Australian Institute of Family Studies

We are Australia’s leading family wellbeing research body. Our work increases understanding about the factors that help Australian families thrive, or that are barriers to their wellbeing. We produce research about ‘what works for families’ and make it accessible to decision makers, researchers, practitioners and the general public.

We were established by the Australian Government in February 1980 under the Family Law Act, 1975.

Previous Issues of Family Matters:

Debra Sutton (Family Matters 99)
Chasing the Sun
Acrylic on canvas 76 cm x 76 cm
Courtesy of the artist
<www.debrasuttonart.com>

Shan Richards (Family Matters 98)
Waterfall Window
Acrylic on canvas 30 cm x 30 cm
Courtesy of the artist
<www.shanrichards.com.au>

Ronald Brown (Family Matters 97)
On Parade
Mixed media on canvas 120 x 90 cm
Courtesy of the artist
View Ron’s work at Gallery 247
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“No, not that one—use the other baking dish.” On the crowded 5.50 pm train from Flinders St to Melbourne’s eastern suburbs, she was on her phone giving instructions to a child at home about putting something in the oven. Forty-something and dressed for the office, this mother was just one of tens of thousands heading home across Australia.

Glued to smartphones on commuter trains and buses or stuck in peak hour traffic, working mothers were making the transition from work to home. The bridge between these two worlds—the “commute”—is increasingly blurred by digital technology but this transition still requires a psychological pivot from who we are at work to who we will be at home. For most this contemporary work-to-home transition is just a part of daily life, as ordinary as brushing your teeth.

The scene on the 5.50 pm commuter train would have been different in 1980 when the first edition of Family Matters was published. Back then, 50% of mothers whose youngest child was aged 5–9 years were in the workforce (1981), compared with 71% in 2016.1 This was before the internet and digital technology had become ubiquitous. The boundary between work/school and home was less porous.

Many challenges are faced by families today as they manage their daily lives and relationships in increasingly disrupted times. Families are facing changes to work and the economy, the ageing of the population, cost of living increases—especially housing and energy—and arguably higher expectations of quality of life.

While a great deal has changed all around us, attitudes and behaviours within families have changed relatively little, with the burden of caring responsibilities still strongly skewed towards women.2 This “stickiness” of responsibilities at home being allocated along gender lines has been the cause of some puzzlement. Is this long-term stability in how families arrange themselves a strength, especially in times of uncertainty, or is it evidence of an unwillingness to adapt that may prove to be a weakness?

In a recent media interview I was asked the question: “Is it us or is it the system?” One of the better questions I have fielded over the years, this generated some reflection about how we are approaching the complex social problems of our time.

The intersection between the individual and the “system” has long been the focus of ideological battles as evidenced in this landmark 100th edition of Family Matters.

At the Australian Institute of Family Studies (AIFS) we see the individual within dynamic family systems as well as the broader social systems and structural context. We seek to understand “what matters most” to individuals and families, and what helps or hinders their wellbeing, in order to identify through research the policy levers and service design elements that can make a positive difference.

Policy and service systems fail when they do not tap in to the interests and motivations of those they are seeking to help. In order for policy and services to be more “human-centred” we require intelligent co-design and the opening up of the traditional barriers between real people and the policy and service designers and deliverers seeking to help them.

In the past year we saw the completion of two royal commissions: the Royal Commission into Institutional Responses to Child Sexual Abuse and the Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory. Their recommendations present major challenges and opportunities for system reforms.

We have recently seen acknowledgement of the failure of the 10-year Closing the Gap initiative and a decision to review and “refresh” the targets. Australia is also building the Fourth Plan of the National Framework for Protecting Australia’s Children (2009–2020) in an environment of increasing numbers of children in out-of-home care, especially Aboriginal and Torres Strait Islander children.

Late last year we saw the national survey on marriage legislation and the subsequent votes in both Houses of Parliament. This issue brought something very private into the public gaze, ultimately seeing tears, applause and even impromptu singing in the House of Representatives. This was an exceptional moment in the history of social policy reform.

The preceding period of public debate on the marriage legislation also saw some advocates claiming the territory of so-called “family values” and others arguing the importance

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1 Baxter, J. Unpublished analysis of census data.
of “individual rights”. This was a new version of an old debate, which has been repeated many times since the first edition of Family Matters in 1980. The concept of the “family” carries many contradictions and values assigned by each of us. These contradictions find themselves reflected in our policy and services—with comparatively less critical analysis evident here than elsewhere, such as in the UK.

At the time of writing, the disruptive international #MeToo movement continues to generate public and private reflection on sexual harassment and assault experienced by women and may be a sign of changing social norms. And the Australian Law Reform Commission review of the family law system has just released an issues paper. Both will have an impact on families.

This 100th edition of Family Matters contains histories of family policy as seen through the eyes of some of the Institute’s former leaders. These accounts of the past 37 years remind us that progress in this area of social policy is uneven and often fiercely contested. Much remains unsolved in our efforts to address complex social problems. The family, despite diverse views, remains at the heart of all of this. But we are yet to find a way of engaging effectively with this complex and dynamic human system with its many moving parts.

The relationships within a family system provide the scaffolding for the development and wellbeing of family members. Yet our policy and services tend to focus attention on individuals rather than these critical relationships. The failure to employ a systemic lens over family relationships leads to fragmented policy responses and missed opportunities to harness the unique power of the family as a “system”.

Family relationships remain powerful influencers in our lives, for good or for bad. The “family”, however conceived in our minds or constituted in reality, has unique power to influence our wellbeing throughout our lives. Our efforts to “fix” individuals, whether children or adults, may be successful up to a point but our inability to address the relational context within which each of us lives is limiting the effectiveness of these interventions. Is it time to “think family” in a new way?

We are also limited in our understanding of “what matters most” to people and what might motivate the kinds of behavioural change we are seeking to catalyse. Using evidence from the behavioural sciences and participatory approaches to service design will deepen our understanding and effectiveness.

We have released the program for our 2018 conference with the theme of What Matters Most to Families in the 21st Century. It is evident from the conference submissions that there is a great deal of work being done at both Commonwealth and state/territory level to reform service systems and the way that policy is designed. Governments and non-government organisations are focused on building and utilising evidence to improve policy and services. One notable promising example comes from child welfare reform in NSW. They have seen a 24% reduction in the number of children and young people entering out-of-home care (OOHC) in 2016/17 compared with 2015/16, including a 19.7% decrease in Aboriginal children and young people entering OOHC.3 We will bring you highlights from our conference in an upcoming issue of Family Matters.

Families policy is not a “soft” topic. Families matter to our economy and our shared wellbeing as a nation. When it comes to babies, children and young people, “family” is the main game, not a sidebar in their lives. Helping, not hindering, families to do their job well is a challenge for policy.

At AIFS we are trying to get knowledge about what works for families into action on the ground.

We would like to thank you all for your support and contributions to Family Matters over the past 37 years and for your helpful feedback. Since its earliest days, Family Matters has been about getting evidence to the people who influence the lives of families, through their research, policy making or practice. We look forward to continuing the conversation about families with you for many more years to come.

3 Information provided by NSW Department of Family and Community Services, 2018.
What promotes social and emotional wellbeing in Aboriginal and Torres Strait Islander children?

Lessons in measurement from the Longitudinal Study of Indigenous Children

▶ Alexandra Marmor and David Harley
Social and emotional development and school readiness

In the Longitudinal Study of Indigenous Children (LSIC—also known as Footprints in Time) parents’ most commonly reported hope for their children was a good education (Department of Families, Housing, Community Services and Indigenous Affairs, 2009), meaning at least school completion to Year 12, the final year of high school (Department of Social Services [DSS], 2011). A smooth transition to school predicts school completion (Huffman et al., 2000), and social and emotional development, which together with cognition and general knowledge, language development and physical wellbeing, is an important factor in children’s readiness to participate in school-based learning experiences (Dockett, Perry, & Kearney, 2010).

The Australian Government’s Better Start to Life approach invests in maternal, child and family health programs that support Aboriginal and Torres Strait Islander families to ensure children are ready to learn when they start school. To guide programs such as these, it is important to understand the nature and determinants of social and emotional wellbeing (SEWB) in Aboriginal and Torres Strait Islander children.

Measuring children’s social and emotional wellbeing

Social and emotional wellbeing is central to the holistic view of health held by Aboriginal and Torres Strait Islander people (Department of Health and Ageing, 2013). A broader concept than Western understandings of mental health and wellbeing, the SEWB of an individual is:

... intimately associated with collective wellbeing. It involves harmony in social relationships, in spiritual relationships and in the fundamental relationship with the land and other aspects of the physical environment. (Haswell, Blignault, Fitzpatrick, & Jackson Pulver, 2013, p. 24)

The absence of mental ill health is necessary but not sufficient for SEWB, a positive concept that values relationships (Henderson et al., 2007). The SEWB of an Aboriginal and Torres Strait Islander child is dependent upon family and community wellbeing and connection to ancestry, culture, spirituality and country. Mental health is important but not central to the child’s SEWB (Figure 1A). Limited quantitative studies indicate that Aboriginal and Torres Strait Islander children have significantly higher rates of social and emotional difficulties, mental health problems and psychological distress than non-Indigenous children (Australian Institute of Health and Welfare, 2009; Priest, Baxter, & Hayes, 2012; Zubrick et al., 2005).

Note: SDQ = Strengths and Difficulties Questionnaire.

Figure 1: (A) Conceptual framework for social and emotional wellbeing (SEWB) of Aboriginal and Torres Strait Islander children; and (B) variables from the Longitudinal Study of Indigenous Children chosen as outcome measures to operationalise this concept.
This disparity is apparent by 3 years of age (Baxter, 2014). Identifying interventions and approaches that promote SEWB will guide policy makers and program managers—particularly those working in the area of maternal and child health.

The Total Difficulties score of the Strengths and Difficulties Questionnaire (SDQ) has been used as a measure of SEWB in Aboriginal and Torres Strait Islander children (Li, Jacklyn, Carson, Guthridge, & Measey, 2006; Priest, Baxter, & Hayes, 2012; Priest, Paradies, Gunthorpe, Cairney, & Sayers, 2011; Skelton, 2015; Zubrick et al., 2005). This 25-item questionnaire was designed to assess the “psychological adjustment” of children and adolescents (Goodman, 2001). The SDQ consists of five scales that score emotional symptoms, conduct problems, hyperactivity-inattention, peer problems and prosocial behaviour. The first four scales are summed to generate a Total Difficulties score, with a higher score indicating more difficulty. The fifth scale is summed to generate a Prosocial Behaviours score, with a higher score indicating better behaviours. The items and their groupings were selected based on their relationship to categories of mental disorders (Goodman, 2001).

However, mainstream mental health assessment tools such as the SDQ do not adequately reflect SEWB (Henderson et al., 2007). Normal behaviour is culturally constructed and these tools may not account for Aboriginal and Torres Strait Islander societal norms or language (Dingwall & Cairney, 2010). Parents, researchers, youth workers and health workers in Aboriginal communities in Sydney who participated in a study by Williamson and colleagues (2010) indicated that the prosocial scale of the SDQ provides information about an Aboriginal child’s relationship with their family that is central to SEWB. These participants indicated that the standard SDQ was acceptable as a measure of mental health but does not assess “connection to or relationship with extended family, Aboriginal identity, feeling that you are accepted by and belong to an Aboriginal community, and the impact and experience of racism” (Williamson et al., 2010, p. 897).

**Method**

We selected a sample of children from the Longitudinal Study of Indigenous Children (LSIC) who were aged 2 years or under at Wave 1, or who entered in Wave 2 aged 3 years or under. The LSIC team have collected data yearly since 2008 (Wave 1). Important features of LSIC include extensive and ongoing community engagement and consultation, and leadership from a steering committee with a majority of Aboriginal and Torres Strait Islander members (Thurber, Banks, & Banwell, 2015).

There is no instrument available that adequately measures SEWB. As a proxy, we used the two SDQ subscale scores to represent children’s prosocial behaviour and mental health. Scores were taken from Wave 6, around the time the children in the sample started school, and were based on the assessment of the primary carer. If these scores were missing, scores obtained from the child’s teacher assessment at Wave 5 were used.

We selected early life exposure variables from Waves 1 or 2 based on factors found by previous studies to be associated with SDQ scores, factors that have a biologically or socially plausible link to SDQ scores, and factors that reflect the activities or intended outcomes of maternal and child health services (Table 1). We incorporated exposures and potential confounders with a $p$ value of 0.25 or less from univariable analyses into linear regression models. Models were adjusted for the geographic clustering in the LSIC sample.

To address the secondary research aim, we first developed a conceptual framework to represent SEWB in Aboriginal and Torres Strait Islander children. This framework guided our selection of variables most closely reflecting the facets of SEWB (Figure 1B). The selected variables were also from around the time of starting school. We used Principal Component Analysis (PCA) to reduce these outcome measures to a new index of SEWB. A successful PCA results in a handful of components to which “common sense meanings” can be assigned (Navarro Silvera et al., 2011). Principal components are continuous variables that can be used in analyses in place of the many variables that were used to create them (Navarro Silvera et al., 2011).

All analyses were conducted using StataSE version 13. This research was approved by the Australian National University Human Research Ethics Committee.

1 “Exposure” refers to any factor that may be associated with an outcome of interest.
<table>
<thead>
<tr>
<th>Variable</th>
<th>LSIC interview question wording or description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother received first antenatal visit &lt; 20 weeks gestation</td>
<td>How far along [in weeks] [were you/was she] in [your/her] pregnancy when [you/she] had [your/her] first check-up?</td>
</tr>
<tr>
<td>Mother did not drink alcohol during pregnancy</td>
<td>After finding out you were pregnant with [child's name] did you drink any alcohol during the pregnancy?</td>
</tr>
<tr>
<td>Mother did not smoke during pregnancy</td>
<td>After finding out you were pregnant with [child's name] did you smoke any cigarettes during the pregnancy?</td>
</tr>
<tr>
<td>Mother did not use any substances during pregnancy</td>
<td>We aren’t after any details here, but after finding out you were pregnant with [child’s name] did you use any other substances like smoking marijuana, drinking kava, sniffing petrol, or taking any illicit drugs during the pregnancy?</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>Can you read out the birth weight from the record book? How much did [child’s name] weigh at birth?</td>
</tr>
<tr>
<td>Global health measure</td>
<td>In general, would you say [child’s name]’s health is excellent, very good, good, fair or poor?</td>
</tr>
<tr>
<td>Not hospitalised in last 12 months</td>
<td>In the last 12 months, did [child’s name] stay in hospital because [he/she] was sick, injured or required surgery?</td>
</tr>
<tr>
<td>Child never had any ear problems</td>
<td>Has [child’s name] ever had runny ears/perforated eardrum/hearing loss (total/partial/one ear)/other ear problem?</td>
</tr>
<tr>
<td>Attends child care, day care or family day care</td>
<td>Does [child’s name] go to child care, day care or family day care?</td>
</tr>
<tr>
<td>Primary carer is employed</td>
<td>Do you have a job?</td>
</tr>
<tr>
<td>Highest qualification of the primary carer</td>
<td>What was the highest qualification that you have completed?</td>
</tr>
<tr>
<td>Parental warmth measure (primary carer)</td>
<td>When answering, please say whether you Always, Often, Sometimes, Rarely, or Never do each thing I ask about:</td>
</tr>
<tr>
<td></td>
<td>• hug or hold [child’s name] for no particular reason?</td>
</tr>
<tr>
<td></td>
<td>• enjoy listening to [child’s name]?</td>
</tr>
<tr>
<td></td>
<td>• enjoy doing things together with [child’s name]?</td>
</tr>
<tr>
<td></td>
<td>• feel close to [child’s name] when [he/she] is happy?</td>
</tr>
<tr>
<td></td>
<td>• feel close to [child’s name] when [he/she] is upset?</td>
</tr>
<tr>
<td></td>
<td>• go out of your way to say how pleased you are when [child’s name] does something really well?</td>
</tr>
<tr>
<td>Stolen Generations</td>
<td>Were you or any of your (or your partner’s) relatives removed from your family by welfare or the government or taken away to a mission?</td>
</tr>
<tr>
<td>Frequency with which family experiences racism</td>
<td>How often does your family experience racism, discrimination or prejudice?</td>
</tr>
<tr>
<td>Total number of people living in household</td>
<td>Derived from household survey question: What are the first and last names of all the people who live in this household, starting with you?</td>
</tr>
<tr>
<td>Number of major life events in previous year</td>
<td>I’d like to ask you about any big things that have happened to you, your family or [child’s name] in the last year... [list possible events][maximum 15 events]</td>
</tr>
<tr>
<td>Number of homes child has lived in since birth</td>
<td>How many homes has [child’s name] lived in since he/she was born?</td>
</tr>
<tr>
<td>Family financial stress</td>
<td>Which words best describe your family’s money situation:</td>
</tr>
<tr>
<td></td>
<td>[1] We run out of money before payday;</td>
</tr>
<tr>
<td></td>
<td>[2] We are spending more money than we get.</td>
</tr>
<tr>
<td></td>
<td>[3] We have just enough money to get us through to the next pay;</td>
</tr>
<tr>
<td></td>
<td>[4] There’s some money left over each week but we just spend it.</td>
</tr>
<tr>
<td></td>
<td>[5] We can save a bit every now and then.</td>
</tr>
<tr>
<td></td>
<td>[6] We can save a lot.</td>
</tr>
<tr>
<td>Index of Relative Indigenous Socio-economic Outcomes (IRISEO)</td>
<td>Based on Indigenous Area of child’s residential address: 1 = most favourable outcome; 10 = least favourable outcome</td>
</tr>
<tr>
<td>Level of Relative Isolation (LORI)</td>
<td>Based on geocoding of child’s residential address.</td>
</tr>
</tbody>
</table>

Note: *Wave 3 data used.

Source: DSS, 2016
Our research standpoint
Licensed users of LSIC data are required to openly acknowledge their research standpoint (DSS, 2013). We are non-Indigenous Australians with middle-class backgrounds. Following Pyett, Waples-Crowe, and van der Sterren (2008), we have approached the research problem and attempted to interpret the data through a strengths-based lens, and to challenge the deficit model of Aboriginal and Torres Strait Islander health. Also, by recognising and favouring Indigenous understandings of SEWB, we have used a decolonising approach.

Results
Characteristics of children in the study sample
A total of 950 children from the LSIC cohort met the age eligibility criteria but only 726 of these (76%) had a SDQ Prosocial Behaviours score at endpoint and were included in the sample. Excluded children were more likely to be low birth weight, have a younger and unemployed primary carer, have a mother who smoked while pregnant, and live in a remote or very remote area (Table 2).

Principal components of SEWB
The PCA of the outcome variables (Figure 1B) included data for 444 children (Table 3). Three principal components emerged. The first, “Child’s connection”, comprised variables representing the child’s connection to community and country. The second, “Child’s helping, sharing and mental health”, was constructed from the child’s two SDQ scores; while the third, “Primary carer’s SEWB factors”, was mostly loaded by the primary carer’s SEWB score and connection to community. Higher component scores respectively indicate: a stronger connection; greater helping, sharing and mental health; and greater connection and SEWB of the carer.

Early life exposures associated with SEWB components
“Child’s connection” component score
None of the early life exposures were strongly associated with a “Child’s connection” component score (Table 4). The regression model predicted a slightly better score for children:
- living in households with 11 or more people, compared with those in two-person households (Figure 2A);
- whose primary carer had less than a Year 10 education, compared with a Year 12 education (Figure 2B); and
- of families that never or hardly ever experienced racism, compared with daily experiences of racism (Figure 2C).
Although experiencing a greater number of major life events was statistically associated with greater connection, the effect was mild. Poorer social and emotional wellbeing at Wave 2 (measured using the Brief Infant-Toddler Social Emotional Assessment [BITSEA] Problem score), which was included in the model as a potential confounder, was also modestly associated with a better score for this component (Figure 2D). A post hoc analysis conducted to check the relationship between this component and SDQ Total Difficulties score showed a moderate positive correlation between these two variables (Spearman’s rho = 0.55, 95% CI 0.48 to 0.61, p = 0.00).

Table 2: Comparison of selected baseline characteristics of children included in and excluded from the study sample

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Included in sample %</th>
<th>Excluded from sample %</th>
<th>p value for difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>49.6</td>
<td>49.1</td>
<td>0.90</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>8.0</td>
<td>15.1</td>
<td>0.01</td>
</tr>
<tr>
<td>Mother did not smoke after discovering she was pregnant</td>
<td>50.9</td>
<td>41.1</td>
<td>0.02</td>
</tr>
<tr>
<td>Mother did not drink alcohol after discovering she was pregnant</td>
<td>78.7</td>
<td>74.1</td>
<td>0.17</td>
</tr>
<tr>
<td>Very good or excellent general health</td>
<td>79.5</td>
<td>76.2</td>
<td>0.30</td>
</tr>
<tr>
<td>Primary carer aged &lt; 20 years</td>
<td>7.0</td>
<td>13.0</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Primary carer completed Year 12</td>
<td>41.0</td>
<td>33.0</td>
<td>0.74</td>
</tr>
<tr>
<td>Primary carer employed</td>
<td>30.2</td>
<td>17.9</td>
<td>0.00</td>
</tr>
<tr>
<td>Primary carer parental warmth score (mean, 95% CI)</td>
<td>4.8</td>
<td>4.7</td>
<td>0.18</td>
</tr>
<tr>
<td>Lived in remote or very remote area</td>
<td>33.4</td>
<td>49.1</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Notes: *Characteristics with a statistically significant difference (p < 0.05) between groups are shown in bold. a Children of eligible age at baseline were excluded if SDQ Prosocial Behaviours score was missing for Waves 5 and 6.

2 These were the only components with eigenvalues greater than one.

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Table 3: Rotated components and loadings from PCA of outcome measures, using oblique promax rotation (n = 444)

<table>
<thead>
<tr>
<th>Assigned component name</th>
<th>Component 1</th>
<th>Component 2</th>
<th>Component 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eigenvale</td>
<td>2.62</td>
<td>1.64</td>
<td>1.04</td>
</tr>
<tr>
<td>Proportion of variance explained</td>
<td>32%</td>
<td>18%</td>
<td>16%</td>
</tr>
<tr>
<td>Variable loadings&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SDQ Prosocial Behaviours score</td>
<td>0.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SDQ Total Difficulties score</td>
<td>-0.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has a connection to country or place</td>
<td>0.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child identifies with a tribal group, a language group or a clan</td>
<td>0.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child does activities with family members to learn about culture</td>
<td>0.46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of days per week child spends time with leaders or elders in community</td>
<td>0.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree to which primary carer feels part of his/her local community</td>
<td></td>
<td>0.70</td>
<td></td>
</tr>
<tr>
<td>SEWB of primary carer</td>
<td></td>
<td></td>
<td>0.65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Component scores</th>
<th>Minimum–maximum</th>
<th>Mean (standard deviation)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-4.0–2.2</td>
<td>-1.5 (1.1)</td>
</tr>
<tr>
<td></td>
<td>-13.7–11.6</td>
<td>2.7 (5.0)</td>
</tr>
<tr>
<td></td>
<td>0.6–17.9</td>
<td>13.3 (3.3)</td>
</tr>
</tbody>
</table>

Note: <sup>a</sup> Only loadings greater than 0.2 or less than -0.2 are shown.

Figure 2: Predicted “Child’s connection” component scores (with 95% CIs) from linear regression for (A) number of people in the household; (B) highest qualification of the primary carer; (C) frequency with which the family experiences racism; and (D) BITSEA problem score at Wave 2
Table 4: Results of linear regression of factors in first years of life associated with “Child’s connection” component score at the time of starting school, Footprints in Time cohort 2008–2013

<table>
<thead>
<tr>
<th>Exposurea,b</th>
<th>Adjusted effect size (n = 230)c</th>
<th>Coefficient</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother did not drink alcohol during pregnancy</td>
<td>-0.22</td>
<td>-0.55–0.11</td>
<td>0.19</td>
<td></td>
</tr>
<tr>
<td>Mother did not smoke during pregnancy</td>
<td>-0.06</td>
<td>-0.39–0.27</td>
<td>0.71</td>
<td></td>
</tr>
<tr>
<td>Mother did not use other substances during pregnancy</td>
<td>0.19</td>
<td>-0.35–0.72</td>
<td>0.49</td>
<td></td>
</tr>
<tr>
<td>Child never had any ear problems</td>
<td>-0.14</td>
<td>-0.44–0.15</td>
<td>0.33</td>
<td></td>
</tr>
<tr>
<td>Attends child care, day care or family day care</td>
<td>0.08</td>
<td>-0.26–0.42</td>
<td>0.66</td>
<td></td>
</tr>
<tr>
<td>Primary carer is employed</td>
<td>0.18</td>
<td>-0.19–0.55</td>
<td>0.34</td>
<td></td>
</tr>
<tr>
<td>Stolen Generations</td>
<td>0.09</td>
<td>-0.18–0.35</td>
<td>0.51</td>
<td></td>
</tr>
<tr>
<td>Highest qualification of the primary carer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than Year 10</td>
<td>ref.</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Year 10/11</td>
<td>-0.27</td>
<td>-0.61–0.07</td>
<td>0.12</td>
<td></td>
</tr>
<tr>
<td>Year 12</td>
<td>-0.56</td>
<td>-1.02–0.10</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>VET qualification</td>
<td>0.16</td>
<td>-0.30–0.60</td>
<td>0.50</td>
<td></td>
</tr>
<tr>
<td>Bachelor degree or higher</td>
<td>0.06</td>
<td>-0.53–0.66</td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td>Parental warmth measure (primary carer)</td>
<td>-0.05</td>
<td>-0.61–0.52</td>
<td>0.87</td>
<td></td>
</tr>
<tr>
<td>Number of people in the household</td>
<td>0.09</td>
<td>0.01–0.16</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>Number of major life events in previous year</td>
<td>0.06</td>
<td>0.00–0.12</td>
<td>&lt;0.05</td>
<td></td>
</tr>
<tr>
<td>Number of homes child has lived in since birth</td>
<td>0.03</td>
<td>-0.11–0.16</td>
<td>0.71</td>
<td></td>
</tr>
<tr>
<td>Frequency with which family experiences racism</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every day</td>
<td>ref.</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Every week</td>
<td>-0.03</td>
<td>-0.96–0.90</td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>-0.62</td>
<td>-1.25–0.003</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td>Only occasionally</td>
<td>-0.55</td>
<td>-1.29–0.20</td>
<td>0.15</td>
<td></td>
</tr>
<tr>
<td>Never or hardly ever</td>
<td>-0.86</td>
<td>-1.53–0.18</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>Family financial stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Run out of money before payday</td>
<td>ref.</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Spending more money than we get</td>
<td>0.25</td>
<td>-0.29–1.19</td>
<td>0.59</td>
<td></td>
</tr>
<tr>
<td>Have just enough money to get us through to next pay day</td>
<td>0.27</td>
<td>-0.18–0.73</td>
<td>0.24</td>
<td></td>
</tr>
<tr>
<td>Some money left over each week but we just spend it</td>
<td>0.10</td>
<td>-0.64–0.84</td>
<td>0.79</td>
<td></td>
</tr>
<tr>
<td>Can save a bit every now and then</td>
<td>0.02</td>
<td>-0.55–0.57</td>
<td>0.96</td>
<td></td>
</tr>
<tr>
<td>Can save a lot</td>
<td>0.22</td>
<td>-0.60–1.03</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>IRISEO</td>
<td>-0.04</td>
<td>-0.11–0.02</td>
<td>0.19</td>
<td></td>
</tr>
<tr>
<td>Level of Relative Isolation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>ref.</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>0.12</td>
<td>-0.18–0.43</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>0.51</td>
<td>-0.05–1.07</td>
<td>0.07</td>
<td></td>
</tr>
<tr>
<td>High/Extreme</td>
<td>0.70</td>
<td>-0.67–2.07</td>
<td>0.31</td>
<td></td>
</tr>
<tr>
<td>Brief Infant-Toddler Social Emotional Assessment (BITSEA) Competency scored</td>
<td>-0.03</td>
<td>-0.11–0.05</td>
<td>0.50</td>
<td></td>
</tr>
<tr>
<td>BITSEA Problem scored</td>
<td>0.04</td>
<td>0.02–0.06</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

Notes: CI = Confidence interval. ref. = Reference group. Variables with \( p \leq 0.25 \) from univariable analysis were included in the regression model. Results with \( p < 0.05 \) are shown in bold. Adjusted for 95 clusters. Potential confounding factor.
“Child’s helping, sharing and mental health” component score

The regression model predicted better scores for children (Table 5):
- living in a household of two people, compared with 11 or more people (Figure 3A); and
- who experienced no major life events, compared with 10 or more events (Figure 3B).

Children with better BITSEA Problem scores at Wave 2 also had slightly better scores for this component (Figure 3C).

Table 5: Results of linear regression of factors in first years of life associated with “Child’s helping, sharing and mental health” component score at the time of starting school, Footprints in Time cohort 2008–2013

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Adjusted effect size (n = 230)</th>
<th>Coefficient</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother did not drink alcohol during pregnancy</td>
<td></td>
<td>0.03</td>
<td>-1.66–1.71</td>
<td>0.98</td>
</tr>
<tr>
<td>Mother did not smoke during pregnancy</td>
<td></td>
<td>1.20</td>
<td>-0.46–2.86</td>
<td>0.15</td>
</tr>
<tr>
<td>Mother did not use other substances during pregnancy</td>
<td></td>
<td>-0.59</td>
<td>-0.43–1.24</td>
<td>0.52</td>
</tr>
<tr>
<td>Low birth weight</td>
<td></td>
<td>-0.90</td>
<td>-3.08–1.28</td>
<td>0.41</td>
</tr>
<tr>
<td>Child not hospitalised in the past 12 months</td>
<td></td>
<td>-0.20</td>
<td>-1.77–1.37</td>
<td>0.80</td>
</tr>
<tr>
<td>Attends child care, day care or family day care</td>
<td></td>
<td>-0.15</td>
<td>-1.65–1.36</td>
<td>0.85</td>
</tr>
<tr>
<td>Excellent, very good or good global health</td>
<td></td>
<td>-1.00</td>
<td>-6.93–4.92</td>
<td>0.74</td>
</tr>
<tr>
<td>Primary carer is employed</td>
<td></td>
<td>-0.27</td>
<td>-1.87–1.33</td>
<td>0.74</td>
</tr>
<tr>
<td>Stolen Generations</td>
<td></td>
<td>-0.11</td>
<td>-1.56–1.34</td>
<td>0.88</td>
</tr>
<tr>
<td>Highest qualification of the primary carer</td>
<td></td>
<td>ref.</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Less than Year 10</td>
<td></td>
<td>1.00</td>
<td>-1.45–3.45</td>
<td>0.42</td>
</tr>
<tr>
<td>Year 10/11</td>
<td></td>
<td>1.81</td>
<td>-0.55–4.18</td>
<td>0.13</td>
</tr>
<tr>
<td>Year 12</td>
<td></td>
<td>0.72</td>
<td>-1.77–0.28</td>
<td>0.57</td>
</tr>
<tr>
<td>VET qualification</td>
<td></td>
<td>1.02</td>
<td>-2.72–4.75</td>
<td>0.59</td>
</tr>
<tr>
<td>Bachelor degree or higher</td>
<td></td>
<td>-0.40</td>
<td>-2.37–1.58</td>
<td>0.69</td>
</tr>
<tr>
<td>Parental warmth measure (primary carer)</td>
<td></td>
<td>-0.40</td>
<td>-2.37–1.58</td>
<td>0.69</td>
</tr>
<tr>
<td>Number of people in household</td>
<td></td>
<td>-0.33</td>
<td>-0.65–0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>Number of major life events in previous year</td>
<td></td>
<td>-0.29</td>
<td>-0.54–0.04</td>
<td>0.02</td>
</tr>
<tr>
<td>Number of homes child has lived in since birth</td>
<td></td>
<td>-0.24</td>
<td>-0.87–0.35</td>
<td>0.45</td>
</tr>
<tr>
<td>IRISEO</td>
<td></td>
<td>-0.16</td>
<td>-0.45–0.14</td>
<td>0.29</td>
</tr>
<tr>
<td>Level of Relative Isolation</td>
<td></td>
<td>ref.</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>None</td>
<td></td>
<td>0.04</td>
<td>-1.48–0.56</td>
<td>0.96</td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td>-0.53</td>
<td>-2.02–1.84</td>
<td>0.66</td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td>-2.27</td>
<td>-4.71–0.17</td>
<td>0.07</td>
</tr>
<tr>
<td>High/Extreme</td>
<td></td>
<td>0.12</td>
<td>-0.20–0.44</td>
<td>0.47</td>
</tr>
<tr>
<td>BITSEA Competency score</td>
<td></td>
<td>0.12</td>
<td>-0.20–0.44</td>
<td>0.47</td>
</tr>
<tr>
<td>BITSEA Problem score</td>
<td></td>
<td>-0.22</td>
<td>-0.34–0.10</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>0.44</td>
<td>-0.94–1.81</td>
<td>0.53</td>
</tr>
<tr>
<td>Age at time of SDQ assessment</td>
<td></td>
<td>0.03</td>
<td>-0.11–0.16</td>
<td>0.81</td>
</tr>
<tr>
<td>Global health measure at time of SDQ assessment</td>
<td></td>
<td>ref.</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Poor/Fair</td>
<td></td>
<td>6.7</td>
<td>-0.71–13.25</td>
<td>0.08</td>
</tr>
<tr>
<td>Good/Very good/Excellent</td>
<td></td>
<td>–</td>
<td>–</td>
<td></td>
</tr>
</tbody>
</table>

Notes: CI = Confidence interval, ref. = Reference group. * Variables with \( p \leq 0.25 \) from univariable analysis were included in the regression model. \( ^{a} \) Results with \( p < 0.05 \) are shown in bold. \( ^{b} \) Adjusted for 95 clusters. \( ^{c} \) Potential confounding factor.
Number of people in household

Child’s strengths and difficulties score

8 6 4 2 0 -2 -4 -6

Number of major life events in last 12 months

0 1 2 3 4 5 6 7 8 9 10 11 12

BITSEA problem score, Wave 2

0 5 10 15 20 25 30 35

Note: A higher component score indicates a greater degree of helping, sharing and mental health.

Figure 3: Predicted “Child’s helping, sharing and mental health” component scores from linear regression for (A) number of people in the household; (B) number of major life events in previous year; and (C) BITSEA problem score at Wave 2

Australian Institute of Family Studies
“Primary carer’s SEWB factors” component score

Similar results were generated from the regression model for the “Primary carer’s SEWB factors” component (Table 6). The model predicted a better component score for children:

- living in a household of two people, compared with 11 or more people (Figure 4A);
- who experienced no major life events, compared with five or more events (Figure 4B); and
- whose primary carer completed Year 12, compared with carer’s Year 10 completion (Figure 4C).

Again, the child’s BITSEA Problem score at Wave 2 also had a negligible negative correlation with the score (Figure 4D).

Table 6: Results of linear regression of factors in first years of life associated with “Primary carer’s SEWB factors” component score at the time of starting school, Footprints in Time cohort 2008–2013

<table>
<thead>
<tr>
<th>Exposurea,b</th>
<th>Adjusted effect size (n = 230)c</th>
<th>Coefficient</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother did not drink alcohol during pregnancy</td>
<td>0.71</td>
<td>-0.41–1.81</td>
<td>0.21</td>
<td></td>
</tr>
<tr>
<td>Mother did not smoke during pregnancy</td>
<td>0.68</td>
<td>-0.34–1.70</td>
<td>0.19</td>
<td></td>
</tr>
<tr>
<td>Child not hospitalised in the past 12 months</td>
<td>0.31</td>
<td>-0.77–1.39</td>
<td>0.57</td>
<td></td>
</tr>
<tr>
<td>Primary carer is employed</td>
<td>-0.50</td>
<td>-1.60–0.59</td>
<td>0.36</td>
<td></td>
</tr>
<tr>
<td>Stolen Generations</td>
<td>-0.29</td>
<td>-1.07–0.49</td>
<td>0.46</td>
<td></td>
</tr>
<tr>
<td><strong>Highest qualification of the primary carer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than Year 10</td>
<td>ref.</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Year 10/11</td>
<td>0.48</td>
<td>-0.53–1.49</td>
<td>0.35</td>
<td></td>
</tr>
<tr>
<td><strong>Year 12</strong></td>
<td>1.68</td>
<td><strong>0.39–2.97</strong></td>
<td><strong>0.01</strong></td>
<td></td>
</tr>
<tr>
<td>VET qualification</td>
<td>-0.31</td>
<td>-1.59–0.98</td>
<td>0.64</td>
<td></td>
</tr>
<tr>
<td>Bachelor degree or higher</td>
<td>1.04</td>
<td>-0.67–2.75</td>
<td>0.23</td>
<td></td>
</tr>
<tr>
<td>Parental warmth measure (primary carer)</td>
<td>0.31</td>
<td>-1.11–1.74</td>
<td>0.66</td>
<td></td>
</tr>
<tr>
<td>Frequency with which family experiences racism</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every day</td>
<td>ref.</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Every week</td>
<td>-1.77</td>
<td>-3.71–3.35</td>
<td>0.92</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>1.40</td>
<td>-1.22–4.02</td>
<td>0.29</td>
<td></td>
</tr>
<tr>
<td>Only occasionally</td>
<td>0.41</td>
<td>-2.34–3.16</td>
<td>0.77</td>
<td></td>
</tr>
<tr>
<td>Never or hardly ever</td>
<td>0.70</td>
<td>-1.96–3.35</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td><strong>Number of people in household</strong></td>
<td>-0.26</td>
<td>-0.47–0.05</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td><strong>Number of major life events in previous year</strong></td>
<td>-0.28</td>
<td>-0.47–0.10</td>
<td>&lt;0.01</td>
<td></td>
</tr>
<tr>
<td>Number of homes child has lived in since birth</td>
<td>-0.002</td>
<td>-0.40–0.40</td>
<td>0.99</td>
<td></td>
</tr>
<tr>
<td>Family financial stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Run out of money before payday</td>
<td>ref.</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Spending more money than we get</td>
<td>-1.20</td>
<td>-3.71–1.31</td>
<td>0.35</td>
<td></td>
</tr>
<tr>
<td>Have just enough money to get us through to next payday</td>
<td>-0.50</td>
<td>-1.73–0.73</td>
<td>0.42</td>
<td></td>
</tr>
<tr>
<td>Some money left over each week but we just spend it</td>
<td>-0.41</td>
<td>-2.38–1.55</td>
<td>0.68</td>
<td></td>
</tr>
<tr>
<td>Can save a bit every now and then</td>
<td>-0.23</td>
<td>-1.70–1.25</td>
<td>0.76</td>
<td></td>
</tr>
<tr>
<td>Can save a lot</td>
<td>-1.16</td>
<td>-3.58–1.25</td>
<td>0.34</td>
<td></td>
</tr>
<tr>
<td>IRISEO</td>
<td>0.04</td>
<td>-0.13–0.21</td>
<td>0.64</td>
<td></td>
</tr>
<tr>
<td>BITSEA Competency scored</td>
<td>0.01</td>
<td>-0.23–0.25</td>
<td>0.93</td>
<td></td>
</tr>
<tr>
<td><strong>BITSEA Problem score</strong>d</td>
<td>-0.09</td>
<td>-0.17–0.02</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>Age at time of SDQ assessmentd</td>
<td>-0.05</td>
<td>-0.14–0.04</td>
<td>0.24</td>
<td></td>
</tr>
<tr>
<td>Global health measure at time of SDQ assessmentd</td>
<td>2.09</td>
<td>0.03–4.15</td>
<td>0.05</td>
<td></td>
</tr>
</tbody>
</table>

Notes: CI = Confidence interval. ref. = Reference group. a Variables with p ≤ 0.25 from univariable analysis were included in the regression model. b Results with p < 0.05 are shown in bold. c Adjusted for 95 clusters. d Potential confounding factor.
All regression models were statistically significant overall and did not violate regression assumptions (data not shown). The models explained 20% of the variability in the “Child’s connection” component scores, 12% of the variability in the “Child’s helping, sharing and mental health” scores, and 18% of the variability in the “Primary carer’s SEWB factors” scores.

Discussion

Main findings

Early life exposures associated with surrogate measures of SEWB at school commencement were household size and number of major life events experienced. Larger households and larger numbers of events were associated with reduced sharing, helping and mental health in the child, and poorer wellbeing in the primary carer. Conversely, more people in the household and exposure to more events were weakly associated with greater connection of the child to community, culture and country.

We were unable to create a single index of SEWB using PCA of LSIC data. Surprisingly, post hoc analysis revealed that measures of connectedness and relationship were positively correlated with poorer mental health, as measured by the SDQ Total Difficulties score. This suggests that the score is a poor proxy for SEWB. Those seeking evidence to support SEWB policy development, program planning and evaluation must be cautious in applying Western biomedical health and wellbeing measures to Indigenous concepts and states.

Comparison with other studies—what does this study add?

Exposure to a greater number of major life events in the early years appeared to be mildly detrimental to “Child’s helping, sharing and mental health” component scores. In a study of the older LSIC cohort at Wave 4, when the children were aged around 7 years, Skelton and Kikkawa (2013) found a similar strength of association between SDQ Total Difficulties score and exposure to major life events in the previous 12 months. In a cross-sectional analysis of data from the Western Australian Aboriginal Child Health Survey (WAACHS) for children aged 4–17 years, Zubrick and colleagues (2005) found that exposure to more than seven major life events in the preceding year increased by...
over fivefold the likelihood of a child being at high risk of clinically significant difficulties (SDQ Total Difficulties score >17), compared with children who experienced two or fewer events.

In the present study, however, experiencing a greater number of events was also associated with greater connectedness to elders, culture and country. It is important to note that, unlike in the WAACHS, not all of the events reported in LSIC are inherently negative. Two of the four most commonly reported events in this sample were pregnancy or a new baby in the household and one of the child’s carers returning to work or study. Large, strong family and community networks increase the likelihood of major life events. For example, the larger the network, the more likely friends and relatives will die, the more likely the child will move between households, and the more likely friends and family will give birth.

In this study, having more people living in the household had a negligible positive association with better “Child’s connection” component scores. However, an opposite and stronger effect of this exposure was observed for the two other component scores. Similarly, children in the WAACHS living with high household occupancy levels were half as likely to have a high risk SDQ Total Difficulties score, compared with those living with low occupancy. Zubrick and colleagues (2005, p. 144) suggest this “may relate to more help being available within the household, greater flexibility in managing stresses, and greater buffering of risk exposures.”

It is not possible to infer household crowding (and related stress) from the number of people reported as living in the household. The LSIC survey question simply asks for the names of “all the people who live in the household” (DSS, 2008), with no clarification about temporary or regular visitors, or people who may sleep elsewhere but use the kitchen and bathroom facilities of the home. In contrast to the WAACHS analysis (Zubrick et al., 2005), we did not calculate household occupancy from the number of bedrooms as well as the number of people who lived in the home. The international standard measure for household utilisation also takes into account the age, sex and relationship status (couples or singles) of occupants (Memmott et al., 2012). However, as Memmott and colleagues (2012) note, it is important to distinguish between a high density of household occupants and household crowding. They argue that crowding is a perception of spatial inadequacy, influenced by a range of factors including the physical setting, an individual’s experience and expectations, their relationship to other occupants, and the occupants’ activities and behaviour. Crowding is an experience that is culturally defined and, for some families and communities, “[high] density may be an expression of proper intimacy with kin and others, which in fact reduces stress” (Memmott et al., 2012, p. 268).

Previous cross-sectional studies of Aboriginal and Torres Strait Islander children of similar ages have found associations between lower SDQ Total Difficulties scores and better general health (Armstrong et al., 2012; Skelton & Kikkawa, 2013); ear health (Zubrick et al., 2005); higher qualification of the primary carer; living in an area of less socio-economic disadvantage (Armstrong et al., 2012) or greater geographic isolation (Zubrick et al., 2005); lower household financial stress (Kikkawa, 2015); having a primary carer who was employed; and living in fewer than four (Williamson et al., 2016) or five homes (Zubrick et al., 2005). In the only published examination of the determinants of better SDQ Prosocial Behaviours scores in Aboriginal and Torres Strait Islander children, Armstrong and colleagues’ (2012) study of the older LSIC cohort found negligible positive effects at Wave 3 for the children who lived in an area of less socio-economic disadvantage at Wave 2. However, none of these factors, occurring in early life, were significant at school entry in this longitudinal study.

The challenge of measuring social and emotional wellbeing

The concept of SEWB cannot be captured using only the SDQ Total Difficulties subscale, the most commonly used measure of Aboriginal and Torres Strait Islander child mental health in large studies. By generating strengths-based outcome measures we have joined Goldfeld, Kvalsvig, Incledon, and O’Connor (2016) in challenging the common assumption that child mental health is the same as the absence of mental illness. These authors argue for a dual continuum model in which mental health is seen as correlated to, but distinct from, mental disorder. However, measuring these two states only will still fail to capture the Indigenous concept of SEWB.

For operationalising SEWB, perhaps what is needed is a “triple continuum model”, which includes a domain of relational health of community, culture and country. We could not achieve this by adding the “connection questions” available for this sample of LSIC children, which prima facie cannot quantify a concept that encompasses a rich web of relationships between flourishing individuals, families, language, culture, spirituality and land and sea country.

Taylor (2008, p. 116) names the intersection between Indigenous culture and government reporting frameworks the “recognition space” (Figure 5). This space is:

… where policy makers and Indigenous people can seek to build meaningful engagement and measurement. This is the area that allows for a necessarily reductionist translation of Indigenous people’s own perceptions of their wellbeing into measurable indices sought by government. What is captured in this space is obviously far from the totality of Indigenous understandings of wellbeing.
We may feel that by choosing standard measures we are ensuring objectivity. However, Prout (2012) warns that reducing Indigenous notions to narrow conventional indicators is a political exercise. In so doing, this “invisibilises many of the positive, enduring and protective factors associated with Indigenous ways of life which are not amenable to this kind of analysis and reporting” (Prout, 2012, p. 320). Our own values and world views also influence our interpretation of these indicators and may be in conflict with Indigenous perceptions of wellbeing. Prout argues, by using non-Indigenous populations as the reference group we are assuming that equity based on these flawed indicators is the ambition for Indigenous populations.

An alternative approach is offered by the Indigenous quantitative methodologies described by Walter and Andersen (2013). In these methodologies, power is returned to communities by framing research through lenses of Indigenous values, ways of being and of knowing. A recent relevant example is the project auspiced by the Kimberley Institute to develop culturally relevant measures of wellbeing for the Yawuru people, who live in and around Broome (Yap & Yu, 2016). In this qualitative project, Yawuru men and women described their concept of wellbeing and selected relevant indicators to develop gender-specific and collective wellbeing frameworks. Although this example was developed for adults in a specific community, the indicators for collective wellbeing listed in Table 7 highlight the complexity of the wellbeing concept and contrast with the much narrower constructs measured by the SDQ scales.

**Strengths of this study**

While recognising our world view and social position, we have attempted to use an Indigenous quantitative methodology for this study. Walter and Andersen (2013, p. 83) define this methodology as one in which “the practices and processes of research are conceived and framed through an Indigenous standpoint”. We were fortunate to have access to the LSIC data—data that were collected using protocols that exemplify this methodology (Walter & Andersen, 2013). We have also taken advantage of the power of the longitudinal LSIC design.

**Limitations of this study**

The non-random purposive sampling technique used for LSIC means generalisation of the results of this study to all Aboriginal and Torres Strait Islander children requires caution. The characteristics of the children excluded from the sample suggest that we may have underestimated the effects of low birth weight, primary carer employment, remote living and maternal smoking. Similarly, missing exposure data reduced sample size for the regression models, possibly lessening the effect of factors significant in univariable analyses.
Only a little of the variation in outcomes is explained by the regression models presented here. This means either there is a great deal of random variation in the outcome measures chosen or there are other factors that we did not include or consider that determine these outcomes. We were constrained in selection of both outcome and exposure variables by the waves in which certain questions were asked by the LSIC team. Furthermore, as there are no clinical measures or clinical record review in LSIC data collection, there may be considerable measurement error for questions about the child’s health and birth weight, depending on the primary carers’ recall and health literacy.

Implications

We have been unable to provide strong evidence to guide policy makers on interventions and approaches regarding intrauterine exposures, characteristics of the primary carer, parenting and care arrangements, or macro-level socio-economic indicators that will promote SEWB in children about to start school. However, our findings are consistent with the social determinants theory of SEWB (Henderson et al., 2007) and supportive of holistic, trans-portfolio approaches. The results also provide some evidence for screening and management of infants and toddlers with social and emotional difficulties for prevention of mental health problems later in childhood.

Measuring SEWB of Aboriginal and Torres Strait Islander children for the purposes of policy development, program planning or evaluation is not straightforward. If mainstream measures of mental health are used to plan and evaluate programs, their limitations must be acknowledged. Ideally, communities would be supported to develop their own measures of wellbeing. This presents a challenge: striking a balance between the need to privilege Indigenous ontologies and epistemologies and the governments’ requirement to demonstrate investment accountability using indicators that can be applied throughout jurisdictions cost-effectively.

References


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New estimates of the costs of children

Peter Saunders and Megan Bedford

Introduction

The costs associated with bringing up children are of intense interest to families and policy makers—the former because they bear most of these costs, and the latter because costs influence a range of family policies. However, producing robust evidence on this topic has proved challenging, in part because there is no agreed method for estimating these costs and the different methods that have been used are each subject to weaknesses.

The most common approach examines detailed data on how families spend their incomes. By comparing the spending levels and patterns of those with and without children, it is possible to deduce how the presence of a child (or children) influences the family budget and to ascribe this difference to the costs of a child (or children). This approach, while popular, must be able to unravel the difference between how much families choose to spend on their children and how much they need to spend. There is little sense in equating the former with the cost of children, since the notion of “cost” implies an element of necessity (associated with meeting the needs of the child). This cost is likely to differ from the choices that families make about how
much to spend, since spending will be determined primarily by how much discretionary income is available, not by what the child needs. Children in “rich” families would therefore be identified as costing more than children in “poor” families. If policies were designed to reflect this difference, it would end up entrenching existing inequalities without appropriately addressing the underlying needs.

Alternatively, the budget standards approach starts with the needs of the child rather than the expenditure of the family. The latter is then derived by adding up the costs involved in meeting the needs of children and other family members and a family budget is derived that will allow the necessary items (and activities) to be purchased. This approach was first applied over a century ago by Seebohm Rowntree (1901) in his study of poverty in York, England, where budgets were derived to identify how much was needed to achieve “merely physical efficiency”—the basis of the poverty line used by Rowntree. In Australia, the approach was adopted by Justice Higgins, who used it to set the basic wage for a working family in the Harvester Decision of 1907.

After decades of neglect, the budget standards approach has been revived, initially following the important UK study by Bradshaw and others in the 1990s (Bradshaw, 1993) and reinforced more recently by contributions from a range of UK researchers including Morris, Deeming and Hirsch (Morris, Wilkinson, Dangour, Deeming, & Fletcher, 1993) and reinforced more recently by contributions from a range of UK researchers including Morris, Deeming and Hirsch (Morris, Wilkinson, Dangour, Deeming, & Fletcher, 1993; Morris & Deeming, 2004; Deeming, 2005, 2010, 2011; Hirsch, 2015). The European Commission recently commissioned and released a major reference budgets report further highlighting the growing interest in the topic and its relevance to social policy design and development (Goedemé, Storms, & Van den Bosch, 2014; Goedemé, Storms, Stockman, Penne, & Van den Bosch, 2015). The term “reference budgets” is now used in the European context, although the Australian literature uses the term “budget standards”, which will be used here to avoid confusion. The influence and application of the budget standards approach at a national level now extends to many countries, including France, Ireland, Italy, Japan, Korea, the Netherlands, Portugal and Spain.

These developments are underpinned by three related factors: first, the enduring appeal of the budget standards approach, which basically mirrors how actual families go about the process of budgeting to meet their needs; second, developments in research methodology that have addressed some of the weaknesses identified in earlier studies; and third, the availability of better data and analytical techniques that have allowed more robust estimates to be produced and made it easier to tailor the budgets to suit specific applications. Despite these important features, the approach remains subject to a number of caveats (discussed further below), which suggests that it can only provide a guide to action and, where possible, it should be accompanied by other evidence before specific decisions are made.

The main use to which budget standards have been put is in assessing the adequacy of incomes, normally minimum incomes such as those that form part of the social safety net: basic levels of pensions and allowances, family payments, the minimum wage and so on. This requires the term “adequacy” to be defined, and following the Harmer Pension Review an income can be identified as adequate when it provides “a basic acceptable standard of living, accounting for prevailing community standards” (Harmer, 2009, pp. xii–xiii). This raises complex questions about the meaning of “acceptable” and “prevailing community standards” that must be given clear articulation if relevant evidence is to be produced. This presents a formidable challenge to any research designed to develop an adequacy standard. Only the budget standards approach addresses these issues head-on.

Other approaches choose instead to either ignore the issue altogether or make a universal judgement—for example, that an income equal to one-half of the median is required to avoid poverty, or that a wage less than two-thirds of the median wage can be used to identify the working poor. Whether or not a specific income level or wage rate is adequate then depends solely on the implicit adequacy judgement without any supportive evidence. In contrast, the budget standards approach seeks to identify what is acceptable in terms of actual living standards and what prevailing community standards are and builds up the budgets from these understandings. This approach provides a far sounder basis for providing an independent assessment of income adequacy because it does not depend on an arbitrary judgement about the meaning of adequacy. Decisions still have to be made as the budgets are constructed and because many of these will be disputed, the budget standards approach is not a panacea. It does provide a flexible but focused method, however, for producing the evidence required to assess income adequacy independently and should therefore form part of the decision maker’s toolkit.

The remainder of this paper describes the main elements of a recent budget standards study conducted by researchers at the Social Policy Research Centre (SPRC) at the University of New South Wales. The focus is on what the new estimates imply for the costs of children although this is only one of a broad range of uses to which the new estimates can be put. The next section provides a brief summary of the methods used to produce the new budgets, followed by a section presenting the new budgets and the estimates to derive the costs of children, compares them with earlier estimates using the same approach and discusses the implications of the findings. The main conclusions to date and areas for further work are summarised at the end.

1 Readers interested in finding out more about the study can access the full report from the SPRC website at <www.sprc.unsw.edu.au/research/publications/sprc-report-series/>. 
Developing the new budget standards

A budget standard indicates how much a particular family living in a particular place at a particular time needs in order to achieve a particular standard of living. It is derived by specifying the standard that the budget is intended to support and then identifying and pricing every item that is needed by the family and each of its members to achieve that standard. Since budgets are normally derived for a range of family types, it is important to ensure that each is designed to achieve the same standard. Since budgets are normally derived for a range of family types, it is important to ensure that each is designed to achieve the same standard.

Developing the new budget standards involved only including items that were necessary to guarantee that all family members could achieve a full and healthy life, albeit one that involves a minimal level of outlays. The budgets for each individual were developed first, and those for extra family members (adults as well as children) were allocated similar items, while jointly consumed family items (e.g., the family home or items of furniture) were adjusted to reflect the change in family size or composition. If this equality of living standards is not achieved, then calculating the differences between the budgets for different families will conflate the cost of achieving a given standard with that involved in moving between standards. This point is important in the current context because the costs of children are normally estimated using the “difference method”, which estimates the costs of children by taking the difference between the budgets for families with differing numbers of children, as explained further below.

Starting from scratch to construct a set of family budget standards is a daunting exercise. In order to minimise the effort (and cost) involved, the starting point for the research described here was the budget standard estimates produced by the SPRC in the 1990s (Saunders et al., 1998). The research that produced those budgets was commissioned by the federal government’s (then) Department of Social Security and the project benefited from the advice and input of a range of experts in all aspects of family and household budgeting, nutrition, health economics and consumer behaviour.

Although the estimates are now over two decades old (the original budgets were priced in 1995), they are still regularly updated to reflect movements in the Consumer Price Index (CPI) by a number of community organisations, who continue to use them to inform adequacy judgements in a number of settings (see, e.g., Australian Council of Social Service [ACOSS], 2012, 2014). One area where the updated budgets have been used regularly is in the annual minimum wage setting process, where a number of submissions have used the estimates to argue for increases. This reflects the widely shared view, expressed in a recent submission to the minimum wage panel, that:

Indisputably, the best evidence in Australia about the needs of low income families is in the budget standards research of the SPRC. (Lawrence, 2015, p. 127)

Against this, the CPI adjustment is clearly a weakness because it effectively assumes that, aside from price rises, “prevailing community standards” are the same today as they were in the mid 1990s and this seems highly implausible. Reflecting this weakness, the Fair Work Commission (2014) has noted that:

We accept that contemporary budget standards measures can provide an effective means of measuring the needs of the low paid, which can be considered together with other relevant data. However, the budget standards measures derived from the 1997 (sic) SPRC study do not provide useful contemporary information about the needs of the low paid. (para. 390 [italics added])

The clear implication is that there is an urgent need to review the original budgets to determine what changes other than price uprating are needed for them to maintain their relevance. This was the motivation for the current study.

In theory, this was a straightforward (if tedious) process that involved examining the detailed item-by-item spreadsheets that underpinned the original budgets and repricing each item using current prices, or replacing the item if it was no longer available. In practice, what started out as a simple exercise soon became complex for several reasons: first, as the original budgets were reviewed it became apparent that there were many instances where the item itself needed to be modified or changed completely rather than just repriced. This was partly to reflect changes in “prevailing community standards” (particularly in the area of communications technology—the original budgets did not include a mobile phone for anyone!), but also to reflect changes in the options available to consumers (e.g., the rapid growth in “home brand” or generic items). There were also many instances where the assumptions built into the original budgets no longer seemed appropriate, particularly in relation to the lifetimes assumed for longer-lasting items, and how these vary with the circumstances of the family.

Finally, a small number of errors were discovered, and these had to be corrected.

Due to the complexities mentioned above, the process of reviewing, revising and repricing the original budgets took far longer than originally anticipated. The original pricing of the food, clothing and household goods budgets began in the second half of 2013 (using as before, nationwide stores such as Woolworths and Kmart) but the new budgets were not finalised until over two years later, in early 2016. This process of review and revision was unexpectedly long because of the necessity to ensure that the revised budgets maintained their consistency both horizontally (i.e., between the different family types at each standard) and vertically.
of whom were involved in the original SPRC study) with
less expensive and enabled them to balance their budget.

Suggested that these items were crucial because they were
brand” or generic brand items in the budgets. Participants
focus group participants was the inclusion of mainly “home
lifetimes of certain clothing items were extended to reflect
out-grown their own clothes. While an explicit allowance
be extremely important and resulted in many changes to the
of the budgets was informed by three key elements. First,
available data (mainly ABS survey data) was used to ensure
that the budgets conformed broadly to what Australians
actually have and do and what they spend their money
on. Second, and importantly, a series of focus groups were
held with the two groups that are the focus of the new
budgets—low-paid working and unemployed individuals
and families—to ascertain how they manage on their low
budgets and, in particular, what economising strategies they
employed to make ends meet.

The feedback provided by these focus groups proved to
be extremely important and resulted in many changes to the
budgets to reflect what was learnt. For example, focus group
participants discussed the importance of “clothes swapping”
and how this enabled them to get “new” school and other
general clothing on a low income for children who had
out-grown their own clothes. While an explicit allowance
was not included in the budgets to allow for this, the
lifetimes of certain clothing items were extended to reflect
it. Another change that reflected comments made by the
focus group participants was the inclusion of mainly “home
brand” or generic brand items in the budgets. Participants
suggested that these items were crucial because they were
less expensive and enabled them to balance their budget.

Third, the accrued experience of the research team (two
of whom were involved in the original SPRC study) with
developing and using budget standards over the last two
decades was valuable in helping to guide new decisions
when they were needed.

One notable trend in the budget standards literature
over recent decades has been the increased reliance on
information and feedback provided by focus groups. This
development reflects the greater constitutive role assigned
to focus groups, particularly in the design of the UK
minimum standards, where it has been argued that:

For society to agree a particular minimum standard of living,
there needs to be informed negotiation and agreement about
what constitutes a minimum, via a derivative of focus group
methodology. (Bradshaw et al., 2008, p. 3 [italics added])

The counterpart to the increased role given to focus
groups is a decline in the impact of “experts” who provide
a range of information about family needs and what is
required to satisfy them. This shift in emphasis is neatly
summarised by Vranken (2010) as one in which the role of
the focus groups has moved away from validating budgets
designed by experts to one in which the focus groups design
budgets that the experts then validate. However, this new
perspective has not been universally adopted and the EU
reference budgets study cited earlier did not follow the UK
in assigning greater weight to focus group input, preferring
instead to draw on information provided by an extensive
network of national experts and informants.

In the current study, the focus groups were not asked to
reach a consensus about the new budgets, only to provide
feedback on preliminary estimates and suggest ways of
improvement. Their role was also restricted by the practical
challenges encountered in recruiting low-paid workers,
who were difficult to get together in one place at one time
due to the availability constraints of being in employment
(often on a casual and/or irregular basis). Ensuring
greater involvement of low-paid and casual workers in the
construction of new budget standards is an important task
for the future.

The standard applied to the new budgets is the minimum
income for healthy living (MIHL), developed by Morris and
other public health researchers in the UK (see Morris &
Deeming, 2004; Morris, Donkin, Wonderling, Wilkinson,
& Dowler, 2000; Morris et al., 2007). The approach involves
a four-stage process: (1) draw on available public health
research to identify personal needs in key areas of health for
particular population groups; (2) translate this information
into ways of living using existing surveys of lifestyles
and public opinion; (3) cost these lifestyles in current
circumstances; and (4) derive the out-of-pocket costs to
individuals, after allowing for prevailing public provisions.

The approach has broad appeal because it specifies the
targeted standard in a comprehensible way that few can
disagree with: the concept of healthy living is now widely
used to promote everything from dietary guidance to the
need for appropriate regular exercise, the use of sunscreen, wearing appropriate clothing and footwear, and access to relevant facilities in the home, workplace and other institutional settings. The list illustrates the broad scope of the healthy living concept and highlights why it can be used as a targeted standard in the current context.

Although the budgets derived here cannot be claimed to be as firmly underpinned by public health research as is the case for the UK research cited above, it is important to note that all four words in the MIHL concept played an important role in guiding the research: Minimum—the focus is on identifying the minimal level of consumption that is consistent with the underlying ideal;Income—the focus is on how much money is needed each week to purchase the necessary items;Healthy—this is the key attribute that determines the items that are needed to ensure its attainment; and Living—which puts the focus on how people lead their lives and what is needed for them to attain and maintain the appropriate standard.

Throughout their development, the revised budgets were continuously reviewed to ensure their consistency with the concept of healthy living—as it affects people (adults and children) in their roles as consumers in the marketplace, as students at school, as parents in the home and as workers in the workplace. This focus on healthy living has the added advantage that it provides an important link between budget standards research and wider debates on social participation and inclusion, thereby increasing the relevance and value of the estimates in a range of public policy contexts.

It is also important to emphasise that the new budgets were constructed on a very conservative basis. In practice, this meant that when identifying the items to include and pricing them the approach that produced the lowest cost was always selected. This approach is in line with the focus on the minimalist nature of the MIHL concept, but also ensures that the budgets provide an appropriate benchmark for assessing the adequacy of the minimal incomes that form part of the social safety net. The overall budgets are therefore “tight” and there is no room to reduce them further without compromising the attainment of the MIHL standard.

The use of the MIHL standard represents a departure from the earlier SPRC study, which derived budgets at the Low Cost (LC) and Modest but Adequate (MBA) standards. These two concepts presented many challenges in the earlier study when trying to translate their definitions into practical budgets, and the decision to abandon them in part reflects these ambiguities. The MIHL standard provides a focus that extends across all areas of the budgets without being overly prescriptive about what the budgets should achieve, and this increased flexibility has made the task more manageable. In round terms, the new MIHL standard lies between the LC and MBA standards although exactly where it lies on that spectrum depends upon the cases being considered and the circumstances of the families to which the budgets apply. This will become evident as the discussion now shifts from methodology to findings.

The new budget standards and the costs of children

The new budget standards were derived for the following five family types: single people (females and males, grouped together into a gender-neutral budget); couple without children; couple with one child (girl, aged 6); couple with two children (girl aged 6 and boy aged 10); and a female sole parent with one child (girl, aged 6). Within each family, one adult (the male for convenience) was assumed to be either employed and being paid the minimum wage, or unemployed and receiving Newstart Allowance (NSA). These two situations reflect each family’s dependence on one of the two main components of the Australian social safety net—the minimum wage and NSA. The research was designed to assess the adequacy of these two payment levels.

Because the focus of this paper is on the costs of children, the following discussion is restricted to couple families with zero, one and two children only. (The approach used to estimate the costs of children in sole-parent families is more complicated than that described below, for obvious reasons, and is not discussed further.) In each family, the prime breadwinner (for convenience the male parent with the exception of the sole family where it is the female parent) is assumed to be either working full-time on the minimum wage or receiving NSA, while his partner is either unemployed (if there are no children) or not in the labour force (where there are children). The partners of the unemployed men are also assumed to be unemployed and receiving the relevant social benefits.

Tables 1 and 2 present the new budget standards for low-paid and unemployed families respectively, with the costs of children estimated in each case by taking the difference between the relevant budgets. The “difference method” is most commonly used to estimate the costs of children within a budget standards context because it takes account of all the ways in which the presence of a child or children will affect the family budget. Some of these are directly related to the presence of the child, including the costs of the food they consume, the clothes they wear and the school expenses they incur. These costs are easiest to identify, and they formed the basis of the important study by Lovering (1984) that produced the first Australian estimates of the costs of children. However, they provide only a partial picture since they exclude all household items that are consumed jointly by all family members, adults as well as children. Only when all of these shared costs are included will the separate costs of each individual family member add up to the total family budget.
### Table 1: New minimum income for healthy living (MIHL) budget standards for low-paid families and estimated costs of children, June Quarter 2016 ($ per week)

<table>
<thead>
<tr>
<th>Budget category</th>
<th>Family type</th>
<th>Costs of child(ren)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Couple, 0 children</td>
<td>Couple, 1 child</td>
<td>Couple, 2 children</td>
<td>6-year-old girl (2)-(1)</td>
<td>10-year-old boy (3)-(2)</td>
</tr>
<tr>
<td></td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td>123.60</td>
<td>156.22</td>
<td>200.91</td>
<td>32.62</td>
<td>44.69</td>
</tr>
<tr>
<td>Clothing and footwear</td>
<td>15.77</td>
<td>23.72</td>
<td>33.20</td>
<td>7.95</td>
<td>9.48</td>
</tr>
<tr>
<td>Household goods and services</td>
<td>99.59</td>
<td>112.72</td>
<td>139.10</td>
<td>13.13</td>
<td>26.38</td>
</tr>
<tr>
<td>Transport</td>
<td>120.75</td>
<td>144.72</td>
<td>144.72</td>
<td>23.97</td>
<td>0.00</td>
</tr>
<tr>
<td>Health</td>
<td>14.45</td>
<td>19.51</td>
<td>24.36</td>
<td>5.06</td>
<td>4.85</td>
</tr>
<tr>
<td>Personal care</td>
<td>27.04</td>
<td>31.03</td>
<td>35.34</td>
<td>3.99</td>
<td>4.31</td>
</tr>
<tr>
<td>Recreation</td>
<td>39.54</td>
<td>62.06</td>
<td>76.99</td>
<td>22.52</td>
<td>14.93</td>
</tr>
<tr>
<td>Education</td>
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<td>27.43</td>
<td>61.26</td>
<td>27.43</td>
<td>33.83</td>
</tr>
<tr>
<td>Housing (Rent)</td>
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<td>392.50</td>
<td>457.50</td>
<td>0.00</td>
<td>65.00</td>
</tr>
<tr>
<td><strong>Total budget</strong></td>
<td><strong>833.24</strong></td>
<td><strong>969.91</strong></td>
<td><strong>1,173.38</strong></td>
<td><strong>136.67</strong></td>
<td><strong>203.47</strong></td>
</tr>
</tbody>
</table>

These other, shared costs are a legitimate component of the costs of children and include the additional energy bills required to keep the home adequately warm and the extra journeys that have to be made (and paid for) transporting children to where they need to be. Other shared cost items are even more obscure, including the extra costs imposed by the greater wear and tear that children impose on items of furniture and domestic appliances such as the refrigerator. In these instances, the assumed lifetimes of the item is lowered when there are children present and this raises the weekly cost (since the purchase price is averaged over a shorter period) relative to those without (or with fewer) children, so that the difference will indicate the extra costs of the child(ren).

### Table 2: New minimum income for healthy living (MIHL) budget standards for unemployed families and estimated costs of children, June Quarter 2016 ($ per week)

<table>
<thead>
<tr>
<th>Budget category</th>
<th>Family type</th>
<th>Costs of child(ren)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Couple, 0 children</td>
<td>Couple, 1 child</td>
<td>Couple, 2 children</td>
<td>6-year-old girl (2)-(1)</td>
<td>10-year-old boy (3)-(2)</td>
</tr>
<tr>
<td></td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td>117.42</td>
<td>148.41</td>
<td>190.87</td>
<td>30.99</td>
<td>42.46</td>
</tr>
<tr>
<td>Clothing and footwear</td>
<td>10.25</td>
<td>15.52</td>
<td>21.67</td>
<td>5.27</td>
<td>6.15</td>
</tr>
<tr>
<td>Household goods and services</td>
<td>88.28</td>
<td>100.59</td>
<td>124.33</td>
<td>12.31</td>
<td>23.74</td>
</tr>
<tr>
<td>Transport</td>
<td>84.94</td>
<td>91.52</td>
<td>97.89</td>
<td>6.58</td>
<td>6.37</td>
</tr>
<tr>
<td>Health</td>
<td>11.94</td>
<td>17.00</td>
<td>21.86</td>
<td>5.06</td>
<td>4.86</td>
</tr>
<tr>
<td>Personal care</td>
<td>25.22</td>
<td>29.87</td>
<td>34.18</td>
<td>4.65</td>
<td>4.31</td>
</tr>
<tr>
<td>Recreation</td>
<td>25.50</td>
<td>43.32</td>
<td>56.64</td>
<td>17.82</td>
<td>13.32</td>
</tr>
<tr>
<td>Education</td>
<td>0.00</td>
<td>23.79</td>
<td>52.93</td>
<td>23.79</td>
<td>29.14</td>
</tr>
<tr>
<td>Housing (Rent)</td>
<td>296.70</td>
<td>296.70</td>
<td>340.00</td>
<td>0.00</td>
<td>43.30</td>
</tr>
<tr>
<td><strong>Total budget</strong></td>
<td><strong>660.25</strong></td>
<td><strong>766.72</strong></td>
<td><strong>940.37</strong></td>
<td><strong>106.47</strong></td>
<td><strong>173.65</strong></td>
</tr>
</tbody>
</table>

The budgets shown in Tables 1 and 2 include an estimate of housing costs that is derived from the weekly rental data produced by the Real Estate Institute of Australia (REIA, 2016). Each family has been assigned a rental dwelling that reflects its size and composition, dwellings were then located within specific suburb types in each capital city and the average rents paid for these dwellings has been derived for the three largest cities: Sydney, Melbourne and Brisbane. The approach has been adopted so that others can vary the assumptions used and see what difference this makes to the budgets and calculations based on them. To maintain their relevance, the new budgets have been updated to the June Quarter of 2016 in line with movements in the relevant component of the CPI (further details are provided in the full report, Saunders & Bedford, 2017).
It is important to emphasise that the cost estimates shown in Tables 1 and 2 refer only to children with the assigned characteristics, that is, to a 6-year-old girl and to a 10-year-old boy. It would not be appropriate to assume that the costs apply to all girls and all boys, or even to all one- and two-child families since the items included in the family budgets will change along with the characteristics of the children.

It should be noted that housing costs for the 6-year-old girl are zero because both the couple with no children and the couple with one child are assumed to live in the same type of dwelling—a two-bedroom unit. If instead, the couple without children were assumed to live (like the single adult) in a one-bedroom unit, this would raise the implied cost of the first child by $73.40 a week for unemployed families and by $76.70 a week for low-paid families (see Saunders & Bedford, 2017, Table 5.11). The zero transport costs for the 10-year-old boy in the low-paid family reflects the assumption that his travel needs are fully accommodated within existing car trips and therefore involve no extra cost. In contrast, the unemployed couple with children has no car and must rely on public transport and therefore incurs extra transport costs in order to meet the needs of the older boy.2

Education costs are zero for the couples with no children because the education costs relate only to children and the budgets include no allowance for adult education.

If the difference method is used to estimate the costs of children, the estimates in Tables 1 and 2 indicate that the weekly cost of the 6-year-old girl at the low-paid MIHL standard is around $137 a week (the difference between ($969.90 and $833.24), and that of the 10-year-old boy around $203 a week (the difference between $1,173.38 and $969.90). The combined cost of the two children (a better estimate in some ways since it averages out the costs that are specific to whichever of the two children is first) is (again using the difference method) $340 a week, or $170 a week per child. At the lower, unemployed MIHL standard these weekly costs are $106 (6-year-old girl), $174 (10-year-old boy) and $280 combined cost of $140 a week per child. In all cases the costs are lower, as expected, at the lower standard, with the difference amounting to about 18% when the costs are combined. The main contributors to these costs are food and housing, followed (in some instances) by education and transportation, although which budget areas contribute most to the overall costs varies across the budgets and family types.

Table 3 compares the new costs of children estimates with those produced in the earlier SPRC budget standards study and, for completeness, the partial cost estimates produced by Lovering (1984) over three decades ago. Attention focuses on how the new estimates compare with those based on the earlier study, updated in line with movements in the CPI between the March Quarter 1997 (when the original estimates apply) and the June Quarter 2016 (when the new estimates apply). The two sets of SPRC-based estimates vary in terms of the methods used to construct the detailed budgets and this compromises their comparability, although the aim of this exercise is to illustrate how relatively minor differences in method can produce estimates that differ greatly over an extended period when the impacts are allowed to cumulate.

What is clear from Table 3 is that the new estimates of the cost of children are considerably higher than those produced by updating the estimates produced earlier. This is despite the new budgets being deliberately kept to a minimum, as explained earlier. The reason for the large difference lies in the uprating process, which allows only for increases in consumer prices but makes no allowance for how “prevailing community standards” have changed over the period. These changes are captured in the new estimates (informed by the focus group feedback and other data used for benchmarking purposes) but are ignored in the updated estimates.

It is implausible to argue that community views on what represents the components of a minimally adequate living standard for Australian children have not shifted upwards over a period when general living standards have risen substantially. On this basis, the updated estimates have little relevance today. Instead, the new budget standards have been specifically designed to capture these changes and the estimates of the costs of children derived from them have similar legitimacy. Perhaps the single most important lesson to take away from Table 3 is the major biases that will be induced if budget standards are simply uprated in line with movements in the CPI, particularly when applied over extended periods.

Table 3: Comparing the new and updated estimates of the costs of children ($ per week, June Quarter 2016)

<table>
<thead>
<tr>
<th>Child characteristics/Source</th>
<th>Modest but adequate</th>
<th>MIHL, low-paid</th>
<th>Low cost</th>
<th>MIHL, unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-year-old child/Lovering, 1984</td>
<td>87.40</td>
<td>-</td>
<td>66.39</td>
<td>-</td>
</tr>
<tr>
<td>6-year-old girl/SPRC, 1998</td>
<td>108.39</td>
<td>136.66</td>
<td>82.06</td>
<td>106.49</td>
</tr>
<tr>
<td>11-year-old child/Lovering, 1984</td>
<td>142.33</td>
<td>-</td>
<td>86.40</td>
<td>-</td>
</tr>
<tr>
<td>10-year-old boy/SPRC, 1998</td>
<td>129.01</td>
<td>203.48</td>
<td>98.91</td>
<td>173.63</td>
</tr>
</tbody>
</table>

Source: Saunders, 1999, Tables 1 & 2 and this article, Tables 1 & 2 above.

---

2 Car-related transport costs increase when the couple includes the 6-year-old girl for two reasons: first, because the average kilometres travelled per day increase, which increases petrol costs; and second, because of the additional cost of a child car seat for the 6-year-old girl, which is required to meet child restraint laws.
Main conclusions and future work

The budget standards approach identifies the key decisions, choices and assumptions involved in estimating how much is needed to achieve a specific standard of living. The MIHL standard that underpins the new budget standards is designed to be consistent with government policy goals in relation to meeting basic consumption needs, achieving healthy living and providing for an adequate level of social participation and inclusion.

The results provide an independent, evidence-based benchmark for assessing the adequacy of the incomes provided by key components of the social safety net including the minimum wage and Newstart Allowance, two of the key pillars of the income support system for working-age Australians. Here, they have been used to derive new estimates of the weekly costs of children, which are shown to vary between $137 and $203 for families in low-paid (minimum wage) work and between $106 and $174 for unemployed families in receipt of Newstart Allowance.

These cost estimates are far above those derived by uprating the estimates produced over two decades ago in line with movements in the CPI, and the difference illustrates the dangers involved in adopting an uprating method that does not allow for changes in prevailing community standards. Since this is a key feature of any reasonable definition of adequacy, its absence renders the estimates produced by CPI-uprating limited to the point of uselessness.

We do not claim that the new estimates alone should form the basis of a campaign to ensure that family payments and other components of the social safety net should be increased to cover the new estimates of the costs of children. However, the onus is on those who argue against such a move to demonstrate how families with children can meet prevailing community standards if they receive incomes that are below those implied by the new budget standards. Where can the savings be made without compromising the attainment of the MIHL standard?

A key advantage of the budget standards approach is this ability to examine the consequences of varying its underlying components and assumptions, one that no other approach shares. Of course, it is always possible to do better and this should be a longer-term goal. An increasing number of countries now see the merits of the budget standards approach and are funding research that will allow new estimates to be produced regularly, in the process expanding research capacity as a new generation of researchers acquires the skills needed to take on the task. As this process evolves, expertise will grow and areas of dispute will diminish as practice accumulates and “conventional wisdoms” emerge. For a country that relies more heavily than most on the income-testing of social benefits, it is difficult to fathom how Australia—once a world leader in budget standards research—has allowed itself to fall so far behind what others are now doing.

The new budget standards project represents a modest first step in addressing this anomaly and the results presented here illustrate how the research can guide current adequacy assessments and allow others to draw on the results in a variety of contexts where adequacy issues are central. These issues affect the living standards of all Australians and impact on the overall level of inequality. It is difficult to see how any level of economic inequality can be tolerated by society if basic needs are not met at an acceptable level, particularly for those at the lower end of the labour market or out of work. The underlying adequacy issues will not go away, and budget standards research can and should play an important role in helping to address them.

References


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Who supports equal rights for same-sex couples?

Evidence from Australia

▸ Francisco Perales and Alice Campbell

Background

Despite significant progress in the form of policies aimed at promoting social equity by sexual orientation (Roseneil, Crowhurst, Hellesund, Santos, & Stoilova, 2013; Valfort, 2017) in highly developed countries such as Australia, there remain large differences in life outcomes between heterosexual and lesbian, gay and bisexual (LGB) people (Hudson-Sharp & Metcalf, 2016; Plöderl & Tremblay, 2015). For example, recent Australian studies have shown that, compared to “straight”/heterosexual people, both gay/lesbian and bisexual people experience worse mental health, increased psychological distress, lower levels of life and safety satisfaction, and a wage penalty (La Nauze, 2015; Perales, 2016; Powdthavee & Wooden, 2015; Sabia, Wooden, & Nguyen, 2017). This state of affairs constitutes an evident example of inequality of opportunity, and an important violation of the Australian quintessential principle of the “fair go”.

The main theoretical paradigm used to explain differences in life outcomes by sexual orientation in the social sciences, the minority stress framework (Meyer, 2003), posits that non-heterosexual people face a number of barriers in their day-to-day lives that affect their ability to function in society. These challenges include distal stressors (cultural heteronormativity, institutionalised stigma) and proximal stressors (experiences of discrimination, felt stigma, internalised homophobia), as well as—for some—stresses associated with the concealment and monitoring of their sexual identities.

This draws attention to the fact that outcome deficits associated with non-heterosexuality are driven by a social environment that is hostile to people whose sexual identities and behaviours do not “conform” to heteronormative societal expectations. That is, suboptimal life outcomes among LGB people have little to do with internal factors but
are instead produced and reproduced by the behaviours of others. Indeed, there is robust international evidence in support of these notions. For instance, LGB people who perceive being subjected to discrimination and stigmatisation on the basis of their sexuality exhibit poorer outcomes than those who do not (Doyle & Molix, 2016; Feinstein, Goldfried, & Davila, 2012), non-heterosexual individuals living in more restrictive ideological and institutional environments experience comparatively worse outcomes (Bauermeister, 2014; Hatzenbuehler, 2014; van der Star & Brinstrom, 2015), and changes in certain laws and/or policies (e.g., the legalisation of same-sex marriage) have positive effects on the wellbeing of LGB people (Everett, Hatzenbuehler, & Hughes, 2016; Hatzenbuehler et al., 2012; Raffman, Moscoe, Austin, & McConnell, 2017).

Long-standing perspectives in sociology and psychology have demonstrated that, for the most part, people's behaviours follow from their beliefs and world views (Kraus, 1995). Consistent with this, individuals' attitudes towards LGB people have been found to significantly predict their intentions (Morrison & Morrison, 2011) as well as their actual behaviours (Mereish & Potteet, 2015) towards people within this collective. Therefore, understanding the factors associated with people's views about LGB issues is important to understanding the mechanisms producing differences in life outcomes by sexual identity, and the social and political change required to reduce these divergences. This poses questions about how attitudes towards LGB people have evolved over time, and about which socio-structural positions are predictive of people holding more (or less) inclusive attitudes.

In this paper, we set out to examine this issue in the Australian context by focusing on individuals' perceptions of whether or not gay/lesbian couples should have the same rights as heterosexual couples, and the extent to which factors such as gender, age, education, religiosity, ethno-migrant background or area of residence are predictive of these attitudes. To accomplish this, we use longitudinal data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey stretching between 2005 and 2015.

**Previous empirical evidence**

Recent international scholarship reveals that in many parts of the world public acceptance of sexual minorities and support for the rights of same-sex couples have increased over the past two to three decades (Smith, Son, & Kim, 2014b; Valfort, 2017). However, there is still substantial variation between countries. For example, in cross-national data covering the 2001–14 period, the average degree of acceptance of homosexuality in Organisation for Economic Co-operation and Development (OECD) countries on a scale from 1 (least support) to 10 (most support) ranged from 1.6 (Turkey) to 8.3 (Iceland), with the OECD average standing at around 5 (Valfort, 2017). Australia's mean score (6) was slightly above the OECD average, which places Australia as the tenth most supportive country out of 35 OECD countries. Another cross-national survey conducted in 2013 found that 54% of Australians endorsed the statement “same-sex couples should be allowed to marry legally”, with Australia ranking eighth of 16 countries surveyed (Smith, Son, & Kim, 2014a). The highest agreement was observed in Sweden (81%) and the lowest in Poland (21%).

Just as there is between-country variability in public attitudes towards sexual minorities and same-sex marriage, so is there within-country variation based on individual characteristics. Recent international studies have identified that factors such as age, gender, religiosity, political ideology, ethnicity, education, income and area of residence are important predictors of people's world views about sexual minorities in general, and the rights of same-sex couples in particular (Armenia & Troia, 2017; Becker, 2012; Haney, 2016; Jackie & Wenzelburger, 2014; Sherkat, De Vries, & Creek, 2010; Smith, Son, & Kim, 2014b).

The Australian body of associated evidence, however, is limited. Consistent with the international literature, recent studies have identified that people living in Australia hold more positive attitudes towards same-sex marriage if they are female, younger, non-religious, live in a major city and rate their political orientation as being more liberal/progressive (Anderson, Georgantis, & Kapelles, 2017; Sloane & Robillard, 2017; Smith, 2016). However, all but one of these studies were cross-sectional (which precludes examination of trends over time), relied on small and/or non-representative samples (which hinder their ability to make statements about the general Australian population, and to detect effect differences between comparatively small population groups), and contained only limited contextual information on individuals' socio-demographic traits.

Other studies have focused on other attitudes related to homosexuality. For example, using longitudinal data from the Australian Longitudinal Study of Health and Relationships, Patrick and colleagues (2013) investigated the socio-demographic predictors of change in attitudes towards same-sex behaviour (“Sex between two adult men/women is always wrong”). They found that religiosity increased the likelihood of becoming more disapproving and decreased the likelihood of becoming more tolerant. However, their data spanned only two years and was collected over 10 years ago.

In the remainder of this paper, we will provide recent Australian evidence on the trends and predictors of public views about the rights of same-sex couples, and reflect on the implications of our findings for contemporary public policy and debates.
Data

The Household, Income and Labour Dynamics in Australia Survey

Our analyses rely on data from the HILDA Survey (Summerfield et al., 2016). The HILDA Survey is a multipurpose, household panel that, since 2001, has collected annual information from a sample of Australian families. The HILDA Survey is highly representative of the Australian population, and its overall wave-on-wave sample sizes are large—ranging from around 12,000 to 17,000 respondents. In this study, we focus on HILDA Survey data from Waves 5 (2005), 8 (2008), 11 (2011) and 15 (2015), when the study included a question asking respondents about their views on the rights of same-sex couples. Our analytical sample comprises 52,748 observations from 21,743 individuals.

Support for the rights of same-sex couples

The relevant HILDA Survey question asked respondents to rate their degree of agreement with the following statement: “Homosexual couples should have the same rights as heterosexual couples do” on a seven-point Likert scale from “strongly disagree” [1] to “strongly agree” [7]. As with all other questions on social attitudes, this item was placed within a self-complete questionnaire, as opposed to the computer-assisted face-to-face interview. This was done to ensure that respondents’ answers did not suffer from social desirability bias due to the presence of an interviewer. On a scale from 1 to 7, the mean of this support variable across all of the HILDA Survey waves containing the requisite information was 4.5 (standard deviation [SD] = 2.3), indicating moderate-to-high levels of support for the rights of same-sex couples.

We also constructed a dichotomous indicator of support for the rights of same-sex couples. This takes the value 0 (no support) when the original, continuous-level variable takes the values 1 to 4, and the value 1 (support) when the original, continuous-level variable takes the values 5 to 7. When using this binary measure, in 53% of the person-year observations respondents reported agreement with the statement that same-sex couples should have the same rights as different-sex couples (Table 1).

Socio-structural predictors

The HILDA Survey collects rich information on individuals’ socio-demographic and economic circumstances. This can be used to derive variables capturing theoretically important factors potentially predicting people’s views about the rights of same-sex couples. Basic descriptive statistics for all of these variables are presented in Table 1.

Gender has been shown to be a strong predictor of views, with women generally having more egalitarian and liberal attitudes towards social issues (Pratto, Stallworth, & Sidanius, 1997). This could be because women have historically been an oppressed social group and so may, as a result, be more sensitive to the oppression of others (Sirin, Valentino, & Villalobos, 2017), or because women are in general more supportive or empathetic than men are, be it due to innate traits or gender-based socialisation (Eagly, Diekman, Johannesen-Schmidt, & Koenig, 2004). In our analyses, we use a dummy variable to capture whether the respondent is female (53.24% of the person-year observations) or male (46.76%).

Table 1: Means and standard deviations on model variables

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>%</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for rights of same-sex couples (1–7)</td>
<td>4.50</td>
<td></td>
<td>2.29</td>
</tr>
<tr>
<td>Support for rights of same-sex couples (0–1)</td>
<td>52.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanatory variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>46.76</td>
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<td></td>
</tr>
<tr>
<td>Female</td>
<td>53.24</td>
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<td></td>
</tr>
<tr>
<td>Sexual orientation (in 2012)</td>
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<tr>
<td>Straight/heterosexual</td>
<td>75.33</td>
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<tr>
<td>Gay/lesbian</td>
<td>1.10</td>
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<tr>
<td>Bisexual</td>
<td>0.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other response, or no information</td>
<td>22.58</td>
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<tr>
<td>Age group</td>
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</tr>
<tr>
<td>15–39 years</td>
<td>41.87</td>
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</table>

Table continued over page
<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>%</th>
<th>SD</th>
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<tbody>
<tr>
<td>40–59 years</td>
<td>34.36</td>
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<td></td>
</tr>
<tr>
<td>60 or more years</td>
<td>23.77</td>
<td></td>
<td></td>
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<tr>
<td>Highest educational qualification</td>
<td></td>
<td></td>
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<tr>
<td>Degree or higher</td>
<td>23.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate or diploma</td>
<td>29.74</td>
<td></td>
<td></td>
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<tr>
<td>Year 12</td>
<td>15.05</td>
<td></td>
<td></td>
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<tr>
<td>Below Year 12, or indeterminate</td>
<td>31.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religiosity</td>
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<td></td>
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</tr>
<tr>
<td>Not religious</td>
<td>52.88</td>
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<td></td>
</tr>
<tr>
<td>Religious</td>
<td>32.27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No information</td>
<td>14.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethno-migrant group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian, not Indigenous</td>
<td>76.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous Australian</td>
<td>2.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrant, English-speaking background</td>
<td>9.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrant, non-English-speaking background</td>
<td>10.98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income quartile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bottom quartile</td>
<td>25.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd quartile</td>
<td>25.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd quartile</td>
<td>25.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Top quartile</td>
<td>25.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area remoteness</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Major city</td>
<td>62.28</td>
<td></td>
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</tr>
<tr>
<td>Inner regional area</td>
<td>25.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outer regional, remote or very remote area</td>
<td>12.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State/territory of residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
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</tr>
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<td></td>
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</tr>
<tr>
<td>2015</td>
<td>28.94</td>
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n (observations) 52,748
n (individuals) 21,743

Notes: Percentages may not total exactly 100.0% due to rounding.
As posed by interest-based theories, people's attitudes about a certain topic are driven by how much stake they have in the issue at hand (Danigelis, Hardy, & Cutler, 2007). Therefore, it is natural to assume that respondents' sexual orientation will be a strong predictor of support for the rights of same-sex couples, with such support being greater among non-heterosexual than heterosexual individuals. Using data from Wave 12 of the HILDA Survey, we constructed a measure of sexual identity that separates respondents into "straight/heterosexual (75.33%), gay/lesbian (1.10%), or bisexual (0.99%). A residual category identifies those who failed to provide a sexual identity or who were not present in Wave 12 of the study (22.58%).

Socialisation theory highlights how the social environment in which people are born and grew up can leave a lasting “imprint” on their social attitudes (Perales, Lersch, & Baxter, 2017). When people are raised in more traditional environments (e.g., earlier in time or in countries that are less developed than Australia), their views about social issues should be more traditional—reflecting the prevailing norms at the time in which they were socialised. Therefore, support for the rights of same-sex couples among older Australians and those from non-English-speaking backgrounds should be comparatively weaker.2 We split respondents into three age categories: 15–39 years (41.87%), 40–59 years (34.36%), and 60 or more years (23.77%); and four ethno-migrant groups: Australian-born, non-Indigenous people (76.87%), Indigenous Australians (2.18%), migrants from English-speaking countries (9.97%), and migrants from non-English speaking countries (10.98%).

Education exposes individuals to ideals of meritocracy and humanism, and has as a result been related to the emergence of egalitarian and progressive views about social issues; for example, gender roles or abortion (Campbell & Horowitz, 2016; Ohlander, Batalova, & Treas, 2005). We therefore expect more highly educated individuals to express stronger support towards the rights of same-sex couples than less educated individuals. In our analyses, we account for education through a set of dummy variables capturing respondents’ highest educational qualification: degree or higher (23.52%), certificate or diploma (29.74%), Year 12 education (15.05%), and below Year 12 education (31.69%).

Similarly, the intergroup contact hypothesis poses that individuals are more tolerant and supportive of non-traditional groups and practices (e.g., abortion, working women, single parents) if they experience direct exposure to them (Dovidio, Love, Schellhaas, & Hewstone, 2017; Mereish & Potate, 2015). Since same-sex couples cluster in urban areas, we would expect comparatively higher support of their rights by people residing in those locations. Using the HILDA Survey data, we distinguish between individuals living in major cities of Australia (62.28%), inner regional areas (25.00%), and outer regional, remote and very remote areas (12.72%), as defined in the Accessibility/Remoteness Index of Australia classification (Australian Bureau of Statistics [ABS], 2001).

Although there is debate about this, most religions tend to be unsupportive of sexual diversity, and religious organisations sometimes actively campaign against the rights of non-heterosexual individuals and same-sex couples (Jackle & Wenzelburger, 2014). Therefore, we would expect religious individuals to be less supportive of the rights of same-sex couples in Australia. Using the available data, we constructed a measure of religiosity based on responses to the following questionnaire item: “On a scale from 0 to 10, how important is religion in your life?”—where higher scores denote a higher importance of religion in people’s lives. Respondents with response scores ranging from 0 to 4 are considered as being non-religious (52.88%), while those with scores ranging from 5 to 10 are considered as being religious (32.27%). Those respondents who did not have information on religiosity fall into a residual category (14.85%).

Inter-group competition theories argue that population groups compete with each other for finite (and often scarce) societal resources, with stronger competition operating between vulnerable groups subjected to financial stress. One way individuals deal with economic threat, and the accompanying threats to their self-esteem and perceived control, is via displaced intergroup competition (Fritsche & Jugert, 2017). As a result, individuals with lower income may have more negative attitudes towards sexual minorities and be less supportive of the rights of same-sex couples than their wealthier peers. Therefore, we also included income quartiles as predictors in our multivariate models. These are constructed using a measure of household, financial-year, disposable, regular income that has been adjusted for inflation using the Consumer Price Index.

Finally, to establish whether there are regional differences in levels of support for the rights of same-sex couples net of all the factors outlined so far, our models include a set of nine dummy variables for each of the Australian states/territories.

---

1 Since sexual orientation can be fluid and changing (Diamond, 2016), it is not ideal to use information on sexual identity from a single time point. Unfortunately, this is all that is available in the HILDA Survey.

2 In practice, non-English-speaking countries include places that are arguably less progressive than Australia (e.g., South-East Asian countries), as well as places that are arguably more progressive (e.g., the Nordic countries). Australian migration from these source countries is skewed towards the former (Department of Immigration and Border Protection, 2016). Therefore, we expect a negative net effect of non-English-speaking country background on attitudes towards the rights of same-sex couples.

3 Information on religiosity was collected in 2004, 2007, 2010 and 2014, whereas information on attitudes towards the rights of same-sex couples were collected in 2005, 2008, 2011 and 2015. Therefore, we were required to transpose responses to those years in which we have attitude data (e.g., from 2004 to 2005, from 2007 to 2008, etc.).
Results

Predictors of the level of support for the rights of same-sex couples 2015

We first analysed the relationships between the variables capturing socio-structural factors and our outcome variables measuring attitudes towards the rights of same-sex couples for the most recent survey wave, Wave 15 (2015).

The first two columns of results in Table 2 present the multivariate regression models of support for the rights of same-sex couples in which the explanatory variables are a set of socio-structural factors of interest. Column 1 shows the results of a logit model of a binary outcome variable capturing support (values 5–7 in the scale). The results of the logit model are expressed as odds ratios (ORs), where ORs greater than one denote positive associations and ORs smaller than one denote negative associations. For comparison purposes, Column 2 shows the results of an ordinary least-squares (OLS) model in which the coefficients give the expected change in the level of support (on a scale from 1 to 7) associated with a one-unit increase in the explanatory variables. Coefficients greater than zero denote positive associations, whereas coefficients smaller than zero denote negative associations.

The results of the binary measure of support for the rights of same-sex couples (Column 1, Table 2) reveal a number of interesting and statistically significant patterns. As expected and all else being equal, support for equal rights is more prevalent among women than men (OR = 2.00; p < 0.001); gay/lesbian (OR = 12.34; p < 0.001) and bisexual (OR = 3.90; p < 0.001) individuals than heterosexual individuals; and people in the 15–39 age bracket, compared to people aged 40–59 years (OR = 0.63; p < 0.001) or 60 years or more (OR = 0.43; p < 0.001). Differences by highest educational qualification, however, were not linear: support was greatest amongst degree-educated people, followed by those with school Year 12 education (OR = 0.82; p < 0.01), those with certificates/diplomas (OR = 0.60; p < 0.001), and finally those with below Year 12 education (OR = 0.49; p < 0.001). The results also yield evidence of a strong religious divide: the odds of support of people who identify as being religious are only 30% of those of people who do not (OR = 0.30; p < 0.001). There were also differences by ethno-migrant status. Compared to Australian-born individuals, migrants from English-speaking countries (OR = 1.14; p < 0.05) were more likely to support equal rights, while migrants from non-English speaking countries were less likely to do so (OR = 0.52; p < 0.001). There was no difference in the level of support of Indigenous and non-Indigenous Australians (OR = 0.92; p > 0.1). Relative to people in the bottom quartile of the income distribution, those in the third (OR = 1.15; p <0.05) and highest (OR = 1.27; p < 0.001) quartiles held more supportive views; and so did people who lived in major cities, compared to those who lived in inner regional (OR = 0.81; p < 0.001) or more remote (OR = 0.61; p < 0.001) areas. There were no statistically significance differences by state/territory of residence.

The direction and statistical significance of the associations between the socio-structural factors and the continuous-level measure of support for the rights of same-sex couples (Column 2, Table 2) were strikingly similar to those for the binary measure discussed before.

<p>| Table 2: Regression models of support for the rights of same-sex couples |
|-----------------------------|-----------------------------|-----------------------------|
| <strong>Characteristics</strong>         | <strong>Year 2015</strong>               | <strong>All years</strong>               |
|                             | <strong>Logit</strong>                   | <strong>OLS</strong>                     |
|                             | <strong>1</strong>                       | <strong>2</strong>                       |
| Gender (ref. Male)          |                             |                             |
| Female                      | 2.00***                     | 0.68***                     |
| Sexual orientation (ref. Straight) | 12.34***                 | 1.32***                     |
| Gay/lesbian                 | 3.90***                     | 0.83***                     |
| Bisexual                    |                             |                             |
| Age group (ref. 15–39 years) |                             |                             |
| 40–59 years                 | 0.63***                     | -0.41***                    |
| 60 or more years            | 0.43***                     | -0.89***                    |
| Education (ref. Degree or higher) | 0.60***                 | -0.45***                    |
| Certificate or diploma      | 0.82**                      | -0.16**                     |
| Year 12                     | 0.49***                     | -0.62***                    |
| Below Year 12, or indeterminate | 0.49***                  | -0.77***                    |
| Table continued over page   |                             |                             |</p>
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Year 2015</th>
<th>All years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Logit</td>
<td>OLS</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Religiosity (ref: Not religious)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious</td>
<td>0.30***</td>
<td>-1.29***</td>
</tr>
<tr>
<td>Ethno-migrant group (ref: Australian, not Indigenous)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous Australian</td>
<td>0.92</td>
<td>-0.08</td>
</tr>
<tr>
<td>Migrant, English-speaking</td>
<td>1.14*</td>
<td>0.15**</td>
</tr>
<tr>
<td>Migrant, non-English-speaking</td>
<td>0.52***</td>
<td>-0.57***</td>
</tr>
<tr>
<td>Income quartile (ref: Bottom quartile)</td>
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<td>1.06</td>
<td>0.03</td>
</tr>
<tr>
<td>3rd quartile</td>
<td>1.15*</td>
<td>0.10*</td>
</tr>
<tr>
<td>Top quartile</td>
<td>1.27***</td>
<td>0.16**</td>
</tr>
<tr>
<td>Area remoteness (ref: Major city)</td>
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<td></td>
</tr>
<tr>
<td>Inner regional</td>
<td>0.81***</td>
<td>-0.19***</td>
</tr>
<tr>
<td>Outer regional, remote or very remote</td>
<td>0.61***</td>
<td>-0.47***</td>
</tr>
<tr>
<td>State/territory (ref: New South Wales)</td>
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<td></td>
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<tr>
<td>Victoria</td>
<td>1.10#</td>
<td>0.12**</td>
</tr>
<tr>
<td>Queensland</td>
<td>0.93</td>
<td>-0.08#</td>
</tr>
<tr>
<td>Western Australia</td>
<td>0.96</td>
<td>-0.04</td>
</tr>
<tr>
<td>South Australia</td>
<td>1.09</td>
<td>0.06</td>
</tr>
<tr>
<td>Tasmania</td>
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<td>0.11</td>
</tr>
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<td>Australian Capital Territory</td>
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<td>Northern Territory</td>
<td>1.09</td>
<td>0.18</td>
</tr>
<tr>
<td>Number of years since 2005</td>
<td>1.11***</td>
<td>0.11***</td>
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<tr>
<td>Interactions with year</td>
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<td></td>
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<tr>
<td>Year * ...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.00</td>
<td>-0.01**</td>
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<td>Gay/lesbian</td>
<td>0.98</td>
<td>-0.10***</td>
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<tr>
<td>Bisexual</td>
<td>1.05</td>
<td>-0.01</td>
</tr>
<tr>
<td>40-59 years</td>
<td>0.99*</td>
<td>-0.00</td>
</tr>
<tr>
<td>60 or more years</td>
<td>1.00</td>
<td>0.01*</td>
</tr>
<tr>
<td>Certificate or diploma</td>
<td>1.02*</td>
<td>0.03***</td>
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<tr>
<td>Year 12</td>
<td>1.04***</td>
<td>0.04***</td>
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<tr>
<td>Below Year 12, or indeterminate</td>
<td>1.01</td>
<td>0.02***</td>
</tr>
<tr>
<td>Religious</td>
<td>0.96***</td>
<td>-0.04***</td>
</tr>
<tr>
<td>Indigenous Australian</td>
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<td>-0.04*</td>
</tr>
<tr>
<td>Migrant, English-speaking</td>
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<td>-0.01#</td>
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<td>Migrant, non-English-speaking</td>
<td>0.97***</td>
<td>-0.02**</td>
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<td>2nd income quartile</td>
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<td>0.01#</td>
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<td>3rd income quartile</td>
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<td>0.02*</td>
</tr>
<tr>
<td>Top income quartile</td>
<td>1.03**</td>
<td>0.02**</td>
</tr>
<tr>
<td>Inner regional</td>
<td>1.01</td>
<td>0.01#</td>
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<tr>
<td>Outer regional, remote or very remote</td>
<td>0.99</td>
<td>-0.01</td>
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Table continued over page
Change over time in the level of support for the rights of same-sex couples, 2005–15

We now move to analyse change over time. Figures 1 and 2 show how the degree of support for the rights of same-sex couples has evolved over the 2005–15 observation period.

Figure 1 captures change over time for the continuous-level measure of support. The results are striking, and reveal a tide of support for the rights of same-sex couples in Australian society. Most noticeably, the percentage of respondents who chose the highest point of the support scale (strongly agree) increased from 19.2% in 2005 to 46.3% in 2015, whereas the percentage of respondents who chose the lowest point of the scale (strongly disagree) decreased from 26.7% in 2005 to 12.9% in 2015. The percentage of people who chose any of the five intermediate responses either remained stable or decreased slightly.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Year 2015 Logit</th>
<th>Year 2015 OLS</th>
<th>All years Logit</th>
<th>All years OLS</th>
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<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Victoria</td>
<td>1.00</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>1.00</td>
<td>0.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Australia</td>
<td>1.02*</td>
<td>0.02*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Australia</td>
<td>1.00</td>
<td>-0.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tasmania</td>
<td>1.00</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>0.99</td>
<td>-0.01</td>
<td></td>
<td></td>
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<tr>
<td>Northern Territory</td>
<td>0.96</td>
<td>-0.01</td>
<td></td>
<td></td>
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<tr>
<td>Constant</td>
<td>4.78***</td>
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</table>

Notes: Statistical significance: # 0.10, * 0.05, ** 0.01, *** 0.001. Results from logit models expressed as odds ratios.

Figure 1: Support for the rights of same-sex couples over time, Likert scale
Figure 2 captures change over time for the binary measure of support, and reveals a very similar trend. In 2005, just 39.8% of the Australian population agreed with the notion that same-sex couples should have the same rights as different-sex couples but this rose to 46.9% in 2008, to 54% in 2011, and ultimately to 66% in 2015.

Change over time in the predictors of support for the rights of same-sex couples, 2005–2015

Columns 3 and 4 in Table 2 present the results of multivariate regression models of support for the rights of same-sex couples in which all of the explanatory variables capturing socio-structural factors are interacted with a variable capturing survey year. These models pool data from 2005, 2008, 2011 and 2015. The coefficients on these interaction terms reveal whether and how the estimated effects of socio-structural factors on attitudes towards the rights of same-sex couples have changed over time. Results in Column 3 are from logit models of the binary support measure, whereas results in Column 4 are from OLS models of the continuous measure of support.

The results for the binary measure (Column 3, Table 2) reveal that, net of compositional differences in socio-structural factors, the odds of supporting the rights of same-sex couples increased by 11% with each additional year since 2005 (OR = 1.11; \( p < 0.001 \)). The interaction effects are of most analytical interest here, and reveal some evidence of changes over time in subgroup differences in support for the rights of same-sex couples. While many of these interactions were statistically significant, their magnitude was generally small—that is, the effects were not substantially significant. There were, however, noticeable exceptions, which we represent graphically.

Figure 3 shows trends over time in support for the rights of same-sex couples by religiosity. This evidences that the gap in support between religious and non-religious Australians has grown. Support rates from religious Australians were estimated at 25.7% in 2005, compared to 45.5% for non-religious Australians. By 2015, the analogous estimates were 47% for religious Australians, and 76.6% for non-religious Australians. Differences in support by religiosity widened from about 20 percentage points in 2005 to about 30 percentage points in 2015.

Figure 4 shows predictions for differences in support over time by highest educational qualification. Interestingly, the “support premium” associated with holding university-level educational qualifications reduced considerably between 2005 and 2015, particularly relative to holding a Year 12 education. That is, university education seems to be progressively less predictive of views towards the rights of same-sex couples over time.

In addition, the OLS models for the continuous-level measure yielded strong and statistically significant evidence of change over time in the degree of support by sexual identity. As shown in Figure 5, this was due to a “ceiling effect”, whereby mean support by gay/lesbian respondents approximated the top of the 7-point Likert scale. This enabled the group of bisexual respondents and, to a lesser extent, the group of heterosexual respondents to catch up in their comparative degree of support over time.

Notes: Shows percentage agreeing to the HILDA Survey statement “homosexual couples should have the same rights as heterosexual couples do”. Agreement: scores 5–7 in 7-point Likert scale.


Figure 2: Support for the rights of same-sex couples over time, binary measure
Notes: Shows proportion agreeing homosexual couples should have the same rights as heterosexual couples in HILDA Survey (agreement: scores 5–7 in 7-point Likert scale). Estimated marginal effects at the means of the control variables.


Figure 3: Support for the rights of same-sex couples over time (binary measure), by religiosity

Notes: Shows proportion agreeing homosexual couples should have the same rights as heterosexual couples in HILDA Survey (agreement: scores 5–7 in 7-point Likert scale). Estimated marginal effects at the means of the control variables.


Figure 4: Support for the rights of same-sex couples over time (binary measure), by highest educational qualification
Discussion and conclusion

Abundant international and Australian evidence demonstrates that non-heterosexual people remain subjected to discrimination and stigmatisation stemming from negative social attitudes, and that these processes have important negative repercussions on their life outcomes. In this paper we have used longitudinal population-level data to examine the degree of support for equal rights for same-sex couples in Australian society, paying attention to trends over time in the level of support and the socio-demographic characteristics of individuals who express high/low support.

Our HILDA Survey results unambiguously show a high degree of societal-level backing for the notion that same-sex couples should have equal rights to heterosexual couples. In 2015, 66% of the Australian population held that view. The HILDA Survey data also provides evidence of overwhelming social change in this regard; as just under 40% of the Australian population expressed support for equal rights for same-sex couples 10 years earlier, in 2005. If attitudes towards same-sex couples are in fact predictive of stigmatising and discriminating behaviours towards LGB people, the observed trend towards support for equal rights paints a positive picture of the future outcomes of Australian sexual minorities.

These societal changes cannot be attributed to compositional changes in population characteristics, at least in those aspects that we have included in our models. This suggests that social change in this arena may be the product of cultural and/or institutional changes at the macro level. Cross-national comparative research has identified that higher levels of gender equality and less heteronormative policy contexts are two macro-level mechanisms associated with more positive attitudes towards non-heterosexual people (Henry & Wetherell, 2017; Henshaw, 2014; van den Akker, van der Ploeg, & Scheepers, 2013). Over the past decade, most Australian states have improved the legal rights of sexual minorities; for example, by recognising same-sex civil unions, granting same-sex couples adoption rights, expunging historical convictions, and equalising the consent age for homosexual and heterosexual sexual behaviours. These legislative changes, together with an increasingly active LGBTI+ movement, may have contributed to the change in societal attitudes reported here.

While a vast majority of the 2015 Australian population supported equal rights for same-sex couples, there was still a non-negligible fraction that did not (about 34%). This poses the question of whether or not differences in support rates are patterned by socio-demographic characteristics. Our analyses reveal clear evidence that this is the case. As expected, support rates were lower among individuals who were male, religious, heterosexual, aged 40 years or over, not holding a university degree, in the bottom income
quartile, a migrant from a non-English speaking background, and living in a regional or remote location.

When we further assessed trends over time in the degree to which these socio-structural positions were predictive of support for the rights of same-sex couples, we found more evidence of continuity than change. There were, however, some exceptions. University-level educational qualifications were found to be less predictive of support in more recent years. This is consistent with diffusion theories of attitude change: higher-status “innovators” adopt non-traditional attitudes first, and over time these attitudes diffuse to lower-status, more traditional groups, such as the less-educated (Pampel, 2011). On the other hand, the gap in support levels by religiosity widened markedly over the 10-year observation period. This is consistent with findings of Patrick and colleagues (2013), who found that religiosity increased the likelihood of developing disapproving attitudes towards same-sex sexual behaviours.

These results have significant implications for policy and practice. Despite a high degree of public support for equal rights by 2015, same-sex couples in Australia were still denied the right to marry and the associated symbolic and practical benefits. Almost all Australian states and territories had allowed same-sex couples to register their relationships, which were treated as de facto unions under federal law and conferred most of the same rights as marriage. However, there is often a significant burden of proof associated with registering a relationship. As a result, while the rights afforded married couples are granted automatically and cannot easily be challenged, same-sex couples have had to jump through several hoops to obtain the same rights (Roberts & Kelly, 2017). Furthermore, unlike marriages, registered relationships are rarely recognised overseas.

In late 2017, at the time of writing this article, the ABS was undertaking a national postal survey to gauge public support for legalising same-sex marriage on behalf of the Australian Commonwealth Government. If the majority of Australians participating in the postal survey voted “yes”, then the government would facilitate the introduction into parliament of a private member’s bill to legalise same-sex marriage, and allow their members of parliament a free vote on the bill. The results, announced on 15 November 2017, indicated that 62% of the survey respondents voted “yes” and 38% voted “No”, with same-sex marriage becoming legal in Australia in December 2017. These results are very similar to the 66% and 34% figures reported in this study—highlighting the external validity of the HILDA Survey as an instrument to gather public opinion.

The relatively small discrepancy between the HILDA Survey analyses and the ABS Survey results may be due to different factors. First, the ABS Survey asked people about same-sex marriage, instead of the rights of same-sex couples more generally, and some people may not consider marriage to be a “right”. Second, 21% of eligible Australians did not participate in the ABS Survey, and these Australians may be more likely to have characteristics associated with support for same-sex marriage (e.g., being younger). Third, some supporters of LGBT issues may have boycotted the ABS Survey—for example, due to perceiving that it would elicit unnecessary national debate and be harmful to LGBT people, due to a lack of support for the institution of marriage or due to the survey’s cost.

Regardless, the results of both the ABS Survey and our HILDA Survey analyses evidence that there has been a clear misalignment between public attitudes and recent legislation. In keeping with the democratic principle that national legislation and public policies should reflect (changes in) the public sentiment, they suggest that the Australian law required amendments to become more inclusive and respectful of individuals in same-sex couples. In fact, if the observed social trends in the degree of support continue over the next few years, the fraction of the population that will actively oppose this notion is likely to become negligible. In addition, legislative change may result in positive flow-on effects on the life outcomes of same-sex couples, by reducing the experiences of minority stress that result from discrimination and eliciting feelings of social inclusion (Everett, Hatzenbuehler, & Hughes, 2016; Hatzenbuehler et al., 2012).
References


The evolution of family research at AIFS

Talking with past Institute leaders

▶ Luisa Saccotelli and Aileen Muldoon

Since the inception of the Australian Institute of Family Studies in 1980, AIFS has been a leading influence on family policy and research in Australia. To celebrate the 100th issue of *Family Matters*, we have asked former leaders of the Institute to take the time to share their experiences, reflect on some of the most ground-breaking work the Institute has undertaken, and reveal their ideas of what important issues are emerging for families now and in the future.

Dr Don Edgar,
Foundation Director, 1980–93

Early days

According to Don Edgar, the idea for an Institute of Family Studies grew out of concerns regarding changes to the Family Law Act in the mid 1970s.

There was some concern the new laws would increase divorce and even destroy marriage, Don said. The establishment of a families institute would ensure there was a body that would monitor the impact of changes in family law, as well as look at other issues affecting Australian families.

Don had been working as a sociologist at La Trobe University, after a stint in Chicago with his wife Patricia and their young daughters.

When chosen as the Institute’s Foundation Director, Don established it in Melbourne, to avoid disrupting the family and because he didn’t want to live in what he saw as “that rarefied Canberra atmosphere”.

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Peering over the white picket fence

Few people knew much about Australian families then. Even the census ignored remarriage, stepchildren and adoption, and little other family research was being done. Don had to “pick the eyes out of whatever there was” and realised a major research program had to be set up. His first seven year plan set the Institute’s direction for many years.

The first longitudinal study on family formation made headlines with findings about young people’s delayed leaving home, delayed marriage, de facto living and the huge diversity of family life. Early work also looked at the child’s-eye view of family life, child care and early childhood development, while the first national family database was set up, now the largest in Australia. AIFS’ work exposed the stereotype of the white picket fence nuclear family and led to new policy approaches.

“I was from a one-parent family, my father was killed when I was 10, leaving five kids under 12 years. My mother worked in the Fletcher Jones factory and I cooked dinner most nights and did the shopping. I had never assumed that women didn’t work.”

The Institute was also starting from scratch examining family law, “there was no research being done there”.

“There was also nothing on ethnic families, so we did the early work on migrant workers, including exploitation in the rag trade.

“We were putting out information that had never been seen before. Every social service agency and government department saw our research as relevant and valuable—except Treasury. They told me to stop sending issues of Family Matters ‘because Treasury has nothing to do with families’. They changed their minds.”

Fearless and independent

Don said despite being a federally funded body, the Institute and the Institute’s board strongly guarded their academic independence.

The Institute used its family database to cost various parties’ budget tax policies to test their effect on different types of families, which was unpopular at times.

“We were scrupulously non-partisan and fearless in presenting the facts and their social implications.

“The problem is that you’re saying, ‘here’s the data and they don’t support what your government or your party policies are trying to say’. We’d argue about that and both I and the board insisted on preserving our academic independence.

“It did mean the debate changed. Nobody could talk about families just in that blanket sense again.”

Who pays for the children?

But it was a fight about who pays for the children in separated families that resulted in the most seismic piece of research. “It was all very haphazard then, you’d get a bit of alimony, the odd payment for children and even though the Family Court was supposed to be non-litigious (there were registrars to talk about property, and counsellors to discuss custody and access issues) the lawyers were in there, of course, and they were about money, so it wasn’t working.

“We did a number of studies that found that after divorce the women and kids were poor and the blokes were getting away with murder.”

In 1984 the Institute released The Cost of Children in Australia report, which set out costs for different ages based on a simple basket of goods, food and clothing and minimal estimated expenses.

Don still remembers that the cost for two year olds was $975 annually and for 11 year olds $1,410.

“When that study came out it was huge. People would say ‘that’s expensive’ but we were able to say, ‘this is absolutely the minimum contribution that children need’.

“It helped governments and welfare agencies improve payments for foster parents and led to the creation of the national child support scheme. AIFS studies were major factors in improving policy. As were our studies on child care, maternity leave and the work–family balance.

“Family Matters was a major instrument in publicising the need for change; every journalist would pounce on each issue and spread the word, so we always had major support when cost cutting was in the air.”

Re-inventing middle age

In 1993 a brush with prostate cancer saw Don step down as director of the Institute. Fortunately, it was treated successfully and these days Don and his wife Patricia are immersed in the fallout from one of the great demographic shifts of our time—the middle ageing of society.

They’re exploring the shift to longer life and the fact that already seven million Australians are aged between 50 and 75—not the new middle age—and they’re all going to need work and a sense of purpose. “Not all of them have super and fancy houses.”

“People will need to reinvent themselves on a personal level and social policies across employment, relationships, education, finances, lifestyle and health will have to change too.”

Opposition Leader Bill Shorten launched their book Peak: Reinventing Middle Age, and Don was also gratified to hear Federal Ageing Minister Ken Wyatt start to use terms such as “lifelong education” and “the longevity economy”.

Nowadays, Don is relishing his freedom while keeping his finger on the pulse of the latest social trends in a continuum of the work he began as the founding director of the Institute.
Demographer drives AIFS early landmark research projects

Other people’s marriages are generally a taboo subject but former AIFS Deputy Director Peter McDonald spent his early career immersed in them, or at least the study of the marriage patterns of Australians. In what is arguably the most comprehensive study of Australian marriage ever undertaken, Peter’s PhD examined marriage in Australia from early settlement in 1778 through to the tumultuous years in the 1970s when the principle of no-fault divorce was introduced in the Family Law Act. Surprisingly, it was not his knowledge of Australian marriage that landed him a job at the Institute. Rather, it was his multidisciplinary skills as an economist and demographer that were the winning combination for a highly diverse social policy Institute keen to establish its credentials.

“In selecting the deputy director’s position, they were tossing up between a policy person—which was not me—but I grew into it—and someone who was more statistical, more multi-disciplinary and more of a demographer,” he said. “The Institute was an interdisciplinary place then with economists, lawyers, psychologists and sociologists and each group brought different skills but we all learnt to work together. That was the real strength of the place.”

Establishing its research credentials

Not long after starting in his role at the Institute, Peter was asked to lead a major study on the Economic Consequences of Marriage Breakdown. The study was a recommendation from the Australian Law Reform Commission’s review of matrimonial property. According to Peter, it was the first major policy study undertaken by the Institute and it was critical to its future.

“The study was an opportunity to prove ourselves,” he said. “It was also really important because it had to establish the Institute in research terms, and we had to do it well. If we had failed, the Institute would probably have been wiped out.”

The study did go well, gaining national and international acclaim for its breadth of research and its findings. Peter remembers the tense discussion with the Law Reform Commission over the terms of reference.

“Initially the Law Reform Commission was interested in a narrow legal study,” he said. “We had to work with them but our group was aware that marriage breakdown has a lot of psychological aspects to it and the relationship between the couple was important. We had to argue with the commission for a much broader study but in the end, they agreed.”

While the study did not result in any changes to matrimonial property law, there were unforeseen consequences that would have financial implications for divorce settlements. “Our study found that property settlements were ignoring superannuation,” he said. “This tended to disadvantage women as the superannuation was generally in the man’s name and women didn’t get access to those funds.” Superannuation benefits were subsequently considered the same as any other item of property on divorce.

The study also yielded detailed information on child maintenance, which greatly assisted the then government to introduce a Child Support Scheme ensuring children of separated parents were not financially disadvantaged by the breakdown of the marriage.

Later, the Institute published a book based on the research titled Settling Up. A follow-up study examined how people fared a few years following the marriage separation. According to Peter, the study showed that most people were able to recover financially after a marriage breakdown “even though the economic consequences were severe at the time”. From the follow-up study, the Institute produced another book, Settling Down, which cemented its international reputation.

Contributing to social reforms

Following the success of the marriage breakdown studies, the Institute continued its involvement in major social policy issues of the time. Peter cites the Institute’s work in the area of social security that contributed to the government increasing the low-income supplement to families as children got older and more expensive, and the Australia Living Standard Study that recommended a dental scheme for low-income families.

According to Peter, families are much better off now than they were 30 years ago—there has been a 50% increase
An accident of fate

David Stanton never set out to become the Director of the Australian Institute of Family Studies. The Minister for Family and Community Services, Jocelyn Newman, asked David to go to Melbourne to “help out” for a month or two until a permanent director could be found.

David, a former senior public servant, was eventually appointed to the job and stayed for the next four years, cementing his reputation as one of the country’s foremost experts on family policies.

It was an irony not lost on him that while he was leading families’ research, he’d left his own family behind in Canberra—his wife, a senior public servant, and a son at university.

“It was a bit incongruous while at AIFS to be working on how to enhance ‘work and family’ policies. It was a bit ironic perhaps but with strong support from my family we were able to manage it.”

Having been in charge of family programs in the then Department of Social Security, working on policy development advice to ministers and running various aspects of departmental operations (including research and evaluation issues), he was delighted by the new opportunity.

Though there were early days of ignominy ... having to recall the Institute’s annual report because it was printed upside down and earning certain notoriety for singing an Elvis song at his first staff Christmas party. He’d been told that everyone sang. No one else did.

New direction

Under his leadership, the Institute’s focus shifted to national policy and it became heavily involved in signature longitudinal studies—the Longitudinal Study of Australian Children (LSAC) and the Household, Income and Labour Dynamics in Australia (HILDA) study.

While winning substantial research contracts helped give financial stability to the organisation, David also encouraged his researchers to initiate other equally fascinating research topics—such as what makes a successful marriage.

Marriage material

“Robyn Parker did this qualitative study, it was very clever and interesting, looking at what are the factors that determine long and successful marriages.

“It was about compromise and understanding and willingness to change over time, of course, and it was fascinating to hear from people who’d been married for 50 and 60 years. Couples emphasised love, trust, mutual respect and good communication. The study was something a bit different.”

The Institute also received special funding from then Women’s Affairs Minister Amanda Vanstone and the Office of the Status of Women to look at what influenced women in deciding how many children they want.

“We asked people retrospectively, how many children they had, how many they wanted, why they’d not had more. That work was developed by Ruth Weston and was well received as an important contribution.”

It was around the time that former Treasurer Peter Costello was exhorting Australians to have one child for you, in real incomes for a start—but he points to a “bunch of families at the bottom end that have really been left behind. The biggest social issue is children growing up in families where nobody works and we need to be looking at how to change the life pathways for those children”.

Peter is more positive about gender equity in family relationships and sees men taking on more of the child care roles than they have done in the past. “I think it is starting but it is a longer-term social change,” he said. “Women themselves are important in that change and they have to demand it.” On this issue, Peter remembers the Institute practising what they preached, introducing permanent part-time work with superannuation, which greatly helped women who had returned to the workforce after having children.

Peter feels the Institute has a special place in his working life, crediting it with broadening his narrow academic focus and teaching him to deal with government ministers and public servants and the media to deliver significant policy reforms. Some of the issues he dealt with at the Institute still hold force. He stops midway during the interview to check the result of the same-sex marriage survey. “It’s YES!” he announces as if heralding the start of another new chapter on Australian marriages.
one for your partner and “one for the country”. Fertility was a hot topic.

“I’m always very conscious that you stand on the shoulders of others, a lot of this work had a long history—divorce and work and family—going right back to the Foundation Director of AIFS, Don Edgar.”

Fix family support

David says that while great achievements have been made in family wellbeing in the past 30 years, there are many challenges requiring urgent attention.

“We’re going to continue to need to focus on the reforms to child support—which have been very significant going right back to the 1975 Family Law Act but which still need more attention before they become fully effective.

“There’s a lot of rhetoric in welfare to work, but if families are going to be successful in moving beyond precarious employment there will be a need for a lot of support in the transition to work, especially for sole parents where there have been cuts in benefits and conditions.

“I’m very concerned there might be an emerging issue of poverty for sole parents and their kids, a situation like we had in the early 1970s when we had the [Henderson] poverty inquiry. Indigenous families are in chronic conditions of poverty and that’s something again to challenge us into the future.

“We also face issues like ageing and the changing nature of the labour market, including more part-time work and contract work. We need to develop a better understanding of the contribution older people make in voluntary roles and caring for grandchildren and the implications of longer periods before becoming eligible for the age pension.

“We also need more support for young people leaving home: there are issues around the housing market, how they transition to independence. With changes to Newstart allowance they are having to depend on parents into an older age.”

Overhaul the tax system

The fault lines are extensive enough to warrant another comprehensive review of the social protection system, according to David.

“The current system is very complex. The time is right for a broad-based, comprehensive review to ensure it is fit for purpose. We have not had such a review since the poverty inquiry in the 1970s.

“I think people understand that if we are going to have a society where there’s a need for a whole new way of working, you can’t leave out the social protection dimension.”

In times of acute pressure on families, good policy initiatives can follow. Times have certainly been tough before: David points to the impact of the 1930s depression and the two world wars. Government and the Parliament actively looked to reform the welfare state during World War II with child endowment and payments to the unemployed being introduced.

“But the fire that’s hottest for families is the one you’re sitting on.

“Families now are facing a lot of pressure, some of it from good things, like the dramatic growth in women’s labour force participation.

“But you can’t achieve all of that without good parental leave arrangements and child care, for example. And while there are challenges, you can certainly ameliorate those.”

David emphasised how much he had enjoyed his time at AIFS. He said he was privileged to work with outstanding and friendly staff (both research and administrative staff), a very supportive board, and ministers and their departments who appreciated and valued the contribution of the Institute.
At the coalface of research
In his current role, Alan Hayes has gone back to the coalface of pioneering social science research in the New South Wales Hunter region.

He’s working with regional communities being buffeted by the global headwinds of major structural change, bracing for declining jobs and experiencing anxiety about their collective future.

His role at the University of Newcastle involves finding ways to support families facing complex challenges, an area where he’s the first to say that “there’s a lot more to do”.

“In a world of global economic development and transitions, we need to think about those who are at risk of missing out or of being left behind by the forces of change,” he said.

“Giving families the opportunities to move out of circumstances like that is a major challenge and that’s part of the overall anxiety communities have because that change is so very unpredictable.”

While evidence-informed policy points to initiatives that may be successful, there’s still the problem of how to make the gains last for large numbers of people.

“Work in randomised controlled trials with selected cohorts is one thing but the real challenge lies in making initiatives work out in the real world.

“Research translation and implementation insights inform not only more successful approaches but they also help ensure that interventions are sustainable and scalable.”

More family support needed
He believes that one of the big challenges families face is the need for better co-ordinated and integrated services and supports, especially for children entrenched in “complex” families.

“Some families have multiple, complex needs spanning health and social services terrain. We’re making real progress in integrating aspects of health care but it’s the wraparound of all the other social services that’s still needed.”

Another emerging issue for families is the need for an improved system of relationship support services that is “less adversarial” to minimise what he sees as some of the worst outcomes for children caught up in relationship breakdowns.

“We’ve been progressively moving things to keep the best interests of the kids at the heart of the family law system, to minimise some of the unintended consequences, which can have very negative, very long-term impacts on a child.

“We’re doing much better but there’s still a lot of damage in some families and we need to continue to improve the system.

“That might sound utopian and idealistic but it’s increasingly an issue and one that the Institute can continue to provide the insights to enable progressive improvement.”

Most impactful piece of research
For Alan, the research with the most impact during his directorship was the Institute’s evaluation of the 2006 Australian Family Law Reforms, which he describes as a “landmark” piece of work.

The 2006 Howard Government reforms sought to bring about a shift in the way families managed separation, emphasising shared responsibility, care and cooperative parenting. Critics argued the reforms shifted the balance too far away from placing children’s interests front and centre of parenting arrangements.

“The scope of our evaluation of those reforms; the intersecting parts; and the way it looked at the whole family law reform package, through a range of methods and longitudinal elements in a large-scale survey was, I think, unprecedented.

“In a relatively short time frame we were able to consider improvements to the system and set directions for a new approach, which would not have been possible without the completeness of that research.”

Baby talk
Well before grappling with issues of family break-up, Alan was a primary school teacher who retrained as a psychologist to focus on child development issues.

He led ground-breaking work in developmental psychology focusing on communication between mothers and babies. Not much was known about how mothers and babies’ communication developed and who was leading the exchanges.

“There was an idea that infants simply pop out in an evolved sense and already know how to communicate with their mothers. We developed a new method to look at the way it actually worked, was it through gaze or vocalisation, or both; was it the infant or the mother driving the interaction?
“The end point that we established, through a number of different means, was that it was the mother driving it all and not a dance in which each partner was equally involved.

“The mother largely created the way the infant learnt and we, in turn, learned how mothers did that.”

Data dispels fiction

Alan believes there will always be a need to have an accurate picture of Australian families to counteract some of the views that can be anecdotal, dated, only partially informed or downright wrong!

Data can tell us who lives in families now, what the life course might look like for individual family members as well as how well families are faring at a particular point in time.

Alan describes the Australian Institute of Family Studies as a “resilient” organisation that has faced multiple reviews and changes in the machinery of government, and thrived under a raft of governments and ministerial portfolios.

“We were forever meeting a new crop of colleagues in Canberra and working to try to get them to understand the value of the work we did.

“But we developed a lot of close relationships with colleagues that way and we got better outcomes by working together to advance the wellbeing of Australian children, families and communities. That’s always been central to the Institute across its life.”

“A tough agenda

Even as a young psychology lecturer, Daryl Higgins was interested in child abuse. He wanted to understand the consequences for individuals but also what caused the different forms of abuse and neglect in families.

They are questions that continue to propel his academic career today. It’s tough stuff and not for the faint-hearted but it’s an area of applied families research he’s always been passionate about.

“It’s about trying to look at the causes of maltreatment and the relationships between the experiences that someone has had and the effects on their lives. It’s complex and involves understanding a whole range of factors and how they relate to broader issues of family dysfunction,” he said.

It’s one of the enduring challenges that families continue to face. As do the people charged with delving into the dark recesses of often complex lives.

“Constantly on my mind is the issue of preventing child abuse and the particular challenge is the issue of how to truly embed a public health approach to this.

“We’re good at tertiary responses like when there’s a full-blown mental health issue, understanding what to do then. But the greatest impact occurs when you stop it happening in the first place so people don’t hit that danger time.”

Putting practitioners in place

Daryl points to a need to have professional practitioners in child care centres, schools, GP clinics and maternal and child health centres—not that he’d call them maternal health centres, a moniker that ignores the 50% of parents who are fathers.

“For example, GPs could provide support to mum or dad dealing with their kids, acknowledging that it’s tricky to do this, or better still stepping in to model how to stop the tantrum getting out of control.

“GPs have been good at doling out injections, scripts and a dose of Ritalin or two, rather than equipping parents with capacity. Perhaps, through the new ‘super clinic’ model, practice nurses could take a lead role supporting parents, and it wouldn’t be stigmatising.

“I’d love it if there was no need for any family services because these practitioners are already embedded in all of these places. We still need the professionals, in fact more of them, but not waiting until there’s a problem.”

Another emerging issue for families is the complexity of the problems they face while services remain largely siloed around, for example, drug and alcohol issues or family violence.

A mother with a drug addiction or a fear of violence can be sent off to all of these different services when “it would be better if the first worker did the running around to help them, instead of expecting clients in distress to actually manage the complexity of the service system”.

Dr Daryl Higgins, Deputy Director (Research), 2011–16
General Manager Clearinghouses, 2005–11
Manager, National Child Protection Clearinghouses, 2004–05

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Past adoption research

It was research into another type of trauma—the fallout from past adoption practices—that Daryl nominates as having had the most impact during his time at the Institute. It was work commissioned by the Australian Government as a way to find out about the experiences of people who’d gone through forced adoptions and establish how to help them.

“It began as a quite small project, a summary around the issues of people affected, we did a literature review and the next work was to do a national scoping study where we identified the full scope of the problem. Governments could see the importance of research in answering a social problem.

“The national apology was a focal point and we were able to take our research right through to being able to say the impacts of forced adoptions were significant and that we need improved services, what people’s needs are, and the different models that could be employed in trauma-informed services.”

Evidence-based programs are one of the great achievements that have been made in family wellbeing over the past 30 years but it’s not always easy to see what works.

“If we’re going to spend the public dollar, how do we identify which services work? It’s difficult because not every service is a manualised program that you can easily assess, it’s part of working out what are promising practices.”

Kitchen confidential counsel

Daryl observed, “Knowing what’s best practice and living it within your own family was not always easy either. It can be a bit hard at times, knowing what the research says you should do and putting that into practice as the parent of teenagers”.

He feels it might have tempered his tendency to be a little bit “didactic” at times. Sometimes, the best expert advice came from much closer to home.

“I was fortunate to have a very supportive partner in Alan and he would call me to account and make me think, ‘I’m not going to be the guy complaining because the dishes were piled up and I can’t even start on dinner.’ Alan had a rule, ‘no nagging for the first hour after you get home’ …not to say I managed it all of the time but I did try.”

In 2013, the Institute published a much-cited paper on same-sex parenting just after the change to a more conservative government in Canberra. The paper suggested that kids in same-sex households did just as well as those in other family types. It wasn’t necessarily a surprise to Daryl.

“There are always complexities and it’s important to be sensitive to the needs of policy makers while still being fearless in saying what needs to be said.”

Ruth Weston, Assistant Director, 2011–16
Currently Senior Research Fellow
Principal Research Fellow, 2001–09

Longest-serving employee notches up over three decades of research

Ironically, when Ruth Weston started working at AIFS more than 30 years ago, she accepted a low paying position to accommodate caring for her own young family. With a background in psychology, Ruth had worked at Melbourne University in the Psychology Department, the Agricultural Extension Research Unit and the State College of Victoria, Burwood (now Deakin University).

With young children to consider, Ruth then took up a very short-term, part-time job at the Institute to analyse a survey dataset. Although this paid less than $10 an hour, she said laughingly, “I enjoyed the work so much that I would have done it for no pay!” She had not expected the work to continue, adding “It turned out that I basically started my career all over again. Now women generally don’t need to start their careers from scratch after having children. That’s a huge change.”

Helping separated families

In the early days at the Institute, Ruth Weston was involved in a major study examining the economic consequences of divorce, led by Peter McDonald. It was at a time when the vast majority of mothers and children were dependent on fathers for financial support, and when this ceased upon separation, single mothers who relied on welfare attracted a great deal of criticism.

“There was not a lot of understanding for single mothers whose reliance on welfare for themselves and for their children arose from their having entered a ‘partnership’ years earlier, whereby they gave up paid work to look after the home and children full-time, thereby promoting the father’s career prospects,” she said.
“With maintenance payments often low and unreliable or non-existent, single mothers were broke, which meant that the kids were broke too. The research raised important issues about financial support for children and ultimately helped contribute to the establishment of the Child Support Scheme.”

The Institute’s evaluation of the 2006 Family Law Reforms was another seminal piece of research Ruth was involved in. In 2006, the government introduced a series of changes to the family law system, partly designed to encourage greater involvement of both parents in their children’s lives after separation.

The Institute was engaged to undertake an evaluation of the changes and to find ways to improve the family law system. No other country had undertaken a study of such magnitude.

“The evaluation involved a large number of studies, including analysis of court files and administrative data, exploring the views and experiences of lawyers, court professionals and judicial officers, family relationship service providers and their clients, and separated parents, using both qualitative and qualitative approaches,” she said.

The evaluation contributed to further amendments to the Family Law Act and was a springboard for other studies.

A strong body of research
According to Ruth, the Institute’s greatest achievement is the culmination of all its research since its inception.

“It is the history of the research that tells the story of what has—and has not—changed over time,” she said.

“Our research on separation has expanded to look at issues like continuing the involvement of both parents in children’s lives, family violence and keeping children safe, and children’s experiences of parental separation, including how they cope living in two households.”

She is proud of the Institute’s focus on changes in Australian families and life-course transitions; the close connection between paid work, family life and family wellbeing; parenting and child wellbeing; and service delivery to families. She points to the huge value of Growing Up in Australia: the Longitudinal Study of Australian Children and the Household, Income and Labour Dynamics in Australia (HILDA) Survey, in contributing to impactful research in the area of family studies.

Challenges for modern families
For Ruth, the perennial challenge for families is inequality. Although gender inequity is not as strong as it once was, many women still receive lower wages and do the bulk of the housework despite longer paid working hours. Also, many women and children are exposed to violence in the home. She is also concerned about the fact that children who have spent much of their childhood in disadvantaged circumstances have a much greater risk of experiencing poverty and social exclusion throughout their lives.

Then there is the time-stress in dual-earner families, and the need to meet the increasing demand for child care linked to increasing numbers of mothers and grandparents in paid work.

However, it is in describing the problems of Indigenous communities that you can hear the angst escalate in her voice. “Indigenous Australians and their families are particularly likely to face huge disadvantage on numerous fronts throughout their lives—lives that tend to be substantially shorter than for other Australians,” she said.

“The 2017 Closing the Gap report shows we are on track to meeting only one of the targets at a national level—that is, halving the gap for Year 12 retention by 2020. On the other indicators, substantial inequality between Indigenous people and other Australians persists, though in some areas there is evidence of significant improvement.”

Ruth sees a number of emerging issues that pose a threat to families. She refers to the “dark side” of the Internet; for example, where problems such as child exploitation, stalking, cyberbullying and identity theft proliferate.

Youth unemployment, homelessness and high housing costs, precarious employment and the growing number of people reaching an age “where they need a great deal of care” are other crucial issues.

Drugs and gambling are also worrying issues, as these can have enormous adverse effects on individuals if they become “hooked” as well as on their families and communities. She also cites elder abuse as a problem that is only now starting to get the attention it deserves, and drug-fuelled abuse of parents by their children, which has yet to receive such attention.

Despite their ups and downs, almost all families manage to raise the next generation to become active and well-adjusted members of society. They will continue to remain the backbone of society, while also drawing on societal resources. As the saying goes: “It takes a village to raise a child.”

Ruth is now the Institute’s longest-serving employee, and considers herself lucky to have spent her working life providing evidence-based research that has had a direct influence in shaping family policy.

“It has just been so exciting to be involved in research that can have an influence on policy. AIFS continues to identify what’s happening in families, linking this with multi-dimensional social forces and decisions made within families. We have to keep monitoring these forces and stay abreast of what is happening to all forms of families. Evidence-based policy development and adjustment are vital.”

Luisa Saccotelli and Aileen Muldoon are consultants with Cut-Through Communications and were commissioned to write this article.
Introducing the National Workforce Centre for Child Mental Health

Improving the lives of infants, children and families

Bradley Morgan, Nicola Palfrey, Rhys Price-Robertson, Sophie Guy, and Jessica Masters

Infants and children are exposed to many experiences, both nurturing and stressful, that influence their mental health (Dogar, 2007). Early childhood mental health involves being able to experience, manage and express emotions; form close, satisfying relationships; and explore and discover the environment (KidsMatter, 2012). Most children learn to cope with adversity, express and regulate emotions, form close and secure relationships, and explore their environment with behaviours appropriate to their individual personality, ecological environment and developmental stage. As well as physical development, children develop socially and emotionally, that is they develop skills around managing relationships, their feelings and interactions with their broader environment. The majority of children, with support from the adults in their life, learn to express and manage emotions in healthy ways, nurture social relationships and successfully contend with life’s challenges.

A substantial minority of infants and children, however, experience more frequent or intense difficulties with their emotions, thoughts, behaviours, learning and/or relationships. Extensive evidence now exists regarding the developmental origins of adult mental health difficulties from adverse experiences in infancy and childhood (Anda et al., 2006; Merrick et al., 2017; Norman et al., 2012; Scott, Varghese, & McGrath, 2010). Despite the prevalence and serious immediate and long-term impact of these challenges, infants and children at risk of, or experiencing, mental health difficulties often go unrecognised, lack access to adequate assessment of their needs, and have low levels of access to services with the capacity to offer appropriate levels of support (Milburn, Lynch, & Jackson, 2008; Paula et al., 2014; “Serious gaps’ in crisis care for children”, 2017). This article focuses on child mental health in Australia, outlining the context behind the recent establishment of the...
Prevalence of infant and child mental health conditions in Australia

There are a number of challenges to providing a clear picture of infant and child mental health in Australia (MacDonald et al., 2005; Twizeyemariya, Guy, Furber & Segal, 2017). Differences in methodology, study parameters and focus, and age limits mean it can be difficult to streamline the myriad studies into a single overall review. However, thanks to ongoing longitudinal studies such as Growing up in Australia: The Longitudinal Study of Australian Children, which commenced in 2004 and follows the development of 10,000 children and families, and the Mater-University of Queensland Study of Pregnancy, which commenced in 1981 with a study of 8,556 pregnant women and continues to follow their children and grand-children, we have a better developmental and ecological understanding of infant and child mental health than ever before.

Notably, there is a lack of information on the mental health of Australian infants under 2 years. This may partly be because of a reluctance to apply diagnostic labels to the earliest signs of disturbance when they can often be transient in the context of rapid developmental changes (von Klitzing, Dohnert, Kroll, & Grube, 2015). It is also further complicated by the fact that the first year of an infant’s life is so intimately embedded within parent and caregiver relationships. One way of identifying the number of infants who may be at risk of developing mental health problems is to look to the prevalence of women experiencing postnatal depression and anxiety, as researchers have found positive correlations between an infant’s exposure to maternal depression (prenatal and postnatal) and increased risk of neurodevelopmental and/or psychopathological disorders (Pawlbry, Hay, Sharp, Waters, & O’Keane, 2009; Soe et al., 2016; Waters, Hay, Simmonds, & van Goozen, 2014).

Infant mental health conditions may present as prolonged dysregulated moods, excessive separation anxiety or problems with sleeping, eating or crying (von Klitzing et al., 2015). If maternal data is taken as an approximate proxy for infant mental health difficulties, then up to 14% of infants may be at risk (Perinatal Anxiety and Depression Australia, 2017). This estimate is similar to results from international epidemiological studies, which indicate that 16–18% of children suffer from a mental health condition at some time during their first five years (see Table 4) (von Klitzing et al., 2015).

The 2015 Australian Child and Adolescent Survey of Mental Health and Wellbeing (Young Minds Matter) (Lawrence et al., 2015) provides detailed information on the prevalence of mental health conditions (i.e., depressive disorder, anxiety disorders, ADHD and conduct disorder) among children and adolescents aged 4–17 years. This survey found that 13.6% of children aged 4–11 years experienced mental health conditions of clinical significance in the previous 12 months. The prevalence of mental health conditions was higher in males (16.5%) than females (10.6%), which can be largely attributed to the higher prevalence of ADHD in males (10.9%) compared to females (5.4%). However, there is some evidence to suggest that this prevalence may be influenced by perceptions of gender; a number of studies have found that ADHD is diagnosed and treated more often in boys than in girls because they are more likely to exhibit hyperactivity and/or disruptive behaviours (Rizzo, 2016; Skogli, Teicher, Andersen, Hovik, & Øie, 2013), while girls with ADHD are more likely to have the predominantly inattentive subtype and are less likely to manifest problems in school (Biederman et al., 2002; Rucklidge, 2010). Australian researchers have also found parents and teachers are less likely to seek mental health and/or learning assistance for girls with ADHD symptoms because they believe it will be less effective than it is for boys (Ohan & Visser, 2009), though data suggests current treatments are likely to be equally effective for both genders (Rucklidge, 2010).

Behavioural and/or attention problems during childhood can indicate past or ongoing exposure to adversity, as children with emotional, mental or behavioural conditions are more likely to have experienced adversity or trauma (Bethell, Gombojav, Solloway, & Wissow, 2016). Behaviours associated with infant and child mental health are often misunderstood as being “naughty” or intentionally willful, and therefore it is less likely that an appropriate and effective solution will be applied (World Health Organization, 2005).

Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC) (Smart, 2010) followed two groups of children over two waves aged 2–3 years and 4–5 years, who were assessed for problem behaviours and competencies. Problem behaviours were ordered from the most to least common into typologies of externalising (56% of children were sometimes or often restless or unable to be still), internalising (49% of children were sometimes or often afraid of certain places, animals or things), dysregulation (50% of children sometimes or often refused to eat, while 41% sometimes or often had trouble adjusting to changes), and other (47% sometimes or often ran away in public places, while 35% sometimes or often did not react when hurt) (percentages are rounded here to the nearest decimal). LSAC also documented specific behavioural problems in 2–3 year olds such as nightwaking (11%) and destructiveness (5%), and in 4–5 year olds such as restlessness/inattention (12%), worrying (3%), tendency to lose their temper (8%), fidgeting (9%) and disobedience (2%) (Smart & Sanson, 2008). Many of these are common childhood behaviours but mental illness symptoms can often be recognised by their unusual duration, frequency and/or intensity.
Focusing on strengths and vulnerabilities

Many children demonstrate resilience, which is adaptive functioning over time in a context of adversity, after exposure to hardship (Center on the Developing Child, 2015; Dubowitz et al., 2016; Masten & Obradovic, 2006). However, when vulnerabilities in the child’s life outweigh the child’s strengths, mental disorder can result (World Health Organization, 2005). Vulnerabilities are areas in the child’s life that could benefit from added support, and include individual factors (such as developmentally inappropriate emotional and/or behavioural responses) and interactions between the child and their environments (such as family stress or problems at school or in the community) (Hunter, 2012). Vulnerabilities are complex and interconnected, and it is common for infants and children to be faced with multiple vulnerabilities, which substantially increases their risk of experiencing mental health difficulties (Guy, Furber, Leach, & Segal, 2016; Kitzmann, Gaylord, Holt, & Kenny, 2003).

Examples of commonly identified strengths and vulnerabilities are provided in Table 1, which is structured according to the ecological level at which the strengths and vulnerabilities occur (i.e., child, family or social environment). Each child will have a unique profile of strengths and vulnerabilities, and it is important for professionals to understand these in order to better assess their requirements and supply effective care.

The cumulation of multiple mental-health risk factors signifies increased risk for developing a mental health condition in later life. There are also a number of Australian children experiencing 4–5 or more risk factors for mental illness, which indicates a higher risk for mental health difficulties. Data from LSAC (Guy et al., 2016) found that at 0–1 years, 16.1% of Australian children had four or more risk factors for adult mental illness. The most prevalent risks among infants were a parent’s problem alcohol use, parent mental illness, and mental illness during pregnancy. By 4–5 years, the rate of children experiencing four or more risk factors had risen to 19.2% and, by 6–7 years, to 25.2%. By 10–11 years, 32.8% of Australian children had experienced four or more risk factors. The most common risk factors among high-risk children (i.e., those with five or more risk factors) aged 10–11 years were parent hostility (68.3%), bullying (45.5%) and low parental warmth (43.6%). The increase in risk prevalence rates over time likely indicates risk accumulation, which Guy and colleagues (2016) note is partly due to early-life exposure to risk factors.

### Table 1: Commonly cited strengths and vulnerabilities for infant and child mental health problems

<table>
<thead>
<tr>
<th>Ecological level</th>
<th>Strengths (Protective factors)</th>
<th>Vulnerabilities (Risk factors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual child factors</td>
<td>• Stable, good temperament • Sociable temperament • Engagement at school • Healthy eating habits • Physically fit • Adequate sleep</td>
<td>• Psychological disturbances in early childhood • Genetic influences • Neurological vulnerability • Temperament and behaviour problems • Neuroticism/low self-esteem • Hearing problems/ear infections • Male gender identification • Early or delayed onset of puberty • Lack of sleep</td>
</tr>
<tr>
<td>Family/parental factors</td>
<td>• Two-parent household • Consistent and supportive parenting style • Parent/carer education level: bachelor degree or higher • Teacher–parent communication • Less than three siblings • Good adult role models • Safe home</td>
<td>• Hostile or neglectful parenting • Low parental warmth • Parent mental illness • Disrupted families • Three or more siblings • Parent/carer education level at Year 10 or below • Teenage/young parents</td>
</tr>
<tr>
<td>Social/environmental</td>
<td>• Medium/high socio-economic status • Encouraging school environment • Support networks • Safe neighbourhood • Strong peer relationships • Community involvement • Activities outside of school • Financial stability • Cultural identity</td>
<td>• Socio-economic disadvantage • Parental unemployment • Housing stress • Parental incarceration • Financial hardship • Unsafe school environment • Bullying</td>
</tr>
</tbody>
</table>

Some groups of infants and children are at a much greater-than-average risk of experiencing multiple vulnerabilities, and are more likely than others to be diagnosed with mental health conditions. Children in out-of-home care, for instance, are more likely to have experienced greater socio-emotional and behaviour problems than other children (Burns et al., 2004). Similarly, children exposed to maladaptive parenting or marital conflict have a significantly greater risk of developing emotional symptoms (Lucas et al., 2013), and financial hardship has consistently been found to predict negative mental health outcomes (Hardt et al., 2008; McLaughlin et al., 2011; Rutherford, Hill, Sharp, & Taylor-Robinson, 2017).

Many Indigenous families and communities in contemporary Australia face immense challenges. Indigenous children are more likely to experience multiple risk factors for mental health; over 45% of children aged 6–10 years were exposed to six or more risks for mental illness. There is also substantial risk in infancy with 67% of children exposed to three or more stressful family events before the age of 1 year (Twizeyemariya et al., 2017). Their strength and resilience is compromised by multiple complex problems, including historical and ongoing dispossession, marginalisation and racism, as well as the legacy of past policies of forced removal and cultural assimilation (Human Rights and Equal Opportunity Commission, 1997).

The Australian Child Wellbeing Project report (Redmond et al., 2016) highlighted a number of unique strengths and vulnerabilities associated with Indigenous children and families, including strengths such as cultural identity, community connections and unique family systems (as conceptualised broadly in kinship networks), and vulnerabilities such as intergenerational trauma, cultural disconnection and family disruption.

While Indigenous children are generally disadvantaged compared to mainstream children in regards to health and socio-economic outcomes (Biddle, 2014), Redmond and colleagues (2016) point out that this information “needs to be balanced with empirical evidence that captures the complexities of how culture and family interact with material and social conditions to shape the wellbeing of Indigenous young people” (p.14). Psychosocial resilience, which is defined as an individual’s ability to successfully maintain or regain healthy mental functioning in the face of social disadvantage or life adversities (Rutter, 1987), is crucial to an individual’s overall state of physical and mental health.

When confronted with adverse or traumatic experiences, individuals with higher resilience coped more effectively and had reduced levels of emotional distress afterwards than those with lower resilience (Hjendal, 2006; Hoge, Austin, & Pollack, 2007; Southwick, Vythilingam, & Charney, 2005). Regardless of the type of adversity, the most common factor among mentally resilient children is the presence of at least one supportive relationship with a parent, caregiver or other adult (Center on the Developing Child, 2015). Therefore, among Indigenous youth, strong community and family relationships, as well as links to cultural traditions, are important components of a resilience framework (Chandler & Lalonde, 1998). It is vital for service and health providers to have an understanding of culturally specific protective factors and how these can help to mitigate risk factors.

**Which workforce groups are currently supporting infant and child mental health?**

Many workforce groups come in contact with infants and children at risk of, or currently experiencing, mental health difficulties. However, the Australian health system is “fragmented and uncoordinated” and there is a lack of early intervention initiatives for children and youth (Roxon, Macklin, & Butler, 2011). It is not always clear what mental health services are available for infants and children specifically, as they are often packaged in with other family health services or non-specialist mental health services such as general practice (GPs), paediatricians, child and maternal health services, and child and family wellbeing and welfare programs. Additionally, the Australian child mental health services that do exist often struggle to bridge the gap between health locale and places where children spend most of their time, such as school, child care and home (Roxon et al., 2011).

The Young Minds Matter (Lawrence et al., 2015) survey indicated that 13.7% of all children aged 4–11 years had accessed a mental health service in the previous 12 months. However, out of 4–11 year olds who identified as having a mental health condition, less than half (48.9%) had accessed services in the past 12 months. General practitioners were the most commonly accessed service and source of referral to other health professionals (29.8% of 4–11 year olds), followed by paediatricians (22.5% of 4–11 year olds). General practitioners, as primary care physicians, are also responsible for developing mental health care plans for patients that grant access to psychological services and Medicare-funded mental health care.

A recent benchmarking study by Segal, Guy, and Furber (2017) reviewed mental health service provision for infants, children and young people by Commonwealth and state and territory funded mental health services. It is clear from this review that current levels of access to mental health services do not match levels of need across the life span. Table 2 shows that among children under 17, the 0–5 age group has the highest prevalence of criteria for a mental illness diagnosis combined with the lowest overall percentage of access to specialist mental health services. This means that there is a large disparity between need and service access.
Table 2: Specialist mental health services, population need and current reach

<table>
<thead>
<tr>
<th>Age range (years)</th>
<th>Meet criteria for a diagnosis</th>
<th>Multiple risk factors indicating probable need of specialist mental health supporta (4+)</th>
<th>Multiple risk factors indicating probable need of specialist mental health supporta (5+)</th>
<th>Current level of access to specialist mental health services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>0–5</td>
<td></td>
<td>16–18b</td>
<td>16.1 (0–1 years)</td>
<td>8.1 (0–1 years)</td>
</tr>
<tr>
<td>4–11</td>
<td></td>
<td>13.6d</td>
<td>19.2 (4–5 years)</td>
<td>10.5 (4–5 years)</td>
</tr>
<tr>
<td>12–17</td>
<td></td>
<td>14.4d</td>
<td>12.1 (2–3 years)</td>
<td>5.4 (2–3 years)</td>
</tr>
<tr>
<td>18–24</td>
<td></td>
<td>26e</td>
<td>28.9 (8–9 years)</td>
<td>21.1 (10–11 years)</td>
</tr>
<tr>
<td>12–25</td>
<td></td>
<td></td>
<td>ATAPSc</td>
<td>0.4</td>
</tr>
<tr>
<td>12–25</td>
<td></td>
<td></td>
<td>Headspacec</td>
<td>1.4</td>
</tr>
<tr>
<td>16–85</td>
<td></td>
<td></td>
<td></td>
<td>11.9e</td>
</tr>
</tbody>
</table>

Sources: a Guy et al., 2016; b Lawrence et al., 2015; c National Survey of Mental Health and Wellbeing (2007); d Segal et al., 2017; e von Klitzing et al., 2015.

Often, children under 5 years cannot articulate their emotions in the same way adults can, and infants cannot articulate them at all. There is also widespread belief in the community that infants and toddlers are too young to remember things that happen to them (World Association for Infant Mental Health, 2016), which indicates that the public are misinformed about the importance of the early years for social and emotional development. This difficulty in recognising and understanding mental health symptoms and risk factors means it is even more important for professionals and those who work with children and families to be educated in signs and symptoms, good practice and care for this age group.

**Introducing the National Workforce Centre for Child Mental Health**

Currently, the infant and child mental health workforce operates across a range of disciplines and traditionally siloed departments (Priddis, Matacz, & Weatherston, 2015). Furthermore, vulnerable populations are at higher risk of missing out on mental health services due to the lack of service integration and existing social and financial barriers this lack helps sustain (Whiteford et al., 2014). Initiatives such as SAFE START in New South Wales and the establishment of the Mental Health Commission in Western Australia have contributed to a growing awareness that women in the perinatal period, infants and children are vulnerable populations with specific needs. However, there are residual gaps around how health practitioners can translate knowledge into evidence-based practice.

Globally, there is growing awareness of the importance of upskilling those who work with infants, children and families (Priddis et al., 2015), so service providers are better able to identify, assess and support mental health issues in this population. Increasing the capacity of workforces to respond to the mental health needs of infants and children requires a deliberate, systematic and long-term response.

In response to *The National Review of Mental Health Programmes and Services* (National Mental Health Commission, 2014), the Australian Government has recently invested in a National Workforce Centre for Child Mental Health (National Workforce Centre), which is a collaboration between Emerging Minds, the Australian Child & Adolescent Trauma, Loss, & Grief Network at the Australian National University (ANU), the Australian Institute of Family Studies (AIFS), the Parenting Resource Centre (PRC), and the Royal Australian College of General Practitioners (RACGP).

The National Workforce Centre aims to develop workforce capacity by developing, using and promoting a strengths-based and trauma-informed approach to infant and children’s mental health among services working directly with infants, children and parents. Strengths-based approaches focus on children and families’
positive resources and capabilities instead of the more traditional focus on deficits and pathologies (Hunter, 2012). A trauma-informed approach to care requires an understanding of how adversity and resilience may impact individuals, a commitment to reducing harm and recognition of the unique profile of strengths and vulnerabilities each child has (Bremness & Polzin, 2014).

Trauma and resilience are often spoken about in tandem but they are not opposite ends of the same spectrum. A child may show signs of being highly traumatised and resilient at the same time (Harvey, 2007). Research suggests resilience may be “domain-specific”; children may exhibit signs of competent functioning in one area (i.e., academic achievement) but show deficits in another (i.e., social relationships) (Luthar, 2006).

The National Workforce Centre also aims to develop capacity in structural change, action planning and implementation, with a focus on regional needs, and organisational change with the end goal of helping service providers promote resilience-building within children and better identify, assess and support infants and children at risk of mental health difficulties.

There are four key components to the National Workforce Centre:

1. An online workforce gateway for members of diverse workforce groups to access resources such as practice guides, training, webinars, tools and apps. Cutting-edge research will be translated into evidence-based practice and an accessible online gateway will be created to help service providers better recognise signs and symptoms of infant and child mental health issues. Previous knowledge interventions have suggested that even in workforce groups with a high foundational knowledge of adversity and mental illness symptomology (such as child welfare and social workers), education and training modules were valuable in facilitating early intervention success (Conners-Burrow et al., 2013).

The National Workforce Centre aims to target both clinical and non-clinical services working with children and parents (see Table 3) to deliver an integrated system of trauma-informed care, while also supporting the child's right to have input into the discussions and decisions surrounding their care, in accordance with Article 12 in the Convention on the Rights of the Child which states that “the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child” UN General Assembly, 1989, p. 3).

2. The National Workforce Centre initiative has employed workforce development officers with specialist knowledge in the areas of infant, child, adolescent and adult mental health to develop resources and training courses to support the development of workforce capacity. As part of this work, needs assessments will be conducted with relevant workforce groups (e.g., GPs) to ensure that the materials developed are relevant to their intended audiences.

Table 3: Target workforce groups of the National Workforce Centre for Child Mental Health

<table>
<thead>
<tr>
<th>Services working with infants, children and families</th>
<th>Non-clinical services</th>
<th>Clinical services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family mental health support services</td>
<td>• General practitioners</td>
<td></td>
</tr>
<tr>
<td>• Communities for Children</td>
<td>• Primary and specialist health care providers</td>
<td></td>
</tr>
<tr>
<td>• Early childhood education and care/schools</td>
<td>• Child health and paediatric services</td>
<td></td>
</tr>
<tr>
<td>• Child wellbeing and protection programs and child protection services</td>
<td>• Child development services</td>
<td></td>
</tr>
<tr>
<td>• Out-of-home care</td>
<td>• Aboriginal community-controlled health and welfare services</td>
<td></td>
</tr>
<tr>
<td>• Foster care support agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Playgroups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Child and family support services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Disability services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Aboriginal community-controlled health and welfare services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services working with parents and guardians</th>
<th>Non-clinical services</th>
<th>Clinical services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parenting programs</td>
<td>• General practitioners</td>
<td></td>
</tr>
<tr>
<td>• Community-managed mental health, alcohol and other drug, and gambling social services</td>
<td>• Primary and specialist health care providers</td>
<td></td>
</tr>
<tr>
<td>• Family violence services</td>
<td>• Adult mental health services</td>
<td></td>
</tr>
<tr>
<td>• Homelessness services</td>
<td>• Alcohol and other drug treatment services</td>
<td></td>
</tr>
<tr>
<td>• Disability services</td>
<td>• Aboriginal community-controlled health and welfare services</td>
<td></td>
</tr>
<tr>
<td>• Family Relationship services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• First responder organisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Aboriginal community-controlled health and welfare services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. A national network of regionally based Child Mental Health Workforce Consultants to support workforce development systems change, knowledge exchange and collaboration. To support implementation, small teams of Child Mental Health Workforce Consultants who work at state and regional levels will support the uptake and implementation of evidence-based practice approaches for identification, assessment and support in the promotion of children's mental health. These consultants will be responsible for the development of high-level relationships with Primary Health Networks and key stakeholders. More broadly, they will be responsible for building and supporting organisational and workplace culture to embrace a range of practices and attitudes aimed at “keeping child mental health in mind”.

4. A communication and knowledge translation strategy to support the implementation of evidence-informed practice. Recognising that knowing what works is not sufficient to affect change, the National Workforce Centre will use an evidence-informed implementation framework (National Implementation Research Network, 2018) to assess, plan and track implementation capacity-building efforts across the three phases of implementation. The exploring phase is characterised by recognising an opportunity for improvement and developing a roadmap of changes required to successfully implement new practices. The installing phase involves supporting the organisation to prepare for the implementation of new practices. Finally, the implementing phase is the period of ongoing monitoring and problem solving once new practices are in place.

The National Workforce Centre builds upon previous Australian initiatives focused on infant, child and parent mental health designed to improve workforce capacity to respond to the needs of infants and children. Each of the five organisations involved in the National Workforce Centre brings different strengths and expertise to the collaboration, including insight into the workforce development needs of numerous health and welfare sectors across the Australian service system. In bringing together existing groups of health, research, evaluation, implementation and communication professionals, the National Workforce Centre will support nationally coordinated and integrated initiatives to improve mental health outcomes for Australian children.

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The National Workforce Centre for Child Mental Health is an Emerging Minds initiative supported by the Australian Institute of Family Studies (AIFS), Australian Child and Adolescent Trauma, Grief and Loss Network (ACATGLN) at Australian National University, Parenting Research Centre (PRC) and Royal Australian College of General Practitioners (RACGP). In leading this initiative, Emerging Minds welcomes the opportunity to work with like-minded partners to improve the capacity of professionals who work with children or parents to identify, assess and support children at risk of experiencing mental health difficulties.

A brief history of Family Matters

Hop Nguyen, Gillian Lord and Carole Jean

The first issue of Family Matters, or the Institute of Family Studies Newsletter, as it was then known, was published in a black and white, A4 format in September 1980, when Genghis Khan’s Moscow topped the charts and Robert Redford’s Ordinary People was playing at the drive-in. Just over 37 years later, we celebrate the 100th issue, Family Matters’ last in print. We look back at its history and highlight some of our most notable stories.

The newsletter’s early years

Between Issues 2 and 18, the newsletter took on a square format and introduced a single colour. The content was comprised mainly of short items about the activities of the Institute and its staff, with more substantive articles appearing intermittently. Divorce and its effect on families was a hot topic in those first few years—hardly surprising given that AIFS was founded by the Family Law Act 1975 (Cth), which pioneered no-fault divorce in Australia. Staff participation at conferences, reports from seminars and meetings, staff profiles and book reviews made up the bulk of the pages.

Things were going smoothly until shortly after the Institute’s fifth anniversary, when budget cuts meant that Issues 14 and 15 had to be drastically reduced. Once the funding was restored, the scope of the newsletter was also restored, and with the following issues, the newsletter became a greater mouthpiece for the Institute.

The birth of Family Matters

In the wake of this uncertain time, there was an editorial shift in the direction of the newsletter. Issue 19 was overhauled to a larger A4 format, the paper stock was improved and the name rebadged to Family Matters. It is from this issue that we’ll highlight some of the articles of AIFS’ flagship publication. Family Matters has been a peer-reviewed publication since 1997. While there are many articles we could have included, these articles show how inclusive and forward-thinking AIFS was for the time, how societal norms about topics such as gender roles and sexuality have changed, and how AIFS contributed to important policy and research flashpoints.

Our highlights

Migrant dreams

“Ethnic Family Decision Making and Youth Destination” by Robyn Hartley (Issue 19, October 1987) was a report on a recently completed study commissioned by the Ministerial Advisory Committee on Multicultural and Migrant Education (MACMME) about “factors in family decision-making which influence student retention at school, choice of post-school destination, and aspirations of students and parents from non-English speaking backgrounds”. “Students felt very much on their own in making decisions about their futures, particularly when parents felt that they could not help very much and teachers were not very encouraging.”

Mums and work

“Mothers in the Workforce” by Helen Glezer (Issue 21, August 1988) shares insights from AIFS Maternity Leave Study “into why some mothers decide to return to work and others choose to remain at home after the birth of a child”. “Just under half the women agree that a woman should give up her job if it inconveniences her husband and children.”

Divorce and children

In “How is it Going to Affect the kids? Parents’ Views of Their Children’s Wellbeing After Marriage Breakdown” by Ruth Weston (Issue 27, 1990), 523 divorced parents were surveyed for AIFS’ Parents and Children after Marriage Breakdown Study. An interesting trend was found among separated fathers who no longer lived with their children, “the importance of children’s wellbeing to non-resident fathers dissipated, reflecting the adjustment of these men to the loss of their children.”

Are young people ready to say I do?

“What Marriage Means to Young Adults in the 1990s” by Christine Millward (Issue 29, August 1991) was a review of findings from AIFS’ 1990 Becoming Adult study, which interviewed 138 23-year-olds. “Women seemed more likely than men (39% compared with 22%) to envisage marrying within the next two years when they were aged 24 to 25.”

Child care for children’s futures

“Child Care in a Caring Society” by Harry McGurk (Issue 46, April 1997) came in the wake of “proposals for quite radical changes to the funding of child care”. The article argues for a balance between thinking child care was a service to meet parents’ work needs, and as an investment in and for children. “The focus of child care should be on the creation of social environments and exchanges that secure the current happiness and wellbeing of all children and nurture their developmental futures.”

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Recognising rainbow families

“Legal Recognition of Gay and Lesbian Families” by Jenni Millbank (Issue 55, March 2000) suggests that lesbian and gay claims to relationship recognition are transforming both what we think of as family, and the domain of family law. “I believe that laws about family exercise an enormous influence over us at times of greatest crisis in our lives (such as death and relationship break-up) and that influence is most felt by those whom the law excludes.”

Indigenous families

Family Matters Issue 75 (September, 2006) was published with the theme “Indigenous Families”, covering a wide range of issues relevant to current policy debates and program development. Some of these articles include “The Intergenerational Effects of Forced Separation on the Social and Emotional Wellbeing of Aboriginal Children and Young People”, “Protecting Indigenous Children”, and “Workin’ Together: Indigenous Perspectives on Community Development”.

Caring for victims of sexual assault

“Caring About Sexual Assault: The Effects of Sexual Assault on Families, and the Effects on Victim/Survivors of Family Responses to Sexual Assault” by Zoë Morrison (Issue 76, June 2007) considers the effects on the families of adult sexual assault victims, and how the reactions and responses of family members can help or hinder the victim’s recovery. “In the field of trauma research, witnessing the trauma of a family member or ‘significant other’ is recognised as traumatic within its own right, creating ‘secondary victims’ of traumas including sexual assault (Figley & Kleber, 1995).”

Bringing cooperation to separation

“The AIFS Evaluation of the 2006 Family Law Reforms: A Summary” by Rae Kaspiew, Matthew Gray, Ruth Weston, Lawrie Moloney, Kelly Hand, Lixia Qu and the Family Law Evaluation Team (Issue 86, March 2011). In 2006, the government amended the Family Law Act 1975 (Cth) and increased funding for new and expanded family relationship services. The aim of the reforms was to bring about “generational change in family law” and a “cultural shift” in the management of separation, “away from litigation and towards cooperative parenting”. The evaluation was based on an extensive research program and provides a comprehensive evidence base on the operation of the family law system.

Fathering today

“Fathering in Australia Among Couple Families with Young Children: Research Highlights” by Jennifer Baxter and Diana Smart (Issue 88, August 2011) reports on aims to increase understanding of the ways in which fathers in couple families who are parents of young children contribute to family life. “Fathers’ mental health was also strongly related to children’s socio-emotional outcomes. In addition, better mental health was associated with a stronger co-parental relationship and more positive parenting practices.”

Changing families

“Trends in Family Transitions, Forms and Functioning: Essential Issues for Policy Development and Legislation” by Ruth Weston and Lixia Qu (Issue 95, December 2014) looks at the various ways in which families have changed over the decades in Australia. It discusses trends in marriage, divorce and cohabitation, and the resulting rise in new forms of families, such as grandparent-headed families, same-sex parented families, couples living apart together, and shared care. “For most of the 20th century, almost all heterosexual couples married then moved in together, whereas the reverse is true today: most couples who marry have already been living with each other for some time.”

To read these and other articles from the rich Family Matters archive (from Issue 27 onward) go to the AIFS website.

Carole Jean and Gillian Lord work in the AIFS Library. Hop Nguyen is a Communications Specialist at AIFS.
A population approach to the prevention of child maltreatment

Rationale and implications for research, policy and practice

Matthew Sanders, Daryl Higgins and Ronald Prinz

Abuse and neglect of children in the home marks the extreme end of a continuum of family conditions undermining child wellbeing. Taking this into account, the prevention of child maltreatment rightfully is focused on optimising the conditions—across the entire population—that promote healthy family relationships and support child development. Here we outline how a population approach to evidence-based parenting support can contribute to the prevention of child maltreatment by reducing the family-related risk factors associated not only with abuse and neglect but also with a broader array of adverse childhood outcomes. We present evidence about the scale of child maltreatment, how the current siloed approaches miss opportunities to reach the necessary audiences, and how the challenges to achieving this can be overcome.

Population approach in the current context

Definition of population approach for child maltreatment prevention

There is general agreement that the prevention of child maltreatment at a minimum involves tackling known risk factors that expose children and young people to harmful familial environments including maltreatment by caregivers/adults. There is less agreement about how to best accomplish this. We argue that successful prevention of child maltreatment necessitates the adoption of a population approach, as has occurred with other major health issues such as tobacco-related cancers, road accidents/fatalities, dental carries and STDs/HIV. Population
approaches have to address a range of issues, from high-frequency issues (such as less-than-optimal parenting) through to relatively common risk factors that drive demand for services/statutory responses, including low-frequency but highly serious problems (where a blend of universal and targeted strategies may be needed—as outlined later). The overwhelming demands on statutory child protection services, and the complications of intersecting systems for responding to young children at risk in the context of family law disputes, increase the need for addressing the primary drivers of maltreatment across the population, before the problems become intractable or harder to remediate. Targeted services, including statutory child protection services, reach only a small proportion of the population and typically quite late in the trajectory of family dysfunction associated with serious maltreatment (Herrenkohl, Higgins, Merrick, & Leeb, 2015; Higgins, 2015).

By “population approach” we mean, first, that the overarching goal is to reduce the prevalence of child maltreatment and associated indicators at a population level (not just within suspected “high risk” groups/locations) and, second, that prevention efforts, especially those pertaining to parenting need, be designed and implemented for community-wide impact. Such an approach would rely heavily on providing supports that are non-stigmatising, drawing on specialised services where necessary, and emphasising local networks and existing sources of support accessible to the majority of families (Child Family Community Australia [CFCA], 2014).

Public health focused interventions to address adverse family environments and the conditions that undermine parental confidence and competence can reach a much greater number of children and their families, and so widen the net for positive preventive effects (Mullan & Higgins, 2014). Although there is a substantial body of research that points to the extensive risk factors for child maltreatment that relate to parenting skills and the quality of the broader family environment (CFCA, 2017), the evidence base shows that strategies to enhance parenting knowledge and skills effectively reduce the severity of risk factors for child maltreatment (Daro & Benedetti, 2014; Prinz, 2016). Rather than assume parenting is an innate characteristic, it should be framed as a learnable skill set that varies across the population and can be supported, strengthened and enhanced regardless of a parent’s current proficiency (Parenting Research Centre, 2017).

The kinds of issues that parenting supports can address include:
1. managing challenging behaviours of children;
2. acquiring basic information about parenting skills and children’s developmental needs;
3. understanding changing contexts as children grow, in terms of responding to children’s typical developmental needs and the parenting skills required for adaptation; and
4. responding to particular challenges such as sensitive/critical periods or unexpected developmental issues (e.g., early/late transition to puberty) or difficult life events (e.g., family separation/divorce; a bereavement; illness or other loss/trauma in the family).

In sum, parenting can be demanding for everyone at different times, and many families can benefit from parenting support in one way or another. Going further, reviews of family law, child protection services and the juvenile justice system point to a common set of family problems that typically lead to contact with these service systems—that is, family violence, mental health issues and addictions to alcohol, tobacco, other drugs and gambling (Higgins & Katz, 2008). Such problems exist on a continuum of severity and are reflected widely in families across the population. The common feature of such parental behaviours or circumstances is that they can impair a family’s capacity to provide positive parenting and ensure that children are safe and protected from harm. Taking into account other sources of parenting stress, it is not surprising that many families could benefit from a population approach to parenting/family supports, above and beyond the aim of child maltreatment prevention. A population approach is a powerful way of reaching families at risk and to normalise parenting support across the entire population.

**Nature and significance of child maltreatment in an Australian context**

While there is currently considerable focus in Australia about children’s exposure to sexual abuse in organisations (e.g., Royal Commission into Institutional Responses to Child Sexual Abuse—Case Study #57), international evidence shows the greatest safety risks children face are at home in the form of abuse or neglect by parents. We do not have accurate, nationwide prevalence data in Australia on child maltreatment (Mathews et al., 2016). Instead, to understand the scope of the problem we rely on counting the activities of the statutory child protection services; namely the receipt and investigation of reports of harm, service provision to families who meet thresholds to address child protection concerns, and the removal of children when positive change does not occur. Such counting is a poor substitute for capturing the extent of harm or risks faced by children across the country.

According to surveys, approximately 5–10% of children experience physical abuse; around one-in-ten are emotionally maltreated; 12–23% witness family violence; and 4–8% experience serious (i.e., penetrative) sexual abuse.

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Compromised conditions of safety within the family environment coupled with variable parenting capacity and skill is the common denominator. When families struggle to provide consistently warm, nurturing and safe environments, children sometimes require protection.

Statutory systems provide the safety nets for responding to children at risk (Mullan & Higgins, 2014); however, if we look at the survey results, such systems only come into contact with a small proportion of children who experience maltreatment (Mathews et al., 2016). This is the gap that the population approach seeks to close.

Why adopt a population approach to child maltreatment prevention?

Prevalence reduction as ultimate goal

A hallmark of population health strategies is an emphasis on addressing community-wide prevalence. This type of metric is highly relevant to child maltreatment prevention, where the shared goal is a reduction in the proportion of children experiencing adverse parenting and family environments. Crisis and emergency services notwithstanding, child maltreatment prevention strategies need to be considered and evaluated in terms of the potential to reduce the prevalence of adverse outcomes (e.g., injuries, foster care placements, childhood mental health disorders) and to increase the prevalence of wellbeing outcomes (e.g., reaching developmental milestones, school achievement, behavioural self-regulation).

Broader prevention to overcome low-frequency outcomes

Official investigated and substantiated cases of child maltreatment in statutory systems, though troubling, nonetheless occur at relatively low rates in the population. The difficulty of trying to prevent a low-frequency outcome such as child maltreatment that comes to the attention and meets the threshold of statutory services is further compounded by difficulties in predicting which parents will engage in child maltreatment and show up in the child protection system. A population approach that enacts broader prevention has the potential to address this challenge.

Programming that is designed for broad population reach increases the likelihood of engaging more parents who might mistreat their children. A related advantage is that population-based prevention can address a wider range of adverse parenting practices than can be achieved by targeting the highest risk families. Child maltreatment experts know that official cases represent only a small percentage of the children who are exposed to deleterious parenting. For example, Theodore and colleagues (2005) in an anonymous telephone survey found that parents self-reported physically abusive behaviours at a rate 40 times higher than the official substantiated rate of child abuse. Similarly, Prinz and colleagues (2016) found in a random household survey that 10% of parents reported spanking their children with an object on a “frequent” or “very frequent” basis. In a similar household survey in Queensland of 4,010 primary caregivers, 43.4% of caregivers reported smacking with their hand and 7.7%, smacking more than once or with an object (Sanders et al., 2007).

Increased normalisation and lowered stigma

Singling out families for intervention on the basis of a risk profile might sound like a cogent approach on the surface...
but parents so identified or characterised might have a different opinion. Common practices such as participation in birth preparation classes, the use of car seats and the incorporation of physical exercise into schools have become normalised and benefit the whole population without stigmatising individuals. Seeking out evidence-based parenting support (especially if such programs or services respect self-determination and a wide variety of acceptable parenting practices), needs to be normalised as a parent’s pathway to happier, healthier children, rather than something that is punitive or that inadvertently marks the parent as deficient, incompetent or misguided.

There is no doubt that targeted interventions have the potential to reduce recidivism for families where child abuse has already occurred (Vlahovicova, Melendez-Torres, Leijten, Knerr, & Gardner, 2017) and have generated promising though uneven evidence of a preventive impact with individual families (Chen & Chan, 2016; Euser, Alink, Stoltenborgh, Bakermans-Kranenburg, & van Uzendoorn, 2015). However, evidence is not yet forthcoming that such targeted strategies, if taken to scale, will reduce the prevalence of child maltreatment in actual population terms. Universal and targeted strategies in blended prevention

One of the concerns about adopting a strictly universal approach to child maltreatment prevention is that families in the population who might need more intensive services will be ignored. The better option to universal prevention is a hybrid approach called blended prevention, which combines universal and targeted elements in an integrated strategy (Prinz, 2015).

Blended prevention has been applied in other areas. For example, universal public policy requires the use of car seats for infants and toddlers (i.e., passage of a law, which is universal in its application) but provisions have been made to make car seats available free of charge to parents who cannot afford them (a targeted facet). Similar strategies have successfully been employed to prevent tobacco-related cancers and heart disease: through price controls, restrictions on the supply and promotion of tobacco products, including the plain packaging introduced recently in Australia, tailored public messages and services, and addressing the underlying disadvantage that contributes to tobacco use (Scollo & Winstanley, 2017; Tobacco Working Group, 2009).

The same concept can be applied to parenting support. Drawing on blended prevention, a well-integrated system of evidence-based parenting support would include broad-reach strategies, such as large-group, low-intensity and media-based strategies, plus multiple levels of more intensive and extensive services and supports. In a well-crafted system, parents who do participate in the more targeted elements would also benefit from exposure to the universal facets. Similarly, parents who are exposed to universal services might be more receptive to targeted interventions when needed.

Impact multiple outcomes with the same intervention

It is legitimate to ask how a strategy for the whole population can be justified to prevent an outcome like substantiated cases of child maltreatment (or even the larger category of notifications) that occurs in a relatively small proportion of families. For example, during 2015–16 only 3.02% of children in Australia received child protection services (AIHW, 2017). The answer is that a smart prevention strategy will address not only the low-frequency outcomes but also have a positive impact on more common outcomes.

Evidence-based parenting support deployed in a blended prevention model can reduce child maltreatment but also has the potential to concurrently reduce or prevent children’s social, emotional and behavioural problems (which are more prevalent than child maltreatment but share many of the same contextual factors and prevention strategies) (Sanders & Mazzucchelli, 2018), improve children’s readiness at school entry (Votruba-Drzal & Dearing, 2017), and reduce trajectories for adverse outcomes in adolescence such as substance abuse, delinquency, school dropout and teen pregnancy (Sandler, Ingram, Wolchik, Tein, & Winslow, 2015).

Application of key population principles

To make a population approach to child maltreatment work, key principles and strategies of a population health approach need to be incorporated (Sanders, Burke, Prinz, & Morawska, 2017). These include the concept of “minimal sufficiency” and having culturally appropriate programs and service system support.

Minimal sufficiency refers to the need to have low-intensity programs that have wide reach in terms of parental participation at an affordable cost. Typically, the population approach involves having universal elements such as media and communication strategies that desigmatise parental involvement and that help to create “pull” demand from parents (legitimising the concept that all parents can benefit from help at some stage).

Interventions need to be culturally relevant to the population. Australia is a multicultural, multi-faith country; however, there is evidence that the basic principles and techniques of positive parenting are viewed as culturally relevant, acceptable and effective with a diverse range of parents (Morawska et al., 2011).

Even when programs are available, and shown to work in a multicultural context, there is no guarantee that the programs will be implemented with fidelity by service providers.
Therefore, any population-based intervention needs to apply learnings from implementation science so that practitioners are appropriately selected, trained, supervised and supported to ensure the sustained use of programs that work (see Sanders, Turner, & McWilliam, 2016).

**Capitalising on multiple settings, delivery formats, and intensity of interventions**

A population approach seeks to employ multiple, different service delivery contexts as an opportunity to promote safe, nurturing parenting in the community. This involves using widely accessed, normative care contexts such as primary health care settings and services, early childhood educational settings, schools, various government and non-government parenting and family support services and programs, and the media. Existing evidence in Australia relating to service access emphasises the importance of non-stigmatising entry points for services (Robinson, Scott, Meredith, Nair, & Higgins, 2012; Stewart, Lohoar, & Higgins, 2011).

**Accumulation of evidence for population effects**

The scientific case for tackling child maltreatment through a population-based approach rests on two complementary lines of evidence. There has been over 40 years of accumulated evidence on the efficacy of group and individual positive parenting programs based on social learning and cognitive behavioural principles through randomised controlled trials. The evidence clearly shows that parenting programs produce sustained positive changes in both child and parent outcomes (Sanders, Kirby, Tellegen, & Day, 2014).

There is also increasing evidence that low-intensity interventions designed to have wide population reach and low-cost, self-directed, technology-assisted interventions such as Triple P Online can be effective in changing parenting practices (Sanders, Turner, & Baker, 2014). Online platforms now provide greater flexibility in the delivery of evidence-based programs and supports. Such technology-based suites can be delivered on a tiered continuum of interventions of increasing intensity and narrowing population reach. Such online platforms can provide an excellent foundation for the development and testing of a system of parenting support.

The second line of evidence, and the subject of fewer studies, relates to trials that have adopted a true population approach to deliver multiple levels of intervention to defined geographical catchment areas and tracked outcomes at a population level. For example, in one of the few place-randomisation studies in the child maltreatment prevention area, Prinz, Sanders, Shapiro, Whitaker, and Lutzker (2009, 2016) demonstrated that community-wide implementation of evidence-based parenting support as a blended prevention strategy could reduce population prevalence of child maltreatment. “Place” in this study was a county with a population between 50,000 and 175,000 people. Randomising 18 counties in South Carolina to either the intervention or usual services, the US study implemented the full Triple P system, which is a tiered, multi-level approach to parenting support, through the existing workforce across several service sectors in the nine intervention counties. Controlling for the five-year baseline period prior to intervention, the study found significant reductions in rates of confirmed child maltreatment cases in the statutory child protection service, out-of-home care placements (i.e., foster care), and hospital-treated child maltreatment injuries compared with the comparison counties (Prinz, 2017; Prinz et al., 2009, 2016).

Another notable population-based initiative, a quasi-experimental study conducted in Ireland, similarly showed that the implementation of a multi-level system that comprised social marketing, low-intensity seminars (mainly delivered through schools—a valuable hub for non-stigmatising population-based service delivery), topic-specific workshops on common problems at different developmental stages (e.g., shopping trips), and an eight-session Group Triple P intervention reduced the level of serious behavioural and emotional problems in children by 37% over a 2.5-year period, as reported by parents in an epidemiological household survey (Fives, Purcell, Heary, Gabhainn, & Canavan, 2014).

A recent meta-analysis of economic analyses of public health interventions in the UK, Western Europe, USA, Canada, Japan, Australia and New Zealand targeting a range of health problems showed that national public health interventions across many diverse types of problems are highly cost saving with a cost–benefit ratio of 8.3 (Masters, Anwar, Collins, Cookson, & Capewell, 2017). Similarly, in the field of child maltreatment the Washington State Institute of Public Policy (2017) estimated that the return on investment was $8.14 for every dollar invested in the Triple P system based on the Prinz and colleagues (2009) population trial.

**Challenges to adopting a population approach**

Some might argue against a population approach in the belief that it is not possible to get the whole population of parents/families to participate. However, it is not necessary nor even desirable for all—or even most—parents to engage with in-person parenting programs or services. In most population-level implementations of positive parenting programs, the aim has been to encourage parents needing or seeking assistance with parenting to reach out and access evidence-based parenting programs, and for other parents—and the wider community—to support these efforts and
thereby remove stigma and other barriers often associated with completing a parenting program.

Marmot and colleagues’ (2010) principle of proportionate universalism is relevant to child maltreatment prevention as it implies that all parents can benefit from support in parenting at various points in their parenting careers, but some need much more support. Having interventions based on the same core principles but which vary in intensity can be very useful. Evidence-based strategies or programs range from low-intensity seminars and discussion groups about specific child-rearing topics (e.g., bedtime problems), to more moderately intensive multi-session active skills training programs for parents with children with more serious child behaviour problems (e.g., oppositional behaviour problems, conduct problems, developmental disorders), to more intensive programs where parenting problems are complicated by domestic violence and/or additional parental relationship, mental health or substance abuse problems.

Others might contend that a targeted approach based on population screening is needed to more accurately identify children at greatest risk and parents most likely to benefit for parenting programs. However, screening and targeted delivery is still very expensive to implement at a population level and runs the risk of introducing stigma for someone identified as a parent who needs extra help with parenting.

An alternative approach is to promote the idea that all parents experience difficulties and challenges in raising their children from time to time and that confronting and dealing with the challenges that come with everyday parenting is normal and healthy, and that it is desirable to get involved in learning the skills and strategies that promote the healthy development of children and families. By only targeting the most vulnerable families, the vast majority of parents experiencing difficulties with parenting will be ignored and it will be very difficult to impact on the prevalence rates of child maltreatment.

**Ways to strengthen the population approach**

As experience grows with the implementation of large-scale population roll-outs of child maltreatment prevention programs, several strategies derived from the broader research literature in prevention science can strengthen the efficacy of the approach.

1. Ensure that the delivery of evidence-based parenting programs is mainstreamed by government agencies across the range of universal service delivery platforms (i.e., included in their funding streams and service requirements) rather than viewed as an add-on that is not the core business of an organisation or only for selected staff employed to deliver parenting support services.

2. Carefully select agencies and staff who have the capacity and motivation to deliver evidence-based programs. Select agencies that are committed to the adoption of a population approach and are prepared to reorient their service priorities to ensure that evidence-based parenting programs are delivered.

3. Build in strong end-user and consumer engagement (i.e., community stakeholders, GP networks, local government, NGOs) to ensure programs that are delivered are locally and contextually relevant.

4. Ensure that parents and children experiencing vulnerability have access to population-based programs. These programs need to be appropriately tailored to the needs of diverse families, including those with: Indigenous parents, parents with mental health and substance abuse problems, parents from culturally and linguistically diverse communities, parents who have been/are incarcerated, same-sex parents and parents of children with disabilities. Targeted engagement strategies are needed to promote the participation of families experiencing vulnerability to access universal services where population-level prevention activities are being undertaken, such as accessing high-quality early childhood care where prevention messages, supports and enablers of positive parenting are embedded.

5. **Target key normative developmental transitions** for the delivery of low-intensity universal parenting programs. There is heightened receptivity of parents at the point of developmental transition. Such developmental milestones include: the commencement of early childhood programs, kindergarten, primary school and high school.

6. Have a strong social marketing strategy supported by government to increase community awareness of the importance of parenting in influencing life course outcomes for children and families. These resources could be used by both government and non-government service providers, as well as advocacy/consumer representative groups. Public messages need to be aspirational, future-oriented, solution-focused and emphasise positive things that can be done by all stakeholders (across the range of universal service platforms) to promote child and family wellbeing (Frameworks Institute, 2016). Avoid media approaches that are alarmist or focus on the horrors of child maltreatment. That approach can inadvertently encourage parents who need support the most to avoid reaching out for support.

**Implications for policy, research, and practice**

The successful implementation of a population-based approach to child maltreatment prevention requires a concerted commitment by Commonwealth, state and territory, and local governments to ensure sufficient
resources are allocated to the task. There are some early signs of this in Australia—such as the initiative under the third action plan of the National Framework for Protecting Australia’s Children, which is focused on early intervention in the early years, particularly the first 1,000 days for a child. Whether this is implemented at a whole-of-population level (rather than at high-risk target groups), however, remains to be seen. There is also the need to complement such initiatives with parenting support strategies across childhood and adolescence. A major challenge in Australia is the absence of a detailed benchmark of parenting behaviours and capacities, which is needed to underpin the implementation and evaluation of such primary prevention strategies.

Policy

1. Fund child maltreatment prevention initiatives that use evidence-based parenting programs that apply population-health principles as a public policy priority. The centrepiece of the population approach needs to be the wide-scale implementation of a tiered, multi-level, evidence-based system of parenting support.

2. Provide longer periods of funding (minimum 5–7 years) to ensure proper planning, an establishment phase, interagency engagement and collaboration, the development of an evaluation framework, and detailed implementation plans conforming to best-practice principles derived from implementation science.

3. In line with the Productivity Commission (2017) recommendations, move towards outcomes-focused funding mechanisms with no discrimination based on whether an organisation is for-profit or not-for-profit. This would create greater flexibility around the types of organisations, including private providers, that can deliver parenting programs and services.

4. Ensure that funding schemes do not inappropriately restrict access to evidence-based parenting programs, such as with Medicare’s Better Access to Mental Health Care Initiative for children with diagnosed mental health problems. To access the scheme, children need to be present during an intervention, whereas most evidence-based parenting programs do not require children to be physically present. Group-based parenting programs that have been demonstrated to be effective for parents of children with a disability should be funded under the National Disability Insurance Scheme. There should be no requirement that children must be present when parents participate in parenting programs to receive funding (unless the evidence-based program itself requires it for parents to practice skills in the presence of their own children).

5. Make greater use of performance-based contracting with agencies that government funds to implement evidence-based practices.

6. Require agencies funded to deliver evidence-based parenting programs to report on key clinical outcomes for each participating family. Mandatory reporting of clinical outcomes should be along the lines used in the UK with the Improving Access to Psychological Therapies (IAPT) scheme (Clark et al., 2009).

7. Build in adequate funding for rigorous evaluations to undertake outcome tracking through the linking of administrative state and Commonwealth data such as the Australian Early Development Census (AEDC), reports of child maltreatment, hospitalisation due to child maltreatment-related injuries and out-of-home care placements.

8. Provide ring-fenced funding for the implementation of a population-based intervention with cross-portfolio commitment similar to that used in the Healthy Child Manitoba initiative in Canada (Healthy Child Manitoba, 2002).

9. Provide funding for a communications campaign that normalises preparation for parenthood and, throughout the parenting journey, encourages participation in parenting programs targeting key developmental transitions such as starting early childhood education, kindergarten, primary school and high school.

10. Ensure strong advocacy and public messaging from government about the importance of parenting in influencing community outcomes for children, parents, families and communities.

11. Incentivise service providers to transform their service priorities to ensure prevention-oriented activities around positive parenting become core business.

Research priorities

1. Build on findings from randomised controlled trials, using well-constructed quasi-experimental design and longitudinal-observational studies.

2. Develop population-level indicators of parenting capacity (knowledge, skills, behaviours) and family wellbeing.

3. Conduct program evaluations that use linked administrative data to track population-level indicators.

4. Conduct implementation research to promote the sustained implementation of evidence-based practices.

5. Conduct research to explore the mechanisms of population-level change in child maltreatment relevant outcomes.

Practice

1. Alignment: Through peer support and supervision, encourage reflective practice and ensure activities and the focus of professionals’ work aligns with the principles and priorities of a population-based public health approach.

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2. **Specialisation**: Develop parenting specialists within services who have advanced-level expertise in the delivery of more intensive evidence-based parenting programs.

3. **Build on local community resources**: In communities with limited resources, or where there is inadequate (or absent) availability of professionals, consider using well-trained and supervised community volunteers as co-facilitators in delivering parenting programs.

4. **Conduct interagency training** to facilitate local networking and interagency collaboration (e.g., see Stewart et al., 2011).

5. **Provide dedicated funding to adapt and deliver** evidence-based and culturally informed parenting programs to address the needs of diverse families, including Indigenous families.

**Conclusions**

After four decades of investment in the development and evaluation of parenting programs both overseas and in Australia, it is time for the Commonwealth and all state and territory governments to make sustained investments in the wellbeing of children and families by funding the implementation of a large-scale comprehensive, multilevel, population-based approach to enhancing the knowledge, skills and competence of Australian parents in the task of raising children. The sustained implementation of a multilevel evidence-based approach adhering to principles of “proportionate universalism” holds the greatest promise in turning the tide of unacceptably high rates of child maltreatment and inadequate parenting, and it must become a public policy priority. Australia is fortunate to have developed a range of high quality evidence-based programs that are readily deployable but the public benefits of these programs to promote the future generation of children requires political will and an ongoing commitment to monitoring outcomes.

**References**


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