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3.1 The role of the family in child wellbeing

The first years of a child's life provide lifelong foundations for health, development and wellbeing. Healthy development requires that children grow and learn in supportive and nurturing families and environments. A child's brain and biological development begins before birth and continues well into adolescence. Children who have a poor start in life are more likely than others to develop problems with health, development, learning and behaviours. These problems may have a cumulative effect over the life course, which can affect capacity to fully participate in society, resulting in increased inequality in social status or social opportunity, reduced labour force participation and entrenched intergenerational disadvantage (National Scientific Council on the Developing Child 2005/2014).

Social determinants, including living conditions and the sociodemographic characteristics of the family, play a critical role in a child's health, wellbeing and learning across the life course, as do factors such as maternal health, quality of parenting, interpersonal relationships, and learning environments (Maggi et al. 2010).

A number of wellbeing indicator frameworks exist both nationally and internationally. An overview of Australian frameworks and indicators that relate to children can be found in the *Mapping of children and youth indicator reporting frameworks* (AIHW 2014e); however, there is no current equivalent framework that specifically focuses on child wellbeing. This article therefore focuses on selected aspects such as the important role of the family in child development and wellbeing, including family functioning, quality of parenting and the effect of jobless families. We also examine the effects of maternal health, as well as safety, recreation and leisure perspectives.

Policy context

Over recent years a key focus for governments, particularly through the Council of Australian Governments (COAG), has been to increase future human capital and workforce participation by ensuring that children have the best possible start in life through measures such as access to quality early childhood education and opportunities to live in healthy, supportive and safe environments.

Accordingly, COAG's *National Early Childhood Development Strategy, investing in the early years* is aimed at ensuring that by 2020 'all children have the best start in life to create a better future for themselves and for the nation' (COAG 2009). An Early Childhood Development Outcomes Framework, focusing on children aged 0–8 years, was established as part of the Strategy (AIHW 2011b). Reporting against the Framework informs COAG of progress against the Strategy, although reporting has not begun as yet.

In addition, the *National Framework for Protecting Australia's Children 2009–2020* (DSS 2009), is a collaborative approach by all levels of government to ensure the safety and wellbeing of Australia's children. This Framework aims to deliver substantial and sustained reductions in levels of child abuse and neglect (see also Chapter 3 'Child protection in Australia').



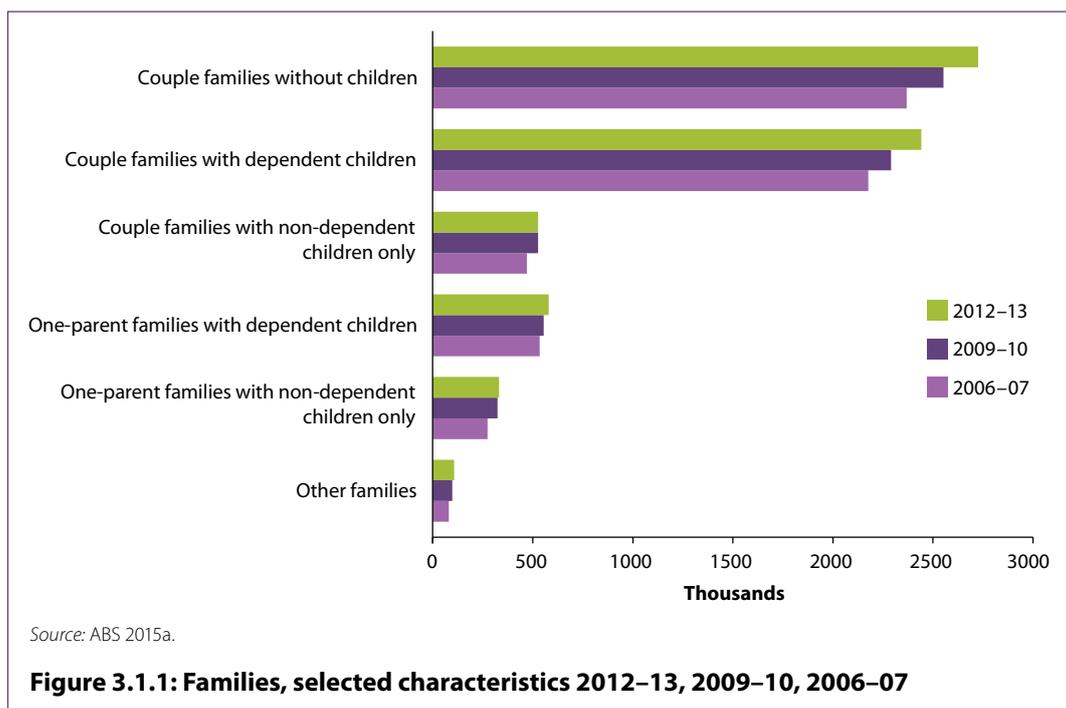
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Families with children

Research has long recognised that families are a child's single most important environment in terms of influence on development (Garbarino 1992), with family relationships and interactions being critically important (Bowes et al. 2009). Consequently, family functioning, quality parenting, and access to social and family supports all contribute strongly to optimal health and wellbeing.

There were an estimated 8.9 million households in Australia in 2012–13. Family households comprised 6.7 million of these households. Family households are dwellings where the occupants are: couples with or without children of any age; lone parents with children of any age; or other types of families such as related adults who live together, for example, adult brothers and sisters. (See Figure 3.1.1.)

The proportion of couple families with dependent children of any age has remained relatively unchanged since 2006, at 36% of all family households (2.4 million households in 2012–13). Lone-person households represent 2.1 million households out of 2.3 million non-family households (ABS 2015a).



There were 2.8 million families with children aged 0–17 years in 2012–13. Intact families with children aged 0–17 years comprised 2.0 million of these family households, with step and blended families accounting for a further 179,000, and lone-parent families 539,000 (ABS 2015a).



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Family functioning

Family functioning relates to the strength and quality of family relationships and the family's ability to nurture, care and provide for one another (PM&C 2009). The quality of family functioning is fundamentally important to societal health and resilience. Conditions that determine the quality of family functioning include: adequate housing; access to social services and support; parenting skills; secure parental employment; financial security; time spent with, and communication between, family members; connection with the community; and family conflict and violence. Families facing adversities in these areas are likely to experience levels of dysfunction that will have health, behavioural and social repercussions for young family members, and poorer outcomes for them later in life (Olesen et al. 2010).

Measuring family functioning is a complex task because it is multi-dimensional in nature and changeable in times of distress. The Positive Family Functioning (PFF) project undertaken by Access Economics (2010) set out themes of family functioning derived from the literature, and, in consultation with an expert reference group, estimated the economic outcomes of positive family functioning.

The themes of family functioning specified were: *emotional*—parent–child relationships, perceived parental and family support; *governance*—rules, expectations and consistency; *engagement and cognitive development*—reading and verbal engagement, quality time fostering the development of educational language and interaction skills; *physical health*—healthy/unhealthy physical activities or environments; *intra-familial relationships*—quality of relationships among all members of the family; and *social connectivity*—involvement of parents and children in activities outside of the family unit.

Several intervention programs to assist family functioning during childhood and adolescence were evaluated as part of the PFF project. The return on investment was estimated to be in the order of \$5.4 billion per annum. The greatest impact occurred when intervention programs were specifically targeted at children, with results including: fewer instances of anxiety and depression; lower rates of criminality; lower rates of addiction and antisocial behaviour; and reductions obesity rates. Productivity gains and savings were also listed as intervention program results (Access Economics 2010).

Evidence suggests that early intervention can have a positive impact on child development and associated life outcomes. For more information on early intervention, see Box 3.1.1.



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Box 3.1.1: Early intervention

Adverse experiences in childhood, including poverty, child abuse and neglect, family violence, parental substance use, early mental health problems, poor health and nutrition, and growing up in a family dependent on welfare, have a negative impact on the social and cognitive development of children, with lasting health and welfare impacts in adulthood (Effective Philanthropy 2014; Heflin & Acevedo 2011; Felitti et al. 1998). Developmental vulnerabilities are evident by the time a child starts school, and are associated with lower educational achievement, increased likelihood of teenage pregnancy, mental health problems, getting into trouble with the law, and poorer job outcomes.

The older a child gets, the more difficult it is for them to catch up to their less disadvantaged peers, and interventions become more costly and less effective (Ramsey & Ramey 1998). Examples of early intervention include those focused on: the child's cognitive, language and social development; parenting knowledge and skills; social support; and the promotion of safe and supportive families and communities. Investing in Australia's children through early intervention policies, strategies and programs provides support to children and their families, tackles problems before they become entrenched and increases the chances of better future outcomes for the child.

Child development

Early childhood is a critical stage in a child's development and is shaped through their ongoing interactions and relationships with their immediate environment (family) and wider social environments (community) (Dunlop 2002). A child's environment is influenced by early learning, and relationships with parents and between parents. Parental involvement can produce positive outcomes in child development through engagement (in terms of the time a parent spends directly engaging with the child in home learning activities such as reading or playing) and accessibility (the time a parent is available to the child) (Wise 2003). The extent of home learning activities has been found to have a greater influence on educational attainment than parents' education and socioeconomic status (Melhuish et al. 2008). A positive home learning environment has also been associated with higher intellectual and social/behavioural scores (Sylva et al. 2004).

Benefits of early intervention

Early interventions in early childhood are programs delivered to improve child health and development that may focus on the prevention of problems or preventing the progression of problems that have already surfaced (Wise et al. 2005). Early intervention aimed specifically at disadvantaged and vulnerable children and families has been shown to positively influence children into adolescence and adulthood (Nelson et al. 2012; Schweinhart et al. 2011). Early intervention can therefore be cost-effective in negating the effects of disadvantage, thereby generating social and economic benefits (London School of Economics 2007).

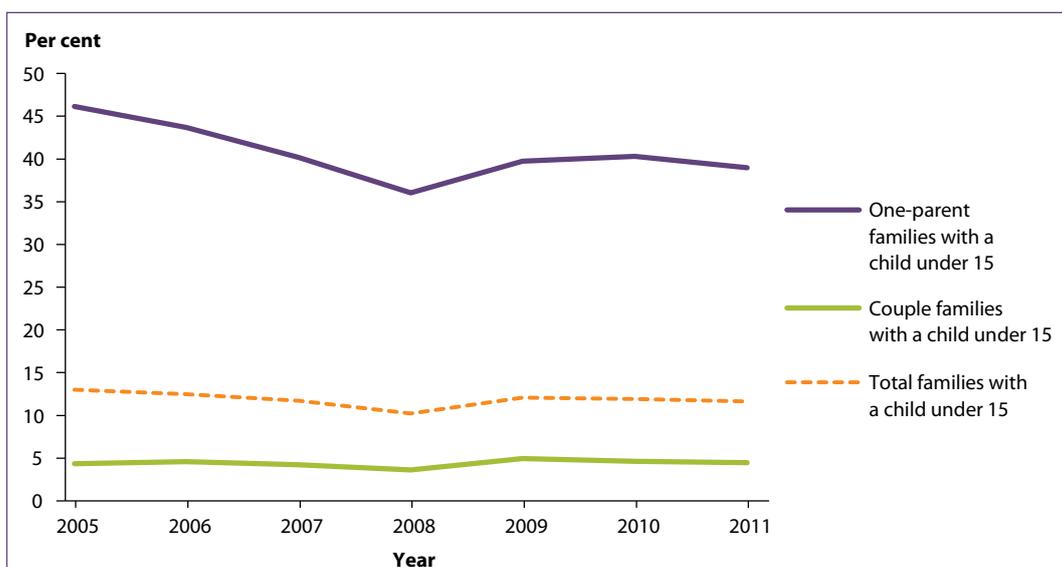
These benefits can come from reduced contact with the juvenile and adult justice systems, reduced notifications of child abuse and neglect, and improved educational and employment outcomes (Moore & McDonald 2013). The younger a child receives support, the greater and longer-lasting the benefits are likely to be (Heckman 2008; Lee et al. 2012). Heckman (2008) argues that for there to be a maximum return on investment, the optimum age for a child to receive support is between 0 and 3 years, and that this must be followed up to be effective.



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Jobless families

Evidence suggests that children in long-term jobless families are disadvantaged in areas of education, housing, social status, economic engagement and health. Such disadvantages can compound from childhood into adulthood and result in 'diminished life chances' over the whole life course (Kalil 2009). Jobless families are families where no person over 15 is employed and/or not in the workforce (ABS 2013c). It is important to note that joblessness includes those who are unable to work for various reasons (Figure 3.1.2).



Source: ABS 2013c.

Figure 3.1.2: Jobless families with a child aged under 15, by family type, 2005 to 2012 (as a proportion of all families with a child aged under 15)

According to the Organisation for Economic Co-operation and Development (OECD), Australia has the fifth-highest proportion of jobless families among OECD member countries at 14.8% (compared with the international average of 8.9%) (OECD 2015). In 2012, there were 1.3 million families that were jobless; of these, 80,000 were couple families with one or more children under 15, and 197,000 were lone-parent families with one or more children under 15 (ABS 2013c).



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Quality of parenting

Social and economic circumstances that affect families and family functioning can also have an effect on quality of parenting. A study by Zubrick and others (2008) used data from the Longitudinal Survey of Australian Children to explore the extent to which family circumstances, stress, support and family relationships are associated with parenting practices across infant and child cohorts, and found:

- higher parenting hostility, as described by characteristics including being angry, raising one's voice and losing one's temper with their child, is associated with higher levels of psychological distress in the primary carer (usually mothers)
- perceived lack of reciprocal support for parenting, and lack of relationship satisfaction, as reported by secondary carers (usually fathers), were associated with lower parental warmth
- parenting practices such as warmth, hostility and consistency, as displayed in interactions between the parent and child, were found to affect child development.

Another way in which parents can influence their children's development is through involvement in their early learning. Children whose parents are involved with their early learning and development have significantly better outcomes, including increased educational engagement and achievements, than children whose parents are not involved. The 2014 Australian Bureau of Statistics (ABS) Childhood Education and Care survey found that for children aged 0–2, 80% were likely to have some parental involvement in informal learning such as reading to a child or telling a story. About 56% of couple families and 57% of lone-parent families were likely to do this 7 days a week (ABS 2015b).

Impact of maternal health

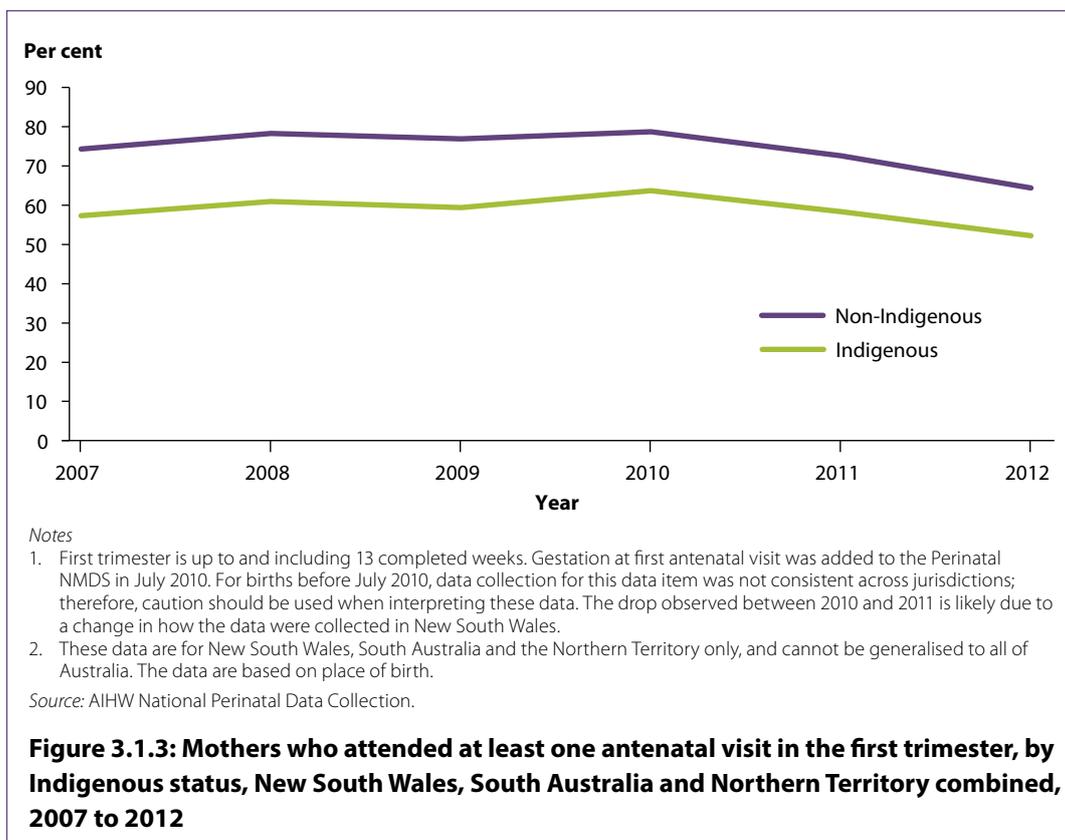
There is much evidence that the lifestyles of pregnant women have a significant effect on the developing fetus. Maternal stress, nutrition, and uptake of risk behaviours during pregnancy are critical factors in determining fetal health and birthweight. Babies born with low birthweights are more likely to have subsequent adverse health outcomes during childhood and into adulthood. Poor maternal nutrition is associated with socioeconomic factors such as family poverty, parental education and unemployment. It can also lead to maternal obesity (Maggi et al. 2010).

Regular antenatal care provides prenatal education and monitoring of the health of the unborn child. A strong relationship exists between regular antenatal care and positive child health outcomes. Women who commence antenatal care in the first trimester tend to be healthier throughout their pregnancies and as a result have healthier babies with higher birthweights (AIHW 2014a). The Australian National Antenatal Care Guidelines suggest that for a woman's first pregnancy without complications, a schedule of 10 visits should be adequate (AHMAC 2012).

In Australia, almost all pregnant women (95%) have at least 5 or more antenatal visits. A smaller proportion of pregnant Indigenous women (83%) attend 5 or more antenatal visits (AIHW 2014a). Antenatal visits are most likely to begin in the first trimester of pregnancy, with 74% of non-Indigenous mothers and 52% of Indigenous mothers attending their first antenatal appointment before 14 completed weeks' gestation (Figure 3.1.3). Nearly all mothers, Indigenous (97%) and non-Indigenous (99%) have at least one antenatal consultation during their pregnancy (AIHW 2013a).



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Substance use in pregnancy

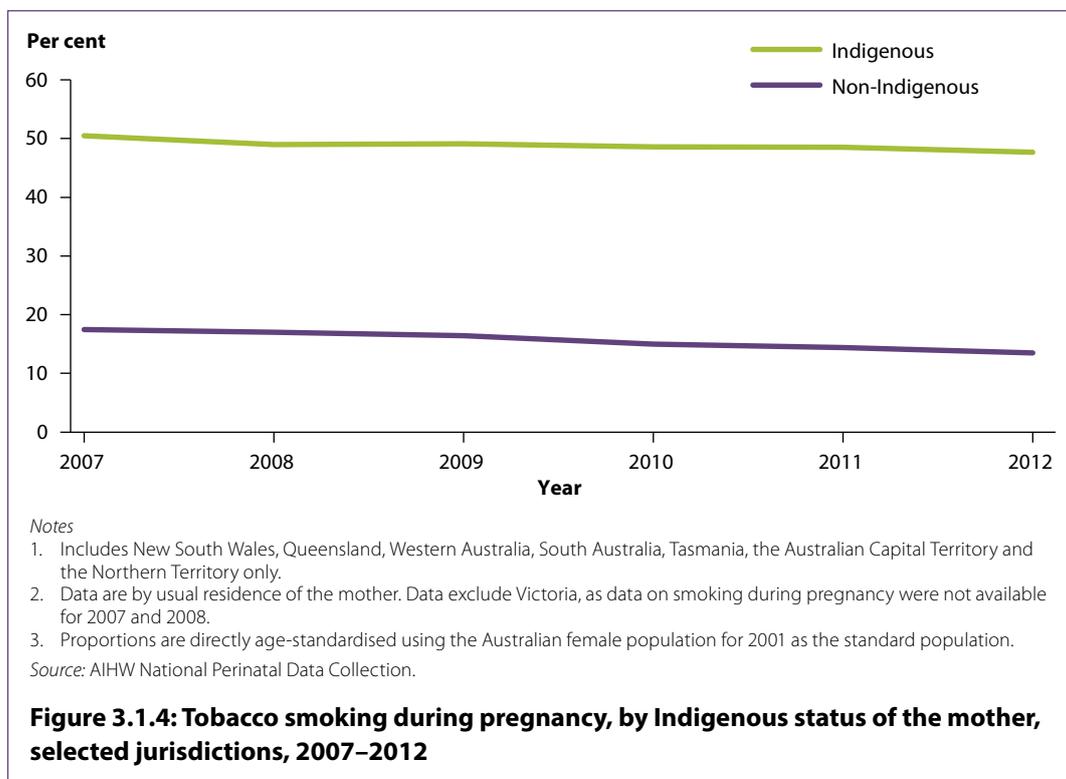
Tobacco

Smoking tobacco during pregnancy exposes the woman and her unborn child to an increased risk of health problems such as miscarriage, low birthweight, premature labour and perinatal death. It is the most common preventable risk factor during pregnancy (Li et al. 2013).

The proportion of women who smoke during their pregnancy continues to fall, but the proportion of Indigenous women who smoke during pregnancy remains at just under 50%. Over the period 2007–2012, the proportion of non-Indigenous mothers who smoked declined from 16% to 14%, while during the same period, the proportion of Indigenous mothers smoking declined only marginally (Figure 3.1.4).



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Alcohol

Alcohol use by pregnant women is another important avoidable risk factor. Alcohol use in pregnancy has negative effects on fetal growth and development during pregnancy, as well as on the wellbeing of the child, in both the short and long terms (AIHW 2011a). Results from the 2013 National Drug Strategy Household Survey show there was an overall decline in the quantity and frequency of alcohol consumption during pregnancy and during breastfeeding from 2007 to 2013 (AIHW 2014d) (see Table 3.1.1).

Table 3.1.1: Drinking alcohol while pregnant or while breastfeeding, women aged 14–49, 2007, 2010, 2013 (per cent)

Drinking alcohol while pregnant	While pregnant ^(a)			While breastfeeding ^(b)		
	2007	2010	2013	2007	2010	2013
More	0.6	**0.4	**<0.1	0.2	**0.1	*1.2
Less	56.6	48.9	46.0	70.1	62.3	59.5
Same amount	2.8	*2.0	*1.2	4.5	3.5	2.7
Don't drink alcohol	40.0	48.7	52.8	25.0	34.1	36.7

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

(a) Base is only pregnant women, or women pregnant and breastfeeding.

(b) Base is women who were only breastfeeding, or pregnant and breastfeeding.

Source: 2013 National Drug Strategy Household Survey.



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Fetal exposure to alcohol is strongly associated with developmental anomalies in unborn children that result in neurological malformations of the brain, and cognitive and behavioural problems—collectively known as Fetal Alcohol Spectrum Disorder (FASD) (Burns et al. 2009). There is some evidence to suggest that the different developmental symptoms associated with FASD correspond to alcohol consumption in different stages of pregnancy. Alcohol use during the first trimester is associated with the onset of FASD, while alcohol use in later pregnancy is associated with cognitive and behavioural problems (Coyne et al. 2008). The associated intellectual and emotional impairments are lifelong and can be profound.

Impact of maternal mental health

Mental health issues affecting pregnant women, such as depression, anxiety and related disorders, can also affect the wellbeing of the baby during pregnancy (Beck 1998; Halligan et al. 2007). Data from the 2010 Australian National Infant Feeding Survey show that 1 in 5 mothers of children aged 24 months or less in 2010 had been diagnosed with depression, and more than one-half of these mothers reported that their depression was perinatal (AIHW 2012a). In Australia, suicide is a leading cause of indirect maternal mortality (AIHW: Johnson et al. 2014). However, the maternal mortality rate for psychosocial morbidity dropped between 2003 and 2010, from 1.2 deaths per 100,000 women to 0.9 deaths per 100,000 women (AIHW: Johnson et al. 2014).

Screening for perinatal depression has been conducted in maternity clinical settings in all jurisdictions in recent years, but very little data exist on screening rates or outcomes at regional or national levels. Postpartum depression (also called postnatal depression) is a common illness suffered by women up to 4 years after giving birth, and it can have long-term negative effects on the child's 'health and social, emotional, cognitive and physical development' (Field 2009; Brown & Woolhouse 2014).

Other factors affecting children's wellbeing

Health

Good health is a crucial element in a child's quality of life and influences participation in many aspects of life, including schooling and recreation activities. Table 3.1.2 summarises key aspects of child health that are reported in detail in other AIHW publications, such as *A picture of Australia's children 2012*, *Children's headline indicators* and *Australia's health 2014*.

Australian infant and child mortality rates fell significantly between 1989 and 2013, with decreases of 56% and 55% respectively. Asthma prevalence among children also fell between 2001 and 2007–08, but then stabilised at 9% in 2011–12. Conversely, rates of overweight and obesity increased between 1995 and 2007–08 (from 21% to 25%) for children aged 5–17, and then remained stable to 2011–12 (26%) (ABS 2013c). However, for most of the indicators in Table 3.1.2, there was either no statistically significant change over time or no clear trend. Trend data for exclusive breastfeeding are not available.

Australia's performance compared with other OECD countries varies across the areas of health that have internationally comparable data available. Australia's results are better than the OECD average for low birthweight, infant mortality, dental health, and overweight and obesity (boys), and are worse than the OECD average for diabetes, cancer, immunisation and overweight and obesity (girls).



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Table 3.1.2: Overview of the health of Australian children

Health topic		Year	Value	Trend	OECD ranking (year)
Birthweight	Live born infants of low birthweight (<2,500g)	2012	6.2%	~	14th out of 34 (2011)
Breastfeeding	Infants exclusively breastfed until around 4 months of age	2010	39.2%	..	Not available
Mortality	Mortality of infants less than 1 year of age	2013	3.6 per 1,000 live births	✓	14th out of 34 (2012)
	Deaths of children aged 1–14	2013	12 per 100,000 population	✓	Not available
Morbidity	Prevalence of asthma among children 0–14	2011–12	9.3%	~	Not available
	New cases of Type 1 diabetes among children 0–14	2011	23 per 100,000 population	~	25th out of 30 (2011)
	New cases of cancer among children 0–14	2006–2010	15 per 100,000 population	~	21st out of 33 (2012) ^(a)
Disability	Prevalence of severe or profound core activity limitation among children	2012	2.5% (0–4 years)	~	Not available
			4.8% (5–14 years)	~	
Dental health	Mean number of decayed, missing or filled teeth at 12 years	2010	1.3	~	9th out of 18 (2008–2012)
Overweight and obesity^(b)	Proportion of children aged 5–17 who are overweight or obese	2011–12	25.7%	~	17th out of 34 (boys) ^(c) 24th out of 34 (girls) ^(c)
Immunisation	Fully immunised children at 2 years of age	Sept 2014	92.4%	~	25th out of 34 (2013) ^(d)

(a) Based on estimated incidence of all cancers excluding non-melanoma skin cancer.

(b) Based on measured height and weight.

(c) Based on data from various years and ages.

(d) Data are an average of the proportion of children immunised at age 1 against diphtheria, tetanus, and pertussis (DTP) (3 doses); measles (1 dose); polio (3 doses) and Haemophilus influenzae type b (Hib) (3 doses). Data for some countries exclude Hib. Results are affected by the policies of different countries, such as compulsory vaccination.

Note: The year of data used for OECD rankings is based on the latest year of data available for the majority of countries. Data for some countries may be for earlier years.

Key: ✓ = favourable trend; ~ = no change or clear trend; .. = no trend data available.

Sources: ABS 2013a, 2013b, 2014a, 2014b; AIHW 2012b, 2014b, 2014c, 2015; OECD 2013, 2014; WHO IARC 2014.



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Safety

Family environments are strongly associated with children's social and emotional wellbeing, and in Australia most families provide safe and supportive environments in which children can thrive and develop. In some instances children are not able to be kept safe, and in the worst cases can suffer abuse or neglect (Mullan & Higgens 2014). In Australia, statutory systems protect children against abuse and neglect. (For more information, see Chapter 3 'Child protection in Australia' and Chapter 4 'Vulnerable young people')

In 2011–12, there were 60,129 hospitalisations due to injury and poisoning for children aged 0 to 14 in Australia. Rates of injury requiring hospitalisation among Indigenous children were around 1.5 times the rate among non-Indigenous children, for every age range from infancy up to 10–14 years. The home was the place of injury for 60% of infants aged less than 12 months, but only for 11.5% of early adolescents aged 10–14. Injuries taking place at school increased with age, from 4.9% for children aged 1–4 to 15.9% for children aged 5–9. For children aged 10–14, the predominant place of injury was at sports events (17.4%) followed by school (12.5%) (AIHW & Pointer 2014).

The most common cause of injury for all children was falls (almost 50% for infants aged less than 12 months, 54% for children aged 5–9 years, and over 40% for children aged 1–4 and 10–14). Intentional injury was highest for infants (5.5% of all causes of injury for this age group) (AIHW & Pointer 2014).

Recreation and leisure

Participation in cultural, sporting and other leisure activities is considered important for children's emotional, physical, social and intellectual development. In 2012, nearly three-quarters (72%) of all children aged 5–14 had participated in organised sport, and/or selected cultural activities, outside of school hours, in the 12 months prior to being surveyed. Six in 10 children (60%) had played organised sport, 71% had attended a cultural venue or event such as a public library or performing arts event, and around one-third (35%) were involved in at least one cultural activity, such as playing a musical instrument, dancing, singing, drama, or art and craft. Participation rates for attendance at cultural venues or events were similar in 2006 (ABS 2012).

Certain groups of children were more likely to participate in either sport or cultural activities, or both. Children born in Australia (73%) or other English-speaking countries (75%) had higher participation rates than those born elsewhere (53%). Children were also more likely to participate if they lived in couple families (76%) than in one-parent families (60%), and in families where at least one parent was employed (77%) than in those where no parent was employed (44%) (ABS 2012).

What is missing from the picture?

Currently no data collection exists within antenatal care services for incidence of maternal mental health, depression and anxiety. Nationally consistent data are needed to describe and monitor these conditions.

Comparable trend data at the national level are not currently available for exclusive breastfeeding (breastfeeding with no supplementary feeding). This information may become available in future ABS health surveys.

Current international data are not available for several key indicators of children's health, including exclusive breastfeeding, child deaths (aged 1–14), asthma and disability.



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Where do I go for more information?

More information about the wellbeing of Australia's children is available at www.aihw.gov.au/child-health-development-and-wellbeing.

Further information on key national indicators of children's health, development and wellbeing can be found in the report [A picture of Australia's children 2012](#).

The report [Hospitalised injury in children and young people 2011–12](#) is available for free download and provides more information on injuries among children.

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