Healthy families, healthy children
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Brolgas Dancing
Mixed media on canvas 76 × 60 cm
Courtesy of the artist and Manyung Gallery Mount Eliza
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Earlier this year, after over 10 years as Director of AIFS, I formally advised the Minister for Social Services, the Hon. Scott Morrison MP of my intention to leave the Institute in order to accept an ongoing appointment from the University of Newcastle as Distinguished Professor of Family Studies and Director of the Family Action Centre, within the Faculty of Health and Medicine. I will take up this new position on 1 July 2015.

I have been honoured to serve as director, privileged to have such talented colleagues with whom to work, and indeed fortunate to have had this opportunity to contribute to the wellbeing of Australia's children, families and communities. It has been most gratifying to see the Institute extend its reach, relevance and responsiveness, while ever-strengthening the rigour of its research, evaluation and dissemination programs.

The vital ingredient in its success has, as with all organisations, been the quality of the staff whom we have managed to attract and retain. Their capacity, talents and willingness to “go the extra mile” have been, and continue to be, so impressive. I particularly value the loyalty, collegiality and commitment of my Deputy Directors, Dr Alison Morehead, Dr Matthew Gray, Ms Sue Tait and Dr Daryl Higgins, Assistant Director Ruth Weston PSM, and senior managers. They have been truly impressive.

I have also greatly appreciated all those across the Australian Government and beyond who have consistently supported me throughout my time here and, more importantly, valued the Institute and its work.

**AIFS Agency Plan**

The development of an AIFS Agency Plan is now a requirement under the new Public Governance, Performance and Accountability Act 2013 (PGPA). The Agency Plan will be a high-level strategic document that outlines AIFS’ research and corporate priorities for the next four years. It will consolidate the previous AIFS Strategic Directions and Research Directions into one document. The Agency Plan outlines AIFS’ vision, mission and values, reflecting the environment in which we work and conveying the ways in which we conduct our work. It also profiles our current research focus, identifies research opportunities for the future and lists some of our recent achievements. The Agency Plan will be available on our new website in August this year.

**New website**

The new AIFS website was launched in May to better communicate the vast experience and knowledge of the institute. It features a fresh and attractive responsive design, showcasing AIFS research expertise, current projects, researchers, resources, publications and podcasts. Visit the website at <www.aifs.gov.au>.

**AIFS 2016 conference**

The 14th biennial AIFS conference will be held at the Melbourne Exhibition and Convention Centre from Wednesday 6 July to Friday 8 July 2016. The organisation of the conference is progressing well and it promises to maintain its reputation as Australia’s premier family studies conference.

**Families and Children Activity Expert Panel**

The Institute has been commissioned by Department of Social Services to manage the establishment of a panel of experts to support, strengthen and evaluate the department’s Families and Children Activity. The panel will help to increase the use of evidence-based programs and practices and continue to build this evidence base through evaluation, with a focus on prevention and early intervention approaches.

Evidence-based program profiles for Communities for Children Facilitating Partners are now available. These profiles highlight programs that have a sufficient evidence base to be considered approved for use under the
30% requirement for Communities for Children Facilitating Partners. These profiles, and other information about the Expert Panel, can be viewed at <www3.aifs.gov.au/cfca/expert-panel-project>.

**Building a New Life in Australia: The Longitudinal Study of Humanitarian Migrants**

Building a New Life in Australia: The Longitudinal Study of Humanitarian Migrants is a long-term research project about how humanitarian migrants settle into a new life in Australia. It is being conducted over five years, with annual data collections spanning participants’ early months in Australia through to their eligibility for citizenship.

Early findings from the first wave indicate that humanitarian migrants in the first few months following their settlement in Australia appear to be adjusting quite well to their new lives, and most feel they have been made welcome. Although few were in employment, most were taking classes to improve their English language skills. However, a substantial minority was suffering mental health difficulties, which is most likely a result of traumatic events experienced before their arrival to Australia.

Planning is well underway for Wave 3 of the study.

**Growing Up in Australia: The Longitudinal Study of Australian Children**

Growing Up in Australia: The Longitudinal Study of Australian Children is a major study following the development of 10,000 children and families from all parts of Australia commenced in 2004.

The next wave of the survey design is complete and includes new measures covering areas such as educational pathways (school, tertiary education, apprenticeships etc.), gambling, driving and work.

The survey will be in the field again in late 2015, when the participants will be aged 12–13 and 16–17 years old.

**Vale Professor Graeme Hugo AO (1946–2015)**

It was with great sadness that the Institute learned of the death of Professor Graeme Hugo AO in January 2015. Professor Hugo was a most eminent academic and highly respected public intellectual who contributed greatly to the understanding of Australian society.

Professor Hugo was a graduate of the University of Adelaide, Flinders University and the Australian National University, and completed his PhD on circular migration in Indonesia. At the time of his death, he was a professorial research fellow and the director of the Australian Population and Migration Research Centre at the University of Adelaide. He was appointed an Officer of the Order of Australia in 2012.

He gave an excellent seminar at AIFS in May 2014 titled *Recent and impending demographic change in Australia: Implications for households, family and housing* (available on at <tinyurl.com/o67v23l>). In this talk, he argued that contemporary demographic shifts occurring in Australia have important implications for households and families, and yet the demography of the family has been neglected in the analysis of change in the Australian population.

The condolences of all at the Institute are extended to his family, friends and colleagues.

**Concluding remarks**

As I embark on the next stage of my journey, I have a sense that the timing is right both for AIFS and for myself. The Institute is well positioned to go from strength to strength. The suite of longitudinal studies, the growth of our evaluation capacity, the extension of our dissemination activities, and our well-developed governance, management and accountability infrastructure, all are reflective of a strong, vibrant and sustainable organisation.

I extend my very best wishes to my successor in taking AIFS to the next exciting stage of its development. I leave with so many rich and warm memories and a deep sense of satisfaction and pride in the achievements of all those I have been so proud to call my colleagues. I have had such a wonderful time contributing to an outstanding organisation!
Farewell to Professor Alan Hayes AM

It is with sadness that we farewell Professor Alan Hayes, who has been the Director of the Australian Institute of Family Studies for more than a decade. Professor Hayes has had a long history with the Institute, but his formal relationship began with his appointment to its Board of Management in July 2000, while he was still Professor of Early Childhood Studies and Dean of the Australian Centre for Educational Studies at Macquarie University. Since becoming the Director of AIFS in September 2004, Professor Hayes has presided over a long period of strong growth in the Institute’s research and organisational capacity to provide high quality services to the Australian Government. He has successfully steered the organisation through stimulating and challenging times, with the Institute increasingly sourcing its revenue from external funders and strengthening its partnerships and collaborations with other research and policy organisations, both in Australia and internationally.

Over the past decade, Professor Hayes has overseen the consolidation and expansion of AIFS research capabilities in a number of areas, such as:

- longitudinal studies, through projects such as Growing Up in Australia: The Longitudinal Study of Australian Children, Building a New Life in Australia, and Pathways of Care: The Longitudinal Study of Children and Young People in Out-of-Home Care;
- forced adoption experiences and their effects on individuals and their families;
- early childhood education, care and services; and
- the influence of place on family health and wellbeing.

In addition, under Professor Hayes, the Institute has further developed its important role of communicating family-related research to policy-makers, practitioners, other academics and the general public. This has been achieved through a strong publishing program, a number of clearinghouses/information exchanges, and an active online presence.

Other highlights of Professor Hayes’ period as Director include celebrating the Institute’s 30th anniversary, holding five highly successful AIFS conferences, moving the Institute from its long-time home in Queen Street to its current La Trobe Street premises, and seeing through two major changes to the Institute’s governance legislation.

Finally, Professor Hayes’ substantial contributions to the social sciences through his work at the Institute were recognised in June 2012 when he was awarded the Member of the Order of Australia in the Queen’s Birthday Honours List.

On 1 July 2015, Professor Hayes will become the inaugural Distinguished Professor of Family Studies and Director of the Family Action Centre at the University of Newcastle. His dedication and leadership will be much missed, but the Institute staff wish him the best success in his new position.
Marriage, cohabitation and mental health

Paul R. Amato

Research consistently shows that married people have better mental health, on average, than do single people. This general conclusion applies to a range of outcomes, including depression (Brown, 2000; Ross, 1995), happiness (Zimmerman & Easterlin, 2006), life satisfaction (Williams, 2003), psychological wellbeing (Kamp Dush & Amato, 2005) and mortality from suicide (Rogers, 1995). Moreover, the marriage advantage has been demonstrated in a variety of countries and regions, including the United States, Australia, New Zealand, Europe and Asia (Diener, Gohm, Suh, & Oishi, 2000; Lee & Ono, 2012; Soons & Kalmijn, 2009).

Compelling reasons exist for why marriage might be good for people’s mental health. First, marriage is an important source of companionship, intimacy and social support (Waite & Gallagher, 2000). Marriage also connects spouses with one another’s social networks, thus expanding the number of people who can be drawn on for assistance. Second, people benefit from the institutional nature of marriage (Cherlin, 2004). Marriage involves social norms and expectations that clarify spouses’ rights and responsibilities toward one another and reduce relationship ambiguity. Moreover, through marriage, people achieve a positively valued social status that other people respect and support. And because marriage is institutionalised, spouses acquire many legal benefits. In the United States, for example, these benefits include access to the spouse’s health insurance, tax deductions for one’s spouse, the option to file joint tax returns and the right to make medical decisions for one’s spouse. Third, the long-term commitment implied by marriage reduces relationship insecurity, and the gradual accumulation of a shared history with one’s spouse is a source of meaning and identity to many people. Fourth, marriage provides financial advantages over singlehood, including economies of scale and the ability to pool income and accumulate wealth more rapidly.

Despite the consistency of research findings, several points of ambiguity remain in this research literature. It is not clear whether:

CONFERENCE KEYNOTE
Compelling reasons exist for why marriage might be good for people’s mental health.

- the association between marriage and mental health is causal or due to the self-selection of healthier people into marriage;
- the benefits of marriage persist indefinitely or fade over time;
- the benefits of marriage extend equally to wives and husbands; and
- the benefits of marriage apply to other types of romantic relationships, such as non-marital cohabitation.

These ambiguities in the research literature led me to initiate a program of research on the effects of marriage and other relationship transitions on people’s mental and physical health. The research described in this article involves one part of that larger program. The current report draws on a large, longitudinal dataset in the United States—the National Survey of Adolescent to Adult Health—and addresses how the transition to cohabitation and marriage affects men’s and women’s reports of depressive symptoms and thoughts of suicide.

Does marriage cause changes in mental health?

Because people do not marry at random, it is difficult to determine whether marriage improves people’s mental health (a causal hypothesis), or whether people with better mental health are more likely to marry (a selection hypothesis). Given the impossibility of conducting experiments, fixed effects models are arguably the best available method to control for selection effects when using correlational, longitudinal data (Allison, 2009). An advantage of fixed effects models is that they control for all unmeasured, time-invariant features of people, such as race and ethnicity, stable personality traits, cognitive ability, family of origin characteristics and many genetic factors. Because fixed effects models involve only within-person variation, each person serves as his or her own “control”. Applied to the current topic, this method answers the question: Does people’s mental health improve after they marry?

Four studies have used fixed effects models to estimate the effects of marriage on health. Zimmerman and Easterlin (2006) found that marriage was followed by an increase in life satisfaction in a 20-year longitudinal German dataset. They observed a similar but weaker effect for non-marital cohabitation. Although life satisfaction declined modestly after the first year of marriage, it remained higher than it had been during the single years. Soons, Liebbröer, and Kalmijn (2009) reached nearly identical conclusions using an 18-year longitudinal dataset from the Netherlands. In the United States, Musick and Bumpass (2012) found that transitions into marriage between the first two waves of the National Survey of Families and Households were associated with increases in happiness and declines in depression, provided that couples did not divorce. These changes were modest in magnitude, however, and tended to dissipate over time. In contrast, Wu and Hart (2002) did not find that marriage between the first two waves of the Canadian National Population Health Survey was associated with changes in depression. They did note, however, that the longer people stayed married, the more depressed they became.

In summary, three of the four studies that have used fixed effects models suggest that marriage has a positive, causal effect on several dimensions of mental health, including satisfaction with life, self-reported happiness and depressive symptoms, although the Canadian study provides a contrary result. Moreover, all four studies suggest that wellbeing declines after the first year of marriage, although the amount of decline varies across studies. None of the four studies found consistent evidence of gender differences. Given the small number of studies that have used fixed effects models, however, additional research is necessary to establish the broader generality of these findings.

Marriage versus non-marital cohabitation

Non-marital cohabitation, like marriage, provides people with companionship, intimacy
Because people do not marry at random, it is difficult to determine whether marriage improves people’s mental health, or whether people with better mental health are more likely to marry.

The current study

My current research draws on the National Longitudinal Study of Adolescent to Adult Health (Add Health) to understand how the transition to marriage affects mental health. Add Health is well suited to assessing the effects of marriage because it follows respondents from adolescence through to their early 30s—the period when most people marry for the first time. The dataset also includes two excellent indicators of mental health: depression and suicide ideation. The current study relies on fixed effects models, which control for all stable (time-invariant) personal characteristics of individuals. Although fixed effects models
control for all stable individual traits, they do not control for traits that change over time. For this reason, the current analysis includes controls for age (and age squared to account for non-linearity), years of education, hours of employment and whether respondents have biological children.

My research also considers whether the estimated effects of marriage decline over time. Although several studies suggest that the benefits of marriage fade after several years, long-term marriages may still be preferable to singlehood. The current study also considers whether non-marital cohabitation is followed by improvements in mental health. Despite the fact that cohabitating relationships tend to be less happy and stable than marriages, prior research suggests that both types of relationships are good for people’s life satisfaction and mental health. Finally, the present study focuses on gender differences in how marriage and cohabitation affect mental health. Although some prior research suggests that both women and men benefit from being in close relationships, the persistence of marital inequality suggests that marriage may still be a more beneficial arrangement for husbands than wives.

Method

Data came from Waves 1, 3 and 4 of the Add Health dataset. Add Health started as a nationally representative survey of 20,745 adolescents in Grades 7 through 12 in the United States in 1994–95. In the first wave, data were collected through in-home interviews with adolescents and one of their parents. Youth were interviewed a second time in 1996, a third time in 2001–02, and a fourth time in 2007–08. (I did not use the second wave because it followed the first wave by only one year.) The final sample included 18,924 respondents for whom at least two waves of data were available; that is, Waves 1 and 3, Waves 1 and 4, or Waves 1, 3 and 4. (Some respondents who missed Wave 3 were tracked and interviewed in Wave 4.)

Table 1 includes descriptive information about the sample by survey wave (weighted). The mean age (in years) increased from a little over 16 in Wave 1, to 29 in Wave 4. (The oldest respondents were 34 at the final wave.) At the time of the first interview, the average adolescent had completed between 9 and 10 years of education. The corresponding figure for Wave 4 was about 14 years. Mean weekly hours of employment increased from about eight during adolescence to over 41 in Wave 4. Only 2% of adolescents had become biological parents by the time of the first interview, although this figure increased to over half of the sample in Wave 4.

Table 1 also shows information on relationship status at the time of the survey. By Wave 3, 18% were married, and 43% by Wave 4. Correspondingly, 15% of youths were cohabiting (but unmarried) by Wave 3 and 18% by Wave 4. Note that these figures underestimate the percentage of respondents who ever married or cohabited, because relationship status is coded at the time of the survey. Respondents who married or cohabited and broke up between surveys are not included in these figures. This qualification is especially relevant to cohabitations, which generally last only a year or two in the United States before breaking up or transitioning into marriage. Although not shown in the table, the mean duration of marriage for married respondents was 2.2 years in Wave 3 and 4.7 years in Wave 4. Correspondingly, the mean duration of cohabitation was 1.9 years in Wave 3 and 3.1 years in Wave 4. (A handful of adolescents were married or cohabiting in Wave 1; these cases were dropped from the analysis because no information on mental health was available prior to relationship formation.)

A measure of depression was based on nine items from the Center for Epidemiological Studies Depression Scale. These items were worded identically in all survey waves, and the mean alpha reliability across all waves was .81. Items were added and the total score was standardised across waves to improve interpretability (mean = 0, standard deviation = 1). Table 1 shows that the mean level of depression was relatively stable across all three waves. The second measure of mental health was a question about suicide: “During the last six months, did you ever think seriously about committing suicide?” The proportion of people responding positively to this question

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<th>Table 1: Descriptive information of sample showing variable means and proportions, by survey wave</th>
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<td><strong>Wave 1</strong></td>
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<tr>
<td>Age</td>
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<tr>
<td>Years education</td>
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<tr>
<td>Hours employed</td>
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<tr>
<td>Have children</td>
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<tr>
<td>Marriage</td>
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<td>Cohabitation</td>
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<tr>
<td>Depression</td>
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<td>Suicide ideation</td>
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Source: Add Health
declined slightly between adolescence and early adulthood.

**Results**

Table 2 shows the results from regressing depression scores on marriage and cohabitation. Although not shown, age, age squared, years of education, weekly work hours and having biological children were included as control variables in the models. Separate models were estimated for men and women. For both genders, the transition to marriage was associated with a decline in symptoms of depression. Moreover, the magnitude of the decline was the same for men (−.15) and women (−.15).

These results are consistent with the assumption that marriage is good for people’s mental health. The table also shows, however, that transitions to non-marital cohabitation were followed by similar declines in symptoms of depression for men (−.16) and women (−.14). Moreover, the estimated effects of marriage and cohabitation were not significantly different from one another. So it appears that living with a partner, rather than marriage per se, was responsible for improvements in depression. Relationship duration (marriage or cohabitation) was not related to depressive symptoms among men. Among women, however, depression was positively related to the duration of both marriage (.02) and cohabitation (.02).

Figure 1 shows the trajectory of depressive symptoms from adolescence to young adulthood (derived from the regression model) for men. The solid line shows the mean depression scores for single men. The line is slightly curvilinear, with a modest rise after the mid-20s. The dotted line shows the mean depression scores for men who shifted into cohabiting relationships at age 23—the mean age at first cohabitation for men in the sample—and then remained in these relationships without breaking up or marrying. This transition was accompanied by a decline in symptoms. Correspondingly, the broken line shows the mean depression scores for men who shifted into marriage at age 27—the mean age at first marriage for men in the sample. Marriage, like cohabitation, was accompanied by a decline in symptoms. For cohabiting men as well as married men, levels of depression rose during the late 20s and early 30s, but the gap in depression between single men and partnered men (cohabiting or married) remained constant over time.

Figure 2 shows the overall trajectory of depressive symptoms for women. Comparing Figure 2 with Figure 1 reveals that depression

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
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<tr>
<td>Marriage</td>
<td>−.15 ***</td>
<td>−.15 **</td>
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<tr>
<td>Duration</td>
<td>.00</td>
<td>.02 **</td>
</tr>
<tr>
<td>Cohabitation</td>
<td>−.14 ***</td>
<td>−.16 **</td>
</tr>
<tr>
<td>Duration</td>
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<td>.02 *</td>
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<td>N observations</td>
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</tr>
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</table>

Notes: Models include controls for age, age squared, years of education, weekly work hours and having children. Significance tests are based on robust, clustered standard errors. * p < .05; ** p < .01; *** p < .001 (two-tailed).

Source: Add Health
scores, overall, were higher for women than men. The solid line in Figure 2 shows the mean depression scores for single women. The line is curvilinear, with a decline from adolescence to the mid-20s, followed by a slight increase after that. The dotted line shows the mean depression scores for women who shifted into cohabiting relationships at age 21—the mean age at first cohabitation for women in the sample. This transition was accompanied by a decline in symptoms. Correspondingly, the broken line shows the mean depression scores for women who shifted into marriage at age 25—the mean age at first marriage for women in the sample. Marriage, like cohabitation, was accompanied by a decline in symptoms. For cohabiting as well as married women, levels of depression rose during the late 20s and early 30s. Contrary to the pattern for men, the gap in depression between single women and partnered women (cohabiting or married) closed during this time. In other words, the benefit of having a residential partner dissipated after several years.

Table 3 shows the results of regressing suicide ideation on marriage and cohabitation. For both genders, the transition to marriage was associated with a decline in suicide ideation. Moreover, the magnitude of the decline was similar for men (–.64) and women (–.69). Similar to the results for depression, these results are consistent with the assumption that marriage is good for people's mental health. The table also shows that transitions to cohabitation were followed by similar declines in suicide ideation for men (–.46) and women (–.56). Although the coefficients for cohabitation were somewhat smaller than the corresponding coefficients for marriage, the differences between them were not statistically significant. Once again, it appears that living with a partner, rather than marriage per se, was responsible for improvements in mental health. Relationship duration (marriage or cohabitation) was not related to suicide ideation among men. Among women, however, marriage duration was positively related to suicide ideation (.07). The corresponding duration trend was positive but not statistically significant for cohabitation. (Note that the number of cases is lower in Table 3 than in Table 2. This is because fixed effects models omit cases that do not change on the dependent variable between waves. So these results are based only on cases that reported thoughts of suicide in one wave and not in another.)

Figure 3 shows the probability of suicide ideation from adolescence to adulthood (derived from the regression model) for men. The solid line for single men reveals a modest decline in the probability during this period. The figure also shows that transitions into cohabitation and marriage were associated with declines in symptoms. Correspondingly, the broken line shows the mean depression scores for women who shifted into marriage at age 25—the mean age at first marriage for women in the sample. Marriage, like cohabitation, was accompanied by a decline in symptoms. For cohabiting as well as married women, levels of depression rose during the late 20s and early 30s. Contrary to the pattern for men, the gap in depression between single women and partnered women (cohabiting or married) closed during this time. In other words, the benefit of having a residential partner dissipated after several years.

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Figure 3 shows the probability of suicide ideation from adolescence to adulthood (derived from the regression model) for men. The solid line for single men reveals a modest decline in the probability during this period. The figure also shows that transitions into cohabitation and marriage were associated with declines in symptoms. Correspondingly, the broken line shows the mean depression scores for women who shifted into marriage at age 25—the mean age at first marriage for women in the sample. Marriage, like cohabitation, was accompanied by a decline in symptoms. For cohabiting as well as married women, levels of depression rose during the late 20s and early 30s. Contrary to the pattern for men, the gap in depression between single women and partnered women (cohabiting or married) closed during this time. In other words, the benefit of having a residential partner dissipated after several years.
between single and married women had largely closed within a few years. Consistent with the results for depression, the benefit of marriage for women’s mental health proved to be temporary.

Discussion

Many studies have found that married people are happier and healthier than single people. But does this mean that marriage is good for people, or does this reflect something about the type of people who get and stay married? Several studies have attempted to answer this question by using fixed effects statistical models. This approach is useful because it controls for all stable characteristics of people. And because this method compares individuals with themselves at different points in time, it is possible to see if marriage is followed by significant improvements in people’s health. Only a handful of studies have used this approach to study marriage, and the results of these studies have not been consistent. Moreover, it is not clear from previous work if non-marital cohabitation has the same benefits as marriage, if the benefits of marriage (and cohabitation) are temporary or long-term, or if the benefits of marriage (and cohabitation) apply equally to men and women.

My research shows that marriage is indeed followed by significant improvements in people’s mental health. Following marriage, people report fewer symptoms of depression and are less likely to think about suicide. Moreover, the benefits of marriage (at least in the first year) are comparable for husbands and wives. These findings are consistent with two other studies that also used fixed effects models (Soons & Kalmijn, 2009; Zimmerman & Easterlin, 2006). So the general notion that marriage is good for you appears to contain some truth. My analysis also suggests, however, that non-marital cohabitation has the same protective effects on men and women’s mental health as does marriage. Moreover, although some previous research has suggested that marriage is more beneficial than cohabitation, my research indicates that the two statuses are equally beneficial. According to the current study, it does not matter whether people are legally married; shifting into any type of intimate, co-residential relationship is followed by improvements in mental health.

This finding casts light on why marriage might be good for people. Some scholars have argued that marriage is beneficial because of its institutional nature. In most Western countries, marriage (a) is defined by laws and social norms that clarify spouses’ rights and obligations to one another, (b) is a highly valued status, and (c) provides a variety of legal and social benefits to spouses. But even though cohabitation is not institutionalised to the same degree as marriage, cohabitation involves similar improvements in people’s mental health. These findings suggest that it is the social support provided by marriage, rather than the institutional nature of marriage, that is beneficial for emotional wellbeing. After all, one doesn’t need to be legally married to a residential partner to enjoy companionship, intimacy and everyday assistance. Moreover, living together and marriage provide the same economies of scale, which can reduce people’s feelings of economic stress.

Before we assume that marriage and cohabitation are interchangeable, however, we should consider the fact that cohabitations are less stable than marriages. In the United States, for example, most cohabitating unions either transition to marriage or break up within two years (Kennedy & Bumpass, 2008). Cohabitation involves similar improvements in mental health. These considerations lead to the question of whether the benefits of marriage and cohabitation persist indefinitely or decline with time. The current analysis indicates that the benefits of intimate residential relationships persist indefinitely for men. Because the Add Health sample consists of young adults, and obligations to one another, (b) is a highly valued status, and (c) provides a variety of legal and social benefits to spouses. But even though cohabitation is not institutionalised to the same degree as marriage, cohabitation involves similar improvements in people’s mental health. These findings suggest that it is the social support provided by marriage, rather than the institutional nature of marriage, that is beneficial for emotional wellbeing. After all, one doesn’t need to be legally married to a residential partner to enjoy companionship, intimacy and everyday assistance. Moreover, living together and marriage provide the same economies of scale, which can reduce people’s feelings of economic stress.

Figure 4: Probability of suicide ideation by age and relationship status for women

Following marriage, people report fewer symptoms of depression and are less likely to think about suicide. Moreover, the benefits of marriage (at least in the first year) are comparable for husbands and wives.
The benefits of intimate residential relationships persisted indefinitely for men. For women, however, the benefits of intimate residential unions began to decline after the first year. This was true for marriage (with respect to depressive symptoms and suicide ideation) and cohabitation (with respect to depressive symptoms). So the answer to the question about long-term benefits appears to depend on gender.

Why might the benefits of marriage for women be short-lived? Early family scholars argued that marriage is an unequal arrangement that benefits husbands more than wives (e.g., Bernard, 1972). So the temporary advantage of marriage for wives may be a reflection of gender inequality. Of course, marriages are more equal today than they were a generation ago (Amato, Booth, Johnson, & Rogers, 2007). Moreover, the benefits of cohabitation also fade for women over time, despite the fact that cohabiting relationships tend to be more egalitarian than marriages (Baxter, 2001). Another explanation involves the notion that women are more attuned to relationship quality than are men. That is, women tend to monitor and think about relationships more than men do, and they tend to become aware of relationship problems more quickly (Thompson & Walker, 1990). In fact, research consistently shows that women are less satisfied than men with their marriages and romantic relationships (Amato et al., 2007). Consequently, it is probable that the decline in mental health following the transition to marriage (or cohabitation) reflects women’s growing awareness of and sensitivity to relationship problems.

Keep in mind that the changes in mental health following marriage and cohabitation shown in Figures 2 and 4 reflect statistical averages and do not apply to all women. Presumably, mental health following marriage or cohabitation remains high for women who continue to be happy with their relationships. Nevertheless, this trend is of concern, especially in households with children, because a general deterioration in mental health has implications for the quality of parenting and children’s wellbeing. Research consistently shows that depression among mothers (and fathers) is associated with problematic parenting behaviours—coercion, lack of affection, disengagement—and an enhanced risk of psychosocial problems among children (Lovejoy, Graczyk, O’Hare, & Neuman, 2000).

States and communities may be able to ameliorate some of these problems by providing resources to strengthen spousal and partner relationships. In the United States, marriage and relationship education has been shown to enhance relationship quality and stability (Hawkins, Blanchard, Baldwin, & Fawcett, 2008), although the benefits of these programs for low-income populations are less clear (Amato, 2014). Similarly, community mental health services for distressed parents and their children have become a feature of modern life in many countries, although disadvantaged populations continue to be under-served (World Health Organization, 2007). Close relationships may be good for people’s mental health, but these relationships do not exist in a vacuum, and supportive policies and services are needed to ensure that strong and health-promoting relationships will form and be sustained for many years.

References


**Professor Paul R. Amato** is Arnold and Bette Hoffman Professor of Family Sociology and Demography at the Pennsylvania State University, USA. This article is based on the keynote address given by Paul Amato at the 13th Australian Institute of Family Studies Conference: Families in a Rapidly Changing World, Melbourne, 1 August 2014.

**Acknowledgements:** This publication uses data from Add Health, a program project directed by Kathleen Mullan Harris and designed by J. Richard Udry, Peter S. Bearman, and Kathleen Mullan Harris at the University of North Carolina at Chapel Hill, and funded by grant P01HD041025 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development, with cooperative funding from 23 other US federal agencies and foundations. Special acknowledgement is due to Ronald R. Rindfuss and Barbara Entwisle for assistance in the original design. No direct support was received from grant P01HD041025 for the current analysis. The Penn State Population Research Institute supported the research described in this publication under award number R24HD041025 from the National Institutes of Health.

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There are many harms to which children in Australia are exposed today. Many of us here would be concerned about harms such as children growing up in poverty; children of asylum seekers being held in detention; children being bullied at school; and, in some communities, children being poisoned by lead.

The harms that I will be exploring today are closer to home—child abuse and neglect—but I want us to take those other, broader harms with us in our thinking as we explore the “packaged” nature of the problems in many troubled families.

**Historical background of child protection**

Child abuse and neglect is not new, it’s been known across cultures and across time, but in Western society, it was in the 19th century that a societal response emerged in relation to this issue (Scott & Swain, 2002).

Scott and Swain (2002) described how this was the time of the first child cruelty legislation in Australia, but long before this, children had been in institutional care in this country. Child cruelty was the term used for child physical abuse by “the child savers”—as they called themselves—in the child rescue movement. They also knew about child sexual abuse. However, the vast majority of the children they encountered suffered from neglect and destitution in the context of extreme poverty. This is why most of the children entered institutional state care or, more likely, especially in Victoria, entered institutions run by churches. The state was actually a most reluctant guardian as it was not seen as the role of the state to violate the privacy of the family or to assume responsibility for children when parents were unwilling or unable to do so.

By the mid-20th century it was very different. There was a welfare safety net that prevented the type of destitution that had occurred in the greatest economic depression of this nation in the 1890s. The 1960s saw the beginning of the de-institutionalisation of child welfare by some of the churches. This was also the time of the
discovery—in fact, it was the rediscovery—of child physical abuse. Radiological surveys identified previously undetected fractures in young children, and the term “the battered baby syndrome” emerged to describe child physical abuse by parents. By the late 1970s, in the wake of second-wave feminism, child sexual abuse was rediscovered. And in this era a massive growth in the role of the state occurred, not just as the guardian of children but also as the investigator of children who might be at risk. This was a broad and vague notion. And as time has gone on, the breadth of issues around which children we think might be at risk has grown exponentially (Scott & Swain, 2002).

We know a lot more about child abuse and neglect now than we knew even a generation ago. It remains true that “maltreatment is one of the biggest paediatric public health challenges, yet any research activity is dwarfed by work on more established childhood ills” (Horton, 2003, p. 443). We know a lot more about the prevalence, incidence and etiology of child abuse and neglect, but we still know little about prevention. That is beginning to change.

We also have a framework of values to guide us, which we once did not have. The United Nations Convention on the Rights of the Child enshrines a child’s right to provision in terms of the basic necessities of life, protection from exploitation and abuse, and participation. The right to participation usually refers to children and young people being involved in decisions affecting them, but as I will argue later, the right to participation can and should go far beyond that.

From an historical perspective, there have been two grand ideas—two inspiring ideas—unfolding and gathering momentum over a century. One is the notion of the child as a holder of human rights. The other is the notion of the child as an emotional being. This has led to the recognition of the risk of psychological harm that might be caused by a broad range of situations that were once not deemed as child abuse or neglect. Examples of this are children witnessing family violence, the use of harsh physical discipline, and young children being left in the care of an older child. These two grand ideas have paradoxically brought our statutory child protection systems to breaking point in many Western societies.

**Child maltreatment in Australia today**

We need to change our response to the problem of child abuse and neglect for four important reasons. The first reason is because child maltreatment is a high prevalence and high incidence problem. The second reason is because it causes intense suffering to children and may cause serious long-term harm. The third reason is because our current child protection systems are overwhelmed. And the fourth reason, rarely acknowledged, is because our current systems have the capacity to harm vulnerable children.

Let us briefly explore each of these reasons for reform.

**Prevalence and incidence of child abuse**

The Australian prevalence estimates, based on a range of studies summarised by Price-Robertson, Bromfield, and Vassallo (2010), are deeply concerning:

- child physical abuse: 5–10% of adults;
- penetrative child sexual abuse: 4–8% of males and 7–12% of females; and
- witnessing domestic violence: 12–23% of children.

The child physical abuse and the penetrative child sexual abuse prevalence estimates come from adults responding to surveys seeking information on their childhood experiences. The estimates on children witnessing family violence come from parents responding to questions about recent events in their households.

The incidence data are also deeply concerning. The Australian Institute of Health and Welfare (AIHW; 2014) reports that in the year 2012–13, Australian statutory child protection services recorded a total of 53,666 substantiated cases involving over 40,000 children. This represents a 29% increase in two years. Four primary
neglect) and long-term adult physical health and mental health problems, especially problems such as alcoholism and attempted suicide. Felitti and Anda (2010) noted that such childhood experiences include:

- parental substance abuse;
- parental separation/divorce;
- parental mental illness;
- battered mother;
- parental criminal behaviour;
- psychological, physical or sexual abuse; and
- emotional or physical neglect.

As the number of these factors in a child’s life increases, the risk of poor adult physical and mental health increases dramatically. Felitti and Anda (2010) concluded that “these findings provide a credible basis for a new paradigm of medical, public health and social services practice. Many of our most intractable public health problems are the result of compensatory behaviours such as smoking, over-eating and alcohol and drug use, which provide partial relief from the emotional problems caused by traumatic childhood experiences” (p. 86).

Overwhelmed child protection systems

By the age of 18, 1 in 4.2 children in Queensland (and 1 in 1.6 Aboriginal and Torres Strait Islander children) are “known to child protection”; that is, have been reported to child protection authorities (Carmody, 2013). In New South Wales, more than 1 in 4 children are known to child protection authorities by the age of 18 (Zhou, 2010). The projection for Victoria is that 1 in 4 children born in 2011 will be notified to the Child Protection Service by the time they end adolescence (Cummins, Scott, & Scales, 2012). There is no child protection system in the world that can respond to demand pressures of this magnitude.

This is the result of three decades of policies based on the mantra “identify and notify”. It is not just the number of reports of suspected child maltreatment. The number of children in out-of-home care has also increased markedly. Figure 1 shows the number of children in care on 30 June in the years 2000 to 2013. The total number of children in care in any given year is greater than that on 30 June and is not known.

As can be seen, in a decade, the number of children in out-of-home care has doubled. There were over 40,000 in state care on 30 June 2013, with Aboriginal and Torres Strait Islander children more than ten times over-represented. The major reason for this increase is not that we are bringing more children into care each

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**Table 1: Reports of child abuse 2012–13, by primary abuse types**

<table>
<thead>
<tr>
<th>Primary abuse type</th>
<th>Reports (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional abuse</td>
<td>38</td>
</tr>
<tr>
<td>Neglect</td>
<td>28</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>20</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>13</td>
</tr>
</tbody>
</table>

Note: Percentages do not total exactly 100.0% due to rounding.
Source: AIHW (2014), p.10

It should be noted that these were the primary abuse types identified, but very often different types of child maltreatment coexist. Furthermore, they should not be taken as a reflection of the prevalence of these problems in the community. Incidence data (that is, on reported cases) are often very different from prevalence data (the actual extent of a problem in the community, whether reported or not).

**Effects of child abuse and neglect**

We know that the long-term effects of child maltreatment can be profound. And while a lot of media attention is given to acts of commission, such as child physical abuse and sexual abuse, it is important to recognise the effects of problems such as severe neglect or witnessing family violence. There is now powerful research on the association between childhood adversity (including abuse and neglect) and long-term adult physical health and mental health problems, especially problems such as alcoholism and attempted suicide. Felitti and Anda (2010) noted that such childhood experiences include:

- parental substance abuse;
- parental separation/divorce;
- parental mental illness;
- battered mother;
- parental criminal behaviour;
- psychological, physical or sexual abuse; and
- emotional or physical neglect.

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**Figure 1: Number of children in out-of-home care on 30 June each year from 2000 to 2013**

Note: These data have been compiled from a range of sources from the AIHW.
year than are leaving care—the major drivers are that children are coming into care at a much younger age than previously and staying in care longer.

“First do no further harm …”

There is no Australian research to date that identifies the effects on children of coming into state care. Given the ethical and legal issues involved, this is not a field in which randomised control trials can be conducted. There is US research, however, which raises deep concerns about the potential of child protection intervention to cause significant harm to children. In a data linkage study of 45,000 Illinois child protection cases, school-aged children at similar risk levels were compared in regard to whether they had been placed in foster care or allowed to remain with their families. Children on the “margin of placement” who remained at home had lower adult arrest rates, lower teen pregnancy rates and better employment than children of similar risk levels placed in foster care (Doyle, 2007).

Why might coming into care and/or being in care be harmful? One reason is the level of placement instability to which they are exposed. Rubin, O’Reilly, Luan, and Localio (2007) followed 729 children for the first 18 months in foster care and found a high level of placement instability. This was strongly associated with a child’s behavioural problems at 18 months, regardless of the level of behavioural problems on entering care. High levels of placement instability pose a serious risk of iatrogenic emotional abuse and psychological harm.

The most recent Australian data on placement instability are worrying. They come from the recent Queensland Child Protection Commission of Inquiry and show that this serious problem is getting worse. There is no reason to believe that placement instability is different in other Australian jurisdictions. In Queensland, of those children exiting care after five or more years between 2004 and 2012:

- those having six or more placements increased from 27% to 34%;
- those having three to five placements increased from 29% to 36%; and
- those having one to two placements decreased from 44% to 31% (Carmody, 2013).

I would like you to think about a child you love and imagine what three or four or five or six placements would do to that child. I have seen children corroded to the very core of their being as a result of multiple placements. Their capacity to trust, their capacity to love, their capacity to be loved—the very essence of their humanity—is deeply damaged, often forever. This is iatrogenic emotional abuse on a massive scale, for every day in this country hundreds of children experience a change in their placement.

We need to do all we can to prevent children coming into care. We need to do all we can to return children safely to their families after being in care. Where that is not possible, we need to do all we can to ensure a permanent arrangement, ideally within the child’s extended family, but if not, a permanent family environment beyond the extended family.

The history of child welfare is paved with the pain of children and parents; the Stolen Generations, the Forgotten Australians, the British child migrants, and those affected by forced adoption policies. Why is it always a generation later that we begin to hear of that? Perhaps placement instability is the greatest harm to which children are currently being exposed.

From harms to hopes

To transform the way in which we respond to child abuse and neglect, we need to have a shared understanding of the problem:

The challenge of ending child abuse is the challenge of breaking the link between adults’ problems and children’s pain. (UNICEF, 2008)

What are these adult problems that cause children’s pain? Delfabbro, Kettler, McCormick, and Fernandez (2012) presented the following data on the characteristics of parents of children entering state care for the first time in 2005:

- parental substance abuse, 69%;
- domestic violence, 65%; and
- parental mental health problems, 63%.

They add up to more than 100% because they often co-exist. It is these “packaged problems” of parents that are causing children’s pain. They are not just “personal problems”. Such problems occur mostly, but certainly not always, in a context of economic and social disadvantage. And in the context of growing social inequality, we need to confront this.

In the Protecting Victoria’s Vulnerable Children Inquiry that Justice Philip Cummins, Mr Bill Scales and I conducted in Victoria in 2011, we found strong data on the correlation between three factors: local government areas with high levels of social disadvantage; high numbers of child protection reports and substantiated cases; and the number of children identified as vulnerable on one or more domains of the Australian Early Development Index.
Across Australian jurisdictions there are highly fragmented and “siloed” service systems that can’t respond easily to “packaged problems”. It is largely organised around single input services based on categorical funding such that families with multiple and complex needs end up involved with a large number of organisations, and a revolving door of referrals. This is very alienating to families, it is very costly and it is largely ineffective.

Some progress has been made toward the vision of a more integrated service system, as depicted in Figure 2. We have broadened and deepened the capacity of some of our universal services—maternal and child health nurses, midwives, early childhood education and care, and some schools—to be more responsive to vulnerable children and their families. A big challenge remains in relation to general practitioners. Moreover, we now have much better targeted services for vulnerable children and their families, and initiatives like the Australian Government’s Communities for Children, which can strengthen that infrastructure.

But still, far too often, in order to get the services that families need, families with multiple and complex needs have to go through the highly stigmatising, humiliating and fear-inducing door of statutory child protection. We must not make families go through that door to get the services they require.

However, we need to go further than reconfiguring our children’s services. We need to bring on board the services that can address the adult problems that cause the children’s pain. Some of these services are named in Figure 2—adult disability (mostly relating to parental intellectual disability), family violence, drug and alcohol, housing and homelessness, correctional, and mental health services.

There are others that could have been added, such as problem gambling services, veterans’ affairs (especially for recent ex-servicemen and women with post-traumatic stress disorders), and refugee resettlement services. There are, indeed, many adult specialist services that need to be able to bring into their thinking and service delivery the needs of children and whole families.

The encouraging development is that in every one of those sectors, we have some excellent exemplars of adult specialist services broadening their focus so that they are inclusive of children and the whole family. The problem is that so often they are isolated and unsustainable exemplars.

The key implications of this analysis are that we need to broaden service provider roles so that they can offer relationship-based, evidence-informed, comprehensive and family-centred responses to a much broader range of needs in families. We need to provide the workforce development and secondary consultation to equip those service providers to do that. And we need to improve inter-agency collaboration and effective referrals where, and only where, multiple services are really required.

This is a three-level reform agenda (see Figure 3 on page 19). It can’t be done solely through workforce development by trying to equip the service providers to work with vulnerable families. It can only be done if it is embedded within an organisational context in which the culture, the climate and the leadership mandates it; otherwise it will die as soon as that service provider ceases to work. The culture is critical—it needs organisations that are committed to something more than their own survival, to a vision that is bigger than themselves. This is becoming harder to find, even among not-for-profit organisations that are ostensibly “mission-led”.

Similarly, it can only be embedded within organisations when they are supported by policy settings, performance indicators and funding models that authorise and facilitate...
Some promising approaches

We have some really promising approaches. At the program level is Parents Under Pressure,\(^2\) developed by Paul Harnett and Sharon Dawe, psychologists from the University of Queensland and Griffith University respectively. It has a very distinctive combination of elements: evidence-informed, family-centred, home-based, and addressing parental substance misuse and mental health, as well as child development and the parent–child relationship. In the UK, it is now subject to a large randomised controlled trial and it is one of the very few programs subject to a randomised controlled trial here in Australia.

At the inter-organisational level, a promising approach is Services Connect,\(^3\) an initiative of the Department of Health and Human Services in Victoria, which uses one key worker to work with families whose needs cut across the parts of that department around housing, disability and child welfare.

At the policy level is Child Aware,\(^4\) an initiative funded by the Department of Social Services under the National Framework for Protecting Australia’s Children, being led by Families Australia and the Australian Centre for Child Protection. It is working in sites of high social disadvantage to bring together adult specialist services and children services, and builds on the capacity of all of those services to “think child, think family”. This is further developing what was previously done by the Australian Centre for Child Protection in 12 sites across Australia under the Protecting and Nurturing Children Program: Building Capacity, Building Bridges.

Lastly, and on a larger level, is Collective Impact,\(^5\) a US-based approach now being implemented in several places in Australia, which uses strong collaborative approaches by key stakeholders to deal with deep and complex social problems. Essential elements in this approach are the shared use of agreed measures to assess progress, and processes that facilitate collaboration.

The need for collaboration

Collaboration across professional, organisational and sectoral boundaries remains a major challenge. What do we need for collaboration to happen? The recent work of White and Winkworth (2012) is particularly helpful in this regard (see Figure 4). There are three categories of pre-conditions for effective and sustainable collaboration: the authorising environment (the mandate to collaborate, or “what we may do”), a shared vision and values (“what we should do” together), and organisational capability (the practical capacity to do it, or “what we can do”).

We also need to understand what brings collaboration undone. In my child protection research I found that there were five different but interrelated possible sources of conflict that can occur across organisational boundaries (see Figure 5 on page 20). The levels of analysis of inter-agency conflict range from the inter-organisational or the structural (e.g., tensions that result from demand pressures and resulting “gatekeeping”) right through to the intrapsychic. In the latter, defence mechanisms such as projection and displacement occur when service providers falsely see other organisations as having the magic wand to protect a child, which they lack. Unless we diagnose these sources of inter-agency conflict, we will not
be able to address them. Conflict that has its primary source at one level of analysis—for example, at the inter-organisational level—can lead to problems at another level, such as the interpersonal. A negative feedback loop thus creates a narrative of inter-agency conflict that often endures.

Population-based reform

Complex social problems cannot be solved solely by services or the reconfiguration of service systems. They require population-based measures that tackle the key risk and protective factors associated with child and family wellbeing. The common risk factors and the common protective factors cut across a range of problems, from low birth weight to school failure, to child abuse and neglect, to juvenile crime.

Let us use one risk factor and one protective factor to illustrate. Parental alcohol misuse is a key risk factor, associated with approximately 70% of children entering out-of-home care. Perhaps most concerning is the inter-generational effects of foetal alcohol spectrum disorder, leading to greatly impaired parenting capacity due to poor impulse control and cognitive deficits.

The evidence is strong—measures such as volumetric taxing, minimum pricing, restrictive advertising and licensing reform can reduce alcohol misuse at a population level (Australian National Council on Drugs [ANCD], 2013). Given the vested interests that oppose such measures, we will need to mobilise the community to support reform on “Big Booze”, as was done in relation to “Big Tobacco”.

Would it be possible to tackle a key protective factor in a population-based preventive strategy? The evidence is not as strong as with alcohol abuse, but perhaps the arguably most powerful protective factor of all—a parent’s deep attachment to their child—is modifiable. Most of us, without thinking, would lay down our lives for our children. In fact, many adults instinctively do this for children who are complete strangers to them.

A study by Boukydis (2006) suggests it is worth trying. Using an ultrasound consultation with a pregnant couple on a routine antenatal visit to help them individualise their unborn child resulted in stronger parental attachment post-birth. If further studies supported such a finding, might we teach midwives and obstetricians to add this psycho-educational intervention of a few minutes’ duration to routine ultrasound consultations?

And what would it look like if we avoided threats to maternal and paternal attachment during pregnancy and immediately after birth? Have we considered whether the now increasingly common pre-birth notifications to child protection could possibly raise the level of cortisol in a pregnant woman’s bloodstream and directly affect her unborn child? Have we considered that the mother’s fear of the child being removed at birth may inhibit her attachment to her unborn child? What if some of our current practices, in the name of protecting children, are actually diminishing parental attachment? To introduce such policies as pre-birth notifications and not undertake research on their intended and possible unintended consequences is unethical.

Another study by Strathearn, Mamum, Najman, and O’Callaghan (2009) in Queensland found breastfeeding was a protective factor in relation to substantiated physical abuse by mothers. If further research supported this, might this too be an area for primary prevention of child abuse?

Children as contributors

What might it look like if we took a public health strategy to addressing the full range of risk factors and protective factors at a population level? Can we think about prevention in ways that go beyond modifying parental behaviour? Is there anything that we might do on a population basis that could directly affect children’s resilience? That is, can we go beyond talking about children as objects of concern in our child protection dialogue and consider children as active agents?

There is a body of well-established research on the importance of required helpfulness in
increasing childhood resilience that has been virtually ignored, despite the fact that we now have a whole industry on resilience-based practice. Elder’s (1974) classic sociology work, *Children of the Great Depression*, provided a re-analysis of the data from the early landmark longitudinal studies of the 1920s in the USA. Elder found that older children (adolescents) were not adversely affected by their families losing more than a third of their income. He explained this in terms of the older children and adolescents acquiring roles that made them contributors in their family. Elder’s much later 1995 study on the Iowa farm crisis in the 1980s and 1990s had a similar finding. The children who adjusted well, compared with those who did not, were “contributors” in their families.

The Werner and Smith (1992) classic study, *Overcoming the Odds*, identified the key factors relating to resilience among children growing up in adversity. One was an active engagement in acts of developmentally appropriate “required helpfulness” in middle childhood and adolescence.

Why have we ignored such research? Is it because as a society, we have reduced children to being consumers and clients and have ceased to consider them as contributors? Think about your own family over three generations. In most families, especially working-class families, children were contributors.

I believe that understanding the role of children as contributors, and how it might relate to their sense of efficacy and agency and their sense of belonging, is an untapped resource.

There are many unanswered questions. We don’t even know the extent of children’s current contribution to the wellbeing of others in their families, in their schools and in their communities. We don’t know how gender, class and culture might shape their role as contributors. Nor do we know how it changes in the transition into adolescence. Nor the degree to which intrinsic or extrinsic rewards might shape such behaviour. We don’t know how being a contributor might work, especially for children who are not prosocial.

There is so much we do not know, but across this country there are many wonderful exemplars of children doing things for others and being valued for that. For example, in my semi-rural community there are primary school-aged children working to save an endangered species, the Helmeted Honeyeater, the avian emblem of Victoria. I observe the children deriving great joy and satisfaction from doing this.

Rutter (1983), the eminent child psychiatrist, said that it seems:

> desirable that we foster personality development in such a way that our children are cooperative and prosocial … not because they feel they have to be so, but rather because they get pleasure from being so. (p. 38)

What if we were to start with a national study, with children as co-investigators, on what children do that is contributing to their families, their schools and their communities, and what they enjoy about doing this? And what if children in every community were to present this to their parents, their teachers and communities? And what if the aggregate findings, were to be presented to the prime minister? That way we could hear children’s vision of Australia and their place in it, based not on the cliché that they are the citizens of tomorrow but because they are the citizens of today.

Adam Phillips, the British psychoanalyst, and Barbara Taylor, historian, in their beautiful little book called *On Kindness* (2009) said:

> The child needs the adult and his wider society to help him keep faith with his kindness. That is to help him discover and enjoy the pleasures of caring for others. The child who has failed in this regard is robbed of one of the greatest sources of human happiness. (pp. 9–12)

Are we robbing our children of one of the greatest sources of human happiness, and possibly one of the greatest sources of resilience?

So what is our shared vision? Can we go beyond 19th century “child rescue”, 20th century “child welfare”, and early 21st century “child protection”? Can we commit ourselves to a child wellbeing movement based on a public health understanding of prevention, and on an understanding of children’s rights that includes the right to participate as contributors?
Endnotes

1 For more information, see the Department of Social Services Family and Children’s Services web page at: <www.dss.gov.au/our-responsibilities/families-and-children/programs-services/family-support-program/family-and-children-s-services>.

2 For more information, see the Parents Under Pressure website: <www.pupprogram.net.au>.

3 For more information, see the Victorian Department of Human Services website: <www.dhs.vic.gov.au>.

4 For more information, see the Families Australia website: <www.familiesaustralia.org.au>.

5 For more information, see the website for Collective Impact at: <www.collectiveimpactaustralia.com>.

References


Professor Dorothy Scott OAM is Emeritus Professor at the Australian Centre for Child Protection, University of South Australia, and Director of Bracton Consulting Services. This is an edited transcript of her keynote address at the 13th Australian Institute of Family Studies Conference: Families in a Rapidly Changing World, Melbourne, 31 July 2014.
Ethical research involving children
Putting the evidence into practice

Anne Graham, Mary Ann Powell and Nicola Taylor

Undertaking research with children and young people gives rise to a number of ethical challenges, dilemmas and issues, both predictable and unforeseen. The stewardship of ethical research is the responsibility of everybody involved, including those engaged in funding, approving and undertaking it, as well as policy-makers and practitioners using research findings in their work. Consequently, there is a need for critical engagement by all stakeholders around some basic, but important, questions that are essentially ethical in nature and require close attention long before the research makes its way to any kind of ethics review committee. Such questions include, “Does this research need to be done?” and “Who will the research benefit and how?” The importance of these kinds of questions intensifies when the research involves children and young people: “Is children’s participation in the research necessary or can the information be obtained in other ways?”; “What would be the likely [ethical] consequences of not involving children?”

The Ethical Research Involving Children (ERIC) project has endeavoured to address these and many more questions that arise when funding, governing or undertaking research involving children. Following extensive research and consultation internationally, the print and web-based resources developed through the ERIC project (Graham, Powell, Taylor, Anderson and Fitzgerald, 2013) provide a useful framework for approaching these and multiple other considerations that are core to ensuring research involving children can justifiably be deemed “ethical”. This article introduces the ERIC project and resources to Family Matters readers and invites further engagement, dialogue and sharing of experience in the continued international movement towards safe, respectful research that foregrounds children’s dignity, rights and wellbeing, across all methodological, social and cultural contexts.

Children’s involvement in research
In recent years there has been a considerable increase in research and evaluation activities
Research that involves children often confronts challenges and dilemmas that arise as part of the research process, and hence could not have been anticipated, or guarded against, at the outset.

Ethical considerations

Alongside children’s increased participation in research, attention is being drawn to the many ethical issues arising as researchers report their own experiences in a range of contexts (see for example, Abebe, 2009; Bone, 2005; Cummins, 2006; Ebrahim, 2010; Lahman, 2008; Mudaly & Godard, 2009; Richter, Groft & Prinsloo, 2007; Trussell, 2008; Valentine, Butler & Skelton, 2001). As a result, there is now a considerable body of literature focusing on numerous areas of ethical concern in different research contexts (Powell et al., 2012). Despite this, researchers and other stakeholders continue to report a sense of isolation and a lack of awareness of or access to resources to support, guide and inform ethical research practice, leaving them reliant on their own ethical principles, previous experiences and institutional ethics requirements (Powell, Graham, Taylor, Newell & Fitzgerald, 2011). The quality of research practice can thus vary considerably. Given this backdrop, some researchers describe a sense of failure or inadequacy when confronted with ethical challenges and dilemmas (Horton, 2008; Robson, Porter, Hampshire & Bourdillon, 2009).

In many international contexts, including in Australia, research practice is governed by institutional or professional procedural ethics, that is, formal ethical review processes and codes of conduct. Gaining approval from an ethics review committee, for example, is standard procedure prior to commencing a research project in many institutions, particularly where the research involves humans or animals. Procedural ethics play an important role, protecting research participants and institutions, and supporting researchers (Alderson & Morrow, 2011).

However, queries are often raised about the evident limitations of procedural ethics in ensuring research is ethical throughout its duration (Gallagher, 2009). While ethical procedures can be rigorous in some respects, such as protecting children from obvious harm, other areas may be less well attended to; for example, ensuring that children are well informed, able to consent or decline without undue pressure and withdraw if they wish (Powell & Smith, 2009). Research that involves children often confronts challenges and dilemmas that arise as part of the research process, and hence could not have been anticipated, or guarded against, at the outset (Alderson & Morrow, 2011; Hill, 2005; Morrow & Richards, 1996). Ethical tensions are evident, for example, in the ongoing negotiation of the multiple relationships in research contexts involving children, beyond the usual researcher–participant pairing, and amplified by power disparities and dynamics particular to adult and child relations (Gallagher, 2008; Holland, Renold, Ross & Hillman, 2010). While some of the issues researchers navigate may be quite specific to the focus or context of their inquiry, these are often linked to broader questions that frame their practice, such as:

- Can I ensure children will not be harmed by involvement in the research?
- How will I respond if children become distressed or upset?
- What information do children need to provide authentically “informed” consent?
- Is parents’ consent always required for children to participate in research?
- If parental consent is required, should this always include both parents’ consent?
- What if children and parents have conflicting opinions about research participation?
- What locations and methods are best for respecting children’s privacy?
- What protocols are in place for responding to a child’s disclosure of harm or abuse?
- What professional services and supports are available if required for children?
Ethical issues reported by researchers include: their capacity to include children in research; consent and access to research participation; overly protective ethical review processes; confidentiality; socio-cultural views of children and childhood; and protection of children. Researchers reported that their ethical training tended to be an informal evolving process, dependent in part on the availability and accessibility of resources, such as publications, supervision, mentoring and collegial support. However, researchers also reported a lack of such resources to support and guide them in attending to ethical issues, with the major influences on their research practice being their own ethical principles and experiences, as mentioned earlier.

At this time, it was also recognised that an important starting point for addressing the matters identified through the survey was to engage critically with existing knowledge in this area through a comprehensive review of literature. This review identified numerous issues clustering around four key areas of ethical concern—harms and benefits, informed consent, privacy and confidentiality, and payment and compensation (Powell et al., 2012).

The findings from the survey and literature review were considered at a 2011 meeting, in London, of internationally recognised experts in research with children and young people, who identified that, in the absence of internationally agreed standards for ethical research with young participants, there was an evident need for accessible, high quality guidance.
ERIC offers a distinctive approach, in which these universal ethical principles are enacted through a framework that promotes reflexivity, rights and relationship as core to the kind of critical engagement required for ethical decision-making.

The ERIC resources

The ERIC approach draws on researchers’ collective knowledge to highlight best practice while grounding ethical decision-making in the realities of everyday research experience. It recognises that while major ethical principles such as justice, benefit and respect are universal, the application of these is affected by the diverse social, cultural, political and methodological settings in which research occurs. ERIC offers a distinctive approach, in which these universal ethical principles are enacted through a framework that promotes reflexivity, rights and relationship as core to the kind of critical engagement required for ethical decision-making.

Reflexivity in ERIC refers to “the capacity of researchers to reflect critically about the impact of their research on participants and their communities, on researchers themselves, and on the body of knowledge under investigation” (Graham et al., 2013, p. 176). Inclusion of rights recognises children’s entitlement to fundamental human rights, alongside those particular rights relevant to their status as children as articulated in the UNCRC. Thirdly, relationship explicitly acknowledges that every research endeavour takes place within the context of multiple relationships, including, but not limited to, those between researchers, children and young people, parents, other family members, guardians, caregivers, significant adults/gate-keepers, institutions and funding bodies. These “three Rs” are integral to the work of ERIC as it attempts to foreground critical engagement, dialogue and collaboration as a cornerstone of ethical decision-making while provoking closer attention on the human dignity and wellbeing of children in any research endeavour.

The ERIC resources are freely available, in a high quality print-based compendium (Graham et al., 2013) as well as via the website <www.childethics.com>, which allows for new material to be added, and interactive dialogue to occur, on an ongoing basis. The resources include:

- an International Charter for Ethical Research Involving Children, which is an aspirational statement of seven commitments that aim to elevate the status, rights and wellbeing of children (see Box 1 on page 27);
- extensive Ethical Guidance that draws on evidence-based literature and researcher experience in relation to four key areas (harm and benefits, informed consent, privacy and confidentiality, and payment and compensation) to offer best practice requirements, discussion of key considerations and challenges that might be met, references to case studies and relevant UNCRC articles, and key questions to promote critical engagement and reflexivity;
- Getting Started, a framework of structured questions, to encourage reflexive engagement with ethical considerations throughout the different phases of the research project;
- a collection of Case Studies written by researchers showcasing actual ethical challenges and dilemmas they have experienced in a wide range of social,
Taylor, 2014). The ERIC project team warmly encourage Family Matters readers, along with the wider child and family research and policy community, to actively engage with the ERIC resources, contribute case studies, recommend relevant journal articles and other resources, and join in the conversation on the Forum by commenting on topics displayed or adding a topic for discussion.

**Conclusion**

The vision of the ERIC project is to encourage ongoing collaboration and dialogue between members of the international research community in supporting, guiding and improving our respective efforts to lead and facilitate ethical research involving children. (For further elucidation of the vision, background, philosophy and underlying principles of ERIC, see also Graham, Powell & Taylor, 2014). The ERIC project team warmly encourage Family Matters readers, along with the wider child and family research and policy community, to actively engage with the ERIC resources, contribute case studies, recommend relevant journal articles and other resources, and join in the conversation on the Forum by commenting on topics displayed or adding a topic for discussion.

**References**


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**Professor Anne Graham** and **Dr Mary Ann Powell** both work at the Centre for Children and Young People, Southern Cross University, New South Wales. **Associate Professor Nicola Taylor** works at the Centre’s Issues Centre, University of Otago, New Zealand/Aotearoa.
Challenges in the family
Problematic substance use and sibling relationships

Lisa Incerti, Claire Henderson-Wilson and Matthew Dunn

Families influence who we are and whether we function in a healthy or unhealthy way (Mayberry, Espelage, & Koenig, 2009). As such, stressful or difficult life crises can pose significant life challenges not only for the individual but also for the individual’s family (Bertrand et al., 2013). When considering potential challenges within the family, it can be helpful to reflect on models that explore what a “healthy”, strong family looks like. One model is DeFrain’s (1999) Family Strengths Model, which considers six elements of a strong, healthy family. These elements are commitment to one another, positive communication, spending time together, showing affection to one another, working through a crisis effectively and having a sense of spiritual wellbeing (DeFrain, 1999). By focusing on family strengths rather than problems, a positive understanding of how families cope with life difficulties can be achieved (DeFrain & Asay, 2007). Some family members have complex needs that can affect these strong family qualities and create challenges within the family structure. One significant challenge that families may be faced with is problematic substance use by one or multiple family members.

A considerable amount of research has reported an association between family and peer environmental influence and an individual’s development and likelihood of developing problematic substance use issues (Avenevoli & Merikangas, 2003; Liddle, 2004; Fagan & Najman, 2005; World Health Organization, 2013). For instance, parenting styles and parental monitoring have been found to be associated with many substance use behaviours. Montgomery, Fisk, and Craig (2008) found that many individuals who used MDMA (“ecstasy”) or engage in polydrug use categorised their parents’ style as neglectful and as having detached and dismissive parenting. In contrast, Kim and Neff (2010) found that parental monitoring may be associated with preventive factors for adolescent alcohol use. This outcome is consistent with earlier research that also found an association between parental monitoring and higher family support having a positive influence on adolescents’ delinquent
A considerable amount of research has reported an association between family and peer environmental influence and an individual’s development and likelihood of developing problematic substance use issues.

Evidence to date has also found that parental substance use may influence a person’s likelihood of developing substance use issues. For instance, research has explored families with problematic alcohol use, and the interaction alcohol has with the family and family members’ personalities. Chassin, Flora, and King (2004) looked at alcohol and substance use and dependence from adolescence to adulthood, and found that participants with a history of alcoholism in the family and negative emotionality may be at greater risk of alcohol and other substance use and dependence. Findings from a recent longitudinal general population study by Alati et al. (2014) found a correlation between greater risk of high alcohol use in adolescence and high drinking levels in parents. This higher risk in adolescence was also positively associated with greater antisocial behaviour. For adolescents in the study that had a less established drinking problem, their parents’ parenting style, particularly harsh parental discipline, was associated with increased drinking behaviour (Alati et al., 2014).

Not surprisingly, it has been found that the quality of sibling relationships is associated with measures of individual wellbeing. For example, Yeh and Lempers (2004) found that adolescents who see their sibling relationships more negatively were likely to experience lower self-esteem, have fewer friendships, feel more depressed and lonely, and participate in greater delinquent and higher substance use behaviours than those who viewed their sibling relationships positively. Similar negative emotions were experienced by participants in a study by McCullough and Simon (2011), which looked at sibling relationships involving one sibling with a disability or chronic illness. Participants in the study expressed feelings of isolation, having difficulties in forming friendships, and being overlooked when it came to the provision of support in their family (McCullough & Simon, 2011).

Although there is an emerging body of literature suggesting links between family dynamics and substance abuse, the experience of having a sibling with a substance use issue has received little attention. Given that research has demonstrated that siblings in families with a child with a disability often feel overlooked when it comes to the provision of support (McCullough & Simon, 2011), it is possible that similar difficulties are experienced within the family for individuals with a sibling with problematic substance use. This study aimed to address this significant gap, and drew upon DeFrayn’s (1999) six qualities of a strong family to answer the research question: “Does a person’s problematic substance use impact upon their sibling relationships?”

Method

Participants

Thirteen women aged between 21 and 56 years old who have a sibling that has or has had problematic substance use were recruited through purposive sampling. Recruitment strategies included contacting agencies who work with people who may have been eligible to participate, such as CatholicCare, Sibling Support and NarAnon. Emails were also circulated to members of the Alcohol and other Drugs Council of Australia “Update” email list with details of the study. Additionally, advertisements for the study were positioned around the the Burwood campus of Deakin University, for example, on noticeboards, in the medical centre waiting room and in public bathrooms. Advertisements were also posted on Deakin University’s online teaching portal.

Procedure

Data analysis was informed by grounded theory techniques (Strauss & Corbin, 1998). Participants were given the option of telephone, Skype or face-to-face interviews,
as the nature of the topic was sensitive. These in-depth interviews were conducted between June and August 2013 and were between 40 and 60 minutes in duration. A semi-structured interview guide was used in each interview to answer the research question. Drawing upon DeFrain's (1999) Family Strengths Model, the six qualities of a strong family outlined in the model were used as an overarching framework. These six qualities are:

- **commitment**: family members show one another how important they are in each other’s lives;
- **appreciation and affection**: members of the family show strong care and love for one another;
- **positive communication**: honest and open discussions take place between family members, as well as members being able to listen to each other; members of family are able to resolve differences in conflict;
- **time together**: family members spend enjoyable time with one another and take an interest in each other;
- **spiritual wellbeing**: the family share values in religion, faith, hope, peace or optimism; and
- **ability to cope with stress and crises**: strong families are able to get through a difficult time or stressful situation efficiently and with minimal damage.

The six qualities of a strong family were used as broad themes, and questions were grouped under these themes to understand whether a person's problematic substance use impacted upon elements of a sibling relationship. Broad, open questions or prompts such as “tell me about your family” and “tell me about any future hurdles you see in your relationship with your sibling” were asked to address the study’s research question and aim, but the responses from the participant also shaped the direction and structure of the interview (Liamputtong, 2013). At the completion of each interview, participants were asked if they had any final experiences that they would like to share that had not been covered thus far. Interviews were digitally recorded and transcribed verbatim.

**Data analysis**

To protect the identity of the participants, identifiable information such as names of places or people, were replaced with a pseudonym during transcription. Organisation and interpretation of the data was implemented through the phases of coding and thematic analysis (Braun & Clarke, 2006). This involved continuous analysis of the data through listening to interviews several times, reading and re-reading transcripts, member-checking and cross-checking. After in-depth coding for similarities, differences, patterns and significant or unique ideas, codes were subsequently defined and further condensed into categories (Saldana, 2013). Clear, broader themes were then formed from these categories to represent the data accurately. Ethical approval was gained from the Deakin University Human Research Ethics Committee (2013–080).

**Key findings and discussion**

Throughout this paper quotes are used to illustrate the research findings. To maintain anonymity of the participants, individuals’ quotes are identified with a number.

**General characteristics**

Thirteen female participants with a sibling that has or has had problematic substance use consented to be interviewed for this study. Eight of the 13 participants’ siblings were brothers, and half of the women interviewed were the older sibling. Participants' ages ranged from 21 years to 56 years. The majority of the siblings with problematic substance use engaged in polydrug use, with substances such as alcohol, cannabis and heroin commonly nominated as substances of concern among the group. Table 1 (on page 32) outlines the key characteristics of the participants, their siblings and the interviews.

**Key themes**

Three key themes and subsequent sub-themes emerged from the data analysis.

**Theme one: Family strengths**

**Acceptance, compassion and love**

I think it [sister’s cannabis use, mental health problems and suicide] made everyone so much more tolerant … changed some of the more judgmental behaviour … and gave us a better understanding. (Participant 12)

The first theme, family strengths, had three sub-themes. The first sub-theme was “acceptance, compassion and love”. Participants reflected on the importance of acceptance, compassion and love when it came to their time spent with their sibling and the closeness they felt. Participants were asked to describe their family, the relationships they had with their family members and how their sibling’s substance use impacted on their affection towards them. Seven of the women interviewed reflected in a positive manner when asked about their family relationships, and explained how important it was for them to be understanding of their sibling. For Participant 9, accepting what one
Love was a significant factor in how participants felt about their relationship with their sibling. Participants were asked about their time spent with their siblings, the sorts of things they would do together and their most difficult times while their sibling had been using drugs. While many participants had some level of sadness or anger towards their sibling, six of the participants who spoke about “love … kindness and compassion” appeared to feel closer and more connected to their sibling. The data suggested that for those who could distinguish between their sibling and their sibling’s addiction, and felt love and concern, this was associated with a much more positive sibling relationship. This finding is echoed by DeFrain (1999), who talks about appreciation and affection, and the importance of members of a strong family showing care and love for one another.

I sincerely think that she can … get through her addiction if she wants to. I know that she’s one of the strongest people that I know. And I truly believe that she can do it. (Participant 5)

Similarly, having compassion involved participants feeling empathy and concern for their sibling. Compassion was a significant factor in how participants viewed their sibling. Eight participants talked about being able to distinguish between their sibling and their sibling’s addiction, and said it made it easier to feel love and concern. This was in turn associated with having a positive effect on the sibling relationship.

I realise how much acceptance we have for him as a person, and respect and love … Just as we’d have if he was struggling with one leg or something, you know … I don’t feel sorry for him; I have a lot of admiration for him. (Participant 13)

In contrast, two of the participants talked about how their sibling’s substance use gave them compassion on a wider level for others, but that it was still very emotional for them to see others in similar situations to their sibling’s as this hit close to home.

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I know that she is still there, I know I still deeply love that person that is still there, and I know the difference between her and the drugs. (Participant 5)

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of problematic substance use and misuse (Velleman, Templeton & Copello, 2005). In contrast, for participants in the present study, the love, acceptance and compassion they felt was intensified after their sibling’s substance use, and occurred after they observed what their sibling was experiencing. Participants felt that these values were strengthened through their experiences and that gave them hope for the future and resilience.

**Trust and honesty**

I’ve felt cool enough to leave him with my children, because they adore him, and I love seeing them together, and it’s so important for me to see that he’s well enough to be able to do that. (Participant 1)

The second sub-theme was “trust and honesty”. Ten of the 13 participants highlighted the importance of having trust and openness for their communication and closeness with their sibling. The importance of trust within the sibling relationship was also imperative when looking into the future. When participants were asked about impending hurdles or challenges in their relationship with their sibling, many felt that striving towards a more open and honest way of communicating would allow for both a greater chance of recovery for their sibling and a closer sibling connection.

If it’s ever going to get back to how close we were before, we’re going to have to have some difficult conversations … just to get the honesty out … this is how I feel about you, and this is what I want out of our relationship … that’s going to be difficult for both of us … but you know I’ve got faith that it’s going to be okay … and we’ll work it out. (Participant 4)

Trust and honesty were also strong variables in participants’ relationships with their parents and other family members. Six participants reflected on how they had to “trust that they can handle it” when talking about their parents, and being open and honest instead of trying to hide things from their parents to protect them. Having positive communication and being able to have honest and open discussions within the family is a theme in DeFRAIN’s (1999) Family Strengths Model. For many participants, honest communication was a significant challenge, but for those that were able to be open and “caring … honest … and sharing [their] concern …” this ultimately strengthened that relationship.

Findings from longitudinal data by Yeh and Lempers (2004) found that adolescents who saw their sibling relationships more positively, felt less lonely and less depressed. Participants in the present study who saw their sibling relationships more positively reflected more on the importance of trusting them and having open and honest communication. Ultimately, it could be suggested, that participants with greater trust and honesty with their siblings felt less lonely and depressed; however, to understand this connection accurately, future qualitative studies would need to explore this theme in greater detail.

**Protectiveness**

I know what’s important to me, I suppose it’s instilled in me, to protect what is close to me … family and being safe is really important. (Participant 10)

The third and final sub-theme was “protectiveness”. This was a significant theme that appeared in nine of the interviews, with participants feeling a sense of protectiveness, either towards their sibling, their parents or themselves. Experiencing this protective role can be positive and enriching for both the individual and their sibling. For those who found protectiveness to be a strength, participants reflected on this role and felt as though they had a level of responsibility when it came to their sibling’s health and wellbeing.

I always feel like I will be the one looking after … me and my brother, I will always … I’ll sort of take on a carer sister role … and I’m not upset about doing that at all, I want to do that, I want to do that for him. (Participant 7)

Having this belief provided Participants 2 and 7, among others, with a role in their sibling’s life, and because they felt responsible, it supported the closeness of the relationship. Likewise, Participant 1 expressed how playing a carer role, enabled her to feel at ease with where her brother was and what he was doing:

My whole thing with him was that if he was living with me at least I’d know where he’ll be, he’s got a roof over his head, I can get food into him when I can. (Participant 1)

Ten of the participants mentioned feeling this strong, innate sense of protection towards their parents and sibling, which resulted in emotional conflict. This was highlighted by one of the participants who expressed “an incredible pressure … to be just, so okay, all the time …”, and play the role of the “good daughter”. DeFRAIN and Asay (2007) discussed commitment in a strong family, and emphasised the importance of all family members showing one another how important they are in each other’s lives. While participants did have this strong sense of protectiveness, which ultimately demonstrated commitment and love, not feeling as though their parents or sibling returned the same feelings was often expressed.

I feel like there’s an incredible pressure on me to be just, so okay, all the time. Because, you know … if anything, if I was to get sick, if I was to do something stupid or
Many of the participants in the present study, felt their own sense of wellbeing and identity was affected by their sibling’s problematic substance use.

Theme two: Family challenges

Sadness, despair and frustration

The family was very, very shattered, and hopeless and angry, and just, hurt. (Participant 12)

The second theme, family challenges, also had three sub-themes, the first being “sadness, despair and frustration”. Participants reflected on a wide range of challenges that they felt were harmful to their relationship with their sibling and parents. For 10 participants, their sibling’s problematic substance use made them feel extremely sad at the loss of the pre-use relationship. The overwhelming stress and worry resulted in these participants feeling a sense of helplessness and despair, particularly when looking into the future. In contrast, the other three participants talked about how they were ashamed of their sibling, angry at the situation and had “given up” on the idea of having a relationship with them. In these three interviews, participants felt their sibling’s problematic substance use was a direct reason why they had withdrawn from their sibling and lost a lot of the closeness in their relationship. This withdrawal subsequently impacted on the way they communicated and engaged with their sibling.

In my teenage years, I was more inclined to try and talk to her and try to get her to see what was going on, and try to get her to stop … in more recent times I’ve sort of given up and just try to ignore her, for the most part, I don’t really feel like anything I say is going to do anything. (Participant 8)

Similar to Participant 8’s feelings, others felt almost powerless when it came to communicating with their brother or sister, and this made them feel frustrated, “… I’ll get frustrated and I, I actually feel very sad … I can’t do anything …” When looking at frustration and difficulty in communicating in the family, DeFranc (1999) and DeFranc and Asay (2007) talked about how a key factor in strong families is that they are able to get through a difficult time or stressful situation efficiently and with minimal damage. Using DeFranc’s (1999) model, problematic substance use can be seen as a form of family crisis. For many participants, it was very difficult to effectively work through this crisis as there were barriers in communication, and the sadness or anger experienced impeded their ability to help their sibling. This often left participants feeling like their relationship was “permanently damaged”.

It’s actually quite sad … to think about … the lovely things that we used to do as kids … the drug use has definitely robbed us of a lot of those lovely things that we used to do together and lovely times … we have a very damaged relationship, and I think when she gets clean it’s gonna take a long time to build that up to what it could possibly be, because … it’s a matter of years and years lost, lost relationship, of lost time, of missed opportunities. (Participant 5)

Participants’ feelings of sadness, despair and frustration in the current study were significant barriers in the sibling relationship. In summary, the 13 women in the present study experienced similar feelings to those noted by Howard et al. (2010), who found that women with a sibling experiencing problematic substance use issues felt angry, frustrated, confused and helpless. In the present study, these feelings were also associated with withdrawal and a need to disconnect from the sibling with the problematic substance use.
Distrust and secrecy

I have virtually no trust for him … if he approached me asking for help, I would greet that with skepticism and with distrust … I think our relationship is permanently damaged. (Participant 10)

The second sub-theme was “distrust and secrecy”. Participants were asked about their relationship with their sibling from early childhood, and questions around trust and privacy were used to understand how their sibling’s substance use might have affected these aspects of their relationship over time. Eight participants felt their sibling’s problematic substance use resulted in distrust, lies and secrecy in their relationship, consequently impacting on their time spent together and communication. For the other five participants, when asked about trust, they talked about communication with their parents and other family and friends. These participants expressed feelings of shame, embarrassment and denial.

She would just lie … the constant lying and the constant manipulation, and dishonesty and distrust, I just went, you know what, do what you have to do, at the end of the day I’m not going to bust my guts for you anymore. (Participant 11)

When placing these findings in context with DeFrain’s (1999) Family Strengths Model, these themes of distrust and secrecy in the family are likely to create an enormous obstacle for siblings in terms of communication, their time spent together and their closeness. Another important element that added to this obstacle was that for all participants, their siblings had poor mental health. Four participants perceived their sibling to have had pre-existing low mood and anxiety during adolescence, and that their substance use had exacerbated their symptoms. Four other participants perceived their sibling to have not experienced a serious mental health problem before their substance use, but to now suffer from a mental disorder such as schizophrenia, bipolar or depression. For other participants, not only did their sibling have a mental illness, but the participants also experienced their own mental health problems such as depression and anxiety. The comorbidity experienced by the participants’ sibling, and the participants’ own mental health issues, created additional challenges for sibling communication and trust.

After his drug use and then his schizophrenia, he started communicating very differently … there are aspects of his communication that are very childlike … his behaviour changed a lot, it wasn’t just about erratic mood swings … when the mental illness came about … much more difficult of course, when there’s two dialogues in his head, and you’re trying to have a discussion, really difficult, and you know the paranoia, and the behaviour that is expressed with that, is much more difficult to manage. (Participant 6)

A study by Gorka, Shankman, Seeley, and Lewinsohn (2013) found that children living with a parent with a substance use issue were significantly more likely to experience depression. Similarly, for participants in the present study, many experienced depression, which they felt was due to their sibling’s substance use and the anxiety their sibling’s use created. This finding may suggest that not only are mental health issues likely to occur for the person using the drugs but, subsequently, members of the family are at greater risk of experiencing their own mental health issues. For Participant 6, who talked above about her brother’s schizophrenia, there is the potential that low mood and attenuated psychotic symptoms may have been present before his cannabis use, and that his substance use may have transitioned him into psychosis. As she said, that behaviour change created problems for their communication.

Also looking at dual-diagnosis, Boscarino et al. (2010) found a correlation between increased risk of present opioid dependence and depression in individuals that had dependence. The comorbidity between mental health and substance use was present in the current study, with many participants’ siblings experiencing depression and other mental health problems from their substance use and dependence. Furthermore, while Gorka et al. (2013) and Boscarino et al. (2010) looked at how families are influential in the development of mental illness and substance use disorders, the present findings enhance understanding into the underlying feelings experienced by siblings. It is evident that distrust and secrecy are experienced in the sibling relationship, and perhaps even more so when mental illness is a factor.

Overlooked and not validated

You feel like you are a second-class citizen in the sibling rank order. (Participant 5)

The final sub-theme for family challenges was “overlooked and not validated”. The feeling of being “overlooked” was a substantial theme throughout the 13 interviews. For all participants this encompassed feeling ignored and as though their experiences were not validated. Many participants struggled with feeling ostracised and isolated from their families because their parents’ primary concern and “fixation” was with their brother or sister.
It can go months where we don’t talk about much else but her, or what’s happening or what can be done, and how we can best support her … it can often be that we really don’t talk about anything but her. And that’s really hard to think that they aren’t interested in me, or what’s happening in my life. (Participant 5)

Participants weren’t directly asked about whether they felt overlooked by their parents or family, yet this theme appeared in each interview. Ten participants said feeling this way had a negative impact on their relationship with their sibling in terms of their closeness and time spent together. For Participant 10, in particular, when she talked about her brother’s problematic cannabis and codeine use, she explained that at times she felt she could not engage with him because it made her feel scared and anxious. This participant also reflected on the lack of parental support and feeling alienated from her parents.

I was basically condemned by them … and ostracised to the point where, you know, I was told I was disgusting for not supporting my brother, that I was a bad sister. I would say that it damaged my relationship with my parents. (Participant 10)

Feeling as though you are appreciated, and having family members show each other commitment and care is a fundamental principle of a strong family (DeFrain, 1999). When members of the family feel left out and overlooked, this suggests that not all family members are equally committed to each other, and shown in the present study’s findings, can damage relationships and openness within the family. This is reflected in the interviews where participants talked about feeling like their own interests and lives were not as important as looking after their sibling and ensuring their sibling was safe and out of trouble.

After so many years of this, you sort of only just have that realisation that they [participant’s parents] don’t know much about what’s going on with me ... which is really hard ... I think that’s one of the hardest things of having a sibling with a serious addiction. (Participant 5)

The present findings can be considered in relation to research in to siblings with a brother or sister with a disability or chronic illness. McCullough and Simon (2011) found that siblings with a brother or sister with a disability felt overlooked and ignored when it came to the provision of support in the family. Just as participants in this previous study felt isolated and experienced a lack of communication with their sibling, the 13 women in the present study struggled with having a voice in their family, and sharing their own lives with their parents or sibling. For some participants, this resulted in choosing not to share their own lives with their family, and dealing with their own battles alone.

**Theme three: Support**

There’s a real sense of your experience not being validated … of being overlooked, and even when you are engaging with drug services, they are so stretched, and you can’t guarantee a good experience. (Participant 6)

The final theme that was evident in all 13 interviews was support. Participants were asked questions around how they communicated with their sibling in difficult times, and how they supported their sibling and themselves. In the study, three of the younger participants had not sought any external support to help them make sense of, or deal with, their sibling’s substance use. These three participants were also less involved in their sibling’s support and treatment.

I’ve never really felt like I’ve needed to [seek support] … I’m sort of … a more solitary person I guess you’d say, I sort of deal with things on my own. (Participant 8)

For four participants trying to help their sibling receive treatment, seeking support was a significant part of their lives. Of importance, both Participants 5 and 10 reflected on how they had been to support meetings and had never met another sibling. This resulted in feeling alone and as though their feelings were not recognised by their parents or support groups. Participant 10 talked about going to a meeting and remembered that:

Everyone was really astounded by what I was saying, and it was kind of a wakeup call to them, like oh my god, my other children are damaged, and I didn’t realise. (Participant 10)

Participant 10, like many of the other participants, felt as though greater attention is placed on the sibling with the problematic substance use, and that it often feels as though their own issues are ignored by their parents. The present study’s findings suggest that because of this perceived lack of parental support and feeling overlooked, participants were less likely to seek support externally.

In contrast to the other interviews in the present study, Participant 12 had lost her sister to suicide, after her sister had problematic cannabis use and mental illness thought to be induced by the prolonged cannabis use. A huge struggle for Participant 12 was the issue of whether her sister received sufficient support when she was experiencing not only problematic substance use but also a mental illness.
Participants felt that their families were not sufficiently involved with support services.

There’s real distrust … we didn’t know what to ask and we didn’t know what was happening … we weren’t given information, we weren’t allowed in the process. (Participant 12)

Related to this point, a theme identified by Flaherty and Donato-Hunt (2012) was that participants felt that their families were not sufficiently involved with support services. Those participants not actively engaged in the support and treatment process felt isolated and displaced from their families (Flaherty & Donato-Hunt, 2012). This was also found in the current study, with many participants feeling left out by support services and overlooked by their families and support agencies. Ultimately, these findings have potential implications for how families come together during the treatment phase and beyond, if services are not sufficiently supporting families and involving them in the treatment process.

A final pattern within the theme of support in the present study was that nine of the participants had gone on to work in the area of addiction, social work, psychology or therapy. As a number of the participants had a history of some kind of addiction in their family, working in the area enabled many to feel greater empathy and compassion for their sibling and family, and gave them “motivation” to understand the drives behind their sibling’s substance use.

Now I’ve gone into counselling and therapy, so I know all this stuff that I didn’t know then. (Participant 13)

Limitations

There were some limitations to this study. Only 13 participants were recruited, and therefore data saturation was not achieved. However, this was not an aim of the study. Similarly, the findings cannot be generalised to the wider community. The findings suggest, however, that if this is how some siblings feel, perhaps others also share these feelings. Therefore, the study provides some suggestions to family practitioners regarding what to consider when working with people who have had these experiences.

The telephone interviews could also be seen as a potential limitation, as the researcher could not observe the participant’s body language. Due to the nature of the study, however, many participants felt more comfortable undertaking a telephone interview, and the results showed that an in-depth insight into the lived experiences of participants was still achieved, regardless of whether interviews were conducted face-to-face or via telephone.

Furthermore, as only females volunteered for participation in the study, respondent bias may have been a possible limitation and impacted on the study’s findings. A recent study investigating the harms experienced by people as a result of others’ alcohol consumption suggested that females were more likely to report being negatively affected by a relative’s alcohol use (Laslett et al., 2010); this could therefore be one plausible explanation for why females took a strong interest in participating in this study. It would be important for males to also have their stories heard, to gain a better understanding into how sibling relationships are impacted, and to also look into how sibling gender affects these issues.

Conclusion

The aim of this study was to gain insight into a person’s lived experience of having a sibling with a problematic substance use issue, and to see how this affects the sibling relationship. From the themes that emerged, it is apparent that some participants felt that their sibling’s problematic substance use negatively affected not only their sibling relationship but also their relationship with their parents. This study provides insight into how substance use can affect family relationships, and the findings from this study have potential implications for family therapy and support services. While
programs to assist siblings and families are developing in the community, the findings from this study highlight the importance of support tailored specifically to siblings. Programs that work on strengthening communication and building or rebuilding trust between siblings might be considered by support services.

References


Lisa Incerti is a research student at the School of Health and Social Development in the Faculty of Health, Deakin University. Dr Claire Henderson-Wilson is a lecturer at the School of Health and Social Development and at the Centre for Health through Action on Social Exclusion (CHASE), both at the Faculty of Health, Deakin University. Dr Matthew Dunn is Senior Lecturer and Conjoint Senior Lecturer at the School of Health and Social Development and the Centre for Health through Action on Social Exclusion (CHASE), Faculty of Health, Deakin University and the National Drug and Alcohol Research Centre, University of New South Wales.

Acknowledgements. The authors wish to thank the women who participated in this study. This study was conducted under supervision by a student researcher to fulfil the requirements of the degree of Bachelor of Health Sciences (Honours) for Deakin University. The University provided funds to conduct the research. Portions of this manuscript were presented at the 2014 Australasian Professional Society on Alcohol and Other Drugs Conference and the 2014 Australian Institute of Family Studies Conference.
A public health approach to enhancing safe and supportive family environments for children

Daryl J. Higgins

Families are the mainstay of safety and support for children's positive development (Bowes, Watson, & Pearson, 2009). Although families can be the source of harm (e.g., from child abuse, neglect or exposure to domestic violence), they can also be the most important source of protection from harm for children when they provide a sense of security, foster self-esteem and respond appropriately to children's needs.

Although most children live in safe and supportive environments, governments in Western, Anglophone countries are aware that too many children are becoming known to statutory child protection services. This has led to a shift in thinking, away from solely concentrating on the actions of "tertiary systems" (which respond to concerns about high-risk families) towards a broader public health approach to protecting all children (Bromfield, Arney, & Higgins, 2014). Rather than focusing on the primary or more severe manifestations of the problem, scholars and policy-makers have sought to adopt a broader public health approach to the safety and protection of all children (Child Family Community Australia [CFCA], 2014). The basic tenet of a public health approach is that the problem of child maltreatment (and its antecedent risk factors) exists on a continuum of severity, and that strategies can be put in place to shift the risk profile of the entire population, resulting in a reduced likelihood of children coming to the attention of statutory authorities (Higgins & Katz, 2008; O'Donnell, Scott, & Stanley, 2008; Scott, 2006).

Researchers in the child maltreatment field have focused their attention—and rightly so—on "problematic families". Not only are more children becoming known to child protection services, but also the range of problems and issues faced by these children and their families extends beyond the most extreme forms of abuse and neglect to encompass broader social problems and family dysfunction (Bromfield, Lamont, Parker, Horsfall, 2010). In particular, researchers and policy-makers have focused attention on the risk factors that statutory child protection services see as the typical "drivers
of demand" for statutory services. Reviews of family law, child protection services and the juvenile justice system reveal a common set of family problems that typically lead to engagement with these service systems—that is, family violence, parental mental illness and addictions to alcohol, other drugs and gambling (Higgins & Katz, 2008). 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.

Although researchers know a lot about the familial risk factors for child maltreatment (e.g., see CFCA, 2013), less is known about the precursors to some of those risk factors, and whether family environments that are more or less problematic can be identified in the general population.

Examining indicators of the wellbeing of children who are growing up in a range of different family environments can increase understanding of how services may be provided to improve family environments more broadly in society, and achieve more than can be achieved through statutory child protection services or through targeted programs to families of children identified through welfare services.

Child protection: Public scourge or public health issue?

In relation to the protection of children, many child welfare advocates and researchers have for over two decades recognised the value of a public health approach—and the language of public health is used in many policy documents and strategies internationally. However, Australia—along with similar countries such as the UK, the USA, Canada and New Zealand—still struggles under the weight of unsustainably high levels of notifications of child protection concerns.

Although there is debate about whether the underlying incidence of maltreatment has changed, there is no doubt that over the past two-and-a-half decades, there has been a very large increase in notifications to statutory child protection authorities (see Table 1). In line with this increase in notifications, there has also been a substantial increase in the number of children living in out-of-home care. As shown in Table 1, the number of children in out-of-home care has risen in absolute terms, as well as when expressed as a rate per 1,000 children in the population (from 3.0 in 1990 to 8.1 in 2014).

In the past 3–4 years, there have been some indications of a slowdown in the rate at which notifications have been rising; however, the number of children living in out-of-home care—which is a more accurate measure of severe cases of maltreatment or high-level risks in that children cannot remain safely in the care of parents—has continued to climb steeply.

Given the continued high demand on statutory child protection services, is the problem that the “public health approach” per se doesn't work, or is it that the strategies being operationalised on the ground are not truly consistent with the stated approach? One could ask: Where are the features of true population-level prevention strategies, as demonstrated in strategies to address road safety or tobacco use?

Key features of successful public health strategies include: public awareness campaigns (implemented in settings such as schools, community organisations, workplaces and the media) with messages that target not only the individual but also broader social attitudes; provision of programs to improve relevant skills; regular surveillance and strict enforcement of prescribed behaviours; and making improvements in environmental circumstances affecting the behaviours and its context. (For further information on public health initiatives and their success, see Ward & Warren, 2007.)

In the public eye, child maltreatment is often seen as being the problem of negligent, undeserving parents, or in the case of sexual abuse, perpetrated by “dirty old men”. It is not seen as being a series of behaviours that occur along a continuum of severity (and frequency), or that broader social attitudes play a role.
Do families where children experience emotional neglect or physical punishment that is abusive start out with the intention of causing harm to their children? Parenting is a challenge for many people—not just those who come to the attention of statutory services. Although parents may emerge from the birthing suite intent on loving and caring for their infant, life throws some “curve balls”, and we disappoint ourselves. And I suspect that is the reality for the majority of parents encountering the child protection system. I am not aware of any empirical evidence to show that parents in the statutory system are typically sadistic and ill-intentioned. If they were, it would make the jobs of caseworkers and judicial officers of the children's courts very easy. But in the absence of such evidence, let us assume that parents of maltreated children are not necessarily callous, intentionally bad people. Life circumstances—whether of their own making or not—have led them down a path where their children are suffering.

The point of my argument is not that we should pity these parents or fail to intervene to protect children. Where the risk is too great to a child's wellbeing for them to remain in the care of their parent(s)—and where all reasonable avenues have been tried to support parents in creating environments free from abuse and neglect—it is society’s obligation to intervene. But in the circumstance where we have experienced unsustainable growth in the number of children removed from their parents, and little data to show that growing up in alternative care is leading to substantially improved outcomes (Higgins & Katz, 2008)—the question remains: What more can be done?

**Public health interventions**

Recognition of the value of a public health approach to the problem of child maltreatment is reflected in the reframing of the policy approach to protecting children. The approach has moved away from focusing mainly on statutory responses to risk-of-harm reports (“tertiary services”), toward services to those families potentially at risk (“secondary services”). There is also an acknowledgement of the need to combine these with primary prevention efforts, drawing on universal services to support the broader population of all families (see Bromfield et al., 2014; Hunter, 2011; O’Donnell et al., 2008; Scott, Higgins, & Franklin, 2012). However, I would argue that universal services as a platform for taking action to shift the risk profile for the entire cohort of children are still lacking. The backbone of such public health interventions should be a suite of wide-scale, stepped or escalating interventions that can reach the broadest of audiences, but link to more specific services for those in need of additional supports.

A public health approach is premised on the understanding that risks to children’s safety and wellbeing exist on a continuum, and that protecting children is everyone’s responsibility, as is explicitly referenced in Australia’s National Framework for Protecting Australia’s Children 2009–2020 (Council of Australian Governments (COAG), 2009a). Similarly, a public health approach, focusing on the causes (also referred to as risk factors or social determinants) of violence underpins the National Plan to Reduce Violence Against Women and their Children 2010–2022 (COAG, 2009b). Although there is commitment to making child safety “everyone’s business”, as it stands, more of the “business” has been funded toward the statutory end of the spectrum (see the analysis of cost for child protection services reported by the Productivity Commission, 2015). Innovations are emerging, however, such as differential response models that invest in secondary services to prevent moderate-risk families needing to receive statutory services (Bromfield et al., 2014).

To fully see the benefits of a public health approach, we need to identify practical strategies to shift the balance of activities into the public health domain, and identify population-wide strategies that can be employed (i.e., primary prevention). Although targeted interventions can and are being applied toward the known drivers of statutory child protection concerns—namely, families experiencing the parental problems of mental illness, drug/alcohol misuse and violence—this does not itself constitute a public health approach. The emphasis should be on examining what are the precursors of child maltreatment (not
Public health interventions begin with actions that are taken at a whole-of-population level, often through already existing universal service delivery platforms, where workers are already coming into contact with families.

Safe and supportive family environments

Parents vary in the degree to which they use positive, effective, non-violent parenting behaviours. Some families struggle to provide consistently warm, nurturing and safe environments. A key strategy in child abuse prevention is to address problematic parenting behaviours, which are seen as being the primary modifiable risk factor. For example, risk factors for child physical abuse include parenting characteristics such as low engagement and negative perceptions of the child (Cummings & Berkowitz, 2014).

The move towards a public health approach to child protection reflects, in some part, a move in research away from viewing parents who maltreat children as a distinct psychological category and towards viewing them as being at one end of a continuum that includes all parents (Azar, 2002; Belsky, 1984; Holden, 2010). Children experience varying levels of risks across this continuum, which at its negative end may present as child maltreatment or cold, unresponsive, highly neglectful or abusive parents.

Two of the core elements of a safe and supportive family environment relate to parenting and interparental conflict. Levels of parental warmth and hostile or angry parenting vary across families. At the extreme end, children may witness domestic violence between parents. However, interparental conflict arises in a broad range of families throughout society (Repetti, Taylor, & Seeman, 2002).

A safe and supportive family environment is one in which parents ideally provide warm, positive interactions and a secure base from which children can safely explore the world to learn about themselves, others and the wider world around them (Holden, 2010; Pettit, Bates, & Dodge, 1997). These families have well-defined (but not rigid) boundaries between parents and children, positive parenting practices, and parental discipline is consistently applied (Baumrind & Black, 1967; Lucas, Nicholson, & Maguire, 2011; O’Connor & Scott, 2007). As children grow it is important that they engage in shared activities with their parents (Wise, 2003). These are important opportunities to develop both cognitive and non-cognitive skills. For example, shared parent–child engagement in reading (Senechal & Schagen, 2002) and play (Tamis-LeMonda, Užgiris, & Bornstein, 2002) has a positive influence on children’s cognitive, social and emotional development.

Researchers have identified a range of negative outcomes for children associated with poor parenting practices, including child aggression or social withdrawal (Pettit & Bates, 1989); and risky behaviour in adolescence (e.g., alcohol consumption; Alati et al., 2010). Risky family environments are characterised by parental anger or hostility towards children (Repetti et al., 2002). Although interparental conflict is an inherent part of any normal relationship, ongoing, high-level conflict is a feature of highly risky family environments and can lead to adverse psychological and behavioural outcomes for children (Cummings & Davies, 2010; Repetti et al., 2002; Zubrick et al., 2008).
Negative conflict tactics, such as hostility, elicit negative emotional responses from children, whereas positive conflict tactics, such as calm discussion, elicit positive emotional responses (Cummins, Goeke-Morey, & Papp, 2003). As well as being distressed by hearing and seeing interparental conflict, children could themselves be drawn in to—or become the focus or target of—arguments and conflict. Conflict can affect children indirectly through its negative effects on parenting, and it can provide a poor model of interpersonal relationships (Amato, 2006).

Population data on family environments
In order to examine the degree to which the family characteristics identified by Minuchin (1978) arise to some extent in all families, Mullan and Higgins (2014) analysed different types of family environments across Australia using the Longitudinal Study of Australian Children (LSAC)—a large, nationally representative study of two cohorts of children (5,000 recruited in infancy; and 5,000 in their kindergarten year, at age 4–5, and tracked every two years since 2004). There are numerous measures of aspects of parenting and more limited measures of parental conflict used across the two cohorts within LSAC.

Mullan and Higgins’ (2014) four key aims were to examine:
- the prevalence of different types of family “groups” or environments (cohesive, disengaged, enmeshed);
- the profile of these three “family environments” in terms of parenting characteristics (warm parenting, angry parenting), parent–child interactions (shared activities to capture positive parent–child interactions and reflect, in part, the extent to which parents are a resource that their children can access), and parental conflict, as well as the social, demographic and economic characteristics;
- whether these different family environments are associated with measures of child wellbeing; and
- whether positive changes in the family environment over time leads to improvements in child outcomes.

Using a statistical technique called latent class cluster analysis, Mullan and Higgins (2014) identified three broad family environments across a broad age range of study children, both in families with two resident parents and in families with a parent living elsewhere from the primary carer:
- **Cohesive**: The largest group of families exhibited average or above-average levels of parental warmth and parent–child shared activities, and below-average levels of hostile parenting and parental relationship conflict (i.e., clear but flexible boundaries) (see Kerrig, 1995). Cohesive families represent an exemplar of a safe and supportive family environment. As we would expect, these families were the majority, supporting the proposition that most Australian children live in safe and supportive environments.
- **Disengaged**: A smaller group of families exhibited below-average levels of parental warmth and parent–child shared activities, average or below-average levels of parental conflict and above-average levels of hostile parenting (see Minuchin, 1978). In such families, there are rigid boundaries (as demonstrated by lower parental warmth) and a tendency to close off access to resources for children.
- **Enmeshed**: The last group was a small number of families who had strikingly higher levels of parental conflict than the other two groups. They had average or slightly above-average levels of parental warmth and parent–child shared activities. These patterns arise in families with boundaries that tend to be diffuse, and these families have been referred to as enmeshed in previous research (see Minuchin, 1978). Higher levels of parental conflict that tends to negatively affect parenting and lower levels of parent–child interactions distinguish these family environments from the two other groups.

Distinguishing between different family environments
The results highlight that risks to children’s safety and wellbeing operate along a continuum that spans all families. There was some limited association between dysfunctional family environments and socio-economic status (SES). At different points in children’s lives, different aspects of SES are associated with particular aspects of family environments. In other words, there is not a consistent pattern. This provides some support for the validity of a public health approach to child protection, because it shows that factors associated with risks for children are evident to a greater or lesser degree across the entire population (as observed with nationally representative LSAC survey data). Of course, it is important to recognise that looking at parenting behaviour and parental conflict is not the only way to assess whether an environment is safe and supportive.

Often, statutory child protection authorities and the secondary service system (support
for families needing extra assistance, with a focus on early intervention) focus their efforts towards low-SES families, where many of the risks of child maltreatment are congregated—either because service delivery (and surveillance) is concentrated in areas of geographic disadvantage or because services are otherwise allocated to those with the greatest apparent need. However, this is not to assume all children growing up in poverty have worse outcomes—or that all socio-economically advantaged children are doing well. The results that Mullan and Higgins (2014) reported suggest to some extent that potentially problematic dynamics within the families are not concentrated in particular socio-economic groups.

The targeting of services to those most in need could be enhanced by identification of families with problematic intra-familial dynamics and targeting people by behaviour rather than targeting people by demographic characteristics. Different family environments are likely have different needs requiring different types of responses.

Public health campaigns that address parenting practices across the population may be an effective means of addressing the more problematic family environments identified by Mullan and Higgins (2014), as population-wide screening of parenting behaviours may not be cost-effective and may have unintended consequences. However, existing services that come in contact with many parents (e.g., perinatal services, health, early childhood education and care providers, etc.) could have a role in identifying those with seriously problematic family dynamics for receiving additional services.

**Family environments and child outcomes**

Mullan and Higgins (2014) considered the associations between family environments and six measures of child wellbeing: weight status; injuries; social and emotional wellbeing; cognitive development; literacy; and numeracy.

There were few consistent significant associations between family environment and children’s cognitive development. However, children in families located toward the disengaged end of the boundary range had, on average, lower reading and numeracy scores, even after controlling for other factors. Patterns were very similar across family environments for children in families with a parent living elsewhere from the primary parent.

There were few significant associations between family environment and children’s health outcomes. Significant results were restricted to children 2–3 years living in families with two resident parents:

- Children aged 2–3 years in families lying toward the enmeshed end of the boundary range were significantly more likely to be underweight (than normal weight).
- Children aged 2–3 years in families located toward the disengaged end of the boundary range were significantly more likely to have two or more injuries per year.

Although there weren’t strong relationships with later cognitive development and health outcomes, Mullan and Higgins (2014) found a different pattern in relation to children’s social and emotional wellbeing:

- In families with two resident parents, children in families positioned toward the disengaged end of the boundary range had significantly lower levels of pro-social behaviour, higher levels of total problem behaviour, and higher levels of externalising problem behaviour when compared to children from more cohesive families.
- Results were very similar for children in families with a parent living elsewhere from the primary parent.
- There were also significant associations highlighting negative social and emotional outcomes for children in enmeshed families, but these were not as pronounced compared with the results for more disengaged families.

**Do changes in family environment affect children’s wellbeing?**

Mullan and Higgins (2014) then went on to look at children whose family environment changed—and whether this change was reflected in children’s outcomes. They found that across the two LSAC cohorts:

- 54–60% of families with two resident parents remained cohesive; in families with a parent living elsewhere from the primary parent, 62% of the birth cohort and 22% of the kindergarten cohort remained cohesive.
- In families with two resident parents, the family environment of 16% of the birth cohort children and 19% of the kindergarten cohort became more cohesive (15% and 20% respectively in families with a parent living elsewhere from the primary parent).
- Children in regional or rural areas were significantly less likely to experience a worsening of their family environment; children with two or more siblings were
The aim of a public health approach to protecting children is to shift the focus away from a narrow band of children requiring statutory intervention toward addressing the needs of all families. Shifting the profile of all families would potentially reduce the number that would be at risk of statutory intervention and improve the daily lives of many children. In terms of public health interventions, three possibilities arise, and this study may provide some helpful insights. The three potential types of interventions are (a) parenting programs and supports; (b) public information programs; and (c) targeted referrals for more intensive family support (i.e., progressive or proportionate universalism).
While parenting programs and home visiting programs have been shown to improve parenting skills, there is not strong evidence that they are sufficient to prevent child maltreatment.

(a) Parenting programs and supports

Parenting programs have been widely used in early intervention strategies targeted toward vulnerable families (Hayes, 2014). However, some argue that parenting programs can be delivered as part of a public health approach to strengthen and support parenting (Sanders, 2008), and to prevent child maltreatment (Sanders, Cann, & Markie-Dadds, 2003; Sanders & Pidgeon, 2011). Prinz, Sanders, Shapiro, Whitaker, & Lutzker (2009) provided evidence showing a significant prevention effect following from the delivery of a parenting program in the United States. An Australian example, the Every Family initiative, trialled the delivery of the Triple P-Positive Parenting Program in 30 sites across three Australian cities—Brisbane, Sydney and Melbourne (Sanders et al., 2005; see triplep.net). As identified by Sanders et al., for success in a public health initiative of this nature it is necessary to have a good understanding of the prevalence of the particular problem behaviours in children being targeted, the prevalence of parent risk and protective factors, and evidence that changing risk and protective factors improves child outcomes. (See the article by Pickering & Sanders on page 53).

There is a range of other evidence-based approaches to supporting parents and addressing problematic parenting behaviour—for example, through individual parenting education, counselling and mediation (particularly in the context of parental separation). Parental education and support is also a key feature of home visiting programs (see Holzer, Higgins, Bromfield, Richardson, & Higgins, 2006), and a range of other evidence-based interventions for families (Casey Family Programs, 2012). Wise, da Silva, Webster, & Sanson (2005) provided other examples of parenting supports and early childhood interventions whose efficacy is supported by good research evidence.

A large body of research provides strong evidence that the home environment—in particular, concrete behavioural patterns of parents (i.e., parenting characteristics)—is an important determinant of children’s early development and wellbeing. However, it should be noted that, while parenting programs (even those with the highest evidence of their effectiveness, particularly those that are modularised, structured, manualised, etc.) and home visiting programs (a suite of services that may include particular components such as parenting programs and coaching or mentoring) have been shown to improve parenting skills, with the notable exception of Prinz et al. (2009), there is not strong evidence that they are sufficient to prevent child maltreatment (Casey Family Programs, 2012; Holzer et al., 2006; Mildon & Polimeni, 2012).

(b) Public information campaigns

Public information programs are a more familiar tool used by governments to effect broader changes in the behaviour of the population in general. Examples abound, including public health campaigns around alcohol, smoking, skin cancer, drink-driving and safe-driving campaigns. A recent Australian campaign that highlighted how parental alcohol consumption affects children offers an interesting template for how such campaigns can be used to educate parents about the influence their behaviour has on children.

Consistent with the World Health Organization Ottawa Charter for Health Promotion, a range of actions can be taken to improve outcomes, based on advocacy, enabling people to take control of factors that affect their wellbeing, and mediating between differing interests in society for the pursuit of health. They need to be targeted at attitudes or behaviours that are modifiable, with clear links to strategies for achieving the desired change. Adopting a broad information campaign may have limited effect if it is not directed toward behaviours that can be changed and does not point to sources of support for bringing about that change. For example, the national and state/territory Quit initiatives are effective in responding to the problem of smoking because it is targeted at broad social attitudes as well as suggesting...
concrete actions and providing access to supports for quitting smoking.7

Research has explored the utility of popular media to promote positive parenting practices more generally (Sanders & Prinz, 2008) and to promote the prevention of child maltreatment (Saunders & Goddard, 2002). Although public information programs can assist, there are limitations to their effectiveness, particularly when knowledge or attitudes alone are insufficient to effect change. There is limited evidence to address the question of whether or not social marketing campaigns are effective in addressing concrete outcomes like rates of child abuse and neglect (unless linked to a suite of other parenting supports and interventions, proportionate to the needs of parents; see Pickering & Sanders on page 53). Also, evaluations of public information campaigns are notoriously difficult to conduct with any rigour (Horsfall, Bromfield, & McDonald, 2010).

(c) Targeted referrals for more intensive family support

Often the distinction between universal and targeted services is presented as a dichotomy; however, there is scope for it to be seen as a continuum, with universal services being the platform for the ramping up or integration of services that would then be classified as targeted. The principle of proportionate universalism (or progressive universalism, as it is also termed) was outlined in the Marmot review of the social determinants of health inequalities in the United Kingdom (see Fair Society, Healthy Lives: The Marmot Review).8 According to this principle, actions must be “proportionate to the degree of disadvantage, and hence applied in some degree to all people, rather than applied solely to the most disadvantaged” (Lancet, 2010, p. 525). It is also important to remember that disadvantage is not static—families (or even communities) can move into and out of disadvantage (Qu, Baxter, Weston, Moloney, & Hayes, 2012).

Although child abuse and neglect (particularly child sexual abuse) occur across all family forms and socio-economic strata and are under-reported, poverty and social disadvantage are generally associated with higher risks of harm, particularly from neglect (Higgins, 2010). Key issues relating to the economic security of families are the availability and adequacy of employment, and systems to support families on low incomes or experiencing unemployment, such as housing, health care and income support, as well as job search and other employment-related services (Adema, 2012; Howe, 2012). Although Australia has a relatively low level of joblessness overall, the number of Australian families in which no adult member of the household is in paid employment is high compared to many other Organisation for Economic Co-operation and Development (OECD) countries. This is the single most important cause of child poverty in Australia, and has been linked to poorer developmental outcomes for children (Hand, Gray, Higgins, Lohoar, & Deblaquiere, 2011). Jobless families are therefore reliant on government income supports. In the past couple of decades, many government payments have become conditional, in an attempt to address concerns about the welfare of children. An example is compulsory income management or welfare quarantining, which aims to ensure household expenditure on priority items that meet children’s needs rather than gambling, pornography, alcohol and junk food, particularly in circumstances where authorities have concerns about child neglect (Taylor, Stanton, & Gray, 2012). Such conditionality is directly or indirectly aimed at shaping parental behaviours and the family environments in which children grow up.

Although services targeted at the most disadvantaged have the greatest impact, it is also true that targeted services would then mean the majority of the population misses out on the particular interventions. Mullan and Higgins (2014) have demonstrated through their analysis of a representative sample of Australian children that less-than-optimal parenting practices and family environments are not restricted to particular demographic groups and cannot be easily targeted—so there is value in considering the role of universal services to deliver information, supports and services for all Australian families, with increased intensity for those who need it most. Universal services can provide the platform to refer people who require them to more specialist services, or provide a continuum of service, so that within the universal service platform more intense services can be provided to those in need. A number of authors have argued for the importance of using universal services as a base or soft-entry point for engaging families that might otherwise be hard to reach (Muir et al., 2009; O’Donnell et al., 2008; Scott, 2006).

Children identified as being at highest risk tend to be concentrated in circumstances of relatively high disadvantage; however, a public health approach would seek to broaden the policy focus to address wider needs that will make positive changes for the bulk of the population. The research is intended to inform policies to address most Australian families, so that child protection systems have to deal...
with a decreasing proportion of families for whom a public health approach is not enough. However, other examples of vulnerability over time might include parental separation, which increases the risk to the safety and wellbeing of children. Family courts often face difficult choices when parents raise concerns about child abuse or violence by their partner during disputes over children’s matters (Croucher, 2014; Higgins, 2007; Kaspiew et al., 2009).

Further research is needed that explores in more depth the population prevalence of parenting skills, family environments and other characteristics associated with the risk of child abuse and neglect, and the various transition points or “vulnerabilities” across the life-cycle for families where children's wellbeing may be at greater risk.

Conclusion

Building on the growing consensus that communities are best served by a public health approach to child protection (COAG, 2009a), in this article I have taken this one step further, and—drawing on empirical evidence outlined in detail in Mullan and Higgins (2014)—demonstrated “proof of concept” that it is possible to identify family environments at a population level that could be the subject of public health interventions. In broad terms, representative population-based data show there are distinct family environments across society that are similar in certain factors associated with parent–child and parent–parent interactions, and that these groups are not directly linked to particular socio-economic groups. The majority of families were cohesive. A smaller—though substantial—group were disengaged. A third group, equally substantial, were enmeshed.

Different family environments, with their dynamic nature, have a strong influence on certain child outcomes, particularly those relating to children’s social and emotional wellbeing. Children with warm, highly involved parents had higher social and emotional wellbeing. Those with less involved parents, and who experienced above-average angry parenting, tended to have lower social and emotional wellbeing. Children in families marked by higher levels of parental conflict were between these two groups. This highlights the importance of parent–child and parent–parent interactions in shaping aspects of the family environment to which children's social and emotional wellbeing are sensitive.

However, I think the most significant aspect of the analysis provided by Mullan and Higgins (2014) was that due to the longitudinal nature of the LSAC dataset, these environments were examined repeatedly over time from infancy to middle childhood. There was considerable change in the family environments for children—and most importantly, that positive changes (where families scores on the measures moved towards the more “cohesive” end of the spectrum), were associated with improvements in children's social and emotional wellbeing. Children in families marked by higher levels of parental conflict were between these two groups. This highlights the importance of parent–child and parent–parent interactions in shaping aspects of the family environment to which children's social and emotional wellbeing are sensitive.

This highlights the potential for public health interventions aimed at improving—and sustaining—dimensions of the family environment that are strongly associated with children’s social and emotional wellbeing (Hunter, 2011). A public health approach draws on families’ strengths, but seeks to support all families to do a better job of providing children with a safe and supportive environment, reducing the likelihood of exposure to violence, maltreatment or neglect (Scott, 2006). Possible interventions include parenting programs and public information programs. Careful tailoring of interventions to specific dynamics arising within families would be beneficial, and programs that can reach a broad cross-section of society are necessary.

Rather than seeing the protection of children solely as the role of statutory authorities, a public health perspective sees the opportunity for all families to have supports to improve their capacity to protect children and creating safe environments for them. However, it is
not sufficient to simply “bolt on” preventive programs to the current child protection processes. Researchers and commentators have argued that the role and function of child protection systems need to be reviewed in the context of the wider range of policies and programs aimed at supporting parents and promoting the wellbeing of children. This is of particular importance in the context of minority and/or marginalised groups, such as Indigenous communities in Australia, for two reasons: (a) Indigenous children are over-represented in statutory child protection activities in Australia (and similarly with First Nations peoples in Canada; see National Collaborating Centre for Aboriginal Health, 2013); and (b) community-owned and community-led initiatives can be used to support the health, wellbeing and safety of Indigenous children in culturally appropriate ways (Higgins & Katz, 2008).

I am not suggesting that community-wide interventions to identify and ameliorate poor parenting practices should occur at the expense of statutory services, or of early intervention services to those at high risk. I am instead arguing for a “proportionate” or “progressive” universal approach: as well as communitywide interventions (parenting campaigns), linked to easily accessed information and services for those parents wanting assistance, further work would need to be done to identify how existing universal service providers who are in touch with families could be used to identify such problematic environments, and re-engage them in an evidence-based practice to improve their parenting capacity and the family environment. This could include a range of services such as antenatal services, maternal and child health services, early childhood educators and schools. These represent the existing service infrastructure that all families access. In addition, where there are points of crisis in a family’s life—like a serious illness, parental unemployment, a bereavement or separation/divorce—then the services that interact with families at these times could be provided with resources and training to screen for, and provide additional support for, families at risk of slipping into a less positive environment. This could include government agencies providing financial assistance to the unemployed or managing child support arrangements post-separation, family relationship services to separating couples (such as those providing mediation services or conducting assessments for family courts), and hospital social-work staff.

Families remain the central focus of identifying risks of maltreatment of children (which are often characteristics or behaviours of parents); families are also central to strategies for protecting children. Although families are not always the only site of violence and maltreatment of children, they can still—along with other agencies and institutions—be enlisted to assist with interventions to support children and keep them safe. Even in relation to prevention of child sexual abuse, while most abuse occurs in families or by known perpetrators, when it does occur outside of the family, families can still play a protective role to prevent abuse, and respond appropriately if it does occur.

The association between family environments and child wellbeing outcomes (especially around social and emotional wellbeing) suggest that the efficacy of policy may be enhanced if policies and services: (a) are attuned or sensitive to different family environments; (b) target behaviour (parental family dynamics) rather than people on the basis of their socio-demographic characteristics; (c) recognise both that families can change for the better and that they can potentially draw on their own prior (positive) experiences; and (d) are directed to all families (e.g., through universal services), based on a public health approach to promote safe and supportive family environments.

All families have a vital role to play in providing children with a safe and supportive environment. The public health space provides governments, agencies and communities with opportunities to recognise that problematic family environments could arise in any family at any time and appropriately intervene.

**Endnotes**

1. Children removed from the care of their parent(s) and placed in “alternative care” due to their family environment being so unsafe that their wellbeing would be seriously compromised if they were not removed are referred to as “looked after children” (e.g., in the UK).

2. Parents answered a number of questions relating to warm parenting (e.g., “How often do you hug or hold this child?”, “How often do you tell this child how happy he/she makes you?”). The “primary” and “secondary” resident parents/carers answered a number of questions relating to angry parenting (e.g., “How often are you angry when you punish this child?”, “How often have you lost your temper with this child?”). The primary parents and the parents living elsewhere from the primary parent stated how often during the week prior to the interview they had read or told a story to the study child, played indoors or outdoors with the study child, engaged in music or other creative activities with the study child, or included the child in everyday activities. In families with two resident parents, both parents answered questions relating to parental conflict (e.g., “How often is there anger or hostility between your partner and you?”; “How often do you have arguments with your partner...
that end up with people pushing, hitting, kicking or shoving”). In families with a parent living elsewhere from the primary parent, the primary resident parent also answered questions relating to conflict with the other parent. The measure of interparental conflict was based on responses to a single question about how well the other parent gets along with the study child’s primary responding parent. For information on LSAC, see: <www.growingupinaustralia.gov.au>.

4 See Holzer et al. (2006) for other examples of parenting programs that have been evaluated. For a comprehensive summary of profiles of programs that have a good evidence base, see <apps.aifs.gov.au/cfca/guidebook/programs>. For a list of other publications on parenting programs, see also: <www.aifs.gov.au/cfca/topics/parenting.php>. Casey Family Programs (2012) published a synthesis of evidence-based interventions that address common forms of maltreatment—many of which are focused on improving parenting capacity. For further information on the evidence base for home-visiting interventions, see: <www.casey.org/home-visiting>. Meldon and Polimeni (2012) reviewed programs that have specifically targeted Indigenous families.


6 See the Ottawa Charter for Health Promotion at: <www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html>.


8 See the Marmot Review at: <www.marmot-review.org.uk>.

References


Dr Daryl J. Higgins is Deputy Director (Research) at the Australian Institute of Family Studies.

Acknowledgements: The views expressed in this publication are those of the author and may not reflect those of the Australian Government or the Australian Institute of Family Studies and cannot be taken in any way as expressions of government policy. As some of the data and arguments are based on Mullan and Higgins (2014), I would like to acknowledge the contributions of my co-author on that paper, Dr Killian Mullan, for whose analytical skills I am gratefully indebted.
### Why parenting programs are so important

The quality of parenting that children receive has a major influence on their development, wellbeing and life opportunities (Repetti, Taylor, & Seeman, 2002; Griffin, Botvin, Scheier, Diaz, & Miller, 2000). Parenting programs that seek to improve parenting practices while simultaneously enhancing child development are vital to establishing a nurturing environment that acts to offset the development of behavioural and psychological problems and lays the foundation for children to contribute to a healthy and functional society (Biglan, Flay, Embry, & Sandler, 2012). There is now broad scientific and interdisciplinary consensus that behaviourally oriented active skills training programs that teach parents positive parenting and contingency management skills are effective. Such programs have transformed child and family-focused mental health support and prevention services (Comer, Chow, Chan, Cooper-Vince, & Wilson, 2013; McCart, Priester, Davies, & Azen, 2006; Menting, de Castro, & Matthys, 2013).

Parenting programs are potentially powerful tools in the prevention and treatment of a range of child social, emotional and behavioural problems including challenging behaviour in children with developmental disabilities (Tellegen & Sanders, 2014; Whittingham, Sanders, McKinlay, & Boyd, 2014), persistent feeding problems (Adamson, Morawska, & Sanders, 2013), anxiety disorders (Rapee, Kennedy, Ingram, Edwards, & Sweeney, 2010), recurrent pain syndromes (Sanders, Cleghorn, Shepherd, & Patrick, 1996), and childhood obesity (West, Sanders, Cleghorn, & Davies, 2010). Positive intervention effects on child and parent outcome measures have been reported across diverse cultures (e.g., Mejia, Calam, & Sanders, 2014; Turner, Richards, & Sanders, 2007), family types (e.g., Stallman & Sanders, 2007), stages of child development (e.g., Salari, Ralph, & Sanders, 2014), and delivery settings (e.g., Morawska et al., 2011). Positive intervention effects have been found to be
maintained over time (e.g., Heinrichs, Kliem, & Hahlweg, 2014) without the need for further booster sessions.

Recent research has also demonstrated how different parenting styles and strategies influence various aspects of brain development. One study showed how harsh parenting reduces telomere length in the brain (a biomarker for chronic stress; Mitchell et al., 2014); while another by Luby et al. (2013) demonstrated how even in environments of poverty, altering the ways children are raised can help alleviate some of the adverse effects of disadvantage and promote healthy brain development in children.

Available evidence about maltreating parents suggests that parent training leads to improvements in parenting competence and parent behaviour (Holzer, Higgins, Bromfield, & Higgins, 2006; Sanders & Pidgeon, 2010). These changes in parenting practice reduce the risks of further abusive behaviour towards children, referrals to protective agencies and visits to hospital. Beyond younger children, potentially modifiable parenting and family risk factors can also be targeted to reduce the rates of emotional and behavioural problems in adolescents (Dekovic, Janssens, & Van As, 2003).

Although studies on parenting programs for parents of teenagers are less extensive compared to studies with younger children (Kazdin, 2005), programs have been demonstrated to improve parent–adolescent communication and reduce family conflict (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001; Chu et al., 2013; Dishion & Andrews, 1995), and reduce the risk of adolescents developing and maintaining substance abuse, delinquent behaviour and other externalising problems (Connell, Dishion, Yasui, & Kavanagh, 2007; Mason, Kosterman, Hawkins, Haggerty, & Spoth, 2003). Parents of adolescents who have participated in parenting programs have reported higher levels of confidence and use of more effective parenting strategies (Spoth, Redmond, & Shin, 1998).

Traditional approaches to parent training involve working with individual families or small groups of parents; although effective, such programs reach relatively few parents and consequently are unlikely to reduce rates of serious child-development problems related to inadequate parenting (Prinz & Sanders, 2007). In a household telephone survey of 4,010 Australian parents with a child under the age of 12 years, 75% of respondents who had a child with an emotional or behavioural problem had not participated in a parenting program (Sanders, Markie-Dadds, Rinaldis, Firman, & Baig, 2007). In addition, the worldwide rate of child behavioural problems is approximately 20% (World Health Organization [WHO], 2005). Thus, the benefits derived from participating in parenting programs are seldom fully realised across communities (Prinz & Sanders, 2007).

A paradigm shift in the way evidence-based parenting interventions are developed, trialled and disseminated is currently underway. Fundamentally, the shift is away from a focus on the individual parent or family unit, towards a community-wide, population-level focus. Biglan et al. (2012) described the shift as being towards a public health paradigm that valued the prevalence of nurturing environments and has, at its core, multiple efforts that act to prevent most mental, emotional and behavioural disorders.

In an Australian context, there are increasing calls from respected researchers and institutions for a public health approach to parenting support. For example, Mullan and Higgins (2014) used data from the Longitudinal Study of Australian Children to explore how different types of family environments influenced child outcomes. The study demonstrated that there is a clear link between family environments and children’s social and emotional wellbeing, and greater emphasis is required to provide families with evidence-based solutions. The authors concluded by calling for the adoption of a public health approach to promoting safe and supportive family environments. Providing all parents, regardless of their circumstances, with access to reliable, evidence-based, easy-to-access support, is critical to this shift in focus.

There are many examples of evidence-based parenting programs that are available around the world. One such program is The Incredible Years, developed by Carolyn Webster-Stratton and colleagues at the University of Washington’s Parenting Clinic (Webster-Stratton, 1998). A core focus of the program is the relationship among parents, children and teachers, and the treatment of behavioural problems through a collaborative home and school environment. Other interventions offer more intensive support, such as The Nurse-Family Partnership established by David Olds, which incorporates a home-visit component to assist first-time mothers and their babies from birth, through to the age of two (Olds, 2006).

To help professionals working in the field navigate the programs available, several groups have established “evidence-based parenting clearinghouses” that offer a summary of all the available parenting programs in a particular region or area. Examples...
of clearinghouses include The California Evidence-Based Clearinghouse (www.cebc4cw.org), and Blueprints for Violence Prevention (www.colorado.edu/cspv/blueprints/index.html). These sites typically sort programs via topic area (e.g., child welfare) and provide key information about each program including cost-effectiveness data, a rating of program evidence and how the program is delivered.

A recent analysis of parenting programs with Australian evaluation data identified 109 programs that targeted a combination of child, parent and family outcomes (Wade, Macvean, Falkiner, Devine & Mildon, 2012). The review used a Rapid Evaluation Assessment (REA) methodology that determined which parenting programs reporting parent, child or family outcomes had been evaluated in Australia and to identify the evidence for those programs. The effectiveness of each program was based on evidence from all papers found in the REA process. The evidence rating scale extended along a continuum from 1 to 6, where a 1 denoted Concerning Practice (“There is evidence of harm or risk to participants OR the overall weight of the evidence suggests a negative effect concerning practice on participants”), and 6 denoted Well Supported (“At least two RCTs have found the program to be significantly more effective than the comparison group”).

Of all programs included in the analysis, the Triple P-Positive Parenting Program and its sister program, Stepping Stones Triple P, were the only programs to receive the highest rating of “well supported”. The Triple P-Positive Parenting Program adopts a public health framework and, combined with the strength of evidence supporting it, provides an ideal case study for how to design and disseminate a system of parenting support within a public health framework in an Australian setting.

Triple P: Parenting as a public health priority

The Triple P-Positive Parenting program (Triple P) was developed by Sanders and colleagues at The University of Queensland. Triple P is built on the premise that there is no more important potentially modifiable target of preventive intervention and conceivably no more powerful means of enhancing the health and well-being of a community than evidence-based parenting practices. Triple P seeks to promote warm, responsive, consistent parenting that provides boundaries and contingent limits for children in a low-conflict family environment.

Triple P is built on the principle of proportionate universalism (Marmot, 2010) whereby it works as both an early intervention and prevention model to help create a society of healthy, happy, well-adjusted individuals with the skills and confidence they need to do well in life. To achieve this, Triple P targets the multiple factors that lay the foundation for lifelong prosperity for both the individual and broader community.

Triple P employs an iterative, consumer engagement model of program development to develop a range of evidence-based tailored variants and flexible delivery options (see Pickering & Sanders, 2013). The program targets children at five different developmental stages: infants, toddlers, pre-schoolers, primary schoolers and teenagers. Within each developmental period the reach of the intervention can vary from being very broad (targeting an entire population) to quite narrow (targeting only vulnerable high-risk children or parents). The five levels of Triple P incorporate universal media messages for all parents (Level 1), low intensity large group (Level 2), topic-specific parent discussion groups and individual programs (Level 3), intensive groups and individual programs (Level 4), and more intense offerings for high-risk or vulnerable parents (Level 5). Figure 1 and Table 1 (from page 56) describe Triple P’s multilevel system of parenting support geared towards...
<table>
<thead>
<tr>
<th>Level of intervention</th>
<th>Intensity</th>
<th>Program variant</th>
<th>Target population</th>
<th>Modes of delivery</th>
<th>Intervention methods used</th>
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<tr>
<td><strong>Level 1</strong></td>
<td></td>
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<tr>
<td>Media and communication strategy on positive parenting</td>
<td>Very low intensity</td>
<td>Stay Positive</td>
<td>All parents and members of the community interested in information about parenting to promote children’s development and prevent or manage common social, behavioural and emotional problems.</td>
<td>Website to promote engagement. May also include television programming, public advertising, radio spots, newspaper and magazine editorials.</td>
<td>Coordinated media and promotional campaign to raise awareness of parent issues, destigmatise and encourage participation in parenting programs. Involves electronic and print media.</td>
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<td><strong>Level 2</strong></td>
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<tr>
<td>Brief parenting interventions</td>
<td>Low intensity</td>
<td>Selected Triple P Selected Teen Triple P Selected Stepping Stones Triple P</td>
<td>Parents interested in general parenting information and advice or with specific concerns about their child’s development or behaviour.</td>
<td>Series of 90-minute stand-alone, large group parenting seminars; or one or two brief individual face-to-face or telephone consultations (up to 20 minutes).</td>
<td>Parenting information promoting healthy development or advice for a specific developmental issue or minor behavioural problem (e.g., bedtime difficulty).</td>
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<td><strong>Level 3</strong></td>
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<tr>
<td>Narrow focus parenting programs</td>
<td>Low–moderate intensity</td>
<td>Primary Care Triple P Primary Care Teen Triple P Primary Care Stepping Stones Triple P</td>
<td>Parents with specific concerns, as above, who require brief consultations and active skills training.</td>
<td>Brief program (about 80 minutes) over three to four individual face-to-face or telephone sessions; or series of 2-hour stand-alone group sessions dealing with common topics (e.g., disobedience, hassle-free shopping).</td>
<td>Combination of advice, rehearsal and self-evaluation to teach parents to manage discrete child problems. Brief topic-specific parent discussion groups.</td>
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<td><strong>Level 4</strong></td>
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<tr>
<td>Broad focus parenting programs</td>
<td>Moderate–high intensity</td>
<td>Standard Triple P Group Triple P Self-Directed Triple P Standard Teen Triple P Group Teen Triple P Self-Directed Teen Triple P Online Triple P</td>
<td>Parents wanting intensive training in positive parenting skills.</td>
<td>Intensive program (about 10 hours) with delivery options including ten 60-minute individual sessions; or five 2-hour group sessions with three brief telephone or home visit sessions; or ten self-directed workbook modules (with or without telephone sessions); or eight interactive online modules.</td>
<td>Broad focus sessions on improving parent–child interaction and the application of parenting skills to a broad range of targeted behaviours. Includes generalisation enhancement strategies.</td>
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continued on page 57
### Table 1: The Triple P system of parenting and family support

<table>
<thead>
<tr>
<th>Level of intervention</th>
<th>Intensity</th>
<th>Program variant</th>
<th>Target population</th>
<th>Modes of delivery</th>
<th>Intervention methods used</th>
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<tr>
<td><strong>Level 5</strong></td>
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<tr>
<td>Intensive family</td>
<td>High intensity</td>
<td>Enhanced Triple P</td>
<td>Parents of children with behavioural problems and concurrent family dysfunction such as parental depression or stress, or conflict between partners.</td>
<td>Adjunct individually tailored program with up to eight individual 60-minute sessions (may include home visits).</td>
<td>Modules include practice sessions to enhance parenting; mood management and stress-coping skills; and partner support skills.</td>
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<td></td>
<td>Pathways Triple P</td>
<td>Parents at risk of maltreating their children. Targets anger management problems and other factors associated with abuse.</td>
<td>Adjunct program with three 60-minute individual sessions or 2-hour group sessions.</td>
<td>Modules include attribution retraining and anger management.</td>
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<td></td>
<td>Lifestyle Triple P</td>
<td>Parents of overweight or obese children. Targets healthy eating and increasing activity levels as well as general child behaviour.</td>
<td>Intensive 14-session group program (including telephone consultations).</td>
<td>Program focuses on nutrition, healthy lifestyle and general parenting strategies.</td>
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<tr>
<td></td>
<td></td>
<td>Family Transitions Triple P</td>
<td>Parents going through separation or divorce.</td>
<td>Intensive 12-session group program (including telephone consultations).</td>
<td>Program focuses on coping skills, conflict management, general parenting strategies and developing a healthy co-parenting relationship.</td>
</tr>
</tbody>
</table>
normalising and destigmatising parental participation in parenting education programs.

The evidence supporting Triple P

Triple P is built on more than 35 years of program development and evaluation. A recent meta-analysis of Triple P (Sanders, Kirby, Tellegen, & Day, 2014) looked at 101 studies (including 62 randomised controlled trials) involving more than 16,000 families. Studies were included in the analyses if they reported a Triple P evaluation, reported child or parent outcomes, and provided sufficient original data. In these analyses, significant moderate effect sizes were identified for children’s social, emotional and behavioural outcomes ($d = 0.475$), parenting practices ($d = 0.578$), and parenting satisfaction and efficacy ($d = 0.519$). Significant small-to-moderate effects were also found for the distal outcomes of parental adjustment ($d = 0.340$) and parental relationship ($d = 0.225$). Significant positive effect sizes were found for each level of the Triple P system for children’s social, emotional and behavioural outcomes, although greater effect sizes were found for the more intense interventions (levels 4 and 5). These results support the effectiveness of light-touch interventions (levels 1, 2 and 3) as affecting key parenting outcomes independently. Significant moderate to large effects were also found for various delivery modalities, including group, individual, phone and online delivery.

Targeting entire communities can be effective in changing population-level indices of children’s social, emotional and behavioural problems. The approach, which involves targeting a geographically defined community and introducing the intervention model, has been carried out in several large-scale evaluations, several of which are in an Australian setting.

Sanders et al. (2008) implemented and evaluated the Every Family project. Every Family targeted parents of all 4–7 year old children in 20 geographical catchment areas in Australia. All parents in 10 geographic catchment areas could participate in various levels (depending on need and interest) of the multilevel Triple P suite of interventions. Interventions consisted of a media and communication strategy, parenting seminars, parenting groups and individually administered programs. These parents were then compared to a sample of parents from the other 10 care-as-usual geographical catchment areas. The evaluation of population-level outcomes was through a household survey of parents using a structured computer-assisted telephone interview. Following a 2-year intervention period, parents in the Triple P communities reported a greater reduction in behavioural and emotional problems in children, coercive parenting and parental depression and stress.

A further promising finding for Triple P in an Australian context emerged from a service-based evaluation of Triple P in New South Wales (Gaven & Schorer, 2013). The evaluation showed that children whose parents attended a Triple P course experienced significant behavioural and emotional improvements. There was a reduction in the number of children with clinically elevated scores on the Strengths and Difficulties Questionnaire (SDQ; Goodman & Goodman, 2009), with approximately 10% of children moving from the clinical to the non-clinical range after Triple P. Practitioner reports of their experience in using Triple P were overwhelmingly positive. The practitioners identified that Triple P had helped them to do their job better, enhanced the services they could offer clients and increased their confidence in helping families. The study found that approximately 90% of practitioners would recommend Triple P to their colleagues.

Prinz, Sanders, Shapiro, Whitaker, & Lutzker (2009) conducted a ground-breaking study linking Triple P to the reduction of child maltreatment at a population level. The study involved randomising 18 counties in South Carolina (USA) to either the Triple P system or to care-as-usual control. Following intervention, the Triple P counties had lower rates of founded cases of child maltreatment, hospitalisations and injuries due to maltreatment and out-of-home placements due to maltreatment. This was the first time a parenting intervention has shown positive population-level effects on child maltreatment in a randomised design, and provides great promise for the potential value of a population approach to parenting support. It also demonstrates to policy-makers the potential of positive parenting programs to enhance the lives of individuals within the community and also the fabric of the community more broadly.

Two additional recent studies investigated the effects of Triple P as a public-health intervention. Sarkadi, Sampaio, Kelly, & Feldman (2014) evaluated Triple P when delivered in preschools in the form of large group seminars (Level 2) along with brief individual primary-care consultations (Level 3). They reported significantly greater health gains (12%) than preschools without the program (3%).

Fives, Pursell, Heary, Gabhainn, and Canavan (2014) evaluated a population-level rollout of Triple P. Approximately 1,500 families were...
selected at random from two Irish Midlands counties and interviewed before and after the implementation of Triple P. A feature of this evaluation was that the interviewed families may or may not have directly accessed Triple P. Results from these interviews were then compared with results from interviews with 1,500 families selected at random from a large, similarly matched county where Triple P was not delivered. Counties were matched on several criteria including socio-economic status, urban or rural setting, previous availability of parenting programs in the area and proximity to the intervention counties.

Significant population-level impacts were recorded across a range of child outcomes including clinically elevated emotional symptoms (29.7% decrease), conduct problems (30% decrease), peer problems (14% decrease), hyperactivity (27% decrease) and prosocial behaviour such as helping others (35% increase). A number of significant gains were also made at the population level for parenting outcomes and strategies. In the Triple P counties, the number of parents reporting psychological distress decreased by 32%, significantly more parents reported a good relationship with their child and significantly more reported using appropriate parenting strategies. In the Triple P counties, significantly more parents reported they were likely to use appropriate discipline following the implementation of Triple P and less likely to use inappropriate discipline for anxious behaviour.

How a public health approach to parenting support works

The rationale behind a public health approach to parenting support is that there are differing levels of dysfunction and behavioural disturbance in children and adolescents, and parents have different needs and preferences regarding the type, intensity and mode of assistance they may require. The multilevel approach of Triple P adopts the position of flexible delivery, tailoring the intensity of intervention to suit need, and selecting the “minimally sufficient” intervention as a guiding principle to serving the needs of parents in order to maximise efficiency, contain costs and ensure that the program becomes widely available to parents in the community. The model avoids a one-size-fits-all approach by using evidence-based tailored variants and flexible delivery options (e.g., web, group, individual, over the phone, self-directed) targeting diverse groups of parents. The multi-disciplinary nature of the program involves the use of the existing professional workforce in the task of promoting competent parenting.

The public health approach emphasises the universal relevance of parenting assistance so that the larger community of parents embraces and supports parents being involved in parenting programs. From a population-level perspective, intervention developers must consider how their program fits with local needs and policy, and be mindful of the cost-effectiveness of their proposed solution. Improved parenting is a potentially powerful cornerstone of any prevention and early intervention strategy designed to promote positive outcomes for children and the community. However, an effective parenting support strategy needs to address a number of significant challenges within a robust implementation framework in order to succeed (Damschroder & Hagedorn, 2011).

Parenting interventions need to be delivered in a non-stigmatising way. Currently, parenting interventions are perceived by many vulnerable and at-risk parents as only being for inadequate, ignorant, failed or wayward parents. To be effective, a whole-of-population approach to parenting support has to emphasise the universal relevance of parenting.
Investment in a population-wide rollout of Triple P would enable every Australian family to access quality evidence-based parenting information and support when needed, regardless of where they live.

Parenting support needs to be flexible with respect to delivery formats (e.g., group, individual, online) to meet the needs of parents in the child welfare system. Having every family receive an intensive intervention at a single location is not only cost ineffective but also unnecessary and undesirable from a family’s perspective. A careful consideration of the cost-effectiveness of interventions is essential when developing and disseminating programs at a population level.

Based on two economic analyses of the Triple P system, it is clear that a public health approach can be cost-effective. In one of the analyses (Aos et al., 2014), it was found that every $1 invested in the Triple P system (i.e., implementation of levels 1-5) yielded a $9 return in terms of reduced costs of children in the welfare system. In the other (Foster, Prinz, Sanders, & Shapiro, 2008), the infrastructure costs associated with implementing the Triple P system (i.e., levels 1-5) in the United States (Prinz et al., 2009) was $12 per participant, a cost estimated to be recoverable in a year by as little as a 10% reduction in the rate of abuse and neglect. Although these savings are striking, it is unclear who absorbs the cost of delivering parenting programs such as Triple P to the community.

Federal and state governments can choose to directly invest in these programs as part of their social welfare and mental health policies. However, in an environment of intense competition for public funds and resources, sustained investment in parenting programs is ultimately a matter of priority, which points to the importance of continued advocacy by researchers, agencies and consumers for government investment in prevention programs. Flexibility of program offering will also make the intervention useful for mandated services—parenting support for foster and adoptive parents and support for families within the child welfare system who are not involved with child protective services.

Reliable measurement of population-level effects

There is a need for a national survey of parenting practices and child wellbeing outcomes in Australia using brief, reliable measures that are sensitive to change to document population-level program effects on
children and parents. Such a survey would be valuable in documenting the impact of policy-level changes and in determining whether specific investments in programs achieved desired outcomes.

The survey would complement the Longitudinal Study of Australian Children by extending the scope to focus on measuring the targets of parenting interventions. Such data would enable community prevalence-rate data on positive and negative parenting practices and the community context of family functioning to be tracked over time. These epidemiological data would provide a valuable planning tool as well as allowing changes in parenting practices (improvements or deterioration) to be monitored over time.

From a policy perspective a regularly conducted comprehensive national parenting survey is consistent with goals of the National Framework for Protecting Australian Children and provides a direct means to describe the experiences of Australian parents in raising their children. The survey could be conducted every three years on a representative sample of Australian children aged 2–12 years and their parents. It could be designed to capture a range of child and parent variables that might be expected to change directly as a result of parenting interventions (e.g., parenting practices) or via changes in policy affecting families (e.g., financial stress) or be a predictor of change (e.g., socio-economic status, gender, family structure or changes in community context).

The development and implementation of a national parenting survey as an epidemiological tool to help evaluate the effects of policy-led changes in services to parents and families is essential. Such an instrument will provide a means for parents to express their opinions about the challenges they face raising their children, the type of help parents would find useful and the value they attach to the help received via parenting programs and the forms of family support. Reliable and change-sensitive measurement of parenting and child behaviour is crucial to the fidelity of a public health approach to parenting support.

Conclusion

There is clear evidence that the early years of children’s lives shape their future, including their physical and mental health, learning capacity, social and emotional wellbeing and life opportunities. All aspects of adult human capital, from workforce skills to cooperative and lawful behaviour, build on capabilities developed during the childhood years. While all parents want the best for their child, many lack the tools to parent effectively.

To improve uptake of programs, a public health approach to parenting support is required. The Triple P system represents a transformational approach to improving the health and wellbeing of the community at large. To our knowledge, the Triple P system is the only parenting program shown to improve parenting practices and child development outcomes when evaluated at a population level. However, strengthening parenting and family relationships across the entire population can only occur if developers work synergistically with practitioners, agencies and policy-makers. When parents are empowered with the tools for personal change they require to parent their children positively, the resulting benefits for children, parents and the community are immense.

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**John A. Pickering** is Head of the Triple P Innovation Precinct, Parenting and Family Support Centre, and Professor Matthew R. Sanders is Professor of Clinical Psychology and Director of the Parenting and Family Support Centre, both at The University of Queensland.

**Disclosure statement**: The Triple P Positive Parenting Program is owned by The University of Queensland (UQ). The university, through its main technology transfer company UniQuest Pty Limited, has licensed Triple P International Pty Ltd to disseminate the program worldwide. Royalties stemming from this dissemination activity are distributed to the Parenting and Family Support Centre, School of Psychology, UQ, Faculty of Health and Behavioural Sciences; and contributory authors. Matthew Sanders is the founder and an author on various Triple P programs and a consultant to Triple P International. No author has any share or ownership in Triple P International Pty Ltd.

The Triple P system is the only parenting program shown to improve parenting practices and child development outcomes when evaluated at a population level.
Attitudes to post-separation care arrangements in the face of current parental violence

Lawrie Moloney, Ruth Weston and Lixia Qu

The issue of appropriate post-separation parenting arrangements in cases of alleged, acknowledged or proven violence in the spousal relationship continues to exercise the minds of judicial officers, legal and social science practitioners, researchers, advocates and, of course, family members themselves—including the children. Among the many variables at play in this difficult area of decision-making are community attitudes to family violence.

Community attitudes have been surveyed with a view to (among other things), providing baseline data against which future changes might be measured. In this article, we report on responses to questions about the appropriateness of three particular care-time parenting arrangements in situations in which a parent is currently “threatening or violent towards the other parent after separation”. Clearly for each individual, such responses are likely to be informed by a number of variables that could only be known via further, more detailed, investigation. However, our working hypothesis at this stage is that the responses reported in this article are likely to be a reasonable proxy for attitudes towards family violence itself.

We provide a detailed analysis of the responses to questions about the three caret-time arrangements. We then place these responses within the context of results from the Longitudinal Study of Separated Families (LSSF), conducted by the Australian Institute of Family Studies (AIFS). This large-scale study of parents who separated after the 2006 family law reforms, sought information at three points in time on a range of issues, including whether or not violence had been reported before or during the separation, the current status of the parental relationship, the parenting arrangements currently in place, and how parents rated the wellbeing of their children.

In light of data from the present study and from the LSSF, we reflect further on post-separation parenting arrangements in the face of present threats and violence. We conclude by suggesting the need for high-quality data...
capable of providing better understandings of the mindsets of respondents, especially those who indicate that parenting arrangements are appropriate even when threats and violence are a present reality.

Sample and method

The data used here are from participants in the Australian Survey of Social Attitudes (AuSSA), conducted in 2012–13. Questionnaires were sent by mail in four waves to random samples drawn from the Australian Electoral Roll. In total, 1,588 persons aged 18 years and over (687 men and 858 women) completed the questionnaire. This represents a response rate of 34%.

Respondents to the survey were asked to indicate their agreement or disagreement with each of the following statements:

Even if one parent is threatening or violent towards the other parent after separation, this parent:

- should be allowed to see the children;
- should be allowed to have the children stay overnight with him/her;
- should be allowed to have shared care (i.e., children spend similar time with each parent).

The response options were: “strongly agree”, “agree” “neither agree nor disagree”, “disagree”, “strongly disagree”, and “can’t choose”. In presenting the results, we refer to the second and fourth of these response options as reflecting “moderate agreement” and “moderate disagreement” respectively. Between 8% and 9% of respondents selected the “can’t choose” option for each of these three questions, taken separately, so these responses were excluded in the analyses.

Views on care arrangements in the face of current parental violence

Table 1 summarises the participants’ responses in relation to each of the statements on care arrangements even if there are parental threats or violence for the sample as a whole and for men and women separately. To assist with interpretation, the percentages who reported strong and moderate levels of agreement and disagreement are provided both combined and separately.

While a little over half (53%) of all respondents agreed that a parent who was threatening or violent towards the other parent after separation should be allowed to see their children, fewer than a third agreed that this should include having the children stay overnight (30%) or that shared care time should be allowed (29%).

Respondents most commonly agreed (strongly or otherwise) that parents who had been threatening or violent towards their children’s other parent should be allowed to see their children; they most commonly disagreed that under these circumstances parents should be allowed to have their children stay overnight or have a shared care-time arrangement.

Men were more likely than women to agree with each statement, with the gender difference being greater with respect to overnight stays and shared care time than with respect to seeing the children.

Table 1: Views about care arrangements, in the face of current parental threats or violence, by gender

<table>
<thead>
<tr>
<th>Even if one parent is threatening or violent towards the other parent after separation, this parent…</th>
<th>Men</th>
<th>Women</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should be allowed to see the children *</td>
<td>55.4</td>
<td>50.9</td>
<td>52.9</td>
</tr>
<tr>
<td>Total agree</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
<td>8.8</td>
<td>5.7</td>
<td>7.1</td>
</tr>
<tr>
<td>Moderately agree</td>
<td>46.6</td>
<td>45.2</td>
<td>45.8</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>16.8</td>
<td>15.1</td>
<td>15.9</td>
</tr>
<tr>
<td>Total disagree</td>
<td>27.8</td>
<td>34.2</td>
<td>31.3</td>
</tr>
<tr>
<td>Disagree</td>
<td>17.8</td>
<td>23.1</td>
<td>20.7</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>10.0</td>
<td>11.1</td>
<td>10.6</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Should be allowed to have the children stay overnight with him/her ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total agree</td>
<td>35.0</td>
<td>24.8</td>
<td>29.5</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>5.4</td>
<td>3.7</td>
<td>4.5</td>
</tr>
<tr>
<td>Moderately agree</td>
<td>29.6</td>
<td>21.1</td>
<td>25.0</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>21.8</td>
<td>15.4</td>
<td>18.3</td>
</tr>
<tr>
<td>Total disagree</td>
<td>43.2</td>
<td>59.8</td>
<td>52.3</td>
</tr>
<tr>
<td>Disagree</td>
<td>28.1</td>
<td>36.5</td>
<td>32.7</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>15.1</td>
<td>23.3</td>
<td>19.6</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Should be allowed to have shared care (i.e., children spend similar time with each parent) ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total agree</td>
<td>35.0</td>
<td>24.7</td>
<td>29.4</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>5.7</td>
<td>3.3</td>
<td>4.4</td>
</tr>
<tr>
<td>Moderately agree</td>
<td>29.3</td>
<td>21.4</td>
<td>25.0</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>25.4</td>
<td>15.3</td>
<td>20.0</td>
</tr>
<tr>
<td>Total disagree</td>
<td>39.6</td>
<td>60.1</td>
<td>50.6</td>
</tr>
<tr>
<td>Disagree</td>
<td>26.6</td>
<td>36.3</td>
<td>31.8</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>13.0</td>
<td>23.8</td>
<td>18.8</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note: The association between responses and gender was tested using chi-square tests: * p < .05; *** p < .001.
Men were also more likely than women to find themselves unable or unwilling to proffer a view (neither agree nor disagree) for each statement. This tendency was most pronounced with respect to the third statement—that even if threatening or violent towards the former partner, the parent should be allowed to have shared care. Specifically, the proportion of men who felt unable to either agree or disagree increased from 17% with respect to seeing the child, to 22% for overnight stays, and to 25% for having shared care time. By contrast, 15% of women selected this response option with respect to each issue.

Strength of views

For each of the three issues, men and women who expressed an opinion tended to select the moderate response option (“agree” or “disagree”) rather than the extreme option (“strongly agree” or “strongly disagree”). However, for all except one comparison, extreme views were more likely to be expressed by those who disagreed rather than by those who agreed with a proposition. That is, strong disagreement was more common than strong agreement. This was particularly the case for women in relation to their views on the allowance of overnight stays or shared care time. Nearly one in four women expressed strong disagreement with this proposition.

Views by gender

Just over half the men (55%) and women (51%) agreed (strongly or otherwise) that even parents who are threatening or violent towards the other parent should be allowed to see the children, while 28% of men and 34% of women disagreed.

Although both men and women most commonly disagreed that these parents should be allowed to have overnight stays or shared care time, women were considerably more likely than men to express disagreement (60% of women compared to 40–43% of men). In turn, 35% of men and 25% of women agreed with each of these two statements (taken separately).

Concordance of views

Of all six comparisons (covering the views of men and women on each of the three statements), the most concordant of views were expressed by women in relation to parents being allowed to have their children stay overnight or to have shared care time, even if threatening or violent towards the other parent (where 60% disagreed with these statements taken separately), while the most divided responses were provided by men in relation to these same two issues (where 35% of men agreed with these statements and 40–43% disagreed).

Agreement with statements on care arrangements, by age and gender

Figure 1 shows the proportions of men and women in four age groups who indicated that they agreed (strongly or otherwise) with each statement. With the exception of women’s views regarding shared care time, agreement with each statement was significantly related to age.

Men and women in all age groups were considerably more likely to agree with parents being allowed to see their children, even if threatening or violent towards the other parent, than with such parents being allowed to have their children stay overnight or to have shared care time. In most cases, the proportions in each age group (taken separately) who agreed about overnight stays and shared care time were quite similar (differing by only 1–4 percentage points).

In addition, women were, for the most part, less likely than men in the same age group to agree with the various issues. The largest gender difference (20 percentage points: 56% of men,
compared with 36% of women) emerged for those under 35 years old regarding threatening or violent parents being allowed to see their children.

For most comparisons, agreement tended to increase with increasing age (i.e., the relationship between agreement and age was typically positive and linear), though the overall relationship was not significant for women.

**Evidence from the Longitudinal Study of Separated Families**

The Longitudinal Study of Separated Families (LSSF) provides an important contextual backdrop against which to consider the difficult question of what, if any, post-separation parenting options are deemed appropriate when family violence is or has been present. The LSSF is a national study of parents with a child under 18 years old at Wave 1 who separated after the 2006 family law reforms and who registered with the Child Support Program in 2007. A total of 10,000 parents were interviewed in Wave 1, some 15 months after their separation. A summary of the sampling and methodology with respect to three waves of this study can be found in Qu, Weston, Moloney, Kaspiew, and Dunstan (2014).

A key finding at Wave 1 was that fewer than half the parents (47% of fathers and 35% of mothers) reported that they had experienced neither emotional abuse nor physical hurt in comparison with 36% of women) emerged for those under 35 years old regarding threatening or violent parents being allowed to see their children.

Percentage points). By comparison, differences in agreement rates of men and women who had not experienced either form of relationship dissolution were modest.

Women’s views on each proposition (taken separately) varied little according to their relationship history experiences.

**Agreement with statements on care arrangements, by relationship history and gender**

Figure 2 shows the proportions of men and women who agreed with each of the three statements, according to whether they had: (a) never experienced divorce or separation from a cohabiting relationship; (b) had experienced a separation from a cohabiting relationship but had never experienced a divorce; and (c) had experienced a divorce. For simplicity, these groups are called “relationship history” groups, with the parents who had experienced a divorce being sometimes referred to as “ever-divorced” parents.

Once again, higher proportions of men and women agreed with threatening or violent parents being allowed to see their children than with the children staying overnight or having a shared care-time arrangement, with the proportions agreeing with the latter two statements being fairly similar.

The difference in the levels of agreement regarding seeing children as opposed to having overnight stays or shared care time was markedly smaller for ever-divorced men than for all other groups, both male and female.

Although men who had experienced divorce were more likely than the other men to agree with each proposition, they were not significantly more likely than other groups to agree that a threatening or violent parent should be allowed to see their children. On the other hand, ever-divorced men were significantly more likely than the other groups of men to agree with the propositions concerning overnight stays and shared care time. In fact, around half of the ever-divorced men agreed with each of these propositions.

Men in each of the three relationship history groups were more likely than women in the same group to agree with the proposition in question. This was especially the case for ever-divorced respondents concerning children’s overnight stays and shared care time (the differences in rates amounted to 23–26 percentage points). By comparison, differences in agreement rates of men and women who had not experienced either form of relationship dissolution were modest.

**Figure 2: Proportions of men and women who agreed with each statement about care arrangements, by relationship history**

Note: Sample sizes for the three items: men: never divorced/separated: n = 393–400, separated/never divorced: n = 56–59, divorced: n = 126–127; women: never divorced/separated: n = 446–472, separated/never divorced: n = 80–84, divorced: n = 157–169. Chi-square tests of the association between responses and relationship history were applied to each item for men and women separately; men p < .001 for overnight stays and shared care. Other responses were not significantly related to relationship history.
A reported absence of violence between parents is strongly correlated with post-separation relationships that are described as friendly or cooperative.

Parents were asked to indicate whether their current relationship with their child’s other parent was “friendly”, “cooperative”, “distant”, “fearful” or entailed “lots of conflict”. Most fathers and mothers in Wave 1 described their relationship in favourable terms; that is, as either friendly or cooperative. This was especially the case for those who had experienced neither emotional abuse nor physical hurt before or during separation, and applied to a minority who had been physically hurt. Specifically, favourable relationships were reported by: around 85% of fathers and mothers who had not experienced either emotional abuse or physical hurt; 55% of mothers and 50% of fathers who had experienced an emotionally abusive relationship that did not involve physical hurt; and 39% of mothers and 36% of fathers who had been hurt physically.

Clearly negative relationships (i.e., highly conflicted or fearful), on the other hand, were most likely to have been experienced by those who had been hurt physically, and least likely by those whose relationship entailed neither form of violence. With the exception of mothers who had been hurt physically, parents were more likely to describe their relationship as highly conflicted than fearful. For example, where they had been physically hurt, the same proportions (around 20%) of mothers described their relationship as highly conflicted and as fearful, whereas 29% of fathers described their relationship as highly conflicted, but only 11% considered it to be fearful.

Distant relationships were reported by 22–23% of mothers and 25–27% of fathers who said that they had experienced either physical hurt or emotional abuse without physical hurt (before or during separation), and by 12% of fathers and mothers who had not experienced either form of violence during that period.

These data suggest that a reported absence of violence between parents is strongly correlated with post-separation relationships that are described as friendly or cooperative. At the same time, reported emotional abuse is clearly not incompatible with the development of relationships described as friendly or cooperative. In addition, compared to reports of emotional abuse before and during the separation, reports of physical hurt before separation are somewhat more likely to lead to post-separation relationships being described as highly conflicted and considerably more likely to lead to relationships described as fearful.

Parents who had experienced family violence were also more prone than other parents to report that mental health problems and/or addiction issues were apparent in their relationship prior to separation (see Figure 2.2, p. 31, in Kaspiew et al., 2009). Further analyses of the data suggested that the greater the number of problems experienced before separation (alcohol or drug misuse, mental health issues, emotional abuse, physical hurt), the more likely parents were to indicate a range of other difficulties up to five years after separation. Issues reported by parents included highly conflicted or fearful inter-parental relationships, safety concerns for parents themselves and/or their child associated with ongoing contact with the other parent, and diminished personal and child wellbeing (Weston, Hayes, & Qu, 2014). There was evidence that although time could have ameliorative effects, a load of problems often made positive outcomes difficult to achieve.

Discussion

There is evidence that the quality of the parental relationship is a core variable with respect to
how well or how poorly children cope with family breakdown. Prior to the 2006 family law reforms, for example, Pryor and Rodgers (2001) reflected on earlier findings from a meta-analysis by Amato and Gilbreth (1999). Both studies reported a link between the post-separation quality of the parental relationship and child wellbeing. These findings were also echoed in LSSF data, which at Waves 1 and 3 found inter-parental relationships to be associated with parental estimates of the wellbeing of their children (see Qu et al., 2014, Figure 8.4).\(^1\)

Though more difficult to measure, there is also likely to be a link between post-separation quality of parental relationships and parental capacity and willingness to cooperate in organising and sustaining child-appropriate care-time arrangements. From the child’s perspective, the capacity of the parents to cooperate over care arrangements would appear to be considerably more important than the precise details of the arrangements themselves (Moloney, 2008; Smyth, 2005). This suggestion is consistent with all three waves of the LSSF data, which revealed weak links, at best, between care-time arrangements and parental assessments of their children’s wellbeing (Kaspiew et al., 2009; Qu & Weston, 2010; Qu et al., 2014).

The LSSF data suggest that, for some families at least, there appears to be room for recovery from the dynamics of violence within a post-separation environment. The circumstances in which this occurs—including the nature of the violence experienced; its correlates, such as mental health and addiction problems; and the type and quality of any pre-separation and post-separation services made use of—deserve more detailed exploration into the future.

In the meantime, a limitation of both AuSSA and the LSSF is that while individual constructions of violent acts are likely to influence individual responses to questions linked to child care arrangements, both studies focus not on individuals but on aggregate data. We know that a relatively large number of individuals responding to AuSSA chose to answer the three care arrangement questions definitively. But at this stage, we know little about the reasons for these responses.

We also know that following the 2006 family law reforms, there was evidence of a tendency to prioritise “meaningful relationships” between children and parents over the safety of the child or other family members (see Chisholm, 2009, 2011; Family Law Council, 2009; Kaspiew et al., 2009). This evidence prompted the drafting of the Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011. The aim of these amendments, which came into effect in June 2012, includes improving the family law system's ability to identify family violence and child safety concerns and, in cases in which these aims are in conflict, to support parenting arrangements that give priority to the protection of children, over their right to enjoy a meaningful relationship with each parent.

Considerable effort has gone into supporting the aims of the amendments. The generally raised profile of the extent and consequences of family violence throughout the family law system has been complemented by initiatives such as the development of the AVERT family violence package (Attorney-General’s Department, 2010) and the DOORS Detection of Overall Risk Screen Framework (McIntosh & Ralfs, 2012). The AVERT package is designed to be used across the family law system to improve understanding of family violence. DOORS has been designed as a screening tool for identifying and assessing risk from family violence, poor mental health, addiction (the LSSF data demonstrate that these three issues are strongly correlated) and other related concerns.

In addition, having noted that one of the solutions to responding effectively to the problem of family violence is to be found in better professional collaboration, a reference from the Attorney-General to the Family Law Council in October 2014 has asked for advice on: opportunities for enhancing collaboration and information sharing within the family law system, such as between the family courts and family relationship services … and between the family law system and other relevant support services such as child protection.\(^1\)

More broadly, the Attorney-General’s Department has commissioned AIFS to evaluate the effectiveness of the family violence amendments legislation. This evaluation, is being conducted at a time when awareness
of family violence as a “silent epidemic” has been further raised by initiatives such as the appointment of family violence prevention advocate, Rosie Batty, as Australian of the Year and by the Victorian Government’s appointment of its Royal Commission Into Family Violence.

The Victorian Royal Commission commenced on 23 February 2015. The background notes accompanying the terms of reference suggest that:

The response to family violence is necessarily complex and requires coordinated and concerted effort across government and the community, including by government departments, courts, police, correctional services, legal services, housing, child protection and family services, schools, health and community organisations.13

In family law settings, an important part of the complexity of the response noted by the Victorian Royal Commission lies in better understanding the conditions under which separated parents adopt a view that care of a child by a perpetrator of violence is acceptable or can be managed. The LSSF data suggest that for at least some parents, separation itself may act as a circuit breaker that permits the re-establishment of a positive relationship capable of supporting good quality care of the children. The data presented in AuSSA, however, tap specific responses to current threats and violence following parental separation. These data suggest that though women are less likely to agree with the proposition, a not inconceivable number of both men and women appear willing to endorse continued parenting—even overnight parenting—by a perpetrator in the face of present threats and violence towards the other parent.

Violence in any form is an unacceptable means of conducting relationships within the family. More importantly, there is now overwhelming evidence that family violence can leave children and other family members feeling helpless, terrified and traumatised. The survey data reported in this article suggest that some individuals do not see present threats and violence as an obstacle to a perceived need for children to continue have both parents in their lives.14

In light of recent initiatives designed to raise awareness of both the extent and devastating consequences of family violence, it is possible that if conducted today, such a survey might yield differing results.15 Notwithstanding this possibility, there remains a need for sensitively conducted high-quality research aimed at helping us understand the thinking that informs the sort of responses emerging from a study such as this—especially those responses that appear to accept the need for continued parenting arrangements by individuals who are currently threatening or violent towards their former partners.

Endnotes

1 See, for example, the National Survey on Community Attitudes to Violence Against Women 2009, by the Victorian Health Promotion Foundation (2010).

2 Results form the LSSF are broadly consistent with results from a more recent survey conducted by ABS using a comparable methodology but based on a different annual cohort of separated parents: the Survey of Recently Separated Parents 2012 (De Maio, Kaspiew, Smart, Dunstan, & Moore, 2015).

3 AuSSA was conducted by the Australian Consortium for Social & Political Research Inc. The questions on which the present article is based formed part of a module on family-related values and attitudes, developed by the Australian Institute of Family Studies, and included in the survey as purchased questions. The survey covered a range of other issues, such as views about gender roles, child care, and intergenerational support.

4 Gender was unknown for 43 respondents.

5 The general patterns of bivariate analysis concerning views on the amount of care-time were similar, regardless of whether the “can’t choose” response option was included or excluded.

6 In relation to the proposition regarding seeing the children, virtually the same proportion of men strongly agreed and strongly disagreed. For all other comparisons men and women were at least twice as likely to indicate strong disagreement than strong agreement, although neither of these alternatives were popular for men. Women were 6–7 times more likely to indicate strong disagreement than strong agreement regarding overnight stays and shared care time.

7 The small number of married people who had separated but were not divorced are here classified as “divorced”. Although it would have been useful to identify the extent to which views of divorced respondents varied according to whether they had children of the relationship, only 27 men and 44 women had separated/divorced after having children.

8 Significantly too, of those parents who had reported the experience of physical hurt, a clear majority (72% of mothers and 63% of fathers) said that their children had been witnesses to these behaviours.

9 Of those who had been emotionally abused but not physically hurt, 18–20% of mothers and fathers described their current relationship as highly conflicted but only 4% described it as fearful, while 5–4% of those who had not experienced either form of violence said that their relationship was highly conflicted and fewer than 1% considered it to be fearful. These results are taken from Table 2.8 (p. 32) in Kaspiev et al. (2009).

10 Parents were asked to indicate whether mental health problems and drug and alcohol misuse existed in the relationship before separation. Although it was not possible to assess the validity of such assessments, our focus was on parents’ perceptions, given the
strong influence of perceived circumstances on levels of distress and sense of wellbeing.

11 The question was not asked at Wave 2.


14 Note that sampling limitations mean the proportions in the general population are unknown.

15 Though sampling issues would mean that direct comparisons would need to be treated with great caution.

References


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**Professor Lawrie Moloney** is a Senior Research Fellow, **Ruth Weston** is Assistant Director (Research), and **Dr Lixia Qu** is a Senior Research Fellow, all at the Australian Institute of Family Studies.
New measures to combat forced marriages

As part of the Federal Government’s efforts to address serious forms of exploitation, the Crimes Legislation Amendment (Powers, Offences and Other Measures) Bill 2015 was introduced to Parliament on 19 March 2015. If passed, this legislative measure will expand the current definition of forced marriage contained in the Commonwealth Criminal Code Act 1995 (Cth) to extend to marriages where a victim does not “freely or fully consent” because they are “incapable of understanding the nature and effect of a marriage ceremony”, and it will increase the penalties applicable for forced marriage offences (Crimes Legislation Amendment (Powers, Offences and Other Measures) Bill 2015, Explanatory Memorandum, p. 1).

The amendments are intended to make it unequivocal that the forced marriage offences apply in circumstances where a person, for reason of their age or mental capacity, is unable to give their free and full consent to marry, with section 270.71 of the Criminal Code Act 1995 (Cth) to be expanded to indicate that “a person under 16 years of age is presumed, unless the contrary is proved, to be incapable of understanding the nature and effect of a marriage ceremony” (Schedule 4, s 3 Crimes Legislation Amendment (Powers, Offences and Other Measures) Bill 2015).

In relation to the increases in penalties, the passage of the bill will result in the maximum penalty for the base offence of forced marriage to be increased from 4 years to 7 years imprisonment and the penalty for aggravated offences (e.g., where the victim is under 18 years of age or where the perpetrator engages in cruel or degrading treatment of the victim or reckless conduct) to increase from 7 years to 9 years imprisonment (Schedule 4, ss 4–7 Crimes Legislation Amendment (Powers, Offences and Other Measures) Bill 2015). These penalty increases are aimed at “ensur(ing) the forced marriage offences align with the most serious slavery-related facilitation offence of deceptive recruiting for labour or services” and to reflect the “seriousness of forced marriage as a slavery-like practice, a form of gender-based violence and an abuse of fundamental human rights” (Crimes Legislation Amendment (Powers, Offences and Other Measures) Bill 2015, Explanatory Memorandum, p. 5). On 26 March 2015, the bill was referred to the Senate Legal and Constitutional Affairs Legislation Committee, which is due to report on 15 June 2015.

In addition to these legislative measures, the Attorney-General’s Department (2015) has released a forced marriage community pack that was developed together with the National Roundtable on Human Trafficking and Slavery’s Communication and Awareness Working Group. The community pack provides access to relevant information and resources, including the Forced Marriage: Safety Plan. The safety plan provides guidelines to assist in the identification of free and full consent to a marriage and advice about how to communicate safely, and encourages the use of the safety plan to enable those at risk of a forced marriage or living in a forced marriage to protect themselves and to access help in a safe way. The Forced Marriage: Safety Plan template is available at: <www.ag.gov.au/CrimeAndCorruption/HumanTrafficking/Documents/ForcedMarriageSafetyPlan.pdf>.

Proposed revisions to s 121 of the Family Law Act 1975

Improvements to information-sharing between the child protection and family law systems will be facilitated if the Civil Law and Justice Legislation Amendment Bill 2014 is passed, according to the Attorney-General George Brandis, who introduced the bill to the Senate on 29 October 2014 (Civil Law and Justice Legislation Amendment Bill 2014, Explanatory Memorandum, p. 2). The proposed legislation seeks to include an additional exception to s 121 of the Family Law Act 1975 (Cth) (FLA), which is the section that prohibits the publication or dissemination to the public (or to a section of the public) of any account of any proceedings (or any part of any proceedings) under the FLA. The proposed exception would permit the provision of certain information (defined as ‘any pleading, transcript of evidence or other document’ by the proposed s 121(9) (aa)) to prescribed child welfare authorities by clarifying that the provision of such information is not “publication or dissemination” for the purposes of s 121 of the FLA. This proposed exception reflects the recommendation of former Family Court of Australia Judge, The Hon. Professor Richard Chisholm AM that the Commonwealth consider clarifying the wording of s 121 “to remove doubt” as to whether s 121 prohibited the provision of information to prescribed child welfare authorities (Chisholm, 2014, pp. 19–20). The Civil Law and Justice Legislation Amendment Bill 2014 is currently before the House of Representatives.

National standards of practice for family assessments and reporting

New Australian standards of practice for conducting and reporting family assessments in family law matters
were released in February 2015. The standards were developed by the Family Court of Australia (FCoA), the Federal Circuit Court of Australia (FCCoA) and the Family Court of Western Australia (FCoWA), with a view to outlining “a minimum standard of practice” and to “provide information to the decision-makers, agencies and legal professionals ... as to what constitutes good practice in family assessments and preparing reports” (FCoA, FCCoA, & FCoWA, 2015, p. 1). The standards outline principles to be applied by family assessors. They cover practical considerations such as the arrangement of assessments (Standards 1–7), communications with parties and representatives (Standards 8–9), conducting and formulating assessments and reporting (Standards 10–33), undertaking home visits (Standard 37), making notifications (Standard 38) and recording and storing information (Standard 39–41), together with considerations relating to cultural issues (Standards 34–36) and to children in family assessments (Standards 16–22).

In relation to the preliminary issues and the arrangement of the family assessment, Standard 1 indicates that prior to the assessment, the role of the assessor and “the purpose and scope of the assessment must be clarified for the family assessor, the parties, the children and the legal representatives” (p. 3). This standard indicates that where the family assessment is ordered by the court, the court order, together with the court’s policies and directions, can indicate the scope and purpose of the assessment, and that parties should be informed of who is to participate and receive guidance as to documents to be provided to the assessor in their case. Standard 3 outlines the relationships that may create or give rise to a perception of a conflict of interest, while Standard 2 specifies the qualifications required of family assessors. Guidance as to information-sharing is provided in Standard 5, which indicates that the consent of the parties is required to obtain information from third parties in the absence of the permission of the court, the independent children’s lawyer (ICL), the legal representatives or that arising from an interagency protocol. Standard 6 outlines the steps that the family assessor should take to ensure that the family assessment process does not give rise to exposure to family violence. This guidance includes an obligation on family assessors to enquire about current or past family violence orders and any safety concerns prior to making arrangements for the assessment, and to facilitate arrangements (including the making of safety plans) to enable a party’s safe attendance and participation in the family assessment process. Standards 8 and 9 provide direction in relation to communication between family assessors and other persons, with the communication between family assessors and ICLs required to be consistent with court orders, the Family Law Rules and the Guidelines for ICLs issued by the FCoA, the FCCoA and the FCoWA.

Standards 10 through to 15 provide extensive guidance for the conduct of “accurate, objective, fair and independent” information gathering for family assessments. Standard 11 stipulates that family assessors use multiple methods that are evidence based and professionally accepted for the collection of information that is accurate and objective, and Standard 13 precludes the provision of advice or therapeutic interventions by the family assessor to those involved in the family assessment. Guidance is provided with respect to the conduct of interviews and observations, with family assessors required to ensure that their arrangements for interviews do not “place any person at risk of family violence intimidation or harassment” and that they enable parties to respond to allegations that are relevant to the formulation of the family assessment (Standards 14 and 15).

The standards specify functions of family assessors relevant to facilitating the participation of children in family law proceedings that affect them and these include meeting with children and informing them of the purpose of interview and the processes to be followed in the assessment, together with the use that will be made of the information that the child provides to the family assessor (including that what the child tells the assessor is not confidential) (Standard 16 and Standard 17). Importantly, Standard 17 provides that “children must be informed that they do not have to provide information, answer questions or express views” about the parenting arrangements if they do not wish to do so. The standards provide that family assessors should be “trained and skilled in forensic interview strategies with children” and that they should ascertain children’s views, “assess their maturity, understanding and ability to form and express their own views” and they should also assess their relationships with their parents and other relevant adults (Standard 19, 20 and 21).

Extensive guidance is provided in the standards with respect to the formulation of assessments, opinions and reporting practices. Of particular significance, Standard 27 requires family assessors to conduct an “expert family violence assessment as part of their report”, making specific reference to the FCoA and FCCoA Family Violence Best Practice Principles (3rd ed.) (2012) and to FCoWA’s Family Violence Policy in this context. Standard 27b also states that where family violence or abuse is established, the assessor should report on:
“the impact of the family violence or abuse” on the child and parent/other adult;

- any protective action taken by a parent/other adult;

- whether the person acknowledges the family violence or abuse, “accepts some or all responsibility” for it and acknowledges that the behaviour was inappropriate;

- whether the person is taking steps (e.g., engaging in a program) to address the issues leading to the behaviour;

- whether the child or parent/other adult requires counselling or treatment;

- whether the person “expressed regret” and demonstrated “some understanding of the impact of their behaviour on the other parent”; and

- whether the person can “reliably sustain” a parenting arrangement with the child and how such an arrangement can proceed in a way that the child feels safe.

The standards also provide guidance for family assessors about making recommendations and the presentation of their assessments both in oral evidence and in their written reports (Standards 28–33). Standard 38 also provides for family assessors to make notifications to the relevant child protection authority where they have “reasonable grounds for suspecting that a child has been, or is at risk of being, ill-treated, abused, seriously neglected or exposed to psychologically harmful behaviour”. The Australian Standards of Practice for Family Assessments and Reporting are now available at <tinyurl.com/kdj6aph>.

Royal Commission into Family Violence established in Victoria

A Royal Commission into Family Violence is currently underway in Victoria. On 23 February 2015, the Premier of Victoria, the Hon. Daniel Andrews, together with Victoria’s inaugural Minister for the Prevention of Family Violence Fiona Richardson, announced the formal establishment of the Victorian Royal Commission into Family Violence (Andrews & Richardson, 2015). The establishment of the Royal Commission reflects an election commitment made by Premier Andrews during the then-opposition leader’s 2014 election campaign, with confirmation that this Commission would take place initially made by Premier Andrews and Minister Richardson on 23 December 2014 (Andrews & Richardson, 2014). Former judge of the Supreme Court of Victoria the Hon. Justice Marcia Neave AO was announced as commissioner and chair of the Royal Commission, which is tasked with “inquiring into and reporting on how Victoria’s response to family violence can be improved by providing practical recommendations to stop family violence” (Victorian Government, 2015, p. 2).

More specifically, the terms of reference provide for the Royal Commission to “establish best practice” for the prevention, early intervention and support for victims of family violence together with “measures to address the impacts of family violence” and the accountability of perpetrators (Victorian Government, 2015, p. 2). The terms of reference also require the commission to investigate the means by which there can be “systemic responses to family violence” (in particular on the part of the legal system, police, corrections, child protection and support services) and how government and community organisations “can better integrate and coordinate their efforts” in this context (Victorian Government, 2015, p. 3). Recommendations are also sought on the best way to “evaluate and measure the success of strategies, frameworks, policies, programs and services put in place to stop family violence” (Victorian Government, 2015, p. 3). Submissions close on Friday 29 May 2015 with the commission’s report and recommendations due to the government by 29 February 2016.

The establishment of this Victorian Royal Commission followed the appointment of a Special Taskforce on Domestic and Family Violence in Queensland on 10 September 2014. This taskforce made 140 recommendations that were intended to “inform a Queensland Domestic and Family Violence Prevention Strategy” (Special Taskforce, 2015, p. 18). The taskforce recommended the development of this Prevention Strategy through community consultation, with the strategy intended to provide “the foundations … for a Queensland that is free from violence and abuse” and which will include a “robust implementation plan”, an “advocacy and audit oversight body” and “comprehensive evaluation framework” (Recommendations 1–5). In support of this prevention strategy, the taskforce recommended:

- the immediate development of a resourcing model for the Domestic and Family Violence Death Review Unit in the Coroner’s office to facilitate policy-makers “to better understand and prevent domestic and family violence” (Recommendation 6); and

- the immediate establishment of an independent Domestic and Family Violence Review Board to “identify common systemic failures, gaps or issues and make recommendations to improve systems, practices and procedures” and to report these
findings and their recommendations to the oversight body (Recommendation 8).

The extensive recommendations also focus on the importance of supporting prevention programs and developing a “consistent and comprehensive communication strategy” (Recommendation 15–18), including the implementation of educational and awareness programs in primary and secondary schools, universities and workplaces, together with training and support measures to encourage workplaces that are supportive to victims of domestic and family violence (Recommendation 15–49 and 64–66). The taskforce recommended training and resources for the medical sector, including the refinement of the “White Book”—Abuse and Violence: Working with our patients in general practice—so that it would be “more prescriptive and provide more definitive advice and decision-making pathways for general practitioners”, together with the facilitation of greater access to domestic and family violence support and referral services in the maternity and emergency medicine context (see Recommendations 50–63).

The taskforce also made recommendations to support an integrated service response that included “an audit of services to ensure adequate resources are available to meet the demand for specialist domestic and family violence services” with a view to establishing a funding and investment model for the long term that will facilitate “collaboration and coordination” and “innovation in service delivery” beginning with:

- the immediate initiation of pilots for an “integrated response model”;
- a common risk assessment framework in line with best practice; and
- legislative and non-legislative steps to promote the sharing of information between agencies (Recommendations 71–79 and 83).

Initiatives to support therapeutic intervention for perpetrators and greater access to services for victims were also recommended (Recommendations 80–89). Recommendations 90–140 relate to proposed amendments to the legal and justice systems including the continued pursuit of the National Domestic Violence Order Scheme (Recommendations 90 and 112), a review of the Victims of Crime Assistance Act with respect to the compensation of victims of domestic and family violence (Recommendation 95) and the establishment of specialist domestic and family violence courts (Recommendation 96). The taskforce also recommend that the government consider making provision for “related family law children’s matters (by consent) and child protection proceedings to be dealt with by the same court” (Recommendation 98). The provision of training, professional development and/or guidance resources for the judiciary, registry staff, lawyers and police personnel was also recommended, together with the revision of court procedures, the establishment of state-wide duty lawyer services and the development of strategies to increase criminal prosecutions of perpetrators of domestic and family violence (Recommendations 101–114, 124–140).

More specifically, the taskforce recommended the introduction of legislative amendments, including the introduction of strangulation as a specific offence, and that the government “consider the sufficiency of penalties for repeat contraventions of Domestic Violence Orders” and conduct a review of the Domestic and Family Violence Protection Act by 31 December 2015 (Recommendations 115–122 and 140). The taskforce’s full report is available at <www.qld.gov.au/community/getting-support-health-social-issues/dv-read-report-recommendation/index.html>.

Family law court filings decrease by 14% between 2004–05 and 2012–13

An AIFS research report, released in February 2015, provides a nine-year perspective on family law court caseloads, and shows an overall decline of 14% in first instance matters.


This research report is based on data provided by the Family Court of Australia (FCoA), the Federal Magistrates Court of Australia (now Federal Circuit Court of Australia) (FCCoA) and the Family Court of Western Australia (FCoWA). In the report, AIFS has analysed the patterns in filings across the three family law courts in Australia. This research builds on findings from a component of AIFS’ evaluation of the 2006 family law reforms (Kaspiew et al., 2009), which examined administrative data on court filings in the three courts between 2004–05 and 2008–09. This report extends the period of examination to the end of the 2012–13 financial year and includes an examination of filings in property matters for this time.
The administrative data was extracted from each court’s CaseTrack system, covering the number of applications for final orders (categorised as being either children-only, children plus property or property-only cases). The report also examined the number of consent order applications (reg. 10.15 occurring in either the FCoA or FCoWA), the orders for Independent Children’s Lawyers (ICLs), and cases involving self-represented litigants (i.e., where one or both parties had no legal representative in the month following the lodgement of the application). It did not include information on appeals or enforcement and contravention applications.

The AIFS report shows an overall decrease in caseload as reflected in applications for final orders across the three courts of 14% in the period examined: an overall decrease in filings in children's matters was offset by an increase in property-related applications. There was also a marked shift in filings during this period from the FCoA to the FCCoA (a 77% decrease in filings in the FCoA and a 52% increase in filings in the FCCoA). By 2012–13, the distribution of filings between the two federal courts stood at 86% in the FCCoA and 14% in the FCoA. This finding supports an observation from Chief Justice The Hon. Diana Bryant that the shift in caseload from the FCoA to the FCCoA, "has resulted in the Family Court of Australia becoming a smaller court, which manages all appeals and deals with the most complex family law matters" (Family Court of Australia, 2015, p. 3).

The report identifies that the proportion of child-related filings (matters involving either children-only or children plus property) decreased overall by 25% across all courts between 2004–05 and 2012–13. With much of this decline occurring in the period immediately following the 2006 family law reforms (from 18,880 child-related cases in 2006–07 to 13,927 in 2007–08), the authors attribute much of this shift to "the introduction of stronger legislative support and greater resourcing in the community sector for family dispute resolution" (Kaspiew et al., 2015, p. 24).

In relation to property matters, the report also highlights the effect of both the Family Law Amendment (De Facto Financial Matters and Other Measures) Act 2008 (Cth)—which removed the legal distinctions between formally married and de facto couples with regard to property division post-separation—and the 2006 repeal of the monetary cap on the FCCoA’s jurisdiction in property-related matters. The findings revealed a 17% increase across all family law courts in the number of applications for final orders related to property-only matters between 2004–05 and 2012–13, with almost all of this increase occurring in the FCCoA and in the period between 2008–09 and 2010–11. While the FCoWA experienced a small increase (9%) in the number of property-only applications over the full period under examination, the federal courts show much greater variance, with a 135% increase in the number of property-only applications in the FCCoA, compared with a 60% decrease in these applications in the FCoA.

The findings in relation to consent order applications show that despite some fluctuation over the period under investigation, the numbers in the FCoA in 2012–13 were not dissimilar to the numbers recorded in 2004–05 (11,316 and 11,617, respectively). Similarly, the number of consent order applications in the FCoWA remained relatively steady (2,464 in 2006–07 and 2,398 in 2012–13).1

When examined by whether the cases related to children or property, the report indicates that the overall pattern of consent order applications in both courts were comparable. Between 2004–05 and 2012–13, the FCoA experienced a 24% decrease in the number of children-only consent orders and a 16% increase in property-only consent orders. Similarly, between 2006–07 and 2012–13, there was a 53% decrease in children-only consent order applications and a 12% increase in property-only cases in the FCoWA. Regarding children plus property consent orders, both courts experienced a notable decrease during the period under examination (37% in the FCoA and 31% in the FCCoA).

Though analysis of the number of orders for ICLs made in cases involving children’s matters showed overall increases across all three courts across the period under investigation, the report shows there was much fluctuation throughout this time. Between 2004–05 and 2008–09, the number of orders for ICLs more than doubled in the FCCoA (from 1,713 to a high of 3,856 in 2007–08), followed by a sharp decline to 2,701 in 2009–10 where it remained fairly constant to 2012–13. The FCoA, however, experienced a steady decline throughout the period under investigation, from 1,623 in 2004–05 to 339 in 2012–13. Conversely, the number of orders for ICLs in the FCoWA steadily increased to 398 in 2012–13, up 55% from 257 in 2008–09 (note: data for FCoWA were only available from 2009–10). Overall, the report showed in 2012–13, orders for an ICL to be appointed were made in around one in four child-related cases across the three family law courts.

The report shows that family law filings involving self-represented litigants declined for the most part between 2004–05 and 2012–13, though the patterns within each court were quite different. The number of self-represented litigants in the FCCoA remained relatively constant during the period under examination, with the largest change occurring between 2007–08 and 2008–09.
(down 9% from 6,405 to 5,807) and the total number in 2012–13 at 5,739. In the FCoA, however, there was a 76% decline in the number of self-represented litigants during the first half of the period under investigation (from 5,530 in 2004–05 to 1,307 in 2008–09) followed by a 28% decrease in the years that followed to 943 in 2012–13. Analysis of the data from the FCoWA showed a decrease in the number of self-represented litigants between 2004–05 and 2007–08 (from 947 to 550); however, the subsequent years of data showed a steady increase, bringing the number of self-represented litigants in 2012–13 to 1,034. Overall, the number of self-represented litigants in the federal family law courts as a proportion of all applications for final orders decreased from 46% in the FCoA and 53% in the FCCoA in 2004–05, to 34% in both courts in 2012–13. The FCoWA showed a slightly different pattern over the period of examination, from 36% of all final order applications in 2004–05 involving self-represented litigants, to around one in four between 2005–06 and 2008–09, before increasing again to 35% in 2012–13.

The report provides a descriptive analysis of the national data on family law court filings and emerging trends over the period from 2004–05—just prior to the introduction of the 2006 family law reforms—to 2012–13, the 12 months following the implementation of the Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011 (“the 2012 amendments”) on 7 June 2012. Further examination of the family law courts data and the effects of the broader social policy and legislative context is currently underway as part of the Evaluation of the 2012 Family Violence Amendments, funded by the Australian Attorney-General’s Department.2 The court filings administrative data analysis component of this forthcoming research will include analysis of other key court filings, likely to be affected by the 2012 amendments, such as the issuing of notices of risk, section 60I certificates (relating to family dispute resolution) and other orders related to family violence and child safety concerns, including data from the courts for the 2013–14 financial year. This current research report will provide a strong baseline with which to measure the effects of the 2012 amendments on the family law courts in Australia and those who use the family law system.


New Notice of Risk for family law matters in the Federal Circuit Court of Australia

A new Notice of Risk form has been introduced by the Federal Circuit Court of Australia (FCCoA) that applies on a national basis to all Applications and Responses seeking parenting orders filed in that court. This follows a pilot conducted in the Adelaide Registry of the FCCoA that required a new Notice of Risk form to be filed in all parenting proceedings in the Adelaide Registry from 4 February 2013. The aim of the pilot was to compare the operation of the Notice of Risk form to that of the Form 4 Notice to identify whether it was a better means of “facilitat(ing) the early identification of a range of risks in parenting matters … and to improve compliance with the legislative requirements” (FCCoA, 2014, p. 2; FCCoA, 2012). The Notice of Risk is intended to operate as a “broad based initial risk screening device to assist the court to identify at the earliest opportunity those matters in which allegations of risk are made so that the alleged risks can be addressed in a timely fashion” (FCCoA, 2014, p. 2). In addition to the requirement that the piloted Notice of Risk form be filed in all matters [so as to better address the risks covered by the Family Law Act 1975 (Cth) s 67Z (allegations of child abuse) and s 67ZBA (allegations of family violence) and to better ensure the court’s compliance with s 69ZQ(1)(aa) (the duty of the court to enquire about past or present abuse, neglect or family violence)], the other significant change was that the Notice of Risk in the pilot was a shorter form that included questions of a more specific nature, that were linked more directly to these legislative provisions.

The evaluation of this pilot concluded that “concerns about lack of compliance with legislative requirements for reporting of risk appear to be justified given the increased level of reporting and the absence of any evidence to suggest that the identified risk is unsupported by the facts” (FCCoA, 2014, p. 9). While the evaluation acknowledged the concerns of lawyers with respect to the imposition on their time when required to complete the form in cases where there were no allegations, it reported that “the majority of legal practitioners found the form easy to navigate and ticking the boxes marked ‘no’ should not be too time consuming” (p. 10). The compulsory Notice of Risk was identified as enhancing compliance and addressing the issue of under-reporting. The evaluation concluded that there were advantages to implementing this Notice of Risk form on a national basis (FCCoA, 2014). Following the evaluation, the Federal Circuit Court Rules were amended to provide for the new Notice of Risk form to replace the previous
Family law update

Access to Justice Arrangements

Productivity Commission Inquiry Report

The Productivity Commission has recommended a review of law and processes for post-separation property division in its report on access to justice arrangements and highlighted a need for better support in family law cases involving family violence. The Productivity Commission’s report, which was released on 3 December 2014, examines “the current costs of accessing justice services and securing legal representation, and the impact of these costs on access to, and quality of justice” (Productivity Commission, 2014 p. iv). The terms of reference issued by the government sought recommendations on “the best way to improve access to the justice system and equity of representation including, but not limited to, the funding of legal assistance services” (Productivity Commission, 2014, p. iv). The commission made five recommendations of specific relevance in the family law context. In relation to the Family Dispute Resolution (FDR), the commission called for improvement in service delivery and “alternative pathways” to accommodate family law matters where there is violence (Productivity Commission, 2014, p. 859). More specifically, the commission recommended that the government conduct a review of current FDR services provision by a range of FDR providers, and of the support that is provided to those families for whom FDR is not appropriate (Recommendation 24.1) and that the review be completed and published by 31 December 2015. The commission further recommended that the review consider:

- the cost of service provision;
- “long-term outcomes, including impacts for parents, children and the future need for formal services”;
- “timeliness of resolution”;
- best practices approaches for FDR (including legally assisted FDR);
- the AIFS Evaluation of the Coordinated Family Dispute Resolution (CFDR) Pilot; and
- appropriate funding for case managers to be appointed at FRCs to coordinate with other relevant bodies including the courts, the police and child

Family Law Council reference on supporting families interacting with the child protection and family law systems

The Federal Attorney-General, Senator George Brandis, issued terms of reference to the Family Law Council in October 2014 requesting advice on whether assistance may be provided by relationship support services and court processes that intersect the child protection and family law systems for families involved in parenting disputes experiencing complex needs including family violence and abuse, neglect, mental health issues and substance abuse.
Matters to be considered by the Family Law Council for this reference are specified on the council’s webpage as follows:

1. “The possibilities for transferring proceedings between the family law and state/territory courts exercising child protection jurisdiction” at present.

2. “The possible benefits of ... family courts exercising the powers of relevant state/territory courts and vice versa” and any changes necessary to enable the exercise of these powers by the courts.

3. “The opportunities for enhancing collaboration and information-sharing within the family law system” (emphasis added) (e.g., between family law courts and family relationship services).

4. “The opportunities for enhancing collaboration and information-sharing between the family law system and other relevant support services such as child protection, mental health, family violence, drug and alcohol, Aboriginal and Torres Strait Islander and migrant settlement services”.

5. “Any limitations in the data that is currently available to inform these terms of reference”.

The Family Law Council is due to report to the Attorney-General on this reference by December 2015.

Endnotes

1 Data for consent orders in the FCoWA were not available for 2004–05 or 2005–06.

2 For more information, see the description for the Evaluation of the 2012 Family Violence Amendments project <www.aifs.gov.au/eval>, which involves a more detailed examination of court filings.

References

Publications


Legislation and other legal instruments

Civil Law and Justice Legislation Amendment Bill 2014

Crimes Legislation Amendment (Powers, Offences and Other Measures) Bill 2015

Explanatory Memorandum, Civil Law and Justice Legislation Amendment Bill 2014

Explanatory Memorandum, Crimes Legislation Amendment (Powers, Offences and Other Measures) Bill 2015

Family Law Act 1975 (Cth)

Dr Rachel Carson is a Research Fellow and Jessie Dunstan is a Senior Research Officer, both at the Australian Institute of Family Studies.
Building evidence to support the reduction of violence against women and children

Heather Nancarrow

Seminar held at the Institute on 11 September 2014

Summary by Alister Lamont and Lan Wang

Heather Nancarrow is the CEO of the newly established Australia's National Research Organisation for Women's Safety (ANROWS). In this seminar, she discussed the key roles and responsibilities of ANROWS, with a particular focus centred on the role it will have in the 2nd Action Plan (called Moving Ahead) of the National Plan to Reduce Violence against Women and their Children 2010–22 (see <tinyurl.com/p4dd9xe> for more information).

The main purpose of ANROWS is to lead national efforts to enhance the evidence base in the areas of domestic violence and sexual assault across research, education and service delivery organisations, to support the National Plan. Developing an evidence base and having that implemented or translated into policy and practice is the main priority. In discussing this, Ms Nancarrow highlighted that the most important aspect of translating research into policy and practice is ensuring that the research is presented in an accessible way.

ANROWS also aims to influence the broader research agenda across related areas, such as homelessness and child protection, so that the intersections of those issues and family and sexual violence are informed by evidence from research.

As such, the organisation focuses on providing authoritative research to a broad audience and does not operate as a lobby or campaign group. While it will still have a strong media presence, its contributions will always be evidence-based.

Ms Nancarrow identified networking between different sectors as a key aspect of ANROWS work. To facilitate this, a networking database has been established, which is similar to a “matchmaking” database where people can find each other, including researchers, policy makers and practitioners who are interested in particular pieces of research and forming teams to apply for grants.

ANROWS also identifies gaps in our knowledge and skills base in specific areas, and supports the development of capacity to fill these gaps. Ms Nancarrow acknowledged that identifying and employing Aboriginal and Torres Strait Islander to join the staff has been challenging and they are exploring effective ways to do so.

Ms Nancarrow discussed ANROWS' first major task set out under the National Plan—developing a National Research Agenda. She highlighted that the agenda was formed around four strategic research themes: experience and impacts; gender inequality and primary prevention; service responses; and interventions and systems. The National Research Agenda was launched on 16 May 2014 and, as well as informing the development of the ANROWS research program, it also provides a framework for, and guidance on, priority areas of research and research themes for academics, researchers, organisations and governments across Australia.

One project that is underway is a collaboration with VicHealth and Our WATCh that is contributing to the development of a national framework for primary prevention. ANROWS is also undertaking work in developing a better understanding of and best practice in knowledge translation and exchange, and is working with the Centre for Domestic and Family Violence Research in Queensland to produce a paper on the state of best practice in judicial education. The organisation is also working collaboratively with the Closing the Gap Clearinghouse and the Australian Institute of Aboriginal And Torres Strait Islander Studies to learn what works in reducing violence in Indigenous communities.

Other areas of specific focus include supporting children who have been exposed to violence, improving the evidence base on perpetrator interventions, and promoting service integration.

In mid- to late 2014, ANROWS conducted its first round of grants applications, with assessment panels ranking the applications according to their merit and how closely they related to the research priorities identified in the National Research Agenda. Ms Nancarrow was very pleased with the diversity of projects and the engagement, collaboration and enthusiasm of the applicants. Future developments for the organisation include holding a conference in 2016 and contributing to annual roundtables convened by the Australian Government.

Selected audio recordings and transcripts of AIFS seminars are available at <aifs.gov.au/events>.
Walking the line: Research, advocacy and impact

Professor Kelley Johnson

Seminar held at the Institute on 9 October 2014

Report by Katharine Day and Lan Wang

Professor Johnson is the Director of the Social Policy Research Centre (SPRC) at the University of New South Wales. In this seminar, she examined how the work of applied researchers in the area of families and social policy can lead to positive change in the wellbeing of people. She noted that there are also pressures on researchers that make it difficult to advocate for or further develop the outcomes from the research. Professor Johnson explored the nature of some of these pressures and drew on case studies of research with people with disabilities, in both Australia and overseas, to identify some of the ways in which research can be used to support better outcomes and increased possibilities for social change.

Professor Johnson began by asking a series of questions: Why do we do research? What do we mean by advocacy and impact? What are the different ways in which they are defined? Is this important and if so, why and to whom? What are the dilemmas involved and how do we manage them?

She suggested that researchers make assumptions that everyone is working from a similar set of values. She discussed the dilemmas for researchers in terms of advocacy and the current research environment, with researchers mostly applying for tenders and having to work to deadlines and in particular ways. She noted the difficulty of completing large research projects and finding support for long-term research. Another dilemma is that often the research is inaccessible to many people, and in particular the people who are the focus of the research.

She also mentioned the issues around credibility and objectivity in research where there is an advocacy element or a goal. On this Professor Johnson argued that researchers must advocate on the basis of their research, whether or not they offend the funders, the government, or the research council or whoever has funded the research. Researchers must not be directed by their fear of losing their funding. She believes the bigger danger would be to start to write in ways that researchers know will be acceptable to the people with power so that research becomes “blanded out”. The importance of research is not just that it is published but that it is done in ways that make a public debate happen, which can then bring about change.

On this point, researchers are being put under increasing pressure to ensure their research has an effect. Professor Johnson explained that in the UK now the government has decided on a research excellence framework through which all universities have to go. Researchers have to prove that their research has had an effect in the community, and the government has decided on an impact measure of 25%. Measuring research takes it within a policy environment concerned with evidence in terms of measurement. She thinks this can encourage good quantitative research, but stresses the need for good qualitative research as well.

So how do researchers deal with these dilemmas? Professor Johnson used case studies from her own research to show how researchers can manage these dilemmas by taking a different approach. She talked about a particular series of projects she was involved with about sexuality and relationships among people with intellectual disabilities in Ireland. In Ireland there exists a law, the Criminal Law Sexual Offences Act 1992, which states that unless people with an intellectual disability or mental health issues are living totally independently in the community, they are only allowed to have sex with someone to whom they are married. This has made support providers reluctant to support relationships among those under their care, while many of those with intellectual disabilities remain unaware of the law. A group of people with intellectual disabilities were involved in a national study with a university and a service provider organisation that looked at these issues around sexuality and relationships. They shared their own stories about their experiences together and the resulting report talked about what they wanted and how they felt about this law. It was picked up by national radio and the result was that for the first time in Ireland people with intellectual disabilities were consulted by the Law Reform Commission about changing the law and, in June 2014, a Private Members’ Bill was put forward to change the law.

Professor Johnson used this example to show that when people’s voices are heard strongly through research, they have credibility and they can advocate more powerfully than through written research alone. She concluded by stressing to researchers the equal importance of developing networks with those who have power and with private organisations, as well as linking with individuals and small groups.
The Hon. Professor Nahum Mushin

Seminar held at the Institute on 12 November 2014

Report by Alister Lamont and Lan Wang

The Hon. Professor Nahum Mushin is an Adjunct Professor of Law at Monash University. In this seminar, he discussed the process leading up to the National Apology on Forced Adoption by the then Prime Minister Julia Gillard MP on 21 March 2013. Professor Mushin outlined the tasks of the Working Group he chaired in developing the apology and recommending measures to improve services to those affected by forced adoption, and what additional lessons can be learned from past adoption practices.

Professor Mushin gave a brief history of forced adoption practices—which he describes as “a dark past in Australia’s history”—and identified why such practices required a national apology. Overall, it is estimated that about a quarter of a million forced adoptions took place from about 1940, with the peak period occurring from the early 1950s to the early 1970s, during which approximately 150,000 such adoptions took place.

Young unmarried pregnant women were encouraged or forced to “give up” their babies for adoption, often without the support of their families or society in general.

The experience of the mothers “giving up” their babies was often harrowing, with many:

- not being informed of their right to revoke consent;
- given no independent advice or representation (most mothers were underage); and
- not being permitted to see their babies after birth (with some being drugged or tied to the bed, or having sheets obscuring baby).

The effects of such practices extend far and wide and have affected so many people, from mothers, children, adopted parents, fathers, other siblings and extended family.

The National Apology Reference Group was established by the then Attorney-General, the Hon. Nicola Roxon MP in June–July 2012. The primary purpose of the group was to draft the apology, which they delivered to the Attorney-General in December 2012. The group included Prof. Mushin, three Senators, and seven mothers, fathers and adoptees who had been affected by forced adoption (including one member of the House of Representatives). They travelled around Australia to conduct extensive, confidential consultations in every capital city except Darwin.

Professor Mushin highlighted that the key difficulties in drafting the apology were the structure, the language used, and dealing with key sensitivities. The Reference Group asked to whom we are apologising, and for what, as well as considering the issue of offering rather than giving an apology. Drawing on the work of the Law Commission of Canada, they recognised five steps to an apology:

- acknowledging the wrong;
- accepting responsibility;
- expressing sincere regret;
- assuring that the wrongs will not recur; and
- providing reparation through concrete measures.

The group was particularly focused on making sure the language used was right. For example, “mother”, “father” and “experiences” were preferred over such terms as “birth mother”, “biological mother”, “relinquishing mother”, “biological father” and “stories”. Prof. Mushin was also firm that the word “illegal” should be included in the apology (and it was), because if the law had been complied with in all its aspects with regard to consent, providing independent advice and the support of guardians to these underaged people, arguably the adoptions would not have been forced.

It was also decided not to include adoptive parents in the apology because of the difficulties arising from what is often great enmity between mothers and adopting parents. Prof. Mushin said that it is very important to resolve this issue to bring closure to the many people affected by this.

The Forced Adoptions Implementation Working Group has been dealing with the concrete measures proposed in the apology. The Australian Government allocated $11.5 million to a range of services for supporting those affected by forced adoptions. These include mental health services and the harmonisation of records such as birth certificates. The National Archives of Australia has also developed an extensive website resource as part of the Forced Adoptions History Project <forcedadoptions.naa.gov.au>. However, the funding for these measures was only for four years.

Prof. Mushin concluded with a summary of the some of the issues that are still to be debated at length, including the issues of inter-country adoption, the notion of the abolition of adoption altogether, and surrogacy.
Institute seminars

Harm reduction and gambling: Building the evidence for policy development

Anna Thomas
Seminar held at the Institute on 24 February 2015

Report by Marissa Dickins and Sophie Vasiliadis

In this seminar, Dr Anna Thomas, Manager and Senior Research Fellow at the Australian Gambling Research Centre <aifs.gov.au/agrc> examined harm reduction interventions in the gambling space.

Dr Thomas outlined Australia’s participation in gambling, highlighting the fact that not all gambling is equal. The forms of gambling most associated with harm include electronic gambling machines (EGMs or “pokies”) and race betting, with online sports betting becoming a growing area of concern. She pointed out that while the proportion of the population who gamble has reduced, the raw number of people who gamble has remained relatively stable, as has the proportion of income that is spent on gambling.

Dr Thomas explained that the emphasis on problem gamblers has been too narrow, as even a single episode of gambling could cause harm in the form of monetary issues, such as being unable to pay bills. The harms associated with problem gambling, including relationship, health, monetary and legal problems, are extensive and pervasive. Gambling harms also affect those around the gambler, and the secondary harms to family members, friends, and workplaces have received little attention in research, policy and treatment.

Dr Thomas then discussed the findings of two evaluations of regulatory interventions. The first evaluated the effects of the removal of automated teller machines (ATMs) from gaming venues, and the second examined the potential effects of a pre-commitment system.

Removal of ATMs from gaming venues

From 1 July 2012, the Victorian government introduced a prohibition on ATMs inside or around Victorian gaming venues. This regulation was supported by considerable evidence that those who experience problems are more likely to access ATMs at gambling venues to fund their gambling, and that both gambling counsellors and those experiencing gambling problems report that easy access to money in venues is an important contributor to gambling issues.

The evaluation found that with ATMs removed, gamblers felt more in control, and that more than 50% of moderate- and high-risk gamblers, and 30% of no- or low-risk gamblers, were supported in managing their gambling-related spend. Some individuals circumvented the intervention by planning ahead (e.g., bringing additional gambling money) or withdrawing money using EFTPOS. While using EFTPOS facilities involved staff interaction and the potential for staff intervention, some gamblers were not dissuaded. This intervention, however, resulted in an average aggregate downturn in revenue of up to 8%, and some reduction in EGM patronage.

The findings of this study show that greater control and reduced potential for harm was experienced by higher risk gamblers through two harm-reduction strategies—moderation of an environmental feature and enhancement of consumer capacity for informed choice.

Pre-commitment system

Pre-commitment requires gaming venue patrons to make decisions about their gambling spend before they begin, and helps them stick to their decisions. There is a significant level of evidence behind pre-commitment systems that shows that gamblers often struggle to keep to their limits and frequently underestimate how much money they have spent. While there are different ways to set up such a system, there are two broad approaches: a “full” system (where gamblers are required to register and use the system to gamble) or a “partial” system (where registration and use of the system is optional).

The review of the evidence into pre-commitment systems indicated that regardless of the approach, pre-commitment is useful for those who use it, including reductions in time and money spent gambling. It was found that the most important factors are simplicity and ease of use.

Pre-commitment was found to operate in two ways to reduce harm: through providing gamblers with an enhanced capacity for informed choice, and by being a way to moderate a risky feature of the gambling environment.

Dr Thomas finished by highlighting the fact that while gambling is an accepted activity within Australia, it is a potentially harmful one. Harm reduction requires continual improvement, and the role of government is to balance consumer and community protection and personal choice. In order to support the role of government, it is essential for policy-relevant research to be conducted to underpin policy development.
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