

So far, the information provided in this report has focused on outcomes for children as well as measuring direct or 'proximal' factors that are known to be significant influences for these outcomes. However, the wellbeing of children also depends largely on wider environmental determinants including the social, emotional, physical and economic wellbeing of children's families and the strength of the communities in which they live. Such influences may be described as indirect or 'distal' factors.

Stanley, Sanson and McMichael (2002) point out that the influence of proximal risk factors can often be so powerful that more distal factors often do not receive the attention they deserve. Epidemiological research of the past, they argue, tended to ignore the important causal sequences and interactions of distal factors, as the influence of proximal factors on child outcomes dominate in statistical modelling. One difficulty with the data currently available in Australia, however, particularly administrative data, is that they cannot fully explain the influences these macro environmental factors will have on health and other outcomes for children.

With the available data, it is possible to examine statistics about the family and community context in which children are currently living, but it is much more difficult to show how these contexts have influenced outcomes for children. Questions such as how physical and mental health status, opportunities for learning and education, and access to health services and leisure and recreational activities are influenced by family and community factors are difficult to answer. It is also equally difficult to explain how these factors influence short- and long-term outcomes for children. These questions are best answered by multivariate and longitudinal research.

Other Australian studies (e.g. Western Australian Child Health Survey and Australian Temperament Project among Victorian children) have shown that the family and community environment and socioeconomic circumstances in which children are growing up have an effect on children's educational, psycho-social and criminal outcomes (Prior et al. 2000; Zubrick et al. 2000b). Neighbourhoods, along with individual circumstances, can also play a major role in shaping children's behaviour. Neighbourhoods where social cohesion is low may increase the vulnerability of families and children, while neighbourhoods with stronger community connectedness may provide a safe and secure environment for families and children (Vinson et al. 1996; Vinson 2004).

The school and community contexts in which children live also have a considerable influence over their health, development and wellbeing. These contexts, along with family, set foundations for learning, behaviour and health over the course of their life (Zubrick et al. 2000c).

By providing information in this section on elements of family structure, parenting and community influences, we can further our understanding of the context in which Australian children are growing up. This chapter presents data on a number of indicators on parental socioeconomic and health status, and the links with extended family, friends and community. Specifically, the chapter provides statistics on:

- types of families that children live in (couple parent and single parent families, and children living in out-of-home care);
- socioeconomic status (parental employment, and families' ability to raise money in an emergency);
- parental health, disability and chronic illness;
- social capital (families' ability to get outside support in time of crisis, ability to rely on friends and community for small favours, contacts with family and friends); and
- neighbourhood safety.

23 Family structure

With the changing social attitudes towards marriage and fertility choices, Australian families have changed dramatically in the last 30 years (ABS 2003h). The result has been an increasing diversity of family types within which Australian children are brought up. Throughout their lives, a number of children will experience a change from living in a couple family to having only one resident parent, while others will move from a lone parent family to a situation where they have new family members. Some children may even experience a number of family transitions before they reach adolescence. These types of changes can impact significantly on children. A child's personal experience of family change can sometimes result in poorer health and wellbeing, especially if changes to family structure are the result of a family breakdown.

Although the dominant type of family in Australia is still the couple family, lone parent families are becoming increasingly common (AIHW 2001; de Vaus 2004). According to 2001 census counts, the proportion of couple families with children was 47% of all families, a reduction of 6.4% from 50.2% in 1971. Lone parent families in 2001 represented 15.4% of all families, a significant increase from 5.7% in 1971 (ABS 2003c).

There are different types of couple families in which children grow up in Australia:

- intact families where the child is the biological, adopted or foster child of both members of the couple;
- blended families where at least one child is the biological child of the couple and at least one child is the stepchild of either member of the couple; and
- stepfamilies where at least one child is the stepchild of either member of the couple and none of the children is the natural or foster child of both members of the couple.

Family structure and child wellbeing

The relationship between family structure and child outcomes is not a simple causal one. A review of a number of research works by Wise (2003) indicate that there are many intervening factors such as parent-child relationship, parenting style and monitoring, and poor parental care or family discord (also see de Vaus & Gray 2003) that determine how children are able to function.

Also, child outcomes resulting from family change are not always negative. Children who have been in a family environment of conflict or abuse may experience positive outcomes following the transition. The response of children to family change can also vary depending on whether the child is more vulnerable or resilient to the effects of change. Nevertheless, research evidence indicates that changing family structure can have negative effects on children (de Vaus & Gray 2003; Ram & Hou 2003).

Studies suggest that children undergoing transitional change from one kind of family to another encounter some difficulties adjusting to new changes and are at an increased risk for mental health and for overall wellbeing (Sawyer et al. 2000; Silburn et al. 1996; Vimpani et al. 2002). Children from non-intact families, particularly lone parent families, are also likely to experience adverse developmental outcomes such as low educational attainment, increased likelihood of engaging in aggressive, antisocial and criminal behaviour and substance use in adulthood (de Vaus & Gray 2003; Deleire & Kalil 2002). This is partly to do with children having to adjust to new parent-child relationships, parental stressors such as changed socioeconomic status, parenting style and discipline, disruption to family cohesion, sibling relationship and parental mental health issues (Deater-Deckard & Dunn 1999 cited in Wise 2003).

Australian families

The ABS categorises Australian families into two broad groups: couple families which includes intact, step, blended and other families and lone parent families. The distribution of Australian children under age 15 years by the type of family they lived in as at June 2003 using more specific categories is shown in Table 23.1.

- In 2003, most children (72%) aged 0–14 years lived in intact families, a family consisting of both natural parents of the child.
- Nearly 20% of children lived in lone parent families. Of these children, 88% lived with lone mothers.

Table 23.1: Children aged 0–14 years, by family structure, 2003 (per cent)

Family structure		Number ('000)	Per cent
Couple families	Intact families ^(a)	2,805.9	72.1
	Step-families ^(a)	118.4	3.0
	Blended families ^(a)	197.5	5.1
	Other couple families	16.0	0.4
Lone parent families	Lone mother	663.1	17.0
	Lone father	88.6	2.3
Total children in all families^(a)		3,889.5	100.0

(a) Includes a small number of children without a natural parent living in the household (e.g. foster children or other related children).
Source: ABS 2003h.

- A small proportion of children (less than 1% or approximately 28,100) aged 0–14 years lived with grandparents. This number includes only the youngest child who is under the age of 15 years. Therefore, the actual number of children under the age of 15 years who live with a grandparent could be higher.

Data from the 2001 ABS Census of Population and Housing highlighted that, in households with Indigenous people, the proportion of children living in one-parent families (44%) was twice the proportion of other children in one-parent households (20%) (ABS 2003i). The census also showed that, in households with Indigenous people, the proportion of children living in multi-family or group households (6%) was higher compared to children in other households (2%).

Changing family structure in Australia

- Between 1992 and 2003, the proportion of children living in one-parent families increased by 36% from 14.2% to 19.3% of all family types.
- The proportion of children living in couple families declined from 86% in 1992 to 81% in 2003 of all family types. Couple families here include step, blended and other families as well.

Family type and employment status

In 2003, in couple families where the youngest child was under the age of 15 years, at least one parent was in employment in 94% of families. In 59% of families where the youngest child was under 15 years of age, both parents

were employed. In lone mother families where the youngest child was under 15, nearly 55% of mothers were not employed in 2003. In 86% of these families, no other person in the household was employed (ABS 2003h).

In lone mother families where the youngest child was aged 0–2 years, only 28% of mothers were employed. As the age of the youngest child increased, the proportion of lone mothers employed also increased. When the youngest child reached the age of 5–11 years and 12–14 years, approximately 53% of women were employed.

Employment status in lone father families was higher but still well below the community average. Over 57% of the fathers in lone father families where the youngest child was aged less than 15 years were employed in 2003.

Couple families with children under 15 had an average income 2.8 times that of lone parent families. Average income figures include wages and salaries as well as government pensions, benefits or allowances received. Even so, the income earned by lone parent families is much lower than that of couple families (ABS 2003c).

From the above data, it can be concluded that compared to children living in couple families, children living in lone parent families have less resources available to them. This may partially explain the higher risk associated with children living in lone parent families. Chapter 25 on 'Economic security' provides detailed information on income and the types of families that children are living in.

24 Family functioning

Family functioning is an important aspect of the family environment that influences child health and wellbeing. In general terms, family functioning is about how families relate, communicate, make decisions, solve problems and maintain relationships. The level of functioning within a family can be affected by changes in family circumstances, the interaction between parental employment and family life, specific relationships between individual family members as well as other external stressors which may affect the home environment.

Defining a single measure of family functioning is problematic. No general agreement exists as to what constitutes 'family functioning', although there is general consensus that proxy measures such as family type are inadequate (Zubrick et al. 2000a). Silburn et al. (1996) in their analysis of the 1993 Western Australian Child Health Survey, measured family functioning using indicators such as marital relationship quality, family discord, life-stress events (for example, divorce) and parent's disciplinary style. They found two aspects of family functioning—family discord and parental disciplinary style—were significant risk factors for children's poor mental health. Research studies in other countries have also shown links between parental conflict and children's wellbeing and behaviour (Grych & Fincham 1990).

The relationships that children maintain with their family, particularly their parents, are among the most important influences on healthy child development and psychological wellbeing (Shonkoff & Phillips 2000). Although it is important to recognise that parenting does not occur in a vacuum, there are many nurturing benefits for children living in families that get on together. These include having positive role models for building relationships, the ability to cope with stressful life events and the development of high self-esteem. On the other hand, families that do not get on well together tend to have high levels of conflict. These problems have adverse short- and long-term effects on the behaviour and wellbeing of children and young people.

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

Table 24.1: Parents' rating of family cohesion in families with children aged 4–14 years, by selected characteristics, 1998 (per cent)

	Poor to fair	Good to excellent
Weekly household income		
<\$420	12.3	87.7
\$421–\$680	11.7	88.3
\$681–\$910	7.1	92.9
\$911–\$1,280	6.9	93.1
>\$1,280	5.2	94.8
Family type		
Original parents	6.8	93.2
Lone parent	12.8	87.2
Blended/ other	11.6	88.4

Source: AIHW analysis of the child and adolescent component of the National Mental Health Survey.

Family cohesion

The 1998 Child and Adolescent Component of the National Survey of Mental Health and Wellbeing examined the relationship between the level of family cohesion, and the mental health of children aged 4–17 years (Sawyer et al. 2000). The survey measured family cohesion by asking parents about their family's ability to get on with one another. Families with difficulty getting on with one another were characterised as follows—'They do not always agree and they may get angry'. Families' ability to get on was rated on a five-point scale, from 'poor' to 'excellent'.

Data for families with children aged 4–12 years are presented in Table 24.1 with distribution by household income and family type.

- The majority of families reported high levels of family cohesion, although the proportion of families rating their ability to get on as poor to fair was higher among the families with lower weekly household incomes.
- Family cohesion also tended to be higher in intact families (93% indicating good to excellent) than in lone parent or blended families (87% and 88% respectively).

Indicator

- **Proportion of children aged 4–12 years living in families where family cohesion is low.**

25 Economic security

Children living in families without economic security are at a greater risk of poor outcomes both in the short and longer term. When talking about economic hardship or poverty in the Australian context, people are usually referring to relative disadvantage. Relative disadvantage means that, in comparison to others in the population, a person has a standard of living that falls below an overall community standard, as opposed to absolute poverty which refers to the minimal needs, such as food and shelter, which a person requires just to survive. While there are probably very few children in Australia who are affected by absolute poverty, some children are living in families that are experiencing relative economic hardship, which can also be physically and socially debilitating.

The immediate impact of economic hardship is evident. Living in a family with low income can affect a child's nutrition, their access to medical care, the safety of their environment, the level of stress in the home, and the quality and stability of their care (Shore 1997). In addition, research confirms that for a number of health and social outcomes, including socio-emotional functioning, mental health, physical health, educational attainment and later employment prospects, children in the lowest income groups are at a higher risk of disadvantage than other children (for an overview, see Bradbury 2003 and Mayer 2002). In addition, evidence of the association between low socioeconomic status (which encompasses education and occupation as well as low income) and less favourable outcomes for children have been demonstrated throughout this report.

'Lack of employment is likely to result in immediate financial hardship, and the absence of a working role model may also impact on a child's long-term prospects for labour market success and other future outcomes'

However, although the strong association between income and outcomes for children is not contested, the mechanism through which poverty impacts on health and wellbeing is not well understood and is the subject of much debate in the research literature. Some researchers argue that more macro-level variables such as a person's position in the social hierarchy or the degree to which individuals are able to participate fully in society may better explain disparities in health and wellbeing (Marmot 2002).

This section examines the proportion of children living in families with low income as well as examining aspects of economic security including parental non-employment. Information is also presented on measures of financial stress, such as the ability of families to raise \$2,000 for something important and the number of families who went without meals as a result of cash flow problems.

Household income

Income distribution is generally analysed using the concept of equivalised income. By using a special type of scaling method, different household types are taken into account. This is important because although a couple with two children may have the same income as a single person, a family has greater needs and so they cannot achieve the same standard of living as a single person. Equivalence scales adjust a household's net income for differences in size and composition. Using this method, persons are then divided into five equal groups, after being ranked according to that income, in order to compare their relative economic wellbeing (Table 25.1).

- In 2002–03, 22% of children aged 0–14 years (854,463) lived in households with incomes in the lowest quintile. The proportion of children in one-parent households with incomes in the lowest quintile was more than twice that of children in couple households, 43% compared with 17%.

Indicator

- **Proportion of children aged 0–14 years living in families where no parent is employed.**

Table 25.1: Equivalent OECD income quintiles for households with children aged 0–14 years, by type of household, Australia, 2002–03 (per cent)

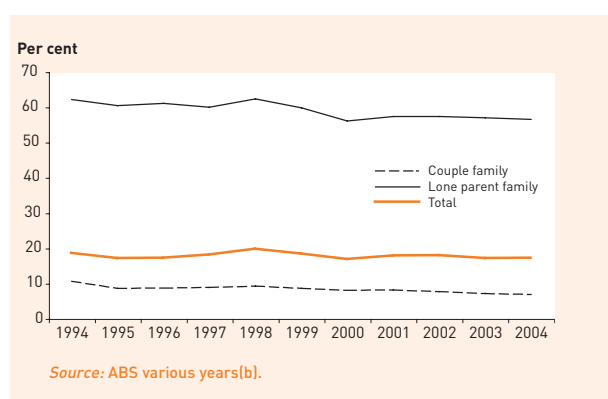
Household composition	Equivalent disposable income quintile					Total	Total ('000)
	Lowest	Second	Third	Fourth	Highest		
Households							
Couple, one-family household	16.6	22.4	26.1	20.6	14.2	100.0	1,698,539
One parent, one-family household	38.3	29.4	21.5	8.0	2.8 ^(a)	100.0	434,600
Multiple family household	11.5 ^(b)	33.0	21.0 ^(a)	23.8	10.7 ^(a)	100.0	63,035
Total households with dependants	20.8	24.1	25.1	18.2	11.9	100.0	2,196,174
Children							
Couple, one-family household	17.3	24.6	26.1	19.4	12.6	100.0	3,091,655
One parent, one-family household	43.2	29.6	18.2	6.9	2.2 ^(a)	100.0	702,937
Multiple family household	16.3 ^(b)	33.9 ^(a)	19.4 ^(a)	22.3 ^(a)	8.2 ^(a)	100.0	99,213
Total children aged 0–14 years	21.9	25.7	24.5	17.2	10.6	100.0	3,893,806

(a) Estimate has a relative standard error of between 25% and 50% and should be used with caution.
(b) Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.
Note: Multiple family households contain two or more families. The vast majority of children in Australia (97.5%) live in one-family households.
Source: ABS unpublished data, 2002–03 Survey of income and housing costs.

Parental non-employment

Studies show that children living in families with no employed parent are at a disadvantage compared to other children because not only is lack of employment likely to result in immediate financial hardship, the absence of a working role model may also impact on a child's long-term prospects for labour market success and other future outcomes.

Figure 25.1: Children aged 0–14 years living in families where no parent is employed, June 1994 to June 2004 (per cent)



- The proportion of all children under 15 years living in families without a parent employed fell from 19% in June 1994 to 17% in June 2004, albeit with some fluctuation over this period.)
- Over the period, the proportion of children with no parent employed was considerably higher for those in one-parent families than in couple families. This is hardly surprising, given that single parents have no co-resident parent available to care for their children while they work. In 2004, among children who lived in couple families, 7% lived in families where neither parent was employed. Of children who lived in one-parent families, 57% lived in families where the parent was not employed.
- Reflecting the growth in the 1990s in the total number of single parents who were not employed, the number of children living in one-parent families where the parent was not employed increased 30% from around 363,000 in 1994 to around 471,000 in 2004. Conversely, the number of children living in couple families where neither parent was employed fell 36% from 341,000 to 219,000 over the same period.

- In 2001, approximately 16% of Indigenous Australian children aged 0–14 years lived in a family where no parent was employed.

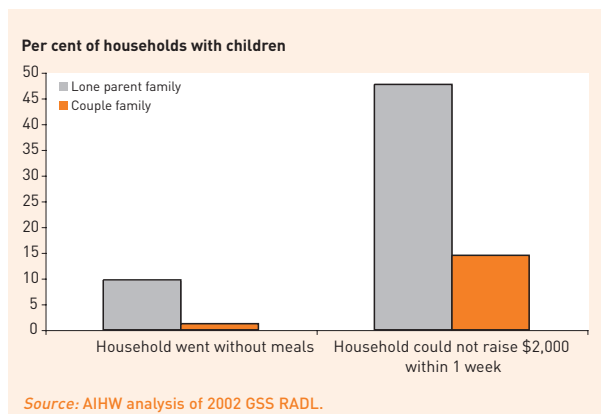
While low income and parental employment can provide a lot of information about poverty and disadvantage, these statistics should not be used in isolation (Brownlee 1990). Many researchers consider that poverty and disadvantage should be measured using both indicators of resources, such as income and indicators of ‘living conditions’.

Financial hardship

Two further indicators of family poverty and financial hardship are the proportion of households with dependent children who went without food because of cash flow problems and the proportion of households with dependent children who would be unable to raise \$2,000 within a week for something important.

As well as collecting information on the number of jobless families, the ABS 2002 General Social Survey asked respondents to report on a number of household financial stress indicators (ABS 2002a). The proportion of households experiencing financial stress varied markedly by family type (Figure 25.2).

Figure 25.2: Households with children aged 0–14 years with indications of financial stress, by family type, 2002 (per cent)



- A small proportion of households with children aged 0–14 reported going without meals because of cash flow problems. Among couple families 1.2% went without meals compared with 9.7% of lone parent families.
- The proportion of households who said they would be unable to raise \$2,000 within a week for something important also varied by household type. For couple families the percentage was 14.5% whereas for lone parent families, the proportion was much higher (47.7%).

Table 25.2: Children aged 0–14 years living in families where no parent is employed, by Indigenous status, 1996 and 2001 (per cent)

Family type		1996	2001
Couple families both unemployed	Indigenous	17.7	15.7
	Other Australians	8.4	6.8
Single parent unemployed	Indigenous	29.9	31.9
	Other Australians	9.5	10.2

Note: Percentages are calculated out of the total number of children including those children where parent's employment was not stated.
Source: 1996 & 2001 ABS Census of Population and Housing, unpublished data.

26 Children in out-of-home care

Out-of-home³ care provides alternative accommodation to children whose parents are incapable of providing adequate care for them, or where alternative accommodation is needed during times of family conflict. Some children are placed in out-of-home care because they were the subject of child protection substantiation and require a more protective environment. While some children are placed in out-of-home care voluntarily, others may be placed through some type of court order. Such orders include care and protection orders, including formal administrative arrangements and other legal orders. This practice, however, differs greatly between jurisdictions:

- In the Northern Territory, all children in out-of-home care are on a court order or some other form of legal authority.
- In New South Wales, Victoria, South Australia, Tasmania and the Australian Capital Territory, children in out-of-home care can be placed on a range of different orders or authorities. (For example, in South Australia, children needing emergency or respite care are often placed in out-of-home care on the authority of their guardians.)

Although a child may be in out-of-home care in conjunction with being on an order, the order does not necessarily specify where the child must reside or that the child be placed in care. More information about out-of-home care can be found in the AIHW publication *Child Protection Australia 2003–04* (AIHW 2005). This report contains more detailed information about child protection in each state and territory of Australia.

Young people in out-of-home care represent a particularly disadvantaged group. Most of them have suffered child abuse or neglect, as well as the breakdown of their families. Compared with the general population, young people in out-of-home care have higher levels of aggressive/violent behaviour, higher levels of substance use, and a higher incidence of intellectual disability, mental health problems and poorer educational outcomes (Cashmore & Ainsworth 2004; Cashmore & Paxman 1996; Jackson 2001).

Where are the children placed?

Many forms of out-of-home care are available to children: foster care, placements with relatives or kin, and residential care. In addition, respite care is available as a form of temporary out-of-home care to provide short-term accommodation for children whose parents or carers are ill or unable to care for them.

Children who are placed in disability services, medical or psychiatric services, juvenile justice facilities, overnight childcare services or supported accommodation assistance placements are not included as these are beyond the scope of the data collection. The data also exclude children in unfunded placements and children living with parents where the jurisdiction makes a financial payment.

The current policy and practice emphasis is to keep children within families as much as possible. Where it has been necessary to place children in out-of-home care, the current practice is to reunite the child with the family as soon as possible. When it is necessary to place a child in out-of-home care, the preferred placement is within the wider family or community. This is particularly the case with Aboriginal and Torres Strait Islander children in accordance with the Aboriginal Child Placement Principle (AIHW 2005). In 2003, 77% of the Indigenous children needing out-of-home care were placed with a relative or kin.

‘Young people in out-of-home care represent a particularly disadvantaged group. Most of them have suffered child abuse or neglect, as well as the breakdown of their families’

³ ‘Out-of-home care’ is defined as out-of-home overnight care for children and young people less than 18 years of age, where the state or territory makes a financial payment.

Table 26.1: Children in out-of-home care at 30 June 2004 (per cent)

Children aged 0–14 years in out-of-home care		
Age (years)	Number	Per cent
<1	621	3.3
1–4	4,314	22.8
5–9	6,836	36.2
10–14	7,117	37.7
Total	18,888	100.0

Source: AIHW 2005.

How many children are in out-of-home care?

At 30 June 2004, there were 18,888 children aged 0–14 years in out-of-home care in Australia. (Table 26.1). Of these children, nearly three-quarters (74%) were aged 5 years and over. Only 3% were under the age of one year.

Trends in out-of-home care

Since 2001, over 11,000 children have been admitted to out-of-home care in Australia each year. Of the children who are already in out-of-home care, a certain proportion is also discharged from care each year. A substantial number of children still remain in care in Australia.

Table 26.2: Children aged 0–14 years in out-of-home care, 1997–2004

At 30 June	Number	Rate per 1,000 children
1997	11,595	3.0
1998	11,526	2.9
1999	12,976	3.3
2000	14,209	3.6
2001	15,396	3.9
2002	16,039	4.0
2003	17,479	4.4
2004	18,888	4.7

Source: AIHW 2005.

- There was an increase of 63% in the number of children aged 0–14 in out-of-home care, from 11,595 in June 1997 to 18,888 in June 2004 (Table 26.2).
- The rate of children aged 0–14 years in out-of-home care also increased between 1997 and 2004, from 3.0 per 1,000 children aged 0–14 years to 4.7.

Characteristics of children aged 0–14 years in out-of-home care

- In 2003–04, 96% of the children in out-of-home care were placed in home-based care including foster care and with relatives/kin. Only 3% of the children were placed in residential care.
- Just over half the children (52%) in out-of-home care were boys.
- At 30 June 2004, there were 3,713 Aboriginal and Torres Strait Islander children aged 0–14 years in out-of-home care. The rate of Indigenous children in out of-home care was over five times that of other Australian children: 20.4 per 1,000 Indigenous children compared with 4.0 per 1,000 for other Australian children.

Indicator

- **Rate of children aged 0–14 years in out-of-home care.**

27 Parents with disability or chronic illnesses

Children who live with a parent with a disability or a chronic illness are sometimes involved in caring for that parent. This can affect children's opportunities for participation in schooling and social activities. Depending on the severity, the wellbeing of children of parents with a disability or mental illness may be affected by such factors as family discord, discontinuity of care, poor general parental skills, social isolation and poverty arising from the parental health status (ABS 1999; AICAFMHA 2001). Children whose parents have a mental illness are likely to be genetically predisposed to mental illness, and are more likely to suffer major depression, to experience learning disabilities and perform poorly academically, and are susceptible to substance abuse (Lancaster 1999; Kowalenko et al. 2000).

Farrell et al. (1999) reported higher rates of emotional and behavioural problems among children who live with a parent with mental illness. An estimate of 25–50% of children whose parents suffer from a mental illness experience a psychological disorder during childhood, adolescence or adulthood, compared to 10–20% in the general population. Similarly, 10–14% of children with a parent with mental illness will be diagnosed with a psychotic illness at some point in their lives, compared to 1–2% in the general population.

What do the data show?

In general, most Australian children live with parents who are in good health. In 2002, according to the HILDA survey, 16% of children in couple families had either or both parents who perceived their health to be fair or poor. The proportion of children in lone parent families where the parent reported to be in fair or poor health was 12.1%.

In 1998, approximately 673,000 (17%) Australian children aged 0–14 years lived with a parent who had a disability. The ABS 1998 Survey of Disability, Ageing and Carers defined 'disability' as the presence of one or more of 17 limitations, restrictions or impairments which has lasted, or is likely to last, for at least 6 months and restrict everyday activities (e.g. loss of sight, incomplete use of arms or fingers, difficulty learning or understanding, etc) (ABS 1999).

'Children who live with a parent with a disability or a chronic illness are often involved in caring for their parent, which can affect children's opportunities for participation in schooling and social activities'

Table 27.1: Children living in families in which a parent had a disability, 1998 (per cent)

	Families in which a parent had a disability		Children living with a parent with a disability	
	Number	Per cent	Number	Per cent
Age of children (years)				
0–4	138,362	14.3	179,655	14.0
5–9	175,160	17.6	239,086	18.1
10–14	199,377	19.5	254,200	19.5
Total 0–14	366,765 ^(a)	17.2	672,942	17.2
Family type				
Couple families with children aged 0–14 years	299,483	17.6	560,698	17.4
Lone-parent families with children aged 0–14 years	67,282	15.6	112,243	16.4

(a) As families can have more than one child in any age group, this number does not add to the total.

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

- There were 366,765 families with children aged 0–14 years (17% of all families with children aged 0–14 years) in which at least one parent reported a disability in 1998.
- Of the 672,942 children aged 0–14 years who were living with a parent with a disability, 17% were living in couple families and 16% of children were living in lone-parent families. There was no difference between the proportions of children living with a parent with a disability in lone-father or lone-mother families (ABS 2000). However, reflecting the distribution of lone-father and lone-mother families in the general Australian population, fewer children lived with a lone-father with a disability than with a lone-mother with a disability (approximately 11,095 and 101,148 respectively).

Of all children aged 0–17 years, the proportion of children living in a family where both parents had a disability was about 2% (89,500), 7% (250,800) lived in a family where only the mother had a disability and 9% (356,400) lived in a family where only the father had a disability (ABS 2000).

Indicators

- **Proportion of parents rating their health as ‘fair’ or ‘poor’.**
- **Proportion of parents with a disability.**
- **Proportion of parents with a mental health problem.**

Type and severity of disability

Table 27.2: Proportion of children living with a parent with a disability, by type and severity of parent’s disability, 1998 (per cent)

Type and severity of disability	Per cent
Main disabling condition	
Physical condition ^(a)	90.5
Mental or behavioural disorder ^(b)	11.4
Severity of limitation	
Profound or severe	27.5
Moderate or mild	72.5
All children 0–14 (‘000)	672.9
<small>(a) Physical condition includes cancers, endocrine diseases, diseases of the nervous system, eye, ear, circulatory system, respiratory system, digestive system and musculoskeletal system, congenital disorders, injuries and other physical conditions.</small>	
<small>(b) Mental or behavioural disorder includes psychoses, neuroses, intellectual and developmental disorders, and other mental or behavioural disorders.</small>	
<small>Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.</small>	

- Of the children living with a parent with a disability in 1998, approximately 91% lived with a parent whose main disabling condition was a physical condition and about 11% with a parent whose main condition was mental or behavioural disorder.
- Approximately 73% of children lived with a parent whose disability was moderate or mild. A smaller proportion of children (28%) lived with a parent with a severe or profound limitation.

The proportion of children aged 0–17 years living in lone parent families with a parent suffering from a mental or behavioural disorder was substantially higher than the proportion living in couple families (17% and 10% respectively) (ABS 2000).

A relatively small number of young children (fewer than 5,500) took primary responsibility for caring for their parent(s). A greater proportion of children living with a parent with a disability provided care in the form of general household help (ABS 2000).

28 Neighbourhood safety

Neighbourhoods will affect children's lives differently depending on the level of advantage or disadvantage, the available resources, and the degree of social cohesion and safety that characterise the area. While other factors such as family characteristics and socioeconomic status are generally considered more important influences on children's overall health and wellbeing, there is growing evidence that neighbourhood influences can impact on children's physical and social development (Putnam 2000; Vinson 2004).

One neighbourhood factor that has been the subject of a wide variety of research relates to feelings of safety and fear of crime. It is widely understood that people should be protected from exposure to crime, particularly violent crime. Victims of violent crime may suffer serious injury, disability or death and, together with those who observe violence, are likely to experience psychological problems, such as post traumatic stress disorder. However, it is becoming increasingly clear that simply fearing the occurrence of these and other crimes is enough to experience a number of other poor outcomes.

Fear of crime

Fear of crime is typically measured in surveys by asking people how safe they feel in their neighbourhood when they are at home alone or on the streets at night and during the day. Whether well founded or not, fear of crime is a serious personal and community problem in that it detracts from people's quality of life and deters participation in the local community. In most cases, children and their families benefit greatly from actively participating in the social and cultural life of the area in which they live. However, people who perceive their neighbourhood as unsafe may be discouraged from accessing local services and recreational facilities and from creating social networks close to their homes.

Fear of crime and concerns about neighbourhood safety can impact on children's health in several ways. Firstly, there is evidence that people who perceive their neighbourhood as unsafe are less likely to engage in physical activity than other people (CDCP 1999). Parents living in areas perceived as unsafe may limit their children's physical activity by keeping them in the home and not allowing them to play outside or walk to school. Secondly, living with stress and anxiety associated with concerns about neighbourhood safety may directly impact on children's health (Ross & Mirowsky 2001).

The 2002 ABS General Social Survey (ABS 2002a) asked respondents to rate their feelings of safety in their neighbourhood. Data show that respondents from around 1 in 10 households with children indicated they felt unsafe in their neighbourhood at least some of the time (Table 28.1).

- The proportion of people in 2002 who felt unsafe both during the day and the night was highest for people in the lowest socioeconomic group (5.1%) and lowest for people in the highest socioeconomic group (0.7%). By contrast, the proportion of people who always felt safe was highest for people in the highest socioeconomic group (95.1%) and lowest for people in the lowest socioeconomic group (83.0%).
- People living in Major Cities were more likely to sometimes feel unsafe (8.3%) than people in Inner Regional areas (6.5%) and people in Outer Regional and Remote areas (5.6%).

'There is growing evidence that neighbourhood influences can impact on children's physical and social development'

Table 28.1: Adults living in households with children aged 14 years or less where neighbourhood is perceived as unsafe, by socioeconomic position and remoteness, 2002 (per cent)

	Always feels unsafe	Sometimes feels unsafe	Always feels safe
Socioeconomic disadvantage			
Lowest 20% (most disadvantaged)	5.1	12.0	83.0
Quintile 2	1.9	9.8	88.3
Quintile 3	1.8	6.0	92.2
Quintile 4	2.0	7.7	90.3
Highest 20% (least disadvantaged)	0.7	4.2	95.1
Remoteness			
Major Cities	2.2	8.3	89.5
Inner Regional	1.2	6.5	92.3
Outer Regional and Remote areas	3.3	5.6	91.1
Australia	2.1	7.6	90.3

Source: AIHW analysis of ABS GSS CURF data, 2002.

Poverty

People with lower incomes generally have a higher fear of crime than wealthier people (AIC: Grabosky 1995). It is well known that crime rates are higher in more disadvantaged neighbourhoods and this is likely to contribute to high levels of fear of crime among poorer people. However, the higher fear of crime among low-income people could also be related to physical and social aspects of the neighbourhoods in which many disadvantage people live. Research has found that features of the physical and social environment which indicate disorder or incivility will increase people's fear of crime (AIC: Grabosky 1995). Many of these signs of disorder and incivility, such as disrepair, rubbish, vandalism, gatherings of young males and public drinking, are more common in disadvantaged neighbourhoods.

The 2002–03 Household and Income Labour Dynamics Survey asked people how common particular signs of disorder were in their neighbourhood. Among parents living with children aged 14 years or less, signs of neighbourhood disorder were generally most common for people with the lowest socioeconomic status and least common for people with the highest socioeconomic status (Table 28.2).

Table 28.2: Parents reporting common signs of disorder in their neighbourhood, by socioeconomic position, 2002 (per cent)

Socioeconomic disadvantage	Homes and gardens in bad condition	Rubbish in streets	Teenagers hanging around	People being hostile and aggressive	Vandalism and theft	Burglary
Lowest 20% (most disadvantaged)	14.1	11.8	26.1	10.0	18.2	21.5
Quintile 2	13.1	8.5	22.6	6.5	13.0	15.6
Quintile 3	10.1	8.4	22.1	6.8	12.6	16.8
Quintile 4	6.4	7.8	14.1	3.6	9.4	13.4
Highest 20% (least disadvantaged)	4.9	4.3	14.0	2.1	8.3	16.6

Source: AIHW analysis of wave 2 HILDA data.

The impact of crime-prone neighbourhoods on children

The effect of merely living in a crime-prone neighbourhood as opposed to being a direct victim of crime is difficult to measure. Many of the negative outcomes associated with living in crime-prone neighbourhoods may also be the result of other factors commonly associated with high crime areas, such as poverty, unemployment and marginalisation.

Recent research has sought to find a direct link between living in a crime prone area and outcomes for children. This research has found that children living in neighbourhoods with high crime rates are significantly more likely to display behavioural or academic problems at school, to experience mental health problems and to become involved in crime themselves (AIC: Weatherburn & Lind 1998; Meyers & Miller 2004). However, this research also found that factors such as good parenting were effective in diminishing or eliminating neighbourhood influences.

Community factors can also be important in building resilience in children. Criminological research broadly supports the notion that crime rates are generally lower in socially cohesive communities and higher in socially disorganised neighbourhoods. Studies have found that social trust and neighbourhood cohesion can help break the link between economic disadvantage and delinquency (Putnam 2000).

Indicator

- Proportion of households with children aged 0–14 years where neighbourhood is perceived as unsafe.

29 Social capital

Research indicates that child development is powerfully shaped by social capital. Trust, networks, and norms of reciprocity within a child's family, school, peer group, and larger community have far reaching effects on their opportunities and choices, and hence on their behaviour and development (Putnam 2000). Children living in communities that have high levels of social capital can benefit from the positive spin-offs of community cohesion. These include: children growing up in relatively safe, low crime neighbourhoods; children being positively influenced by high trust, cooperative relationships in their surroundings; and children growing up in well-resourced areas, relatively free from poverty (Stone 2003). Braatz and Putnam (1996) and Francis et al. (1998) state that when parents and citizens become actively involved in schools students perform better, teachers become more committed, and parents and citizens take a keener interest in children's educational wellbeing (World Bank 1999).

Definitions of social capital and social cohesion

'Social capital refers to connections among individuals—social networks and the norms of reciprocity and trustworthiness that arise from them. In that sense social capital is closely related to what some have called "civic virtue." The difference is that "social capital" calls attention to the fact that civic virtue is most powerful when embedded in a sense network of reciprocal social relations. A society of many virtuous but isolated individuals is not necessarily rich in social capital' (Putnam 2000:19).

'Social cohesion can be described as the connections and relations between societal units such as individuals, groups (and) associations' (Berger-Schmitt 2002:2, following McCracken 1998). Embedded within this concept are feelings and attitudes such as shared values, trust, and a sense of belonging which shape and moderate these connections and relations (cited in AIHW 2003d:46).

'People living in disadvantaged areas where social cohesion is high cope better than those from equivalent areas where social cohesion is lower'

Different studies have used varying indicators to measure social capital. Due to data deficiencies, measures of social capital used in this section are limited to ‘social and support networks’ which Vinson (2004) defines as an element of social cohesion. Vinson prefers the term social cohesion to social capital as he believes that ‘social cohesion subsumes some of the most important elements of “social capital”’. The main indicator of a support network is the access to social support in times of crisis. Additional information on the ability of families to ask for small favours and having regular contact with family and friends will also be included.

Access to social support is suggested to have a positive impact on health (Baum et al. 2000) and to buffer stress (Cassel 1976). Findings by Vinson (2004) and Putnam (2000) also indicate that people living in disadvantaged areas where social cohesion is high cope better than those from equivalent areas where social cohesion is lower. The amount and frequency of contact with family and friends may indicate the strength of a social network as these are the people that one will turn to in time of need for care and support.

ABS 2002 General Social Survey (GSS) data on various measures of social and support networks by family characteristics (family type, region of residence, employment status and number of people employed) are given in Table 29.1.

Table 29.1: Adults living in one-family households with children aged 14 years or less who had social support, by household type, 2002 (per cent)

Household characteristics	Able to get support in time of crisis	Could ask for small favours	Has weekly contact with family and friends
Family type			
Couple family	95.2	95.1	96.3
Lone parent family	94.7	90.9	95.6
Region of residence			
Major Cities	95.2	94.0	96.6
Inner Regional	95.8	95.4	95.2
Outer Regional and Remote	93.9	96.5	95.7
Employment status			
Employed	96.4	96.4	96.7
Unemployed	90.7	91.3	95.6
Not in labour force	92.1	89.4	94.6
Number employed in household			
None	88.4	86.0	92.0
One	94.2	93.5	96.9
Two or more	96.9	96.7	96.6

Source: AIHW analysis of 2002 GSS RADL.

Access to social capital

- Most Australian families with children in 2002 were able to access social support in times of crisis.
- For many families with young children it is important to maintain a strong link with their families, friends, neighbours and community to whom they can turn when in need for support. This support can come in many forms: being able to get help in times of crisis; asking for small favours like taking a child to school; being able to talk things over or seek advice.
- Regardless of family type, those with children aged 0–14 years had support available to them during a crisis.
- Compared to those living in Major Cities and Inner Regional areas, those with children living in Outer Regional and Remote areas had less support available in a crisis.
- Being in the labour force and having one or more people in employment made it more possible for those with children to get support during a crisis.
- Couple families and those in employment had regular contacts with family & friends and were in a better position to ask for small favours.
- Couple families with children aged 14 years or less were in a better position to ask for small favours than were lone parent families with children of the same age. Both family types with children had regular contacts with family and friends.
- Place of residence had virtually no impact on the ability of people to have regular contact with family and friends but living in Major Cities made it difficult to ask for small favours.

Indicator

- **Proportion of households with children under 15 years of age where respondent was able to get support in time of crisis from persons living outside the household.**