Australian Bureau of Statistics

TVW TELETHON INSTITUTE FOR Child Health Research

Western Australian Child Health Survey

Family & Community Health













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Western Australian Child Health Survey

Family and Community Health

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FOREWORD

The Western Australian Child Health Survey represents a significant contribution to our understanding of the health and well-being of families in the 1990s. Since its initial launch in 1995, the findings on child physical and mental health have seen a wide uptake in both state and federal arenas, where they have influenced current policy and planning. Considerable international interest has also been focused on the Child Health Survey methods and findings.

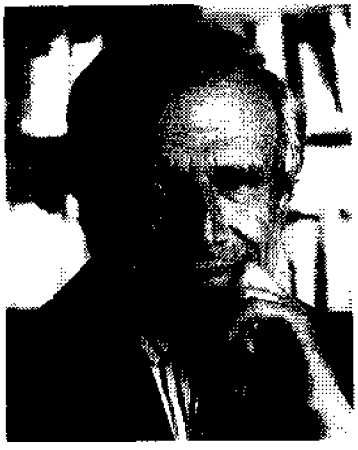
This volume presents a unique and detailed description of family and community health. The account is unique for its focus upon the family as the unit of study rather than individuals within families. It is detailed in its attention not only to the health and mental health of families but also to the variety of settings, communities and neighbourhoods in which families live and participate. From these descriptions emerges a rich picture of how Western Australian families are managing the tasks of both work and care, and of the changes taking place in family capacities to balance these responsibilities.

Community life and access to amenities and services are comprehensively described. Here not only do we have confirmation of the known variability in the distribution of community services and amenities, but we can also see that some families have better access to these amenities compared with others. The research team documents indices of community well-being as an important first step in the study of how communities either support the work of families or set the context for immediate disadvantage and possible future cycles of inter-generational disadvantage.

The findings demonstrate that both couple and one parent families are likely to be working and working long hours. In couple families, there is little evidence to suggest that the mental health of children is any different if the principal caregiver stays at home or is in paid employment. However, children in one parent families appear to be less likely to have a mental health problem when the parent is employed. While income from work is a critical component of the provision of family care, this may be at the cost of principal caregivers' physical or mental health – particularly where the parent is alone in managing the responsibilities of child-rearing and work. It is important also to note the increasing shift from traditional and unpaid child care to the market of paid child care. These data require us to move beyond the current rhetoric about the choice to work, flexibility in the workplace and the effects of formal child care. They call for active policies, planning and standards to ensure that families are supported in their needs to balance the demands of paid work and domestic life.

Also emerging from these data is a description of the tasks involved in parenting and the ways in which parenting is distributed not just within the immediate family but beyond the family perimeter. Parents have provided a remarkably frank appraisal of their capacity to meet their many responsibilities. The data confirm families as the pre-eminent agents responsible for the development of children. However, they also show that parents do not see the family as an exclusively self-sufficient unit through which all of the parenting task and all of parental satisfaction can be derived. Parental relationship quality, access to friends and confidants, life stresses, work and health all moderate the task of parenting.

The readership for this volume of results is potentially vast. Health and social planners at all levels will find data of specific relevance to their tasks in policy and planning. Professionals interested in family health and mental health will find evaluations of important risk settings as well as insights into how future services might adapt to changing family and community profiles. Finally, the descriptions of both the survey methodology and findings are essential reading for researchers in setting the future research agenda in the area of family health.



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ABOUT THIS PUBLICATION

Views expressed

The views expressed in *Western Australian Child Health Survey: Family and Community Health* relating to the implications of survey findings for future directions in public health, and the commentary on survey findings, are those of the TVW Telethon Institute for Child Health Research and not necessarily those of the Australian Bureau of Statistics.

Related publications

This publication is the second of three from the Western Australian Child Health Survey. The first publication, *Developing Health and Well-being in the Nineties* (Catalogue No. 4303.5) was released in April 1995. The third publication, *Education and Health* (Catalogue No. 4305.5), is expected to be available later in 1996.

The following terms are used consistently throughout this publication:

Children

The term 'children' refers to persons aged 4 to 16 years at the time the survey was conducted.

Families

The term 'families', where used to describe results from the Western Australian Child Health Survey, refers to those families in which there was at least one child aged 4 to 16 years.

Caregiver/parent

The Western Australian Child Health Survey directed a large proportion of its questions to children's principal caregivers. Given that the principal caregiver was almost always a parent of the child, the terms 'caregiver' and 'parent' are often used interchangeably throughout this publication, and include original and step parents and other permanent caregivers.

Symbols and other usages

*	relative standard error between 25 and 50 per cent
**	relative standard error of 50 per cent or more. See Appendix A – Survey Enumeration.
n.a	not available
..	not applicable
-	nil or rounded to zero
p	preliminary

For more information about data contained in the following text and tables, please refer to the Glossary at the end of this publication.

Inquiries

- *for further information* contact Jeff Carlton at the National Youth Statistics Unit of the ABS on (09) 360 5374, or the Division of Psychosocial Research at the TVW Telethon Institute for Child Health Research on (09) 340 8533.
- *for information about other ABS statistics and services* please refer to the last page of this publication.

PREFACE

The 1993 Western Australian Child Health Survey, a large scale epidemiological survey of the health and well-being of Western Australian children, was undertaken by the TVW Telethon Institute for Child Health Research (ICHR). Funding for the survey was provided by Healthway (the Western Australian Health Promotion Foundation), the Australian Rotary Health Research Fund, the Health Department of Western Australia, and the State Statistics Committee.

Funding for this publication was provided by Family and Children's Services, the Health Department of Western Australia, and the Australian Rotary Health Research Fund.

Design and development of survey methodology and instrumentation, and fielding of the survey was done in consultation with the Australian Bureau of Statistics (ABS).

Production of the series of publications from this survey is a collaboration between the ICHR and the ABS. This publication is the second in the series; the first, *Western Australian Child Health Survey: Developing Health and Well-being in the Nineties* (ABS Catalogue No. 4303.5) provided a comprehensive picture of the mental and physical health status of Western Australian children. The third, *Education and Health* (ABS Catalogue No. 4305.5 – yet to be released) will examine associations between the physical health, mental health and educational attainment of 4 to 16 year-old students attending primary and secondary schools in Western Australia.

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INTRODUCTION

This second volume of findings from the Western Australian Child Health Survey considers aspects of family and community life which are relevant to the care, development and socialisation of children in the 1990s. The first three chapters document the increased diversity of family experience in terms of the changing demography of the family, the characteristics of neighbourhoods and local communities, and the income and work arrangements of families. Chapters Four and Five then describe some of the important associations which exist between these contextual factors and family functioning and the health and well-being of parents and children. The final chapter discusses the increased range of choices which parents and other family caregivers have with regard to the manner in which they organise their work and family responsibilities. It also considers some of the risk and protective factors which need to be acknowledged in the formulation of public policy and planning of services for children and families.

THE TVW TELETHON INSTITUTE FOR CHILD HEALTH RESEARCH

The TVW Telethon Institute for Child Health Research is a centre of excellence for the conduct of research in child health. Founded in 1987, the Institute's research programs include the study of asthma and allergic disease, birth defects, child and adolescent mental health, childhood death and disability, leukaemia and other cancers, and Aboriginal health and infectious disease.

The Institute's mission is to improve the health of children through the development and application of research into:

- causes of ill health;
- the maintenance of good health;
- prevention of ill health; and
- the treatment of conditions affecting children.

SURVEY OBJECTIVES

The survey's primary objectives are to define priority targets for existing health, education and social services, and to build an epidemiological knowledge-base from which preventive strategies can be developed to facilitate the social, emotional, academic and vocational competency of young people. A notable feature of this survey is its emphasis on identifying the developmental and environmental factors which enable and develop adolescent competency, resiliency and employment readiness.

The specific aims of the study are to:

- Estimate the prevalence and distribution of mental health problems in Western Australian children aged 4 to 16 years;
- Estimate the prevalence and distribution of other chronic medical conditions and limitations and how they contribute to mental ill-health and reduced function;
- Estimate the prevalence and distribution of adverse health behaviours (e.g. smoking, alcohol and drug misuse, and unprotected sexual activity);
- Describe children's use of health care, education, juvenile justice and social services;
- Develop estimates of risk and markers identifying children at increased risk for various health, educational and vocational outcomes; and
- Identify markers resulting in protection from, and amelioration of, poor mental health and adverse health behaviour(s).

SURVEY DESIGN

The design and development of the survey methodology and instrumentation was done in consultation with the Australian Bureau of Statistics. Efforts have been made to ensure that the data collected are both scientifically relevant and pertinent to current government information needs and policy initiatives. To do

this, reference groups were convened in early 1992 with representation from the various government departments and community agencies which have a stake in the outcome of the survey findings.

This process involved senior policy input from the Western Australian State Departments of Health, Education, Community Development and Police; the Alcohol and Drug Authority; the Authority for the Intellectually Handicapped; the Catholic Education Office of Western Australia; the Association of Independent Schools of Western Australia; the Aboriginal Affairs Planning Authority; the Perth Aboriginal Medical Service; and the Australian Institute of Family Studies.

PILOT SURVEY

A pilot survey of 260 Perth metropolitan households with 4 to 16 year-old children was conducted between 24 August and 7 September 1992. This field-tested the survey methodology and established its community acceptability, with a household participation rate of 72 per cent. Consent was also obtained to contact schools to obtain information relating to individual students and the characteristics of their school environment. A total of 162 government and non-government schools participated in the pilot survey. The pilot data were used to refine the final survey process, survey instruments and data collection procedures.[1]

MAIN SURVEY

The main survey commenced on 5 July 1993 and was completed on 27 September 1993. A random sample of 1,776 households throughout metropolitan and country regions of Western Australia was approached, with 1,462 (82 per cent) consenting to participate. A total of 2,737 children aged 4 to 16 years was surveyed. Collection districts across Western Australia were sampled and 27 trained interviewers conducted the household interviews. Data were gathered from consenting families from three main sources:

- the principal caregiver (see *Principal caregiver* in the Glossary);
- adolescents aged 12 to 16 years; and
- the school principal and teacher(s) of surveyed children.

On 10 October 1993 all survey children who were in school (1,963 children) were followed up through survey instruments that collected details from the school principal and the classroom teacher. A total of 413 schools statewide was involved and 96 per cent of all school survey materials were returned. This allowed estimates of health, mental health and competencies as observed in the school context. Information about the school culture was also collected.

SURVEY CALIBRATION

The clinical calibration phase of the Child Health Survey was conducted from 17 March 1994. A random sample of 260 families was drawn, stratified by the presence or absence of a mental health disorder in a randomly selected child seen during the household survey. Experienced mental health professionals then visited the home and conducted a structured psychiatric interview with the caregiver and the child aimed at generating DSM-III-R clinical diagnoses (see *DSM-III-R clinical diagnoses* in the Glossary). This allowed the calibration of the entire survey sample against another criterion of mental health disorder.

SURVEY SIGNIFICANCE

The large scope, complex sampling and sophisticated survey methodology makes this project one of considerable scientific significance. The active involvement of government departments and other agencies in the project design should also ensure that important policy questions are addressed and that critical information is obtained to assist the planning and effective delivery of services to Western Australian children, adolescents and families in the 1990s.

ENDNOTES

1 Carton AF, Zubrick SR, Silburn SR. The Western Australian Child Health Survey: Pilot study. *Australian and New Zealand Journal of Psychiatry*, 29(1), 48-57.

1 CHARACTERISTICS OF FAMILIES

The family unit is the most significant social structure in our society. Over the last three decades, considerable diversity in the make-up of family units in Western Australia has developed with the emergence of alternative family forms through de facto living, divorce and remarriage. The traditional image of a married couple heading the family unit is now less common than in the past.

Examining characteristics that contribute to the diversity of family and social life (including material and cultural resources and the need for economic and social support) is essential to an understanding of the environment in which the growth and development of children in the Western Australian Child Health Survey has taken place.

FAMILIES – A POPULATION PERSPECTIVE

Data from the 1992 Survey of Families in Australia[1] have been used in this Section to –

- establish a profile of Western Australian families;
- define the area of interest for the Western Australian Child Health Survey – families with children aged 4 to 16 years.

The 1982 Families Survey and 1992 Survey of Families paint a clear picture of the changing nature of family life in Australia, particularly the emergence of diversity in family forms (such as one parent and de facto families) over the past three decades. However, despite this increased diversity, the predominant family type is still a couple family with children.

The Australian Bureau of Statistics defines a family as 'two or more people living in the same household who are related to each other by blood, marriage, de facto partnering, fostering or adoption'. While, for many people, the concept of family extends beyond household boundaries to provide a wider sphere of interaction and support (their extended family), the focus for the Child Health Survey has been on aspects of family life within a single household.

FAMILIES: 1982 – 1992

The Survey of Families estimated that there were 459,200 families in Western Australia in 1992, a 30 per cent increase over the ten years since 1982. Over the same period, growth in the Estimated Resident Population was lower at 22 per cent, while the average size of family households remained stable at 3.3 people.

TABLE 1.1 Families: Growth in family types, 1982-1992

Family type	*1982*	*1992*	*Change 1982-1992*
	– '000 –		per cent
Couple only	116.7	157.7	33.1
Couple family with children—			
Original	n.a.	219.0	..
Step/blended	n.a.	18.4	..
Registered married	186.8	221.3	18.5
De facto	6.5	16.0	146.2
Total	*193.3*	*237.3*	*24.6*
One parent	40.3	59.2	46.9
Other family	4.0	*5.1	27.5
All families	**353.2**	**459.2**	**30.0**

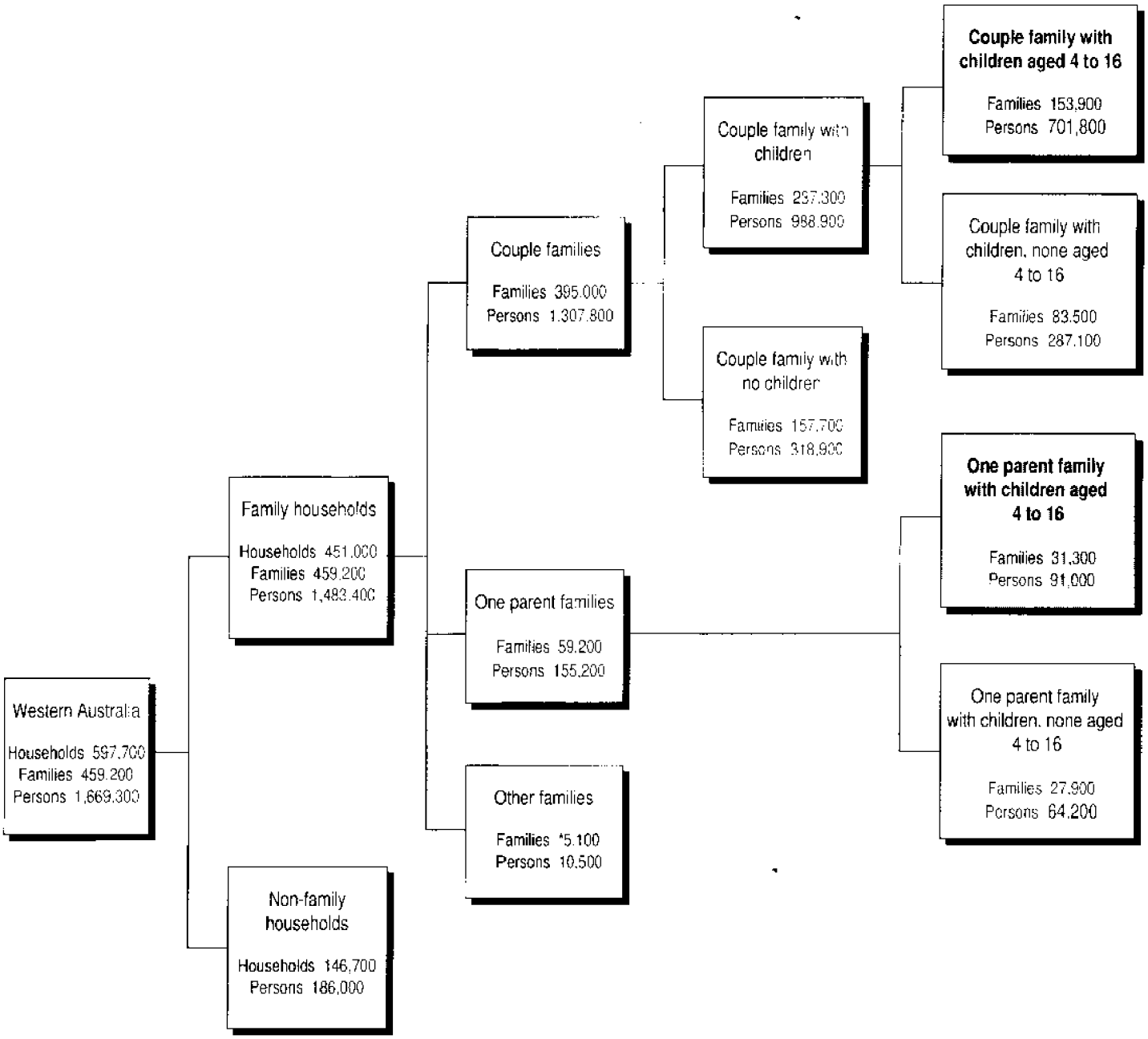
Source: *1982 Families Survey; 1992 Survey of Families in Australia*

Just over half (52 per cent) of all families were couple families with children, a slight fall from the 55 per cent recorded in 1982. Another 34 per cent were couple only families while one parent families comprised 13 per cent (11 per cent in 1982).

FAMILIES WITH CHILDREN

The majority (65 per cent) of families in 1992 were families with dependent or non-dependent children. Over the ten years to 1992, there have been significant changes in the formation and structure of families with children. Prominent

FIGURE 1.1 Number of families and persons(a): 1992



(a) In addition to couples, parents, children and other family persons, family households may also include unrelated individuals. Therefore, the number of people in family households will not equal the number of people in families. A total of 9,800 unrelated individuals lived with families.

Source: *1992 Survey of Families in Australia*

among these have been the rapid growth of one parent families and de facto couple families.

One parent families. Between 1982 and 1992, one parent families grew at the fastest rate of all the major family types, by 47 per cent (from 40,300 to 59,200). There have been a number of reasons for this significant growth. Most one parent families are formed through separation and divorce rather than through single parenthood.

The 1992 Survey of Families found that over half of all lone parents in 1992 were divorced or separated (57 per cent) compared with never-married parents (20 per cent).[1] Since the introduction of the *Family Law Act 1975*, which enabled no-fault divorce to be granted on the grounds of mutual consent, the divorce rate has been at consistently higher levels in the 1980s and early 1990s than at any time before 1975.

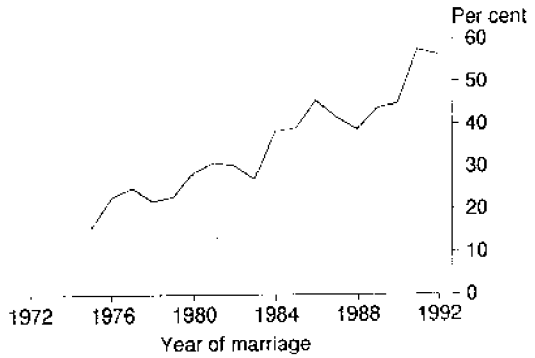
Other factors influencing one parent family formation have included a change in society's attitudes towards the family and provision of financial support through the introduction of such mechanisms as the Sole Parent Pension.

Most one parent families are a transitional form of family unit.[2] Subsequent marriage or partnering of lone parents has been a significant factor in the growing emergence of step and blended families.

De facto couple families. De facto relationships are becoming increasingly common in Western Australia. In the ten years to 1992, the number of de facto families with children more than doubled, from 6,500 to 16,000.

There is an increasing trend for couples with or without children to live together, particularly as a form of trial marriage. The 1992 Survey of Families in Australia found that, nationally, 56 per cent of all couples who married in 1992 had cohabited before their marriage, compared with 16 per cent in 1975.[1]

FIGURE 1.2 Registered marriages(a) preceded by a period of de facto living



(a) Data relate only to marriages from 1975 onwards. Persons in a second or subsequent marriage were asked about their current marriage only. Previously married persons in a de facto relationship were not questioned about periods of pre-marriage cohabitation.

Source: *1992 Survey of Families in Australia*

Accompanying the rise in the proportion of people living together before registered marriage has been a steady fall in crude marriage rates. In Western Australia, the crude marriage rate in 1983 was 7.7 marriages per 1,000 of mean population compared with 6.1 in 1992.

Step and blended families. Family blending occurs where a child(ren) from a previous relationship of either partner of a couple (i.e. step child(ren)) are residing in a couple family.

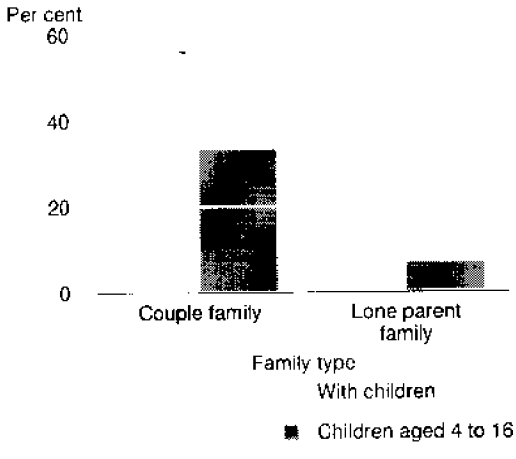
An increasing number of step and blended families is the result of families reforming following separation or divorce of one or both partners (See *Step family* and *Blended family* in the Glossary). The proportion of persons remarrying following divorce is continuing to rise. Almost one-quarter (24 per cent) of bridegrooms in 1992 were remarrying after divorce compared with 21 per cent in 1982 and only 8 per cent in 1972. There were similar proportions of brides remarrying after divorce. The proportion of marriages in which both partners had previously been divorced has also increased – from 3 per cent in 1972 to 10 per cent in 1982 and 13 per cent in 1992.[3]

In 1992, there were an estimated 12,000 step families containing almost 18,000 children and 6,000 blended families containing a total of 17,000 children. Step and blended families in 1992 comprised 8 per cent of couple families with children.

FAMILIES WITH CHILDREN AGED 4 TO 16 YEARS

The sample for the WA Child Health Survey was drawn from the population of Western Australian children aged 4 to 16 years. Thus, families in scope of the survey were those in which there was at least one child aged 4 to 16 years.

FIGURE 1.3 Families with children, as a proportion of all families



In 1992, families with children represented 65 per cent of all Western Australian families. Of these families, 62 per cent (an estimated 185,200) were families with children aged 4 to 16 years.

Couple families with children aged 4 to 16 years (153,900) represented one-third of all families

and 83 per cent of all families with children aged 4 to 16 years.

SURVEYED FAMILIES – DEFINING THE POPULATION

The Western Australian Child Health Survey did not sample from the total population of Western Australian children aged 4 to 16 years. Two groups were excluded:

- *Aboriginal children in families living in country areas.* Their exclusion was due mainly to difficulties associated with establishing a framework from which to select a representative sample, and to the logistics of collecting data from sometimes widespread and isolated communities.

  In a recent report from the Government Taskforce on Families in Western Australia, it was recommended that the Institute be commissioned and funded by the Western Australian Government to provide information to the Aboriginal community about the mental health of Western Australian Aboriginal children and their families.[4]

- *Children living alone, in group homes, or non-private dwellings.* In these arrangements, either there were no caregivers present, or the caregivers were not in a position to provide independent information about these children.

SURVEYED FAMILIES – TERMINOLOGY

In the Child Health Survey, the terms 'family', 'children' and 'child' have specific meanings.

Family. The term 'family' refers only to families which have children aged 4 to 16 years living with them. Family types are further classified in this report as 'one parent' and 'couple' families, based on information provided about current relationships between people living in the household, not registered marital status. Couple families may be classified as 'original' or 'step/blended' families (see *Original family* in the Glossary).

Caregiver. The *principal caregiver* (see Glossary) is the person who spends most time with the surveyed child(ren), and provided survey information about the child(ren). In most (95 per cent) cases, the principal caregiver was female.

In 81 per cent of families, the principal caregiver reported having a partner or spouse present. These people were termed the *secondary caregiver* (see Glossary). In 96 per cent of cases, the secondary caregiver was male.

The terms 'caregiver' and 'parent' are used interchangeably throughout this publication.

Children, child. These survey terms refer to persons aged 4 to 16 years inclusive. For purposes of analysis and presentation of findings, they are further grouped into the following age cohorts:

- younger children – aged 4 to 11 years;
- adolescents – aged 12 to 16 years.

'Younger adolescents' and 'older adolescents' refer to 12 to 14 year-olds and 15 to 16 year-olds respectively.

SURVEYED FAMILIES – A PROFILE

THE SURVEY POPULATION

The Western Australian Child Health Survey approached only families with 4 to 16 year-old children. At the time of the survey, it was estimated that 168,600 families were in scope of the survey. There were 302,900 children aged 4 to 16 years living in these families.

TABLE 1.2 Family type

	Families		*Children aged 4 to 16 years*	
Family type	*No. ('000)*	*Per cent*	*No. ('000)*	*Per cent*
Couple families—				
Original	121.5	72.1	223.6	73.8
Step/blended	15.4	9.1	29.0	9.6
Total	*136.9*	*81.2*	*252.6*	*83.4*
One parent families—				
Male	3.2	1.9	4.6	*1.5
Female	28.6	16.9	45.6	15.0
Total	*31.7*	*18.8*	*50.2*	*16.6*
All families	**168.6**	**100.0**	**302.9**	**100.0**

While greater diversity in family forms has developed in recent decades, original couple

families (72 per cent) remain the predominant family type among surveyed families.

Just over 9 per cent (15,400) of families were step or blended families, each family type being represented in similar proportions.

Nearly one in five families (31,700) were one parent families, caring for 17 per cent (50,200) of 4 to 16 year-olds. In 90 per cent of these families, the lone parent was female.

FAMILIES IN REGIONS

For the purposes of the survey, the State was divided into six survey regions (see *Survey regions* in the Glossary and Appendix B – Western Australia: Survey Regions). Almost three-quarters (73 per cent) of Western Australian families lived in the Perth metropolitan area. Within the Perth metropolitan area, the region with the highest number of families (38 per cent) was the South metropolitan region.

Over half (53 per cent) of families living outside the metropolitan area were located in the Southern WA region, while 13 per cent were located in the Far North WA region – the least populous of the six survey regions.

Couple families represented around 80 to 82 per cent of all families in each region except the Far North WA region, where the proportion was 92 per cent.

FAMILIES AND CHILDREN

Children in the Child Health Survey were grouped into two age cohorts: younger children (aged 4 to 11 years) and adolescents (aged 12 to 16 years). These age ranges, generally speaking, represent two stages of a child's physical, intellectual and social growth and development. Each of these stages presents different parenting and child-rearing challenges for the children's caregivers.

Table 1.4 shows the extent to which these age ranges, and the differing family circumstances they represent, were distributed across family types.

TABLE 1.4 Families: Age group of children (Per cent)

	Couple families		*One parent families*	*All families*
	Original	*Step/ blended*		
Families with children aged—				
4 to 11 years only	51.5	40.5	41.8	48.7
12 to 16 years only	25.7	16.4	36.6	26.9
Both 4 to 11 years and 12 to 16 years	22.8	43.0	21.6	24.4
All families	**100.0**	**100.0**	**100.0**	**100.0**
number ('000)	**121.5**	**15.4**	**31.7**	**168.6**

Almost 49 per cent of families comprised only younger children. Step and blended families and one parent families, having been formed from a previous relationship or marriage, were more likely to contain older children. Almost three in five of step and blended families and one parent families contained 12 to 16 year-olds. A greater mix of younger children and adolescents occurred in step and blended families (43 per cent of these families) compared with one parent families (22 per cent).

TABLE 1.3 Family type: Survey regions ('000)

	Perth metro				*Country*				
Family type	*North metro*	*South metro*	*East metro*	*Total*	*Southern*	*Central*	*Far North*	*Total*	*Western Australia*
Couple families--									
Original	29.5	34.9	24.3	88.8	17.3	10.9	4.5	32.7	121.5
Step/blended	4.2	3.9	3.1	11.2	1.7	1.7	0.7	4.2	15.4
Total	*33.7*	*38.8*	*27.5*	*100.0*	*19.0*	*12.6*	*5.3*	*36.9*	*136.9*
One parent families	8.6	8.3	6.8	23.6	4.8	2.9	*0.5	8.1	31.7
All families	**42.3**	**47.0**	**34.3**	**123.6**	**23.8**	**15.5**	**5.7**	**45.0**	**168.6**

Family size. The majority of surveyed families (83 per cent) had two or more 4 to 16 year-old children. Most commonly, families comprised two children (45 per cent), followed by three or more (38 per cent), and one 4 to 16 year-old (17 per cent).

Family size varied across family types. One-third of one parent families comprised a lone caregiver and one child. Step/blended families most commonly had three or more children (46 per cent).

TABLE 1.5 Families: Size (number of children) (Per cent)

Number of children aged 4 to 16 years	Couple families			One parent families	All families
	Original	Step/ blended	Total		
1 child	13.2	14.8	13.3	33.5	17.1
2 children	46.7	39.6	45.9	38.9	44.6
3 or more	40.1	45.6	40.7	27.5	38.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
number ('000)	**121.5**	**15.4**	**136.9**	**31.7**	**168.6**

AGE OF PARENTS

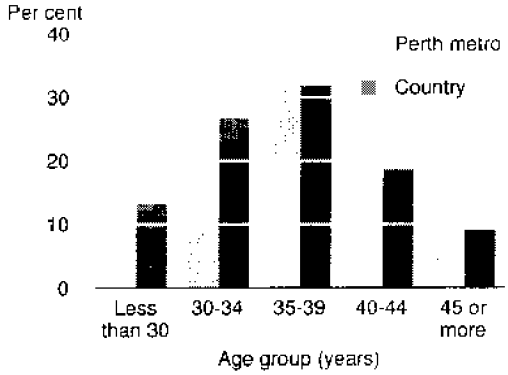
One determinant of a child's development is the preparedness of the parent(s) to perform a caregiver role. Couples are generally marrying and having children at a later age, resulting in a changing age structure and a different set of life skills in the parent population. This may impact on caregivers' effectiveness as parents and their ability to manage children through successive stages of life.

In recent years, the age of both partners at marriage has been increasing. Over the period 1985 to 1993, the median age of Western Australian bridegrooms rose from 26.9 years to 29.3 years. The median age of brides over the same period had similarly increased, from 24.5 years to 26.5 years.[3,5]

From the Child Health Survey, the average age of principal caregivers was 37 years, with the middle 50 per cent of principal caregiver ages ranging from 32 to 41 years. Secondary caregivers were, on average, older than principal caregivers, with a mean age of 40 years.

Figure 1.4 illustrates the difference in age distributions between principal caregivers living in the Perth metropolitan area and country areas. As a general rule, principal caregivers were older in the Perth metropolitan area, where the average age was 38 years, compared with 36 years in the country.

FIGURE 1.4 Region: Age group of principal caregiver



Coinciding with couples marrying at older ages, is a trend toward parents having children at a later age. Western Australian data show that, from 1973 to 1993, the proportion of all births to mothers aged less than 25 years dropped from 48 per cent to 25 per cent.[5,6] Alternatively, over the ten years to 1993, age-specific birth rates have increased significantly for women in age groups over 30 years. This has been particularly evident among 35 to 39 year-olds, where the rate has risen 64 per cent over this period. The reverse is true of younger women, further suggesting that they are postponing childbirth or choosing not to have children.[5]

Table 1.6 provides an analysis of families by age of children, to highlight families which are relatively 'older' and 'younger'. A negligible proportion of families had a youngest child aged 12 to 16 years when the principal caregiver was less than 35 years of age, and only 13 per cent of these caregivers had their eldest child aged 12 to 16 years, indicating only a small proportion of caregivers beginning child rearing in their early-twenties or before.

On the other hand, 32 per cent of principal caregivers aged over 44 years had a youngest child aged 4 to 11 years, and 10 per cent had an eldest child aged 4 to 11 years. This is consistent with the trend for parents to start child-rearing at a later age.

TABLE 1.6 Family type: Age of principal caregiver: Age group of youngest and eldest child (Per cent)

	Age group of principal caregiver (years)		
	Less than 35	*35 to 44*	*45 or more*
COUPLE FAMILIES			
Age group of youngest child—			
4 to 11 years	99.7	71.1	34.2
12 to 16 years	**0.3	28.9	65.8
Age group of eldest child—			
4 to 11 years	88.4	37.6	*10.0
12 to 16 years	11.6	62.4	90.0
All couple families	**100.0**	**100.0**	**100.0**
number ('000)	**44.1**	**74.1**	**18.6**
ONE PARENT FAMILIES			
Age group of youngest child—			
4 to 11 years	94.7	56.8	*22.8
12 to 16 years	**5.3	43.2	77.2
Age group of eldest child—			
4 to 11 years	78.8	28.3	**11.3
12 to 16 years	21.2	71.7	88.7
All one parent families	**100.0**	**100.0**	**100.0**
number ('000)	**10.1**	**16.3**	**5.3**

MARITAL STATUS

An estimated 127,800 families, representing 76 per cent of all families and 93 per cent of couple families, were headed by couples living in a registered marriage.

Couple families. Among original families, the great majority (98 per cent) comprised registered married couples and their children. Within step and blended families, the proportion of de facto couples increased to 41 per cent (6,300). This reflects, in part, the greater likelihood for previously married people to live together before a second or subsequent marriage.[1]

One parent families. The majority of one parent families (74 per cent) were formed as a result of either separation or divorce. The incidence of separation or divorce among lone parents was higher in the Perth metropolitan area (79 per cent) than in country areas (58 per cent). Around 15 per cent of lone parents (4,800) had never married.

TABLE 1.7 Marital status

	Families		*Children aged 4 to 16 years*	
	No. ('000)	*Per cent*	*No. ('000)*	*Per cent*
COUPLE FAMILIES				
Original—				
Registered married	119.3	98.2	220.8	98.7
De facto	2.1	*1.8	2.8	*1.2
All original families(a)	*121.5*	*100.0*	*223.6*	*100.0*
Step/blended—				
Registered married	8.4	54.8	15.7	54.0
De facto	6.3	41.2	12.5	43.2
All step/blended families(a)	*15.4*	*100.0*	*29.0*	*100.0*
ONE PARENT FAMILIES				
Separated	10.4	32.8	20.1	40.1
Divorced	12.9	40.8	18.7	37.2
Widowed	*3.3	*10.3	*4.7	*9.4
Never married	4.8	15.2	*6.2	*12.4
All one parent families(a)	**31.7**	**100.0**	**50.2**	**100.0**

(a) Includes marital status not stated.

Age of children. Children living in de facto families were generally younger (average age 9.0 years) compared with those in registered married families (average age 9.8 years). This is consistent with the fact that three-quarters of de facto families were step and blended families, and over 83 per cent of step and blended families contained children aged 4 to 11 years.

The average age of children of separated lone parents was 9.5 years compared with 11.9 years for divorced lone parents.

BIRTHPLACE

An analysis of the country of birth of caregivers is important because of the pressures and disadvantages that may be encountered by those from non English-speaking backgrounds. Often these people do not have the same network of support – from extended family, and through a lack of knowledge of existing services of support. Barriers can also exist as a result of cultural, custom and language differences. Difficulties with employment opportunities often pose additional strains on economic well-being.

Children in these families can face additional pressures, as they try to juggle adjusting to their new community with parental expectations of maintaining their traditional values and habits from their country of origin. The difference between these lifestyles is also capable of fostering inter-generational conflict.[4]

All of these factors influence the emotional and mental well-being of children in these families.

Most caregivers in families were born in Australia – 65 per cent of principal caregivers and 59 per cent of secondary caregivers. For the remainder, the predominant birthplace was the UK and Ireland, but another 14 per cent and 17 per cent of principal and secondary caregivers respectively were born in non English-speaking countries.

TABLE 1.8 Birthplace of principal and secondary caregivers

	Birthplace of principal caregiver		*Birthplace of secondary caregiver*	
Birthplace	*No. ('000)*	*Per cent*	*No. ('000)*	*Per cent*
Australia	109.5	65.0	81.2	59.3
Main English-speaking countries—				
UK and Ireland	27.8	16.5	25.6	18.7
New Zealand	5.7	3.4	4.4	3.2
Other	*1.5	*0.9	*1.3	*0.9
Total	*35.0*	*20.7*	*31.3*	*22.9*
Non English-speaking countries—				
Asia	10.3	6.1	8.4	6.2
Europe	8.1	4.8	10.3	7.5
Other	5.5	3.3	5.1	3.7
Total	*24.0*	*14.2*	*23.8*	*17.4*
Not stated	**0.2	**0.1	**0.6	**0.4
All countries	**168.6**	**100.0**	**136.9**	**100.0**

In 47 per cent of families at least one caregiver had been born overseas. Twenty per cent (33,800) of families had at least one caregiver born in a non English-speaking country. Almost half of these families (16,200) had all caregivers born in a non English-speaking country.

In comparison, only 5 per cent (15,700) of children were born in a non English-speaking country. If we consider children with a non English-speaking background as those born in a non English-speaking country and/or whose parents (one or both) were born in a non English-speaking country, then 20 per cent (62,000) of children can be considered to have this background.

TABLE 1.9 Birthplace of parents

	No. ('000)	*Per cent*
COUPLE FAMILIES—		
Both born in Australia	64.9	38.5
One parent born in Australia and one overseas in—		
English-speaking country	24.7	14.6
Non English-speaking country	12.3	7.3
Both born overseas—		
English-speaking countries	15.5	9.2
Non English-speaking countries	13.7	8.1
One in English-speaking country and one in non English-speaking country	5.2	3.1
All couple families(a)	*136.9*	*81.2*
ONE PARENT FAMILIES—		
Born in Australia	23.4	13.9
Born overseas in English-speaking country	5.8	3.5
Born overseas in non English speaking country	*2.5	*1.5
All one parent families(a)	*31.7*	*18.8*
All families(a)	**168.6**	**100.0**

(a) Includes not stated.

LANGUAGE

In most families (87 per cent), both caregivers spoke English only. In 21,000 families at least one caregiver – and in 76 per cent of these families, both caregivers – spoke a language other than English at home. Individually, there were over 18,800 (11 per cent) principal caregivers and another 15,600 (11 per cent) secondary caregivers who spoke a language other than English at home.

Speaking a language other than English at home did not necessarily imply a limitation with the English language. Nearly 84 per cent of principal caregivers who spoke a non-English language at home spoke English well or very well; for secondary caregivers, the corresponding figure was 87 per cent.

A negligible proportion of families had both caregivers with a low level of proficiency (those who spoke English not well or not at all) in the English language. However, of those families with at least one caregiver who spoke a

non-English language at home, 21 per cent had at least one caregiver with a low proficiency in English.

TABLE 1.10 Language spoken at home by caregivers

Language spoken	*No. ('000)*	*Per cent*
Couple families—		
Both English	117.5	69.7
One English/one non-English	5.1	3.0
Both non-English	13.2	7.9
One parent families—		
English only	29.0	17.2
Non-English	*2.6	*1.5
Not stated	*1.1	*0.6
All families	**168.6**	**100.0**

EDUCATION

Education plays a vital role in determining employment prospects and career opportunities. Consequently, caregiver education levels can have a strong influence on a family's economic well-being. Additionally, parents' particular educational background and experiences can affect their role as informal educators of their children, and shape their children's future educational circumstances.

FIGURE 1.5 Caregivers: Highest level of qualification: Proportion receiving more than $30,000 individual income

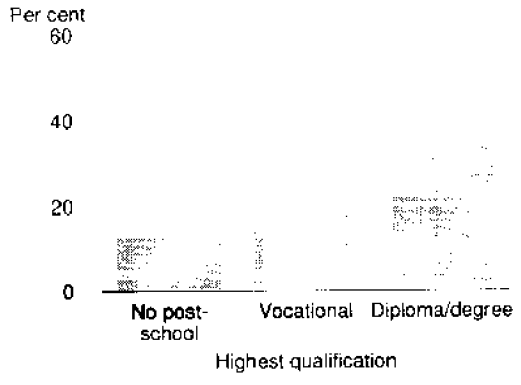


Figure 1.5 demonstrates the association between education and personal income. Fewer than 1 in 7 (14 per cent) caregivers with no post-school qualification received more than $30,000 in annual individual income. Incomes were generally higher for those with post-school qualifications. Caregivers with incomes of more than $30,000 represented 28 per cent of those with a vocational qualification, and 42 per cent of those with a diploma or degree.

In 35 per cent of families, all caregivers held a post-school qualification. In another 31 per cent of families, no caregiver held a post-school qualification.

TABLE 1.11 Highest qualification of caregivers ('000)

	Principal caregiver: Qualification			
Secondary caregiver	*No post-school*	*Vocational*	*Diploma/ degree(a)*	*Total(b)*
COUPLE FAMILIES				
Qualification—				
No post-school	33.5	10.6	6.5	51.8
Vocational	25.9	14.3	6.5	48.5
Diploma/degree(a)	10.1	5.4	16.3	32.2
Total(b)	**71.2**	**30.9**	**30.4**	**136.9**
Proportion(b) (%)	**52.0**	**22.6**	**22.2**	**100.0**
ONE PARENT FAMILIES				
Total	**18.3**	**8.1**	***3.8**	**31.7**
Proportion (%)	**57.7**	**25.4**	***12.0**	**100.0**

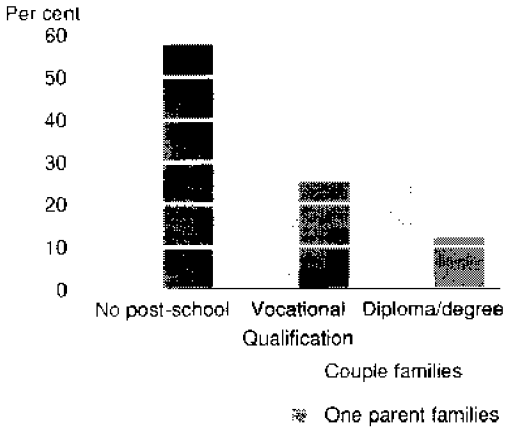
(a) Includes diploma, bachelors degree and higher degree. (b) Includes 'other' qualification and not stated.

The support that spouses are able to provide each other may have a positive effect on the ability of partners in couple families to participate in education. Caregivers in one parent families are more likely to face barriers to education, and are twice as likely as couple families to indicate that caring for children was a barrier.[7] The survey results indicate that principal and secondary caregivers in couple families were more likely to have a post-school qualification compared with lone caregivers (48 per cent and 61 per cent compared with 42 per cent respectively).

Figure 1.6 further highlights that couple families are, firstly, more likely to have a caregiver with a post-school qualification and, secondly, more likely to have a caregiver with a higher qualification, than one parent families.

There is also a greater propensity for male caregivers to have a tertiary qualification than females (61 per cent compared with 46 per cent).

FIGURE 1.6 Family type: Highest qualification among caregivers in couple and one parent families



ENDNOTES

1 *Focus on Families: Demographics and Family Formation* (ABS Catalogue No. 4420.0).

2 Graycar A, Jamrozik A. *How Australians Live: Social Policy in Theory and Practice*. Melbourne: Macmillan, 1989.

3 *Marriages, Australia* (ABS Catalogue No. 3306.0).

4 Taskforce on Families in Western Australia. *WA Families – Our Future: Report of the Taskforce on Families in Western Australia*. Perth: Family & Children's Services, 1995.

5 *Demography, Western Australia* (ABS Catalogue No. 3311.5).

6 *Western Australian Year Book* (1979), No. 17 (ABS Catalogue No. 1302.5).

7 *Focus on Families: Education and Employment* (ABS Catalogue No. 4421.0).

2 FAMILIES IN COMMUNITIES

Communities may be formed through geographical or residential proximity. However, the sharing of common interests, beliefs and attitudes, and joint ownership often underpin what is commonly meant by "community". What are some of the characteristics of Western Australian communities and neighbourhoods? Which amenities are important in family life and activity? How connected are families to their neighbourhoods? The Western Australian Child Health Survey asked caregivers about their homes, neighbourhoods and local communities in order to secure a better picture of family life and activity.

THE FAMILY HOME

The family home is of considerable social and economic importance. Most of the time that families spend together is in the family home. It provides a family with shelter and security, while its location determines access to local schools and shops, neighbourhoods and friends.

A family's standard of living can be measured with reference to their type of housing, nature of occupancy and access to community amenities and services. In turn, each of these measures can often be determined by how much choice a family has in selecting their home.

CHOICE OF A PLACE TO LIVE

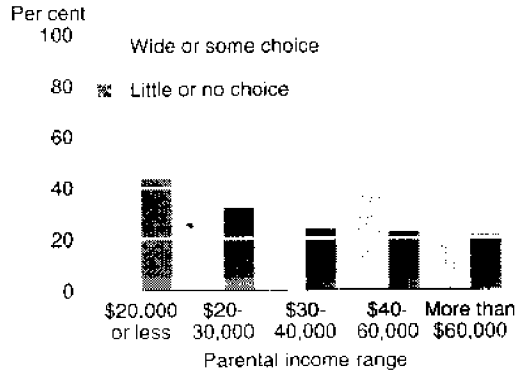
Choice about the type and location of the family home is an important feature of family and community life. A number of factors can influence the choice families have in selecting a place to live. For example, the desire for proximity to amenities such as schools, shops, churches and recreational facilities can compete with the need to be near work or public transport, or conflict with a desire for wide open spaces. Also, a family's degree of choice can be dictated by time available to look for accommodation and access to finance.

Families in the Child Health Survey more commonly reported having a wide choice in selecting a place to live (43 per cent) while just over one-quarter (26 per cent) reported having some choice. Another 16 per cent had little choice and 12 per cent (20,600 families) reported having no choice at all.

Income and choice. Parental income (see *Parental income* in the Glossary) was a significant factor in determining the degree of choice in selecting a place to live. This was particularly the case for families in the lower income ranges, the majority of whom were one parent families.

Over 43 per cent (15,700) of families in the lowest income range, that is, those receiving $20,000 or less, considered they had little or no choice. Among families with incomes from $20,001 to $30,000, the proportion was lower at 33 per cent, and less than one-quarter (23 per cent) of families with an income over $30,000 reported having little or no choice.

FIGURE 2.1 Parental income: Amount of choice in selecting a place to live

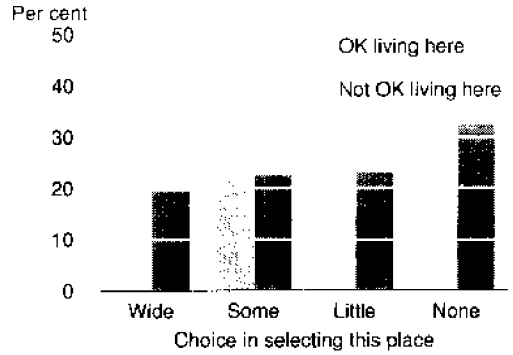


Region and choice. The amount of choice that families had in selecting accommodation differed across regions. Families living in country areas were more likely (odds ratio 4:1) to report having no choice at all in selecting a place compared with families living in the Perth metropolitan area (see *Odds ratio* in the Glossary). This was particularly so for families living in the Central WA region (29 per cent) and the Far North WA region (47 per cent).

Choice and satisfaction. Principal caregivers were asked how they felt about living in their dwelling. One in ten (16,600) reported that they did not "feel OK about living here".

Responses were a reflection of the degree of choice principal caregivers had in selecting their dwelling. As Figure 2.2 shows, of those who did not feel OK about living in their dwelling, almost one-third (32 per cent) indicated they had no choice at all, compared with 10 per cent of principal caregivers who were satisfied with their place of residence.

FIGURE 2.2 Principal caregivers' satisfaction with place of residence: Amount of choice in selecting this place



Alternatively, principal caregivers who had no choice were more likely (odds ratio 7:1) to express dissatisfaction than were caregivers who had a wide choice.

TYPE OF DWELLING AND TENURE

Most couple families (93 per cent) and one parent families (83 per cent) were living in a separate house at the time the survey was conducted.

TABLE 2.1 Families: Nature of occupancy(a) (Per cent)

	Couple families		*One*	
Nature of occupancy	*Original*	*Step/ blended*	*parent families*	*All families*
Owned	35.7	20.0	22.7	31.8
Being bought	45.2	44.3	26.5	41.6
Renting	17.2	33.4	49.6	24.8
Neither owned, being bought or renting	*1.4	**2.3	**1.2	*1.4
All families	**100.0**	**100.0**	**100.0**	**100.0**
number ('000)	**121.5**	**15.4**	**31.7**	**168.6**

(a) Excludes not stated.

Nearly three-quarters (73 per cent) of families owned or were purchasing the house in which they lived. Couple families were more likely than one parent families to own or be purchasing their home (79 per cent compared with 49 per cent).

Half (15,700) of one parent families were renting their accommodation compared with one-third of step and blended families and only 17 per cent of original families. One parent families were more reliant on government agencies for rental accommodation than were couple families (47 per cent and 33 per cent respectively).

CHARACTERISTICS OF THE FAMILY HOME

TABLE 2.2 Family type: Characteristics of the family home (Per cent)

Family home characteristic	*Couple families*	*One parent families*	*All families*
Safe places for children to play outside	87.3	75.5	85.1
Quiet neighbours	82.7	78.2	81.9
Quiet neighbourhood	81.5	68.3	79.0
Close to schools, colleges or university	75.6	80.2	76.4
Close to shops	73.6	82.0	75.2
Good heating or cooling	74.4	62.3	72.1
Environment with trees, no pollution	74.8	59.2	71.9
Good access to local parks	71.1	72.4	71.3
Close to public transport	64.8	71.9	66.1
Little traffic in the street	67.3	54.6	64.9
Privacy from neighbours	66.4	48.7	63.1
Well established garden	64.8	52.8	62.6
Easy access for work	61.0	52.2	59.3
Close to friends	55.8	55.8	55.8
Good security	55.7	49.3	54.5
Good investment potential	55.9	43.0	53.5
Requires low maintenance	51.8	57.3	52.8
Sits on a large block of land	51.0	41.1	49.2
Has four or more bedrooms	52.5	30.2	48.3
Close to other family members	41.6	46.2	42.5
Close to people of the same ethnic or cultural background	37.2	25.1	35.0
Separate private space for parents	30.0	22.3	28.6
New or newly renovated home	28.2	23.4	27.3
Country setting, rural lifestyle	26.2	17.6	24.6
Home with a low deposit price	13.4	19.0	14.4
Home finance provided by the vendor	6.1	*6.2	6.1

Families in the Child Health Survey were asked to indicate from a list of potentially desirable

characteristics, which applied to their current home and its setting.

Safe places for children to play, quiet neighbours, a quiet neighbourhood and close proximity to schools and shops were most commonly (over 75 per cent of families) reported as characterising the setting of families' current homes.

Couple and one parent family homes. There were notable differences between the characteristics of homes of couple and one parent families. In terms of the setting of the home, more couple families than one parent families reported having safe places for their children to play outside; a quiet neighbourhood; privacy from their neighbours; a good environment with no pollution; and relatively little traffic in the street. However, more one parent families reported being close to shops or to public transport.

In respect of the home, four or more bedrooms; on large blocks; good heating or cooling; well established gardens; and good investment potential were characteristics more frequently reported by couple families.

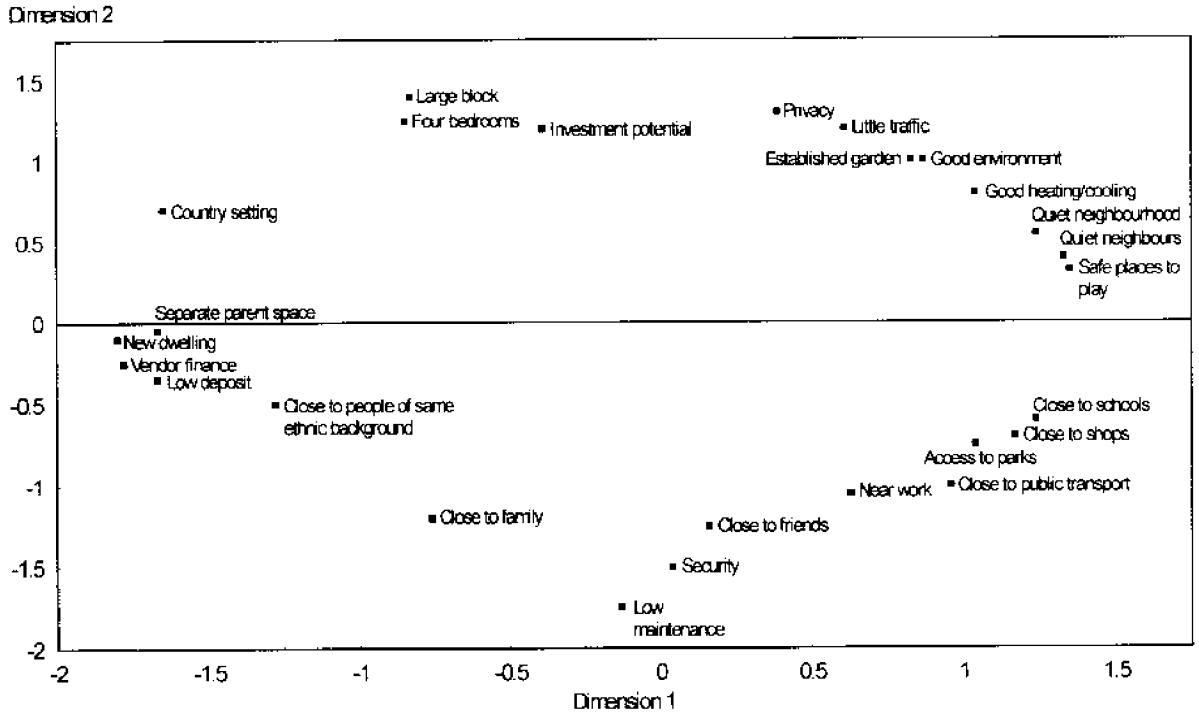
A number of factors may have contributed to differences between the characteristics of couple and one parent family homes. One parent families had less choice in selecting a place to live, and they were more likely to be renting their accommodation and to be living in medium density housing.

One parent families, in general, had considerably lower parental income than couple families. The survey indicates an association between income and some desirable home characteristics – for example, families with incomes over $60,000 per year were more likely than those receiving incomes of $20,000 or less to have safe places for children to play outside (odds ratio 3:1), to have a quiet neighbourhood (odds ratio 3:1) and to have a dwelling with good heating and cooling (odds ratio 3:1).

Relationships between characteristics. Figure 2.3 presents a diagrammatic representation of relationships between family home characteristics.[1,2] To construct the diagram, caregiver responses were analysed in terms of the degree to which one characteristic of the family home was reported and a second characteristic also reported. This degree of association was a determining factor in the placement of each characteristic in the diagram.

Where two desirable characteristics were frequently reported as applicable to the family home, the distance between such characteristics in the diagram is relatively small. For example, homes 'close to schools' were often reported as also being 'close to shops'; similarly, homes 'close to people of the same ethnic or cultural background' also reported being 'close to other

FIGURE 2.3 Relationship between characteristics of the family home



family members'. The reverse is true when characteristics of the family home did not often apply together, so that elements such as a 'country setting with a rural lifestyle' and being 'close to public transport' were relatively wide apart.

The pattern of the characteristics describing family homes is also important. Visual inspection of Figure 2.3 shows roughly four common groupings of characteristics of the family home: privacy/safety, proximity to amenities, newness, and size. These groups reflect what is commonly known about homes and their settings. Thus, a home with privacy is likely to be associated with safety and comfort. Homes that entail proximity to one amenity are likely to be close to others. A new dwelling more often has space for parents or is associated with a low deposit, but may not be associated with proximity to amenities. Finally, homes on large blocks may be larger themselves or associated with rural settings.

NEIGHBOURHOOD CHARACTERISTICS

Urban, suburban and town environments that either bring people together or discourage contact are largely shaped by the nature of their physical surroundings. Such influences as the level of safety of the surroundings, their visual appeal, and the availability of, and ease of access to, facilities and services are critical to community functioning.

The survey examined families' satisfaction with various characteristics of their neighbourhood, and access to particular neighbourhood facilities and services.

SATISFACTION WITH THE NEIGHBOURHOOD

Families reported the highest level of satisfaction in respect of environmental factors, such as the cleanliness of the streets (86 per cent), distance from factories (80 per cent) and the quality of the air (77 per cent). Also, more than four in five (81 per cent) families were satisfied with their access to a major daily newspaper.

TABLE 2.3 Families who expressed satisfaction with characteristics of their neighbourhood (Per cent)

	Perth metro				*Country*				
Neighbourhood characteristic	*North metro*	*South metro*	*East metro*	*Total*	*Southern*	*Central*	*Far North*	*Total*	*Western Australia*
Media services—									
Access to major daily newspapers	86.9	79.6	82.4	82.9	77.0	77.9	54.2	74.4	80.6
Quality of TV reception	81.1	74.3	76.0	77.1	71.6	69.3	71.6	70.8	75.4
Access to national TV networks	78.5	73.4	72.0	74.8	51.7	54.3	32.2	50.1	68.2
Environment and pollution—									
Cleanliness of the streets	88.1	86.5	85.4	86.7	82.8	87.0	71.6	82.8	85.7
Distance from factories	86.5	76.9	81.2	81.4	75.5	75.5	67.2	74.5	79.5
Cleanliness of the air	76.1	76.2	66.8	73.6	85.9	92.0	87.2	88.2	77.5
Number of trees	79.2	74.1	76.5	76.5	67.6	77.6	60.3	70.1	74.8
Level of traffic noise	59.8	67.2	57.9	62.1	65.0	66.7	69.2	66.1	63.2
Recreation—									
Access to a playing field	85.2	72.5	71.4	76.5	60.0	60.2	52.2	59.1	71.9
Access to public park with play equipment	81.8	70.5	70.6	74.4	55.8	57.9	45.6	55.2	69.3
Access to a venue for teenagers	30.2	26.1	23.8	26.9	20.1	15.7	*15.0	17.9	24.5
Safety—									
Good distance from highways/major roads	71.5	78.1	72.8	74.4	70.3	70.7	71.6	70.6	73.4
Street lighting	65.3	56.9	56.2	59.6	48.8	48.2	43.7	48.0	56.5
State of the footpaths	63.6	53.2	51.8	56.4	32.8	42.2	33.6	36.1	51.0
Safe road crossings for children	53.5	56.3	41.1	51.1	42.2	42.8	43.2	42.5	48.8
Visibility of police services	38.7	37.4	35.0	37.2	46.5	55.4	66.7	52.2	41.2

Access to a venue where teenagers can get together received the lowest response (24 per cent) of the factors considered here by families. Broadly, issues concerning neighbourhood safety were recorded with the least level of satisfaction – about half were pleased with the state of the footpaths and safety of road crossings (51 per cent and 49 per cent respectively), and 41 per cent were satisfied with the visibility of police services.

In the majority of cases country families reported less satisfaction with characteristics of the neighbourhood than Perth metropolitan families. The most significant exceptions being in the cleanliness of the air and visibility of police services.

ACCESS TO NEIGHBOURHOOD FACILITIES AND SERVICES

The majority of families reported being satisfied with their access to facilities, services and shops.

TABLE 2.4 Satisfaction with access to particular facilities (Per cent)

	Perth metro				*Country*				
Facility/service/shop	*North metro*	*South metro*	*East metro*	*Total*	*Southern*	*Central*	*Far North*	*Total*	*Western Australia*
Retail outlets—									
Newsagent	94.5	90.8	89.2	91.6	87.0	83.4	80.8	85.0	89.9
Shopping centres	94.4	88.6	90.6	91.2	82.7	69.4	75.1	77.2	87.4
Video shop	91.1	75.3	79.2	81.8	78.2	71.8	74.1	75.5	80.1
Hardware store	81.1	76.7	82.0	79.7	78.7	71.7	56.8	73.5	78.0
Take-away food stores	80.2	74.4	72.8	76.0	60.6	55.9	45.4	57.0	70.9
Recreational facilities—									
Outdoor playing fields	88.7	82.0	78.0	83.2	79.6	74.0	67.6	76.2	81.3
Swimming complex	70.8	66.7	66.1	67.9	73.9	73.1	56.4	71.4	68.8
Indoor sports centre	64.9	60.4	62.7	62.6	62.0	45.5	38.7	53.3	60.1
Leisure facilities—									
Public library	84.4	82.0	82.6	83.0	83.3	82.7	88.9	83.8	83.2
Hotel, tavern or liquor outlet	77.7	74.4	71.6	74.8	71.0	68.3	67.1	69.6	73.4
Range of restaurants	66.5	62.0	61.5	63.4	56.4	53.7	54.2	55.2	61.2
Movie theatre	60.3	55.0	55.2	56.9	36.8	27.5	66.4	37.4	51.7
Hall for live theatre/performance	27.2	37.2	32.2	32.4	49.4	56.5	51.9	52.2	37.7
Emergency services—									
Ambulance service	63.1	68.8	65.8	66.0	82.3	83.4	72.6	81.4	70.1
Fire brigade	57.4	69.4	65.8	64.3	76.0	79.9	73.7	77.0	67.7
Police station	63.9	60.0	56.5	60.4	79.4	80.3	87.1	80.7	65.8
Child specific—									
Community/child health clinic	74.7	66.8	61.9	68.1	74.5	70.2	72.4	72.8	69.4
Organised kids activities	48.6	59.4	51.7	53.5	65.8	55.8	69.2	62.8	56.0
Child care facilities	48.2	54.4	49.0	50.8	53.8	51.6	59.2	53.7	51.6
After school care	45.1	49.4	45.9	46.9	39.4	34.6	47.0	38.7	44.7
Amenities and services—									
School	93.5	89.5	93.7	92.0	94.4	91.3	94.2	93.3	92.4
General practitioner	94.0	88.6	89.0	90.6	85.6	76.1	50.2	77.8	87.2
Post office	83.6	79.3	83.7	82.0	85.4	85.5	86.2	85.5	82.9
Bank	82.7	79.1	79.0	80.3	80.2	76.5	83.4	79.3	80.0
Post box	81.0	73.9	78.4	77.6	78.3	78.0	56.6	75.4	77.0
Public transport systems	83.6	80.4	76.2	80.3	43.2	29.3	37.0	37.6	69.0
Church	69.0	61.0	65.1	64.9	66.1	70.1	62.1	67.0	65.4
Telephone box	65.6	59.4	66.3	63.4	69.8	71.7	63.7	69.7	65.1
Community centre	57.5	54.0	58.2	56.4	46.8	40.3	60.1	46.2	53.7

Families were most satisfied with their access to schools (92 per cent), newsagents (90 per cent) and shopping centres (87 per cent). In contrast, only 38 per cent were satisfied with their access to a hall for live theatre or performance, and 45 per cent with after school-care.

Satisfaction with access to facilities varied across regions. In particular, responses from families in the Far North WA region indicate a consistently lower accessibility of services and facilities. This is especially evident when looking at access to general practitioners, indoor sports centres and take-away food stores.

Perth metropolitan families were far more likely to be satisfied with access to public transport systems (odds ratio 7:1), movie theatres (odds ratio 2:1) and take-away food stores (odds ratio 2:1) than country families. The reverse is true when considering halls for live theatre or performance (odds ratio 2:1) and the emergency services.

VIOLENCE, CRIME AND SOCIAL PROBLEMS

Problems in the neighbourhood. Principal caregivers were asked if they had been affected by a range of social problems in their neighbourhood. The problems most frequently reported included burglaries – reported by 25 per cent of caregivers, noisy and reckless driving (20 per cent), car stealing (16 per cent), unemployment (15 per cent), poverty (13 per cent), vandalism (13 per cent), and people leaving the area (11 per cent).

Regional differences were also evident – families in country regions reported lower levels of car stealing and burglaries than those in the Perth metropolitan area. However, reports of reduced school choice, isolation, alcohol abuse, violence in the house, people leaving the area, and unemployment were more frequent in the country.

In general, one parent families reported higher levels of social and neighbourhood problems. This was most evident when considering burglaries, car stealing, poverty, marital problems, and violence in the home.

It is important to note that most of the questions asked of caregivers about violence, crime and social problems were directed at assessing whether they had been affected by the occurrence of these events in their neighbourhood, rather than directly within the family.

For example, the finding that one parent families are being affected by higher levels of burglaries, car stealing, poverty, marital problems, and violence in the home is not uncommon. These events may be highly inter-related and specific causal mechanisms are not tested in these data. For some, poverty may provide a general backdrop against which violence in the home endangers family members and results in lone parent status. In other instances, geographical proximity permits observation of these problems without necessarily a direct experience of them within the family.

TABLE 2.5 Problems that have occurred, or affected families, in the neighbourhood
(Per cent)

	Region		*Family type*		
Problem	*Perth metro*	*Country*	*Couple families*	*One parent families*	*All families*
Burglaries	28.6	16.8	22.7	37.6	25.4
Noisy/reckless driving	20.2	17.9	18.7	23.4	19.6
Car stealing	18.8	10.0	14.4	25.3	16.4
Unemployment	13.4	19.2	14.7	16.3	15.0
Poverty	12.7	14.6	10.9	23.3	13.2
Vandalism	13.9	11.0	12.8	*14.6	13.1
People leaving the area	8.8	16.5	11.2	*9.5	10.9
Marital problems	8.5	11.4	7.3	17.6	9.3
Reduced choice of school	3.8	12.4	5.6	*8.0	6.1
Harassment	6.3	5.0	5.2	*9.3	5.9
Parent-youth conflict	5.2	7.9	5.2	9.2	5.9
Isolation	*3.6	10.7	4.7	*8.8	5.4
Alcohol abuse	*2.7	8.0	3.3	*7.4	4.1
Violence in the home	*2.2	5.1	1.8	8.2	3.0
School truancy	2.8	3.0	2.3	*5.2	2.8
Drug abuse	*2.0	3.9	*1.9	*5.3	2.5
Child abuse	*1.7	*2.1	*1.2	*4.5	1.8

Victims of crime. In more than 22 per cent of families, a family member had been the victim of theft, assault, malicious damage or some other crime, in the last three years. These crimes had affected more one parent families (32 per cent) than couple families (20 per cent).

Caregivers arrested. According to principal caregivers, about 4 per cent of them and 7 per cent of their spouses/partners had been arrested

or charged with an offence other than a minor traffic violation.

For principal caregivers, those in the lowest range of parental income most frequently reported such an offence – 9 per cent of caregivers, in comparison with an average of 3 per cent across all other income ranges. When considering family type, only 2 per cent of principal caregivers in original families had been arrested or charged for a violation other than a minor traffic offence, compared with 10 per cent of lone parents and 9 per cent of caregivers in step/blended families.

CONNECTING WITH FAMILY AND NEIGHBOURS

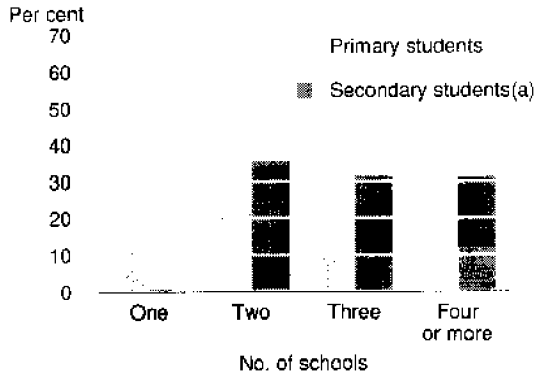
FAMILY MOBILITY

Modern living has been accompanied by mobility. In addition to migration from overseas, it has been increasingly the case for families to shift dwellings, suburbs, regions and states.

Over a quarter (27 per cent) of all families reported having lived in their current dwelling for two years or less, and over a half (53 per cent) for up to five years.

Another way of looking at family mobility is to examine how often children change dwellings and schools. On average, 4 year-old children have lived in at least two different dwellings. This average increased to three dwellings for 8 year-olds, and to nearly four dwellings for those aged 14 years. Despite this apparent mobility, most (61 per cent) primary school students had attended only one primary school, and another 25 per cent had been to two.

FIGURE 2.4 Primary and secondary school students: Number of schools attended



(a) Includes both primary and secondary schools attended.

Regional differences. Higher levels of mobility were associated with the Far North WA and Central WA regions, where 39 per cent and 36 per cent of families respectively had lived in their current dwelling for less than two years. This compares with approximately one in four families in the Perth metropolitan area and Southern WA region.

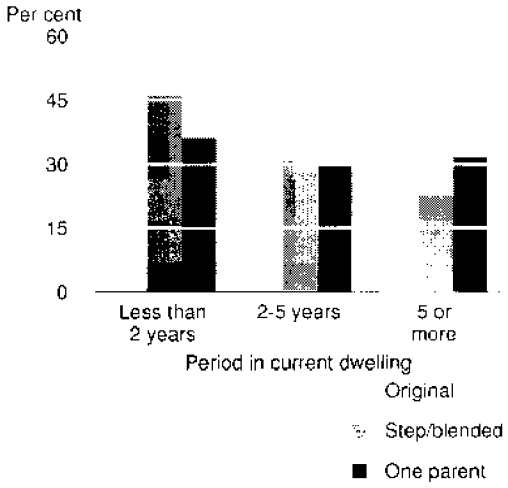
Family type. Another feature of family mobility is its relationship to family structure. Original families had generally been living in their current dwelling for substantially longer periods than step/blended and one parent families.

TABLE 2.6 Period in current dwelling
(Per cent)

	Perth metro				*Country*				*Western*
Period	*North metro*	*South metro*	*East metro*	*Total*	*Southern*	*Central*	*Far North*	*Total*	*Australia*
6 months or less	12.2	9.4	10.2	10.6	9.4	13.3	12.4	11.1	10.7
7 months to 2 years	14.2	15.6	13.3	14.5	16.4	22.2	26.5	19.7	15.9
Between 2 and 5 years	23.7	28.4	29.7	27.2	22.8	25.1	36.2	25.3	26.7
5 to 10 years	23.3	29.1	32.1	27.5	30.4	25.3	18.1	27.1	27.7
11 years or more	22.6	17.1	14.8	18.3	20.7	14.1	5.4	16.5	17.8
Total(a)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
number(a) ('000)	**42.3**	**47.0**	**34.3**	**123.6**	**23.8**	**15.5**	**5.7**	**45.0**	**168.6**

(a) Includes not stated.

FIGURE 2.5 Family type: Period in current dwelling



NEIGHBOURHOOD SUPPORT

Caregivers were asked a series of questions on how well they knew their neighbours. The questions focused on tasks that drew upon different levels of knowledge, familiarity and trust of a neighbour. They range from minding children and getting small items of shopping, to lower level tasks such as keeping an eye on the house when away.

TABLE 2.7 Knowledge of neighbours (Per cent)

	Perth metro	*Country*	*Western Australia*
Know neighbour well enough for them to—			
Keep an eye on house	85.1	87.4	85.7
Mind child for an hour	71.7	77.0	73.1
Water the garden	70.0	77.8	72.1
Feed a pet	62.7	71.5	65.1
Lend something	61.8	72.5	64.6
Get items of shopping	52.4	64.1	55.5
Talk when feeling down	49.3	58.3	51.7
Lend five dollars	41.6	50.7	44.1
Mind child regularly	29.0	36.7	31.1

Regional differences existed in these neighbourhood support variables. Families living in country regions were more likely to provide support to neighbours, especially with tasks that require greater familiarity, such as minding a child regularly and borrowing money.

This observation was also made when considering family type. Essentially, responses by couple families suggested they knew their neighbours better than one parent families knew their neighbours. Couple families were more likely to be able to ask neighbours to mind a child regularly (33 per cent compared with 22 per cent), feed a pet (69 per cent compared with 47 per cent), borrow five dollars (46 per cent compared with 35 per cent) or water the garden when away (74 per cent compared with 62 per cent).

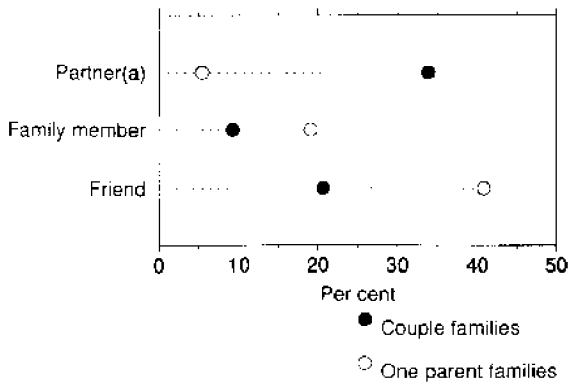
SOMEONE TO TALK WITH

Friends, neighbours, family members and relatives form part of a general network that can be used for social support. In addition to aspects of neighbourhood support discussed above, the Child Health Survey interviewed caregivers about their access to a confidant. Having someone to confide in with thoughts and problems is an integral part of an individual's support network, and can be a positive influence on emotional and psychological well-being.

Only 9 per cent (15,000) of principal caregivers reported not having someone who they could confide in. Income, geographic location and family structure did not appear to appreciably influence the likelihood of having a confidant.

For those who had someone to confide in, the confidant was most commonly their partner (29 per cent) or a friend (24 per cent). They were less likely to be a member of their family (11 per cent) – that is, other than their partner or children, and only occasionally was a confidant found to be the caregiver's child or a professional. Nearly 30 per cent of principal caregivers had at least one person to confide in but could not identify a main confidant.

FIGURE 2.6 Principal caregivers with a confidant: Relationship of selected main confidants



(a) 'Partner' for one parent families can be interpreted to mean a previous partner or a non-resident partner.

The main confidant for principal caregivers in couple families was most frequently (34 per cent) their partner. For lone parents they were most likely to be a friend (41 per cent) or a family member (19 per cent).

RELIGION

One in five principal caregivers described religion as being very important to them. More than twice this proportion (42 per cent) regarded it as not having any influence in their life.

Religion appeared to be of similar importance to original and one parent families, but less so among step and blended families. Over 56 per cent of step/blended families found religion unimportant, compared with two in five for other family types.

Attendance at services. Over half (54 per cent) of principal caregivers attended religious services at least once a year. About half of these people attended on a regular basis; that is, at least once a month.

TABLE 2.8 Family type: Importance of religion and attendance at religious services
(Per cent)

	Family type			
	Original	*Step/ blended*	*One parent*	*All families*
Importance of religion—				
Very important	21.9	*13.0	18.3	20.4
Reasonably important	37.5	30.5	36.6	36.7
Not important at all	40.0	56.5	40.5	41.6
Attendance at services—				
At least once a month	31.7	*11.2	13.9	26.5
Once/twice a year	25.8	26.8	32.1	27.0
Never	42.1	61.7	49.3	45.2
All families(a)	**100.0**	**100.0**	**100.0**	**100.0**
number ('000)	**121.5**	**15.4**	**31.7**	**168.6**

(a) Includes not stated.

Those living in the Perth metropolitan area participated in services more commonly than those in country regions. This was particularly evident in the Far north WA and Southern WA regions – 62 per cent and 53 per cent of principal caregivers in these regions respectively never attended religious services, compared with a State average of 45 per cent.

Family type was also associated with attendance at services. Whereas 32 per cent of principal caregivers in original families attended at least monthly, the same was true of only 14 per cent and 11 per cent of one parent and step/blended families respectively.

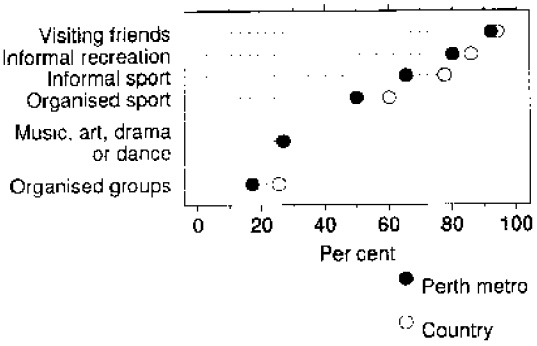
RECREATION AND LEISURE

Recreation is an important component of family and community life and is crucial to the way in which people evaluate their quality of life. Recreational activities include passive or active involvement in a range of leisure pursuits in which individuals feel they have some choice and can perform in their own time. The focus may be upon sporting, artistic, cultural, educational or other activities enjoyed for their social, entertainment or skill-development value.

Activities outside of school. The following analysis refers to children who were attending a school. Caregivers of these children were asked about the type of activities their children engaged in outside of the school environment.

Over half (53 per cent) of all children who attended school were involved in organised sport, and over two-thirds engaged in informal sport (69 per cent). Most children spent some time visiting friends (93 per cent) and participating in informal recreation, such as going to the movies and swimming with friends (82 per cent). However, only one in five (19 per cent) participated in organised groups such as cubs, guides, or church groups.

FIGURE 2.7 Children attending a school: Involvement in organised and informal activities



Country children were more likely to participate in organised and informal activities than Perth metropolitan children, particularly in organised groups (26 per cent compared with 17 per cent), organised sports (60 per cent compared with 50 per cent), and informal sports (77 per cent compared with 66 per cent).

There was relatively little association between family type and the level of participation in this set of activities. Children of couple families were more likely to participate in organised sports (55 per cent compared with 43 per cent), and to visit friends (94 per cent compared with 87 per cent).

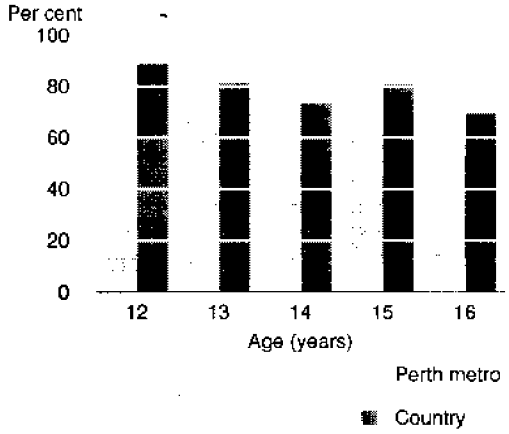
Adolescent participation in sport and exercise. Participation in organised sport is one of the main recreational activities enjoyed by people of all ages and is an important means of obtaining regular exercise and social contact. All people, young and old, benefit from regular exercise through improving cardiovascular fitness and overall muscle strength.[3] There is also increasing evidence that regular exercise has significant mental health benefits.[4] To encourage more young people to take up and continue their involvement in such health enhancing activities, it is important to describe the individual and community factors associated with participation.

The Child Health Survey collected information from adolescents aged 12 to 16 years regarding the amount and type of exercise they had engaged in during the past week and their participation over the past year in sports where they received adult coaching. Apart from physical education classes at school, almost seven in ten (69 per cent) adolescents had played one or more organised sports during the past year which involved adult coaching. Most of these adolescents had taken part in one or two sports (40 per cent and 27 per cent respectively), 21 per cent had participated in three or four sports and 12 per cent had played five or more sports in the past year.

Among adolescents, levels of participation in organised sports declined at older ages. Whereas 77 per cent of 12 year-olds played at least one sport where they received adult coaching, the same was true of only 57 per cent of 16 year-olds. This fall was particularly evident among the male adolescent population, where participation among 12 year-olds and 16 year-olds was 80 per cent and 52 per cent respectively.

Participation levels also varied according to location. Adolescents living in country areas, compared with Perth metropolitan adolescents, were more commonly engaging in coached sports (79 per cent compared with 66 per cent respectively).

FIGURE 2.8 Adolescents: Participation in sports involving adult coaching



Moderate exercise. Just over half (52 per cent) of all adolescents indicated that they had walked or ridden a bicycle for at least 30 minutes at a time (including riding to school) in the previous day.

Aerobic exercise. For the purposes of the survey, aerobic exercise included any sustained vigorous physical exercise (such as fast bicycling) as well as sporting activities (such as basketball, tennis, jogging, or swimming) that resulted in the adolescent sweating or breathing hard.

Nine out of ten adolescents had partaken in some form of aerobic exercise during the week prior to the Survey, with females exercising to a lesser degree than males. For example, 64 per cent of adolescent females reported exercising less frequently than 4 days in the last week, compared with nearly 49 per cent of males.

CHILD CARE

An increasing proportion of parents need to make arrangements for the care of their children when, for various reasons, they are unable to provide this care themselves. The need for regular child care arises when parents are working, studying or looking for work. Parents also require occasional care for their children for personal reasons, such as the need to do shopping, to care for relatives, to visit the doctor or dentist, to visit friends, to take part in social activities or to have respite from the 24 hour responsibility of caring for children. Some parents actively choose to make child care arrangements for the good of their children – for example, in assisting children to learn to cope

with increased periods of separation before they commence school.

The need to make child care arrangements varied for different types of families. Almost half (47 per cent) of children from one parent families had received some form of child care, compared with just over one-third (36 per cent) of children from couple families.

TABLE 2.9 Children: Family type: Children who received child care

Family type	*Number ('000)*	*Per cent*
Couple families—		
Original	79.6	35.6
Step/blended	10.8	37.1
One parent families	23.4	46.6
All children who received child care	**113.8**	**37.6**

A feature of contemporary Australian society is the wide variety of arrangements which parents make to provide child care at home or elsewhere through formal and/or informal arrangements with relatives and non-relatives. Among the formal child care arrangements available to parents are: before and after school care programs; pre-school and kindergarten; long day care centres; and family day care.

BEFORE SCHOOL CARE

The families of 4 per cent of children made arrangements for the care of their children before school. This involved the care of primary school-aged children (4 to 11 year-olds) in the majority of cases (90 per cent). Of the families who used before school care, 55 per cent reported they used it regularly while the balance used it only sometimes.

AFTER SCHOOL CARE

Parents of 15 per cent of children made child care arrangements for the time between the finish of school and the parents' return from work. For 42 per cent (19,800) of these children, after school care arrangements were made regularly, and the remainder (27,000), only sometimes.

The most frequent providers of all after school care were grandparents or other relatives (who provided care for 47 per cent of children), and neighbours or friends (43 per cent).

TABLE 2.10 Children who received after school care: Providers

Provider	*Number ('000)*	*Per cent*
Grandparent/other relative	21.9	46.7
Neighbour/friend	20.0	42.8
Paid child minder	5.8	12.3
Out of school hours care	4.5	9.6
Older brother/sister	3.1	*6.6
Regular child care	*2.6	*5.6
Other	*0.9	*2.0
All children who received after school care(a)	**46.8**	**100.0**

(a) Total may be less than the sum of the components because parents could use more than one type of provider.

CHILD CARE DURING SCHOOL HOLIDAYS

For most working parents, school holidays are a time when special arrangements need to be made for the care of their children. About 20 per cent (an estimated 59,600 children) had such care arrangements made. Of these, almost two-fifths (39 per cent) had holiday care arrangements made regularly and the remainder only sometimes.

TABLE 2.11 Children who received school holiday care: Providers

Provider	*Number ('000)*	*Per cent*
Grandparent/other relative	37.0	62.1
Neighbour/friend	21.2	35.5
Paid child minder	4.6	7.8
Out of school hours care	7.2	12.2
Older brother/sister	5.0	8.5
Regular child care	*3.1	*5.2
Other	**1.3	**2.1
All children who received school holiday care(a)	**59.6**	**100.0**

(a) Total may be less than the sum of the components because parents could use more than one type of provider.

For children's holiday care, parents reported making arrangements most commonly with grandparents or relatives (62 per cent), and with neighbours or friends (36 per cent).

OUT OF SCHOOL HOURS CARE AND PARENTS' WORK

The kind of arrangements made by parents for the care of their children either before or after school depend primarily on parents' work commitments and the number of caregivers within the household.

In couple families, the proportion of children receiving out of school care increased from around 6 per cent of families where one or both caregivers were not employed, to 22 per cent where both were employed. Similarly, in one parent families, 13 per cent of children whose parent was not employed received out of school care in comparison with 28 per cent of children with an employed caregiver.

TABLE 2.12 Children: Parental employment arrangements: Children receiving out of school care(a)

Parental employment arrangement	*Number ('000)*	*Per cent*
Couple families—		
Both employed	30.9	21.5
One employed	5.3	*6.0
None employed	**0.9	**6.1
Total(b)	*38.2*	*15.1*
One parent families—		
Employed	*6.8	28.4
Not employed	*3.5	*13.3
Total(b)	*10.3*	*20.5*
All children who received out of school care	**48.4**	**16.0**

(a) Children receiving before school and/or after school care. (b) Includes not stated.

CHILD CARE WHEN PARENTS ARE ILL

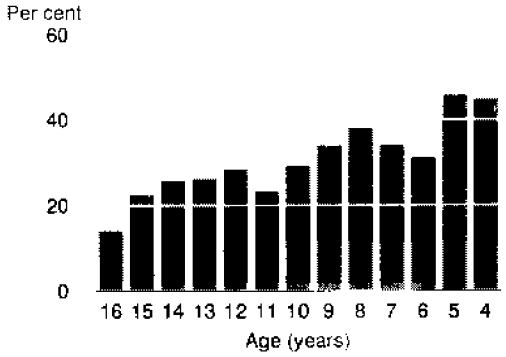
The parents of one in five children reported having to make special child care arrangements when they (the parents) were ill. Most commonly (82 per cent) these arrangements involved grandparents or other relatives providing care. Other arrangements included care provided by neighbours or friends (20 per cent), older siblings (7 per cent), out of school programs or other paid child care (5 per cent).

DAY CARE IN EARLY CHILDHOOD

The Child Health Survey sought information from caregivers as to whether their children had attended regular day care during early childhood. Nearly one in three (31 per cent, or 93,000) 4 to 16 year-olds had at some time attended regular day care for at least half a day per week. Of the children who had ever attended regular day care, 19 per cent had done so by the age of one year, and 73 per cent had attended by the age of three years.

The proportion of children who were reported by parents to have used regular day care increased steadily for each successive age group in the survey. Fewer than one in six (14 per cent) children aged 16 years had ever attended regular day care (i.e. for half a day a week). By contrast, about 45 per cent of 4 to 5 year-olds had attended regular day care.

FIGURE 2.9 Proportion of children who have used day care by age



KINDERGARTEN AND PRE-SCHOOL ATTENDANCE

Kindergarten, play groups and pre-primary schools provide stimulation and opportunities for children to develop cognitive and social skills in preparation for formal schooling. Children's attendance at such centres also fulfils some parents' needs for child care to enable their resumption of work, study or participation in other activities. In the year of the survey, 5 year-old children in Western Australia were eligible to attend State pre-primary schools on 2 half-days per week. This has since increased to 4 half-days per week depending on the local availability of pre-primary school placements. However, in 1993, the majority (93 per cent) of children aged 4 to 16 years had attended some form of kindergarten or play group for at least half a day a week before the age of 5. Nearly 10 per cent of children had attended this often by the age of 3 years. A further 50 per cent had done so by 4 years of age and another 34 per cent had done so by the age of 5 years.

COMMENTARY

These data supply an unusually rich and detailed description about the family home and neighbourhood characteristics of families. They provide an opportunity to assess the presence of and access to the many amenities, services and facilities that comprise the diversity of neighbourhood and community life. Also provided are details about family experiences of major social problems such as poverty or difficulties with the law. These descriptions move from the particular experiences and resources of individual families to a more general picture of family and community life. This move from the particular to the general requires cautious interpretation.

The general view of Australian neighbourhood and community life reflects many positive aspects. Almost seven in ten (69 per cent) families reported having at least some choice in selecting a place to live. Most were living in a separate house with nearly three-quarters (73 per cent) of families owning or purchasing the dwelling in which they lived. A safe place for children to play, a quiet neighbourhood, proximity to school and some shops, good heating/cooling, and access to parks and a clean environment are prominent among the list of characteristics of the majority of family homes. While family mobility is frequently cited as being high when measured by changes of dwelling, the majority of such shifts take place in ways that maximise continuity of schooling for children.

However, this general view conceals regional differences. For example, while the vast majority (87 per cent) were happy with their access to a general practitioner, this is not true across all regions of the State – only 50 per cent of those living in the Far North WA region reported they were satisfied with their access to a GP; also, about 12 per cent of families in country regions reported a reduced choice of school compared with 4 per cent of Perth metropolitan families.

Additionally, there were variations in these characteristics between different family types. The disadvantage and inequity that lone parents experience in access and participation remains prominent in these data. Rental accommodation and lower levels of perceived safety and privacy were more common for lone parents and their children. For example, one in five couple families had experienced a theft, assault or malicious damage in the last three years, whereas nearly one in three one parent families reported this experience. Lone parents also reported greater difficulties in connecting with and gaining support from their local neighbourhoods.

Communities and neighbourhoods are frequently cited as being instrumental in their ability to support family life and encourage health and well-being. It is likely that neighbourhoods and communities contribute to inter-generational cycles of disadvantage in families. Yet, specific mechanisms by which this happens are not well documented, nor are there generally good measurements of community and neighbourhood characteristics that permit regular study of their relationship to health and well-being. The data in this section show that there are both regional and family differences in provision, use, exposure and access to a range of services, features and problems.

ENDNOTES

1 Kruskal JB, Wish M. *Multi-dimensional scaling*. London: Sage Publications, 1978.

2 Arabie P, Carroll JD, BeSarbo WS. *Three way Scaling and Clustering*. London: Sage Publications, 1987.

3 Nutbeam D, Wise M, Bauman A, Harris E, Leeder S, eds. *Goals and Targets for Australia's Health in the Year 2000 and Beyond*. Commonwealth Department of Health, Housing and Community Services. Canberra: Australian Government Publishing Service, 1993.

4 Department of Health and Human Services, Health Promotion Service. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC, 1990.

3 INCOME AND WORK

The well-being of families, in terms of the standard of living and quality of life of the family members, is greatly influenced by the economic resources of the family unit as well as family size and composition. Regular income is the main resource by which most families finance their household expenditure and make provision for the future through such avenues as savings and investments.

Participation in the labour force remains a principal source of income for most families. For couple families, there are a number of options that each parent can take up in order to balance paid work with their family caring commitments. For lone parents, opportunities to enter the labour force are often constrained by child care responsibilities.[1]

This Chapter looks at the income and work arrangements of couple and one parent families and examines the degree to which the composition of families influences their economic well-being.

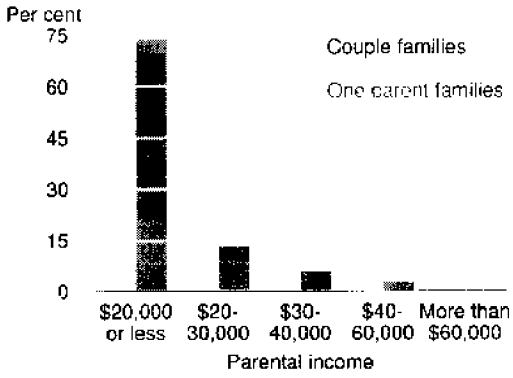
INCOME AND FAMILY TYPE

Income in this publication is analysed in terms of the parental income within families (see *Parental income* and *Income ranges* in the Glossary). The Child Health Survey collected details of individual gross incomes of the principal caregiver and any spouse or partner. In couple families, parental income represents the combined gross incomes of both caregivers.

DISTRIBUTION OF INCOME

The distribution of parental income varied considerably between family types but remained comparable between Perth metropolitan and country families.

FIGURE 3.1 Family type: Parental income



Couple families. For couple families, fewer than one in ten (9 per cent) received $20,000 or less per year. The highest proportion had parental incomes in the range $40,001 to $60,000 (29 per

TABLE 3.1 Parental income
(Per cent)

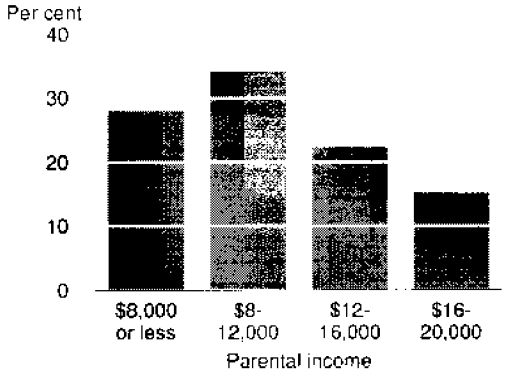
	Family type						
	Couple families						
Income range	Original	Step/blended	All couple families	One parent families	Region: Perth metro	Region: Country	All families
$20,000 or less	9.6	*6.3	9.2	73.8	21.6	20.8	21.3
$20,001-$30,000	19.0	26.5	19.8	13.3	18.4	19.1	18.6
$30,001-$40,000	17.7	22.8	18.3	*6.2	16.7	14.0	16.0
$40,001-$60,000	29.6	23.0	28.8	*2.8	24.0	23.7	23.9
More than $60,000	17.1	16.2	17.0	**0.5	13.8	14.1	13.9
Not stated	7.2	*5.2	7.0	*3.4	5.6	8.3	6.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
number ('000)	**121.5**	**15.4**	**136.9**	**31.7**	**123.6**	**45.0**	**168.6**

cent). Another 17 per cent (23,200) received in excess of $60,000 per year.

One parent families. In comparison, the great majority (74 per cent or 23,400 families) of one parent families received incomes of $20,000 or less per year. Only a small proportion (approximately 3 per cent) of these families were in the highest two income ranges, that is, they received more than $40,000 annually.

A closer examination of one parent families receiving $20,000 or less shows that more than three in five (62 per cent) had incomes lower than $12,001, as illustrated in Figure 3.2.

FIGURE 3.2 One parent families with parental income of $20,000 or less: Income level



COMMENTARY

There are a number of reasons why one parent families are strongly represented in the lower income ranges. First and foremost, couple families, relative to lone parents, generally have an extra caregiver as a potential source of income. The absence of a partner also has adverse affects on the lone caregiver's capacity to generate income. For instance, the 1992 Survey of Families found that lone parents were far more likely to experience barriers to both participating in the labour force and undertaking further education. Caring for children was the most common barrier, and was experienced by a greater proportion of lone parents than parents in couple families.

As a result, one parent families typically experience lower levels of labour force participation, higher part-time employment levels, and are more reliant on government pensions and subsidies for income than caregivers in couple families.[1,2] Some of these issues are examined more fully later in this chapter.

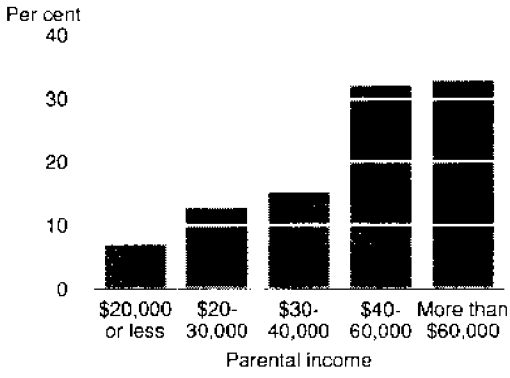
It is important to remember that 50,200 Western Australian children aged 4 to 16 years lived in one parent families (see Table 1.2), and that for over 24,400 of these children the family income was less than $12,001 (see also Government Pensions and Benefits). The relationship between poverty and illness is well documented[3] although research is needed to understand how and in what ways poverty contributes to specific patterns of illness and health care use in families and children.[4]

INCOME SHARE

In just over 6 per cent of families, caregivers did not report their income. In determining and describing income share, these families were excluded.

There was a disproportionate spread of total parental income among families. Families with parental incomes greater than $40,000 per year comprised 40 per cent of families who reported their income, yet received almost two-thirds (65 per cent) of total income. Families with incomes of $20,000 or less (of which 65 per cent were one parent families) comprised almost one-quarter (23 per cent) of families, but received only 7 per cent of total income.

FIGURE 3.3 Parental income(a) and share of total income



(a) Excludes families where parental income was not stated.

FAMILY COMPOSITION AND INCOME

The economic well-being of families determines the quality of food, clothing, housing, schooling, health care and other goods and services that parents are able to provide their children. The composition of families, in terms of the number

and age of children and the number of parents, may result in differing standards of living for families with comparable incomes. For example, it should be borne in mind that couple families have an extra adult placing additional demands on income.

Number of family members. Analysis of Child Health Survey data in this publication is usually in terms of 4 to 16 year-old children and their families. In discussing associations between income and the number of family members, it would not be meaningful to do so without considering all children in families dependent on that income. For this reason, data used in the following analysis and in Table 3.2 include children aged 0 to 3 years as well as those aged 4 to 16 years (see *Dependent children* in the Glossary).

Economic hardship is most likely to affect families in the lowest income range, particularly those with more dependent children. Families receiving $20,000 or less income and who had two or more dependent children made up 12 per cent (an estimated 20,300) of all families. Three in five (12,300) of these families were one parent families.

Table 3.2 indicates that families with more dependent children are associated with smaller incomes. Of couple families with three or more children (aged 0 to 16 years), 57 per cent received a parental income of $40,000 or less. In comparison, in those families with two children or one child, 47 per cent and 35 per cent respectively were in this income bracket.

Couple families tended to be largest in the income range $20,001 to $30,000, where the average number of 0 to 16 year-old children was 2.4. Family size decreased at higher parental income levels, to a point where families in the highest income range had, on average, 1.9 children.

Age of children. Families whose youngest child was aged 4 to 11 years were more likely to be receiving lower incomes than those with children of adolescent age. It is often the case that child care demands are higher for children of a younger age – this, in turn, can have a bearing on parents' availability for employment. These demands also have a more pronounced affect on lone parents, in the absence of an available partner to share child care responsibilities.

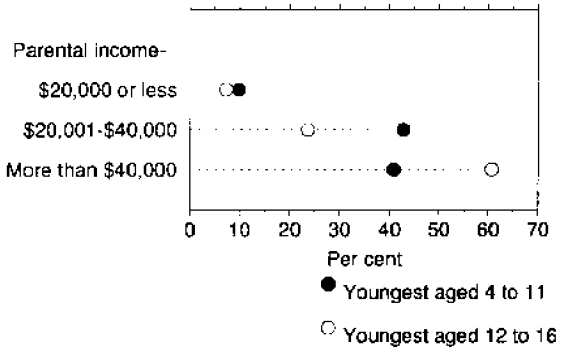
Among one parent families, 79 per cent of those with the youngest child aged 4 to 11 years received income of $20,000 or less, compared with 65 per cent where the youngest child was aged 12 to 16 years.

TABLE 3.2 Family size (number of children aged 0 to 16 years): Parental income levels

	Number of children aged 0 to 16 years							
	One		*Two*		*Three or more*		*All families*	
Income range	*No. ('000)*	*Per cent*	*No. ('000)*	*Per cent*	*No. ('000)*	*Per cent*	*No. ('000)*	*Per cent*
				COUPLE FAMILIES				
$20,000 or less	4.5	13.8	4.4	7.1	3.6	8.7	12.6	9.2
$20,001-$30,000	3.3	9.9	12.6	20.3	11.2	26.8	27.1	19.8
$30,001-$40,000	*3.8	*11.6	12.2	19.7	9.0	21.5	25.0	18.3
$40,001-$60,000	11.0	33.5	18.4	29.7	10.0	23.9	39.5	28.8
More than $60,000	8.0	24.3	10.7	17.3	4.5	10.7	23.2	17.0
Not stated	*2.3	*6.9	3.7	5.9	3.6	8.5	9.5	7.0
All couple families	**33.0**	**100.0**	**62.1**	**100.0**	**41.8**	**100.0**	**136.9**	**100.0**
				ALL FAMILIES				
$20,000 or less	15.7	32.4	12.4	17.0	7.9	16.7	36.0	21.3
$20,001-$30,000	5.7	11.9	13.9	19.1	11.7	24.6	31.3	18.6
$30,001-$40,000	4.6	9.5	13.1	18.0	9.2	19.5	27.0	16.0
$40,001-$60,000	11.5	23.7	18.6	25.5	10.3	21.8	40.4	23.9
More than $60,000	8.2	16.9	10.7	14.7	4.5	9.4	23.4	13.9
Not stated	*2.7	*5.6	4.1	5.6	3.8	8.0	10.6	6.3
All families	**48.4**	**100.0**	**72.9**	**100.0**	**47.4**	**100.0**	**168.6**	**100.0**

For couple families, those in which the youngest child was aged 4 to 11 years most commonly had incomes in the range $20,001 to $40,000 (43 per cent). Most (61 per cent) families in which the youngest child was of adolescent age received incomes of more than $40,000.

FIGURE 3.4 Couple families: Age of youngest child: Parental income



GOVERNMENT PENSIONS AND BENEFITS

Most families with 4 to 16 year-olds (86 per cent) received the family allowance (child endowment). Another 21 per cent were paid the family allowance supplement and 6 per cent received rent assistance.

The 1992 Survey of Families found that those families whose main source of income was government pensions and benefits were predominantly in the lowest quintile of income. It also demonstrated that one parent families were far more likely to have government pensions and cash benefits as a main source than couple families.[5]

The Child Health Survey determined the type of government pensions and cash benefits received, but not the level of reliance on them as a source of income. Survey results did show higher proportions of one parent families than couple families in receipt of the family allowance supplement (27 per cent compared with 20 per cent) and rent assistance (18 per cent compared with 4 per cent). Of one parent families, 59 per cent received the sole parent pension and/or Jobs, Education and Training (JET) scheme payment.

WORKING LIFE

Paid employment remains the principal means for families to acquire income. Accordingly, greater involvement in the workforce by parents has a positive influence on families' economic well-being. Couple families are generally more able to balance work and family responsibilities than lone parents, who traditionally face greater barriers to labour force participation and employment.[1]

PARTICIPATION IN THE LABOUR FORCE

Recent decades have seen the increased participation of women in the labour force and a decline in male participation. From 1973 to 1993, the labour force participation rate among women rose 10 percentage points to 52 per cent, while the rate for men dropped 8 points to 74 per cent.[6] This reflects, among other things, a change in attitudes to the roles of men and women in the family and work environments.

When considering family type, labour force participation has been found to be higher among partners of couple families than lone caregivers.[2]

One parent families. From the survey, in over 36 per cent of one parent families, the caregiver was not in the labour force.

In country areas, almost half (49 per cent) of lone parents were not in the labour force compared with just under one-third (32 per cent) in the Perth metropolitan area.

Couple families. In 33 per cent of couple families there was at least one caregiver not in the labour force. In most of these cases (84 per cent), one of the partners was employed (predominantly the secondary caregiver).

EMPLOYMENT

Couple families experienced greater levels of employment than one parent families. In 93 per cent of couple families, at least one parent or partner was employed, whereas only half of caregivers in one parent families were employed.

For families in country areas, the difference was even more pronounced. Just under 43 per cent of lone parents living in the country were employed. In comparison, 60 per cent of couple families had both caregivers in paid employment and another 34 per cent had one caregiver employed.

Despite the increased participation by females in the labour force, male partners were still the most likely to take on the responsibility of employment. In 90 per cent of couple families

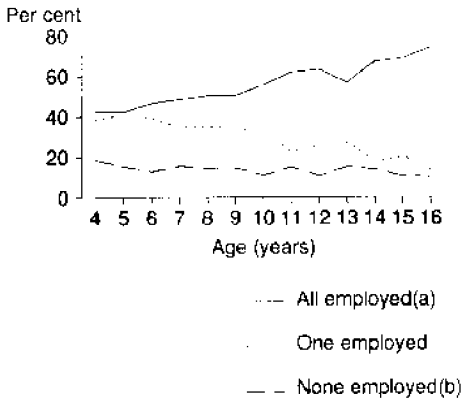
TABLE 3.3 Level of employment in families

	Perth Metro		Country		Western Australia	
	No. ('000)	*Per cent*	*No. ('000)*	*Per cent*	*No. ('000)*	*Per cent*
			COUPLE FAMILIES			
Both caregivers employed	57.4	57.4	22.0	59.7	79.4	58.0
One caregiver employed—						
One unemployed	6.9	6.9	*1.5	*3.9	8.4	6.1
One not in the labour force	27.3	27.3	10.6	28.8	38.0	27.7
Total	*35.3*	*35.3*	*12.5*	*33.9*	*47.8*	*34.9*
Neither caregiver employed—						
Both unemployed	*1.0	*1.0	*0.1	**0.2	*1.1	*0.8
Both not in the labour force	*1.5	*1.5	*0.8	*2.3	*2.3	*1.7
One unemployed/one not in the labour force	3.8	*3.8	1.1	*3.0	4.9	3.6
Total(a)	*6.5*	*6.5*	*2.1*	*5.7*	*8.6*	*6.3*
All couple families(b)	**100.0**	**100.0**	**36.9**	**100.0**	**136.9**	**100.0**
			ONE PARENT FAMILIES			
Caregiver employed	12.4	52.5	3.5	42.6	15.9	50.0
Caregiver unemployed	*3.6	*15.3	*0.7	*8.8	*4.3	13.6
Caregiver not in the labour force	7.6	32.2	3.9	48.6	11.5	36.4
All one parent families(b)	**23.6**	**100.0**	**8.1**	**100.0**	**31.7**	**100.0**

(a) Includes those who were not employed but who did not state whether they were unemployed or not in the labour force. (b) Includes not stated.

where only one partner was employed, the secondary caregiver was the employed person (where 96 per cent of all secondary caregivers in families were male).

FIGURE 3.5 Children: Age of child: Level of employment in family



(a) Includes employed lone caregivers. (b) Includes caregivers who are unemployed and not in the labour force.

Figure 3.5 shows that the level of caregiver employment increased with child age; whereas only 42 per cent of 4 and 5 year-olds had all caregivers in the family employed, this figure was 74 per cent among families of 16 year-olds.

PERMANENT, CASUAL AND TEMPORARY EMPLOYMENT

Employed caregivers most commonly had a job in which they worked on a permanent basis. Secondary caregivers were more likely to be in permanent employment than principal caregivers (96 per cent compared with 76 per cent). Principal caregivers were employed on a casual basis nearly 6 times as often as secondary caregivers.

TABLE 3.4 Employed caregivers: Permanent, casual and temporary employment (Per cent)

	Principal caregivers	*Secondary caregivers*
Permanent	75.7	95.7
Casual	18.9	3.4
Temporary	5.4	*0.8
All employed caregivers	**100.0**	**100.0**
number ('000)	**100.4**	**122.5**

UNEMPLOYMENT

The survey was conducted at a time when unemployment levels for both couple and one parent families with dependent children were higher than previous years.[7]

Over 10 per cent of couple families had at least one caregiver unemployed, with a small proportion of these having both caregivers unemployed. Nearly 14 per cent of lone caregivers were unemployed.

TABLE 3.5 Level of unemployment in families (Per cent)

	No. ('000)	*Per cent*
COUPLE FAMILIES		
Both caregivers unemployed	*1.1	0.8
One caregiver unemployed	13.2	9.7
Neither caregiver unemployed(a)	119.7	87.5
All couple families(b)	**136.9**	**100.0**
ONE PARENT FAMILIES		
Caregiver unemployed	*4.3	13.6
Caregiver employed	15.9	50.0
Caregiver not in the labour force	11.5	36.4
All one parent families(b)	**31.7**	**100.0**

(a) Includes both employed; both not in the labour force; and one employed, one not in the labour force. (b) Includes not stated.

INCOME AND WORK

As might be expected, fewer employed caregivers in a family corresponded with lower parental income. In couple families with neither caregiver employed, 87 per cent of families received incomes of $30,000 or less. This proportion fell to 37 per cent where one caregiver was employed, and further to 18 per cent among those couple families with both employed.

Family income levels for couple families were substantially higher than for one parent families, even at equivalent levels of caregiver employment. In families where only one caregiver was employed, 8 per cent of couple families, compared with 58 per cent of one parent families, had incomes of $20,000 or less.

FIGURE 3.6 Unemployment in families: Parental income

(a) Families with at least one caregiver unemployed.

Families which were affected by unemployment were likely to have lower incomes than other families, as shown in Figure 3.6. Of the 18,700 families with one or more unemployed caregiver(s), most (72 per cent) had incomes of $30,000 or less. Most frequently (48 per cent) these families received an income which placed them in the lowest income range; that is, they received $20,000 or less. For all other families,

TABLE 3.6 Level of employment in household: Parental income (Per cent)

	Couple families				*One parent families*		
Parental income	*Both employed*	*One employed*	*Neither employed(a)*	*Total*	*Employed*	*Not employed*	*Total*
$20,000 or less	4.7	8.4	54.4	9.2	58.5	89.1	73.8
$20,001-$30,000	13.2	28.8	32.7	19.8	19.8	*6.9	13.3
$30,001-$40,000	13.1	28.6	**6.2	18.3	*10.6	**1.8	*6.2
$40,001-$60,000	36.6	20.9	**4.4	28.8	**5.7	**0.0	*2.8
More than $60,000	25.0	7.0	**0.0	17.0	**0.9	**0.0	**0.5
All families(b)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
number ('000)	**79.4**	**47.8**	**8.6**	**136.9**	**15.9**	**15.9**	**31.7**

(a) Includes both unemployed; both not in the labour force; one unemployed, one not in the labour force. (b) Includes income not stated.

these proportions were 36 per cent and 18 per cent respectively.

HOURS WORKED

Achieving a satisfactory balance between the competing demands of work and caring for children is a difficult task for many parents. It involves important decisions about their standard of living and the most appropriate way to meet their family responsibilities, particularly for lone parents and parents with younger children.

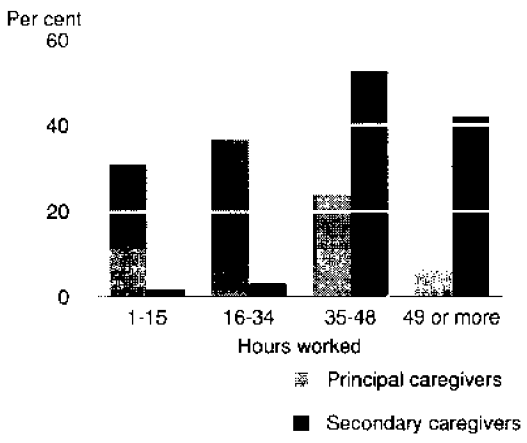
Principal caregivers, who were predominantly women, were more likely to respond to changes in family demands by seeking part-time, casual or temporary employment or by excluding themselves from the labour force.

Part-time employment for both males and females has grown markedly over the last 20 years. The proportion of persons working part-time has doubled over this period. In part, this can be attributed to growth in service industries, the predominant employer of part-time workers. It also stems from a number of other developments across all industries (including extended working hours, new technology, and changed award conditions), which have strongly affected both the supply and demand side of the labour market.[8]

HOURS WORKED BY CAREGIVERS

Almost 95 per cent of employed secondary caregivers worked full-time hours (that is, 35 hours or more per week). Most frequently (53 per cent or 64,600) they worked from 35 to 48 hours.

FIGURE 3.7 Employed caregivers: Hours worked per week



In contrast, responses of employed principal caregivers indicated a high incidence of part-time work, with 68 per cent working less than 35 hours per week. A sizeable proportion of these (46 per cent) were working 15 hours or less.

There are a number of reasons which lead people to work part-time hours, including attendance at educational institutions, personal preferences, and the requirements of the job.[9]

Average hours worked. Principal caregivers worked an average of 25 hours per week, about half that of secondary caregivers (48 hours). Average weekly part-time and full-time hours worked by principal caregivers (17 hours and 43 hours respectively) were also below those for secondary caregivers (19 hours and 49 hours).

OCCUPATION GROUP AND HOURS WORKED

As established earlier, secondary caregivers worked substantially longer hours in their employment than did principal caregivers. This was true across all occupation groups (see *Occupation* in the Glossary).

Managers and administrators clearly worked the longest hours for both principal caregivers (an average of 40 hours) and secondary caregivers (56 hours).

TABLE 3.7 Employed caregivers: Occupation group: Average hours worked per week

	Average hours worked by—	
Occupation group	*Principal caregivers*	*Secondary caregivers*
Managers and administrators	39.7	56.2
Professionals	29.1	46.7
Para-professionals	25.4	44.5
Tradespersons	32.8	48.1
Clerks	22.5	40.7
Salespersons and personal service workers	22.4	48.6
Plant and machine operators, and drivers	29.4	51.6
Labourers and related workers	21.1	40.8
All employed caregivers	**24.8**	**47.7**

FAMILY EMPLOYMENT ARRANGEMENTS

The idealised two caregiver family in which one caregiver works for wages and another stays at home to care for children is increasingly rare.

More now than ever households are seeking more than one income in order to support family members, their lifestyles and standard of living.

Employment levels and hours worked, within families, varied with family structure:

Couple families. More than 87 per cent of couple families had at least one caregiver employed full-time.

TABLE 3.8 Parental employment arrangements in couple and one parent families

Parental employment arrangement	*Number ('000)*	*Per cent*
COUPLE FAMILIES		
Both full-time	21.1	15.4
One full-time, one part-time	56.1	41.0
One full-time, one not employed	42.3	30.9
Both part-time	2.2	1.6
One part-time, one not employed	5.5	4.0
Both not employed	8.6	6.3
All couple families(a)	**136.9**	**100.0**
ONE PARENT FAMILIES		
Employed—		
Full-time	6.2	19.4
Part-time	9.6	30.4
Not employed	15.9	50.0
All one parent families(a)	**31.7**	**100.0**

(a) Includes not stated.

In 41 per cent of couple families, one caregiver was employed full-time and the other (most frequently the principal caregiver) was employed part-time – this was the most common employment arrangement in couple families. Approximately another one in seven (15 per cent) had both caregivers in full-time employment. In less than one-third of couple families (31 per cent), only one caregiver was employed, working full-time.

Only 6 per cent of couple families reported that both caregivers were not employed.

One parent families. In one parent families where the lone caregiver was employed (15,900), 36 per cent were employed full-time. Reasons for the low participation in full-time employment include the cost, suitability and availability of child care and the length or flexibility of full-time working hours.[1]

Average hours worked. In practical terms these patterns of work impact upon the time available to spend with children and other family members. Table 3.9 shows the average number of hours worked by caregivers in couple and one parent families. The figures here are important as they reflect the amount of time taken up by employment in families of different types and employment arrangements.

The uptake of part-time employment by different family types has varying economic significance and reflects the different resources, opportunities and skills of the part-time workers in these families.

TABLE 3.9 Parental employment arrangements in couple and one parent families: Average total hours worked by caregivers in household(a) (Hours per week)

Parental employment arrangement	*Average total hours*
Couple families—	
Both full-time	92
One full-time, one part-time	67
One full-time, one not employed	48
Both part-time	39
One part-time, one not employed	17
Both not employed	0
One parent families—	
Full-time	40
Part-time	16
Not employed	0

(a) In couple families, the average is of the sum of the hours worked by both caregivers.

AGE OF CHILDREN

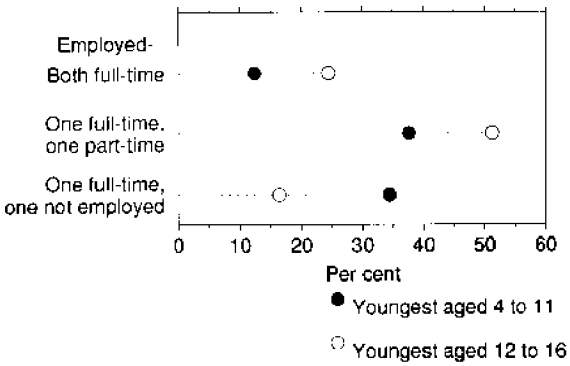
Couple families with younger children (those whose youngest child was aged 4 to 11 years) structured their employment options differently from couple families with older children (those whose youngest child was aged 12 to 16 years). Caregivers in families with younger children were less likely to be both employed – whereas 52 per cent of these families had both caregivers employed (either part- or full-time), the proportion was higher (77 per cent) for families with older children.

In addition, parents with older children were both employed full-time twice as often as parents in younger families (24 per cent and 12 per cent respectively).

These differences between older and younger families partly explain the positive association

between age of children and income, as discussed earlier in this chapter.

FIGURE 3.8 Couple families: Age of youngest child: Most common employment status'



Among one parent families, the proportion of lone parents working full-time increased from 12 per cent of families with younger children to 29 per cent of families where the youngest child was of adolescent age.

The fact that part-time employment remained predominant for employed lone caregivers, regardless of the age of their children, suggests that the absence of a second caregiver to share the caring role remained an inhibiting factor to full-time workforce participation.

COMMENTARY

Caring for children and working to earn an income are inextricably linked. Obtaining a job and its income is seen to be necessary in a family's provision of care. However, once obtained, work erodes both the time and energy needed by caregivers to care for children and others. Some family types, notably those with two caregivers, are more able to share the need for a job and income with the need to supply care to children and other family members. For lone caregivers the choice of obtaining a job with income versus remaining out of the labour force in order to care for children may not exist at all. Even where it does exist, such a choice for lone caregivers often results in accepting high levels of poverty, which subsequently impacts upon family life, health and the quality of care. Work and family income are important contexts for understanding the health and well-being of all family members.

The following points illustrate the importance of the work and income data presented here from the Child Health Survey:

- Similar proportions of principal caregivers (most of whom are women) in one parent and couple families were not in the labour force. Over one-third (36 per cent) of all lone parents were not in the labour force. This was true of 31 per cent of principal caregivers in couple families.
- The average week of employment entails 48 hours of work for secondary caregivers although this ranged from 41 hours to 56 hours depending on occupational group. When principal caregivers were employed they worked 25 hours per week, on average, although this varied from 21 to 39 hours for individual occupational groups.
- About 58 per cent of employed lone parents were earning $20,000 or less per year. For couple families where one caregiver was employed, about 8 per cent had this level of family income. Where both were employed, this figure is only 5 per cent.

Finally, central to the description of employment is a description of the time allocated by caregivers to paid employment and its relationship to the time available to provide care to family and children. The amount of time caregivers spend in employment is increasing. However, paid work is not the only work in which families are engaged and it is critical to understand the contribution that unpaid household work makes to the care of the family. In Australia, preparing meals, cleaning, laundry, and shopping consume more hours per week of labour time than do the wholesale and retail trade sectors. As well as this, child care as a main activity within the family consumes as much or more time per week as the community services sector or the manufacturing sector.[10] It is in the context of the household and its unpaid labour that the care of most Australian children under the age of five years takes place.

Changes in the household patterns of employment and work, the uptake of employment by both caregivers, and the mix of part- and full-time employment are impacting on these care arrangements. Such changes are producing demands for alternate forms of care, more flexible workplace arrangements, and a wider understanding of the role that schools play in the provision of care.

ENDNOTES

1 *Focus on Families: Work and Family Responsibilities* (ABS Catalogue No. 4422.0).

2 *Focus on Families: Education and Employment* (ABS Catalogue No. 4421.0).

3 National Health Strategy. *Enough to Make You Sick: How Income and Environment Affect Health.* Canberra: National Health Strategy, 1992.

4 Harris P. *All Our Children: Children's Entitlements to Health, Education and Community Services.* Melbourne: Brotherhood of St Laurence, 1990.

5 *Focus on Families: Income and Housing* (ABS Catalogue No. 4424.0).

6 *The Labour Force, Australia* (ABS Catalogue No. 6203.0).

7 *Labour Force Status and Other Characteristics of Families, Australia* (ABS Catalogue No. 6224.0).

8 *Australian Social Trends, 1994* (ABS Catalogue No. 4102.0).

9 *Working Arrangements, Australia* (ABS Catalogue No. 6342.0).

10 Ironmonger D. The value of care and nurture provided by unpaid household work. *Family Matters* 1994;37:46-51.

4 FAMILY FUNCTIONING

While family structures can be diverse and membership varied, all families, whether they are original, step/blended or one parent families, are faced with achieving some degree of acceptance of each individual, reaching consensus on decisions, communicating feelings, and solving day to day problems. Families vary in their abilities to transact many of these important functions. Relationship quality, the health of each family member, the presence of life stresses, work and finance each contribute to how caregivers and children manage the many demands of family life. This chapter examines influences that impact upon family functioning, including marital relationship quality, family discord, life-stress, and parental self-efficacy.

MARITAL RELATIONSHIP QUALITY

Sixty-three per cent of all families were couple families with both partners in their first marriage; 12 per cent reported that one or both partners had been married previously; and 5 per cent reported they were in a de facto relationship. The remaining 19 per cent of families were one parent families.

Principal caregivers in couple families were asked a range of questions aimed at determining the quality of their relationship with their spouse or partner.

When asked to rate their relationship, 44 per cent described it as 'excellent'. Another 44 per cent stated their relationship was 'good', while 10 per cent said it was either 'fair' or 'poor'. Similar responses were observed regardless of whether partners were in their first marriage, remarried or in a defacto relationship.

Partners did things together for enjoyment quite frequently – 64 per cent of caregivers in couple families reported doing something together for enjoyment at least once a week. More than 63 per cent showed signs of care to one another at least daily, and another 21 per cent did so around 2 to 6 times a week.

Quarrelling was reported less frequently – at least once a week by 21 per cent of caregivers in couple families, whereas 54 per cent said it occurred once a month or less. In 2 per cent of families that quarrelled the partners reported getting "physical" or hitting each other when they quarrelled. In 10 per cent of cases, caregivers reported that they never quarrelled.

FAMILY DISCORD

The Child Health Survey asked principal caregivers about general family functioning using the *McMaster Family Assessment Device* (see Glossary). This involved caregivers assessing their ability to plan and make decisions, provide support, accept one another, express feelings, and get on well together. This assessment scale allows identification of the more serious problems that result in family discord.

Using the Family Assessment Device, it was estimated that over 12 per cent of families could be considered to have a high level of family discord.

TABLE 4.1 Families: Level of family discord: Incidence of family function characteristics (Per cent)

Family function characteristic	*High discord*	*Low discord*	*All families(a)*
Avoid discussing concerns	70.9	12.9	20.4
Cannot talk about sadness	63.5	12.0	18.9
Planning activities is difficult	52.6	11.4	16.8
Making decisions is a problem	55.7	6.6	13.1
Do not confide in each other	51.4	4.4	10.5
Do not express feelings	47.6	3.5	9.4
Unable to solve problems	43.8	3.2	8.9
Bad feelings in family	40.2	2.2	7.8
Do not get on well together	32.1	2.2	6.8
Do not feel accepted for who we are	28.2	3.1	6.5
Individuals are not accepted	24.7	2.0	5.2
Cannot turn to each other for support in times of crisis	18.7	2.0	4.3
All families ('000)	**20.7**	**131.4**	**168.6**

(a) Includes cases where the level of discord was not stated in the Family Assessment Device.

There were significant disparities between families considered to have high discord and those with low discord, in their reporting of various characteristics of family function. Most commonly, families with high discord tended to avoid discussing concerns and fears (71 per cent); could not talk to each other about sadness (63 per cent); had problems making decisions (56 per cent); found planning family activities difficult due to misunderstandings (53 per cent); and were unable to confide in each other (51 per cent).

Not surprisingly, when a family did not function well it had a negative impact on the level of personal happiness of the caregivers. In families with high discord, 25 per cent of principal caregivers said they were not too happy in their life, compared with 3 per cent in families which functioned well.

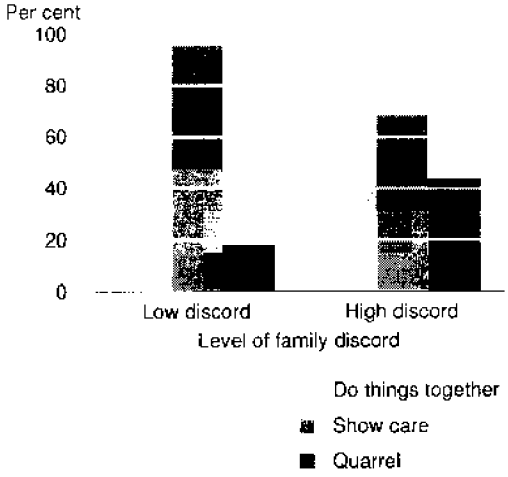
TABLE 4.2 Couple families: Level of family discord: Frequency of parental relationship characteristics (Per cent)

Frequency of parental relationship characteristics	*High discord*	*Low discord*
Do things together for enjoyment—		
Once a day or more	**3.3	10.3
1-6 times per week	39.6	56.6
2-4 times per month	30.6	20.8
Less than once a month	24.4	11.3
Total(a)	*100.0*	*100.0*
Show signs of care for each other—		
Once a day or more	24.9	68.6
1-6 times per week	44.5	26.8
2-4 times per month	*14.5	*2.4
Less than once a month	13.9	*0.9
Total(a)	*100.0*	*100.0*
Quarrel—		
At least once a week	44.1	18.2
1-4 times per month	32.6	35.3
Less than once a month	15.7	35.0
Never	*5.4	10.8
Total(a)	*100.0*	*100.0*
All couple families ('000)	**15.1**	**112.5**

(a) Includes not stated.

Caregivers in couple families were asked about the frequency with which they did things together for enjoyment or showed each other care, and how often they quarrelled. When compared with families in which there was high discord, caregivers in families with low discord were more likely (at least once a week) to do things together (67 per cent compared with 43 per cent), show each other care (95 per cent compared with 69 per cent) and were less likely to quarrel (18 per cent compared with 44 per cent).

FIGURE 4.1 Couple families: Level of family discord: Parental relationship characteristics which occur at least once a week



Marital relationship quality and family discord were found to be related. When compared with caregivers from families with low discord, those caregivers in families with high discord were more likely (odds ratio 12:1) to report their marital relationship to be fair or poor (43 per cent compared with 6 per cent).

FUTURE DIRECTIONS

The vast majority (89 per cent) of couples, whether in their first marriage, remarriage, or de facto relationship, reported the quality of their marital relationship to be good or excellent. Other studies have shown that, for a large proportion of these couples, the relationship quality will decline over time, leading to distress and divorce.[1] It is significant that 12 per cent of families reported high levels of discord. These families were characterised by poor communication, and difficulties with decision making and the expression of feelings. Their caregivers were far more likely to report a lesser quality marital relationship. Problems in communication are well documented as being central to the breakdown of relationships.[2,3] At the outset of a relationship many couples assume that they communicate with one another well or that, in the course of their

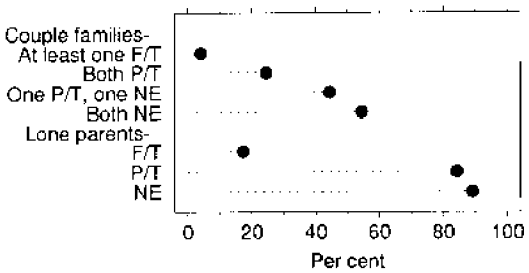
relationship, these skills will develop. The evidence for this is not reassuring.

Continued investment in programs that offer couples skill development in communication, counselling, support and guidance offer a realistic avenue to reduce the rate of relationship breakdown and/or reduce the impact of this breakdown on caregivers and family members.[4,5]

EMPLOYMENT, INCOME AND FAMILY FUNCTION

The relationship between employment, income and family functioning is complex. Families may be of several types (original, step and blended, or one parent families). Family functioning varies in response to these family types and the events resulting in them. Additionally, the events leading to structural differences in families produce major differences in employment opportunities and incomes for caregivers. Obviously, unlike one parent families, couple families have the opportunity for more than one caregiver to be employed part- or full-time, and this impacts upon family income.

FIGURE 4.2 Families: Parental employment arrangements(a): Proportion in the lowest income range

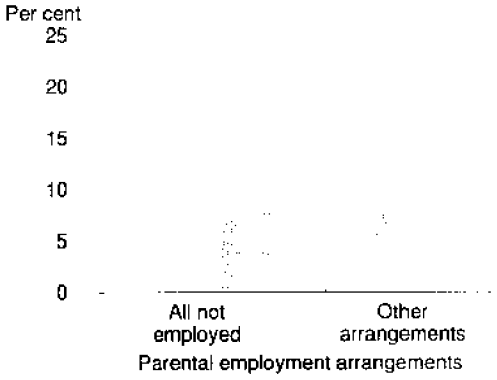


(a) F/T = employed full-time; P/T = employed part-time; NE = not employed (unemployed or not in the labour force).

Family income varies in response to differing employment arrangements, especially the number of caregivers employed and their hours worked. In couple families where only one caregiver was employed full-time, 4 per cent were in the lowest income range. This compares with 17 per cent of full-time employed lone parents. Similarly, over 54 per cent of couple families where neither caregiver was employed were in the lowest income range; while 89 per cent of lone caregivers who were not employed, were in the lowest income range.

Levels of family discord were notably higher in couple and one parent families when all caregivers were not employed. These families, collectively, were more likely (odds ratio 3:1) to report high levels of discord, than families with other employment arrangements.

FIGURE 4.3 Families: Parental employment arrangements: Proportion with high levels of family discord



These associations between income and employment arrangements, and discord are important in light of the association between discord and the health and mental health of family members. This association is discussed in more detail in the section *Family Functioning and Health* in Chapter 5.

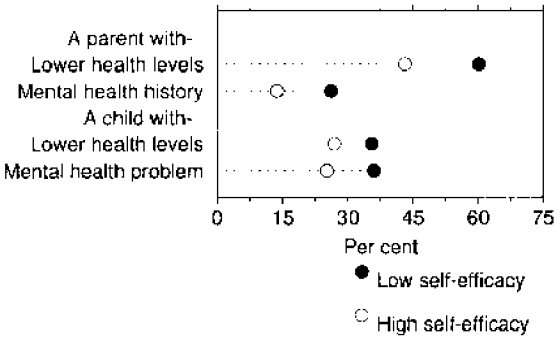
PARENTAL SELF-EFFICACY

Managing the tasks of day to day living requires energy, skill, support and experience. Both people and situations require managing and may do so without a caregiver necessarily having much control over either. Self-efficacy refers to a caregiver's assessment of how well they think they manage a variety of day to day tasks (see *Self-efficacy* in the Glossary). Examples of these tasks include: working out a problem with a child; getting something done under a lot of pressure; doing something for the first time; or making an important decision. Caregivers were asked a range of questions aimed at assessing how well they were managing, and to determine how confident they were that they could manage in a number of settings and situations. Caregivers who were rated in the lowest 10 per cent of this assessment were said

to have 'low' self-efficacy – implying that they were not managing well.

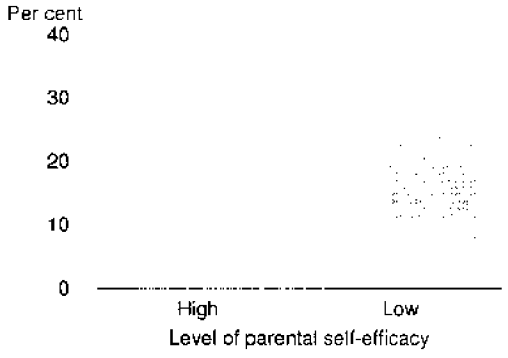
Physical and mental health status. There were associations between self-efficacy and the physical and mental health of caregivers. The families of caregivers with low self-efficacy were more likely (odds ratio 2:1) to have a caregiver with a lower level of general health (that is, a self-rated general health status of 'good', 'fair' or 'poor'), and more likely (odds ratio 2:1) to have at least one caregiver with a history of mental health problems (that is, reported that they had ever been treated for an emotional or mental health problem), than those with high self-efficacy.

FIGURE 4.4 Families: Parental self-efficacy: General and mental health status of parents and children



Family functioning. There was a strong association between self-efficacy and family discord – about 10 per cent of families who were managing well had high levels of discord, compared with 33 per cent of families where caregivers had low self-efficacy.

FIGURE 4.5 Families: Parental self-efficacy: Proportion of families with high discord



One parent families. Lone caregivers were more likely (odds ratio 2:1) to report difficulties in managing well when compared with caregivers in couple families.

Employment status. Parental self-efficacy was also associated with their employment status. Those from families where no caregiver was employed were more likely (odds ratio 4:1) to have low self-efficacy than parents from families with at least one caregiver employed full-time.

FUTURE DIRECTIONS

Friends and family commonly ask, "How are you managing?" For caregivers in the Child Health Survey, the data indicate that this question is meaningful. Some of the important factors that are associated with the ability of caregivers to manage essential, day to day tasks are, notably: physical and mental health; the health of other family members; work and income; and the level of family discord. The finding of this association with health, work, and family functioning has been documented in other Australian studies.[6]

The causal direction of these factors with parental self-efficacy is not explained. For example, poor caregiver health certainly may cause a decline in the caregiver's ability to manage on a day to day basis. However, poor skills in, and supports for, managing day to day tasks may of themselves lead to poor attention to personal health and result in illness. Whatever the causal direction, these data suggest that better support of families through periods of difficulty can be achieved. The better integration of health, mental health and community services in government and non-government sectors can help in this process.

PARENTING STYLES

One of the many functions of a family is the provision of care to children. Traditionally, the acquisition of the skills to be a parent took place within families and, often, between generations. Learning to be a parent, to care for children and other family members, to encourage their development and to respond with help occurred in settings where opportunity to observe how to do many of these tasks was available, along with help from family and friends.

The Western Australian Child Health Survey asked caregivers about the parenting behaviours they used to deal with children's misbehaviour and the methods they employed to encourage desirable behaviours. Additionally, adolescents were asked to report on their perception of the parenting style used by their caregivers. Information was also sought from caregivers about the specific areas of their children's behaviour which presented them with most problems and whether, during the past six months, they had felt the need for outside help in disciplining their children.

FREQUENCY OF DISCIPLINING

The frequency with which parents disciplined their children changed markedly with the increasing age of the children. For example, while the parents of 21 per cent of younger children (4 to 11 year-olds) reported punishing or disciplining their children's behaviour at least daily, the parents of only 5 per cent of adolescents (12 to 16 year-olds) said they needed to exercise discipline this often. For younger children, the most common frequency of parental discipline was once or twice a week (36 per cent). For adolescents, the most common frequency of discipline was less often than once every few months (30 per cent).

METHODS OF MANAGING CHILD BEHAVIOUR

Most parents use a combination of reasoning, reinforcement and punishment to manage and guide their children's behaviour. This generally varies with the age of the child.

The parents of seven in ten children reported that they frequently used reasoning or explaining things to deal with child behaviour problems. The next most common disciplinary methods reported to be used frequently were shouting or yelling (29 per cent), sending the child to his/her room (14 per cent), and taking away privileges (10 per cent). Other, more coercive, methods of discipline (such as smacking, shaking, or hitting with an object) were reported to be used much less frequently.

As a general rule, disciplinary methods were used less frequently among adolescents, particularly when the method was more coercive. The caregivers of only 3 per cent of younger children reported smacking their children frequently, and another 27 per cent did so sometimes. For adolescents, this occurred sometimes or more frequently in only 6 per cent of cases.

Hitting a child with an object (e.g. a wooden spoon or belt), and shaking or shoving was reported rarely. The parents of 72 per cent of 4 to 11 year-olds reported never hitting them with an object; the same was true among the caregivers of 82 per cent of adolescents. Similarly, shaking or shoving was said to be never used as a disciplinary style for most younger children (73 per cent) and adolescents (80 per cent).

TABLE 4.3 Children: Parents' use of disciplinary methods
(Per cent)

	Frequency				
Disciplinary methods	*Never*	*Seldom*	*Some-times*	*Freq-uently*	*Total(a)*
4 TO 11 YEAR-OLDS					
Reason with child	**0.1	7.5	19.1	73.1	100.0
Shout or yell	2.1	21.2	44.5	32.1	100.0
Take away privileges	12.5	31.3	45.5	10.5	100.0
Send to room	8.2	32.6	40.4	18.6	100.0
Smack with hand	15.9	54.6	26.7	2.6	100.0
Shake or shove	72.7	24.4	2.5	*0.2	100.0
Hit with object	72.5	23.4	3.8	*0.2	100.0
12 TO 16 YEAR-OLDS					
Reason with child	**0.0	12.5	21.5	65.8	100.0
Shout or yell	5.3	29.9	40.0	24.6	100.0
Take away privileges	21.7	35.4	34.4	8.2	100.0
Send to room	32.8	41.6	19.2	6.2	100.0
Smack with hand	56.0	37.9	4.8	*1.0	100.0
Shake or shove	80.0	17.2	2.1	**0.4	100.0
Hit with object	81.5	16.8	*1.4	**0.0	100.0

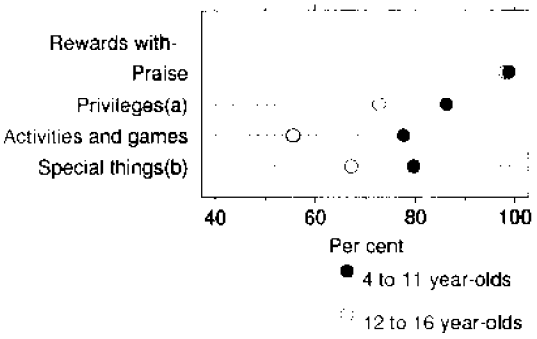
(a) Includes not stated.

USE OF REWARDS AND OTHER REINFORCEMENTS

There were a number of methods that caregivers used for rewarding a child for an achievement or good behaviour.

Parents of almost all (99 per cent) children stated that they reward them with praise. Other reinforcements, such as rewards in the form of privileges, extra activities, and favourite snacks and lollies, etc. were all commonly endorsed, particularly among younger children.

FIGURE 4.6 Children: Age: Parental reinforcements used sometimes or frequently



(a) For example, being read a special story, given extra pocket money or being allowed to stay up late. (b) For example, favourite meals, lollies, chips, toys, magazines or tapes.

CHILD BEHAVIOURS WHICH PRESENT DIFFICULTY FOR PARENTS

TABLE 4.4 Children: Areas of behaviour which parents reported as frequent(a) problems (Per cent)

	Age group (years)		*All*
	4 to 11	*12 to 16*	*children*
Household chores	51.1	54.2	52.2
General behaviour	42.1	28.0	37.0
Watching television	35.9	36.5	36.1
Eating habits	37.8	22.9	32.4
Sleeping times	29.2	28.9	29.1
Study habits/homework	21.6	39.8	28.2
Wish for more independence	20.1	23.6	21.4
Clothes/appearance	15.4	18.8	16.6
Withholding important information	12.1	21.7	15.6
Hair styles	10.9	13.0	11.6
Loud music	4.0	20.6	10.0
Pocketmoney amounts	6.8	11.8	8.7
Amount of money they spend	5.1	14.0	8.3
Rules for going out	7.0	10.6	8.3
The friends they go out with	7.0	9.6	8.0
Frequency that they go out	4.7	13.2	7.8
Religion	3.8	4.5	4.1
Not knowing where they are	2.6	4.7	3.4
Coming home too late	*1.6	4.8	2.8
All children ('000)	**192.6**	**110.3**	**302.9**

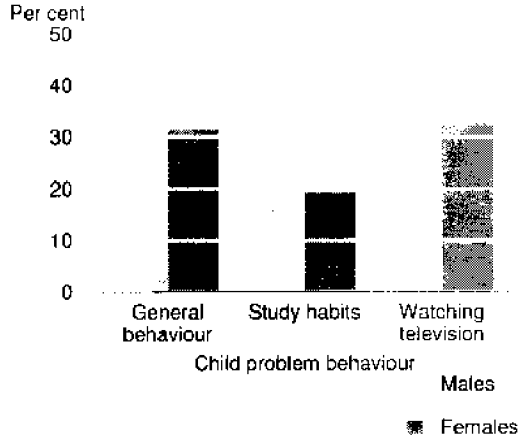
(a) Those where the response was 'sometimes', 'frequently' or 'very frequently'.

The Child Health Survey asked parents about a range of child behaviours which parents commonly report as causing them problems with their children. The most frequently encountered problems appeared to be with 'internal' matters, such as household chores, general behaviour, watching television and eating habits. Matters concerning 'external' activities, appearance and money were reported much less often.

In general, parents reported child behaviour problems more frequently among adolescents than younger children, particularly when considering problems with loud music, the frequency they go out, the amount of money spent, and study habits. The exceptions to this were with regard to general behaviour and eating habits.

There were discernible differences between males and females in the problems reported frequently. The most notable disparities were with study habits, general behaviour and watching television – in all of these cases the problem was reported more commonly among boys than girls.

FIGURE 4.7 Children: Sex: Selected problem behaviours



PARENTAL DISCIPLINARY STYLE

As has been noted earlier, parents differ in the frequency with which they use particular disciplinary and reinforcement methods. Analysis of the seven disciplinary methods considered in this survey indicated two main clusters – one comprising more coercive methods of discipline and the other non-coercive methods. There also appeared to be two broad patterns in the frequency of use of reinforcements.

Defined, from these two characteristics, were four common parental disciplinary styles. They are, in order of frequency:

Encouraging parenting style. This was the most common (49 per cent) pattern of parenting, characterised by high use of rewards and reinforcements and low frequency of coercive methods of discipline.

Inconsistent parenting style. Children reared with this pattern of parenting (38 per cent) have experienced a high frequency of coercive methods of discipline while simultaneously being given high levels of reinforcements.

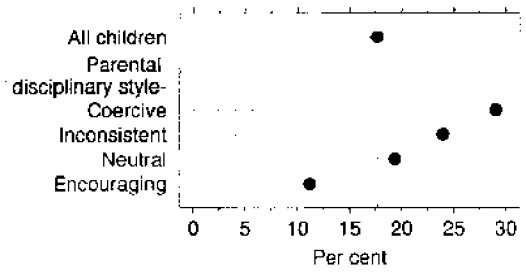
Neutral parenting style. Characterised by low frequency of coercive discipline and low use of reinforcements. Over 7 per cent of children fell into this category.

Coercive parenting style. This pattern of parenting was characterised by high levels of coercive discipline and low use of reinforcement. The parents of 5 per cent of children were considered to have this style.

PARENTAL DISCIPLINARY STYLE AND CHILD MENTAL HEALTH

There were increased rates of mental health morbidities among those children whose parents were considered to use coercive or inconsistent disciplinary styles – 29 per cent and 24 per cent of children exposed to these styles respectively had a mental health problem, compared with an overall average of 18 per cent. In general, these children also exhibited elevated risks for a number of the *behavioural syndromes* (see Glossary) defined by the *Child Behaviour Checklist* (see Glossary). This was particularly evident when considering delinquency, attention and social problems, and somatic complaints.

FIGURE 4.8 Children: Parental disciplinary style: Proportion with a mental health problem



PERCEIVED NEED FOR HELP OUTSIDE OF THE FAMILY

The parents of 9 per cent of children reported that, during the six months prior to the survey, they had felt in need of outside assistance in disciplining their children. The need for outside help was associated with family type, level of general family functioning, and parental disciplinary style.

Family type. The parents of almost 20 per cent of children in one parent families expressed the need for outside help in disciplining their children, in comparison with 7 per cent in couple families.

Parental disciplinary style. Parents reported requiring help more often in families that were considered to have inconsistent and coercive styles of parenting – 16 per cent and 12 per cent respectively. In contrast, these frequencies were 4 per cent in families when the parenting style was encouraging and 5 per cent when the style was neutral.

Family functioning. Parents in families with high levels of family discord were more likely (odds ratio 2.5:1) to report that they felt the need for outside help in disciplining their children, than parents in families with low discord.

FUTURE DIRECTIONS

The skills needed and used in parenting children are only a part of a general range of skills needed in supporting, caring for and managing a family. The profile of parenting in the 1990s, as generally portrayed in the media, would suggest that parents are confused about their role and anxious about societal expectations for them to be 'super-parents'. Despite the perception of parents experiencing increasing difficulty with child behaviour, the data on parenting from the Child Health Survey reveals a significantly different picture.

A large majority of parents do not feel any need for outside assistance in managing their children's behaviour. Most parents seldom use physical punishment to discipline their children, exercising other methods of behavioural management, including reasoning, taking away privileges, and shouting or yelling.

Parenting style is, of course, also influenced by family circumstances, life-stress events and the skills and resources available to the family.[7] Those families which were more likely to report a need for external assistance in managing their children's behaviour included one parent families, families which used inconsistent and coercive disciplinary styles and those with poor general family functioning.

There is clearly a need to ensure that parents are made more aware of the protective value of positive methods of parenting and the potentially adverse consequences of harsh or inconsistent discipline. Interventions which extend parents' repertoire of positive parenting skills have been shown to be effective in maintaining long-term improvements of parent-child interaction, reducing the likelihood of physical abuse and in reducing rates of conduct and other mental health disorders.[8,9,10]

It is also crucial that the community, through government and other social institutions, acknowledge and support parents in their parenting role. This needs to be demonstrated in social and economic policies, industrial relations, child care, education and community development, through such means as:

- Parenting information and training targeted at parents before and during the child's early (pre-school) years.
- Parenting services, courses and support groups being made more readily available at other key points in development (such as the transition from primary to high school) when the need for different parenting skills and information become relevant.
- Developing innovative and flexible strategies to make parenting resources more accessible and attractive to larger numbers of parents, including those from lower socio-economic groups, Aboriginal and migrant groups.

SOCIAL SUPPORTS AND FAMILY HEALTH

The concept of 'social support' has been operationally defined as the range and quality of supportive relationships which individuals have with significant others and their community. Such relationships are generally held to facilitate personal efficacy, health and the ability to manage stress. They may include the personal connections which individuals have with friends, family, neighbours, workmates and others. In its broadest sense, social support also includes access to tangible supports such as housing and income and other functional supports such as information, advice and services.

One of the problems arising from the use of such a broadly defined concept has been the fact that global measures of social support have, by and large, shown poor correlations with a range of health outcomes.[11] The Child Health Survey therefore examined the relationship between indicators of specific aspects of social support and measures of parent, child and family health. These indicators of social support included the availability of a confidant, neighbourhood supports, and the disruption of these supports which can arise through frequent family relocation.

AVAILABILITY OF A CONFIDANT

The availability of a confidant with whom a caregiver can talk or confide in about themself or discuss personal problems is one aspect of social support which is significantly associated with family and child health. In families where caregivers reported not having a confidant, the principal caregiver also reported a lower level of physical health more frequently than in families where this support existed (47 per cent compared with 31 per cent). Additionally, these families more often had at least one child in the household with a lower level of physical health (38 per cent compared with 27 per cent), or with a mental health problem (39 per cent compared with 25 per cent).

Families in which the principal caregiver did not have a confidant were more likely (odds ratio 3:1) to report high family discord than those where the principal caregiver had a confidant.

NEIGHBOURHOOD SUPPORT

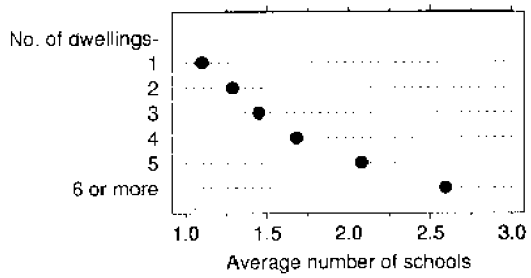
Neighbourhood support (see *Connecting with Families and Neighbours* in Chapter 2) also contributes to family well-being. Many caregivers know their neighbours well enough to ask them to mind a child for an hour in an emergency, water the garden or feed a pet when away on holiday. Caregivers who did not know their neighbours this well were almost twice as likely to report a high level of family discord.

FAMILY MOBILITY

A notable feature of family life in the 1990s is the frequency with which families with children move home. The Child Health Survey found that nearly 27 per cent of families with 4 to 16 year-olds had been living in their current dwelling for a period of two years or less (Table 2.6 provides more details about family mobility). Where family relocation involves a move to another neighbourhood it may entail a change of school and the disruption of local friendship and social support networks for both children and parents.

The number of primary schools a child had attended rose, on average, with the greater number of dwellings lived in, but at a less than directly proportional rate. Primary school children who had lived in only one dwelling had attended on average, 1.1 schools, compared with an average of 2.6 schools for those who had lived in 6 or more dwellings.

FIGURE 4.9 Primary school children: Number of dwellings lived in: Average number of primary schools attended



It could be suggested that the effects of mobility appear to be more profound on children, as the survey reveals that 33 per cent of children in families that had moved within the past two years had a mental health problem, in comparison with 18 per cent from families who had resided in their current dwelling for 11 years or more.

LIFE EVENTS, STRESS AND HEALTH

The Child Health Survey provided an opportunity to ask caregivers if certain life events had occurred in the 12 months prior to the survey. A total of 33 specific events were probed (see *Life-stress events* in the Glossary). After discarding variables with insufficient responses and grouping those that were highly correlated, a total of 20 life events warranted inclusion here. These included death and problems with health, relationships, money and the law, and comprise some of the most frequently stressful of life's events.

Seventy-six per cent of all families experienced at least one life-stress event (of these 20) in the twelve months prior to the survey. The most frequently reported of these life-stress events included serious illness (30 per cent), unemployment or financial problems (22 per cent) and serious family arguments (21 per cent), followed by close family members being away (19 per cent) and a favourite family pet dying (18 per cent).

TABLE 4.5 Families: Main life-stress events in last 12 months
(Per cent)

Life-stress event	*Number ('000)*	*Per cent*
A close family member was very ill or had been hospitalised	51.2	30.4
Unemployment/financial problems	37.3	22.1
Serious family arguments	35.1	20.8
A close family member was away from home a lot	31.6	18.7
A favourite family pet died	29.5	17.5
A close relative died	20.1	11.9
Child's best friend moved away	15.5	9.2
Family member in drug/legal strife	11.5	6.8
Close family member had serious emotional problems	11.4	6.8
Parents were separated or divorced	11.3	6.7
A close family member was robbed	11.2	6.7
Trouble with child care	10.6	6.3
New household members	9.6	5.7
Child frightened by someone's behaviour	9.1	5.4
Struggled to provide necessities	9.0	5.3
High family mobility	8.9	5.3
Unsafe neighbourhood	8.5	5.0
Close family member has a physical handicap	6.8	4.1
House is very crowded	5.4	3.2
Child witnessed bad injury	3.9	2.3

Family type. The frequency with which families reported these life-stress events varied with family type. Many of the events reported may have occurred in the transition a family makes from one type to another – for example, where caregivers separate and the family becomes a one parent family. In general, one parent

families experienced life-stress events more frequently than both original and step/blended families.

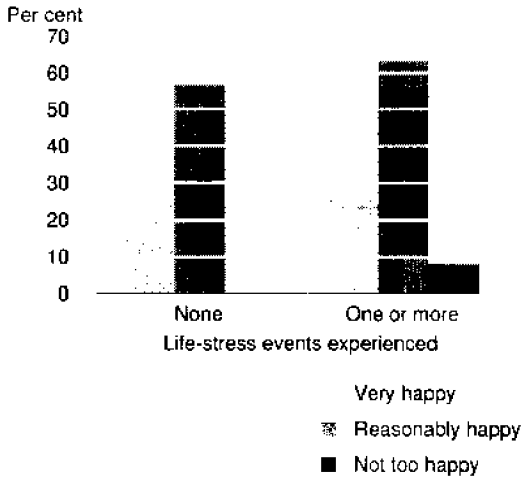
Family conflict was a common life-stress event, evidenced by higher rates of arguments in step and blended and one parent families. For one parent families there were additional stresses related to poverty, as seen in the higher rates of reported unemployment and financial stress (see Chapter 3 for more details on employment and income).

TABLE 4.6 Family type: Selected life-stress events (Per cent)

	Family type		
Life-stress event	*Original*	*Step/ blended*	*One parent*
Unemployment/financial problems	19.9	17.4	32.9
Serious family arguments	17.6	28.0	29.8
Family member in drug/legal strife	4.3	*10.7	14.8
Close family member had serious emotional problems	4.3	*5.7	17.0
Child frightened by someone's behaviour	3.5	*7.8	11.5
Struggled to provide necessities	2.8	*5.0	15.3
Unsafe neighbourhood	*4.0	*4.8	9.2

Happiness. Certainly life-stress and happiness are related. Principal caregivers in families which had experienced at least one life-stress event in the previous 12 months were likely to be less happy than those in families which had not. Alternatively, among caregivers who reported being "not too happy", 98 per cent reported one or more life-stresses.

FIGURE 4.10 Families: Life-stress events experienced in last 12 months: Happiness of principal caregiver



Self-efficacy. Exposure to life-stress has an impact on caregivers' ability to manage day to day tasks. Approximately 5 per cent of principal caregivers in families which had experienced no life-stress events reported low self-efficacy, compared with 11 per cent of caregivers in families which had at least one life-stress event in the previous year.

Family well-being. Parental health and mental health also varied with the reporting of life-stress. Families which had experienced life-stress events were more likely (odds ratio 2:1) to report at least one caregiver with a lower level of physical health, or to report poor mental health in at least one caregiver.

These families also reported higher incidences of at least one child with a mental health problem (29 per cent), compared with families where no life-stress event had occurred (17 per cent).

Relationship quality. Perhaps not surprisingly, the quality of the relationship between partners in couple families was found to be related to life-stress events, particularly with events such as family arguments, or unemployment or financial problems. For example, 26 per cent of partners described their relationship as 'fair' or 'poor' when the family had experienced serious family arguments during the past 12 months – compared with 7 per cent of partners in families which had not reported this experience.

FUTURE DIRECTIONS

While it may be said that life wasn't meant to be easy, the data on life-stress events suggest that for some life is harder than for others. Undoubtedly many of these life events co-occur. For example, serious illness can lead to loss of employment, financial problems and stresses that result in arguments, deteriorating relationships and even separation or divorce. It is also important to realise that illness and hospitalisation are life events, and some of these associations reflect this fact.

The association established here between life events, happiness and health is also well documented in other studies of well-being and stress.[12] The mechanism that links life-stress and health is not addressed in these data. Good quality research must focus on collecting longitudinal data, measuring both the occurrence of the life event and the level and enquire about factors that helped or

exacerbated the adjustment to the event and do this for different family members. Concurrent information regarding the health and mental health of family members should also be collected.

CHILD DISABILITY AND FAMILY HEALTH

In the first volume of results – *Western Australian Child Health Survey: Developing Health and Well-being in the Nineties* (ABS Cat. No. 4303.5) – disability was considered in terms of limitation of independent function, and encompassed the following elements: children who couldn't walk or who were limited in their ability to use transport or to play, and those requiring supervision in getting around the neighbourhood or to carry out tasks of daily living (see *Disability* in the Glossary).

Under this definition, nearly one in twenty children aged 4 to 16 years had a disability, and 8 per cent of families had at least one child with a disability. This section examines the effect that these disabilities have on the family.

TABLE 4.7 Families: Number of children with a disability: Family health characteristics (Per cent)

	No. of children with a disability	
Family health characteristic	*At least one*	*None*
At least one child with—		
A lower level of health	56.7	25.4
A mental health problem	47.6	24.3
At least one parent with—		
A lower level of health	62.4	44.3
A mental health history	*14.6	14.9
Happiness of principal caregiver—		
Very happy	*19.0	32.0
Reasonably happy	70.6	60.9
Not too happy	9.3	6.0
Total(a)	*100.0*	*100.0*
High use of medical services(b)	47.8	20.2
Low parental self-efficacy	*12.1	9.3
Poor family functioning	18.8	11.7
All families ('000)	**12.8**	**155.8**

(a) Includes not stated. (b) Highest quartile of use of medical services.

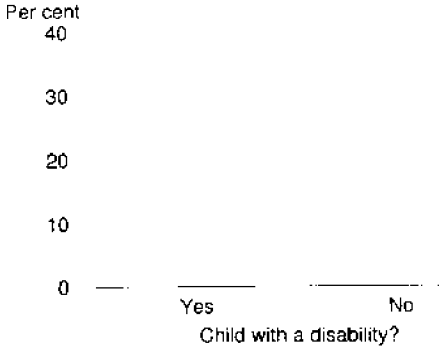
Several associations are evident in families where there are children with disabilities. Families of children with disabilities were more likely (odds ratio 4:1) to report a child with a lower level of general health when compared with other families. These families also had a greater likelihood (odds ratio 3:1) of reporting a child with poor mental health, and were more likely (odds ratio 4:1) to fall into the highest quartile of families using medical services, when compared with families without children with disabilities. These findings are important because neither health nor mental health was used to define disability.

There was also an association between the health of the principal caregiver and child disability – principal caregivers were more likely to report they had a lower level of health when there was a 4 to 16 year-old child in the family who had a disability.

Principal caregivers stated more frequently that they were very happy in their life when none of their children had a disability, compared with those caregivers who had at least one child with a disability.

When considering child disability within families, it is interesting to note that no significant associations could be found with the mental health status of caregivers, parental self-efficacy, the frequency of life-stress events, or the levels of family functioning.

FIGURE 4.11 Families: Whether there was a child with a disability: Proportion of principal caregivers who were very happy in their life



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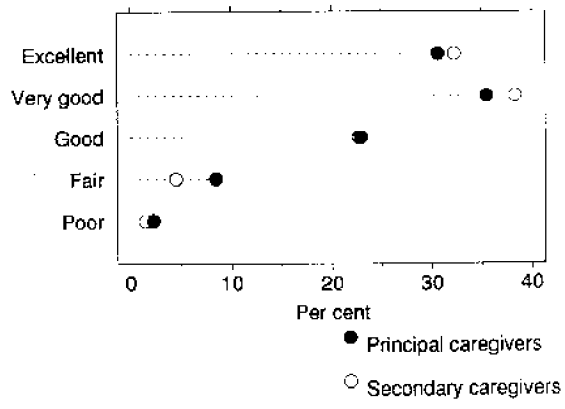
5 FAMILY HEALTH AND MENTAL HEALTH

The factors influencing the health status of the family are numerous and wide-ranging. The physical and mental health of parents is a crucial part of this complex picture and can have a decisive impact on the health status of children. This section considers aspects of parents' well-being and their association with various family living and work arrangements. It discusses parental health risk behaviours, such as tobacco use and alcohol consumption, and the relation of these behaviours to the uptake of similar risk behaviours by adolescents. The links between family functioning and the health and well-being of parents and children are explored and risk and protective factors are identified as potential targets for promoting positive child mental health.

THE GENERAL HEALTH OF PARENTS

Parents were asked in the Child Health Survey to make an evaluation of their own general health and to indicate whether they had any chronic medical conditions or functional limitations, due to a permanent or long-term health problem, which restricted their normal daily activities. Most parents (66 per cent of principal caregivers and 71 per cent of secondary caregivers) reported themselves to be in excellent or very good physical health. Over a quarter of parents (28 per cent and 29 per cent respectively) had a chronic medical condition or health problem of a permanent or long-term nature (i.e. more than 6 months). Over 12 per cent of principal caregivers and 11 per cent of secondary caregivers (an estimated 36,100 caregivers in total) reported a health related functional limitation of their ability to carry out normal daily activities.

FIGURE 5.1 General health of principal and secondary caregivers



Principal caregivers, 95 per cent of whom were female, were slightly more likely to report having a lower level of general health (that is, a self-rated general health status of 'good', 'fair' or 'poor') than secondary caregivers. Parents' self-rated health status was not found to vary significantly with age. This is not particularly surprising given the relative youth of caregivers (median ages of 36 years and 39 years for principal and secondary caregivers respectively). Similarly, parents' rates of chronic medical conditions or functional limitations restricting activity were not found to increase significantly with increasing age.

PHYSICAL HEALTH OF LONE PARENTS

At the time of the survey, 19 per cent of families with 4 to 16 year-old children were one parent families. Previous studies have indicated that the health of lone parents is generally poorer than that of parents from couple families.[1] The results from the Child Health Survey support these findings.

By their own report, lone parents were more likely to have a lower level of health (51 per cent) than principal caregivers in couple families (30 per cent). They were also more likely to report suffering from a chronic medical condition (40 per cent versus 25 per cent), and to have some functional limitation in daily life (24 per cent compared with 9 per cent).

PARENTS' USE OF TOBACCO AND ALCOHOL

Levels of tobacco and alcohol use are known to be important risk factors for many health problems. In targeting preventive efforts it is important to understand the relationship between these behaviours in parents and the effect this may have on the uptake of similar behaviours in children. The Child Health Survey therefore asked parents and adolescents about

their regular consumption of tobacco and alcohol.

PARENTS' TOBACCO SMOKING

Over one-quarter of principal and secondary caregivers smoked cigarettes regularly (27 per cent of each). Over two in three (70 per cent, or an estimated 31,300) principal caregivers who smoked said they had tried to quit or reduce their smoking in the six months prior to the survey. A slightly lower proportion of secondary caregivers (57 per cent) reported having done so. Almost 58 per cent of these principal caregivers, and 47 per cent in the case of secondary caregivers, said they had been successful in quitting or reducing their smoking over this period.

Relationship with adolescent smokers. Smoking is generally regarded as the single most preventable source of chronic ill health and disease in the community. As the majority of adult smokers commence their tobacco habit in adolescence, a major goal of health promotion has been to minimise the rate of smoking uptake and reduce the levels of smoking in children and adolescents.[2]

The Child Health Survey demonstrated clearly that adolescents who had ever smoked or become regular smokers were more likely to be in families where either of the parents was a smoker. In those families, 42 per cent of adolescent children had smoked more than just once or twice, compared with only 20 per cent of adolescents from families where neither parent smoked.

TABLE 5.1 Adolescents: Parental smoking: Adolescents' level of smoking (Per cent)

Adolescents' smoking	*One or both parents smoked*	*Neither parent smoked*
Ever smoked	41.6	20.2
Ever smoked daily for a month	25.8	8.0
Smoked the previous day	14.5	4.3
All adolescents ('000)	**44.1**	**64.5**

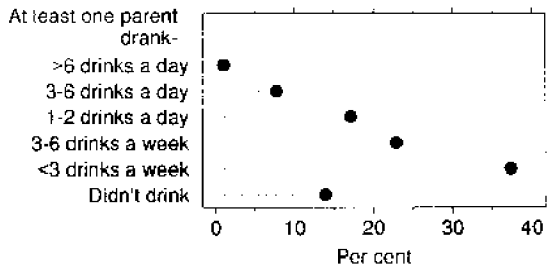
COMMENTARY

Family smoking has long been held to be an important risk factor for the onset of smoking. A recent review of prospective studies of adolescents' uptake of smoking concludes that the contribution of family smoking is low in contrast to other risk factors such as socio-economic status, peer bonding and modelling, refusal skills, general self-esteem, and health knowledge, attitudes and intentions about smoking.[3] It is interesting to note that while Western Australia's community wide anti-smoking campaign (Quit) primarily targeted adults, there has been a concomitant reduction in both adult and teenage smoking over the years 1984 to 1993.[4,5] The Child Health Survey finding on the association between adolescent and parent smoking may therefore reflect a secular change where a reduction in parental smoking is lessening the likelihood of adolescents taking up smoking.

PARENTS' ALCOHOL CONSUMPTION

In over one-quarter (26 per cent) of Western Australian families with 4 to 16 year-old children, at least one of the parents reported drinking one or more standard drinks of alcohol daily. In one in seven families (14 per cent), neither caregiver drank alcohol at all.

FIGURE 5.2 Families: Parental alcohol consumption(a)



(a) Highest level of consumption among caregivers in the family

Connection with adolescents. The patterns of alcohol and marijuana use for adolescents from families where the parents drank alcohol regularly did not differ greatly from those whose parents drank infrequently. However, when compared with those from families where the parents did not drink alcohol at all, adolescents whose parents drank alcohol on a daily basis were more likely to have drunk alcohol (61 per

cent against 40 per cent), to drink alcohol regularly (14 per cent compared with 1 per cent), and to have used marijuana (21 per cent compared with 10 per cent).

TABLE 5.2 Adolescents: Parents' alcohol consumption: Adolescents' use of alcohol and marijuana
(Per cent)

Adolescents' alcohol and marijuana use	*At least one parent drank alcohol daily*	*Parents drank less often than daily*	*Parents do not drink alcohol*
Ever drunk alcohol	61.0	57.7	40.5
Drank 3 or more times last month	14.1	9.6	**0.8
Used marijuana	20.9	17.9	*10.1
All adolescents ('000)	**30.8**	**62.1**	**17.3**

COMMENTARY

In 1986 the National Health and Medical Research Council recommended a maximum intake of four standard drinks a day for males and two standard drinks a day for females. Consumption above these safe levels is likely to cause health and social consequences to the drinker. Since Western Australia initiated a major alcohol education program in 1985 (Drinksafe) there is evidence of improvements in the knowledge of health risks associated with excessive alcohol consumption, and greater understanding of what levels of drinking can be considered safe for males and females. This has been accompanied by improvements in the proportion of adults with safe daily drinking levels and a slight decrease in their overall per capita consumption of alcohol.[6] By contrast, over the period 1984 to 1993, there appears to have been little change among Western Australian teenagers in their frequency of drinking and overall level of alcohol consumption.[7]

PARENTS' MENTAL HEALTH STATUS

The mental health of parents can impact significantly on family relationships and can be an important influence on the development of children's physical health and emotional well-being. Children of parents with certain mental health disorders may also be at increased risk of similar types of mental health problems themselves.[8,9] For these reasons, the Child Health Survey sought information on the mental health of parents by asking about their well-being and their utilisation of mental health treatment services.

Mental health treatment. Almost 13 per cent of principal caregivers, and 4 per cent of secondary caregivers, reported ever having received treatment for an emotional or mental health problem. Of those principal caregivers reporting mental health treatment, over one-quarter (29 per cent or 6,200) had received treatment within the last 6 months and around one in six (17 per cent or 3,600) had ever been hospitalised for treatment.

Lone parents were more likely to report having received mental health treatment than principal caregivers in couple families (27 per cent compared with 9 per cent).

TABLE 5.3 Parents: History of mental health treatment

History of mental health treatment	*Principal caregivers*		*Secondary caregivers*	
	No. ('000)	*Per cent*	*No. ('000)*	*Per cent*
Ever received treatment	21.5	12.7	5.1	3.7
Received treatment in last 6 months	6.2	3.7	*1.2	*0.8
Ever hospitalised for treatment of mental health disorder	3.6	2.2	*2.0	*1.4
All caregivers	**168.6**	..	**136.9**	..

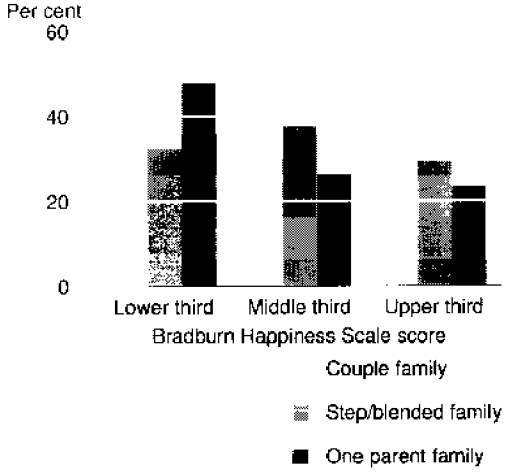
Parents' self-assessed well-being. The Bradburn Happiness Scale (see *Bradburn Happiness Scale* in the Glossary) was used to measure principal caregivers' subjective assessments of their well-being during the previous few weeks. Scores on this scale were used to classify caregivers as falling within the upper, middle and lower thirds of self-assessed well-being. In addition, principal caregivers were asked, "taking things all together, how would you say things are for you these days?". Where applicable, the principal caregiver also responded to this question on behalf of the secondary caregiver.

Relationship quality, family type and general physical health were all found to be closely associated with principal caregivers' subjective assessment of their well-being.

Principal caregivers with lower levels of general health were more likely to report being 'not too happy' than those with excellent or very good health (11 per cent compared with 3 per cent). The responses were similar when considering secondary caregivers (9 per cent and 4 per cent respectively).

Almost half (48 per cent) of lone parents had Bradburn Happiness Scale scores in the lower third, compared with less than one-third of principal caregivers in original and step/blended families (32 and 30 per cent respectively).

FIGURE 5.3 Principal caregivers: Family type: Self-assessed well-being



PARENTAL HEALTH AND CHILD HEALTH

The health status of parents affects not only their own well-being and the level of family functioning but is related to the physical and mental health of children. In families where one or both caregivers had a physical or mental health problem, there was an increased incidence of children with mental health problems and lower levels of general health.

PHYSICAL HEALTH

Depending on the specific circumstances of the family, the physical health of the parent and that of the child is mediated through a variety of factors including genetic inheritance, behavioural modelling and lifestyle factors, and the physical living conditions shared by the family. Whatever the causal relationship may be, the interdependence of parent and child health has important implications for strategies for interventions aimed at improving the health of children.

In families where one or both parents reported lower levels of general health, 30 per cent of children were also reported as having this general health status, compared with only 10 per cent of children in families where both parents rated their general health more highly. Similarly, the proportion of children with lower health levels was greater in families where one or both parents suffered from a chronic medical condition (23 per cent) than for children from other families (16 per cent).

PARENTAL MENTAL HEALTH AND CHILD WELL-BEING

The children of families where either caregiver had received treatment for a mental health problem were in poorer health than other children. When one or both parents had a mental health history (that is, reported that they had ever received treatment for an emotional or mental health problem), over one-quarter (29 per cent) of children were reported to have a lower level of health, compared with 18 per cent of children from families where neither parent had received mental health treatment.

TABLE 5.4 Parental health factors: Proportion of children with physical and mental health problems (Per cent)

	Child health status	
Parental health factors	*Lower level of general health*	*Mental health problem*
Lower level of general health—		
One or both parents	30.5	20.4
Neither parent	10.4	15.4
Chronic condition—		
One or both parents	22.9	18.4
Neither parent	16.3	17.0
Limited in daily functioning—		
One or both parents	24.1	21.0
Neither parent	18.3	16.9
Mental health history—		
One or both parents	28.7	27.6
Neither parent	17.9	16.1

Children whose principal caregiver had a mental health history were more likely to have an emotional problem which interfered with their

normal functioning at school (14 per cent) than children from other families (7 per cent).

FAMILY FUNCTIONING AND HEALTH

Principal caregivers play a crucial role in nurturing and sustaining the general health of the family. In terms of physical health, their activities are often focused on matters of nutrition, cleanliness, and hygiene, all of which provide a basis for sound development of children and the prevention of illness and disease. They are also the providers of care when a family member is ill or has a disability. This involvement in physical care is continued over into the emotional and social environment of the family, highlighting the importance of the principal caregiver to the general well-being of children.

General health. The survey highlighted that a relationship exists between the level of family discord and caregiver's health. Relative to families with low levels of discord, families with high levels of discord were more likely (odds ratio 3:1) to have a principal caregiver with a lower level of general health.

TABLE 5.5 Principal caregivers: Health factors: Families with high discord

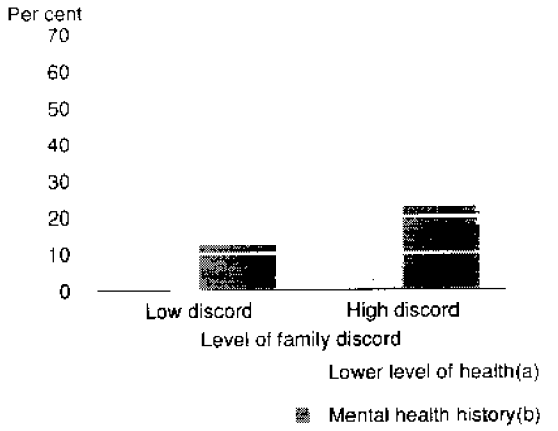
	Families with high discord(a)	
Principal caregiver – health factors	*No. ('000)*	*Per cent*
General health—		
Higher level	9.4	8.3
Lower level	11.3	20.3
Chronic condition?—		
No	13.3	10.9
Yes	7.4	15.8
Limited in daily functioning?—		
No	16.6	11.1
Yes	4.1	21.2

(a) Families in the lowest decile of scores, as determined by the Family Assessment Device.

This pattern was also evident for other indicators of physical and mental health. Sixteen per cent of families where the principal caregiver suffered a chronic medical condition had high discord, in comparison with 11 per cent of families where the principal caregiver had no such condition. Similarly, 21 per cent of families where the principal caregiver had a health related limitation in their daily functioning, had high discord, in comparison with 11 per cent of families where the principal caregiver had no such limitation.

Mental health. In 15 per cent of families at least one caregiver had been treated for a mental health problem. Families with high levels of discord were twice as likely to have a caregiver with a history of mental health problems – in practical terms, 23 per cent of families with high discord and 12 per cent of those with low discord had at least one caregiver who reported a mental health problem.

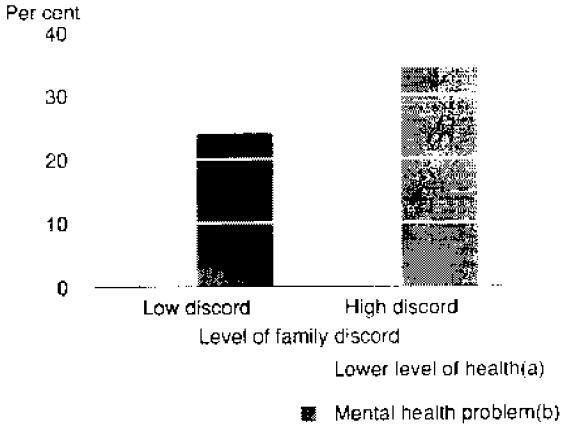
FIGURE 5.4 Families: Level of family discord: General and mental health of caregivers



(a) At least one caregiver with a lower level of general health. (b) At least one caregiver who had ever been treated for an emotional or mental health problem.

Similarly, relative to families with low levels of discord, those with high levels of discord were more likely (odds ratio 2:1) to have at least one child identified with a mental health problem, and also more likely (odds ratio 2:1) to have a child with a lower level of general health.

FIGURE 5.5 Families: Level of family discord: General and mental health status of children



(a) At least one child with a lower level of general health (b) At least one child with a mental health problem.

FUTURE DIRECTIONS

The health and mental health of parents is significantly associated with the well-being of children and the overall capacity of the family to function well. It is likely that poor parental health and poor child health may add to a general context of disadvantage that lead some families towards a chain of adverse experiences.[10] The causal basis of this association requires careful longitudinal work with samples of sufficient size to enable pinpointing the onset of good and poor outcomes in both children and their parents.[11,12]

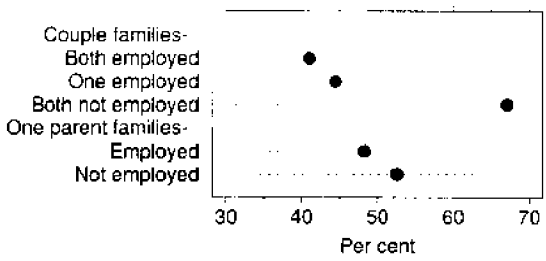
WORK, HEALTH AND THE FAMILY

Patterns of well-being are often associated with employment status. The physical and mental health of caregivers and their ability to manage are affected by employment arrangements and family type (see Chapter 3 – Income and Work, for more details regarding employment arrangements).

General health of caregivers. About 45 per cent of families reported at least one caregiver to have a lower level of general health.

Caregiver general health appears to be associated with employment. In comparison with couple families where both caregivers were employed, families with both caregivers not employed were more likely (odds ratio 3:1) to have a lower level of self-rated general health.

FIGURE 5.6 Parental employment arrangements: Proportion of families with at least one caregiver with a lower level of general health



Parental mental health. In general, lone parents were more likely (odds ratio 3:1) to have ever been treated for a mental health problem than were one of the caregivers in a couple family. Confident inferences cannot be made between the levels of employment within family types and parental mental health due to the standard errors associated with these figures.

Child physical health. No evidence of association could be found between poor general health in children and either parental work arrangements or family type.

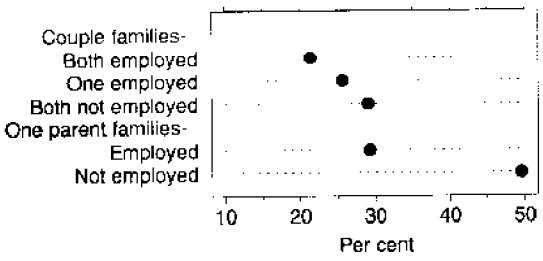
Child mental health. Families where the lone parent was not employed were more likely (odds ratio 3:1) to report having at least one child with a mental health problem, when compared with couple families where both caregivers were employed full-time. About 26 per cent of families had at least one child with a mental health problem; this rate rises to 50 per cent among lone parents who were not employed.

TABLE 5.6 Level of employment in household: Family health characteristics (Per cent)

	Couple families				*One parent families*		
Family health characteristics	*Both employed*	*One employed*	*Neither employed(a)*	*Total*	*Employed*	*Not employed*	*Total*
At least one caregiver with a lower level of physical health	41.0	44.4	67.1	44.3	48.3	52.5	51.1
At least one caregiver with a mental health history	11.1	13.4	*13.2	12.0	33.6	21.2	27.0
Low parental self-efficacy	5.4	10.2	*22.7	8.1	*10.4	21.6	15.8
A child with a lower level of physical health	24.8	32.5	27.1	27.7	25.1	31.3	28.1
A child with a mental health problem	21.4	25.7	29.1	23.1	29.3	49.6	39.2
All families ('000)	**79.4**	**47.8**	**8.6**	**136.9**	**15.9**	**15.9**	**31.7**

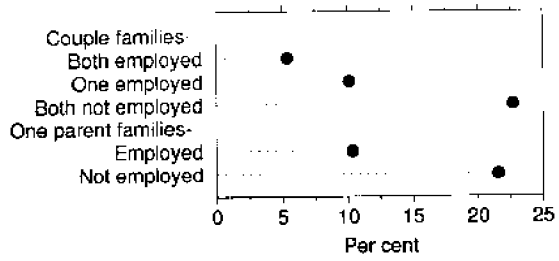
(a) Includes both unemployed; both not in the labour force; one unemployed, one not in the labour force.

FIGURE 5.7 Parental employment arrangements: Proportion of families with at least one child with a mental health problem



Parental self-efficacy. Where all caregivers in a family were not employed they were far more likely to be having difficulty managing day to day tasks relative to those families where at least one caregiver was employed.

FIGURE 5.8 Parental employment arrangements: Proportion of caregivers with low self-efficacy



FUTURE DIRECTIONS

In practical terms, family health and well-being vary with respect to employment levels.

The Child Health Survey data show that studies of the relationship between work, family health, family function and structure need to account for considerable interaction. Future studies should take particular care to distinguish original and step/blended families as well as the age of children when considering work patterns in couple families. The partnership arrangements and supports in one parent families should also be better defined. Care also should be taken to measuring the amount of time engaged in paid and unpaid work by principal and secondary caregivers, to allow a better view of work arrangements as they affect families and the children in them.

COMBINED EFFECT OF KEY FAMILY VARIABLES ON CHILD MENTAL HEALTH

Establishing the interaction of risk and protective factors associated with child mental health provides a rational means of estimating the likely benefit of different prevention strategies. Bivariate analysis of the Child Health Survey data identified four family variables clearly associated with increased risk of child mental health morbidity. These were: family income, family type, family discord and parental disciplinary style. In order to measure the relative strength of each of these risk indicators while controlling for the effect of the others, a *logistic regression* analysis was performed (see Glossary). This statistical technique usually assumes that the observations under consideration are independent of one another. However this assumption is violated when observations in the sample are 'clustered' (e.g. in areas or families). It is possible to adjust the estimating equations in the regression analysis to account for correlations between observations in the sample (see *Generalised Estimating Equations* in the Glossary).

Over 19 per cent of the sampled children were excluded from the analysis. Most (72 per cent) of these were excluded because of missing data on one or more variables, and the remainder because they were above the maximum cluster size (i.e. family size) of six (this was used to reduce correlated error).

TABLE 5.7 Distribution of key family variables (Per cent)

Variable	*No. ('000)*	*Per cent*
Parental disciplinary style—		
Encouraging	148.6	49.1
Coercive	15.5	5.1
Neutral	21.6	7.1
Inconsistent	116.3	38.4
Family type—		
Original	223.6	73.8
Step/blended	29.0	9.6
One parent	50.2	16.6
Level of discord—		
Low	229.0	75.6
High	33.9	11.2
Total(a)	**302.9**	**100.0**

(a) Includes not stated.

In the first stage of building the regression model it was established that family income did not reach significance in predicting child mental health status, and as a result this variable was dropped from the analysis.

When fitted to the Child Health Survey data, this model had an explanatory power to correctly classify 83 per cent of children with mental health problems solely on the basis of a knowledge of each child's family type, their parents' disciplinary style and whether or not significant family discord was present (Goodness of fit – χ^2 =118, df=6, p<.0001). The adjusted odds ratios for a child having a mental health problem for each of the family variables are shown below in table 5.8 together with their associated confidence intervals.

TABLE 5.8 Predicted risk for child mental health problems associated with key family variables (Per cent)

Variable	*Significance (p level)*	*Odds ratio(a)*	*Confidence Interval (95%)*
Parental disciplinary style—			
Coercive	<0.0001	3.3	1.9 - 5.6
Neutral	0.0004	2.2	1.3 - 3.7
Inconsistent	<0.0001	2.2	1.7 - 3.0
Family type—			
Step/blended	<0.0001	2.4	1.6 - 3.6
One parent	<0.0001	2.5	1.8 - 3.5
Level of discord—			
High	0.0004	1.7	1.2 - 2.4

(a) The odds ratios are calculated relative to the first category of each family variable i.e. for 'family type' the odds are relative to original family; for 'level of discord' the odds are relative to low family discord; and for 'parental disciplinary style' the odds are relative to encouraging parenting style.

The overall risk associated with the presence of more than one of the risk indicators considered can be determined by multiplying their associated adjusted odds ratios. Thus children with the greatest risk of having a mental health disorder would be those living in a one parent family where significant family discord and a coercive parenting style are present. The increased risk associated with this combination of factors is therefore 14.0 (i.e. 2.5 x 3.3 x 1.7). It should be noted that the population of this sub-group is relatively small, and the calculated odds ratios for fine categories should be treated with caution.

These findings highlight important issues relevant to the targeting and implementation of prevention strategies. They show that regardless of family income, children in one parent and step/blended families have an increased risk of mental health problems than children in original families when similar conditions of family discord and parental disciplinary style apply. These data also indicate the extent to which the protective effects of positive family relationships and encouraging parenting can offset the risks associated with the particular family structure a child happens to be living in.

FUTURE DIRECTIONS

The Child Health Survey findings highlight the interdependent and holistic nature of family health and the importance of strategies that address family health and well-being for the long-term goal of improving the physical and mental health of children. This has implications for the way in which agencies and professionals target and deliver primary and preventive health services and raises questions for future research:

- What are the causal mechanisms whereby good health of parents results in a better health status of children?
- Will low cost health and educational interventions aimed at improving the health of high risk parents also result in the prevention of child health problems?
- What long-term effect does the social drug use of parents have on the general health and drug use of their adolescent children?
- Will the reduction in adult smoking translate into a lower rate of uptake of smoking by children?

The increased diversity of family living and working arrangements has implications for the health and well-being of children and parents. The survey findings regarding the physical and mental health outcomes associated with various patterns of family living add to the growing body of knowledge concerning risk and protective factors for child physical and mental health. Better understanding of the causal mechanisms underlying these risks is needed to help governments and other agencies formulate policies and direct resources to improve mental health outcomes for all families and children.

Future research should consider some of the following questions:

- What kind of interventions and investments can society make to reduce the likelihood of marital breakdown?
- What is it about being reared in one parent or step/blended families that results in increased risk for children?
- Which preventive strategies and family interventions are best able to maximise the protective effects of positive family relationships and parenting skills?

The next chapter considers some of these issues.

ENDNOTES

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6 FAMILY AND COMMUNITY HEALTH

by Sven Silburn, Stephen Zubrick and Alison Garton, TVW Telethon Institute for Child Health Research

Now, more than ever, caregivers are faced with an increased range of choices about how they organise their work and family responsibilities. These decisions are made in a social context that includes: the composition of the family; the resources available in terms of employment, income and time; their knowledge and skills in parenting; the supports available from family, friends and neighbours; and the extent to which these are backed up by broader community and environmental factors such as 'family friendly' industrial relations policies, and access and entitlement to child care and other benefits.

WORK AND THE FAMILY IN THE 1990s

The meaning of work to families. In the many discussions about work and its impact upon caregivers and families it is easy to forget that work is also a developmental task. Through the activities of work adults can develop, extend and contribute to their own growth, their family and community. Work, whether it is paid or unpaid, can supply a sense of self-esteem and self-efficacy, friendships, social networks, independence and purpose.

What is valued as work is important to those engaged in it. At present the recognition given to the value of unpaid work, and particularly the work done by caregivers in the home, remains small. Unpaid labour is not usually part of the official record, nor is a monetary value attached to it. While the Parenting Allowance represents a step towards recognising the value of caring provided by parents who choose to stay at home, it is still the case that in either time or money the value of the labour provided at home remains out of mainstream "monetary" evaluation or reporting.[1]

The income provided by employment is a critical component to the provision of family care. In addition to the central role that income plays in securing the necessities of family life, the data in the Child Health Survey consistently show better levels of well-being in the children in families with higher levels of parental employment.

The increase of working families. The decisions that families have made and are making show an increasing uptake of employment by family caregivers. The modal Western Australian family is now a dual earner family. While similar proportions of principal caregivers (mostly women) are not employed in both couple and one parent families, these proportions are decreasing over time. In practical terms, this means that since 1980 an increasing proportion of women have been participating in earning the family income. Whatever may be said about the advantages and disadvantages of employment and its impact upon the family, must be said in the context of a steady and increasing trend in caregiver employment.

Increasing choices for families. The choice about employment, its amount, regularity, timing and encroachment upon family life is much more problematic. At present the choice of whether or not to be employed almost exclusively concerns women. In couple families, where one caregiver can secure family income, the other caregiver may have the option of not being employed or have flexibility in choosing an employment level suited to personal and family needs. For a one parent family these choices may not exist at all, and as these data show for the majority of lone caregivers, the choice to be employed still results in high levels of poverty relative to other family types.

Choice of employment is also used to refer to flexibility in the onset and timing of employment itself. Once again, achieving flexibility in employment arrangements is still predominantly an issue advanced by and on behalf of women. This, of course, is a broad generalisation and while there are encouraging changes to industrial practices and worker expectations there is also evidence to suggest that flexibility in the workplace means different things to employers than to employees.[2] Whatever may be said about choice must take into consideration the fact that the average number of hours worked per week in full-time employment has increased between 1981 and 1993.[3] From the Child Health Survey, secondary

caregivers were found to be working an average of 48 hours per week in 1993. This impacts upon the economy of family care.

The economy of family care. Practically speaking, there is only so much time in a week and so many hands that can supply all the care a family needs. Employment erodes the energy available for the care of all family members and disrupts continuity in family caring. In couple families, the traditional roles were of a father who worked and a mother who stayed home. In effect this arrangement tied the father's time and energy to securing family income and the mother's time and energy to the supply of care to the family. This arrangement is a choice that many families still make today but the Child Health Survey data and other data sources show this choice being made less and less.

The survey data also show that the combination of work and family responsibilities may have important health and mental health implications for some families. In couple families there was little difference in the likelihood of children aged 4 to 16 years having a mental health problem whether both parents were employed or if one parent stayed at home. In one parent families, parental employment was associated with better child mental health. However, the data also show that the income related benefits from the principal caregiver's work outside the home can be at the expense of that parent's physical and mental health – particularly where the parent is alone in managing the responsibilities of child-rearing and work. These findings modify earlier findings which suggested that women who work outside the home generally have better physical and mental health.[3] It is also significant that the persons working the longest average working day are mothers in couple and one parent families.[5]

The increased participation of both caregivers in the workforce then has considerable significance in the economy of family care and for caregivers and their communities. The uptake of employment by women is still only rarely matched by an uptake of family care responsibilities by male caregivers. Workplaces are still far from 'family friendly' and they remain limited in their capacity to reflect some of the needs of employees for meeting their family responsibilities. Without first a commitment to parents (both mothers and fathers) spending time with children, advances in the workplace to increase flexibility for men and women to meet their family responsibilities will remain hampered.

In the absence of workplace flexibility, families now seek care arrangements through other avenues. As in other surveys,[6] data from the Child Health Survey show a steady uptake in the use of some form of day care by the caregivers of the survey children. This includes securing home care, day care, after school and before school care and many other individual arrangements. In effect the unpaid value of family care has increasingly been shifted into the growing paid market of care provision. Despite consistent evidence showing increases in caregiver employment and use of child care the need for research into the negative and positive consequences of child care still remains hampered by the debate of whether caregivers should use it at all. There is a critical need to document the consequences of not providing high quality affordable day care given trends in caregiver employment.[7]

FUTURE DIRECTIONS

Data from the Child Health Survey lend considerable support to many of the current recommendations that aim at addressing the needs of families in the 1990s.[1,2] These include:

- Developing workplace arrangements that enable any caregiver more choice in meeting family responsibilities;
- Maintaining supports and benefits that acknowledge the value of caregiving and enable a caregiver greater choice to stay at home;
- Encouraging quality care arrangements for children in both public and private sectors;
- Defining the role of schools in the provision of care; and
- Encouraging better research methods aimed at more appropriate measurements of caregiver time spent in work and care and measuring the value of this work in monetary and personal terms.

THE FAMILY AND CHILD MENTAL HEALTH

Approaches to the prevention of mental health morbidity either centre on reducing the prevalence of specific risk factors (e.g. the number of low income families) or aim to

interrupt the mechanisms by which risk factors result in high rates of morbidity. Good psychosocial outcomes generally correlate with the absence of specific risk indicators but this is not always necessarily the case. The early literature on childhood risk factors placed emphasis on the importance of cumulative risk. Children exposed to multiple stresses or experiencing a succession of chronic adversities have an increasing likelihood of adverse outcomes with higher levels of risk exposure.[8,9] More recently, there has been interest in identifying 'protective' factors in children, families, their communities and broader social environment that result in greater individual resilience despite adverse risk.[10]

Three groups of protective factors recurrently identified in studies of children exposed to chronic stresses such as family poverty, child abuse or multiple foster placements are: *individual temperament*, including activity level, reflexiveness, cognitive skills and positive responsiveness to others; *family interaction*, marked by warmth, cohesion and the presence of some caring adult such as a grandparent who takes responsibility in the absence of responsive parents or in the presence of marital discord; and *external support*, which can serve as a parental substitute e.g. a teacher, neighbours, parents of peers or an institutional structure such as a school, caring agency or recreational group.[11]

Low income families. There is now a broad literature on the relationships among family structure, family processes and child and adolescent psychosocial outcomes. From this literature, family income is frequently identified as a foremost 'predictor' of outcomes. For example, in the USA income accounts for between 30 per cent and 50 per cent of the difference in high school graduation and school achievement ratios among children from one and two parent households.[12] However, as income disparities and their consequences for families vary between countries, it cannot be assumed that the risk associated with income identified in one part of the world will necessarily have the same significance in another.

In Australia, Jolly et al (1991) asserted that poverty is "arguably the single greatest threat to child and community health."[13] These authors were nevertheless frustrated in their search for definitive Australian evidence of the association between poverty and child health for anything more than a basic set of health indicators. Most of these, they observed, were morbidity and mortality data, and, while valuable, reflect only a narrow definition of health.

In Western Australia, the Child Health Survey found that children in low income families (i.e. with household income below $20,000 per annum) have an increased prevalence of mental health morbidity in comparison with their peers in households with higher income (25 per cent compared with 16 per cent of children from families with parental incomes over $30,000). However, this association does not, in and of itself, further an understanding of the underlying psychosocial and behavioural mechanisms whereby poverty produces adverse mental health outcomes for children. In exploring this further, it emerges that household income is of lesser importance than other more proximal relationships affecting the ability of parents to provide children the stability and security they need. Irrespective of income, the family variables found to be most salient in accounting for child mental health were: family type, level of family discord and parental disciplinary style.

Family composition. Central to the changing context of parenting in Western Australia in the 1990s is the increased proportion of children growing up in non-traditional family forms. Despite the extent of this change over the past decade, the majority (74 per cent) of Western Australian children aged 4 to 16 years in 1993 were living with both parents in their original families. These children were found to have lower rates of mental health problems than children in step/blended and one parent families (14 per cent compared with 26 per cent and 29 per cent respectively). This is consistent with the picture which has emerged from recent American and European research.[14] However, the mechanisms whereby children living in non-traditional family forms come to have higher risks for adverse mental health requires further explication.

One parent families. The data from the Child Health Survey indicate that over and above the risks associated with low household income, children growing up in one parent families are disadvantaged in a number of ways that may compromise their health, mental health and future prospects. In this and other studies where the effects of low household income or other measures of socio-economic adversity are controlled for, children and adolescents from one parent families are consistently more likely than their peers in couple families to have

mental health problems or to engage in health-compromising behaviours, such as drug and alcohol use, unprotected sex, cigarette smoking and dropping out of school.[15,16]

It is important to recognise that in Western Australia in 1992 only 20 per cent of lone parents with children had never married and that 57 per cent were divorced or separated. It is thus difficult to disentangle the effects of marital separation from the effects associated with managing the task of parenting alone. However, there is now a significant body of recent research which suggests that the nature of family disruption associated with parental separation may be more important than either the separation itself or the type of family structure which results. Several lines of evidence support this conclusion.

Firstly, a major British longitudinal study on the long-term outcomes for children who have either experienced family disruption or grown up in one parent families (or both) indicates that children who live with lone parents who have been widowed often do as well as children raised in intact couple families. On the other hand, children who have experienced the separation or divorce of their parents frequently have poorer average outcomes than those who have not.[17,18]

Secondly, in the period immediately surrounding separation and divorce, most family members experience emotional distress and disrupted functioning.[19,20] Lone parents, absorbed with their own problems of recovering emotionally and surviving financially, often communicate more poorly, are less affectionate, and less supportive and sensitive to the needs of their children, than are mothers with partners. Many newly separated mothers are restricted in the amount of time they can devote to their children because they have just commenced employment.[21] Lone parents in the initial readjustment phase are often more restrictive, use more coercive methods to manage child behaviour, and make fewer demands for maturity than mothers in intact families. At the same time, children (particularly boys) are more likely to become less compliant and to act out feelings of anger.[20]

The third line of evidence comes from studies which demonstrate that the financial loss which commonly follows marital breakdown is a major family stress, and one which increases risks of psychosocial and adjustment problems. Divorce is now widely recognised as a major cause of child poverty.[22] Such economic hardship has been shown to elevate the risk of poor child nutrition and physical health;[23] to reduce resources and parental support for children's education;[21] to increase the likelihood of relocation to less socially cohesive and poorly serviced neighbourhoods;[24] and to increase the likelihood that adolescents will enter delinquent sub-cultures.[21]

Finally, for many adolescents in one parent families, a major cause of increased psychosocial risk is that they are more likely to be given early autonomy for control over their own behaviour. For example, in such decision making areas as choice of friends, choice of clothes, ways of spending money and the time they must come home. A major national study of American youth has shown that early autonomy in these areas has adverse consequences for adolescents regardless of socio-economic status and family types. It also indicates that granting such early autonomy is a more frequent (and understandable) response of the overburdened single parent.[25]

Step/blended families. Although the proportion of one parent households is growing, largely as a consequence of dissolving marriages, it should be remembered that one parent households are not usually a permanent family living arrangement. Step/blended family formation has increased, partly through greater rates of re-marriage, but there is also a growing tendency for divorced persons to cohabit rather than remarry and to 'try out' family life with a potential step parent before committing to remarriage. The actual number of children living in these transitional family arrangements is unknown as such information is not easily defined or currently being routinely recorded.

A recent review of the British research indicates that formation of step and blended families carries higher risks for children whose parents live with a new partner after separation and divorce, than those whose parents have been widowed.[26] This would suggest that, over and above the disruption associated with the parental separation, custodial parents' remarriage and the establishment of new partner relationships constitute potentially stressful transitions for children. Where one or both parents have children from a previous partner (or partners), complex permutations of step/blended sibling, parent and extended family relationships may arise. Given the lack of ready precedents or an accumulated wisdom to guide the formation of these new family

relationships, many parents and children feel poorly supported and confused in having to find their own way through some of the predictable 'hazards' common to many of these 'new' family experiences.

Family discord. Dysfunctional family relationships have long been recognised as generic risk factors which predispose children and their parents to mental health problems.[16] Positive family experiences are clearly protective and enable individuals to cope more effectively with adversity. Therapeutic interventions for children usually focus on changing family patterns of interaction and family interventions are now recognised as important strategies for promoting mental health. Regardless of household income, parental disciplinary style or family composition, where family discord is present children are significantly more likely to have a mental health problem than when the family functions well. This highlights the importance of finding ways to assist families to foster interactions which lessen the likelihood of such discordant relationships. Key areas of family interaction associated with positive mental health outcomes include communication skills, expression and regulation of feelings, decision making and conflict resolution skills.[27]

Parenting style. Parenting style refers to the nature of interactions and child-rearing practices which characterise family life. The nature of these interactions and parents' individual responses to specific behaviour in their children are clearly influenced by a range of family circumstances such as the quality of the marital or partner relationship, day-to-day stresses, major life events and the social supports, information and other resources available.[28] Despite the unpredictable and variable nature of these influences, the literature suggests that most parents nevertheless develop characteristic ways of dealing with their children's behaviour which are relatively stable and measurable over time.[29]

The Child Health Survey shows that children who are reared with a predominantly encouraging style of parenting have substantially lower rates of mental health problems than children whose parenting is characterised by coercive or inconsistent discipline (11 per cent versus 29 per cent and 24 per cent respectively). This is an important finding for two reasons: firstly, these parental styles are potentially modifiable behaviours and secondly, as risk indicators, they affect large numbers of children. However, it is also important to stress caution in the interpretation of this family risk indicator. While it is true that it identifies a particular population of children with an increased frequency of mental health problems, the nature and direction of the causal relationship can only be definitively established from prospective longitudinal data or other types of research such as controlled cross-cultural comparisons.

Family violence and child abuse. Child abuse and neglect may be considered the worst extremes of parenting style. It is now well established that children exposed to violence and other abusive behaviour within the family have a substantially increased risk of adverse mental health outcomes. For example, adolescents who were physically abused or neglected as children are twice as likely to be arrested for a violent offence or to be admitted to hospital for suicidal behaviour.[30,31] Victims of child sexual abuse often display immaturity and emotional problems, including anxiety disorders, aggression and antisocial behaviour problems.[32]

Childhood experiences of family violence are also frequently transmitted from one generation to the next, though discontinuities in this process have been shown to be associated with various intervening and ameliorating factors.[33] Measuring the extent and nature of violence towards children within families with any reliability is difficult and has led to a situation where exaggerated claims or denials can be made. Indicator measures, such as hospital admission records, crisis care and police emergency call data, have therefore been the best available benchmarks for monitoring trends of more serious abuse and for exploring its contemporaneous association with other factors.

Physical punishment. While the Child Health Survey did not set out to measure child abuse per se, the information provided by parents regarding their use of physical punishment and their perceived need for help in managing children's behaviour may be considered as proxy measures of less severe but more prevalent forms of physically abusive behaviour towards children. These data confirm that harsh forms of parental discipline, such as frequent smacking and shouting, are associated with elevated risks for adverse child mental health adjustment. However the mechanism(s) through which this association is effected remains subject to debate.

The recent literature on early socialisation and parental discipline suggests that while such

negative parenting practices may often be a product of child-parent characteristics e.g. more aggressive children producing more extreme efforts at control,[34] there is also an increasing body of evidence to suggest that the onset of certain mental health problems (e.g. disruptive behaviour disorders) occur early in childhood (i.e. by the age of five years) and are typically associated with patterns of coercive parent-child interaction.[35,36] A range of parent skills training and clinical interventions have now been shown to be effective in extending parent's repertoire of positive parenting skills.[37] Where such interventions occur sufficiently early, i.e. before negative interaction patterns become entrenched over a period of years, they have been shown to be effective in maintaining long-term improvements in parent-child interaction and in reducing subsequent rates of conduct disorder and other mental health problems.[38,39]

FUTURE DIRECTIONS

Data from the Child Health Survey on parenting and family life lend support to current recommendations to strengthen families and parenting in the 1990s.[40] These include:

- Improving the availability and consumer acceptability of educational and pastoral programs for couples preparing for long-term relationships and marriage;
- Ensuring the provision of an increased range of services for couples experiencing relationship difficulties, including counselling, education, group work and other services;
- Developing strategies to improve community attitudes and knowledge about parenting and public awareness of the fundamental contribution which caregivers make to the well-being and future of the community;
- Broadening the range of parenting resources to take account of the particular needs of children living in one parent and step/blended family arrangements, Aboriginal and migrant families, and families with socio-economic disadvantage; and
- Further developing programs aimed at the prevention of violence and other abusive behaviour within families and changing community attitudes towards violence more generally.

STRATEGIES FOR SUPPORTING FAMILIES

Programs which have been successful in supporting and strengthening families in their task of rearing children have taken many forms. Most of these centre on early interventions to support the capacity of parents to optimise their children's health and development. They include: improved preparation for parenting; preventive health care in the first few years; quality infant day care – especially where combined with parent support and education for children from high risk families; parent education programs which foster effective discipline, parental teamwork and communication skills; and improving the availability of support to parents with teenage children.[41] Family oriented therapy and counselling services have also been shown to be costly but effective means of treating a wide range of mental health problems and of providing assistance to families in distress.[42]

Changing models of intervention. Over the past decade there has been a major shift in the way in which health, education and other human services organisations have provided resources to support families raising children. There has been a progressive move away from a treatment oriented, case-based model of service delivery towards the development of a stronger focus on prevention and interventions targeting specific groups or whole populations. There has also been a parallel development of empowerment models of intervention which are premised on the belief that all people have the capacity to master a wide range of developmental tasks and functions – if they are afforded the opportunity to learn.

These changes have, to some extent, been a consequence of the unmet demand for services and the need to develop more efficient strategies of service delivery.[15] At the same time there has been a growing appreciation that empowerment oriented interventions offer distinct advantages in the manner in which they enable people to access and utilise formal and informal supports. Through supporting individuals in developing their own coping resources and facilitating their access to informal supports, empowerment approaches decrease the likelihood of dependency on professionals and formal service systems for some or all family resources.

Enhancing a sense of community. The ability of parents, schools and others responsible for the care and development of children is supported by the facilities and resources available within

their own local community. The Child Health Survey data showed that children in communities characterised by high levels of neighbourhood support and participation in community activities had lower rates of mental health problems. Similarly, children reared in settings of high family mobility had increased rates of mental health problems. Family resource programs therefore need to be directed towards recognising families' need for interaction and support, and understand that the ability to relate to others enhances interdependencies and mutually beneficial exchanges among community members.

The goal of such programs should be to facilitate a sense of belonging, and the type of civic engagement and social trust which constitutes Australia's *social capital* and which is considered to be a distinguishing feature of healthy communities.[43] In the analysis of the effects of America's declining voluntary participation in community organisations (such as parents and teacher groups, youth groups, religious organisations and service clubs, etc) several studies show a correlation between levels of civic culture and measures of well-being and positive economic outcomes. Communities with low indices of social capital are by contrast characterised by high levels of distrust and loss of social cohesion. Such communities tend to produce an increased probability of conflict and social isolation, demands for law and order, and contempt for power and authority.

Shared responsibility and collaboration. Families require and receive support from public and private sources which complement their many roles and tasks in raising children. The importance of the informal networks of support to families offered by neighbours, communities and the workplace has recently been highlighted.[44] These link people and enhance the flow of resources which are necessary for families to have the time, energy, knowledge and skills to carry out family functions, particularly their parenting responsibilities. However, in encouraging the development of such informal networks of support, particularly in disadvantaged communities, it is also important that this not be at the expense of the availability of formal supports such as child care, family support centres, effective schools and information services which are relevant to the changing needs of families and children.

Families in advanced industrial societies like Australia cannot be expected to be self-sufficient. Meeting the needs of children and parents in today's diversity of family life requires a building and strengthening of the social infrastructure through the development of more effective partnerships between families, all levels of governments, community and religious organisations, businesses, industry and unions. This includes advocacy on behalf of children to ensure that public policy keeps pace with changing circumstances. It also requires recognition on the part of families and the general community of the importance of parenting and its value to children and society.

FUTURE DIRECTIONS

The Child Health Survey documents some of the implications of recent social and economic changes for Australian family and community life. In light of these changes, public policies to support the capacity of families and communities to optimise the healthy development of children should reflect the following issues:

- The current measurement of economic productivity must be accompanied by an improvement in the monitoring and measurement of other domains of labour and care, as well as health and social outcomes. The fact that increasing numbers of caregivers in families are working longer hours may reflect responses to economic reforms introduced in the Australian workplace. This increasing work effort has major implications for how families provide care for themselves and their children and the quality of life they enjoy. It also has an impact on the time and energy available to participate in community and civic life. While few would dispute the importance of national productivity and the work it represents, indices of this productivity reflect only one aspect of a country's wealth.
- Over-arching mechanisms to co-ordinate inter-sectoral collaboration in the development and provision of relevant and effective services for children and families are needed. The emphasis on productivity in public and private sector reform has seen an increasingly narrow focus in the charters and performance indicators of the various key human service agencies concerned with the health, education and well-being of children and families. This would appear to have resulted in the relative neglect and lack of accountability in some areas of service where overlapping responsibilities for children are seen to exist.

- Formal avenues for advocacy for children are required to ensure that both parents' and children's interests are given a proper voice and that government and other agencies providing services for children are kept accountable. A model with a broad overview of government activity affecting children and legal powers similar to that of an ombudsman is needed. Such an office could be responsible for hearing complaints and investigating concerns relating to children and report to the people through parliament.
- Increasing community involvement and participation in local government is required if new prevention and promotion programs for family and child health are to be effective. Civic and social participation at the level of the local community has beneficial health and social outcomes for families and children. In terms of the functions they perform, local councils are the level of government most proximal to families. They enforce public health regulations, regulate building and housing, coordinate facilities for child care and neighbourhood support, and provide recreational facilities and opportunities – to name but a few. These functions enable families to more readily meet their responsibilities in work and care. The decreasing community participation in local government is impairing the effectiveness of these functions in meeting the needs of families.

THE SURVEY IN PERSPECTIVE

The findings of the Child Health Survey add to the growing body of knowledge on how changing family patterns and community life pose potential risks and opportunities for positive growth, in the development and socialisation of children.[1,2,3] While the survey data provide a cross-sectional picture of how children and their families are faring in the various living arrangements which characterise Western Australian family life in the 1990s, they do not enable any conclusions to be drawn about the long-term outcomes of these living arrangements. They do, however, offer a unique perspective on how these issues presently affect the child population, and provide a means of estimating the number of children and families exposed to various risk and protective factors.

The identification of groups of children and families at increased risk of various problems or in need of services can assist the development of more efficient and equitable allocation of scarce resources for individual and family interventions. Improved understanding of the mechanisms or causes whereby some children are at increased risk also makes it possible for rational prevention programs to be developed which aim at reducing the incidence and prevalence of psychosocial problems in particular groups of children. Finally, the survey information on the aspects of family and community life which are associated with positive outcomes for children informs public debate and the formulation of public policy to promote the health and well-being of all children, their families and society in general.

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APPENDIX A – SURVEY ENUMERATION

INTRODUCTION

Appendix C of the publication *Western Australian Child Health Survey: Developing Health and Well-being in the Nineties* (ABS Catalogue No. 4303.5) described the sample design for the Child Health Survey. This appendix provides more details of how the survey was conducted and administered. In the final publication in this series of three, titled *Western Australian Child Health Survey: Education and Health* (to be published later in 1996), a more extensive outline of data analysis methods will be given, so that a complete description of the survey methodology will be provided over the series of publications.

RELIABILITY OF ESTIMATES

As estimates from the Child Health Survey are based on information obtained from the occupants of a sample of dwellings, they are subject to sampling variability; that is, they may differ from the figures that would have been produced if all in-scope dwellings had been included in the enumeration. This variability, known as the *sampling error*, can be estimated from the sample data. One measure of this sampling error is given by the *standard error*, which indicates the degree to which an estimate may vary from the value that would have been obtained from a full enumeration (the 'true' population figure). There are about two chances in three that a sample estimate differs from the true population value by less than one standard error, and about nineteen chances in twenty that the difference will be less than two standard errors.

Alternatively, sampling variability can be presented by the relative standard error, which is obtained by expressing the standard error as a percentage of the estimate to which it refers.

Some of the standard errors associated with estimates in this publication are relatively high. In general, the smaller the estimate and the smaller the sub-population on which it is based, the higher the relative standard error. In this publication those estimates with associated relative standard errors higher than 25 per cent but less than 50 per cent are marked with a single asterisk (*). Where the relative standard error is 50 per cent or more, the corresponding estimate is marked with a double asterisk (**). The usefulness of estimates with such high relative standard errors is limited.

Standard errors for all estimates in this publication are available on request. For information on standard errors contact the National Youth Statistics Unit of ABS on (09) 360 5328.

ONTARIO CHILD HEALTH STUDY

The Western Australian Child Health Survey was based on the Ontario Child Health Study which was conducted in early 1983 under the auspices of Statistics Canada. The sample design used in Western Australia has a number of similarities to that used for the Ontario study. Also, the questionnaires used in the Ontario study were used as a starting point in developing data items for inclusion in the Child Health Survey questionnaires.

FORM DESIGN

To obtain a comprehensive insight into child health it was necessary to survey a number of different aspects of children's lives. This, in turn, required the development of a number of questionnaires and other associated forms.

The following elements shape the design of a questionnaire, from form length to the type of questions framed and their sequence:

- characteristics of the respondents (e.g. age, education);
- type of questions and question design (e.g. tick box or write-in answers);
- time available to ask questions;
- copyright and other legal requirements;
- number of potential responses to each question;
- cost considerations (e.g. printing, reporting burden on respondents).

The development of the questionnaires for the Child Health Survey was a two stage process. Initial development involved research of subject matter (including literature and other information from related surveys) and consultations with clients. Questionnaires were developed and progressively modified, following ABS form design standards, and were field tested in the pilot survey.

The final development phase incorporated feedback from the pilot survey, and lead to a considerable rationalisation of the size and content of the set of questionnaires used.

The final survey required 16 different questionnaires as well as a number of associated forms (e.g. consent form) to collect all the survey information (See Appendix A – A Guide to the Field Instruments in *Western Australian Child Health Survey: Developing Health and Well-being in the Nineties* (ABS Catalogue No. 4303.5) for an outline of the questionnaires). These questionnaires were directed at four main respondent groups:

- general household (interviewer based);
- child specific (self-completed);
- primary school (self-completed);
- secondary school (self-completed).

As an indication of the number of forms requiring completion, a family comprising a principal and secondary caregiver, a primary school student and secondary school student would need to have 22 individual questionnaires ranging in size from 1 to 19 pages completed.

SAMPLE SELECTION

The area of Western Australia was stratified into six regions (3 metropolitan; 3 country) for the survey (See Appendix B – Western Australia: Survey Regions). Within each of these regions a probability sample of Census Collection Districts (CDs) was selected. Maps of each selected CD were prepared for use by the interviewers. A randomly selected starting point was marked on each CD map along with an indicated direction of travel. For each CD a *skip interval* was derived. This indicated the number of dwellings the interviewer was to 'skip over' between selections. For instance, if the skip interval was 4, then the interviewer would visit the 1st, 5th, 9th, 13th, etc households on the route. The skip interval was based on the number of dwellings in the CD, and the proportion of in-scope households in the CD taken from the 1991 Census of Population and Housing. The skip interval was designed to achieve the desired number of in-scope selections within one complete circuit of the CD. If a block of flats was encountered on the route, each flat was treated as a separate household. Also counted as dwellings were:

- permanently-occupied garages;
- residences above or behind shops;
- granny flats attached to houses;
- flats of any other sort;
- caravans.

The following were not counted when applying the skip interval:

- shops, factories and offices;
- dwellings converted to non-residential use;
- dwellings under construction;
- demolished or derelict dwellings;
- vacant blocks of land.

If no-one was at home on the initial visit to a household, the interviewer made up to five visits to the household, spread over different days and different times of the day in an effort to make contact. If no contact resulted after five visits the selected household was excluded from the survey.

The interviewers continued around the CD until the assigned number of eligible households (not necessarily all responding) was found. This was 10 households in CDs in the Perth metropolitan area, and 12 households in CDs in other parts of the state. If a full circuit of the CD was completed without finding the required number of eligible households then the interviewer would commence on a second circuit of the CD, starting at the dwelling next to the original starting point. Where two or more separate households were living in the same dwelling, all of the households were enumerated in the survey.

A skip interval covering the entire CD was used to minimise geographic clustering of the sample within selected CDs. This was designed to produce a more evenly representative sample by reducing the possibility of over-sampling respondents from one small area, all exhibiting similar characteristics.

PILOT SURVEY

Before the conduct of the main survey, a pilot survey was conducted on a smaller sample of households in the Perth metropolitan area. It was conducted between August 24 and September 12, 1992, and approached 865 dwellings, of which 254 were found to be within scope (i.e. contained at least one child aged between 4 and 16 years inclusive). Of the 254 eligible households, 195 agreed to participate in the survey and responded at least to the personal interview questionnaires. There were 12 interviewers employed on the pilot survey, which included 24 CDs.

The pilot survey was used to field test the survey methodology and refine the survey questionnaires. It provided valuable information on participation rates for the design of the main survey. Additionally, it allowed for refinement of the survey administration and estimation of survey costs.

INTERVIEWER TRAINING

Twenty-seven interviewers were employed on the main survey (14 in the Perth metropolitan area, and 13 in the country regions). All were experienced interviewers who had previously worked on a number of ABS household surveys, and had undergone intensive interviewer training. In addition to this, a separate training session was conducted for this survey. This training covered the particular subject matter of the survey, as well as special techniques and arrangements necessary to cope with the sensitive nature of the survey.

FIELD ENUMERATION

The field enumeration took place over a three month period commencing in early July and running through until the end of September 1993. An ABS officer was outposted to the Institute for Child Health Research to co-ordinate the field enumeration phase, and to supervise the interviewers.

Work load assignments were allocated to interviewers on a fortnightly basis during the enumeration period. Breaks were provided between each assignment in anticipation of the stressful nature of some of the interviews.

Each assignment in the Perth metropolitan area consisted of two CDs from which 20 in-scope households were to be obtained. In country areas each assignment was two CDs from which 24 in-scope households were to be obtained.

An even spread of areas was allocated in each assignment period to minimise any seasonality effects that otherwise may have been encountered because of the three months enumeration time frame.

INTERVIEWING

A household was considered in scope if there was at least one child aged between 4 and 16 years inclusive. Because no lists of eligible households existed, an area sampling methodology was employed where households were selected and screened to determine if they were eligible to participate in the survey.

Once screening had determined a household to be in scope, interviews were conducted of the principal caregiver, who was the parent or legal guardian who spent the most time with the child(ren). In most cases the principal caregiver was the child(ren)'s mother.

The survey was voluntary, and the principal caregiver's consent was obtained before proceeding with the interviews. The principal caregiver was asked to sign a form, which, gave consent for the interview itself; for the survey team to approach the child(ren)'s school; to access individual hospital, birth and medical records; and to being approached in the future for possible follow-up studies. Householders were also asked to provide some next of kin details, to assist in contacting participating families in the future, should follow-up studies be undertaken.

Four survey forms were administered in the personal interview. Firstly, a Household Record Form (HRF93) was used to record basic demographic data about the household, and was also used for survey administration. There were two Family Background Questionnaires (FAMA93 and FAMB93). The first collected basic data about the household. The second was specific to the parents and was administered to both the principal and secondary caregivers of a family. Finally the Child Health Questionnaire (CHQ93) was administered (to the principal caregiver) for each in-scope child.

When non English-speaking households were encountered the Translator and Interpreter Services supplied by the Department of Immigration and Ethnic Affairs were used. With the aid of multi-lingual prompt cards a separate appointment for interview was arranged, where the survey interviewer was accompanied by an interpreter.

SELF-ENUMERATED FORMS

Once the personal interviews had been completed, a series of forms was left with the respondents to complete at their leisure. Most of these forms were given to the principal caregiver, however any children aged between 12 and 16 years inclusive were provided with a youth self-report form. Separate consent forms were completed by the relevant youths prior to filling out the youth self-report.

Every effort was made to ensure that the self-enumeration forms were simple to understand and straightforward to fill out, with comprehensive instructions. A toll-free number was also provided to respondents for any inquiries.

The interviewers called back to the respondents' household to collect the completed self-enumeration questionnaires. Confidential return envelopes were provided, so that each individual respondent's forms could be kept confidential from other members of the household. If no contact could be made with the household within three return visits, reply-paid envelopes were left for the return of the questionnaires.

TEACHER REPORTS

For all children in the survey who were still in school, permission was sought from the principal caregiver to ask questions of the child(ren)'s teachers. To facilitate this part of the survey, approaches to schools were co-ordinated by grouping together all survey children attending the same school, and sending survey forms through the school principal. To ease the burden on schools with larger numbers of children in the survey, funds for providing teacher relief were made available to individual schools. With this approach a high degree of co-operation was obtained from schools.

In primary schools, questions were asked of both the principal and the classroom teacher. In high schools, questions were asked of the principal, counsellor or form teacher, and English language or literature teacher. As well as filling out self-enumerated forms about the children and the schools, this phase included a vocabulary test and a logic test that was administered to the children by the classroom teacher, or English language or literature teacher.

FOLLOW UP FOR NON-RESPONSE

As the survey was voluntary, no follow-up was undertaken of households refusing to participate in the study. However, where reply paid envelopes were left for posting back self-enumeration forms, these households were followed up for any outstanding questionnaires. In the Perth metropolitan area two interviewers were assigned to visit dwellings with outstanding questionnaires. In the country areas, because of the expense of travelling large distances, intensive follow-up was undertaken by telephone.

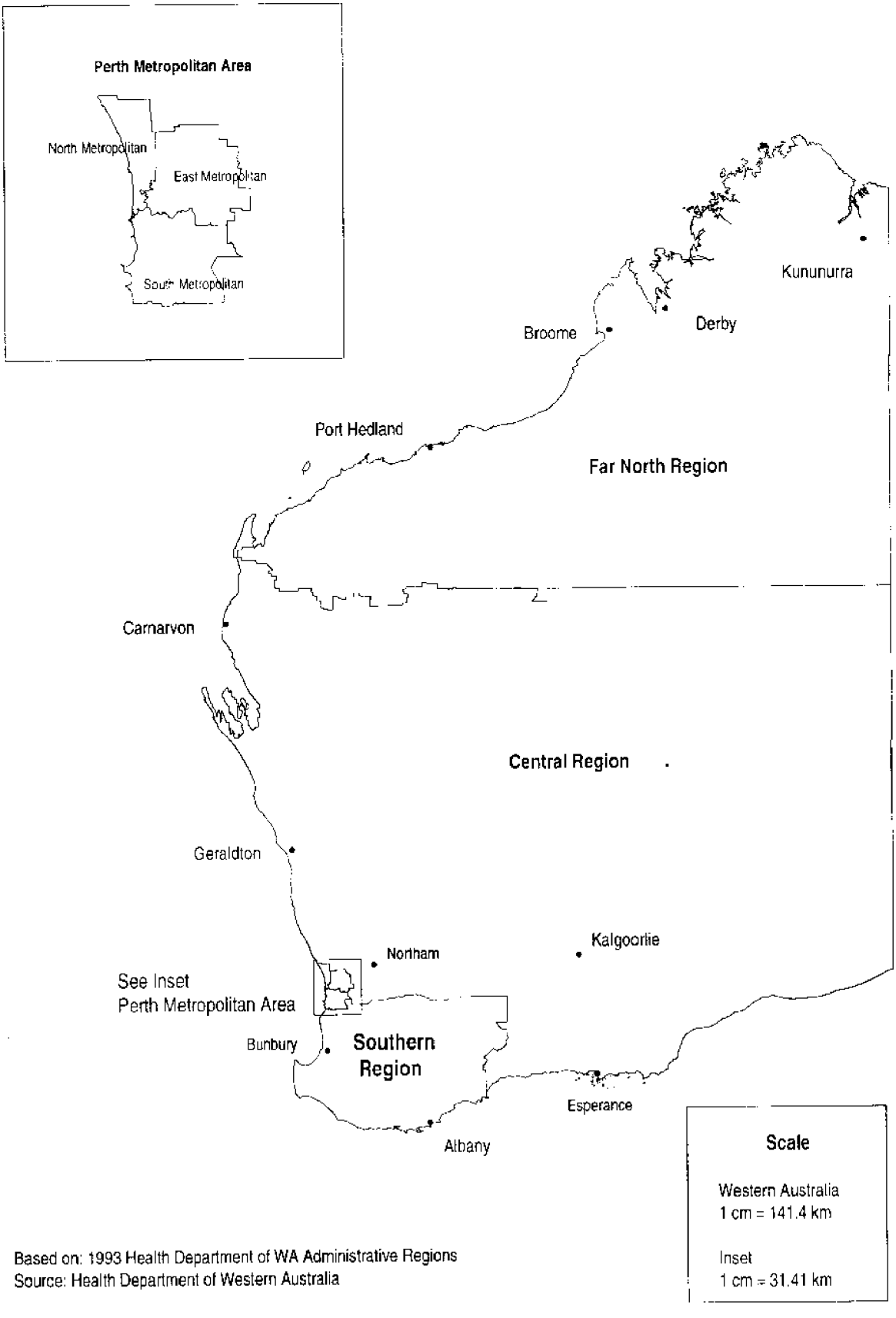
Both methods proved successful in maximising response rates for self-enumerated survey questionnaires.

Return of teacher forms was also followed up by telephone, to maximise response rates from schools.

COUNSELLING SERVICES

The Child Health Survey collected sensitive information about emotional health and well-being. There was a potential that participation in the survey could result in some distress to the respondent. Each interviewer had a fact sheet giving contact details for a range of relevant services which was given to respondents where appropriate. The Institute maintained a toll-free number which respondents could call to discuss any concerns. Any distressed respondents were referred through this to appropriate services.

APPENDIX B – WESTERN AUSTRALIA: SURVEY REGIONS



Based on: 1993 Health Department of WA Administrative Regions
Source: Health Department of Western Australia

GLOSSARY

BEHAVIOURAL SYNDROMES

Child Behaviour Checklists (CBCLs) completed by caregivers and teachers were used to determine whether or not a child had a mental health problem (see *Mental health morbidity* and *Child Behaviour Checklist* below). A mental health morbidity was defined where the CBCL Total T Score (see *T Score* below) was equal to or greater than 60 on either the parent or teacher checklist. Individual syndrome scales on the parent or teacher checklists were judged to be abnormal where they equalled or exceeded 67 in the presence of an abnormal Total T Score. Eight specific child mental health problems (behavioural syndromes) were thus defined: delinquent; thought; attention; and social problems; somatic complaints; aggressive behaviour; anxiety/depression; and withdrawn behaviour.

BLENDED FAMILY

A blended family is a couple family where there are two or more children, of whom at least one is the natural child of both of the parents, and at least one is the step child of one of the parents.

BRADBURN HAPPINESS SCALE

The Bradburn Happiness Scale is a ten item questionnaire which has been widely used in population surveys to measure psychological well-being or happiness. The questions probe how often people have felt various positive and negative affects during the past few weeks. The reported frequency of the positive and negative affect responses are separately summed and then used to derive an overall affect-balance score which is converted to a stanine. The affect-balance scores have been shown to correlate with overall self-rating of happiness.[1]

CHILD BEHAVIOUR CHECKLIST

Administered to the principal caregiver, this 112-item instrument, when combined with the teacher report, formed the main instrument to estimate mental health morbidity among children.[2] The main categories of morbidity to be estimated were: delinquent behaviour, aggressive behaviour, withdrawn, anxious/depressed, somatic complaints, social problems, thought problems, and attention problems.

DEPENDENT CHILDREN

Dependent children are usually defined as resident children aged under 15 years or resident children aged 15 to 24 years who are studying full-time.

The Child Health Survey had insufficient information to determine whether or not 'children' aged 17 to 24 years were dependent students. Therefore, the definition used here for dependent children is all children in families aged 16 years or less.

DISABILITY

A disability, as defined by the *Western Australian Disability Services Act*, is: attributable to an intellectual, psychiatric, cognitive, neurological, sensory or physical impairment or a combination of impairments; permanent or likely to be so; chronic or episodic in nature; and resulting in a reduced capacity of the individual for communication, social interaction, learning, mobility and a need for continuing support services.

Survey questions were structured to capture the essential elements of this definition. For the purposes of the Western Australian Child Health Survey, a disability was defined as the presence of one or more of the following functional limitations: needing any help with transport due to an illness, injury or medical condition; needing help or supervision in getting around the neighbourhood, for reasons other than age; unable to walk without assistancefrom someone; needing physical help with eating, dressing, bathing or going to the toilet, for reasons other than age; and, any limitation in the kind or amount of ordinary play or activity the child could do with other children.

DSM-III-R CLINICAL DIAGNOSES

Clinical diagnoses based on The Diagnostic and Statistical Manual of Mental Disorders issued by the American Psychiatric Association.[3] This manual details criteria for psychiatric diagnoses. Since the Survey, DSM-IV has been published.

GENERALISED ESTIMATING EQUATIONS

Ordinary logistic regression assumes that all observations are independent. In the Child Health Survey this is not so, as the survey has been selected in stages. A sample of Census Collection Districts (CDs) was drawn, and within these, dwellings were selected. All in-scope children were selected in each selected dwelling. It is highly likely that there will be correlations within families and CDs. To account for this a more general modelling procedure, known as Generalised Estimating Equations (GEEs), was used.

This technique has been shown theoretically to produce consistent estimates of the regression parameters and reliable standard errors. The analysis here used GEEs to fit a logistic regression model with an 'exchangeable' correlation structure to the survey data which assumes a fixed but unknown correlation between subjects within the same family. This correlation is estimated by the modelling procedure. This techique is described in Liang and Zeger (1986).[4]

INCOME RANGES

See also *Parental Income*

To assist in the analysis and presentation of income data, parental incomes were ranked into five groups. These groups are as close to quintiles as can be obtained. The proportion of families contained within each range, of those who stated an income, is shown in the following table:

Annual income	*Proportion of families*
$20,000 or less	22.8
$20,001–$30,000	19.8
$30,001–$40,000	17.1
$40,001–$60,000	25.5
More than $60,000	14.8

LIFE-STRESS EVENTS

Life stress characterised by the occurrence of major life events requiring change in ongoing adjustment is a significant factor associated with the onset of many illnesses.[5] In order to ascertain the occurrence of major life events in the child's family during the previous 12 months, the Child Health Survey used Sandler and Block's modification of Coddington's Life Stress Inventory.[6]

LOGISTIC REGRESSION

Logistic regression is a modelling technique that is used to investigate the relationship between the probability of a certain outcome (in this case child mental health morbidity) and a set of explanatory variables. Logistic regression is discussed in several statistical publications – see, for example, Agresti (1984).[7]

MCMASTER FAMILY ASSESSMENT DEVICE

The General Functioning Scale of the McMaster Family Assessment Device (FAD) was used as a global measure of the health of family functioning. It consists of 12 statements about families to which respondents indicate they agree or disagree (on a four point scale). This short form of the FAD was derived from an item analysis of the full 60 item scale and includes questions concerning problem solving, communication, role delineation, affective responsiveness, affective involvement and behaviour control. The scale has been shown to have good reliability, internal consistency and validity in distinguishing between non-clinical families and families attending a psychiatric service.[8]

MENTAL HEALTH MORBIDITY

See also *Behavioural syndromes.*

Caregivers, teachers and adolescents each completed a Child Behaviour Checklist (CBCL) designed to identify child behavioural and emotional problems. Responses from both caregivers and teachers were used to determine whether or not a child had a mental health problem (morbidity). A mental health morbidity was defined where the CBCL Total T Score (see *T Score* below) was equal to or greater than 60 on either the parent or teacher checklist. Combining information from parents and teachers was done in line with recommendations by Bird et al (1990).[9]

OCCUPATION

Listed categories are the major occupation groups defined by the Australian Standard Classification of Occupations.[10]

ODDS RATIO

The odds of a given event is the ratio of the probability of its occurrence to the probability of its non-occurrence. The odds ratios used in this

publication are a measure of relative risk, derived from a formula which examines the association between, in most of the Child Health Survey cases, a risk factor (exposure), and an adverse health outcome.

ORIGINAL FAMILY

An original family is a couple family containing one or more children, the child(ren) being either the natural child(ren) of both of the parents, an adopted or foster child(ren), or a combination of these child types.

PARENTAL INCOME

Parental income was calculated by adding the individual gross incomes (incomes before deduction of tax, superannuation payments and health insurance payments) of the principal caregiver and any spouse or partner. Gross income included wages, salaries, overtime, family allowance and other benefits, child support, superannuation, interest received, dividends and business income.

Caregivers were not asked to state their exact income, only to indicate the range into which their income fell. The income categories used were:

Per year	*Per week*
Less than $3,001	Less than $58
$3,001–$5,000	$58–$96
$5,001–$8,000	$97–$154
$8,001–$12,000	$155–$230
$12,001–$16,000	$231–$308
$16,001–$20,000	$309–$385
$20,001–$25,000	$386–$481
$25,001–$30,000	$482–$577
$30,001–$35,000	$578–$673
$35,001–$40,000	$674–$769
$40,001–$50,000	$770–$961
$50,001–$60,000	$962–$1,154
$60,001–$70,000	$1,155–$1,346
More than $70,000	More than $1,346

PRINCIPAL CAREGIVER

For each household, a principal caregiver was nominated to provide information about the selected child(ren). This was the person who was considered to spend the most time with the child(ren). In most cases, the principal caregiver was the child(ren)'s mother.

SECONDARY CAREGIVER

The spouse or partner of the main or principal caregiver of the child(ren) is referred to as the secondary caregiver. This person was almost always male, and was predominantly the child(ren)'s father.

SELF-EFFICACY

The Child Health Survey modified Cowen et al's Perceived Self-Efficacy (PSE) Scale to develop an adult measure of the perceived self-efficacy of parents.[11] The questionnaire asks parents to rate (on a 5 point scale) their confidence in managing 22 day-to-day tasks and situations which may arise in various settings. These include tasks such as making important decisions, dealing with new work, travelling alone to a new place, working out a problem with a child etc. The modification of PSE involved changes to seven of the original PSE items pertaining to the family and school context. These were replaced with items reflecting comparable tasks encountered by adults. Using data collected in the pilot for the Child Health Survey the adult version of the PSE was shown to have sound construct and content validity. This measure of parental self-efficacy has also been shown to have significant associations with parenting style and child adjustment.[12]

STEP FAMILY

A step family is a couple family containing one or more children, none of whom is the natural child of both of the parents, and at least one is the step child of one of the parents.

SURVEY REGIONS

Survey regions are the smallest geographic areas of Western Australia for which Survey results are available. The regions are based on the 1993 Health Service Management Regions used for administrative purposes by the Health Department of Western Australia.

There are six survey regions: three within the Perth metropolitan area, and three country regions (see Appendix B – Western Australia: Survey Regions).

The Perth metropolitan area coincides with the Perth Statistical Division, and comprises North metropolitan, East metropolitan and South metropolitan regions, the division being on the basis of Statistical Local Areas (SLAs) and postcodes. SLA boundaries were used in all

cases except for two SLAs: Stirling Central, and Canning – where the division was on the basis of postcode boundaries.

The Western Australian country regions are: the Southern region (comprising the South-West, Lower Great Southern and Upper Great Southern Statistical Divisions); Central region (Central, Midlands and South-Eastern Statistical Divisions); and Far North region (Pilbara and Kimberley Statistical Divisions).

T SCORE

The number of Child Behaviour Checklist problems reported for each child was converted to a normalised T Score i.e. a score based on a normal distribution with a mean of 50 and a standard deviation of 10. T Scores provide a convenient metric that is similar for all scales. They also permit judgements to be made as to whether a child has relatively few or many problems in comparison with the general population of children of the same age and sex.

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