivating them to parent differently but also as making it harder to cope with life as a parent. Having had a positive experience of family life with your own parents is perceived by service providers and mothers alike as key to learning positive values about care and love for children, knowing about the basic needs of children and how to go about parenting.

“Quite often your background and your childhood just puts the lid on your wonderful ability to create and be out there and feel good and positive about what you do...” (M, parent support worker).

Having had the experience in childhood of caring for younger siblings is viewed as positive.

“If people who are parents for the first time haven't had previous experience with looking after their young brothers and sisters or other peoples' kids sometimes they do need help but they don't know where to look for it.” (R, mother of two children under 4 with disabilities).

Expectations of my children's future

In Interview Two, parents were asked about how they saw their children's future, both in positive and negative terms. When questioned about positive expectations less than 2% of responses were “can't see a positive future”. Most commonly, parents expressed non-specific positive hopes for their children's futures (eg. wanting the best for them, wanting to see them healthy, happy and successful). When mentioned, specific positives related to good upbringing and their children's personal strengths and “moral standards”; the availability of educational and new employment opportunities (eg. technology); positive social relationships (eg. friends, family, sport); and safe, positive community environments.

When questioned about negative expectations of their children's future, the most common response was “can't see any negatives” (approximately 20% of total responses). Following this, the concerns most commonly expressed were related to

drugs, alcohol and crime; their children's challenging behaviours; the negative effects of family conflict/break-up, violence and abuse, and partner/child's father involvement in crime/drugs; and the lack of safety and stability in their local environment and in the world more generally. Other concerns related to the lack of employment opportunities; their children's poor health/disability; early school leaving/poor educational achievement; racism; and poverty/financial insecurity.

Given the contexts of multiple disadvantage in which these parents and children live, the fact that participants, for the most part, readily expressed hope for their children's future can be seen as testament to their commitment and personal strength as parents.

Your resources for parenting?

Other open-ended questions in Interview One related to participants' experiences of help with the tasks of parenting, their strategies for coping and perceived gaps in sources of help and support included:

- What helps you most now in your task as a parent of young children?
- What do you do that helps you to cope when things get a bit much?
- What would help you most as a parent of young children, that you do not presently have, or have enough of?

Themes drawn from this data and from the doctoral research conversations again reflect the interplay of parent commitment and agency with their political, social, economic, cultural and environmental contexts of opportunity and constraint.

“My own personal skills and qualities”

The joy of being a parent – feeling your children's love and being able to enjoy, nurture, educate and comfort them – is perceived by participants as a great resource for parenting. Participants identify the skills of household management as helpful and in particular, managing time well, being able to keep track of things and organising stimulating activities for the kids.

Participants point to the value of their own willingness to give priority to their children's needs ahead of their own – “*my kids come first...*”, along with the personal qualities of “thinking positive”, persistence, “will power”, self-reliance, patience, having a “realistic” view of a positive future and determination to get through the difficult times. In the in-depth conversations with mothers and their service providers, the social isolation that results from the tendency for mothers to be invisible (“*...just like a piece of the furniture in children's lives.*”) and the social undervaluing of the important role of mothers are highlighted. Participants spoke about the ways that feeling recognized and appreciated helps them fulfil the tasks of parenting young children.

Other personal qualities participants name as important resources for parenting are: being able to recognise your own strengths, knowing what you want, being self-confident or having high self-esteem. Related to these is being able to stand-up to criticism and judgement about your children and your parenting from others and from yourself (‘self-blame’) “*...being strong in your own mind and not allowing others to control or manipulate me...*” (K, mother of 6 young children).

“Being there” for your children, knowing what to do to help them, being consistent in your approach (especially to managing children's behaviour) and being able to solve problems as they arise are seen by participants as helpful “*...identify the main*

problem and sort it and other little problems linked to it will sort themselves." (R, mother of two young children). It also helps if you are self-aware (*"I recognise when I'm getting to boiling point and take time out by locking myself in the toilet."*), open to developing your skills and prepared to seek help.

The in-depth research conversations reveal the helpfulness parents find in being able to recognise that there are choices you can make, making a choice/decision and being active and focused in its implementation. In light of the context of multiple social, material and environmental disadvantages and the previous observation that mothers' needs come after everyone else's, the mothers talk about the significant barriers they face in making choices that "are best for me" and in being prepared to ask for help when needed because of the "secrecy" and "shame" of having problems.

"Having time out"

The helpfulness for participants having time out or time off stood out from the analysis of the data. Time off when the children are at school or asleep in bed, time out from the routine tasks of caring for children, time out for parents and children to calm down and to manage anger and frustration, time for self-care, time to get things done and time to get involved in community or school activities. For participants who have no family support or who parent in particularly difficult circumstances (such as insecure housing, domestic violence, children with disabilities) it can be *"...day in, day out, every minute with the kids."*

"Practical help and supportive relationships"

The valued sources of help for participants that come from their love and commitment for their children and from the children themselves have already been described. *"My kids keep my mind strong, keep my head above water..."*(K, mother of 6 young children). The most frequently identified source of help with the tasks of parenting young children are the practical support and advice given by a husband, partner or boyfriend, the parent's mother and other family and friends. Analysis from the in-depth research conversations with mothers and service providers sheds light on different aspects of this support.

Most mothers emphasise the value of talking and listening to other women and parents, knowing that there are others with similar problems and so feeling less alone with the problem and less to blame – *"If the same thing is happening for them it can't be just me, just my fault..."*. It is helpful to have another adult to talk to (some mothers talked about being at home all day with only the company of babies and young children) and particularly to be listened to without judgement. Some point to the helpfulness of reciprocal friendship as in shared outings, minding each other's children and in sharing experiences – *"What would you do in this situation?we help each other..."* For some, being part of a community group – sport, adult education, volunteering, church, social, women's/parent's support – results in feeling more visible, recognised as a person with strengths – *"...not just a mother, daughter, sister..."*.

"The effects of family conflict, violence and abuse"

Whilst many mothers of the parents participating in the research provide regular childcare for their grandchildren and advice regarding parenting, the usefulness of this support may be compromised by conflict between mother and parent. Some participants talk about feeling criticised and undermined by their mothers, while at the same time appreciating their support with childcare. Some participants receive no support from their parents due to situations of mental illness, physical illness, violence, abuse, geographical distance and/or family breakdown.

“Access to helpful services and community resources”

In Interview One, study participants identify community services as a valued source of help. Various aspects related to the role of services in helping with the tasks of parenting young children have been addressed above. The following list is a summary, from the perspective of parent participants, of what and how services can help:

- provide information about what services and resources are out there for parents of young children
- access to someone to talk over problems with
- a service provider who is “there for me”, willing to “walk alongside” me to facilitate/advocate access to services and support
- a service provider who has children and been through many of the same things
- having my strengths recognised
- being listened to without judgement
- practical help and support with a new baby and young children (before kindy/school age)
- access to childcare in a variety of forms
- access to housing, medical care, financial support for unexpected needs
- a ‘woman-centred’ service response – that is, focus on what is most important in my life at the time. This means being able to respond flexibly to the many interwoven issues and demands in my life.

Highlights: Parent reports of their own and their children's health and well-being

The proportion of participants rating their general health status as 'very good' or 'good' is 40%, less than the South Australian population (50%). A lesser proportion rated their health at the extremes of either 'excellent' or 'poor' compared with the SA population.

Compared with a random sample study of psychological distress in the South Australian population study participants reported three times the frequency or more of the occurrence of stressful life events.

The most frequently occurring stressful life events were; another child being born into the family, being on social welfare, parents unemployed, greater financial worries and discipline problems with children.

Using the GHQ as a measure of current mental health, approx. 53% of study participants were likely to have one or more mental disorders [sample population of South Australians over 15 years – 14%].

Participants made very positive assessments of their parenting skills, confidence and satisfaction.

41% of participants reported having a diagnosed or ongoing physical

problem or concern about their children's health; 20% a developmental problem or concern; and 22% an emotional or behavioural problem or concern.

Using a different tool 27% of participants reported one significant area of concern regarding their children's learning, development or behaviour and 15% two or more significant concerns.

Parent 'confidence': decreases with increasing number of child health and well-being concerns; increases with parent's age; and increases with weekly income.

Low level of completed education and financial hardship are significantly linked with poor child health outcomes.

Reports of emotional/behavioural concerns are almost twice as high for sole parent families than for families with two parents.

There are marked variations in prevalence rates of child health and well-being concerns in Collection Districts across the Metropolitan Adelaide geographic regions from which the study sample was drawn.

Highlights: Parenting in Your Own Words

The rewards and challenges of parenting

- expressions of love, seeing your children happy, healthy and growing
- commitment to your children and to wanting the best for them
- social pressure to be a 'good' parent/mother
- The hard work and constant demands of caring for children
- The challenges of finding appropriate childcare
- adequate financial support, safe and secure housing, transport
- access to services and community resources
- effects of unsafe, unhealthy neighbourhood environments on children
- Communicating with children and managing their behaviour and special needs
- Worry about children's health and development
- own needs generally come last
- negative effects of insufficient sleep, lack of time for self, continuing stress, violence and abuse, social isolation and lack of support and appreciation
- positive effects of developing an identity and purpose in addition to that of 'mother'
- detrimental effects of social isolation and lack of support and appreciation
- The effects of family history reflected in outcomes for children
- having had a positive experience

Resources for parenting

- the joy derived from children is a great resource for parenting
- being prepared to give priority to children's needs ahead of your own
- skills- household management, problem solving
- personal qualities - thinking positive, will power, self-reliance, patience, determination, self-confidence
- being able to stand-up to criticism and judgement about your children and your parenting from self and others
- Benefits of having time out from the routine tasks of caring for children
- Getting involved in community/school activities
- Practical help and supportive relationships most frequently received by family friends
- Value in feeling recognised and appreciated by others, being listened to without judgement
- Community services identified as a valued source of help. Useful services include access to childcare in a variety of forms, housing, medical care, financial support and someone to "walk alongside" me to facilitate access to services and support

Fathers

There is a significant but limited amount of Australian research available regarding the role of fathers in early childhood development. Changing cultural definitions and expectations regarding the role the father plays in raising his children have been the main focus of existing research. The needs, in particular the service needs of fathers, have not received as much attention. In fact, a review of the literature shows that there has been a conspicuous lack of research into the service needs of fathers.

Among the 500 parents who participated in Interview One, there were 41 (8%) fathers (including one grandfather). Their ages ranged from 21 to 46 years (none of them were teenagers i.e., younger than 20 years as defined for this project). The majority (30) were born in Australia, only four fathers were of Aboriginal descent. Twenty fathers were living in one-adult households and 15 fathers were either married or had a partner. On average, they had two children in their households, although not necessarily full time or their own.

Most of the fathers (73%) had no more than 11 grades of completed education. Forty-one per cent of them claimed to live on an annual family income of \$20,000 or less, and for almost three quarters (30) of them, the main source of income was some kind of government monetary assistance. Twenty-one fathers (51%) lived in South Australian Housing Trust accommodation, while only eight (20%) reported that they owned or are paying off their dwelling.

Fourteen fathers were interviewed in Stage Two regarding several aspects of their life such as life control, degree of choice in deciding where to live, coping, support and use of services. Among the group, money was the most frequently mentioned factor that would give them more control over their life. For five fathers, there was nothing they could think of that would give them more control of their life. Eight out of 14 fathers had a large degree of choice when deciding on a place to live. The remaining six fathers, in contrast, felt they had very little or no say in the matter.

The fathers were questioned on how they coped when things get too much. Most fathers tried to get time out or relax (e.g., I go and have time out on my own; I try to catch up on sleep when I can; put the kids in their room by themselves and give me some time by myself), and/or get support from others (e.g., I'd go and see my family, or my support person; I ask for my partner's help; I sort of try and control things myself; If I find I can't, I go to a few mates and seek their advice). A number of fathers reached for a cigarette, a drink, or food. On the other hand, no father admitted to yelling or screaming when under too much pressure as a parent.

Table 10: What Fathers do when things get too much

Category	Number of responses
relaxation/time out	12
get support from family/other people	12
diversion(s)	7
eat/drink/smoke/drugs	10
cry/yell/scream	0
keep calm/positive/pray	2
nothing/not much	5
doesn't happen	5
don't know/not sure	0

Note - Multiple responses per parent were possible.

Fathers indicated that they needed a variety of services. No particular service was needed more than another, although 'child/family/day-care' was mentioned most often; however, the number of participants was small and these results should only be considered to be indicative.

As shown in Table 11 most fathers indicated that they would prefer that services are delivered away from the home.

Table 11: Fathers' Preferred Mode(s) of Service Delivery

Mode of service delivery	Number of responses
away from home	7
home visit	1
mixture (e.g., either phone or home visit)	3

Note - Multiple responses per parent were possible.

Most fathers indicated (Table 12) that they find out about services through other agencies and the phone book.

Table 12: Fathers' Ways of Finding Out About Services

Source	Number of responses
advertisement	1
agencies	7
luck	1
pamphlets	1
phone book	6
word of mouth	4

Note - Multiple responses per parent were possible.

When questioned on their perceived level of support as a parent, 54% of fathers perceived they had 'no-one' or 'one or two' people to call upon for support, compared to 31% of mothers. While fathers perceive poverty to be a factor in their family's life, they were found to access services differently, conveying a greater sense of self-reliance and isolation. The findings from this study suggest that the service needs of fathers require a good deal more research to unravel some of the complexity and provide reliable information on which to base policy responses.

Teenage Parents

Most of the parents (458 out of 500) who participated in the study were women. Of these 458, 28 were teenagers (i.e. defined as 19 years or younger in this project), with the youngest mother being only 16 years old at the time of Interview One. Ten mothers were only 17 when they became parents for the first time.

Eighty-six percent of the teenage mothers were Australia-born, and 18% were of Aboriginal origin. Most teenage mothers in the sample were living in a two-parent family (defined here as a family where the mother/parent reported having a spouse, live-in partner, or live-in boyfriend).

On average, the teenage mothers lived in a household with approximately one child and only three had completed Year 12 or Matriculation. Forty-six percent claimed to not know their family annual gross income, while 29% reported an estimated annual income up to \$20,000. This is not surprising, because for 71% of the mothers (one mother did not provide this information), the main source of income was some form of government assistance. Most of the teenage parents did not have access to a car. Furthermore, 13 mothers and their families (46%) rented from the South Australian Housing Trust, and only one mother reported to own her house.

In the last 12 months, the majority of teenage parents turned to their family for assistance with childcare or babysitting. Partners and ex-partners were also popular choices for support with childcare.

Aboriginal Parents

The study participants overall illustrate a demographic profile that presents challenges to positive child outcomes, such as early school leaving, low income, high unemployment, teenage parents, high fertility and high mobility. However, both Aboriginal and non-Aboriginal parents of Aboriginal children registered even higher rates of these challenges.

Families with Aboriginal children comprised 11% of the study participants (13% when households with both Aboriginal and non-Aboriginal children in the same family were included). There was a higher prevalence of teenage parenthood amongst Aboriginal parents, with 72% of Aboriginal parents reporting having their first child as teenagers. This compares to the overall rate of teenage parenthood in the study of 47%. Over half (55%) of Aboriginal families were sole parents (compared to 48% for all participants). Nationally, in 2001, 22% of all families with children under 15 were sole parent families (ABS 2002).

Aboriginal households in the study had more children and higher child to adult ratios than the total study population, with an average of 2.65 children per household, and a child to adult ratio of 1.25. There was a small but statistically significant result for how much support parents felt they had. The proportion of Aboriginal parents who felt that 'many' people were there to support them as a parent was 49% (slightly higher than the total study population response of 37%). This perhaps is a reflection on the higher number of adults in the households of Aboriginal parents interviewed.

Parents with Aboriginal children had lower school attainment rates. Education levels among Aboriginal parents were particularly low, with only one Aboriginal parent reporting to have completed year 12 or higher. The average number of times Aboriginal parents in the study moved house was 4.8 over the last five years. Both Aboriginal parents and non-Aboriginal parents with Aboriginal children reported even fewer years in the area, with 52% of Aboriginal parents, and 64% of non-Aboriginal

parents with Aboriginal children being in the area for only 2 years or less (compared to 49% for the total study population).

As discussed in the *Parent's reports of Children's Health* section, parents were asked about their children's physical, developmental and emotional / behavioural development. Differences regarding the responses from Aboriginal parents compared to non-Aboriginal parents were not significant. Almost all parents (Aboriginal and non-Aboriginal) sought help or advice regarding their children's physical health, development and emotional / behavioural well-being. There were no statistically significant differences in relation to physical health concerns of child development problems. For child behavioural and emotional problems 30% of Aboriginal parents reported a problem or concern, compared to 22% for all parents participating in the study.

Aboriginal use of community support as a source of help for child physical, developmental and behavioural and emotional problems was lower than the average for the whole study population, with 36% using this form of help compared to 48%. Formal health service use however was high, with all Aboriginal parents participating in the study reporting to have accessed these services, compared to 96% of the total study population. Aboriginal parents reported a slightly higher sense of general safety and support within their neighbourhoods than the total study population.

Overall, a higher rate of 'at risk' factors such as teenage pregnancy, lower school completion rates and higher mobility were evident among Aboriginal families. The study findings indicated that Aboriginal participants rarely involved themselves in the informal community (beyond family) for help or advice regarding their children.

Support and Service Use

Parents' access to and use of services, as well as sources of informal support and help with the care of young children, were key themes of the *Families at Risk* study. Questions that informed the study design at the outset included:

- *Are there families living in situations of multiple disadvantage who are not using existing support services?*
- *What are the barriers to their access?*
- *In their similar contexts of multiple disadvantage, why are some families 'high' service users and others 'low' (or no) users of services?*
- *What level and types of social or informal support are available to parents living in situations of multiple disadvantage?*

To explore these questions participants were asked a range of general and specific questions in both interviews about sources of support and help with parenting. Data was collected about help-seeking in relation to different aspects of the care of children at three 'levels':

- an *informal level*, involving partners, ex-partners, close family members, friends and neighbours
- a *community level*, through for example, childcare, kindergarten and schools and community-based services for example, Child and Youth Health, community health, welfare and housing services
- a *formal/professional level* for example, doctors, hospitals and specialists.

In Interview One, following parental reports of child health problems/concerns, participants were asked a general question - "*Overall, if you were to seek help with your child(ren), what kind of help would you say you use most of all and why?*" The response to these questions highlighted that many used family sources for help with their children.

Table 13: Help-seeking related to Child Health Problems / Concerns

Source	%
Don't use any	0.6%
Family	61.3%
Friends	11.7%
Neighbours	1.4%
Medical services	16.0%
Community services	6.1%
Social services	0.8%
Other	2.0%

Note - Number of responses was 489

Informal support

When specifically asked about their informal sources of help with their child(ren)'s physical, developmental and emotional or behavioural problems/concerns in the past 12 months, participants clearly indicated their reliance on family, primarily mothers and siblings. Participants reported much less reliance on more distant family and friends for help and advice regarding concerns about their children, and minimal use of neighbours or acquaintances.

Table 14 below indicates the importance of family and partners as sources of financial help.

Table 14: Sources of Financial Help utilised in the last 12 Months

Source	Number	%
Family/partner/ex-partner	185	41.3
Friend/neighbour/acquaintance	33	7.4
Government/welfare/financial counsellor	90	20.1
Church/charity	111	24.8
Financial institution	7	1.6
Pawn shop	8	1.8
Other	14	3.1

Note - number of responses was 448

It is likely that the extent of participants' reliance on family, welfare, church and charity organisations for financial assistance reflects the reliance of the study population on government income support payments (74% of the sample), that 90% of participants had no participation in paid work, and that 70.8% of participants assessed their household income as *just enough* or *not enough* to live on (see *Employment and Income*).

In Interview Two participants were asked about other sources of help with parenting and daily living, specifically in relation to the domains listed below.

Source of support/help	Domain ¹⁴
Parent's mother	Childcare/babysitting (IA)
Parent's father	Shopping (IA)
Parent's partner	Cooking/cleaning (IA)
Parent's child(ren)	Gardening/home maintenance (IA)
Parent's brother(s)/sister(s)	Transport (IA)
Aunty(s)/Uncle(s)	Advice on parenting (A)
Other relative(s)	Shoulder to lean on/emotional support (EC)
Non-custodial parent	
Friends	
Neighbours	

Participants relied primarily on their partner, family (particularly their mother) and friends in all domains whilst the non-custodial parent, neighbours, the parent's father, children, aunty(s)/uncle(s) and other relatives were little relied on for any type of help or support. Table 15 illustrates the most frequently relied upon sources of support and domains (using an arbitrary cut-off point of 25% of participants).

¹⁴ The 7 domains of support were classified using House's scheme: (1981, as reported in Bowling, 1997:90) *emotional concern* (EC=liking,love); *instrumental aid* (IA=services); and *appraisal* (A=information for self-evaluation).

Table 15: Sources and domains of support upon which at least 25% of participants rely

Support	Domain	%
Partner:		
• helping with gardening, home maintenance	IA	44.4
• providing emotional support	EC	40.0
• babysitting, caring for children	IA	37.1
• doing shopping	IA	30.2
• doing cooking, cleaning	IA	29.3
• providing transport	IA	27.3
Parent's mother:		
• babysitting, caring for children	IA	43.4
• giving advice on parenting	A	41.50
• providing emotional support	EC	38.0
Friends:		
• providing emotional support	EC	42.9
• giving advice on parenting	A	42.0
• babysitting, caring for children	IA	37.1
Parent's brother(s)/sister(s):		
• Babysitting, caring for children	IA	29.3

Note - Number of responses was 205

The extent to which partners are relied on for instrumental aid and emotional support, but were not relied on as a major source of advice about parenting is interesting to note (less than 25% of participants indicated they rely on their partners for advice about parenting). Parents with and without partners rely on their mothers, siblings and friends for babysitting/childcare, advice on parenting and emotional support, but not as much for other forms of instrumental aid. As indicated in the *Parenting in Your Own Words* section of this report, support from a parent's mother may be compromised by family conflict and in particular, conflict between mother and daughter. Some parents talked about feeling criticised and undermined by their mothers and at the same time appreciating their support with childcare.

Further analysis revealed that parent's age was inversely related to relying on instrumental aid and parenting advice from others, the older the parent, the less they counted on others for these types of support. On the other hand, no relationship between parent's age and emotional support was evident. A relationship regarding satisfaction with the parenting role was apparent, with the less satisfied parents relying on others less for parenting advice.

Childcare services

In Interview One participants were asked about all sources of support and help with childcare/babysitting in the past 12 months Table 16 below indicates their reliance on family and friends compared with their use of community-based childcare services.

Table 16: Sources of childcare/babysitting utilised in the past 12 months

Source	Number	%
Family	509	53.0
(ex) Partner	168	17.5
Friend	104	10.8
Child care centre	83	8.6
Family day care	29	3.0
Neighbour	23	2.4
Out of school hours care	14	1.5
Acquaintance	11	1.1
Kindergarten	10	1.0
Other	3	0.3
Respite care	3	0.3
FAYS	2	0.2
Playgroup	2	0.2

Note - Number of responses was 961

Use of Formal Services for help with child problems/concerns

General medical practitioners were the most used formal source of help for physical (462), developmental (75) and behavioural/emotional (59) problems with children.

Hospitals were the second most frequently used service regarding 'physical' concerns (238), followed by Child and Youth Health (CYH) nurses (77), medical specialists (66), the Parent Help Line (42), allied health professionals (32) and community health centres (14). After general medical practitioners, allied health professionals were the second most used service for 'developmental' concerns (43), followed by medical specialists (41), CYH nurses (40), and hospitals (24).

Regarding 'behavioural' concerns, CYH nurses and medical specialists were the second most used services (25 each) after general medical practitioners, followed by allied health professionals (24), and the Child and Adolescent Mental Health Service (CAMHS) (15).

Some observations about help-seeking

It was hypothesised that the inter-relationships between levels of help sought may offer insights into how families can best be supported. Not surprisingly, the strongest predictor of high formal service use was found to be the recognition of a problem - that is, having a concern. Further analysis of the findings indicates that high formal service use is very strongly linked with high use of both informal and community support. This appears to contradict the idea that parents with strong connections to family and community might need, or make use of, fewer services or that parents who rely on services do so because they lack family or community support. Rather, 'help-users' seek help and support from informal, community and formal sources giving weight to the suggestion that help-seeking is an individual capability. In the context of evidence of the barriers to people living in situations of multiple disadvantage accessing help and support and evidence that low-income parents are less likely to believe in or seek out help (see for example Keller & McDade 2000), it seems likely that 'help-seeking' needs to be learned and supported.

Teenage mothers were found to be higher formal service users for sickness and injury, but lower users for developmental, emotional/ behavioural problems or concerns. A weak association was found between low confidence and low satisfaction with parenting and higher formal service use.

Services working together

In the lives and living environments of the participants in the *Families at Risk* study there are multiple and interwoven issues (including social, economic and neighbourhood inequalities, family instability, young maternal age, sole parenthood) that are widely known to place both adults and children at risk of poor health, well-being and personal development outcomes. From the perspective of human service systems, these families are likely to need or use multiple services and recent research through the 'Clients in Common' project has confirmed that multiple service use is concentrated in disadvantaged areas of Adelaide (Department of Health, Department for Families and Communities & GISCA 2005).

In the *Families at Risk* study, the more areas of concern that a participant had regarding their child(ren)'s health, the more likely they were to have experienced multiple service use. That is:

- 15% of participants reporting 'no concerns'
- 20% of participants reporting one area of concern
- 30% of participants reporting two areas of concern
- 47% of participants reporting three areas of concern
- 75% of participants reporting severe or multiple concerns

had used more than one service at a time for their child(ren).

In Interview Two, the following questions were asked¹⁵:

- *Have you ever had to use more than one service at the same time for any of your children?*
- *What were some of the things that you found worked well?*
- *What were the most common problems you found with services not working well together?*
- *What suggestions do you have for how services could work better together with you, to help you and your family?*

Forty-one (20%) of the 202 participants answered 'yes' to having experienced using multiple services. Of these, 25 (61%) reported that the services worked well together; 9 participants (22%) reported that the services did not work well together; and 7 (17%) said services worked well together in one way but not well in another way.

Participants identified the following issues as key to whether or not services work well together for them and their children.

- **Communication and information** – consistency in diagnosis, treatment approach and information/advice to parents; effective and appropriate communication and referral processes between services.
- **Respectful relationships** – listening well to parent; not judging, blaming or 'looking down' on parent; services/service providers being supportive of each other; continuity of service provider to aid the development of trust.
- **Access to services** – information about what services are available; appointments being available locally, without long delays or gaps between them; opening hours that enable access; eligibility criteria that do not exclude children from getting help; timely follow-up.
- **Quality service/treatment response** – assessment and treatment/service responses that achieve optimal outcomes for the child; enabling/educating the parent to best support the child's needs; recognising and responding to the urgency of safety issues.

¹⁵ These questions were requested by the Manager, Northwest Children and Families Integration Project, Women's and Children's Hospital.

As part of the interview process, parents made suggestions for service improvement. These included listening more to the parents; improving the access to services (eg. through the provision of more staff and services, shorter waiting lists and less strict eligibility criteria); better network systems between the services; and more information and advertising on the type of services available.

Schools as a source of support

Whilst most participants report that their kindergarten and primary school age children 'love school' (nearly two-thirds of participants report that their children like or love school/kindy/childcare); less than 5% reported an unequivocal 'no', they don't like school. The fact that many parents saw school as a positive experience in their young children's lives highlights them as potential settings for a community based, non-threatening means to service provision for these families at risk. When questioned on how school services differ from other services for parents and families, the most common responses were that they were educational (20% of responses) and that they know the child/family and are part of the community (15%).

What are helpful services for women with young children?

Components of effective service networking highlighted in the interviews with parents are confirmed and extended by data from the doctoral research component of the *Families at Risk* project. A helpful service relationship, according to both parents and service providers, can be summarised as comprising three main elements:

1. the way a service views women;
2. the ways in which 'problems' are understood;
3. the relationship between the service/service provider and the woman and children.

Using these headings, the perspectives of women and service providers on 'helpful' services are outlined below.

The ways women are viewed

Helpful services recognise the capabilities of women and their important role in the support of and caring for their families. *"I really respect and acknowledge the huge input that they've had with their children before they even come here"* (K, childcare support worker). They also understand that there are many constraints within legal, social, economic and family structures that operate against women living their lives in chosen ways.

Within this context, unequal power relations between women and men, the inequitable distribution of parenting and family support responsibilities often carried by women and the expectation that women's needs will always come last (after children, men and family) are experienced as major difficulties.

Others referred to the effects of the dominant expectation that they take sole responsibility for care of their children:

"I've got a lot of friends but I don't really like asking them to look after my kids though. I just don't really think it's their burden to look after my kids. I suppose that's the way a lot of people feel. I don't want someone else to look after my kids 'cos then I feel like a bad mother." (N, mother of five children under 11 years of age)

"My in-laws work and I don't have family here but I don't like asking friends to take my kids because I can't cope...accessing some respite can be very very challenging." (K, mother of two early primary school age children)

Service providers in what the participants deem to be 'helpful services' recognise and value the many ways in which women act to support and protect their children in the face of the numerous constraints they encounter, rather than focussing on their individual 'failures' as mothers. M, a parenting support worker explains:

"We expect families in a most vulnerable time, and their most poorest time, after you've had a baby is the poorest time in your life. We expect people to do everything with things they don't have, that we have, and we couldn't do things without".

Moreover helpful services regard mothers as individuals, with many complex and interrelated facets to their identity, rather than "just a piece of furniture" in their children's lives. J, a mother of two adult children and a new-born, speaks of her recent participation in further education:

"There have been times in my life when I've thought I'm invisible... I'm a person down there [adult education centre]. Not somebody's mum and I'm not somebody's daughter or sister or whatever. I'm me down there, which is very important and something I want to keep going."

The ways 'problems' are viewed

The experiences of the women and their service providers affirm that 'helpful' service responses arise from a social view of health, in which health inequities, social isolation and exclusion, violence and abuse, are seen as social injustices, rather than as products of individual dysfunction or deficit. They see that what individual people think and do needs to be understood within the context of the barriers and possibilities created by social structures and practices.

From the service-provider's point of view this appears as:

"We need to think about where the woman is, what position she's in and what can we do in that space of time to be able to assist her to be wherever she wants to be." (A, service provider)

A woman receiving services experiences this as:

"She'd [service provider] always give me suggestions, she would never tell me 'do this, do that' because I think I would have rebelled on that... For me it was that I needed the reassurance that what I was doing was OK and [service provider] gave me that...and these are suggestions about maybe how to go about this or how to go about that." (P, mother of a four year old)

The relationship between the service/service-provider and women

In contrast to dominant views of the importance of professional distance to ensure 'objectivity' and discourage 'dependence', women place a high value on having a close relationship, akin to a feeling of friendship, between themselves and their service providers. R, a mother of two children under three years of age describes her experience:

"I don't see her as a child health nurse, I actually see her as a friend. I see that she's here not to put me down or anything else, not to tell me the way I'm bringing up my kids is not the right way."

A feeling of the worker 'being there' for the woman, being prepared to stand in her shoes and 'travel the journey' alongside her are key elements of this close relationship. K, a mother of a three year old provides an example:

"... She [service provider] did a lot of hours, a lot of you know, driving around helping me and that was a lot of sacrifice there. ... I feel like I'm really special, I'm like a favourite, even though I may not be, I feel like it."

From the perspective of K, a childcare support worker:

"I feel like I've walked a mile in the women's shoes. I believe their stories and I know what they're saying is right..."

S, mother of two children under five years old, expresses the value of this sense of feeling believed and having her experiences validated by others:

"...she's [service provider] about the only person who will listen and not contradict what I'm saying, not saying to me 'oh, that's wrong'. ...it's given me strength to fight through to what I say I want to do because I'm not really that bad."

H, a family counsellor, describes her approach based on working with people not on them, and asking them not telling them, what needs to be done, in the belief that they know best:

"... as I learnt more about the impact of abuse on children and on families I gained knowledge about the resourcefulness that families can have, and the wisdom and the strength that families can have in dealing with awful stuff that can happen in their lives quite often and yet still being able to survive...still wanting the best for their kids."

Being treated as worthy, capable and knowledgeable, and being treated with respect in a relationship of mutual trust is fundamental to helpful services *"...when people are speaking to me right you feel good about yourself."*

Arguably, this expert knowledge of some women and service providers about what constitutes helpful services is no surprise, and has been heard and documented before (Halpern 2000; Consumer Focus Collaboration 2001; Page 2003). Yet, the women articulated these ideas of helpful service in dynamic relation to their more common experiences of unhelpful services – services that do not believe them or validate their experiences, treat them as incapable and without knowledge, focus on their supposed failures when the 'problem' is defined by outside 'experts', and so on.

Highlights: Support and Service Use

Child health and well-being – sources of help and support in the past 12 months:

61% of participants had sought help from family, 12% from friends and 23% from medical, community or social services.

For those who sought formal sources of help and support:

GPs were the most used source of help for all child physical, developmental and behavioural problems or concerns.

Physical health problems – GPs then hospitals

Developmental problems – GPs then allied health professionals

Behavioural problems – GPs then Child & Youth Health and medical specialists.

Childcare, housework, transport & finances - sources of help in past 12 months:

Most relied on partners, their mother, other family and friends for help with childcare as well as housework and transport.

24% of participants used formal childcare or family day care services.

Financial help – 49% from family, friends & neighbours; 25% from churches and charities; 20% from government service agencies.

Service use patterns:

Teenage mothers and sole fathers were higher users of services for child sickness and injury but lower for developmental and behavioural issues.

Higher users of formal services also accessed more informal support from family, friends and community resources, suggesting help-seeking is a capability.

21% of participants had used multiple services, 61% of these said these services worked well together.

Multiple service use satisfaction issues: communication, consistency of information and approach, respectful relationships, access to services, quality service responses.

Highlights: Participants' perceptions of what makes a helpful service

The ways parents/mothers are viewed

- focus on 'strengths' & the ways mothers act to support and protect their children rather than on their individual 'failures' as parents.
- mothers have many facets to their identity – 'parent' is only one facet
- what individual parents think and do happens within the context of the barriers and possibilities created by living environments and social structures
- unequal power relations between women and men result in;
 - inequitable distribution of parenting ; family support responsibilities carried women
 - a common expectation that women's needs will always come last (after children, men and family)
 - violence, abuse and social isolation
- women need 'safe space' to share their stories and develop a critical understanding

The ways the 'problems' of parenting are viewed

- health inequalities are mostly attributable to social injustices, rather than as products of individual deficit
- a person's strengths/capacity to deal with these external difficulties can be built
- for parents of young children both 'coping' 'not coping' are 'normal'
- services need to understand the effects power and the ways that unequal power can work against the interests of women children in service intervention
- services need to recognise the value of a sense of belonging and opportunities to develop friendships

The relationship between the service/service-provider and service user

- service users want to be treated as worthy, capable and knowledgeable, and treated with respect in a relationship of mutual trust
- a 'close' relationship, akin to a feeling of friendship
- the service provider should be prepared to stand in the client's shoes and 'travel the journey' alongside her
- working with people not on them, asking them not telling them what needs to be done

Access to quality services

- information about what services are available; opening hours and appointment times that enable access; eligibility criteria that do not exclude children from getting help; timely follow-up.
- assessment and treatment/service responses that achieve optimal outcomes for the child and build parent capacity
- consistency in diagnosis, treatment approach and advice to parents
- effective and appropriate communication and referral processes between services

Policy and Service implications

Through its innovative sampling methodology the *Families at Risk* study has produced local evidence drawing attention to the strengths and challenges for parents living in situations of chronic and multiple disadvantage with children aged 0 to 7 years. Data from the study confirm the high prevalence of known risk factors detrimental to parents' and children's health and well-being¹⁶. It is clear that the lives of the majority of these parents and young children are under-resourced, stressful and isolated. Interventions are required that open up pathways out of disadvantaged life situations. Such measures not only tackle disadvantage directly with resulting improvements in health and well-being status and reductions in the costs of problem interventions, but can also provide parents and children with the material and psycho-social resources to make positive life changes.

To achieve improved outcomes for families at risk a paradigm shift is required so that unequal outcomes for families and children are seen as social injustices more than as products of individual dysfunction and deficit. Comprehensive and holistic service responses need to be developed within the context of the barriers and opportunities for health and well-being that operate in people's lives. In line with existing South Australian 'early years' policy and program initiatives, the study findings point to the need for sustained primary prevention and early intervention effort in the most disadvantaged localities of Metropolitan Adelaide. Consistent with the emphasis on cross-government and cross-sector action in South Australia's Strategic Plan (Government of South Australia 2004), the findings highlight the need for continuous and coordinated commitment at all levels in order to address the multiple and interwoven challenges for parents and young children living in situations of chronic and multiple disadvantage. Whilst addressing disparities in the social determinants of health involves many areas of social and economic policy that largely fall outside the jurisdiction of health and welfare departments, the health and welfare sectors can play a key role.

The South Australian Government's *Generational Health Review* (GHR) recommended a whole of Government approach and a focus on social and economic factors, with the Health Portfolio working in partnership with other sectors and departments to contribute to better outcomes for children and families.

'GHR believes early childhood should be a priority for a whole-of-government approach to ensure coordination and focus across government, and provide clear accountability for specific outcomes. There should be a strong early intervention and prevention focus, particularly on the social and economic factors impacting on health and wellbeing of children and families.' (Government of South Australia 2003, p. 156).

In Australia, there has been substantial work done to develop frameworks to guide the concerted and co-ordinated commitment necessary to nurture and support the health and well-being of young children and their families (for example National Public Health Partnership 2003; SA Department of Human Services 2000; Nosser & Alperstein 2002; King 2002; Turrell et al. 1999; Homel 1999).

¹⁶ Reviews of the early childhood literature point to similar conclusions from a large number of studies in relation to risk and protective factors and associated outcomes for children. Risk factors include: child characteristics (not studied in the *Families at Risk* project); parents and their parenting style; family factors and life events; and socio-economic factors. See for example: National Public Health Partnership (2003).

A recent report published by the NSW and Queensland Commissions for Children and Young People, together with the National Investment for the Early Years (NIFTeY), *A Head Start for Australia: An Early Years Framework*, identifies key areas for action and strategies to underpin them. The policy and service implications derived from the *Families at Risk* study fit comfortably within this framework. Whilst the *Head Start* framework is concerned with maximising the health and well-being of all children it also recognises the need for significant investment to improve the health and well-being of children with the poorest outcomes – including children living in poverty¹⁷

The following policy and service implications are drawn from the *Families at Risk* study. They relate to:

1. Life chances - social inclusion
2. Living environments – housing and residential mobility
3. Living environments – neighbourhoods and social cohesion
4. Mental and emotional health and well-being
5. Support for parenting
6. Childcare
7. Service planning and provision
8. Intersectoral action
9. Role of the health system

1. Life chances – social inclusion

Gender and Young Parents

Ninety-two per cent of parents who participated in the study are women/mothers and 47% of the study population (72% of Aboriginal parents) were 20 years or younger when first becoming a parent. This is significant as women (particularly *young* women) and children are most vulnerable to poverty and other forms of disadvantage. The study findings confirm evidence from the literature that age at first becoming a parent, income and level of education are associated with children's health and well-being outcomes¹⁸. Policy and service implications range from broad - that is, addressing the social determinants of health and well-being - to specific service and program innovations, and include:

- The need to apply a 'gender' and a 'youth' lens to parent support issues and to policy and service development with a focus on providing and facilitating supportive resources and environments for young mothers and children.
- Implement strategies that reduce disadvantaged women's/young women's poverty so that their (and their children's) basic needs can be met and enable them to direct their resources to other aspects of their lives, including completing school education, participating in further education and employment programs;
- Increase public resources and opportunities for mothers (and particularly young mothers) of young children to receive support and recognition. Helpful public resources include playgroups, occasional childcare, childcare supporting school retention and adult education, women's/young women's

¹⁷ Other groups of children whose outcomes are particularly poor include: indigenous children; children with mental health problems; children who have been abused; children living in out-of-home care; children in the juvenile justice system; children with a disability (Calvert & Smith 2004). Of course, these groups are not mutually exclusive.

¹⁸ Financial hardship, low level of completed education and young age are also key risk factors in crime prevention, child protection and women's safety strategies.

groups, health and community services and programs, home help services, safe and fun public parks and playgrounds, and other local 'opportunity structures' such as shops, cafes, community halls and meeting rooms; and

- Provide advocacy and support for disadvantaged women/young women to negotiate service systems.

Whilst the number of fathers participating in the study was small the indications are that their service use is different from mothers. For example, fathers seek help less readily, have a preference for services delivered away from home, and rely on formal sources of information more than word of mouth. It is clear that more research in relation to the experiences and service support needs of fathers is needed.

Education

There is also a wealth of evidence linking a wide range of health and well-being outcomes to level of educational attainment. Particularly significant in the context of the policy emphasis on education as a route to employment is the fact that 73% of the *Families at Risk* study participants had less than 12 years of completed education, while only 2% of participants were currently engaged in further education (90% of participants had no paid work). Whilst it is not within the scope of this study to make specific policy recommendations related to education, the study findings affirm the emphasis of education and social inclusion policies on school retention and participation in further education.

The *Families at Risk* study findings affirm the current emphasis on pre-school and school settings on health and well-being education, particularly through the implementation of a range of 'health promoting schools' strategies.

Universally and locally provided, early childhood centres and schools offer potential to be used as settings for parent/family and community support and participation.

Employment and income

There is also a wealth of evidence linking a wide range of health and well-being outcomes to unemployment and low income. In 64% of participating families in the *Families at Risk* study, the children were growing up in a household with no wage earner. Ninety percent of participants were not engaged in any paid work. Almost three-quarters of participants relied on the minimum level of income support provided by Government. Seventy-one per cent of all study participants regarded their household income as 'just enough' or 'not enough' to live on.

Whilst it is not within the scope of this study to make specific policy recommendations related to employment and income, the study findings affirm the need for investment in a range of anti-poverty strategies.

Aboriginal Families

Whilst the study had no specific focus on Aboriginal families and the actual numbers of Aboriginal families who participated may be too small to draw reliable conclusions, the study results appear to confirm what is already known about socio-economic risk factors for Aboriginal families and their vulnerability to ill-health and reduced well-being (ABS 1999). In comparison to the study population as a whole, Indigenous parents were more likely to have had their first child as teenagers, were even more

highly mobile having moved house on an average of 4.8 times in the past 5 years and even less likely to have 12 years of completed education.

The continuing challenge for human service agencies and in particular, Aboriginal organisations is to provide leadership across government to reduce the level of disadvantage and poor health and well-being outcomes for Indigenous populations. There is a need for population and context specific service and program responses that support community capacity to improve outcomes for Indigenous families with young children and keep them safe. The development and implementation of service and program responses should build on existing initiatives through consultation with Indigenous populations and human service agencies (all sectors and all levels).

2. Living environments - housing and residential mobility

Living conditions, in terms of both housing and neighbourhood characteristics, are a major determinant of health and well-being. More than 80% of participants in the study rented public (56%) or private (25%) housing. More than half had moved house three or more times within the past five years. For the study population, choice of housing was largely limited by affordability and location of public housing stock as well as their vulnerability (to domestic violence and other unsafe situations). Almost three-quarters of participants perceived that they had little or no choice about their current housing circumstances.

It is clear from the study that this population is particularly vulnerable to housing allocation decisions. The residential mobility of these families poses challenges for service delivery, particularly so in relation to service continuity and coordination and also for parents to be aware of available community based services. Furthermore, frequent house shifting may limit the development of supportive neighbourhood relationships. This is reflected in other findings from the study which indicate parents reliance primarily on family support, and very little on neighbourhood support.

These findings support some of the current thinking related to the future development of public housing, in particular:

- Addressing issues of availability and affordability of housing, particularly for young mothers
- Avoiding the concentration of public housing stock in particular localities
- Addressing the current problems of concentration through strategies that address the broad social determinants of health and well-being, including local employment, neighbourhood development, education and childcare opportunities, and so on.

3. Living environments – neighbourhoods and social cohesion

Better health and well-being are associated with neighbourhood characteristics and access to support from social and community networks or connections. The *Families at Risk* study, as its name suggests, drew its sample population from geographic areas of concentrated disadvantage that are in many ways unsupportive environments for families with young children. Participating families relied primarily on family support, less on friends, and very little on neighbourhood support. This low level of social connection exists alongside high local crime/social disorder rates, low levels of trust, a low sense of safety, and little community involvement or shared concern for maintaining order within their neighbourhoods. Social isolation and the lack of safe and supportive environments for parents and young children requires focus in terms of policy and innovation in service provision.

It is recommended that increased resources be devoted to neighbourhood community development, to enable them to become healthier communities that better meet the needs of their members. Possible strategies include:

- Create safe, attractive physical environments – including parks, playgrounds, streets and buildings;
- Subsidise programs and provide transport to encourage children to participate in sport and recreational activities;
- Develop comprehensive community based initiatives that connect residents in communal activities;
- Provide opportunities, particularly for women, to learn advocacy and leadership skills that they could apply towards community development initiatives.

The impact of crime and social disorder on families' sense of safety and well-being affirms the need for crime prevention strategies and strategies that protect and improve the safety of women and children. Strengthening the involvement of residents in community and neighbourhood based crime prevention strategies could benefit all families.

4. Mental and emotional health and well-being

The findings of the *Families at Risk* study confirm evidence from the literature regarding the associations between chronic and multiple disadvantage, stressful life events, and people's mental and emotional health (Avery et al 2004) For many disadvantaged parents with young children living with the effects of the unequal distribution between social groups of access to education, employment and other resources and opportunities for health and well-being, experiences of isolation, alienation, distress and powerlessness are common.

“Upstream” policies and strategies that address the social determinants of health and well-being as well as interventions that foster resiliency in children, families and communities are keys to improving mental and emotional health. Comprehensive, early intervention initiatives can strengthen people's capacity to respond to multiple stressors by effectively addressing the many risk factors that undermine resiliency and promoting the development of protective factors²⁰.

²⁰ See for example: The Centre for Community Child Health (2000) *A Review of the Early Childhood Literature*, Department of Family and Community Services, Canberra.

Examples of strategies that can contribute to improved mental and emotional well-being for parents and children living in situations of chronic and multiple disadvantage include:

- Inclusion and participation in social programs such as early childhood education and childcare, adult education, employment, housing, community and neighbourhood development; and
- Population based parent support and early childhood development programs such as nurse home visiting, community midwifery, parent support networks, enriched centre-based childcare and pre-school programs, and school-based health promotion programs.

5. Support for parenting

Full-time parenting is demanding work with long hours, no holidays, no pay, a lot of responsibility and little recognition. Even more demanding is full-time parenting with limited financial resources, few social or community networks, limited parenting support and few affordable, accessible opportunities to entertain children. Adopting a view that it is 'normal' for parents of young children to need support and that both 'coping' and 'not coping' are to be expected for all parents suggests that support for parents and children should be an entitlement and be provided in a whole variety of ways.

The *Families at Risk* study goes some way to revealing the daily lives of parents of young children living in situations of multiple disadvantage. The research highlights their considerable hope, commitment and effort in wanting the best for their children. The findings highlight many of the stressors and challenges of parenting in contexts of multiple disadvantage. Many of the parents displayed considerable hope, commitment and achievements in the face of coping with such challenges.

At the broadest level, these findings lead to a recommendation that services and programs should focus greater attention on building and maintaining supportive structures and practices - such as access to safe, adequate housing, recreation and play, adequate income, practical support, education, childcare, health services, community networks and opportunities for friendship, rather than on individual deficit in skill, lifestyle, behaviour or responsibility.

More specifically, participants talked about their need for time out from the demands of caring for children. It seems likely that women who parent alone and parents who have little or no support from other family members have fewer opportunities for respite than other parents. There is a clear need for appropriate service provision (eg. by service agencies, community organisations, schools etc.) which allows for more opportunities for parents to take time out for themselves while their children are safely cared for (eg. affordable and accessible childcare, local parent drop-in centres, support groups, recreation facilities for adults).

At a broader level, the study findings suggest the need for a different way of thinking and speaking about parental 'responsibility'. According to the current use of the term, 'responsible' parents make positive choices that ensure the best for their children. Missed in this formulation are the significant inequalities that exist (particularly between men and women) in responsibility for care of children and in access to the resources necessary to make 'responsible' choices. Rather than the emphasis being on how can parents be made more responsible (the implication being that they are not responsible enough), the 'problem' is inadequate and unequal access to resources,

It is recommended that:

- Human services agencies and programs recognise and respect the strengths and resourcefulness of parents/mothers;
- Service providers be trained and encouraged to honour and support parents' efforts to raise their children well and acknowledge gender inequalities in power and responsibility;
- Services support the relationship between parent/mother and child(ren) by providing a parent/woman-centred response²¹.
- Appropriate service provision allows for more opportunities for parents to take time out for themselves while their children are safely cared for.

6. Childcare

Participants in the study reported low-level use of centre-based childcare or family day care services. There is a wealth of evidence that highlights the benefits of participation in quality childcare for early childhood development. In addition, parents of young children require some form of childcare if they are to work outside the home, participate in education, or engage with their community(s). The reports from study participants suggest that childcare not only needs to be flexible, affordable, conveniently located and accessible (in terms of hours, cultural sensitivity, suitability for children with differing abilities, etc.), but it must meet parents' standards if they are to feel comfortable leaving their children there (see Case Studies – Appendix D). These standards are likely to vary depending on the parents' values, upbringing and other experiences. For example, a parent experiencing domestic violence or who experienced neglect or abuse as a child may be unwilling to leave their children in the care of a stranger until a trusting relationship can be established.

It is recommended that more research is needed in relation to the barriers and what would support the use of formal childcare services by families with young children living in situations of chronic and multiple disadvantage.

7. Service planning and provision

The health and well-being of people living in situations of multiple disadvantage is influenced by the interplay between a number of factors in such a way that linking their health and well-being concerns to one causal factor may be impossible. Definitions or categories of service and eligibility requirements can mean that the 'consumer' has to have a situation and a story that meets these administrative definitions. These 'labels' for service 'doorways' whilst useful for prioritising and allocating resources, most often reflect professional and administrative ways of thinking and organising, and may not reflect parents' lived experiences. In this way, according to parent reports, services can be unhelpful.

This supports arguments for a change of thinking, away from the dominance of 'boundary driven', professionally defined services focused on particular problems.

Service organisations need to open their 'borders' and develop links, exchanges and dialogue with other sectors/agencies as well service users. This may mean giving up or at least sharing the authority to define 'needs' and being willing and able to join others to address concerns and achieve common goals. Flexible structures and competent collaborative practices are necessary for this to happen.

²¹ There are numerous existing examples of 'woman-centred' service models in South Australia – for example: community midwifery, women's health, domestic violence, sexual assault.

Given the predominant use by study participants of universally and publicly provided services (including GPs, hospitals, and schools) it is likely that the most effective strategies will be those that are universal or linked to such services. Health Action Zones in the United Kingdom²² provide an example of how additional resources can be targeted to particular populations (eg. children with additional needs) or particular geographic areas by building on locally provided universal services.

The recommended focus is on:

- Universal and comprehensive provision of supports for families with young children, with ‘additional needs’ provision linked to universal programs (eg. nurse home visiting, early childhood education, schools).
- Fitting the service to the person not the person to the service.

Multiple service use

Many parents living in situations of multiple disadvantage and in particular, parents with multiple concerns regarding their child(ren)’s health and well-being, have a great deal of interaction with ‘the system’ (illness care, education, welfare, housing, social security, justice, etc.). Difficulties with this interaction, as reported by parents, include: difficulty getting access to services and/or individual providers; lack of continuity in providers; inconsistent information; disrespect; feeling judged or blamed; and a general lack of response to their concerns and needs.

- These sectors need sufficient resources so that they are adequately staffed by individuals who are appropriately trained, capable of responding to people’s needs and able to demonstrate understanding of and respect for service users.
- Human services agencies involved with the lives of parents and children living in situations of multiple disadvantage need to be aware that in their efforts to assist, they may be adding to or compounding the problems of their service users (see for example “Chris’s story” in Appendix D).

Enabling participation

The *Families at Risk* project follows other studies in providing an example that parents can provide valuable insights into the reality of living in situations of multiple disadvantage. However, it is an ongoing challenge for policy makers and services to find ways to listen to parents’ experiences, connect them to each other, and build on and use their strengths.

- Services should be locally based and locally responsive and include as much participation and control by service users as is feasible. In addition, services should be accountable to the communities in which they operate and/or the population groups they serve.
- Implement strategies to eliminate barriers to people participating in policy, program and service development. These could include providing practical support and resources – for example: transport, childcare, ‘sitting’ fees, learning support, etc. – as well as recognizing and allowing space for the ways in which the challenges of parenting in situations of multiple disadvantage limit people’s ability to confidently contribute.
- Develop innovative strategies to obtain parents’ input into policy and program development – for example: using art and/or participatory action research.

²² www.haznet.org.uk

Use different strategies appropriate to different contexts and different population groups/communities.

- Foster and develop supportive networks for parents living in situations of multiple disadvantage so that their stories can be told, common issues and priorities can be identified, and priorities and agendas for action can be developed.

8. Intersectoral action

There is growing recognition that employment, social supports, physical environments and education have all been linked with the health outcomes of communities, as illustrated by Figure 1 (page 17). If we focus on individual factors or only on some community context issues, a large part of our population (indeed those with the greatest needs such as people with mental illness, Indigenous and socioeconomically disadvantaged people) are likely to continue to experience poorer health.

Addressing these social determinants of health involves many areas which fall outside the jurisdiction of health and welfare departments. It is vital that all sectors are engaged in strong partnerships and collaborative work on a range of policy inputs and services to address the social determinants of health and subsequent inequalities, and to solve issues where the solutions fall across multiple sectors.

9. Role of the health system

Whilst acknowledging that addressing the social determinants of health requires intersectoral and community action, the health system can play an important role.

More specifically the health system can:

- raise awareness of the social determinants of health, assess the health impacts of policies, and advocate for health promoting policies and programs in other sectors (such as schools, workplaces, early childhood centres);
- engage with communities and other partners in ways that integrate and strengthen action and build capacity for future action;
- co-ordinate health planning activities to address the social determinants of health;
- develop health organisation capacity including workforce development and research.

References

- Al-Yaman, F, Bryant, M & Sargeant, H 2002, *Australia's children: their health and wellbeing 2002*, AIHW Catalogue No. PHE 36, AIHW, Canberra.
- Andrews, G., Hall, W., Teesson, M., & Henderson, S. 1999, *The mental health of Australians*. Mental Health Branch, Commonwealth Department of Health and Aged Care, Canberra.
- Armstrong M & Goldfeld S 2004, *Good beginnings for young children and families: a feasibility study*. A report prepared by the City of Wodonga and the Centre for Community Child Health, Royal Children's Hospital, Melbourne.
- Australian Bureau of Statistics [ABS] & Australian Institute of Health and Welfare [AIHW] 1999, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Catalogue No. 4704.0, Commonwealth of Australia, Canberra.
- Australian Bureau of Statistics [ABS] 2001, *Census of Population and Housing*, Commonwealth of Australia, Canberra.
- Australian Bureau of Statistics [ABS] 2002, *Australian Social Trends 2002*, Catalogue No. 4102.0, Commonwealth of Australia, Canberra.
- Australian Bureau of Statistics [ABS] 2003, *Household Income and Distribution 2000-01*, Catalogue No. 6253.0, Commonwealth of Australia, Canberra.
- Australian Bureau of Statistics [ABS] 2004, *Australian Social Trends 2004*, Catalogue No. 4102.0, Commonwealth of Australia, Canberra.
- Avery, J, Dal Grande, E, Taylor, A & Gill, T 2004, *Which South Australians Experience Psychological Distress?: Kessler psychological distress 10-item scale July 2002 – June 2004*, Department of Health, Adelaide.
- Bor, W, Najman, JM, Andersen, MJ, O'Callaghan, M, Williams, GM, & Behrens, BC 1997, 'The relationship between low family income and psychological disturbance in young children: An Australian longitudinal study', *Australian and New Zealand Journal of Psychiatry*, vol 31, pp. 664-675.
- Boyle, MH & Lipman, EL 2002, 'Do places matter? Socio-economic disadvantage and behavioural problems of children in Canada', *Journal of Consulting and Clinical Psychology*, vol. 70, no.2, pp. 378-389.
- Calvert, G & Smith, R 2004, 'A national framework for promoting health and well-being in the early years', *Health Promotion Journal of Australia*, vol. 15, no. 2, pp.99-102.
- Cameron, H, Murray-Harvey, R, Russell, A & Slee, P 2000, 'Families in change – for better or for worse', paper presented at the *Second International Conference on Child and Adolescent Mental Health*, Kuala Lumpur, Malaysia.
- Coghlan D, Kiing JSH & Wake M 2003 'Parents' evaluation of developmental status in the Australian day-care setting: Developmental concerns of parents and carers', *Journal Paediatric Child Health*, vol 39:49-54.
- Consumer Focus Collaboration 2001, *The evidence supporting consumer participation in health*, Consumer Focus Collaboration, Melbourne.

- Dal Grande, E, Woollacott, T, Taylor, A, Starr, G, Anastassiadis, K, Ben-Tovim, D, Westhorp, G, Hetzel, D, Sawyer, M, Cripps, D, & Goulding, S 1999, *Interpersonal violence and abuse survey*, Department of Human Services, Adelaide.
- Glascoe FP 1997, 'Parents' concerns about children's development: prescreening technique or screening test?', *Pediatrics*, vol.99, pp. 522-528.
- Glover, J. & Tennant, S 1999, *A Social Health Atlas of Australia, Volume 5: South Australia*, 2nd edition, Openbook Publishers, Adelaide.
- Goldberg, DP & Williams, P 1988, *A user's guide to the GHQ*, NFER Nelson, London.
- Government of South Australia 2003, *Better Choices Better Health: Final Report of the South Australian Generational Health Review*, (J Menadue AO, Chair Generational Health Review), Government of South Australia, Adelaide.
- Government of South Australia, 2004, *South Australia's Strategic Plan: Creating Opportunity*, (M Rann, Premier), Government of South Australia, Adelaide.
- Green, K 2004, *We Did It Together": Low-Income Mothers Working Toward a Healthier Community*, Prairie Women's Health Centre of Excellence, Health Canada, viewed 15 October 2004 <<http://www.pwhce.ca/didItTogether.htm>>.
- Halpern, R 2000, 'Early childhood intervention for low-income children and families', in *Handbook of Early Childhood Intervention*, eds J P Shonkoff & S J Meisels, Cambridge University Press, UK.
- Hertzman, C 2002, *Leave No Child Behind! Social Exclusion and Child Development*, The Laidlaw Foundation, Toronto, Canada.
- Hetzel, D, Page, A, Glover, J & Tennant, S 2004, *Inequality in South Australia: Key determinants of wellbeing. Volume 1: The Evidence*, Department of Health (SA), Adelaide.
- Hamel, R 1999, *Pathways to Prevention: developmental and early intervention approaches to crime in Australia*, National Anti-Crime Strategy, Attorney-General's Department, Canberra.
- Irwin, A 2001, *Sociology and the Environment*, Polity Press, Cambridge, UK.
- Jerulsaem, M & Schwarzer, R 1992, 'Self-efficacy as a resource factor in stress appraisal processes', in *Self-efficacy: Thought control of action*, ed R Schwarzer, Hemisphere, Washington DC, pp. 195-213.
- Keating, DP & Hertzman, C (eds.) 1999, *Developmental Health and the Wealth of Nations: Social, Biological, and Educational Dynamics*, Guildford Press, New York.
- Keller, J & McDade, K 2000, 'Attitudes of low-income parents toward seeking help with parenting: Implications for practice', *Child Welfare*, vol. 79, no. 3, pp. 285-312.
- King, L 2002, 'The settings approach to achieving better health for children', *NSW Public Health Bulletin*, vol. 9, no.11, Sydney.
- LeClair, JA 2001, 'Children's behaviour and the urban environment: an ecological analysis', *Social Science and Medicine*, vol.53, no. 3, pp. 277-292.
- Levanthal, T & Brooks-Gunn, J 2000, 'The neighbourhoods they live in: the effects of neighbourhood residence on child and adolescent outcomes', *Psychological Bulletin*, vol.126, no.2, pp. 309-337.

- Marmot, M. & Wilkinson, R (eds) 1999, *Social Determinants of Health*, Oxford University Press, Oxford, UK.
- McLeod, JD & Shanahan, MJ 1996, 'Trajectories of poverty and children's mental health', *Journal of Health and Social Behaviour*, vol. 37,(September), pp. 207-220.
- McLoyd, VC 1998, 'Socio-economic disadvantage and child development', *American Psychologist*, vol. 53, no.2, pp. 185-204.
- Murray-Harvey, R & Slee, PT. 1998, 'Family stress and school adjustment. Predictors across the school years', *Early Child Development and Care*, vol. 145, pp.133-149.
- National Public Health Partnership 2003, *Promoting the Development of Children's Health in Australia: a population health perspective. A scoping Study and Review of the Child Health Literature*, Child and Youth Health Intergovernmental Partnership.
- Nosser, V & Alperstein, G. 2002, 'Key initiatives to achieve health gains for children', *NSW Public Health Bulletin*, vol 9(6-7), Sydney.
- Office of Crime Statistics Research 2000, *Average reported crime rates in the suburbs*, Government of South Australia, Adelaide.
- Page, L 2003, 'One-to-one Midwifery: Restoring the "with Woman" Relationship in Midwifery', *Journal of Midwifery & Women's Health*, vol. 48, no.2, pp. 119-125.
- Pickett, KE & Pearl, M. 2001, 'Multilevel analyses of neighbourhood socioeconomic context and health outcomes', *Journal of Epidemiology and Community Health*, vol. 55 (February), pp. 111-122.
- Pregnancy Outcomes Unit, *2001 Confinements data*, Department of Health South Australia, Adelaide.
- Public Health Services Branch, Queensland Health 2004, *Social Determinants of Health – Role of Public Health Services*, Queensland Health, Brisbane.
- Rutter, M. 2003, 'Poverty and child mental health: Natural experiments and social causation', *Journal of the American Medical Association*, vol. 290, no. 15, pp. 2063-2064.
- Sampson, RJ, Raudenbush, SW & Earls, F. 1997, *Neighbourhoods and violent crime: A multilevel study of collective efficacy*, Science, vol. 277, pp. 918-924.
- Schneiders, J, Drukker, M, Ende, J, van der, Verhulst, FC, Os, J, van, Nicolson, NA 2003, 'Neighbourhood socioeconomic disadvantage and behavioral problems from late childhood into early adolescence', *Journal Epidemiological Community Health*, vol 57, pp. 699-703.
- Slee, PT & Shute, RH. 2003, *Child Development: Thinking about theories*,. Arnold, London.
- Slee, PT 2002, *Child, Adolescent and Family Development*, 2nd edn, Cambridge University Press, Melbourne.
- South Australian Department of Health, Department for Families and Communities and GISCA 2005, *Common Clients Pilot Project: Final Report*, Department of Health, Adelaide.
- South Australian Department of Human Services 2000, *Healthy Start: Implementation Plan 2000-2011*, Department of Human Services, Adelaide.

- Taylor, A, Dal Grande, E & Parsons, J 1997, *Mental Health Status of South Australians*, SA Health Commission, Adelaide.
- Turrell, G, Oldenburg, B, McGuffog, I & Dent, R 1999, *Socio-economic determinants of health: Towards a National Research Program and a Policy and Intervention Agenda*, Commonwealth Department of Health and Aged Care, Canberra.
- Umberson, D. 1992, 'Relationships between adult children and their parents: Psychological consequences for both generations', *Journal of Marriage and Family*, vol. 54, pp. 664-674.
- VicHealth 2004, *The health costs of violence: Measuring the burden of disease caused by intimate partner violence*, Government of Victoria, Melbourne.
- Walkate, S 2001, 'Fearful communities?', *Urban Studies*, vol. 38, pp. 929-939.
- Wilkinson, R. & Marmot, M (eds) 1998, *The Solid Facts: Social Determinants of Health*, World Health Organization, Geneva.
- Wilkinson, R & Marmot, M (eds) 2003, *The Solid Facts: Social Determinants of Health*, 2nd edn, World Health Organization, Copenhagen.
- Wright, M. & Oberklaid, F 2003, 'Child Development – issues in early detection', *Community Paediatric Review*, vol. 12, no. 1.

Appendices

Appendix A: Project Aims

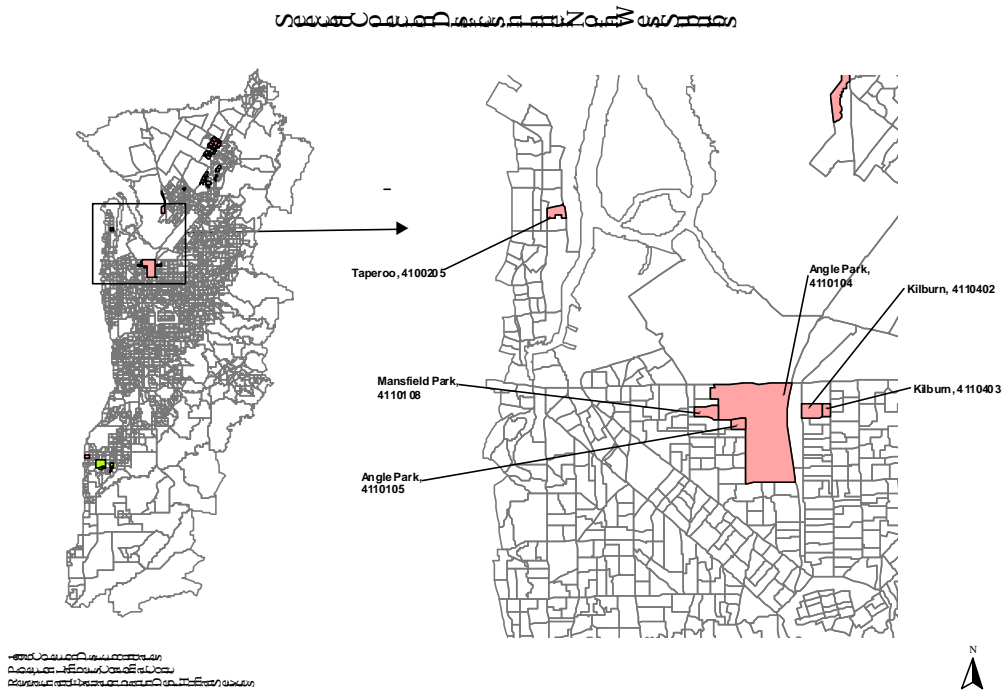
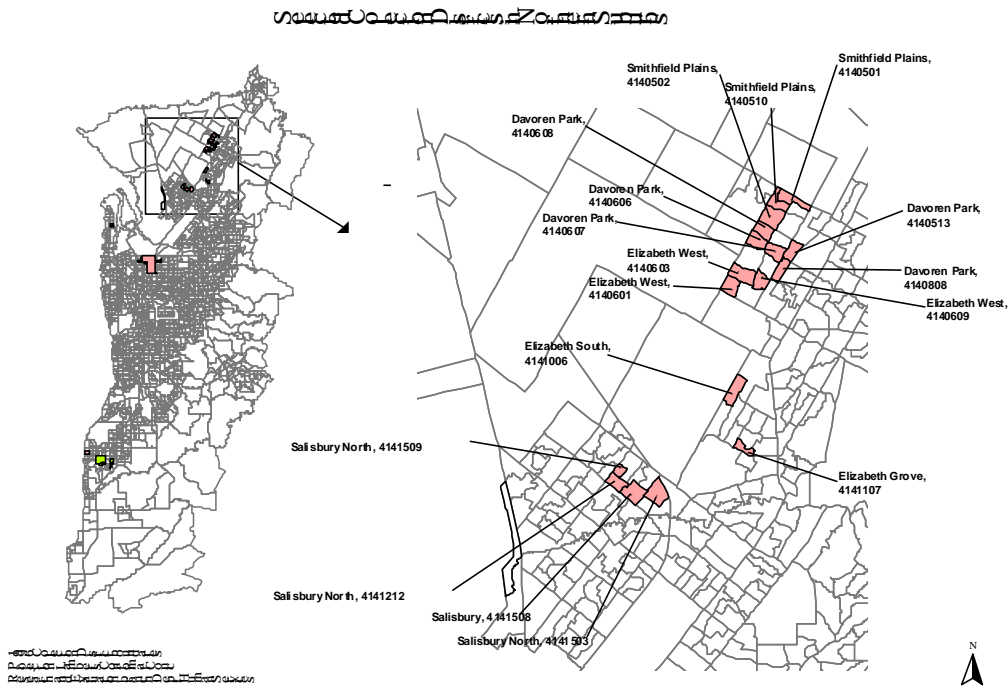
1. *To employ an innovative sampling procedure to establish contact with a sample group of families who are at risk.*
2. *To document the demographic indicators, as well as person (parent and child), family, and community characteristics of risk and resilience, including the extent of service use among the families.*
3. *To examine differences between families who are high and low service users on various factors including child adjustment, social capital, personal and family strengths, available resources, and barriers to resources use.*
4. *To utilise the research findings at a community level to promote some common understanding between the service providers and families of the way in which barriers to service use can be overcome.*

Appendix B: Collection Districts included in the Families at Risk study

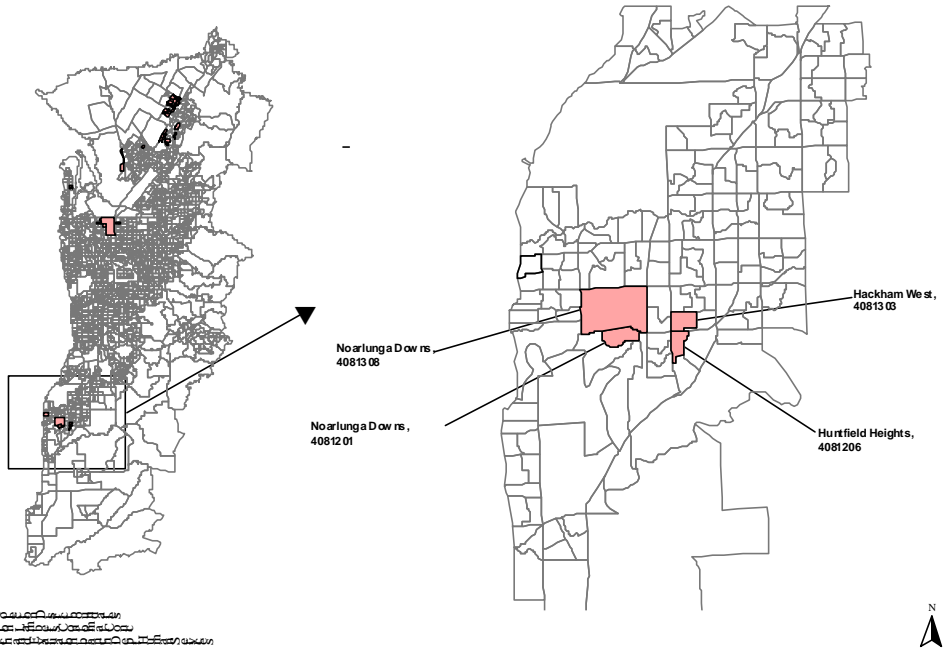
Collection District	Statistical Local Area	Suburb	1996 SEIFA (Index of disadvantage)	Total households with children 0-4*	Proportion of households with children 0-4* %	Total SAHT Household*	Proportion of SAHT households in CD* %	TOTAL Households*
4141508	Salisbury	Salisbury North	556.453	93	35.77	194	74.62	260
4141212	Salisbury	Salisbury North	569.945	78	33.05	182	77.12	236
4140501	Munno Para	Smithfield Plains	575.026	62	26.5	157	67.09	234
4110403	Enfield - Pt A	Kilburn	575.33	27	25.71	96	91.43	105
4140607	Munno Para	Davoren Park	598.765	37	21.76	112	65.88	170
4110402	Enfield - Pt A	Kilburn	600.768	51	24.52	184	88.46	208
4140510	Munno Para	Smithfield Plains	603.762	44	27.33	112	69.57	161
4141503	Salisbury	Salisbury North	604.528	105	33.12	253	79.81	317
4140502	Munno Para	Smithfield Plains	606.693	61	32.28	124	65.61	189
4140609	Munno Para	Davoren Park	616.278	37	21.14	92	52.57	175
4141107	Elizabeth	Elizabeth Grove	616.442	33	25	107	81.06	132
4141509	Salisbury	Salisbury North	622.609	32	27.35	69	58.97	117
4110104	Enfield - Pt B	Angle Park	624.853	35	26.32	112	84.21	133
4081303	Noarlunga	Hackham West	629.176	37	19.47	130	68.42	190
4140513	Munno Para	Davoren Park	632.229	22	31.88	51	73.91	69
4081206	Noarlunga	Huntfield Heights	639.304	39	18.75	163	78.37	208
4110108	Enfield - Pt B	Mansfield Park	641.21	54	21.77	175	70.56	248
4110105	Enfield - Pt B	Angle Park	642.917	37	21.64	119	69.59	171
4140808	Elizabeth	Davoren Park	646.938	22	26.83	52	63.41	82
4100205	Port Adelaide	Taperoo	655.038	76	41.08	156	84.32	185
4140601	Munno Para	Elizabeth West	657.525	69	32.7	104	49.29	211
4140606	Munno Para	Davoren Park	662.318	55	25.82	91	42.72	213
4140603	Munno Para	Davoren Park	666.184	106	34.64	153	50	306
4141006	Elizabeth	Elizabeth South	669.675	29	26.36	68	61.82	110
4140608	Munno Para	Davoren Park	681.605	64	31.07	146	70.87	206
4081308	Noarlunga	Noarlunga Downs	696.31	34	19.43	138	78.86	175
4081201	Noarlunga	Noarlunga Downs	701.596	43	19.28	186	83.41	223

* Data source: ABS 1996 Census of Population and Housing

Appendix C: Maps of Collection Districts included in the study



Map of the Noarlunga Peninsula



Appendix D: Case Studies illustrating helpful service responses

Stories that illustrate the complexities of social inequalities and disabling environments in the lives of mothers and young children and helpful service responses

Tina

Tina has three children, one pre-school and two primary school age. One year ago she decided to separate from her husband after many years of being subject to his drunken verbal abuse and harassment. A year on, Tina describes the effects of the abuse as well as the effects of self-blame and being blamed by her family and children for her husband's drinking, his abuse, her failure to make the marriage work and her failure to control her children's problem behaviours. These effects have included, physical ill health (breathing difficulties, vomiting), mental and emotional distress including panic attacks, depression and several suicide attempts and difficulties managing her children's behaviour. Her adverse reaction to a particular medication (an anti-depressant) took many months to get right.

As part of the discharge plan from two months in hospital following one suicide attempt, Tina was given a number of service options for counselling and support. She describes not having a car, the demands of being a full-time single parent and the shame associated with having problems and needing help, as making it difficult for her to make contact with these services.

During her stay in hospital Tina's mother cared for the three children. Although she has a fairly good relationship with her mother, Tina sees her mum as not being "in a situation where she wants to look after the kids". Like for other mothers she knows, until the kids start at kindergarten/school there is nowhere to leave them, even for five minutes – "it is day in day out with the kids, morning to night..." Tina has not used formal childcare services because she doesn't trust that her children will be safe, doesn't want to be tied to booking them in at regular times to keep a place, and because she shares the dominant idea in her family that it is *her* responsibility to care for her own children.

Tina eventually found help from a service close to home that supported women's participation by providing on-the-spot occasional childcare (now defunded). Her school-age daughter was attending a kids' programs at this same service. From Tina's perspective, the supportive, drop-in environment of the service provides safe, "neutral ground" with formal and informal opportunities to meet and talk with the staff and other mothers and have a coffee, "without expectations". The service is part of an active network of community services and school support programs and through these Tina has accessed personal counselling, participates in providing reading support in her children's school, supports their participation in sport, and is part of a local group that does gardening and clean-up work together to help out each other and others in need.

For Tina, 'community' has both positive and negative aspects. She knows quite a few mothers from her children's kindy and school but is reluctant to invite them into her home for coffee because she doesn't like "gossip" and feels the pressure of having to have a tidy, clean home and well-behaved children. She recognises that the local area in which she lives has a "bad name", part of the stigma of social disadvantage,

but she sees her particular street as an exception – *“I couldn’t ask for a better lot of people around me...”*

Regina

Regina describes herself as a “mother to everyone”. She lives in a publicly rented three-bedroom house with eight others - her two toddlers, her current partner, her ex-partner (father of her children) and his current girlfriend, her younger sister, her baby and current partner. None of the adults are in paid employment. Centrelink has recently suspended Regina’s payments due to their lack of clarity about who lives in the household and who is supporting her to care for the children. Her ex-partner, current partner and sister have epilepsy and Regina describes herself as the main one in the household who knows what to do to help when they fit. Her sister, who has never been a tenant in her own right has been unable to secure private rental housing and is on a wait-list for public housing. Regina believes her sister may never be able to live in her own home because of her worsening epilepsy and her partner’s physical health problems. Regina’s two children have respiratory health problems, diagnosed developmental delay and are clients of intellectual disability and child protection agencies.

Regina acts as mediator when there are relationship problems between adults in the household and manages the numerous crises as they arise in her life and the lives of those who depend on her. She sees her childhood experiences as contributing to these strengths.

Following her parents’ separation and her mother’s mental breakdown when she was seven years old, Regina had a primary role in the care of her two young siblings. At this time, the family had frequent contact with crisis care and other agencies. As a teenage mother, Regina ended contact with her mother and step-father in circumstances of emotional and physical abuse and her parents’ non-acceptance of her partner, the father of her baby.

Over the past year and a half, Regina has developed what she describes as a trusting and helpful relationship with her child health nurse although this trust has been seriously challenged at different times. Regina experiences the nurse as a friend who is there to help and support, someone who believes in her, recognises and actively supports her considerable problem solving skills and her commitment to do the best for herself and her kids. Working together, with a focus on what is important in Regina’s life at that time and for the future, they have been addressing a broad range of issues and crises as they arise. From the perspective of the child health nurse, it is fundamental that her agency supports her in this approach that is different from the more dominant focus on achieving child health and development milestones/standards. At times, the effects of different and sometimes conflicting mandates, service systems, cultures and practices between the multiple agencies involved in the lives of Regina and her ‘family’ have presented serious challenges to the child health nurse’s advocacy for and relationship with Regina and her children.

Kit

Born in a south Asian country and adopted at eleven years of age by middle-class Australian parents, Kit never attained confident literacy skills and left school early. Kit describes both herself and her partner as the “black sheep” in their families and when their baby was born neither had any family support they could count on. At the time of the birth, during her hospital stay, Kit and her partner accepted the offer of long-term parenting support from a regionally based pilot program targeting ‘at risk’ families.

In the baby's first two years with her partner spending long hours at work, Kit at home and without support from family or friends, found the demands for her baby's care increasingly difficult to manage. In her own words - *I didn't realise how quick he would start needing, like he wouldn't co-operate with me to change his nappy and I found it really hard, and I didn't know how to like keep him down just to change his nappy.* Feeling hopeless and increasingly frustrated, Kit stayed at home more and more. On "bad days", overwhelmed by anger and the baby's demands, Kit hurt her baby by *"...either yelling at him or just dumping him really hard when I shouldn't have..."* To her partner, Kit was an angry woman with a problem she should do something about. However, when the parent support worker organised a childcare place to enable K to undertake a literacy program and voluntary work, the partner refused to pay for it. He responded similarly to a proposal that Kit join a sports team to be involved in something she really enjoyed and was good at. Despite his 12 hour a day involvement in paid work, Kit and her partner experienced increasing financial pressure. Although Kit was good at finances and budgeting, her partner wasn't. She thought he had been paying the bills but he hadn't.

When a child from her partner's previous relationship joined their family, conflict escalated to a crisis point resulting in physical injury to both adults, the partner taking their child interstate, Kit being charged with assault, and an on-going custody dispute in the Family Court. This incident and being forcibly separated from her child for several months seriously affected Kit's physical and emotional health. She was diagnosed with depression and at the same time took on a huge workload in terms of the number of services she had to make connection with – legal, financial assistance, psychiatric, medical, child protection, housing and so on. With no car and with debts to manage leaving insufficient money for food, Kit relied on charities and government agencies for food vouchers. At this time, Kit experienced the intensive practical, emotional and advocacy support provided by the parent support worker as invaluable. From the perspective of the worker, the close support of her service manager and the flexibility of the service model enabled her intensive and broad ranging involvement.

Now with interim shared custody arrangements, which allocate around forty percent of her child's weekly care to Kit, she is required by Centrelink to be actively seeking paid part-time work. With frequent health appointments and two on-going court cases in different court systems Kit feels not ready to look for work and sees this ruling as *"really hard and cruel"*. Her early school leaving and poor literacy are barriers to Kit gaining employment other than cleaning which is the only work she has ever done. In recent months, with the encouragement of the parent support worker, Kit is increasingly involved in no-cost community learning as well as cultural programs and in her local community centre as a volunteer.

Leanne

The public housing tenancy Leanne shared with her violent, drug-using partner was 'at risk' making her eligible for intensive support from a non-government human services agency tenancy support worker. There were neighbour complaints, major property maintenance issues, health concerns, and the rent had been unpaid for a long time. Whilst Leanne's five children were the subjects of multiple child protection notifications none had resulted in any personal contact with the child protection agency.

Prior to this tenancy, during her fifth pregnancy Leanne's partner had ended their on-again, off-again relationship. Not close to her mother and with her father no longer alive, her only supports were her brother and one friend she'd had since school. Sick and frequently hospitalised during her pregnancy and with four young children, she

rented a two-bed caravan in the backyard of a friend's house. For one hour each day she was allowed access to the toilet and shower, but not the kitchen, in the friend's house. For the remaining time, the back door was securely locked. Despite having another relationship, Leanne's ex-partner continued to aggressively attempt to control her money and her life.

Finally separated and with her ex-partner out of her life, Leanne has a new partner. With the intensive support of the tenancy support worker they live with her now six children (three under 3, one kindergarten-age and two school-age) on the *"other side of town"* from her last tenancy. From Leanne's perspective she feels settled and is a proud tenant. She describes this new house as having provided *"the foundation of life"*. Feeling in charge of the household, she has been working alongside the tenancy support worker to address a broad range of issues - safety, finances, schooling, child development and better managing her children's challenging behaviours. She describes one of her biggest challenges as *"to get my kids to listen to me and do the right thing, do what they're told"*. The thing she says she *"dread[s] every day of my life..."* happened recently – her eldest child was brought home in a police car having smashed a window at a local building site.

Leanne describes her circle of connections and support as small – her current partner (father of her sixth child and unemployed), her brother (who has neither partner nor children and is unemployed), the girlfriend she's had since school days and her tenancy support worker. She says she doesn't trust many people because so many people have broken trust before. Although she might like to, with four pre-school age children Leanne has no time to be involved in her older children's school or in local support, learning or action groups. She describes herself as *"not one for child care"* although she says she recognises that getting him amongst other children of his own age might help the slow development of her 2 year olds speech.

Chris

Whilst 25 year-old Chris was out of the house engaged in part-time work she trusted the care of her 3 year old son (from a previous relationship) to the care of her live-in partner. Over a period of months Chris became increasingly worried about health and behavioural problems in her son that were much later confirmed to be the effects of child abuse perpetrated by her defacto. When she first felt worried, Chris consulted with a general practitioner who dismissed her concerns. As her child's problems worsened Chris sought the opinion of a different general practitioner who similarly dismissed her concerns.

Abuse was confirmed some months later following the child's after-hours admittance through the emergency department of the children's hospital.

Confirmation of abuse and the hospital stay marked a drastic turning point in their lives. To ensure her child's safety and prevent him being placed in an alternative care situation Chris was required to move out of her home. Being partway through a private rental lease she had to continue paying rent until another tenant was found and during this time she was ineligible for public housing because she was privately renting (a home that she couldn't live in with her child). She had to give up her part-time job because in order to ensure her child's safety she was not permitted by the child protection authority to leave him in anyone else's care. Under great financial and emotional stress, Chris and her son moved 'home' to her parents who she describes as being very supportive. The frustrating slowness of the criminal justice system is illustrated by it being more than 12 months before the police moved to lay charges against the perpetrator of the abuse. Meanwhile, Chris describes herself as the one literally left 'holding the baby' and managing all the enforced changes in their lives.

Chris's parenting stress increased as her child's behaviour became more and more challenging – sleepless nights, angry and violent outbursts, and refusing to let Chris out of his sight. Blaming herself for leaving her child in an abusive situation and not picking up the warning signs earlier, feeling judged by family (other than her parents), friends and others for the child's 'bad' behaviour and feeling powerless to help her child effectively, Chris was feeling outraged and desperate. After "giving up" on the child protection service which she experienced as unhelpful, it took months of dogged persistence on her part to find any financial help or personal and parenting support. Through a non-government welfare agency she joined a group of parents who shared similar experiences to her own. Hearing how they dealt with their children's behaviour and "...*knowing I wasn't the only one going through it*" was helpful. Through her participation in this group and with the on-going support of the family counsellor/group facilitator, Chris was motivated to contribute her story to the Child Protection Review in the hope that others would not have to go through what she has and continues to experience.