Part VI

WHAT KIND OF FAMILIES AND COMMUNITIES DO AUSTRALIA'S CHILDREN LIVE IN?

So far, this report has focused on health, learning and educational outcomes for Australian children, as well as risk and protective factors that influence these outcomes. However, wider environmental determinants also play a role in determining children's health and wellbeing. This includes the social, emotional, physical and economic wellbeing of families, and the strength of the communities in which they live.

Families play a crucial role in the lives of children, providing them with physical, emotional and economic support. Children who are raised in stimulating and nurturing environments have been shown to have better outcomes throughout their lives. Neighbourhoods also play a role in shaping children's health and wellbeing, with strongly connected communities associated with positive outcomes for children. The school and community contexts in which children live have a considerable influence over their health, development and wellbeing. These environments set the foundations for children's learning, behaviour and health over the course of their life.

Part VI provides information on family relationships, parental and community influences, and links with extended family, friends and the community, with the aim of improving our understanding of the contexts in which Australian children are growing up, and how these influence outcomes for children. Specifically, *Part VI* provides information on:

- family functioning
- family economic situation
- children in non-parental care
- parental health status
- neighbourhood safety
- social capital.

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

Indicator		Value	Trend
Family functioning	Under development	Data not available	..
Family economic situation	Average weekly real equivalised disposable household income for households with children in the second and third income deciles (2005–06)	$347	✓
Children in non-parental care	Children aged 0–14 years in out-of-home care (2008)	6.5 per 1,000	×
	Children aged 0–17 years in grandparent families (2006–07)	0.4%	✓
Parental health status	Parents rating their health as 'fair' or 'poor' (2006)	13%	..
	Children living with parents with disability (2003)	19%	..
	Parents with mental health problems (2006)	21%	..
Neighbourhood safety	Percentage of households with children aged 0–14 years where their neighbourhood is perceived as safe or very safe (2006)	86%	..
Social capital	Households with children aged 0–14 years where respondent was able to get support in time of crisis from persons outside the household (2006)	94%	~

Key: n.a = not available; ✓ = favourable trend; × = unfavourable trend; ~ = no change or clear trend; .. = no trend data presented.

26 Family functioning

The relationships that children have with their family, particularly their parents, are among the most important influences on child development and psychological wellbeing.

There are no national data on family functioning for families with children aged 0–14 years.

Family functioning is a key element of the family environment that influences child health and wellbeing. In general terms, family functioning is about how families interact, communicate, make decisions, solve problems and maintain relationships. The level of functioning within a family can be affected by changes in family circumstances, relationships between individual family members, the balance between parental employment and family life, and other external stressors that may affect the home environment. As such, families will often go through stages of strength and instability (Silberberg 2001).

The relationships that children have with their family, particularly their parents, are among the most important influences on child development and psychological wellbeing (Shonkoff & Phillips 2000). Living in a dysfunctional family can have adverse short- and long-term effects on the behaviour and wellbeing of children. A number of studies have found that elements of family functioning—such as family discord, communication and parental disciplinary style—are significant risk factors for children's poor mental health (Silburn et al. 1996; Sourander et al. 2006; Vostanis et al. 2006). Other research has found that children with a learning disability are more likely to come from poorly functioning families, and parental conflict during childhood has been linked with criminal behaviour later in life (Altarac & Saroha 2007; Fergusson & Horwood 2002).

There are many benefits for children living in strong and stable families, regardless of family type. These include having positive role models for building relationships, the ability to cope with changing circumstances and stressful life events, and higher self-esteem (Geggie et al. 2000; Shek 2002).

Although there is no real consensus on what constitutes 'family functioning', a number of Australian and international studies have identified similar key components: positive communication; spending time together; affection, support and commitment to the family; and adaptability (CFFC 2003; DeFrain 1999; Geggie et al. 2000; Wolcott 1999; Zubrick et al. 2000).

This chapter outlines the complexities associated with measuring family functioning, and provides information on children living in healthy functioning families.

MEASURING FAMILY FUNCTIONING

Due to the dynamic and multi-dimensional nature of family functioning, defining an indicator of family functioning is problematic. The level of functioning within a family may vary as families go through periods of change and stress—measuring family functioning at a single point in time will not capture this inherent changeability. Additionally, while using a single measure may not adequately capture the complexity of family functioning, the use of multiple detailed measures may be too cumbersome.

The Growing up in Australia: the Longitudinal Study of Australian Children (LSAC) collects an extensive range of family functioning measures, based on the interconnected relationships within a family—for example, conflict and relationship satisfaction between parents, discipline style and warmth between parents and children, and cohesion between siblings. While this provides a wealth of detailed information on specific components of family functioning, there is no measure of overall family functioning that could be reported for a national indicator.

Using a summary scale that can provide an overarching measure of family functioning is preferable for indicator-based reporting. The General Functioning Scale of the McMaster Family Assessment Device provides a single summary measure of family functioning, derived from a number of questions about communication, problem-solving, support and closeness within the family (Epstein et al. 1983). This scale is considered to have good reliability and validity (Byles et al. 1988; Miller et al. 1985). It was recommended as a measure of overall family functioning in a report by the Australian Government Department of Family and Community Services, and it has been used in a number of state-level surveys across Australia, and in national surveys overseas (Rowe et al. 2004; Zubrick et al. 2000).

HOW MANY CHILDREN LIVE IN HEALTHY FUNCTIONING FAMILIES?

Key national indicator: Proportion of children aged 0–14 years living in families reporting healthy family functioning

No national data are available on family functioning in families with children aged 0–14 years. Information on family functioning, based on the General Functioning Scale of the McMaster Family Assessment Device, is available from New South Wales and Victoria. Results from Victoria are presented here for families with children aged 0–12 years.

In 2006 in Victoria:

- Of families with children, 82% reported healthy family functioning and 16% reported unhealthy family functioning (family functioning was unknown for 2% of families).
- Unhealthy family functioning was more likely to be reported among families where the child had a special health care need (21%).
- One-parent families were more likely to report unhealthy family functioning (24%) than couple families (14%); however, this pattern may be affected by socioeconomic disadvantage.
- Families with children reporting unhealthy family functioning were less likely to be able to raise $2,000 in an emergency (an aspect of social capital) and were more likely to live in low socioeconomic status areas (Vic DHS 2007a).

Family cohesion

Family cohesion, that is, the ability of the family to get along with one another, is one aspect of family functioning. The LSAC measured family cohesion in families of two cohorts of children in Wave 2. At Wave 2, children in the birth cohort were aged 2–3 years and children in the child cohort were aged 6–7 years (see *Appendix 2* for more information on the LSAC).

According to the LSAC, family cohesion was reported to be 'excellent', 'very good' or 'good' in the vast majority of families of both cohorts—95% and 93% for families of 2–3 year olds and 6–7 year olds, respectively. The remainder of families reported 'fair' or 'poor' family cohesion.

Family functioning in Aboriginal and Torres Strait Islander families

The 2000–2002 Western Australian Aboriginal Child Health Survey measured family functioning using a culturally appropriate scale developed specifically for the survey. It included questions on support, communication, financial management and traditions within the family. Families with scores in the highest quartile of the family functioning scale were categorised as having 'very good' family functioning, although it was acknowledged that, in reality, the majority of families scored highly on the scale (Silburn et al. 2006).

See *Part IX* for further detail on these findings.

27 Family economic situation

Low family income can adversely affect the health, education and self-esteem of children.

In 2005–06, there were an estimated 421,300 low-income households with children aged 0–12 years. Weekly income for these households was on average $218 less than among middle-income households with children.

For most families, regular adequate income is the single most important determinant of their economic situation. Children living in families without adequate income are at a greater risk of poor health and educational outcomes, both in the short- and long-term. Children living in low-income families are more likely to have insufficient economic resources to support a minimum standard of living. This can affect a child's nutrition and access to medical care, the safety of their environment, level of stress in the family, quality and stability of their care, and provision of appropriate housing, heating and clothing (ABS 2006c; Shore 1997).

Studies have shown that children from low-income families are more prone to psychological or social difficulties, behavioural problems, lower self-regulation and elevated physiological markers of stress (Barnett 2008). An emerging field of research is investigating children's perspectives on economic adversity. Redmond's (2008) review reveals that a primary concern of economically disadvantaged children is being excluded from activities that other children appear to take for granted and the embarrassment that this can cause.

Notwithstanding the importance of adequate income in alleviating poverty and contributing to personal health and wellbeing, income poverty is just one dimension of poverty:

> Poverty encompasses a multitude of deprivations that are related, but not restricted, to low income or income inequality…aspects of living that are not easily named or measured, such as quality of life, social cohesion, family and social networks, autonomy and opportunity for future prosperity are also important in assessing levels of poverty. (Carson et al. 2007)

In this sense, children who are economically disadvantaged are not necessarily the most disadvantaged children.

Close family relationships, particularly closeness to at least one parent, appear to protect children from the worst effects of economic disadvantage. In contrast, economic disadvantage coupled with low family support, or strained or abusive relationships can cause children to lower their aspirations, exclude themselves from activities or engage in antisocial behaviour (Heady et al. 2006). Although this chapter focuses on income disadvantage and jobless families, many of these other issues are covered in other chapters of this report.

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

HOUSEHOLD INCOME

A household's income is derived from regular and recurring cash receipts, including money from wages and salaries, government pensions and allowances, and other sources such as superannuation, child support and profit or loss from business or investment income (ABS 2007b). This chapter presents results from the ABS Survey of Income and Housing, which measures net household income, that is, disposable income after the deduction of income tax liability and the Medicare levy.

The ABS 2005–06 Survey of Income and Housing found that people in the 'low-income' group accounted for about 11% of disposable household income nationally. The 'low-income' group is defined as the 20% of the population in the second and third income deciles (the lowest decile is not used because household income is not always a good indicator of the total economic resources available to many people with incomes close to nil or negative; ABS 2007b).

Income is usually received by individuals but shared among family members. Household size and composition can therefore have a large impact on the material standard of living that a given income can support. Income distribution and trends are generally analysed using the concept of equivalised income, whereby an equivalence scale is used to adjust household income for household size and composition (for details of the modified OECD equivalence scale used by the ABS see ABS 2007c).

In this chapter 'household income' refers to average equivalised disposable household income in 2005–06 dollars and 'low-income households' refer to households in the second and third income deciles.

Headline Indicator: Average real equivalised disposable household income for households with children aged 0–12 years in the second and third income deciles

In 2005–06, low-income households with children aged 0–12 years:

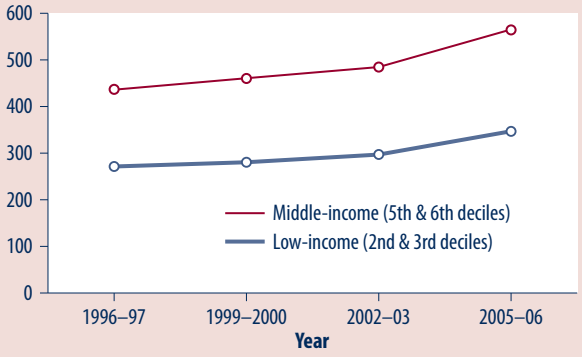
- accounted for 421,300 households Australia-wide and received on average $347 a week
- received on average $218 a week less than medium-income households with children aged 0–12 years (fifth and sixth income deciles) (ABS 2005–06 Survey of Income and Housing, unpublished data).

Between 1996–97 and 2005–06:

- The average income of low-income households with children aged 0–12 years increased in real terms by 28%, slightly less than the increase recorded by middle-income households with children aged 0–12 years over the same period (30%) (Figure 27.1).
- The rate of increase for both low- and middle-income households with children aged 0–12 was greatest between 2002–03 and 2005–06 (for example, the average annual increase was nearly 6% for this period for low-income households compared with under 2% annually between 1996–97 and 2002–03). This coincides with a period of relatively high employment rates, wage growth and return on investments, although other factors, such as methodological improvements to the survey (for example, the inclusion of salary-sacrificed amounts and more refined questions) and changes to personal income tax rates and thresholds may also have contributed (ABS 2007b).

Income is not the only economic resource available to households. Households with higher levels of wealth can use these assets to support a higher standard of living. Outright ownership of a dwelling, for example, can substantially reduce living costs. The ABS uses the concept of 'low economic resources' to encompass low income and low wealth (ABS 2006c). There is fairly close agreement between low income and low total economic resources for families with children, many of whom live in private rental or public housing.

Internationally, 10 out of 24 OECD countries had a lower proportion of children living in relative income poverty than Australia— in 1999, 12% of Australian children aged 0–17 years lived in households with equivalent income of less than 50% of the median household income (UNICEF 2007b).



Note: Data for all years are expressed in 2005–06 dollars.
Source: ABS Surveys of Income and Housing, unpublished data.

Figure 27.1: Mean equivalised disposable income for households with children aged 0–12 years, 1996–97 to 2005–06

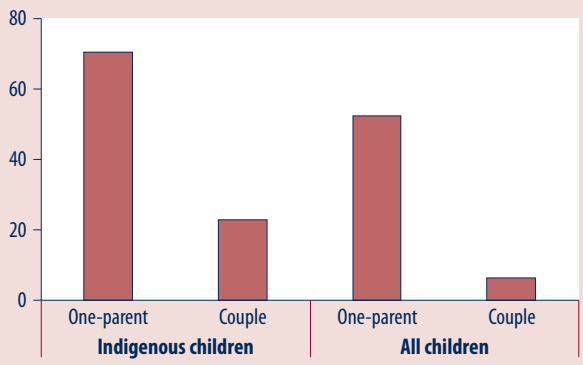
JOBLESS FAMILIES

Jobless families are disproportionately likely to be reliant on welfare, have low incomes and experience financial stress. Members of jobless households report worse physical and mental health and lower life satisfaction than members of households where someone is employed (Heady & Verick 2006). Studies on the effects of unemployment on other family members have identified relationships between parental joblessness and family conflict, family breakdown and child abuse (McClelland 2000). Secure employment provides financial stability, self-confidence and social contact for parents, with positive effects flowing on to children.

In 2006, among children aged 0–14 years:

- Around 15%, or 543,600, lived in jobless families, a decline from 19% in 1996 (ABS 1996 and 2006 Censuses, unpublished data).
- Over half of children (52% or 362,800) in one-parent families did not live with an employed parent, compared with 6% in couple-parent families (180,800 children).
- Nearly half (45% or 67,600) of Indigenous children aged 0–14 years lived in jobless families—3 times the proportion of all children. The higher proportion of Indigenous children living in one-parent families would have contributed to this higher rate (45% of Indigenous children live in one-parent families compared with 20% of all children); 71% of Indigenous children living in one-parent families did not live with an employed parent (Figure 27.2).

Australia had the second highest proportion of working-age jobless families with children aged 0–17 out of 24 OECD countries in 2000 (UNICEF 2007b), largely due to the relatively high rate of one-parent households in Australia and the high rate of joblessness among this group (Whiteford 2008).



Source: ABS 2006 Census of Population and Housing, unpublished data.

Figure 27.2: Children living in jobless families, by Indigenous status and family type, 2006

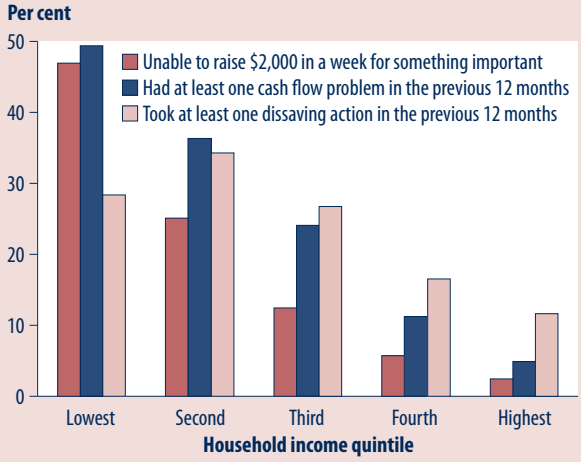
FINANCIAL STRESS

Financial stress is not limited to households with low incomes, nor does being on a low income necessarily imply that a person experiences financial stress. However, people in the lower household income quintiles were more likely to report a range of financial stressors.

According to the ABS 2006 General Social Survey, almost half (47%) of households with children aged 0–14 years in the lowest income quintile reported being unable to raise $2,000 within a week. A similar proportion (49%) reported at least one cash flow problem in the previous year, and more than a quarter (28%) took at least one dissaving action in the previous year (see note to Figure 27.3 for explanation of dissaving actions). This compares with 3%, 5%, and 12%, respectively, in the highest income quintile (Figure 27.3).

One-parent families with children aged 0–14 years were more likely to have experienced financial stress than couple-parent families with children:

- Of one-parent families, 42% reported they could not raise $2,000 within a week for something important, higher than the 12% of couple-parent families.
- Half (50%) had experienced at least one cash flow problem in the previous year compared with 19% of couple-parent families.
- One-third (34%) took at least one dissaving action in the previous year, compared with 22% of couple-parent families (AIHW analysis of ABS 2006 General Social Survey confidentialised unit record file).



Notes

1. Cash flow problems include not being able to pay bills, mortgage or rent on time; going without meals or being unable to heat home; seeking financial assistance from family, friends or a welfare agency.
2. Dissaving actions include reducing home loan repayments, drawing on accumulated savings, increasing the amount owing on credit cards, taking out a personal loan, borrowing money from family or friends, selling assets and other actions.
3. Quintiles formed using equivalised disposable household income of all households for which income was known.

Source: AIHW analysis of ABS 2006 General Social Survey confidentialised unit record file.

Figure 27.3: Selected financial stress indicators by equivalised household income, households with children aged 0–14 years, 2006

28 Children in non-parental care

Children in out-of-home care represent a particularly disadvantaged group—most have experienced child abuse or neglect, as well as the breakdown of their families.

In 2008, around 26,700 children were in out-of-home care (6.5 per 1,000). Indigenous children are overrepresented in out-of-home care at 9 times the rate of other children.

The vast majority of children in Australia live with one or both of their parents, however, in some cases parents are unable to care for their children and fulfil their parental responsibilities. The reasons for this are varied, and may include parental substance abuse, incarceration of a parent, the death of one or both parents, a parent's mental or physical illness, a child's disability or poor health, or the child's need for a more protective environment (AIHW 2007a).

Children living in non-parental care represent a particularly disadvantaged group. Many have suffered child abuse or neglect, or family relationship breakdown (particularly breakdowns in parent–child relationships), while others have suffered emotional trauma through the loss of one or both parents. The need to support and strengthen positive outcomes for children living in non-parental care is of critical importance, especially as many more children today are living in non-parental care than 20, and even 10, years ago.

Children in non-parental care are living in a variety of living arrangements, for example in foster care, with grandparents or other relatives, and in residential care. Over the last 30 years there has been a shift away from the use of residential care for children at risk of abuse and neglect towards foster care and other forms of home-based care, including relative/kinship care. In Australia, kinship care is largely provided by grandparents, and much of the kinship care for children, including the care provided by grandparents, occurs outside the formal child protection system (Smyth & Eardley 2008). Most children placed in out-of-home care are eventually reunited with their families (AIHW 2009c).

The focus of this chapter is on children living in out-of-home care through contact with child protection authorities in the states and territories (formal out-of-home care). However, other types of non-parental care are also discussed: children in grandparent families and those in disability supported accommodation.

CHILDREN IN OUT-OF-HOME CARE

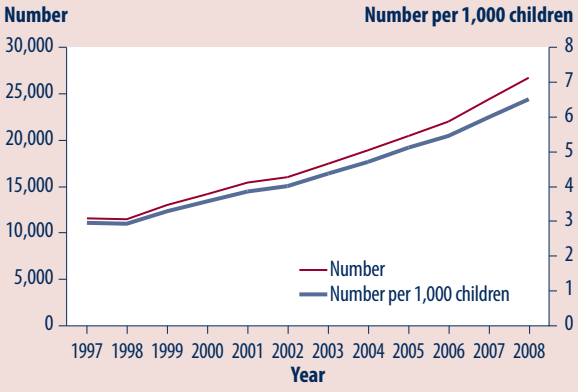
Out-of-home care provides alternative accommodation for children and young people who are unable to live with their parents; it is defined as overnight care for children under 18 years of age, where the state or territory makes a financial payment or where a financial payment has been offered but has been declined. Although no national data are available on the reasons children are placed in out-of-home care, reasons could include child abuse or neglect, or a parent's inability to care for the child. Out-of-home care can include placements with relatives other than parents. Children in out-of-home care include those in both legal and voluntary placements (see also *Chapter 34 Child abuse and neglect*). The data exclude children who are living in out-of-home care outside the auspices of the child protection system, such as placements made in disability services, medical or psychiatric services, juvenile justice facilities, overnight child care services or supported accommodation assistance services. However, some jurisdictions are not always able to exclude these placements from the data, and this should be taken into account when comparing state and territory figures. Children in unfunded placements are excluded from the National Child Protection Data Collection held by the AIHW.

Key national indicator: Rate of children aged 0–14 years in out of home care

As at 30 June 2008, among children aged 0–14 years:

- Around 26,700 were living in out-of-home care, a rate of 6.5 per 1,000 children (Figure 28.1).
- The number and rate of children in out-of-home care has more than doubled since 1997—the number has increased from 11,600 to 26,700 and the rate from 3.0 placements per 1,000 children in 1997 to 6.5 in 2008 (Figure 28.1).

This increase results from more children commencing out-of-home care than are being discharged each year rather than simply more children commencing out-of-home care. The increased duration of out-of-home care placements reflects the increasing complexity of family situations faced by these children (Layton 2003; Tennant et al. 2003; Vic DHS 2002). Some of these factors include low family income, parental substance abuse, mental health issues and family violence.



Note: Children in out-of-home care as at 30 June.
Source: AIHW National Child Protection Data Collection.

Figure 28.1: Children aged 0–14 years in out-of-home care, 1997 to 2008

Living arrangements of those in out-of-home care

In 2008, among children aged 0–14 years:

- The majority of children in out-of-home care were in home-based care (95%), either foster care (49%) or living with relatives (46%). Smaller proportions of children were in residential care (3.2%) or other care arrangements (1.8%) (Table 28.1).
- Older children were generally more likely to be in out-of-home care—71% of children in out-of-home care were aged 5–14 years and only 4% were infants.
- Infants were less likely than older children to have been living with relatives (33% compared with 46% of children aged 1–14 years), but were more likely to have been in foster care (65% compared with 48% of children 1–14 years).
- Although the proportions were relatively small, children aged 10–14 years were more likely than younger children to have been in residential care (6.7% compared with less than 2% for younger children).

Are rates of out-of-home care different for Aboriginal and Torres Strait Islander children?

In 2008, Aboriginal and Torres Strait Islander children aged 0–14 years were 9 times as likely to be in out-of-home care as non-Indigenous children (44 in every 1,000 compared with 4.8). A further discussion of these data and the overrepresentation of Indigenous children in out-of-home care is presented in *Part IX*.

Table 28.1: Children aged 0–14 years in out-of-home care, type of care at 30 June 2008

	Relatives/kin		Foster care		Residential care		Other		Total	
Age	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
< 1 year	356	1.3	701	2.6	20	0.1	6	< 0.1	1,083	4.1
1–4 years	2,950	11.0	3,542	13.3	46	0.2	86	0.3	6,624	24.8
5–9 years	4,490	16.8	4,488	16.8	123	0.5	172	0.6	9,273	34.7
10–14 years	4,465	16.7	4,404	16.5	656	2.5	212	0.8	9,737	36.4
Total	**12,261**	**45.9**	**13,135**	**49.2**	**845**	**3.2**	**476**	**1.8**	**26,717**	**100.0**

Source: AIHW National Child Protection Data Collection.

OTHER TYPES OF NON-PARENTAL CARE

Grandparent families

Grandparent families can generally be defined as those in which grandparents are raising their grandchildren. Typically, grandparents take on the role of primary carers of their grandchildren because parents are no longer able to fulfil their parental responsibilities. The reasons for this often include parental substance abuse, the death of one or both parents, a parent's mental or physical illness, or the child's need for a more protective environment (COTA 2003). For grandparents, the increase in responsibility in fully caring for their grandchildren has legal, financial, lifestyle and health consequences that can adversely effect their health and wellbeing.

Data on grandparent families are drawn primarily from the 2006–07 ABS Family Characteristics and Transitions Survey, with some additional information from the 2006 ABS Census of Population and Housing. The survey has the advantages of providing a clear identification of the child–guardian link in a household and allowing comparison with data from 2003, while having the disadvantage of a reduced sample size in 2006–07, which increases the statistical uncertainty of estimates. The 2006 Census was the first for which an analysis of grandparent families was possible. While the Census is a rich source of information and gathers information from a large proportion of the Australian population, it is not as robust as the Family Characteristics and Transition Survey at establishing the child–guardian connection in a household. For example, in more than half (54%) of grandparent families (as classified by the Census), there were other adults or children present who, in some cases, may have been the parent of the child.

Key national indicator: Proportion of children aged 0–17 years in grandparent families

According to the ABS 2006–07 Family Characteristics and Transitions Survey:

- There were an estimated 14,000 grandparent families with children aged 0–17 years (about 0.5% of all families with children). This equates to an estimated 18,900 children (0.4% of all children) (ABS 2008h; AIHW analysis of ABS 2006–07 Family Characteristics and Transitions Survey confidentialised unit record file).
- Between 2003 and 2006–07, the estimated number of grandparent families with children aged 0–17 years declined from 22,500 (95% CI ± 5,500) to 14,000 (95% CI ± 7,000). While this decline was statistically significant, the relatively large confidence intervals indicate that the size of the decline is uncertain.

Some key findings from the 2006 Census of Population and Housing for grandparent families with children aged 0–14 years include:

- Indigenous children were more likely to live in grandparent families—4.6% of Indigenous children compared with 0.6% of all children. Around one-third (32%) of children living in grandparent families were Indigenous.
- Children living in grandparent families were twice as likely to be living in a household with a lower or very low gross equivalised household income than children living with their parents. Grandparents caring for children also had a lower rate of outright home ownership than other older Australians.
- Grandparent families were on average slightly smaller than couple-parent (natural or adoptive) families—4.04 people compared with 4.15—but were slightly larger than one-parent (natural or adoptive) families (3.02). On average there were 1.9 grandchildren in each grandparent family (ABS 2009).

Disability supported accommodation

Children living in disability supported accommodation represent a very small proportion of children in non-parental care—the majority of children with disabilities live at home. Those who cannot be cared for at home may live in disability supported accommodation funded under the Commonwealth State/Territory Disability Agreement (CSTDA).

In 2006–07, 49,192 children aged 0–14 years accessed CSTDA support, representing one-fifth of all service users. Of these children, the majority (99%) were not living in supported accommodation for CSTDA service users (domestic-scale accommodation or supported accommodation facilities), but were in other types of accommodation such as their homes, usually with parents ('private residences' in Table 28.2). Children aged 10–14 years accounted for 62% of children who stayed in supported accommodation for CSTDA service users (167 of the 268 children who were accommodated) (Table 28.2).

Table 28.2: Users of CSTDA-funded services aged 0–14 years, age by residential setting, 2006–07

Age group (years)	Domestic-scale supported living facility	Supported accommodation facility	Private residence	Other/not stated	Total
0–4	32	23	14,831	982	15,868
5–9	25	21	17,510	2,140	19,696
10–14	105	62	11,300	2,161	13,628
Total	**162**	**106**	**43,641**	**5,283**	**49,192**

Notes

1. Service user data are estimates after the use of a statistical linkage key to account for individuals who received services from more than one service type outlet during the 12-month period.
2. Service user data were not collected for all CSTDA service types.
3. 'Other' includes residence in an Aboriginal or Torres Strait Islander community; boarding house or private hotel; independent living in a retirement village; residential aged care facility; psychiatric or mental health community care facility; hospital; short-term crisis, emergency or transitional accommodation facility; public place or temporary shelter; and other.

Source: CSTDA National Minimum Data Set 2006–07, unpublished data.

29 Parental health status

Raising children involves physical, emotional and financial demands that can pose significant challenges to a parent with disability or a mental health problem.

Around 13% of parents living with children rated their health as fair or poor and around one-fifth were affected by poor mental health. An estimated one-fifth of children live with a parent with disability.

Children living with a chronically ill parent can experience stressful life events that can negatively affect their health and wellbeing. This is because a parent with a chronic illness, such as kidney failure or mental illness, may experience frequent medical procedures and hospitalisations, loss of income, dependency on other family members, changes to the appearance of their body, social stigmatisation and, in some conditions, the possibility of premature death (Romer & Barkmann 2002).

In these circumstances, the physical, emotional or economic needs of children may not be met, increasing their risk of long-term mental health and behavioural problems (Barkmann et al. 2007; Romer & Barkmann 2002). Studies have also shown that children whose parents have a mental illness are also more likely to experience learning disabilities and perform poorly academically, and are susceptible to substance abuse (Kowalenko et al. 2000; Lancaster 1999).

While many parents who have a chronic illness or disability are capable parents, these health problems can affect the parent–child relationship. Depending on the severity of the parental illness or disability, the wellbeing of children may be affected by factors such as family discord, discontinuity of care, poor parenting skills, social isolation and poverty, and they may experience developmental delays (ABS 1999; AICAFMHA 2001; McConnell et al. 2003).

A child living with a chronically ill parent or parent with disability may also take on greater responsibilities or, in some cases, care for the parent. Taking on a caring role may be rewarding; however, it can also significantly affect the life of a child or young person. These children may be less involved in community, educational and social activities (CA 2001). The ability of children to cope in these circumstances varies with their age, gender, developmental stage, personality, severity of their parent's health condition and the support they receive from other family members (Steck et al. 2005).

Children living with parents who are problematic alcohol or substance users are at greater risk of poor health and wellbeing outcomes. The impact of parental substance use on children may differ between families depending on their level of risk and protective factors; however, children are at greater risk when exposed to multiple risk factors over a long period of time. These factors may include parental mental health problems, socioeconomic disadvantage, social isolation, crime and violence (including verbal, physical and/or sexual) (Dawe et al. 2007). Parents who are problematic alcohol or substance users often have co-existing mental health problems.

This chapter explores four aspects of parental health: parents' self-assessed health status, parents with disability or poor mental health, and parental substance use.

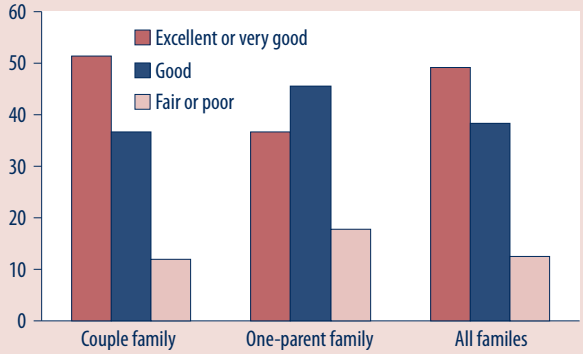
PARENTS WITH POOR HEALTH

Even relatively mild health conditions that do not greatly affect a parent's functioning may lead to some adverse outcomes for children. An individual's rating of their own overall health is often used as an indicator of health status and, at the population level, as a predictor of health service use and mortality (AIHW 2008b).

Key national indicator: Proportion of parents rating their health as 'fair' or 'poor'

In 2006, according to the Household, Income and Labour Dynamics in Australia (HILDA) Survey, among parents of co-resident children aged 0–14 years:

- An estimated 13% of parents (or around 446,000) rated their health as fair or poor. The majority of parents rated their health as good, very good or excellent (87% or an estimated 3.1 million parents) (Figure 29.1).
- Parents in one-parent families were more likely to rate their health as fair or poor compared with parents in couple families (18% and 12%, respectively), consistent with findings that indicate that one-parent families have a greater risk of social disadvantage in terms of employment, housing, income and social participation, leading to poorer health outcomes (Robinson 2008).



Source: AIHW analysis of Household, Income and Labour Dynamics in Australia Survey, Wave 6.

Figure 29.1: Self-assessed health status of parents with co-resident children aged 0–14 years, 2006

PARENTS WITH DISABILITY

Raising children involves physical, emotional and financial demands that can pose significant challenges to a parent with disability. Parental disability can affect children in different ways, for example by reducing family income or limiting opportunity for community participation. Some children who provide intensive ongoing care to a parent with disability may have their schooling interrupted, with long-term implications for educational attainment, employment and the successful transition from home to independent living (CA 2001).

In the ABS Survey of Disability, Ageing and Carers (SDAC), a person is considered to have disability if they reported at least one of a list of impairments, health conditions or limitations that restricted everyday activities and that had lasted—or was likely to last—for at least 6 months (see *Appendix 2* for more information on this survey).

Key national indicator: Proportion of children living with parents with disability

According to the ABS 2003 Survey of Disability, Ageing and Carers, among children aged 0–14 years in 2003:

- About one in five, or 742,800, lived with a parent with disability (Table 29.1). Almost one-quarter, or 172,800, of these children lived with a parent who had severe or profound core activity limitation (meaning that they sometimes or always needed assistance with activities of daily living—self-care, mobility or communication).
- Around 69,000 children were caring for a parent with disability, representing around 1.7% of all children. The proportion of these children who were primary carers can not be determined, as primary carers were only identified among those aged 15 years and over in this survey.
- There were around 435,100 families with children where there was at least one parent with disability, representing one-fifth of all families (Table 29.1).

Table 29.1: Children living with a parent with disability, 2003

	Couple families		One-parent families		Total with one or both parents with disability	
Age group	Number ('000)	Per cent	Number ('000)	Per cent	Number ('000)	Per cent
0–4 years	174.4	16.6	28.6	16.8	203.0	16.6
5–9 years	199.0	19.1	50.6	19.6	249.6	19.2
10–14 years	231.2	22.3	59.0	20.4	290.3	21.9
Children 0–14 years[a]	**604.6**	**19.3**	**138.2**	**19.3**	**742.8**	**19.3**
Families[b]	**337.0**	**19.6**	**98.1**	**20.7**	**435.1**	**19.9**

(a) Children aged 0–14 years living with at least one parent with disability.
(b) Families with children aged under 15 years where at least one parent has disability.
Note: As families may have more than one child, the number of children with a parent with disability is greater than the number of parents with disability.
Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

PARENTS WITH A MENTAL HEALTH PROBLEM

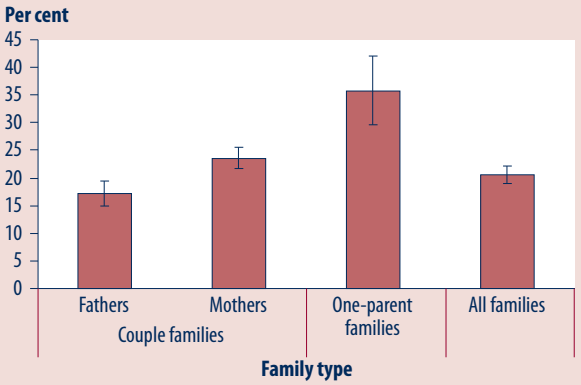
Children living with a parent with a mental health problem may be at increased risk of social, psychological and physical health problems compared with children in families not affected by mental illness. An estimated 25–50% of children living with a parent with a mental health problem experience a psychological disorder during childhood, adolescence or adulthood compared with 10–14% of children in the general population (Mayberry et al. 2005). This may be due to a combination of factors that increase the risk of mental health problems among children, including genetic inheritance, poverty, homelessness and extra caring responsibilities (Fudge & Mason 2004). Children may also experience physical and/or sexual violence, verbal abuse, neglect, loss of close intimate contact with a parent, and social and emotional problems as a result of poor parental mental health (Cooklin 2006).

Measuring the number of children with a parent with a mental health problem is difficult as the parental role of people accessing mental health services is not always recorded and definitions of mental health can vary in survey data. One measure of mental health is available from the Short Form 36 (SF-36)—a 36-item questionnaire that measures eight domains of subjective health. The scores from this questionnaire can be summarised to produce a single measure of mental health: the Mental Health Component Summary (MCS) score. An analysis of population averages suggests that an MCS score less than 41 is indicative of poor mental health.

Key national indicator: Proportion of parents with mental health problems

In 2006, according to the Household, Income and Labour Dynamics in Australia Survey (HILDA), among parents with co-resident children aged 0–14 years:

- Around one-fifth (21%) had MCS scores of less than 41, indicating poor mental health (Figure 29.2).
- A significantly higher proportion of mothers scored poorly (MCS score of less than 41) than fathers (24% and 17%, respectively).
- Lone parents were almost twice as likely to have an MCS score of less than 41 as parents in couple families (36% and 19%, respectively).



Note: AIHW analysis of Household, Income and Labour Dynamics in Australia Survey, Wave 6.

Figure 29.2: Parents with co-resident children aged 0–14 years with a Mental Health Component Summary score of less than 41, by family type, 2006

Does parental health status vary across population groups?

In terms of mental health, there was no statistically significant difference in MCS scores between Indigenous and non-Indigenous parents according to the 2006 HILDA Survey. This may be due to the small number of Indigenous parents in this survey. There are no reliable national estimates of self-assessed health or disability status for Indigenous parents.

Parents living in the lowest socioeconomic status (SES) areas were more likely to report fair or poor health (17%) and to have an MCS score indicative of poor mental health (26%), than those in the highest (SES) areas (7% and 15%, respectively), according to the 2006 HILDA Survey.

Parental substance abuse

There is limited national data available on illicit substance use among parents in Australia. According to the 2007 National Drug Strategy Household Survey, an estimated 12% of parents with children aged 0–14 years used either an illicit substance (such as marijuana or ecstasy) or a licit substance for non-medical purposes (such as pain killers) in the previous 12 months. This was slightly lower than among adults without children (14%).

Risky and high risk alcohol use for short and long-term harm among parents was also estimated in the 2007 National Drug Strategy Household Survey. Risky and high risk alcohol use was defined using the 2001 Australian alcohol guidelines (NHMRC 2001) (Table 29.2).

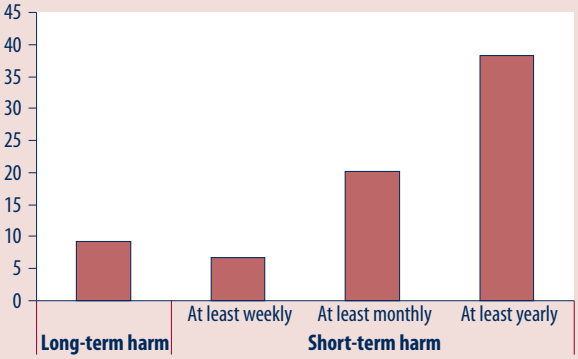
Table 29.2 Alcohol consumption associated with harm among people aged 18 years and over

Alcohol consumption associated with harm	Short-term harm		Long-term harm	
	Risky	High-risk	Risky	High-risk
Males	7 to 10 standard drinks on any one day	11 or more standard drinks on one day	29 to 42 standard drinks per week	43 or more standard drinks per week
Females	5 to 6 standard drinks on any one day	7 or more standard drinks on any one day	15 to 28 standard drinks on any one day	29 or more standard drinks per week

Source: NHMRC 2001.

In terms of alcohol use among parents with dependent children aged less than 15 years:

- An estimated 7% of parents drank at risky or high-risk levels for short-term harm at least weekly. One in five (20%) and two in five (38%) parents drank at these levels at least monthly or yearly (Figure 29.3).
- An estimated 9% of parents drank at risky or high-risk levels for long-term harm.



Note: The alcohol risk categories are based on the NHMRC Alcohol Guidelines 2001 (NHMRC 2001). The AIHW is currently reviewing the presentation of these survey data given the recent release of the NHMRC *Australian Guidelines to reduce health risks from drinking alcohol 2009* (NHMRC 2009).

Source: 2007 National Drug Strategy Household Survey, unpublished data.

Figure 29.3: Risky and high-risk alcohol use for short- and long-term harm among parents of children aged 0–14 years, 2007

30 Neighbourhood safety

Children are shaped not only by their family environment, but also by the neighbourhood contexts in which they live.

Around 86% of households with children perceived their neighbourhood as safe or very safe all the time in 2006.

Children are shaped not only by their family environment but also by the neighbourhood context in which they live. A number of neighbourhood characteristics influence child outcomes, including the availability of local social networks, peer influences, quality of local services, economic opportunities, and exposure to crime and violence (Curtis et al. 2004). Parental perception of these neighbourhood characteristics can have a significant impact on children's health, development and wellbeing.

High neighbourhood quality has been associated with positive outcomes for children, including lower levels of child maltreatment and youth delinquency, and higher levels of physical and mental health and educational attainment. One of the most common indicators of neighbourhood quality is parents' perception of neighbourhood safety (Ferguson 2006). This is often associated with how safe people feel when they are alone at home during either the day or night, and refers to individuals' perceptions of their vulnerability to, or protection from, personal harm. Fear of crime, whether founded or perceived, detracts from quality of life and is a deterrent from participation in the local community.

Parental perception of neighbourhood safety affects children's daily activities, as parents typically exert substantial control over where children spend their time. Fear of exposing their children to risks may lead parents to restrict their children from outdoor activities, particularly while unsupervised (Galster & Santiago 2006), which could lead to a more sedentary lifestyle and weight gain.

SAFETY OF CHILDREN'S NEIGHBOURHOODS IN AUSTRALIA

The data in this section are drawn from the ABS 2006 General Social Survey. Respondents were asked about their feelings of safety when home alone during the day and at night. In 2006, only a very small number of respondents from households with children aged 0–14 years reported that they felt unsafe or very unsafe, and due to the high relative standard errors associated with such small numbers, these estimates cannot be presented. The indicator of neighbourhood safety presented here is therefore defined as the proportion of respondents who reported that they felt safe or very safe when home alone during the day and at night.

Key national indicator: Proportion of households with children aged 0–14 years where their neighbourhood is perceived as safe or very safe

In 2006, of those respondents living in households with children aged 0–14 years:

- The majority (86% of households) reported feeling safe or very safe all the time (that is, both during the day and at night). Respondents were more likely to feel safe or very safe during the day (96%) than at night (86%) (Table 30.1).
- Those living in the lowest socioeconomic status (SES) areas were less likely to always feel safe or very safe compared with those in the highest SES areas (78% of households compared with 88%).
- Those living in *Major cities* were less likely to have reported feeling safe or very safe all the time compared with those living in *Inner regional* and *Other* areas (84% compared with 89–90%).

- A higher proportion of respondents from Australia and mainly English-speaking countries reported feeling safe or very safe all the time, compared with respondents from mainly non-English-speaking countries (87% of households compared with 79%).

Table 30.1: Households with children aged 0–14 years where neighbourhood is perceived as safe or very safe, 2006 (per cent)

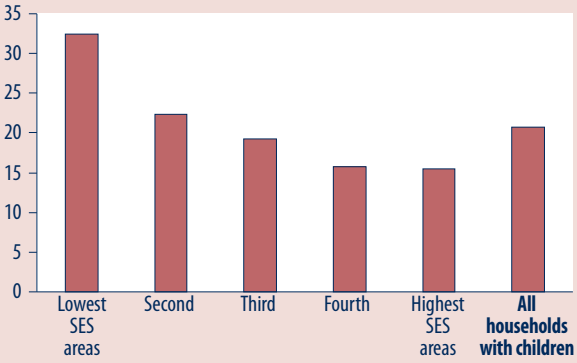
	Always feels safe or very safe		
Household characteristics	**Day and night**	**During day**	**At night**
Socioeconomic status[(a)]			
Lowest SES areas	78.1	91.1	78.2
Highest SES areas	88.2	96.8	88.3
Remoteness			
Major cities	83.6	94.8	83.7
Inner regional	89.3	97.7	89.4
Other areas[(b)]	89.8	96.2	89.7
Country of birth			
Australia and mainly English-speaking countries[(c)]	87.1	96.6	87.2
Other (mainly non-English-speaking countries)	78.7	90.9	78.9
Australia	**85.6**	**95.6**	**85.7**

(a) See *Appendix 1 Methods* for explanation of socioeconomic status (SES).
(b) Includes *Outer regional* and *Remote areas*. Very remote areas were excluded from the Survey.
(c) Mainly English-speaking countries include Canada, Ireland, New Zealand, South Africa, United Kingdom and United States of America.
Note: Excludes respondents who are never home alone during the day and/or night.
Source: AIHW analysis of ABS 2006 General Social Survey confidentialised unit record file.

NEIGHBOURHOOD CRIME

In addition to collecting information on perceived neighbourhood safety, in 2006 the ABS General Social Survey asked respondents if they had been the victim of assault or break-in during the previous 12 months. Among respondents from households with children aged 0–14 years:

- One in five (21%) had been a victim of assault or break-in during the previous 12 months.
- The proportion who were victims of assault or break-in was twice as high among those living in the lowest socioeconomic status (SES) areas (32%) compared with those from the highest SES areas (16%) (Figure 30.1).



Note: See *Appendix 1 Methods* for explanation of socioeconomic status (SES).
Source: AIHW analysis of ABS 2006 General Social Survey confidentialised unit record file.

Figure 30.1: Households with children aged 0–14 years where respondent was a victim of assault or break-in, by socioeconomic status, 2006

31 Social capital

Families with rich social networks have been found to have increased access to information, material resources, and friends and neighbours to assist them in managing their daily lives and problems.

Most families with children (94%) were able to access social support and had weekly contact with family and friends (97%).

Social capital is an important aspect of the social context in which a child develops. Social capital can be understood as networks of social relationships, characterised by norms of trust and reciprocity; it is the name given to quality relationships that enable people to come together to collectively share experiences or resolve problems and where all involved can achieve mutually desired benefits (Stone & Hughes 2000). Strong connections between individuals promote a sense of belonging and provide access to support. This can be represented by the degree to which people feel they can get assistance from neighbours, allow their children to play outside safely, and participate in community activities (Zwi & Henry 2005).

Families with rich social networks have been found to have increased access to information, material resources and friends and neighbours to assist them in managing their daily lives and problems. For children, the benefits of social capital include positive mental health and behavioural outcomes in childhood and later life, reduced school dropout rates and an increased likelihood of gaining meaningful employment (Ferguson 2006). Strong family relationships and supportive neighbourhoods protect children and young people against the adverse effects of socioeconomic disadvantage, leading to improved health for children and youth in economically poor communities (Attree 2004 cited in Zwi & Henry 2005).

Social capital can be measured in a variety of ways. The ABS, for example, has developed the Social Capital Framework, which contains four broad dimensions to describe social networks and relationships: network qualities, network structure, network transactions and network types. The Framework is based on the notion that people have social networks and relationships with other people in society such as family members, friends, neighbours, colleagues and acquaintances, and with organisations (ABS 2006a).

Due to this multi-dimensional nature of social capital, it is difficult to summarise in one measure. Measures of social capital used in this section are limited to social support networks, due to lack of data. Support networks, a key aspect of social capital, can act in a variety of ways, such as provision of information or emotional, practical or financial support, and these in turn provide individuals with a sense of belonging. Social support in a time of crisis has been selected as the key national indicator, as having someone to rely on in emergency situations is a safety net that is vitally important, and especially so for families with children. Contact with family and friends and sources of social support (where families with children could ask for small favours) are also presented here as indications of the positive aspects of social networks.

Key national indicator: Proportion of households with children aged 0–14 years where respondent was able to get support in time of crisis from persons living outside the household

According to the ABS 2006 General Social Survey, of those households with children aged 0–14 years:

- Over 94% were able to get support in times of crisis from someone outside the household (Table 31.1), a similar proportion to all households (93%). The person contacted for support was most often a family member (87%), a friend (76%) or a neighbour (38%). These proportions were similar to those reported in the ABS 2002 General Social Survey.
- About 94% could ask for small favours, and 97% had weekly contact with family or friends.
- Couple-parent households were slightly more likely than one-parent households to be able to get support in a time of crisis or to ask for small favours (almost 2 percentage points higher), while making contact with family or friends was similar for both family types.

- Of households where the respondent was employed, 96% were able to get support in a time of crisis. This was greater than the 91% of households where the respondent was unemployed and the 89% where the respondent was not in the labour force.

Do these measures of social support networks vary across population groups?

The data presented in Table 31.1 suggest an association between these three measures of social support networks and socioeconomic status, and also between these measures and country of birth. There was little variation across remoteness areas for these measures.

- Households with children in the lowest socioeconomic status (SES) areas were less likely to be able to access these three measures of social support than families in the highest SES areas:
  - 6 percentage points lower for 'able to get support in a time of crisis' or 'able to ask for small favours'
  - 3 percentage points lower for 'weekly contact with family or friends'.

  However, over 90% of respondents living in the lowest SES areas still reported that they had access to these measures of support (Table 31.1).
- Households with children where the respondent was born in a mainly non-English-speaking country compared with those born in Australia or in a mainly English-speaking country were less likely to:
  - be able to get support in times of crisis (84% of households compared with 96%)
  - be able to ask for small favours (86% compared with 96%)
  - have weekly contact with family or friends (94% compared to 97%).

The ABS 2002 National Aboriginal and Torres Strait Islander Social Survey found that the majority (91%) of households with an Indigenous respondent with children aged 0–14 years were able to get support in a time of crisis from someone living outside the household; slightly lower than the proportion of all respondents from households with children aged 0–14 years (95%) in the ABS 2002 General Social Survey. See *Part IX* for further information on social capital in the Indigenous context.

Table 31.1: Measures of social support networks in one-family households with children aged 0–14 years, 2006 (per cent)

Household characteristics	Able to get support in time of crisis[a]	Could ask for small favours[b]	Has weekly contact with family or friends
Family type			
Couple-parent family	94.8	94.4	96.9
One-parent family	92.9	92.7	96.4
Employment status			
Employed	96.2	96.3	97.3
Unemployed	90.8	86.6	91.4
Not in labour force	89.0	87.7	95.8
Socioeconomic status[c]			
Lowest SES areas	90.9	90.6	94.3
Highest SES areas	96.4	96.3	97.9
Remoteness			
Major cities	93.9	94.0	96.9
Inner regional	95.3	94.7	96.3
Other areas[d]	95.4	93.5	96.7
Country of birth			
Australia and mainly English-speaking countries[e]	96.5	95.7	97.3
Other (mainly non-English-speaking countries)	84.2	86.1	94.3
Australia	**94.4**	**94.1**	**96.8**

(a) Able to get support in times of crisis from persons living outside the household.
(b) Able to ask for small favours from someone living outside the household. Examples of small favours include looking after pets or watering the garden, collecting mail or checking the house, minding a child for a brief period, help with moving or lifting objects, and borrowing equipment.
(c) See *Appendix 1 Methods* for explanation of socioeconomic status (SES)
(d) Includes *Outer regional* and *Remote* areas. *Very remote* areas were excluded from the Survey.
(e) Mainly English-speaking countries include Canada, Ireland, New Zealand, South Africa, United Kingdom and United States of America.
Source: AIHW analysis of 2006 ABS General Social Survey confidentialised unit record file.