



Thriving in Adversity: A positive deviance study of safe communities for children

National Research Agenda for Protecting Children – Final Report

Never Stand Still

Arts & Social Sciences

Social Policy Research Centre



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1. Executive Summary

This is the final report of the *Thriving in Adversity* study conducted by researchers at the Social Policy Research Centre (SPRC), University of New South Wales (UNSW) as part of the National Research Agenda for Protecting Children 2011-2014. The study is a contribution to the research priority 'making a community safe and supportive for its children – understanding the conditions necessary to create a child safe and child friendly community (Promoting Safe Communities)'.

The conceptual framework for this project is positive deviance (PD), which builds on decades of research into the risk and protective factors for child maltreatment. The PD approach is strengths-based and practice-driven, and emerges from the recognition that in every disadvantaged community there are individuals and families who are doing unexpectedly well. These individuals and families have practices and strategies that are both positive and deviant in that they differ from those of most of their peers.

The project focuses on two levels of maltreatment risk factors: (a) individual characteristics which are highly associated with child maltreatment and so place parents

with those characteristics in 'risk communities'; and (b) community level characteristics of exclusion and deprivation, which are also highly associated with child maltreatment.

The methodology consists of four phases: a national Delphi study, data analysis to identify communities in which outcomes are unexpectedly positive, qualitative data from those geographical communities and from 'communities of affinity' in which a significant risk factor for maltreatment is present.

Delphi Study

We conducted a national survey of experts in the field of child welfare to investigate which social practices and norms help to produce positive outcomes for children in disadvantaged communities. The approach adopted for the survey was a modified Delphi study, conducted online.

The strongest findings from the Delphi study about the factors that promote safe families and communities were:

- social resources and knowledge for parents;
- experience and knowledge of children prior to becoming a parent;

- strong, healthy relationships between parents/caregivers;
- capacity to ask for assistance;
- high levels of community engagement and connectedness;
- positive and strong connections with other families; and
- social, recreational, and cultural resources, to allow parents to expand their social networks.

Identifying communities

To identify communities where outcomes are unexpectedly positive, we analysed data on child protection outcomes (where available) and child wellbeing outcomes. We used this data to identify communities where the recorded outcomes differed from predicted outcomes. The analysis explored bivariate correlations and multivariate models encompassing a range of risk factors.

Area-based regression analysis was undertaken as a method to identify local government areas (LGAs) with positively anomalous outcomes in the two most populous states of Australia, New South Wales (NSW) and Victoria. The variables selected for the multivariate models were identified on the basis of conceptual groupings of the variables and the strength of the statistical bivariate relationships.

From these models we devised a shortlist of communities, from which we then selected four LGAs as case studies for qualitative analysis: Maribyrnong and Moreland in Victoria, and Port Macquarie-Hastings and Holroyd in NSW. The purpose of the qualitative research in this study was to explore the characteristics of families and communities that make a difference in keeping children safe in the presence of risk factors.

Case studies: geographic communities

The second case study set focused on the four LGAs that were identified as having positively anomalous child protection (where available) and child wellbeing outcomes. We interviewed service providers from child care and family support services in the four LGAs identified, and asked them their views on what helps some families thrive and do well in circumstances that prove challenging for others.

As with the other components of the project, these interviews identified access to formal support services as important. This is only possible if services are available, if families know about them, and if the services are trusted. Formal support services can supplement families' financial, educational and social resources, which is especially critical in areas where resources are low.

The interviews also highlighted the family characteristics that are important. These included routines and rituals such as shared time together, strong parental relationships, and the capacity to adapt to new circumstances, such as having a child with disability or adjusting to different cultural norms after moving to Australia. A sense of hope, self-belief, ambition, and the capacity to seek help are also important.

Access to informal support, from extended family and friends, was judged as important because it can assist families in everyday matters and in crises, and also be helpful for recognising when circumstances are becoming overwhelming and bring in support from formal services. Social networks can also assist in promoting wellbeing and combatting isolation. Being part of a social network was regarded as critical for all families, but particularly critical for those who lacked extended family support, including recently arrived migrants and families who had moved interstate, as well as for parents with a child with disability.

Religious churches, temples and mosques were also seen as important community venues through which individuals could build social networks and strengthen their cultural identity. Faith-based networks, however, were identified as potentially divisive if individuals held conflicting perspectives. Sporting events were also identified as important for culturally and linguistically diverse (CALD) groups to make contact with individuals from other backgrounds.

Having access to both formal support and informal social activities in the local community was considered crucial to enable families to thrive and do well. Playgroups that connected families with children were identified as a key building block in strengthening communities because they were free, accessible, and did not discriminate on the basis of language or culture.

Community sporting events were also identified as important for building community cohesion.

Mentoring programs were identified as empowering and strengthening practices that could help families navigate service systems, adjust to parenting a child with disability, and give young people with a parent in prison a reliable and committed adult to provide support and advice.

Service providers also talked about the challenges facing families in their communities, and the strategies they used to try to overcome them. These challenges are associated with the consequences of living in circumstances of poverty and disadvantage, including the challenges of finding suitable employment and the resultant lack of income, housing insecurity and housing affordability, transport difficulties, drug and alcohol use, inadequate transport services, domestic violence, and poor mental health. The interviews highlighted the importance of ensuring services are accessible, trusted, and able to respond flexibly to the needs of families.

Case studies: parents who use drugs and parents with mental illness

The first case study set focused on 'at risk' communities, that is, families where the parents share characteristics associated with a high risk of child maltreatment. Consistent with the focus of the project on strengths and protective factors, we describe these families in terms of shared interests rather than risks and designate them as 'affinity communities'. The two affinity communities selected for study were parents with mental illness and parents who use drugs. While most of the parents we interviewed talked about supportive people or services that helped them, our focus was on what families do, not on what services deliver.

In interviews, parents were asked about their experiences of raising children and family life. We included questions about sources of information and support, typical family routines and parenting practices, as well as routines and practices around managing drug use and managing mental illness.

There were a number of connections between the findings of the Delphi study and those of this case study. Both highlight the importance of

support to parents from friends and extended family, and the availability and accessibility of formal services. They both identify knowledge about the demands and realities of parenting as being an important factor in keeping children safe.

Some of the strongest themes to emerge from interviews with parents were around deliberate, planned, and selective communications with children, schools and services about managing drug use and mental illness. Parents also talked about the importance of being able to choose whether or not to disclose details of their circumstances to other people, and ensuring that children were not exposed to them in a state of intoxication or mental distress.

Although this project was not focused on specific services or support models, formal support services also emerged as very important.

All of the parents had significant personal resources on which to draw which assisted them in times of crisis. Most were educated to university level, had connections to paid employment, and had support from friends and family. The benefits of these included emotional support and information, assistance with child care and household chores, provision of treats for children (trips to the movies, time away from younger siblings), connections to culture, and friendship.

The interviews also identified a number of strong themes that were not highlighted in the Delphi study. We found that the capacity to use services strategically and to persist with seeking help seem to be connected to a sense of self-identity and acceptance, and parents' lack of shame about drugs and mental health problems.

A number of parents reported a strong commitment to shared parenting and active involvement from fathers. A slightly unorthodox attitude to parenting, and gender equality in the relationship, may be factors in gaining the support that is needed from services rather than settling for what services initially want to provide. These parental characteristics are also protective factors for children's wellbeing.

Conclusion

A number of common themes recurred across the Delphi study and qualitative research with

parents and service providers. In particular, the importance of formal and informal support emerged as a very strong theme. Support is important for parents in two ways: (a) supporting them as parents, by building their knowledge and resources in raising children; and (b) supporting them as people, by building social relationships and connections.

Considerable resources are required to be a competent and safe parent: material, social, and educational. Much of the research on the intensification of parenting (see p.8 below) focuses on 'mainstream' parents, but these elevated responsibilities are also felt by parents from stigmatised and vulnerable groups.

We can also identify the need for further work in this area. We found little evidence that communities have been encouraged to track

and monitor their successes in protecting children. Most people, including researchers, are accustomed to focusing on individual parents and families. Families are the most important influence on children's lives, but better information on the impact of communities on protecting families and children, and the strategies that families use that are protective, is needed.

There are also challenges in defining communities, and these in turn present challenges in managing and analysing data on communities. If services and communities were encouraged to measure outcomes at a community level, rather than only at an individual or service level, and to collect and manage data on these outcomes, this gap could be addressed.



2. Introduction

This is the final report of the *Thriving in Adversity* study conducted by researchers at the Social Policy Research Centre (SPRC), University of New South Wales (UNSW). The project was jointly funded by the Commonwealth and the States and Territories of Australia as part of the National Research Agenda for Protecting Children 2011-2014. This study contributes to the research priority 'making a community safe and supportive for its children – understanding the conditions necessary to create a child safe and child friendly community (Promoting Safe Communities)'.

This study is situated within a positive deviance framework. Positive deviance (PD) builds on decades of research into the risk and protective factors for child maltreatment. The PD approach is strengths-based and practice-driven, and driven from the recognition that in every disadvantaged community there are individuals and families who are doing unexpectedly well. These individuals and families have practices and strategies that are both positive and deviant in that they differ from most of their

peers. PD emerged in developing countries, when nutrition researchers began examining why some children in poor communities were not malnourished when most were. They found that the parents of the well-nourished children added foods to their children's meals that were readily accessible to everyone in the community, but widely regarded as unsuitable for young children (Zeitlin, 1991). Since that time, PD has been the basis of public health, education and healthcare initiatives in Africa, Asia and the United States. In recent years, it has been used to develop successful interventions in Australia, including a strategy to address rates of smoking in NSW prisons (Awofeso et al., 2008), and to understand hepatitis C infection in injecting drug users (Friedman et al., 2008).

However, most PD research on child protection has taken place primarily in development contexts, for example addressing girl trafficking in Indonesia and child soldiers in Uganda. The focus of this project, in contrast, is the Australian communities in which child protection and child wellbeing outcomes are unexpectedly positive.



3. Background

Child protection research and policy has evolved from a focus on individual pathology to a more comprehensive ecological account of risk and protective factors at child, parent, family, and community level (for examples see Centers for Disease Control & Prevention, 2014; Lamont & Price-Robertson, 2013).

At the community level, there are strong associations between economic disadvantage and child maltreatment (Belsky, 1980; Gilbert et al., 2012). Community-level influences are also disproportionately important for disadvantaged families. In Gabarino and Sherman's (1980) formulation, for example, rich people can better 'afford' a weak neighbourhood than poor people, because the latter must rely on available resources for support.

At the individual level, domestic and family violence, parental alcohol and other drug (AOD) misuse and parental mental health problems are strongly associated with child maltreatment and statutory child protection interventions. AOD use is estimated to be a factor in up to 50 per cent of child protection cases in Australia and internationally (De Bortoli et al., 2013), and serious case reviews in the UK identified that at least two of the three factors were present

in 68% of cases involving child maltreatment that resulted in life threatening injuries or death (Brandon et al., 2010).

Many protective factors are the absence or antithesis of risk factors, and vice versa. For example, while parental alcohol and other drug use is a risk, parents' 'healthy lifestyle' is protective. Similarly, the presence of a single parent is a risk, while a father's involvement in parenting is protective (cited in Commonwealth Task Force, 2003). Child protection interventions are designed to remove the presence of risk, or ameliorate against its likely impact.

However, there are challenges for practice and policy in implementing the findings from this research. First, although risk factors are well known, they have poor predictive capability and so are not useful to decisions about where to target policies and programs. That is, while child maltreatment is associated with parental alcohol and other drug misuse, and parental mental health problems, many parents with these characteristics are highly competent parents. Second, many risk factors are not easily changed, either by interventions or otherwise. Third, risk factor research is very top-down, and based on expert assessment and intervention.

Because it rarely makes effective use of local knowledge, it can translate into deficit models that blame individuals for structural-social disadvantage and fail to engage communities (France et al., 2010; France & Utting, 2005).

One aim of this project was to identify protective factors for families with significant risk factors for child maltreatment, especially drug use and mental health problems. Risk assessments based only on these parental characteristics are extremely difficult for inexperienced practitioners or community members because their presence is so strongly associated with severe child maltreatment, and very common in families where children are removed from parents (Brandon et al., 2010; Cleaver & Unell, 2011; De Bortoli et al., 2013; Velleman & Templeton, 2007). Moreover, these risk factors for maltreatment are a normal part of life for many people. Although illicit drug use is relatively unusual (and fewer than 40 per cent of people currently using alcohol drink on a weekly basis), more harm is caused by drug use to those with few resources (AIHW, 2011). Further, mental health problems are anything but rare phenomena in communities, with the Australian Bureau of Statistics (ABS) estimating that almost half of Australians have had a mental disorder at some point in their life (ABS, 2008).

The purpose of the qualitative research in this study was to explore the characteristics of families and communities that make a difference in keeping children safe in the presence of risk factors. This has important implications for practice and policy because, as the literature demonstrates and our research also found, the surveillance by child protection agencies of families who do not require statutory intervention is significant, costly, and distressing for parents (Bilson et al., 2013). There is substantial research literature on effective practices and principles for working with families with a risk of maltreatment and parents with complex problems, but this literature by its nature focuses on (a) those families who need support in their parenting, and (b) service delivery and formal support (Al et al., 2012; Dawe & Harnett, 2007).

In contrast, in this project, we have attempted to identify strategies, practices and habits that families use independently of parental support services. Most of the parents we interviewed

talked about supportive people or services that helped them, but our focus was on what families do, not on what services deliver. These findings are an important supplement to the broader literature on effective practices, because they illuminate the lives of families who are not necessarily in receipt of services, and so add to our understanding of different ways of parenting amongst vulnerable groups. They also add to our understanding of the attitudes and beliefs of these parents about formal support services, and the reasons why they would choose to seek help from them, or not.

The literature identifies the specific aspects of parenting that are typically impaired by AOD misuse and mental health, and which tend also to be refractory to change:

- lack of sensitivity and responsiveness to children's emotional and physical needs (Suchman et al., 2004; Velleman & Templeton, 2007);
- lack of understanding and knowledge about children's developmental and cognitive needs (Suchman et al., 2006);
- difficulty in acquiring and maintaining the skills needed to bring up a child, and in establishing routines such as mealtimes, bedtimes, and getting children to school (Cleaver & Unell, 2011); and
- difficulty in providing adequate supervision, boundaries and guidance. AOD intoxication that induces unconsciousness in parents places children at risk if supervision from other competent adults is not available (Cleaver & Unell, 2011; Scaife, 2008).

However, the social and material resources of families are important confounding influences and the literature suggests that these may be at least as significant as other risk factors. Many parents with problematic AOD use and/or mental health problems live in poverty, which can damage parental capacity and children's outcomes. For example, Suchman and Luther (2000) examined variations in parental involvement, autonomy, and limit-setting between a group of opiate-using mothers and a matched comparison group. They found that socioeconomic status and mothers' perceptions of their children's behaviour were more important to parenting problems than drug

use per se. Similarly, Suchman and colleagues (2004) cite research on attachment-based parenting interventions which shows that these interventions, if narrowly focused, are insufficient to address the problems in parenting caused by poverty, and that parenting interventions should be offered as part of a comprehensive program that addresses material needs such as food and housing. These findings indicate that socio-demographic risks and children's behaviour contribute at least as much to parenting problems as 'addiction'. This suggests that parental resources, including income, mediate the risks of mental health and AOD problems.

Our project also contributes to the understanding of 'good enough' parenting and family relationships (Winnicott, 1960). Mental health problems and substance misuse are highly stigmatised and associated with very poor outcomes for children. As a consequence, there are few public representations of safe and competent parenting by people from these communities. Parents who use drugs and parents with mental illness have few public role models or realistic standards to follow. Practitioners with child welfare responsibilities who come into contact with these parents (notably teachers, social care workers, and health care workers) often have very limited information on which to make judgements about the children's safety. Beyond standardised risk assessment tools, and knowledge of rare but high profile instances of child murder in which caregivers had mental health or substance misuse problems, these workers may have very little knowledge about the lives and relationships of these groups of parents. This research contributes to filling this gap in information by describing the regular, loving family lives of people who face significant challenges in parenting, including long-standing mental health problems and regular use of illicit drugs. Although their lives and relationships do not always conform to mainstream standards, they practice ways of keeping children safe and loved that are rarely documented.

The lives of these families are also affected by changing norms of family lives and parenting, particularly the intensification of parenting, or the increasing responsibilities assigned to

parents for their children's physical, emotional, psychological and cognitive outcomes and achievements. The practice of parenting has come under increasing scrutiny over the last two decades in the UK, North America, Australia and other comparable nations, with the field of parenting culture studies emerging to critically examine what this 'turn to parenting' (Daly, 2013) means for contemporary parents. No longer conceived of as simply a relationship, 'parenting' has come to be viewed as "an occupation requiring a 'tool kit' form of knowledge that can be taught to parents through 'expert' specialist advice and instruction" (Edwards & Gillies, 2005, p. 3). Parenting in the age of 'intensive parenting', the dominant ideology of socially appropriate child rearing (Hays, 1996), demands that parents devote themselves fully to the parenting enterprise. It holds that 'children are innocent and priceless, that their rearing should be carried out primarily by individual mothers and that it should be centred on children's needs, with methods that are informed by experts, labour-intensive and costly' (p. 21). It is argued that intensive parenting demands 'middle-class circumstances and resources' (Aurini & Davies, 2005; Chudacoff, 2007; Fox, 2006; Quirke, 2006; Vincent, 2010) and that even those with ample resources struggle to meet these intensive parenting standards (Nadesan, 2002; Quirke, 2006; Wall, 2004). The potential for very young children to learn numeracy and literacy skills, if their parents provide a facilitating home learning environment, is being translated from research to the public domain via websites and other resources for parents. As Smyth (2014) and others argue, this imposes a responsibility on parents to learn 'skilled' pedagogical parenting, which assumes that parents have the resources to take on this responsibility.

Previous research has pointed out that the era of intensive parenting has the potential to widen the gap between middle class and disadvantaged parents. Our research shows that marginalised and disadvantaged parents also experience the demands of intensive parenting in addition to experiencing the additional pressures of contravening normative expectations of what it means to be a 'good parent'.



4. Methods

The methodology for this study consisted of four phases: a national Delphi study, data analysis to identify communities in which outcomes are unexpectedly positive, qualitative data from those geographical communities and from 'communities of affinity' in which a significant risk factor for maltreatment is present.

4.1 National survey

The aim of the national survey was to investigate which social practices and norms help to produce positive outcomes for children in disadvantaged communities. The approach adopted for the survey was a modified Delphi study, conducted online. The Delphi method is a combination of qualitative and quantitative processes that draws mainly upon the opinions of identified experts to develop theories and projections for the future. The goal of this method is to reach a consensus among the group of experts by the end of this multiple-round questionnaire process. In this instance, a decision was taken to limit the number of rounds to two with a view to minimising the research burden on participants, and maximising the response rate while also taking time and resource limitations into account (Keeney et

al., 2001). The uniqueness of Delphi lies in its reliability, and in its ability to be administered remotely without direct participant interaction.

The development of the round 1 survey drew on the SPRC's expertise in the areas of inequality, poverty and social exclusion/inclusion; disability, mental health and wellbeing; households, families and communities; care; social policy administration and organisation; and indigenous people. The survey reflects the shift in child protection research and policy from a focus on individual pathology to a more comprehensive ecological account of risk and protective factors at child, parent, family, and community level (Commonwealth Task Force, 2003).

Email invitations to complete an online survey were sent between August and September 2013 to 29 experts in government and non-government organisations, including commissions for children and young people in the states and territories, early childhood organisations, and non-government organisations in the field of family support and disability organisations. All email contact maintained participants' anonymity. However, the initial email contact invited participants to identify other individuals they considered as

having expertise in the field of child welfare, thereby facilitating an ‘expert snowballing’ recruitment process. The first survey received 14 responses and the second survey received 10.

4.2 Data analysis

The aim of the data analysis was to identify geographic communities where risk factors associated with child protection reports are anomalous with child protection and child wellbeing outcomes.

The data analysis builds upon the research conducted using data for NSW by Nivison-Smith and Chilvers (2007) and Butler et al. (2009). This research employed bivariate correlations and area-based regression analysis to identify factors that were positively associated with child protection referral rates. The unit of analysis in this research was Local Government Areas (LGAs). In their analysis, the community level factors associated with poorer outcomes for children were:

- proportion of children and young people aged 0-17 years living in single parent families;
- proportion of low income (<\$500 per week) families with children;
- proportion of families with children where at least one parent was Indigenous;
- proportion of families with children where no parent progressed beyond year 11 at school; and
- urban location (Butler et al., 2009: 3).

The authors stress that their analysis was based on cross-sectional, point-in-time data and that it identifies associations not causality. Using area-based regression analysis the authors also explored the characteristics of LGAs with actual child protection referral rates that were 20 per cent lower than the predicted rates based on their regression model. These areas were regarded as ‘resilient’ communities. Factors identified in this study that were possibly related to an area’s resilience were:

- community cohesion and social character;
- level of services and support networks;
- economic disadvantage;
- drug and alcohol availability; and
- instability (Butler et al., (2009):3).

However, this study noted that it was ‘unable to identify a single factor or set of factors that

contributed to resilience across all LGAs’ (Butler et al., 2009: 3). In addition, the authors caution that their case studies revealed that some LGAs were statistically classified as resilient due to issues relating to child protection reporting rates, such as under-reporting or high reporting thresholds. They note that under-reporting may arise due to factors such as “small town syndrome” or people being reluctant to report issues regarding neighbours or friends, the geographic dispersion of communities which may result in greater social isolation, and factors which lead to a higher prevalence of familial rather than other forms of care, and as a consequence ‘children do not come in contact with mandatory reporters prior to school’ (Butler et al., 2009: 8).

For this project we employed a similar method to identify communities where actual child protection outcomes (where available) and child wellbeing outcomes differ from the predicted outcomes, based on bivariate correlations and multivariate models that include a range of risk factors. To address some of the limitations of child protection outcomes (e.g., under-reporting and false positives) we included developmental outcomes from the Australian Early Development Census (AEDC). Data scoping of possible dependent variables and independent variables for these models for all of Australia was undertaken. Restrictions on gaining access to child protection data in a number of states and delays in gaining access to the AEDC 2012 data for all Australian states mean that the analysis reported in this report draws on data for child protection (2010-11) and child wellbeing (AEDC 2012) for Victoria and child wellbeing only for NSW (AEDC 2009 and 2012). NSW was chosen as additional information about key independent variables at LGA level (domestic violence, crime statistics) was readily available.

Independent variables were identified and extracted from various data sources based on key risk and protective factors outlined in the literature and available data. The variables encompassed risk factors such as: domestic violence, substance use, mental health issues, psychological stress, social isolation, and perceptions of safety. They also included socio-demographic factors which conceptually encompass the prevalence

of family disadvantage in communities with respect to education, employment and income, family composition and young motherhood, neighbourhood socio-economic disadvantage, residential mobility or neighbourhood instability, cultural diversity, and the 'social character' of the community, as proxied by rates of volunteering, domestic work undertaken, and providing child care for own and other children.

Data sets containing the dependent and independent variables for Victoria and NSW were constructed for the analysis. The caveats noted above must be borne in mind when interpreting the data analysis as the analysis is limited to the variables available at LGA level and do not encompass all risk and protective factors identified in the literature and the qualitative research.

The bivariate analysis explored relationships between dependent variables in Victoria and between dependent and independent variables in Victoria and NSW. Independent variables with stronger statistical relationships were selected to classify LGAs as 'positively deviant' based on bivariate relationships. LGAs that were below median values for LGAs within each state for the dependent variables and were above or below the median for the independent variable (depending on which direction indicated higher risk or greater disadvantage) were classified as anomalous or positively deviant in each state. LGAs were ranked according to their score on the risk factor for independent variables.

Area-based multivariate regression analysis was undertaken for Victoria and NSW. Due to the relatively small number of LGAs in each state (79 for Victoria and 152 for NSW) and the high correlation between independent variables (such as the proportion of low income families, proportion of families with parents with low education, and proportion of jobless families in a community) resulting in multicollinearity, the regression models were each limited to a small number of independent variables. In addition, multicollinearity was addressed through the use of the ABS Index of Socio-Economic Advantage and Disadvantage (IRSAD) as an independent variable, which encompasses an overall measure of relative disadvantage and advantage within a community including, among other factors, education, income and

employment. Variables selected for the models were identified on the basis of conceptual groupings of the variables and the strength of the statistical bivariate relationships. The final four models considered in relation to all the dependent variables in both states were:

- Model 1:** Neighbourhood risk and disadvantage: Domestic violence and ABS Index of Relative Socio Economic Advantage and Disadvantage (IRSAD).
- Model 2:** Risk Factors: Domestic violence, alcohol use or crime, psychological stress, and social support.
- Model 3:** Socio-demographic factors: lone parent families, low income families, and families with Aboriginal or Torres Strait Islander parent/s.
- Model 4:** Neighbourhood strengths or 'social character' factors: volunteering, domestic work, and care for other people's children.

Predicted scores for the dependent variable for each LGA based on the regression models were generated and compared to the actual scores on that variable. LGAs with predicted scores that were 20 per cent higher than the actual score were classified as positively deviant for that model and ranked according to their predicted score.

Final selection of LGAs for qualitative data collection was based on consideration of LGAs that were classified as positively deviant for both dependent variables for the respective states, were below median for both dependent variables, and below median values based on the IRSAD values for LGAs within that state. The number of children who sat the AEDC in each LGA was also a consideration and LGAs with fewer than 80 children in this category were excluded. A shortlist of 6-10 LGAs was considered for each state, including metropolitan and regional LGAs.

The selection process also explored data on suburbs or regions within each of the shortlisted LGAs for AEDC outcomes and socio-economic disadvantage (ABS Index of Relative Socio-economic Disadvantage (IRSAD)). The within-LGA analysis examined if there were suburbs

or local regions that could also be classified as having positive anomalous outcomes. This approach aimed to explore if the selection of LGAs was robust once consideration of socio-economic diversity, and also diversity of children outcomes within LGAs had been taken into account. Specifically, it sought to identify whether more disadvantaged areas within LGAs also had poorer outcomes for children based on AEDC data and whether more advantaged areas were associated with better outcomes. Socio-demographic data, including the number and geographical distribution of children within regional LGAs was also explored. This additional within-LGA analysis resulted in the decision to select two metropolitan LGAs in Victoria due to a lack of robust findings of anomalous outcomes for regional LGAs in an area with sufficiently high numbers of children that could be regarded as a 'geographical community'. In making this selection, the IRSAD median was defined as the median for metropolitan LGAs rather than the median for the State as metropolitan LGAs in general had higher IRSAD scores. After this process, two LGAs from each state were selected for further consideration in the qualitative analysis.

While both conceptual and statistical considerations were used in the selection of LGAs, a number of important limitations should be noted with this analysis. Data on child protection outcomes have the limitations outlined above in relation to under-reporting, reporting thresholds, service contexts and practices, and geographical characteristics of the LGA. The AEDC data are an assessment of development for children entering the first year of school and therefore does not encompass the wellbeing of all children in that community at that point in time. Data for dependent variables were not always complete for all LGAs due to small reported numbers and these LGAs were consequently excluded from the relevant analysis. Data on independent variables are also restricted to that which is available by the LGA and accessible at the time of analysis. The within-LGA review identified the importance and influence of the choice of geographical scale for analysis of the findings. This issue also raises the question of what constitutes a geographical community for children. For example, particularly

within metropolitan areas, children may reside in one LGA but may attend child-care or engage with health and other services within another LGA, particularly if these services are close to the parent's place of work. In this case, the factors that are influencing child protection and child wellbeing outcomes may be located outside the geographical sphere identified by a residential LGA. Social and service communities for children may also cross administrative boundaries, and thus regions surrounding LGAs with positive anomalous outcomes may also need to be considered in addition to the LGA itself.

4.3 Case studies

The first case study set focused on 'at risk' communities, that is, families where the parents share characteristics associated with a high risk of child maltreatment. Consistent with the focus of the project on strengths and protective factors, we describe these families in terms of shared interests rather than risks and designate them as 'affinity communities'. The two affinity communities selected for study were: parents with mental illness and parents who use drugs.

The study was approved by UNSW Australia's Human Research Ethics Committee (HREC Ref: # HC14023) in March 2014 and recruitment commenced for the communities of affinity case study shortly afterwards.

An arm's length recruitment approach was used for the communities of affinity case study. Organisations that work with parents with mental illness and parents who use drugs were asked to circulate a flyer about the research in which interested participants were asked to make direct contact with the researchers. This arm's length approach, in combination with snowball sampling, yielded 13 participants – comprising eight parents who use drugs and five with mental illness. The interviews were all conducted between April and June 2014, and all were conducted by phone.

Eight of the participants were female, and the sample included three couples. The participants ranged in age from 33 to 63 years; most were partnered. Nine were of Anglo-Australian heritage, two were Aboriginal, one was Laotian,

and one was Anglo-New Zealander. Five of the 12 parents had one child, four had two children and three had three children. The children ranged in age from two years to 33 years. The majority of interview participants (12 out of 13) were educated to university level and all resided in Sydney or Canberra. Most were engaged in paid employment, with 10 of the 13 undertaking full-time employment. Six of the families had multiple vulnerabilities. Children in two families had disabilities, and in four families both parents were drug users or had mental illness.

All study participants took part in a semi-structured, one-on-one telephone interview. These interviews ranged between 30 minutes and one hour and twenty minutes in duration. The interview schedule (see Appendix B) guided the interview questions, so as to ensure that specific attention was paid to the research aims whilst also allowing for flexibility in eliciting a range of responses and experiences from participants (Bryman, 2012). The interviews were audio-recorded and transcribed verbatim and the interview transcripts were checked for accuracy against the recordings. The study data were organised, coded, and analysed with the assistance of NVivo (V10). Two interviewers developed the coding framework using a deductive thematic analysis approach, whereby interview transcripts were read and re-read with a view to identifying patterns of meaning across the data (Patton, 2002). Within this approach, themes were identified in explicit or surface meanings of the data (Braun & Clarke, 2006) so as to explore the core research domains; that is, the family practices and strategies that are known to be important in determining child safety and wellbeing within families. The interviews were coded by a single researcher.

The second case study set focused on the four LGAs that were identified as having positively anomalous child protection (where available) and child wellbeing outcomes. For these geographic communities, telephone interviews were conducted with practitioners in four geographic communities with the aim of identifying the factors that help to create supportive communities for children. The aim of the interviews was to identify the family behaviours and practices that lead to positive

child outcomes. We selected four LGAs as case studies for qualitative analysis: Maribyrnong and Moreland in Victoria, and Port Macquarie-Hastings and Holroyd in NSW. The rationale for this selection was based on the quantitative analysis which is described below. It should be noted at the outset that the selection of LGAs is not an exact science due to data limitations, and that while these LGAs were chosen as case studies, other LGAs may also have anomalous outcomes for children.

Interview participants were sourced through organisations that had good knowledge of the families in their communities, usually as a consequence of providing child care or family support services. Organisations were contacted by phone and email, and staff were invited to participate in a telephone interview. Some of these services provided support to families of children with disability; some provided services and support in culturally and linguistically diverse (CALD) communities, and others provided a range of universal services in disadvantaged communities.

A total of sixteen interviews were conducted in September 2014. The interviews lasted between 45 minutes and 60 minutes and were recorded with individuals' consent. An interview schedule was utilised by two interviewers who asked participants to discuss five key topics concerning their families and the communities in which they were based. The interviewers did not follow a specified list of questions but rather explored the issues raised by the interviewees. The five key topics discussed during the interviews were:

1. the challenges facing families in their communities;
2. whether some families appeared to be doing well in spite of the challenges they faced;
3. how those families who appeared to be doing well differed from other families that were not doing so well;
4. what successful behaviours and practices these families engaged in that enabled them to do well when other families were not doing so well; and
5. what other families in the community could learn from those families who were doing well.

4.4 Caveats and limitations

The caveats around the quantitative data analysis are explained in Section 4.2.

Participants in the qualitative study were recruited through support services and peak bodies. We did not test family functioning, but rather relied on the assessment of referring agencies and the parents themselves. Referring agencies were provided with a brief screening tool to assist them to identify families who would be appropriate informants.

All the parents who used drugs were long term injecting drug users, and the most commonly

used drug was heroin or another opiate. This limits the generalisability of the findings as there are no established treatment programs for stimulants. Future research could address this gap by purposive recruitment of stimulant users. The parents were also highly educated and for the most part in paid employment. While this also limits the generalisability of the findings, as education is known to be a protective factor for children, it is also an important corrective to the over-representation in the research literature of parents who use drugs as being poorly educated and socially excluded.



5. Findings: Delphi study

5.1 Summary of round 1 survey findings

In the first Delphi survey round, a total of 14 surveys were completed by experts from government and non-government sectors. The round 1 survey consisted of a series of closed and open questions, and comprised two parts: questions concerning 'safe families' and questions concerning 'safe communities'.

5.1.1 Safe families

There are well-established risk and protective factors for individuals, families and communities, and many of these are demographic characteristics or other factors which are fairly static or difficult to change. For this survey, adopting the positive deviance approach, we looked particularly for naturalistic factors that occur in daily practice and are achieved without significant effort or resources. We were also interested in elaboration of the mechanisms by which these factors work; that is, whether they have a direct effect on children's safety, whether they provide knowledge and resources on child-rearing to parents, or support parents' wellbeing and thereby contribute to children's safety. These included parents' social networks,

experience and knowledge of children prior to becoming a parent, strong intergenerational and extended family relationships, strong relationships between parents/caregivers, living arrangements, and the capacity to ask for help from formal (services) and informal (friends, family) sources. For each aspect, participants were asked to indicate whether they felt the issue probed was important or not important for keeping children safe, and they were requested to provide commentary on why they were important.

Many of the comments related to caveats and conditions on these positive factors. For example, strong intergenerational relationships and gaining knowledge of children's needs from growing up in a large family are positive only if the family of origin is safe. Equally, strong relationships between parents are not protective if the relationship is strong but abusive. It is important, then, to emphasise that none of the characteristics or experiences described below is positive in all circumstances. Our focus was on identifying why positive factors are positive.

Unsurprisingly, the survey indicated agreement that parents' social networks (e.g., time spent with other adults and involvement in community

activities) were important for keeping children safe. Through the open-ended responses, a range of reasons was offered as to why they served to keep children safe. The reasons given were that parents' social networks:

- give children other adults to turn to when their home life is disordered;
- support parents thereby enhancing their ability to care for their children;
- increase children's visibility;
- help children develop a sense of belonging to a wider community;
- model positive relationships for children;
- help parents learn about community resources and parenting support;
- provide parents with practical and emotional support;
- broaden children's social and developmental opportunities; and
- create employment/education/training pathways for parents.

We asked whether experience and knowledge of children prior to becoming a parent, for example by growing up in a large family, or having care responsibilities, is important. While the majority of respondents (79%) agreed that this is important, it was also noted that prior experience and knowledge could be harmful if the family of origin was abusive, and that positive role models may be more important.

The majority of respondents (93%) felt that strong intergenerational and extended family relationships were important for keeping children safe. The commentary noted the ways this happened by:

- increasing the number of people monitoring children's care;
- supporting parents thereby enhancing their capacity to care for their children;
- helping children maintain a sense of belonging if their home life is disordered;
- providing parents with respite when needed;
- being a source of financial support; and
- giving children access to trusted adults if they feel unsafe or unhappy at home.

The consensus view (100%) was that strong relationships between parents/caregivers were

important for keeping children safe, and the open-ended comments elaborated on this view:

- important for keeping children safe regardless of whether parents are together or not (and many sole parents are very capable of raising healthy, happy children);
- important for parents' emotional wellbeing which in turn enhances their capacity to care for their children;
- help keep children safe by minimising the conflict that children are exposed to;
- help keep children safe by ensuring that children do not feel torn between their parents;
- help keep children safe by ensuring that children receive consistent parenting; and
- help keep children safe by modelling positive social and emotional relationships.

Respondents' views concerning the importance of living arrangements, e.g., children spending time in different houses with different caregivers, were mixed, albeit with the majority (67%) indicating that living arrangements were important. The comments indicate that spending time in different houses with different caregivers can be beneficial in some circumstances because it maintains connections with different parents/caregivers. Most of the responses, however, constructed this as not problematic in certain circumstances rather than actively beneficial, and less preferable to stable living arrangements. This is in contrast to the strategies identified in previous research conducted by Richter and Bammer (2000) with heroin-using mothers. In that research, one of the ways that mothers said that they keep children safe is by placing them with another trusted carer.

As noted earlier, our focus is naturally occurring support and practices rather than services. However, it takes considerable resources to be a 'good enough' parent and as we were concerned with parents with few resources, we asked about the capacity to gain access to resources. The consensus view (100%) was that the capacity to ask for help from formal (services) and informal (friends, family) sources was important for keeping children safe for a number of reasons, relating to both timely support that stops problems escalating, and addressing the risks of isolation.

5.1.2 Safe communities

The survey probed a number of characteristics of communities. These included the community's location (i.e. metropolitan, regional, remote); whether the community was settled or transient; and the social, recreational and cultural characteristics of the community.

Although 70% of respondents rated the community's location as important, the open-ended responses suggested that the location is not important in itself, but rather the infrastructure and strength of community connections that are present. The level of community engagement and connectedness, on the one hand, and the employment opportunities and supporting infrastructure, services and support, on the other, were described as more important than whether the location is metropolitan, regional, or remote. This is somewhat surprising given the challenges faced by many rural and, especially, remote communities.

Respondents' views concerning the importance of the settled/transient characteristics of communities were mixed, albeit with the majority (73%) indicating that this is important. The open-ended comments indicate that social capital, social networks and service accessibility may be higher in settled communities.

The consensus view (100%) was that the social, recreational and cultural characteristics of a community were important for helping to keep children safe. In the open-ended comments, respondents highlighted a number of positive outcomes flowing from social, recreational and cultural events, whilst also highlighting the importance of accessibility and affordability. The benefits of these include:

- opportunities for children's engagement in the community thereby increasing their visibility;
- opportunities for children to connect with adults not related to them in whom they may confide if necessary;
- helping children develop a sense of belonging;
- offering families healthy modes of community engagement;
- giving children and adults opportunities for positive affirmation;
- generating pathways to employment/

education/training/skills development;

- broadening parents' and children's social networks;
- strengthening community relationships and helping to promote a sense of shared responsibility for children; and
- being a good indicator of families' integration into their community.

Respondents were also invited to nominate additional features of families and communities that were important for helping to keep children safe. These included:

- child-friendly communities and environments;
- responsive and culturally sensitive health, education and community services;
- good infrastructure – transport, health, education, housing, and shops;
- opportunities to celebrate cultural identity;
- education and work being considered important;
- that children are not stigmatised by association (e.g., if parents use alcohol or other drugs);
- links to spiritual resources, such as church;
- encouraging children to speak up if they are feeling unsafe;
- a good understanding of the parenting role and responsibilities; and
- warm, child-centred parenting rather than strict, discipline-focussed parenting.

5.2 Summary of round 2 survey findings

Following the iterative character of the Delphi technique, the findings from the round 1 survey were used to develop the round 2 survey instrument, which consisted of closed responses only. The development of the round 2 survey instrument involved analysing and summarising the round 1 survey findings. In the round 2 survey, participants were asked to review and rank these summarised findings "in order to identify issues of greatest salience" (Hsu & Sandford, 2007). The summarised findings of the round 2 survey were organised by theme as per the round 1 survey. The purpose of this feedback process was to allow participants "to reassess their initial judgements

about the information provided in previous iterations” (Hsu & Sandford, 2007: 2).

Through the first round survey responses, the experts identified a range of factors that are important for keeping children safe in their families and communities; that the interaction of different factors is important; and that there is no single factor that keeps children safe. The purpose of the round 2 survey was to encourage respondents to consider the responses they gave in the first survey and attempt to isolate and rank the factors that they considered most important for keeping children safe.

In November 2013, the second round survey was sent to 13 of the 14 individuals who completed the first survey (one round 1 survey was completed anonymously). Following a reminder email and phone call, 10 of the 13 surveys were completed in the second round, representing a response rate of 77%, which is marginally higher than the 70% response rate recommended for a Delphi study (Keeney et al., 2001). In response to the round 1 survey questions, participants were invited to elaborate on how families and communities could help to keep children safe in open-ended comments. In the round 2 survey, these responses were summarised, allowing respondents to evaluate their own and others’ perspectives on the aspects of family and community life that contribute to keeping children safe. Respondents were invited to rank their responses on a 7-point scale from strongly disagree to strongly agree, which were subsequently converted into a composite score. With 10 survey responses per item, the range of possible scores is between 7 and 70, where a score closer to 70 indicates strong agreement, and a score closer to 7 indicating strong disagreement.

5.2.1 Safe families

In the round 1 survey, respondents offered a range of reasons as to how parents’ connections with other adults in the community can help keep children safe. In the second round, the most highly ranked reason was because these connections support parents, thereby enhancing their ability to care for their children. However, it is worth noting that based on the scoring (out of a possible 70), there was strong agreement about the importance of most of the factors identified for keeping children safe.

Parents’ connections with other adults in the community can help keep children safe by...	Rank
... supporting parents thereby enhancing their ability to care for their children	1 (65)
... helping children develop a sense of belonging to a wider community	2 (64)
... providing parents with practical and emotional support	2 (64)
... giving children other adults to turn to when their home life is disordered	3 (63)
... helping parents learn about community resources and parenting support	3 (63)
... modelling positive relationships for their children	4 (62)
... broadening children’s social and developmental opportunities	5 (60)
... increasing children’s visibility	6 (59)
... creating employment/education/training pathways for parents	7 (51)

In terms of gaining experience and knowledge of children, it was widely regarded that the most important factor is gaining this knowledge prior to becoming a parent, and the second most important factor is having positive role models.

Experience and knowledge of children prior to becoming a parent...	Rank
... gives parents a better grasp of the realities and demands of parenting	1 (55)
... is not as important as having positive role models to emulate	2 (48)
... is not as important as much can be learned subsequent to becoming a parent.	3 (40)
... is not as important as possessing common sense	4 (39)

The most highly ranked reason why strong, healthy intergenerational and extended family relationships can help keep children safe was because they provide important support for parents. However, again, it is worth noting that there was strong agreement concerning most of the other reasons offered as to why strong, healthy intergenerational and extended family relationships were important for keeping children safe.

Strong, healthy intergenerational and extended family relationships can help keep children safe...	Rank
... by supporting parents thereby enhancing their capacity to care for their children	1 (65)
... by giving children access to trusted adults if they feel unsafe or unhappy at home	2 (63)
... by increasing the number of people monitoring children's care	3 (62)
... by helping children maintain a sense of belonging if their home life is disordered	4 (61)
... by providing parents with respite when needed	4 (61)
... by being a source of financial support	5 (56)
...but can be substituted by responsive and accessible local community services	6 (42)

Four reasons were equally ranked in first place as to why strong, healthy relationships between parents/caregivers help to keep children safe. These four reasons represent a range of viewpoints, with three of the four emphasising the importance of positive relationships, with the fourth acknowledging that strong relationships between parents are not always possible if the parent is the source of risk for the child.

Strong, healthy relationships between parents/caregivers ...	Rank
... are important for keeping children safe regardless of whether parents are together or not	1 (62)
... help keep children safe by minimising the conflict that children are exposed to	1 (62)
... help keep children safe by modelling positive social and emotional relationships	1 (62)
... are not always possible if a parent is the source of risk for the child	1 (62)
... help keep children safe by ensuring that children do not feel torn between their parents	2 (61)
... are important for parents' emotional wellbeing which enhances their capacity to care for their children	3 (59)
... help keep children safe by ensuring that children receive consistent parenting	3 (59)

The most highly ranked reason as to why children spending time in different houses with different caregivers can help keep children safe was because it helps maintain contact with different parents/caregivers. Interestingly, the next most highly ranked response was that spending time in different houses with different caregivers can actually increase the risk to children in some circumstances.

Children spending time in different houses with different caregivers...	Rank
... can prove beneficial by maintaining connections with different parents/caregivers	1 (56)
... can increase the risk to children in some circumstances	2 (54)
... is not problematic as long as children feel safe and experience consistent parenting styles	3 (52)
... can help to protect children and keep them safe in some circumstances	4 (50)
...can be confusing for children if they experience discontinuity in school, friendships and recreational activities.	5 (48)
...is not problematic as long as parents engage in frequent and effective communication	6 (40)
... is beneficial if children experience inconsistent parenting in their usual home environment [N.B. one statement omitted due to missing response]	7 (39)

The highest ranked reasons why parents' capacity to ask for help from formal (services) and informal (friends, family) sources helps keep children safe were because problems can be addressed before they escalate and families' sense of isolation can be reduced.

The capacity to ask for help from formal (services) and informal (friends, family) sources helps keep children safe...	Rank
... because problems can be addressed before they escalate	1 (61)
... by reducing families' sense of isolation	1 (61)
... because it alerts organisations/services to parents' needs	2 (60)

The capacity to ask for help from formal (services) and informal (friends, family) sources helps keep children safe...	Rank
... because support is easier to provide if families ask for help when they need it	3 (58)
... because it increases the likelihood of parents changing their behaviour	4 (53)

5.2.2 Safe communities

The level of community engagement and connectedness that families have where they live were considered slightly more important for keeping children safe than the level of employment opportunities and supporting infrastructure, services, and support in the location.

A community's location (i.e. metro, regional, or remote)...	Rank
... is less important than the level of community engagement and connectedness that families have	1 (54)
... is less important than the level of employment opportunities and supporting infrastructure, services and support in the location	2 (51)

Whether a community was settled or transient did not influence whether respondents felt that they could help keep children safe. However, while the composite score resulted in an equal ranking for both, it is worth noting that the responses to the first statement were concentrated on the agreement end of the scale, while the responses to the statement concerning transient groups were spread over a wider range of points on the scale, encompassing a broader spread of viewpoints.

Settled/transient communities	Rank
Settled communities can help keep children safe if the community relationships are positive	1 (57)
Transient groups (e.g. migrant families) can form strong connections with one another and help keep children safe	1 (57)
Settled communities are preferable to transient communities because families in settled communities can form connections with other families and professional support within the community	2 (51)

The chief reason why social, recreational and cultural resources in a community were regarded as important for keeping children safe was because they broaden parents' and children's social networks, followed closely by the fact that they offer families healthy modes of community engagement. Again, it is worth noting that there were just a few points between most of these ranked factors.

Social, recreational and cultural resources in a community can help keep children safe...	Rank
... by broadening parents' and children's social networks	1 (58)
... by offering families healthy modes of community engagement	2 (57)
... by helping children develop a sense of belonging	3 (56)
... by providing opportunities for children's engagement in the community thereby increasing their visibility	4 (55)
... by providing opportunities for children to connect with adults not related to them, and in whom they may confide if necessary	4 (55)
... by generating pathways to employment/ education/training/skills development	4 (55)
...by strengthening community relationships and helping to promote a sense of shared responsibility for children	5 (54)
... if they are affordable	5 (54)
... by giving children and adults opportunities for positive affirmation	6 (53)
... by being a good indicator of families' integration into their community	7 (52)
... if they are accessible without parental involvement	8 (42)

From a list compiled from the summarised open-ended comments in the round 1 survey, respondents were asked to rank from 1 to 10 the factors they felt were most important for keeping children safe, where 1 was most important, 2 was slightly less important, and so on. In the table below, the factors are ranked in order from 1-8 as some factors received an equal ranking, while the column labelled 'No.', presents a figure where a lower score is the most highly rated. These numbers provide a good indication of

the diversity of feeling in regard to the listed factors. The two most highly rated factors for keeping children safe tapped into families with warm, child-centred parenting, and a good understanding of the parenting role and responsibilities.

Rank	No.	Important for keeping children safe
1	17	Warm, child-centred parenting rather than strict, discipline-focused parenting
2	31	A good understanding of the parenting role and responsibilities
3	35	Encouraging children to speak up if they are feeling unsafe
4	41	Child-friendly communities and environments
4	41	Responsive and culturally sensitive health, education, and community services
5	51	Good infrastructure – transport, health, education, housing, and shops
5	51	That children are not stigmatised by association (e.g., if parents use alcohol or other drugs)
6	61	Education and work being considered important
7	69	Opportunities to celebrate cultural identity
8	77	Links to spiritual resources, such as church

5.3 Discussion

The strongest findings about the factors that promote safe families and communities were social resources and knowledge of parenting. Among the factors considered most important for keeping children safe in their families were warm, child-centred parenting—arguably something most parents have to work at rather than a naturally occurring practice—and the importance of social support for parents from other adults in the community and from extended family. Having experience and knowledge of

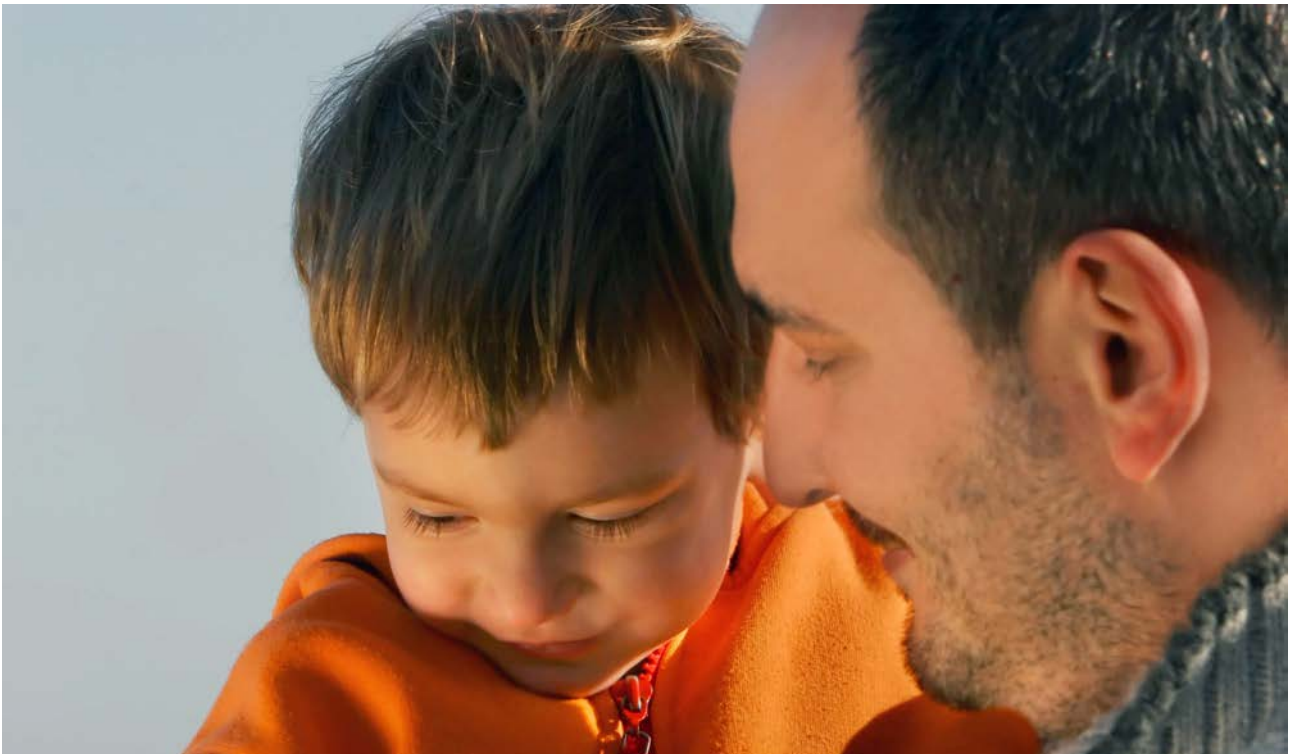
children prior to becoming a parent were also considered important for promoting children’s safety because it can give parents insight into the realities of parenthood.

Strong, healthy relationships between parents/ caregivers were considered important for keeping children safe regardless of whether parents were together or not because they minimise the number of conflicts that children are exposed to and model positive social and emotional relationships.

The findings concerning whether spending time in different houses with different caregivers helps to keep children safe were less strong than other findings. Although we expected responses to indicate the importance of respite or shared responsibility for caregiving among parents with few resources and often high levels of stress, the findings were instead for the most part about the conditions required to ensure that this was not detrimental.

The findings also point to the importance of early intervention, with parents’ capacity to ask for help from formal and informal sources considered important for keeping children safe if parents sought support before problems escalated. This capacity to ask for help was also considered important for reducing parents’ feelings of isolation.

Community-level factors that were identified as most important for helping to keep children safe included the level of community engagement and connectedness that families have where they live. The transient or settled character of a community was not considered in itself to enhance or detract from children’s safety; rather, positive and strong connections that families had with other families were considered key to children’s safety. Having a range of social, recreational and cultural resources in a community was considered important for keeping children safe because they gave parents the opportunity to expand their social networks.



6. Identifying geographic communities with anomalous outcomes for children

6.1 Introduction

As outlined in the Methods section (Section 4.2) in this report, the aim of the data analysis was to identify geographic communities where risk factors associated with child protection reports are anomalous with child protection and child wellbeing outcomes.

The data analysis builds upon the research conducted by Nivison-Smith and Chilvers (2007) and Butler et al. (2009) for NSW, which employed bivariate correlations and area-based regression analysis to identify factors that were positively associated with child protection referral rates. The unit of analysis in this research was Local Government Areas (LGAs). Section 4.2 outlines their key findings and important caveats attached to their research and the method employed in the data analysis to locate anomalous LGAs in our project, as well as limitations of this approach.

For this project we employ a similar method to identify communities where actual child protection outcomes (where available) and child wellbeing outcomes differ from the predicted outcomes, based on bivariate correlations and multivariate models, which include a range of

risk factors. In addition to considering child protection outcomes, we include developmental outcomes from the Australian Early Development Census (AEDC). In part, this decision is driven by limited availability of data for child protection outcomes. We also considered child development outcomes to address known issues in child protection under-reporting and inconsistencies in reporting.

The analysis below is undertaken for Victoria where child protection data as well as AEDC data for 2012 were available. In NSW, AEDC data for 2009 and 2012 were readily available by LGAs as well as key independent variables, such as data on domestic violence. The caveats noted in Section 4.2 should be borne in mind in interpreting the following analysis. As in the previous research, the analysis for this project identifies associations, not causality, as it also uses cross-sectional, point-in-time data.

This section of the report first outlines the dependent and independent variables used for the analysis, then the bivariate relationships identified in the analysis and the LGAs that are classified as anomalous for a number of key independent variables. The multivariate models are then described along with the LGAs

identified as having anomalous outcomes. Key features of selected LGAs and their suburbs are then described to outline the rationale for the final selection of LGAs.

6.1.1 Child protection and child wellbeing indicators

The selection of child protection and child wellbeing indicators for this analysis was based on data availability at LGA level at the time of the analysis. Data for such indicators in Victoria is available through the Victorian Child and Adolescent Monitoring System (VCAMS) indicators published by the Department of Education and Early Childhood Development.

For NSW, data for AEDC 2009 and 2012 were used. The definition and source of the dependent variables for this analysis are outlined in Table 6.1.

As outlined below, a number of caveats should be borne in mind in the interpretation of the dependent variables, including that LGAs may have under-reporting of child maltreatment or high reporting thresholds for child protection. In addition, the denominator in the AEDC variable is the number of children who were assessed against the AEDC, not the number of five year olds in the area, and the coverage of the AEDC may also vary by area.

Table 6.1: *Dependent variables for Local Government Areas (LGAs)*

Variable	Description	Source
Child abuse	Child abuse substantiation per 1,000 children 0-17 years (July 2010 - 30 June 2011) Number of investigations of child abuse notifications for children aged 0-17 years old that were substantiated for the year 2010-11 / Estimated resident child population aged 0 to 17 years	VCAMS, Indicator 20.1 Client Relationship Information System (CRIS)
Child protection orders	Children on child protection orders per 100 children aged 0-17 years Number of children aged 0-17 years who are the subject of care and protection orders as at 30 June/ Estimated resident child population aged 0 to 17 years	VCAMS, Indicator 20.2 Client Relationship Information System (CRIS)
Out of home care	Children in out of home care per 1,000 children aged 0-17 years (2011) Number of children aged 0-17 years who are in out-of-home care as at 30 June/ Estimated resident child population aged 0 to 17 years	VCAMS Indicator 20.3 Client Relationship Information System (CRIS)
AEDC 2012 Victoria	Proportion of children who are developmentally vulnerable on 2 or more domains Number of children developmentally vulnerable on two or more AEDC domains/ Number of children who were assessed against the AEDC	VCAMS Indicator 4.1 Australian Early Development Census (AEDC) Centre for Community Child Health
AEDC 2009 NSW	Proportion of children who are developmentally vulnerable on 2 or more domains Number of children developmentally vulnerable on two or more AEDC domains/ Number of children who were assessed against the AEDC	Social Health Atlas of Australia (May 2013 release)
AEDC 2012 NSW	Proportion of children who are developmentally vulnerable on 2 or more domains Number of children developmentally vulnerable on two or more AEDC domains/ Number of children who were assessed against the AEDC	AEDC Website [Data downloaded 29/08/14]

Sources: Department of Education and Early Childhood Development (2013), PHIDU (2013)

6.1.2 Risk factors for child maltreatment

The literature highlights key risk factors in families and communities for child maltreatment and wellbeing, which include domestic violence, substance use, mental health issues and social

support and perceptions of safety. Data on some of these factors have been obtained at the community level for LGAs and are outlined in Table 6.2.

Table 6.2: Independent variables for Local Government Areas (LGAs): Risk factors

Variable	Description	Source
Family violence incident (Victoria)	Family incident reports rates per 100,000 population 2011-12	Victoria Police Law Enforcement Assistance program (LEAP) Family Incidents reports 2008-9-2012-13 http://www.police.vic.gov.au/content.asp?a=internetBridgingPage&Media_ID=72311
Family incident with children present (Victoria)	Family incident reports where children present rates per 100,000 population 2011-12	Extracted from Victoria Police Law Enforcement Assistance program (LEAP) Family Incidents reports 2008-09-2012-13 http://www.police.vic.gov.au/content.asp?a=internetBridgingPage&Media_ID=72311
Incidents of Domestic Violence (NSW)	Incidents of domestic violence related assault as recorded by NSW Police for each NSW LGA: rate per 100,000 population 2009 and 2012	Extracted from NSW Recorded Crime Statistics 2008-2012 rankings spreadsheet' http://www.bocsar.nsw.gov.au/bocsar/bocsar_crime_stats/bocsar_detailedspreadsheets.html
Liquor offences	Incidents of liquor offences as recorded by NSW Police for each NSW LGA: rate per 100,000 population 2009 and 2012	Extracted from NSW Recorded Crime Statistics 2008-2012 rankings spreadsheet http://www.bocsar.nsw.gov.au/bocsar/bocsar_crime_stats/bocsar_detailedspreadsheets.html
Alcohol Use	Alcohol consumption at levels considered to be a high risk to health (modelled estimate), persons aged 18 years and over 2007-08. Age standardised rate per 100 population ¹	Social Health Atlas of Australia May 2013 Release
Mental Health	Better Access Care Program: Preparation of Mental Health Care Plan by GPs, 2009/10. Age standardised rate per 100,000 population	Social Health Atlas of Australia. Compiled by PHIDU based on data from the Department of Health and Ageing, 2009/10; and average of ABS Estimated Resident Population, 30 June 2009 and 30 June 2010. MBS Item Nos: 2702, 2710, 2712, 2713
Psychological Stress	High or very high psychological distress levels (K-10) (modelled estimate), persons aged 18 years and over 2007-082	Social Health Atlas of Australia May 2013 Release
Social Support	Persons aged 18 years and over who are able to get support in times of crisis from persons outside the household (modelled estimates)	Social Health Atlas of Australia May 2013 Release
Safety	Persons aged 18 years and over who feel very safe/safe walking alone in local area after dark (modelled estimates)	Social Health Atlas of Australia May 2013 Release

Table notes: 1. "The data are self-reported data, reported to interviewers in the 2007–08 NHS. The level of health risk was based on estimated alcohol consumption in the seven days prior to interview using two components – the number of days on which the respondent reported consuming alcohol in the previous week; and the quantity consumed in the most recent days on which they consumed alcohol. For people who drank on no more than three days in the last

week, their daily consumption was simply the total consumed divided by seven. Harmful use of alcohol is defined as average daily consumption of more than 75 ml (three standard drinks) for males and 50 ml (two standard drinks) for females". Social Health Atlas of Australia. 2. The data have been derived from the Kessler Psychological Distress Scale-10 items (K-10), which is a scale of non-specific psychological distress based on 10 questions asked of respondents about negative emotional states in the 4 weeks prior to interview. 'High' and 'very high' distress are the two highest levels of distress categories (of a total of four categories). The estimates have been synthetically predicted at the Statistical Local Area (SLA) level from the 2007-08 National Health Survey (NHS), conducted by the ABS: a note on modelled estimates is at http://www.publichealth.gov.au/data_online/notes_estimates_Aust_2007-08.pdf.

A number of caveats should be borne in mind for the interpretation of the alcohol use, psychological stress, social support, and safety data. These estimates are developed from statistical models that have applied rates from national samples to geographic areas based on

the characteristics of the communities. As such, the rates are not based on the actual prevalence rates measured within those communities.

6.1.3 Socio-demographic factors: family and community characteristics

The literature also highlights socio-demographic factors at the family and community level that are associated with outcomes for children, and data on these factors to be used in this analysis are outlined in Table 6.3. The factors conceptually encompass the prevalence of family disadvantage in communities with respect to education, employment and income, family composition and young motherhood, neighbourhood socio-economic disadvantage, residential mobility or neighbourhood instability, cultural diversity, and the 'social character' of the community, as proxied by rates of volunteering, domestic work undertaken, and providing child care for own and other children.

Table 6.3: Independent variables for Local Government Areas (LGAs): Family and community characteristics

Variable	Description	Source
Children in lone parent families	Proportion of children aged either 0-6 years or 0-17 years who live in lone parent families	ABS Census of Population and Housing 2011 Customised data request. SPRC Analysis
Children in jobless families	Proportion of children aged less than 15 years in jobless families	Social Health Atlas of Australia Compiled by PHIDU based on ABS Census 2011 (unpublished) data
Aboriginal and Torres Strait Islander families	Proportion of families with children aged either 0-6 years or 0-17 years with at least one parent who is Aboriginal and Torres Strait Islander	ABS Census of Population and Housing 2011 Customised data request. SPRC Analysis
Low income families	Proportion of families with children aged either 0-6 years or 0-17 years with low income ¹	ABS Census of Population and Housing 2011 Customised data request. SPRC Analysis
Jobless families	Proportion of families with children aged either 0-6 years or 0-17 years with no parent employed	ABS Census of Population and Housing 2011 Customised data request
Low education families	Proportion of families with children aged either 0-6 years or 0-17 years with no parent progressing beyond year 11 in education	ABS Census of Population and Housing 2011 Customised data request. SPRC Analysis
Young mothers	Proportion of families with children aged 0-6 years with mother aged between 15-24 years	ABS Census of Population and Housing 2011 Customised data request. SPRC Analysis
Regional Socio-economic advantage and disadvantage	ABS Index of relative socio-economic advantage and disadvantage score 2011	ABS 2033.0.55.001 - Socio-economic Indexes for Areas (SEIFA), Data Cube only, 2011 Table 3

Variable	Description	Source
Government housing	% of dwellings rented from the government housing authority 2011 ²	Social Health Atlas of Australia Compiled by PHIDU based on ABS Census 2011 data
Residential mobility	% persons with a different address 5 years ago 2011	ABS Census Table builder data. SPRC calculation based on data extracted from usual residence database
Non-English speaking background	% persons born in (non-English speaking countries)	ABS Census Table builder data. SPRC calculation based on data extracted from usual residence database
Volunteering	% adults aged 15 years and over who spent time doing unpaid voluntary work through an organisation or group, in the twelve months prior to Census Night.	ABS Census Table builder data. SPRC calculation based on data extracted from usual residence database
Domestic work	% adults reporting they did 15 hours or more per week of domestic work	ABS Census Table builder data. SPRC calculation based on data extracted from usual residence database
Child care - all	% adults reporting care for own and other children aged under 15 years in the two weeks prior to Census night	ABS Census Table builder data. SPRC calculation based on data extracted from usual residence database
Child care for other children	% adults reporting care for other people's children aged under 15 in the two weeks prior to Census night	ABS Census Table builder data. SPRC calculation based on data extracted from usual residence database

Table Notes: 1. Low income is defined as less than \$1,000 per week gross family income in 2011. Negative and nil incomes are excluded from the numerator, which assumes that they are not low income families, and the “not stated” incomes are excluded from the denominator, which assumes that they are proportionally distributed between low and non-low income families. 2. The data exclude the population in the 2.5% of dwellings for which the tenure type was not stated (the proportion excluded was calculated based on the Australian data).

6.2 Data analysis

6.2.1 Bivariate relationships

Dependent variables

Table 6.4 shows the relationships between the AEDC variables and the child protection referral rates for Victorian LGAs. Data on child protection outcomes are difficult to obtain for a number of jurisdictions and so the AEDC 2012 variable is used to proxy for child wellbeing within the community in NSW. In Victoria, there is a relatively strong (>0.5) positive correlation between the proportion of children who are developmentally delayed on 2 or more AEDC domains two of the child protection dependent variables: rates of substantiated child abuse and the proportion of children in out of home care. In considering which communities may have positively anomalous outcomes, the analysis below will focus primarily on the two dependent variables of AEDC 2012 for children aged 0-6 years, and the rate of substantiated child abuse for children

aged 0 -17 years. The relatively strong correlation between rates of substantiated child abuse and development vulnerability on AEDC domains supports the use of AEDC data for assessing child wellbeing outcomes in NSW, where child protection data were not available.

Table 6.4: Relationships between the dependent variables, Victoria: Correlation coefficients

	Correlation with developmentally vulnerable on 2 or more AEDC domains 2012	Sig	n
Child abuse	0.597	<0.001	76
Child protection orders	0.387	<0.001	73
Out of home care	0.555	<0.001	74

Note: Numbers of LGAs used in the analysis vary as data were confidentialised for some LGAs due to small numbers so they have been removed from the analysis.

Dependent variables and risk factors

Tables 6.5 and 6.6 report on the bivariate relationships between the child outcomes and the key risk factors for the states of Victoria and NSW. The rate of family incidents reported by police in a community in Victoria and for domestic violence in NSW has a strong positive correlation (>0.5) with a higher rate of children being developmentally vulnerable on 2 or more AEDC domains. In Victoria, family violence is

also highly correlated with rates of substantiated child abuse. The modelled rates of high reported psychological stress have a moderate positive correlation with the dependent variables (0.460 with AEDC 2012 and 0.377 with child abuse). A similar finding holds for the modelled rate of alcohol use. Higher rates of social support – also constructed through modelled estimates - have an expected negative correlation with the AEDC variable, but no significant correlations with child abuse.

Table 6.5: Relationships between the dependent variables and key risk factors, Victoria: Correlation coefficients

	Correlation with developmentally vulnerable on 2 or more AEDC domains 2012*	Sig	N	Correlation with rates of substantiated child abuse 2010-11**	Sig	N
Family incidents	0.525	<.0001	73	0.752	<0.001	77
Family incidents with children present	0.522	<.0001	73	0.755	<0.001	77
Mental health care plans	0.045	0.707	73	-0.079	0.495	77
Psychological stress	0.460	<.0001	73	0.377	<0.001	77
Alcohol use	0.244	0.038	73	0.445	<.0001	77
Social support	-0.329	0.005	73	-0.072	0.533	77
Safety	0.125	0.291	73	0.211	0.065	77

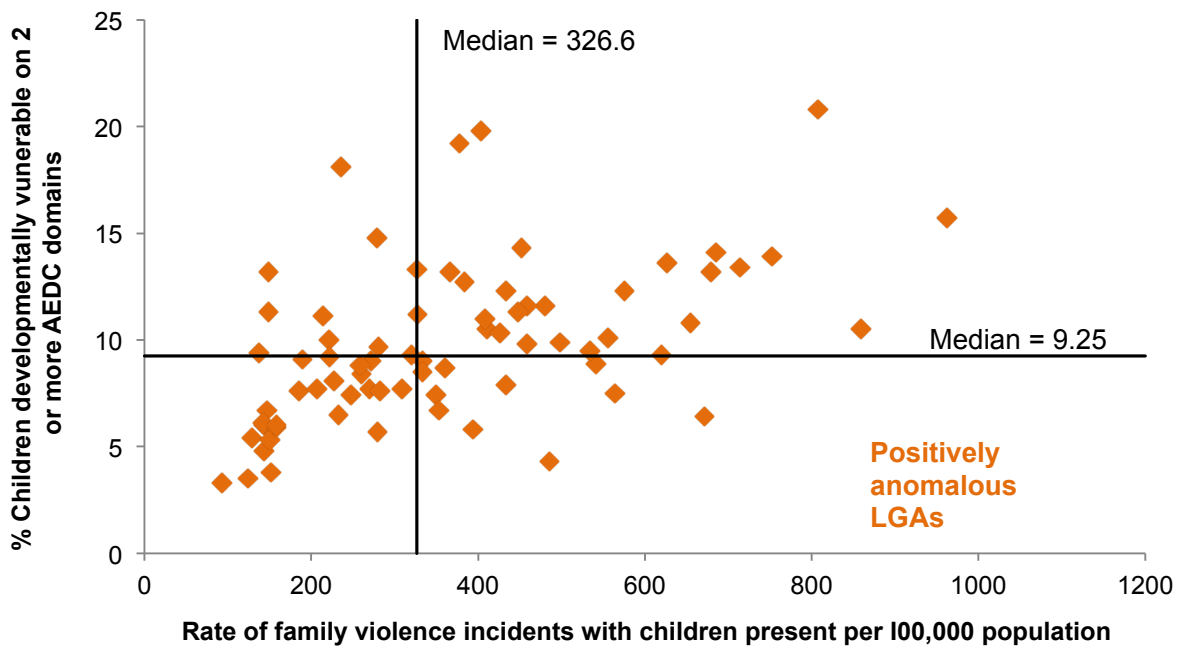
Notes *Pearsons Correlation co-efficient, **Spearman correlations coefficient

Table 6.6: Relationships between the dependent variables and key risk factors, NSW: Correlation coefficients

	Correlation with developmentally vulnerable on 2 or more AEDC domains 2009*	Sig	N	Correlation with developmentally vulnerable on 2 or more AEDC domains 2012*	Sig	N
Domestic violence	0.501	<0.001	140	0.552	<0.001	140
Liquor offence	0.224	0.008	140	0.243	0.004	139
Mental health care plans	-0.198	0.015	151	-0.167	0.041	15
Psychological stress	0.385	<0.001	150	0.376	<0.001	150
Alcohol use	0.153	0.060	150	0.091	0.270	150
Social support	-0.310	0.001	150	-0.368	0.001	150
Safety	-0.108	0.188	150	0.141	0.084	150

Notes *Pearsons Correlation co-efficient

Figure 6.1: Victoria LGAs: Correlation of proportion of children who are developmentally vulnerable on 2 or more AEDC domains in 2012 and rate of family violence incidents with children present, 2011-12

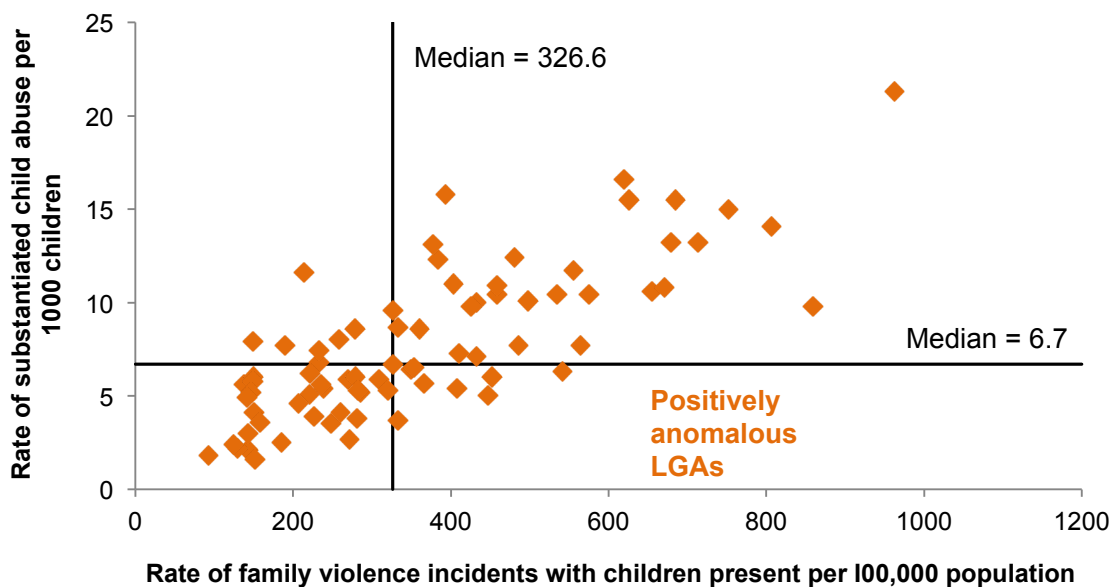


Note: Median value for proportion of children developmentally vulnerable on 2 or more AEDC 2012 domains is 9.25 and the median value for rates of family violence with children present is 326.6

Figures 6.1 and 6.2 graph the data points for the LGAs in the relationship between the two dependent variables and the rate of family violence incidents with children present. The relationship between the rates of family violence and child protection outcomes is stronger than the relationship between family violence

and child development outcomes. LGAs are classified as anomalous if they are below median on the outcome, and above median on the risk factor variable. Data points in the lower right-hand quadrant indicate LGAs with anomalous outcomes in that these LGAs report higher rates of the risk factor, but relatively low

Figure 6.2: Victoria LGAs: Correlation of rates of substantiated child abuse 2010-11 and rate of family violence incidents with children present, 2011-12



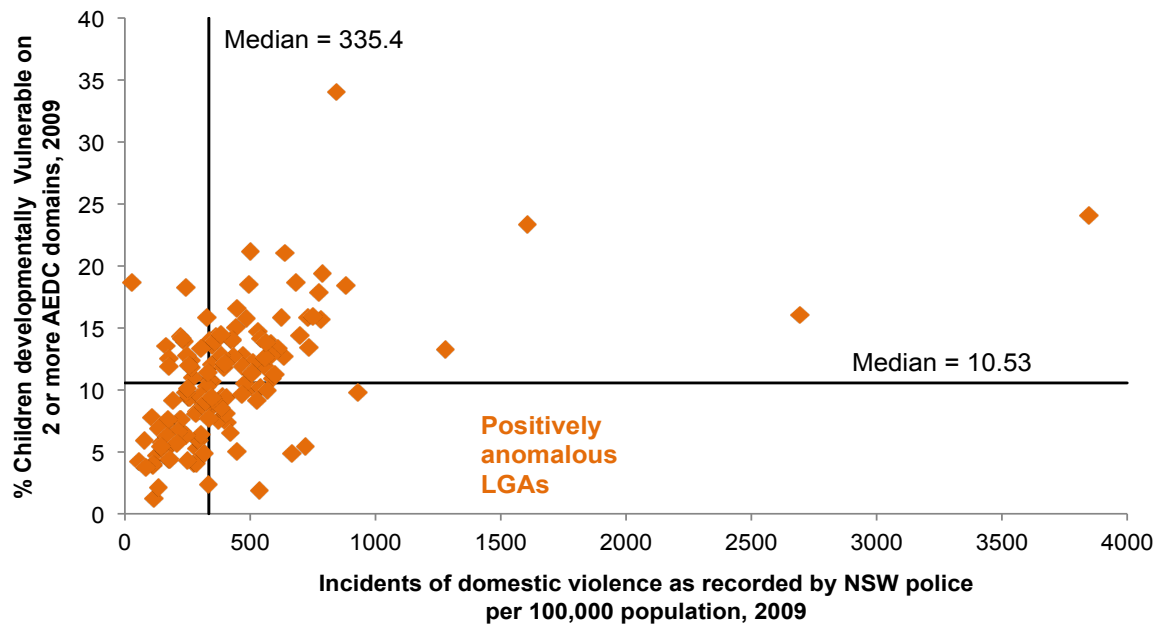
Note: Median value for rate of substantiated child abuse per 100,000 is 6.7 and median value for rates of family violence with children present is 326.6

rates of poor outcomes on the AEDC. The LGAs located in the lower right-hand quadrant for both dependent variables in Figures 6.1 and 6.6 are reported in Table 6.7.

Figures 6.3 and 6.4 graph the relationship between the dependent variables and the rate

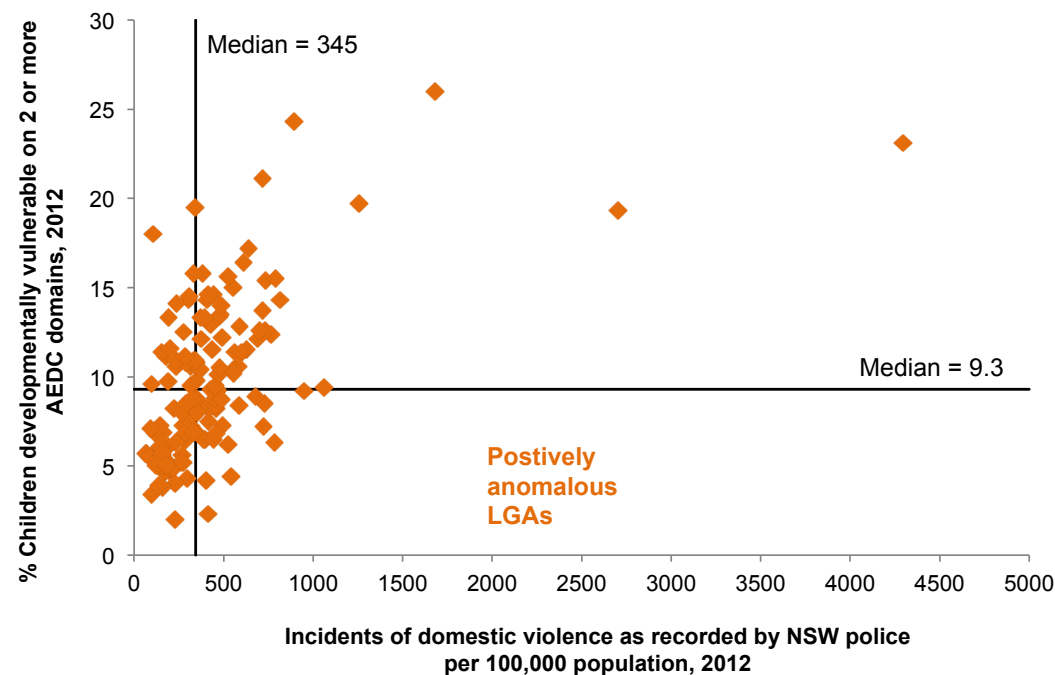
of domestic violence in the LGAs for NSW for 2009 and 2012 respectively. The graphs show that there are a small number of outliers with very high scores either on the risk factor or the rates of domestic violence. Once again, LGAs located in the bottom right-hand quadrant

Figure 6.3: NSW LGAs: Correlation of proportion of children who are developmentally vulnerable on 2 or more AEDC domains in 2009 and rate of family violence incidents in 2012



Note: Median value for proportion of children developmentally vulnerable on 2 or more AEDC domains in 2009 is 10.53 and the median value for rates of domestic violence incidents recorded by NSW police is 335.4.

Figure 6.4: NSW LGAs: Correlation of proportion of children who are developmentally vulnerable on 2 or more AEDC domains in 2012 and rate of domestic violence incidents in 2012



Note: Median value for proportion of children developmentally vulnerable on 2 or more AEDC domains in 2012 is 9.3, and median value for rates of domestic violence incidents recorded by NSW police is 345.

have anomalous outcomes. LGAs that have anomalous outcomes in both years of AEDC data are reported in Table 6.8.

Tables 6.7 and 6.8 report on the bivariate relationships between the dependent variables and the socio-demographic factors for the states of Victoria and NSW, respectively. Due to the different reference populations for the dependent variables in Victoria, the population of families used in the Census socio-demographic variables differs for the two dependent variables: for the AEDC variable the family population is all families with at least one dependent child aged 0-6 years, and for the rate of substantiated child abuse, the family population is all families with at least one dependent child aged 0-17 years. In NSW, the population is all families with at least one dependent child aged 0-6 years.

The findings for both states have strong similarities to the previous analysis undertaken for NSW, although there are some inconsistencies. Socio-demographic factors that have strong

positive relationships (>0.5) with poorer outcomes on the dependent variables are:

- Children living in lone parent families
- Children living in families where no parent is employed
- Families where no parent progressed beyond year 11 in education
- Families with mothers aged between 15 and 24 years
- Families with low incomes (although this relationship was stronger in Victoria than NSW)

Strong negative relationships were found with:

- ABS Index of Relative Socio-economic Advantage and Disadvantage

Less consistently, these variables had moderate to strong relationships with poorer children's outcomes:

- Families with at least one parent from an Aboriginal or Torres Strait Islander background
- Higher rates of government housing

Table 6.7: Relationships between the dependent variables and socio-demographic factors: correlation coefficients, Victoria

	Correlation with developmentally vulnerable on 2 or more AEDC domains 2012	Sig	Correlation with rates of substantiated child abuse	Sig
Children in lone parent families	0.651	<.0001	0.750	<.0001
Children in jobless families	0.749	<.0001	0.674	<.0001
Aboriginal and Torres Strait Islander families	0.251	0.032	0.626	<.0001
Low income families	0.691	<.0001	0.653	<.0001
Jobless families	0.745	<.0001	0.679	<.0001
Low education families	0.713	<.0001	0.722	<.0001
Young mothers	0.593	<.0001	0.780	<.0001
Regional socio - economic advantage and disadvantage	-0.702	<.0001	-0.708	<.0001
Government housing	0.188	0.112	0.495	<.0001
Residential mobility	-0.065	0.583	0.025	0.829
Non-English speaking background	-0.067	0.576	-0.395	<0.001
Volunteering	0.099	0.406	0.227	0.047
Domestic work	0.226	0.054	0.324	0.004
Child care - all	-0.107	0.368	-0.047	0.682
Child care for other children	-0.076	0.522	0.275	0.016
N	78		77	

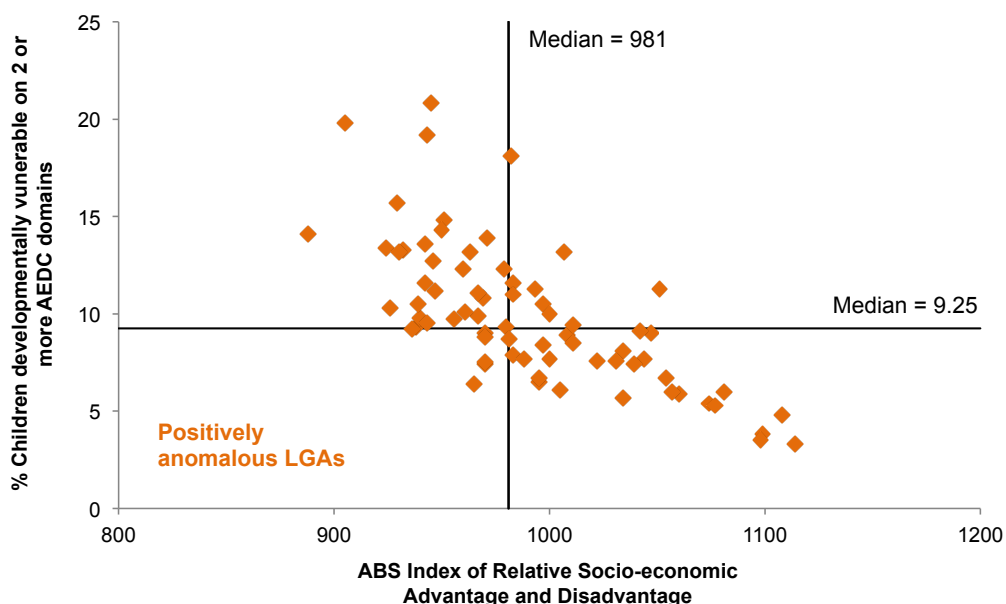
These variables formed the basis for consideration of LGAs which have anomalous

positive outcomes for the predictor variable and modelling for the multivariate analysis.

Table 6.8: Relationships between the dependent variables and socio-demographic factors: correlation coefficients NSW

	Correlation with developmentally vulnerable on 2 or more AEDC domains 2009	Sig	Correlation with developmentally vulnerable on 2 or more AEDC domains 2012	Sig
Children in lone parent families	0.557	<.001	0.482	<.001
Children in jobless families	0.574	<.001	0.575	<.001
Aboriginal and Torres Strait Islander families	0.486	<.001	0.657	<.001
Low income families	0.448	<.001	0.467	<.001
Jobless families	0.557	<.001	0.539	<.001
Low education families	0.534	<.001	0.599	<.001
Young mothers	0.547	<.001	0.522	<.001
Regional socio-economic advantage and disadvantage	-0.541	<.001	-0.513	<.001
Government housing	0.391	<.001	0.432	<.001
Residential mobility	-0.160	0.050	-0.244	0.003
Non-English speaking background	-0.148	0.069	-0.143	0.080
Volunteering	-0.036	0.657	0.027	0.744
Domestic work	0.142	0.083	0.070	0.396
Child care- all	-0.034	0.681	-0.054	0.514
Child care for other children	0.012	0.887	-0.078	0.340
N	151		151	

Figure 6.5: Victoria LGAs: Correlation of proportion of children who are developmentally vulnerable on 2 or more AEDC domains in 2012 and IRSAD score, 2011

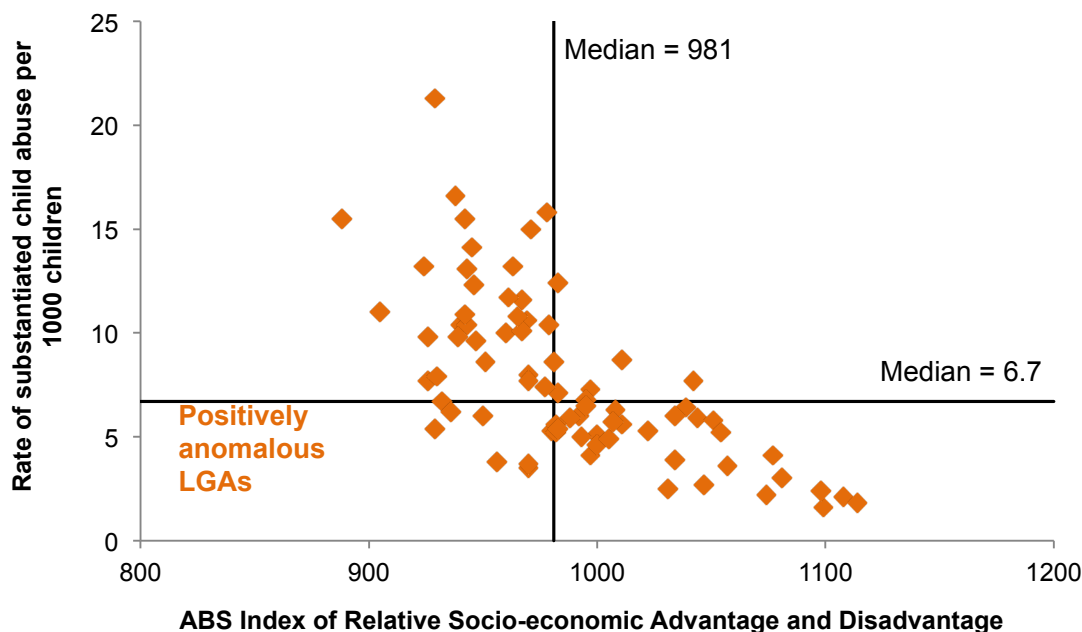


Note: Median value for proportion of children developmentally vulnerable on 2 or more AEDC 2012 domains is 9.25, and median value for IRSAD for LGAs in Victoria is 981.

Figures 6.5-6.8 show the relationships between the dependent variables for Victoria and NSW and the ABS IRSAD. Higher values of the IRSAD indicate greater advantage, so in this case, LGAs that have data points located in the bottom left hand side of the graph are those with anomalous outcomes. The graphs show

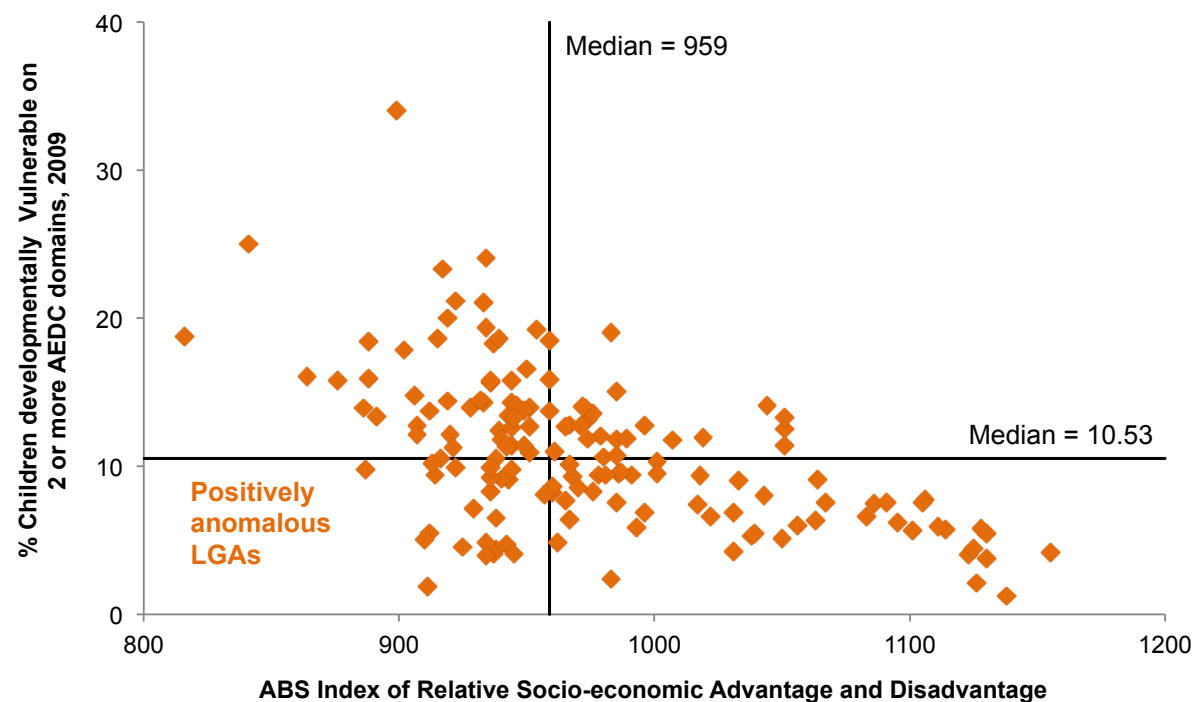
a stronger negative correlation between the dependent variables and the IRSAD in Victoria than NSW although there are a number of outliers in the NSW graphs. LGAs in Victoria and NSW that were classified as having anomalous outcomes for both dependent variables are listed in Tables 6.7 and 6.8 respectively.

Figure 6.6: Victoria LGAs: Correlation of rates of substantiated child abuse, 2010-11 and IRSAD, 2011



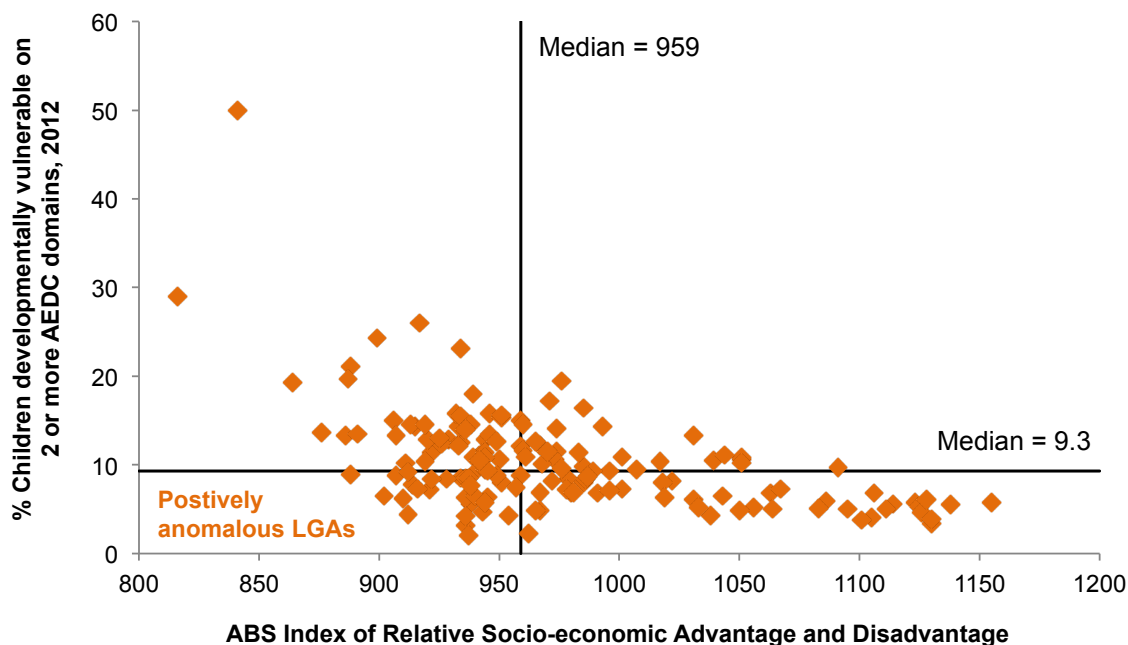
Note: Median value for rate of substantiated child abuse per 100,000 is 6.7, and median value for IRSAD for LGAs in Victoria is 981.

Figure 6.7: NSW LGAs: Correlation of proportion of children who are developmentally vulnerable on 2 or more AEDC domains in 2009 and IRSAD, 2011



Note: Median value for proportion of children developmentally vulnerable on 2 or more AEDC domains in 2009 is 10.53, and median value for IRSAD 2011 for LGAs in NSW is 959.

Figure 6.8: NSW LGAs: Correlation of proportion of children who are developmentally vulnerable on 2 or more AEDC domains in 2012 and IRSAD, 2011



Note: Median value for proportion of children developmentally vulnerable on 2 or more AEDC domains in 2012 is 9.3, and median value for IRSAD for LGAs in NSW is 959. Outlier LGA with high score on AEDC 2012 does not appear in Figure 5.4 due to lack of data for the LGA for domestic violence incidents.

6.2.2 Classification of anomalous LGAs based on bivariate relationships

LGAs were classified as having anomalous outcomes or as anomalous on the basis of bivariate relationships between the dependent variables and the independent variables. In

each case, the analysis identified LGAs which were below median values for the dependent variables and above or below median values for the independent variables, depending on the variable. The median values for the variables are reported in Table A1 in the Appendix. LGAs identified as having anomalous outcomes in this

Table 6.9: LGAs with anomalous outcomes in relation to both AEDC 2012 and rates of substantiated child abuse 2010-11 in Victoria for independent variables

Domestic violence	IRSAD	IRSD	Alcohol use	Social support	Lone parent families	Jobless families	Low income families	Young mothers	Aboriginal and Torres Strait Islander families	Low education
Cardinia	Moira	Moira	Macedon Ranges	Manningham	Moira	Moira	Moira	Corangamite	Moira	Moira
Moorabool	Alpine	Maribyrnong	Whitehorse	Whitehorse		Maribyrnong	Alpine	Moira	Moyne	Corangamite
Knox	Corangamite	Corangamite	Nilumbik	Knox		Moreland	Corangamite	Cardinia	Indigo	
Corangamite		Alpine	Banyule	Moonee Valley				Moyne	Alpine	
			Kingston	Cardinia						
			Knox	Port Phillip						
			Bayside	Kingston						
			Stonnington	Kingston						
			Moonee Valley	Moreland						
			Monash	Monash						
			Glen Eira	Maribyrnong						
			Maribyrnong							
			Moreland							
			Whitehorse							
			Boroondara							
			Manningham							
			Monash							

Notes: Based on bivariate analysis of data for Victorian LGAs. Ranking in table is based on higher rates of independent variables for the substantiated child abuse analysis. Shaded are LGAs finally selected.

Table 6.10: LGAs with anomalous outcomes in relation to AEDC 2009 and 2012 in NSW for independent variables

Domestic violence	Liquor offences	IRSAD	Psychological stress	Support	Lone parent families	Jobless families	Low income families	Young mothers	Aboriginal and Torres Strait Islander families	Low education
Narrandera	North Sydney	Warrumbungle Shire	Marrickville	Holroyd***	Narrandera	Warrumbungle Shire	Warrumbungle Shire	Bogan*	Bogan*	Walcha*
Warrumbungle Shire	Wakool*	Narrandera	Newcastle	Burwood	Glen Innes Severn	Lithgow	Glen Innes Severn	Glen Innes Severn	Warrumbungle Shire	Glen Innes Severn
Lithgow	Walcha*	Glen Innes Severn	Wollongong	Marrickville	Lithgow	Glen Innes Severn	Glen Innes Severn	Lithgow	Warren*	Warrumbungle Shire
Wagga Wagga	Wagga Wagga	Lithgow	Lithgow	Ashfield	Warren*	Warrumbungle Shire	Wakool*	Walcha*	Narrabri	Lithgow
Newcastle	Narrabri	Lithgow	Glen Innes Severn	Hurstville	Warrumbungle Shire	Narrandera	Bombala*	Narrabri	Walcha*	Narrandera
Maitland	Manly	Bogan*	Maitland	Lithgow	Port Macquarie-Hastings	Walcha*	Narrandera	Warrumbungle Shire	Narrandera	Narrabri
Narrabri	Waverley	Bombala*	Lake Macquarie	Warrumbungle Shire	Port Macquarie-Hastings	Warren*	Gloucester*	Gloucester*	Glen Innes Severn	Narrabri
Holroyd***	Narrandera	Tumut Shire	Macquarie	Ryde	Port Macquarie-Hastings	Narrabri	Warren*	Gloucester*	Glen Innes Severn	Tumbarumba*
Port Macquarie-Hastings	Port Macquarie-Hastings	Gloucester*	Port Macquarie-Hastings	Randwick	Bogan*	Port Macquarie-Hastings	Berrigan	Narrandera	Gloucester*	Wakool*
Port Macquarie-Hastings	Berrigan	Berrigan	Wollongong	Wollongong	Narrabri	Port Macquarie-Hastings	Bogan*	Warren*	Lithgow	Gloucester*
Tumut Shire	Mosman	Warren*	Ashfield	Tumbarumba*	Wagga Wagga	Bogan*	Port Macquarie-Hastings	Wagga Wagga	Tumut Shire	Bogan*
Lake Macquarie	Tumut Shire	Narrabri	Burwood	Dungog	Gloucester*	Tumbarumba*	Port Macquarie-Hastings	Tumut Shire	Wagga Wagga	Bombala*
		Corowa Shire	Warrumbungle Shire	Gloucester*	Lake Macquarie	Gloucester*	Walcha*	Upper Hunter Shire	Port Macquarie-Hastings	Gundagai*
		Tumbarumba*	Gosford	Narrabri	Murray		Tumbarumba*	Corowa Shire	Gundagai*	Tumut Shire
		Gundagai*	Gloucester*	Bombala*	Walcha*		Lithgow	Gundagai*	Upper Hunter Shire	Warren*
		Port Macquarie-Hastings	Hurstville	Glen Innes Severn				Wakool*	Murray	Dungog
				Waverley						Maitland
										Upper Hunter Shire

Notes: * denotes LGA where fewer than 80 children sat the AEDC in 2012. *** indicates anomalous result for 2012 but not 2009. Shaded are LGAs finally selected.

analysis for Victoria and NSW respectively are identified in Tables 6.9 and 6.10 below.

The LGAs are ranked according to highest level of risk factor in the analysis. While all LGAs are only included if they had positive anomalous outcomes for both dependent variables (unless otherwise indicated), the ranking in the table is based on the outcomes of the independent variables for one of the dependent variables in each state: for Victoria this is the rate of substantiated child abuse, and for NSW it is the rate of children developmentally vulnerable on 2 or more domains for the AEDC 2012.

Table 6.7 also includes the ranking for the ABS Index of Relative Socio-economic Disadvantage (IRSAD) as well as the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD). This was included to test the sensitivity of the outcomes to the choice of ABS Index of relative socio-economic status for areas and also because it identified an additional metropolitan LGA within Victoria for further scrutiny.

1 'In a multiple regression analysis, multicollinearity exists when two or more independent variables are highly correlated; this makes it difficult, if not impossible, to determine their separate effect on the dependent variable' (Vogt, 2005).

2 The results for the regression models are available from the authors on request.

Classification of anomalous LGAs based on multivariate relationships.

As outlined in Section 4.2, area-based regression analysis was undertaken as a method to identify LGAs with positive anomalous outcomes. The variables selected for the multivariate models were identified on the basis of conceptual groupings of the variables and the strength of the statistical bivariate relationships. After reviewing a number of models and identifying problems with multicollinearity¹, four models were selected to be used for the final analysis as outlined below².

Model 1:

Neighbourhood risk and disadvantage: Domestic violence and ABS Index of Relative Socio-economic Advantage and Disadvantage (IRSAD). This model encompasses the broadest range of factors relating to socio-economic disadvantage in the community as well as the most highly correlated risk factor of domestic violence.

Model 2:

Risk factors: Domestic violence, alcohol use or crime, psychological stress, and social support. This model encompasses variables that seek to proxy for the key risk factors relating to domestic

violence, alcohol, mental health issues, and social isolation.

Model 3:

Socio-demographic factors: lone parent families, low income families, and families with Aboriginal or Torres Strait Islander parent/s. This model focused on the socio-demographic factors within a community. The final model was the outcome of a review of models that also included variables for jobless families, low education families, and families with young mothers; however, multicollinearity was too high to include all these variables in the model.

Model 4:

Neighbourhood strengths or 'social character' factors: Volunteering, domestic work and care for other people's children. This model aimed to identify LGAs with anomalous outcomes by considering protective factors within a community.

Predicted scores for the relevant dependent variables were calculated for LGAs based on each of the models. LGAs with predicted scores that were 20 per cent higher than their actual score were classified as anomalous. Tables 6.11 and 6.12 list the LGAs that were anomalous for

both dependent variables for each of the models for Victoria and NSW. The LGAs are ranked by the highest predicted value for the model. A decision was made to focus on the results of the first three models in selecting LGAs due to the low explanatory power (adjusted R2) of Model 4.

The relatively few LGAs identified through this method for Victoria compared to NSW may be a result of the different dependent variables used in Victoria, alongside the lower number of LGAs in Victoria.

Table 6.11: LGAs with anomalous outcomes for both dependent variables based on regression models and below median values for both dependent variables, Victoria.

Model 1: Neighbourhood risk and disadvantage (IRSAD)	Model 2: Risk factors	Model 3: Socio-demographic factors
Alpine	Cardinia Alpine Port Phillip** Stonnington** Nillumbik**	Moira Alpine

Notes ** denotes LGAs with relatively high scores on IRSAD indicating greater advantage.

Table 6.12: LGAs with anomalous outcomes for both dependent variables based on regression models, NSW

Model 1: Neighbourhood risk and disadvantage	Model 2: Risk factors	Model 3: Socio-demographic factors
Narrandera	Warrumbungle Shire	Bogan*
Warrumbungle Shire	Holroyd***	Warrumbungle Shire
Lithgow	Narrandera	Warren
Narrabri	Narrabri	Narrabri
Tumut Shire	Marrickville	Walcha
Port Macquarie-Hastings	Wakool*	Narrandera
Wakool*	Newcastle	Glen Innes Severn
Holroyd***	Port Macquarie-Hastings	Gloucester*
Glen Innes Severn	Wollongong	Lithgow
Lake Macquarie	Randwick	Port Macquarie-Hastings
Gundagai*	Gundagai*	Gundagai*
Berrigan	Blue Mountains	Berrigan
Gloucester	Berrigan	Wakool
Corowa Shire	Camden	Murray
Walcha*	Gloucester*	Upper Lachlan Shire
Blue Mountains	Ashfield	Blue Mountains
	Walcha*	Kiama
	Waverley	Camden
	North Sydney	Waverley
	Manly	Lane Cove
	Kiama	Woollahra
		North Sydney

Notes: * denotes LGA where fewer than 80 children sat the AEDC in 2012. *** indicates anomalous result for 2012 but not 2009. Shaded cells are LGAs finally selected.

Selecting LGAs

Based on the bivariate and multivariate analysis above, the LGAs below were shortlisted for Victoria and NSW. Overall in this process, given some of the data limitations, we gave greater weight to general measures of socio-economic disadvantage as assessed by the IRSD and IRSAD and the measures of domestic and family violence. In the selection process, we considered regional and metropolitan areas in each state.

We selected four LGAs as case studies for qualitative analysis: Maribyrnong and Moreland in Victoria, and Port Macquarie-Hastings and Holroyd in NSW. The rationale for this selection is described below. We should note at the outset that the selection of LGAs is not an exact science due to data limitations, and that while these LGAs were chosen as case studies, other LGAs may also have anomalous outcomes for children.

Victoria

The final shortlist for Victoria summarised in Table 6.11 was based on considering the outcomes of the bivariate and multivariate analysis, a review of AEDC data for 2012, the IRSD 2011 for suburbs and local regions within LGAs based on data extracted from the AEDC website, as well as Census population numbers data for resident children.

The review of the AEDC and IRSD data aimed to identify whether the higher socio-economic status of suburbs or local regions was associated with better outcomes for child development, as measured by the AEDI, and lower socio-economic status areas associated with poorer outcomes. If that were consistently the case, the classification of the whole LGA as anomalous may be a statistical artefact based on geographical scale chosen for the analysis. The review then sought to identify LGAs where anomalous suburbs and local areas existed within the LGA. In addition, for regional LGAs, the review of the population data aimed to ensure that identified communities had sufficient numbers of children within a small enough area for the findings regarding a 'geographical community' for children to be robust.

The within-LGA data review suggested that due to the diversity in socio-economic status

and children's outcomes within LGAs as well as geographical dispersion of the population of children, the data available at specific geographical levels may not be adequate to identify smaller areas that could be regarded as a 'geographic community' for children where anomalous outcomes for children were clearly evident in regional areas. In addition, the geographical size and socio-economic diversity of the metropolitan LGA, Cardinia, led to concerns about identifying a geographic community of children with anomalous outcomes. It is likely that anomalous outcomes for children exist within smaller regions within these areas, as in other regional areas in Victoria. This issue should be the subject of further research with a greater range of variables and knowledge of the local area. Given concerns about data adequacy for regions, we focused on metropolitan LGAs in Victoria that were supported by the data used in this analysis.

Maribyrnong was a metropolitan LGA that had been identified as anomalous on some criteria (IRSD, alcohol use, social support and jobless families) in the bivariate analysis. This LGA was also classified as anomalous for Model 1 and Model 2 in the child development regression, and anomalous for Model 3 for the child abuse regression. While diversity in socio-economic status for suburbs existed within the LGA, the AEDC and IRSD data indicated that a number of suburbs (Footscray, Maidstone, and West Footscray) were both below the state LGA median for AEDI (9.3) and the IRSD (993), and thus classified as anomalous suburbs on this criteria. These suburbs also had more than 80 children who had sat the AEDC. (See Appendix Table A2). While Maribyrnong had below median results for reported incidents of family violence with children present, it had higher disadvantage on socio-economic factors measured by the IRSAD, and ranked relatively higher on the proportion of families where no parent was employed and the two risk factors of risky alcohol use and lacking social support. On this basis, Maribyrnong was selected for further qualitative analysis.

In order to identify another metropolitan LGA that closely met the criteria in this analysis, and due to metropolitan LGAs generally having

higher socio-economic status, we established a median value for metropolitan LGAs for Victoria to identify relative disadvantage. The outcome of this change in threshold identified Moreland as a possible LGA as it had been classified as anomalous on the alcohol use, social support, and jobless families criteria, and was below the metropolitan median on the IRSAD for LGAs. Within the LGA, the suburbs of Brunswick West, Coburg, Coburg North, Hadfield, and Pascoe Vale could be regarded as anomalous based on the metropolitan LGA median value for the IRSD (1026.5). All but one of these suburbs also had more than 80 children who sat the AEDC (Table A3 in Appendix). Based on these data, the LGA of Moreland was also chosen for further qualitative analysis.

NSW

In NSW, more weight was given to the findings related to the independent variables of domestic violence and general socio-economic disadvantage as assessed by the IRSAD as these variables had strong associations with children's outcomes. Thus, the initial shortlist of LGAs for selection was based on LGAs with anomalous outcomes in both years for the regressions for Model 1, and also LGAs with more than 80 children who sat the AEDC in 2009 and 2012. Key statistics for these LGAs are outlined in Table 5.12. Once again, a within-LGA analysis suggested that the geographical dispersion for the outer regional and remote LGAs would make it difficult to robustly identify anomalous local areas that could be regarded as a 'geographic community' for children' given the available data.

Both Port Macquarie-Hastings and Lithgow were consistently anomalous on the bivariate analysis: Port Macquarie-Hastings was anomalous on all but the young mothers and low education criteria while Lithgow was anomalous on all

but the liquor offences criteria (Table 6.8). While Port Macquarie-Hastings was anomalous on all regression models, Lithgow was not anomalous for Model 2 risk factors. In making the decision between Port Macquarie-Hastings and Lithgow, child development outcomes, as indicated by the AEDC scores for the two years, were also considered, and these were more consistently further below median in Port Macquarie-Hastings than Lithgow. The AEDC results were also based on a larger number of children in Port Macquarie-Hastings. Reviewing the areas within the LGA indicated that the area of Port Macquarie/North Shore had a relatively low score on the AEDC 2012 (5.2) while having an IRSD score close to median (975.5), and a relatively high number of children who had sat the AEDC. Based on this evidence, Port Macquarie-Hastings LGA was chosen as a regional area in NSW.

The selection of the metropolitan LGA in NSW encountered some similar difficulties as in Victoria, with metropolitan LGAs in NSW generally having higher socio-economic status than those in the regions. The metropolitan LGA of Holroyd was identified as anomalous in regression Models 1 and 2 in 2012, but not 2009. It was also ranked as anomalous in the bivariate analysis with regard to domestic violence and lacking in social support. In addition, in terms of socio-economic status, the LGA scores for Holroyd were only just above the state LGA medians for NSW. Within the LGA, the suburb of Merrylands West had anomalous outcomes based on the AEDC and IRSD score, and two other relatively low socio-economic status suburbs had scores that were relatively close to median for the AEDC. Given these findings, Holroyd was chosen as it had a combination of factors that suggested that it warranted further qualitative analysis.

Table 6.13: Selected characteristics of shortlisted LGAs in Victoria

LGA	Region	Number of children aged 0-17 years	Number of children who did AEDI 2012	Rates of substantiated child abuse	Proportion of children vulnerable on 2 or more AEDI domains 2012	Family incidents with children present per 100,000 population	IRSAD	Comments
Cardinia	Metropolitan	19602	1186	6.3	8.9	541.2	1008	High on risk factors of DV and young mothers. Above median IRSAD. Just below median for AEDI and Abuse. Large geographical LGA with diverse populations within LGA.
Maribyrnong	Metropolitan	12680	792	5.9	7.7	269.6	988	Relatively low on violence, relatively high on jobless families. Lower IRSAD than Cardinia, and lower AEDI and abuse scores.
Corangamite	Regional	3958	221	3.7	9.0	333.3	970	Just above median for violence, relatively low SES, relative high on low income families, young mothers, and low education. Low abuse score.
Moira	Regional	6164	347	6.2	9.2	221.6	936	High on all socio-demographic risk factors except violence. Just under median for both AEDI and abuse.
Moreland	Metropolitan	26102	1527	4.6	7.7	207	1000	Suburbs within the area who appear PD on the AEDI and IRSD and seem relatively more disadvantaged are: Coburg, Coburg North, Hadfield and Pascoe Vale.
Yarra Ranges	Metropolitan	33383	1853	5.3	7.6	282.3	1022	Large geographical LGA with diverse populations within LGA. Healesville and surrounds appeared to be one area with anomalous outcomes.

Table 6.14: Selected characteristics of shortlisted LGAs in NSW

LGA	Remoteness	Number of children who did AEDI 2009	Number of children who did AEDI 2012	Proportion of children vulnerable on 2 or more AEDI domains 2009	Proportion of children vulnerable on 2 or more AEDI domains 2012	Reports of domestic violence per 100,000 population 2012	IRSD/ IRSAD	Comments
Warrumbungle	Outer/regional remote	139	145	5.0	6.2	524.5	911/910	Relatively small number of children in large geographical region. Relatively high on risk factor of domestic violence. Identified as anomalous on all variables except young mothers.
Narrabri	Outer regional	175	184	9.1	6.5	443.0	953/940	Relatively small number of children in large geographical region. Identified as anomalous on all variables except stress and low income.
Lithgow	Mostly inner regional	227	247	10.5	7.3	496.1	924/916	Relatively high AEDI score for 2009. Identified as anomalous on all variables except liquor offences.
Tumut shire	Outer regional	141	144	9.2	4.2	400.0	951/936	Relatively small number of children in large geographical region. Identified as anomalous on all independent variables except stress, lone parents, jobless families, and low income.

Port Macquarie-Hastings	Mostly inner regional	803	837	8.1	7.5	416.6	969/957	Relatively low AEDI scores both 2009 and 2012. High number of children. Identified as anomalous on all independent variables except social support, young mothers, and low education.
Holroyd	Major City	1557	1512	14.1*	8.2	420.1	966/972	Drop in AEDI between 2009 2012- only below median in 2012. Identified as anomalous in regression Models 1 and 2 for 2012, also on domestic violence and social support in bivariate analysis for 2012.

Notes * denotes not below median in 2009

Conclusion

The data analysis in this section aimed to identify 'geographic communities', where risk factors associated with child protection reports and child development are anomalous with children's outcomes. In this analysis, LGAs were the spatial proxies for children's 'geographical communities'. The data analysis process involved scoping available data sources, the construction of data sets, and classification of LGAs as anomalous geographic communities on the basis of a review of literature on risk and protective factors, conceptual groupings, and bivariate and multivariate analysis. In addition, within-LGA analysis of child development outcomes and socio-economic status was undertaken to review if the classifications were robust to considerations of diversity of socio-economic status and children's outcomes, as well as density of child populations within regional LGAs.

From an initial shortlist of six LGAs for each state, the analysis identified Maribyrnong and Moreland as two metropolitan LGAs with potential for anomalous outcomes in Victoria and Port Macquarie-Hastings (regional) and Holroyd (metropolitan) in NSW. While this analysis drew on a range of data and a number of criteria in

selecting LGAs, there are important caveats to be noted in this analysis. This includes the limitations of available data which may mean that it is challenging to confidently classify LGAs as having anomalous outcomes for children.

The analysis process also identified a number of limitations and dilemmas to still be addressed in the statistical classification of LGAs as 'anomalous', and it should be noted that we made choices as to the weight to attach to key risk factor variables based on both conceptual and data quality decisions in deciding on the LGAs for further qualitative exploration. Data on protective factors at LGA level, such as services for children and quality of the environment for play, need further investigation in future research and was beyond the scope of this project.

The analysis also highlighted the question of the effect of choice of geographical scale on identified outcomes. The analysis highlights the question of how to conceptualise a 'geographic community' for children, especially in defining the boundaries of communities. Services for children, such as child care, may be located closer to a parent's place of work, and children and their families participate in social networks and communities that are in different LGAs from those where they live.



7. Findings: qualitative case studies of geographic communities

7.1 Strengths: families thriving in adversity

This section reports the findings of sixteen qualitative interviews conducted with practitioners in the four LGAs that were identified as having positively anomalous child protection and child wellbeing outcomes (see section 4.3). The aim of the interviews was to identify the factors that help to create supportive communities for children. Participants were sourced through organisations with good knowledge of the families in their communities, usually as a consequence of providing child care or family support services.

In keeping with the positive deviance framework of the study, a key focus of the interviews was to try to unpack what helps some families thrive and do well in circumstances that prove challenging for other families. Specifically, the interviews sought to uncover what behaviours, practices, and strategies parents employed to help them cope, thrive and achieve positive outcomes for themselves and their children. The key strengths and strategies identified were: a reliance on formal support networks; family characteristics; informal support, including

extended family support and social support networks; having resources; and strong communities. The final section identifies some lessons that can be learned from some of the practices in place in the communities that help to strengthen families and help them cope with adversity.

7.1.1 Formal support

Changes in social support, particularly the decline in support provided by extended families, requires societies 'to institutionalize most of the informal-support functions of the extended family' through community-based programs and government funded projects (Zeitlin et al. 1990). Service providers acknowledged that not all families dealing with adversity needed to draw on formal support mechanisms, with many having a raft of resources – financial, educational, and social – to draw on or a resilience that enabled them to cope and thrive in the face of adversity. However, for those families lacking these resources and resilience, engagement with the formal support system was considered critical for helping them to deal with the challenges they faced. The benefits that parents were seen to reap

through engagement with the formal support system included improved parenting skills, improved life management skills, an improved ability to tackle problems, greater knowledge of the service system, greater opportunities for personal development, and the development of a wider social support network. Gaining access to formal support was seen as particularly important for socially isolated families who were often subsequently linked in with other formal and informal support services.

Formal support was identified as critical for helping families to deal with challenging life events and contribute to improved outcomes for children and families. A multitude of reasons were offered for how these support systems helped families by:

- normalising parenting challenges;
- providing parenting courses;
- helping families identify their strengths to enable them to better cope with challenges;
- helping parents prioritise the issues they need to address (sometimes even before tackling the issue about which they first made contact with a particular service);
- providing parents who are overwhelmed by their circumstances with relevant information in small, manageable amounts;
- helping parents identify what they are not coping with;
- linking parents up to other formal support that might address more pressing issues which are holding families back;
- interagency collaboration to ensure that all of the family's needs are met;
- giving parents opportunities to develop social connections with other parents in their community, e.g., through playgroups and parent information evenings;
- offering parents non-threatening, non-stigmatizing, soft entry points for engaging with services, e.g., through running a toy library in conjunction with specialised family support services;
- giving culturally and linguistically diverse (CALD) parents opportunities to attend English classes;
- facilitating adult education/training (e.g., to become a playgroup facilitator) through the

provision of on-site child care;

- being responsive and available when parents reach out for support;
- helping parents navigate the service system and access the support they need;
- offering free or affordable services;
- giving marginalized groups 'somewhere to go... somewhere you can talk that's safe'; and
- fostering community concern and neighbourliness by encouraging clients to look out for their neighbours.

7.1.2 Family characteristics

Service providers were asked to talk about the ways in which they felt that the families who did well in spite of the challenges they faced might differ from other families not doing as well in similar circumstances. A number of differences were identified including: family values, rituals, and routines; parents' relationships; and parents' attitude/mindset/traits.

Values, rituals, and routines

A number of service providers identified the importance of norms and routines for strengthening families and helping them to deal with adversity. One service provider spoke of an activity that helped families to identify the values they hold, and what values they wished to develop further, such as 'We do fun things together'. Despite not being able to identify their values initially, the activity cards assisted families to identify what they wanted more of, and how they could achieve that.

Several service providers spoke of the importance of quality, shared family time for strengthening families. This encompassed consciously setting aside time to spend together, to share meals, and to celebrate milestones.

We see that in some situations, where other families are very talkative and they are quite open, and they have structured time where they do sit and talk, and you always see that you know they're the most positive ones. Whereas others are just no talk at all.

Routines within the household were also identified as an important strategy for families as they were perceived to give some structure to their day. It was also recognised that these

routines provided positive role modelling, especially if a parent was in employment:

They push to get the children out of bed, push to get their children to school, so just generally if the family can get in a routine, the children thrive by being at school all the time, yeah and also the parents - you know the children see the parents' work ethic, and it's yeah generally a more positive thing if they're seeing mum and dad having to be places and having to do things.

Parents' relationships

Strong, positive relationships between parents and caregivers were also reported to make a positive difference to how families coped with adversity, particularly in families with a child with disability. A service provider recalled a low-income family she had worked with that was struggling to cope with a child with autism, who was very physically abusive towards them. Despite the challenges this family faced, the parents learned to effectively manage the child's behaviour so well that he was able to attend a mainstream school. In trying to determine what enabled this family to cope, the service provider emphasised that the family unit was strong. Both parents being 'on the same page' with respect to managing a child with disability was identified by another service provider as critical to helping them deal with challenges. Another benefit of a strong, supportive parental relationship was the ability to step in and take over when the other parent was feeling overwhelmed.

Two service providers working with CALD families referred to gendered cultural expectations with regard to parenting, and the cultural clash many experienced in Australia. CALD parents who were able to negotiate these new relationships and expectations together were considered to be coping better than those who were at odds with these expectations.

Parents' knowledge, beliefs, and attitudes

When asked why some parents and families cope better with adversity, service providers found it a challenge to pinpoint what specifically sets them apart from those families who might struggle to a greater extent, leaving aside their access to formal and informal support. Discussions of why some families do better than others often centred on individuals'

innate characteristics – 'something you can't necessarily give to people'. Many of these personal traits, or characteristics, are linked with the concept of resilience, that is, a capacity to bounce back or recover from a setback. Other personal traits, or characteristics, which were noted related to individuals' capacity to deal with adversity. The traits mentioned include:

- a desire and willingness to change their circumstances;
- having sufficient energy to affect change;
- resilience that enables them to deal with a challenge;
- proactively seeking assistance and support;
- a capacity to engage with services;
- being trusting of formal services;
- an ability to prioritise;
- having ambition;
- self-belief;
- a sense of hope;
- being resourceful;
- being determined; and
- an ability to self-manage.

7.1.3 Informal support

Informal support was identified as key to helping families and children to thrive and do well in spite of the challenges they might face in their day-to-day lives. The informal support systems identified through the interviews were: social networks and family support. Social networks refer broadly to the friendships that individuals form over their lives through different channels. Family support was identified as a crucial support mechanism for many families facing adversity, and it is largely immune from outside influence. That is, one either has family support or one does not. Social networks, however, can be strengthened and promoted by organisations operating within the formal support system.

Extended family support

The types of assistance provided by extended families noted by the service providers related predominantly to support with caring for children on both a practical and emotional level, but it also extended to financial support, support with temporary accommodation, being a source of encouragement for children and young people,

and critical for preventing children being placed in out of home care.

Supportive grandparents were seen as incredibly important in situations where parents were struggling with a child with disability. Service providers spoke of grandparents and extended family attending disability support groups, and speaking to service providers when they recognised that the parent was not coping and unwilling or unable to disclose their situation to formal support services. Service providers also spoke of extended families stepping in when parents were overwhelmed after receiving their child's autism diagnosis, and assisting with the management of the child's care and support needs.

Grandparents were also very important sources of support in cases where parents and/or children were born overseas and had not had the opportunity to develop social networks of their own. Staff spoke of parents from India and China arranging visas for grandparents who would come to Australia for three to six months at a time in order to take care of children while parents worked, or when parents had to attend appointments with a child with disability. Grandparents and extended family provided not just practical support, but also emotional support by being on hand to listen to parents, or to give parents some respite. Extended family support was not only important for helping families deal with challenging circumstances, but also for enabling parents to manage work or study by assisting with day-care/school drop-offs and pick-ups, giving parents the opportunity to extend their working hours, or enabling parents to cancel their child care arrangements for the duration of the grandparent's visa. These types of support were considered important for improving families' finances and overall wellbeing.

Although many individuals identified family support and connections as critical to helping families cope with and thrive in challenging circumstances, many also pointed out that family connections can also be a negative influence. Where parents are struggling to cope with the behaviour of a child with disability, grandparents occasionally added to parents' stress levels by attributing the child's challenging behaviour to poor parenting.

Social networks

Individuals' social networks were identified as critical to families' ability to cope and thrive in challenging circumstances. Having a network of friends and acquaintances to rely on was considered important for:

- promoting wellbeing;
- combatting isolation;
- sharing knowledge about support and services available; and
- helping families gain a sense of perspective if they are facing particular challenges.

Being part of a social network was regarded as critical for all families, but particularly for those who lacked extended family support, including recently arrived migrants and families who had moved interstate, as well as for parents with a child with disability.

Many of the service providers interviewed were acutely aware of the importance of social networks for their clients' sense of wellbeing and community connectedness, and their organisation made efforts to foster these informal social networks among their client groups. The promotion of informal support through formal mechanisms highlights the overlap between formal and informal support, with the former often operating as a springboard for the latter.

Parent-child reading groups for recently arrived migrants provided parents with opportunities to network by providing afternoon tea after the group sessions. Play groups more generally were regarded as key to helping individuals develop social connections with other parents on safe, neutral territory, which could be further developed outside of the organised playgroup. Maternal child and health services were also identified as a critical stepping stone for CALD clients, whereby staff might identify a socially isolated mother and work to provide her with opportunities to build a social network:

So the staff will take her to things, find people to link her with, and build her resilience. Some of that is helped by the service system but a lot of it is helped by women looking after each other.

The link between formal and informal support was brought into focus by another individual who commented on the vital role played by maternal child and health services in identifying a mother

and children at risk and linking her up to social support services. One traumatised and socially isolated mother was dealing with the recent death of her husband. As a result of introducing her to an organisation that runs play groups, this mother has developed social connections, and her children have begun to thrive:

She's linking in and she's talking about normal things, you know, she's talking about what's happening in the local community, what events are on that I could go to, you know, what specials are on at the supermarket – all those little things, those connections that she's making with other people – their daughter started talking again, so you can start to see how her being connected into the community, connected in with other people to talk to, and lift her mood which then impacts the whole family.

The nexus between formal and informal support was highlighted in another interview, in which the service provider commented on how her organisation attempts to promote clients' concern for other members of their community, particularly those who may not be linked in with any services:

We also talk about within the groups about looking out, what's happening in our local community? Are you seeing a neighbour that you know isn't home with young kids but we're not seeing them, you know? Are they not getting out? Would you like – you know, is there a way that you could invite them?

Service providers were also aware that some families managed to develop social networks outside of their organisation. Some CALD groups were recognised as working hard to develop and maintain social networks with other members of their CALD community, with some managing to successfully establish social networks through their children's school or day-care. Other comments included how parents from CALD backgrounds had the ability to identify others from their CALD group, and how their shared experience of migration/social isolation could positively influence their ability to access and engage these newly arrived families:

So someone will see someone at the shop, they'll recognise that they're from a similar culture and go 'Hey, we're going to this, why don't you come?' Often yeah, they'll turn up

at the group and they'll go 'Oh, I've brought a friend', which is lovely.

Religious churches, temples, and mosques were also seen as important community venues through which individuals could build social networks and strengthen their cultural identity. Faith-based networks, however, were also identified as potentially divisive if individuals held conflicting perspectives. Sporting events were also identified as important for CALD groups to make contact with individuals from other backgrounds.

Support groups for parents with a child with disability were also considered critical for promoting social connections and combating isolation, with interviewees commenting on how parents often maintained connections with other parents when they exited their service. Through these formal support groups, parents had the opportunity to listen to and learn from other parents facing similar parenting challenges:

Say a new family has a child with a really severe autism and the family is managing but struggling I guess emotionally with it, so the day to day running is fine but just accepting and it would be nice if they were able to talk to someone who has been in their shoes, so we might link them up.

7.1.4 Resources

A family's access to resources - financial, educational, and social – can make a crucial difference to how they cope with adversity. Education was mentioned by several service providers working in child disability support. It was noted how a parent's ability to conduct internet searches and process the information they found enabled them to pursue different avenues of support and better advocate on behalf of their child. On the other hand, some felt that education and finances alone did not always engender resilience in the face of adversity:

I think education and money help, however you can have education and money and fall in a big heap and be very vulnerable.

A number of service providers were eager to emphasise that it is individuals' unmet basic needs – housing, income, and food – that

made it impossible for families to cope with challenging circumstances:

Doing specific things for a child with a disability might rank low ultimately when you are trying to be housed and have employment and eat and sleep somewhere.

Having basic needs met was regarded as critical for enabling families to tackle the challenges they faced.

7.1.5 Strong communities

Having access to both formal support and informal social activities in the local community was considered crucial to enable families to thrive and do well – ‘when you have a strong community you have stronger families.’ Play groups which connected families with children were identified as a key building block in strengthening communities because they were free, accessible, and did not discriminate on the basis of language or culture. Community sporting events were also identified as important for building community cohesion. Facilitating informal gatherings in the community that people can ‘take ownership and run’ was also identified as vital for building social connections:

There’s a program that’s just started recently called ‘Open table’ and I think they have something like 200 people turning up and it’s – they’re lunches. So things like that really provide an opportunity for families to come together and also local festivals

Local churches were also identified as contributing to community building events:

There’s a local church community that every Wednesday they go for lunch, whatever food is left over people get to take food home, but it’s not just about the food, it’s about coming together, sharing stories, checking in on each other.

Organisations that adopted a place-based, community-building approach consulted with community stakeholders to identify what the community desired. They also trained individuals to become community leaders who help to build community cohesion and combat social isolation:

When you’ve got those happening in a community where on the weekend if there’s a mum in the shopping centre and someone sees

her, that’s great because every time they see her they’ll say ‘When are you coming back, bring your kids along to such and such’, and it just really makes her feel important.

Ongoing funding to strengthen communities was considered critical to improving overall wellbeing and helping families connect with formal and informal support that might enable them to cope better with adversity:

Then it’s not so much the individual characteristics at all of families. We can’t often influence that, but we can do an enormous amount about having a connected community.

7.2 Lessons – knowledge sharing

The positive deviance, strengths-based focus of this study sought to identify beneficial behaviours and practices that could be recommended and supported by service providers working in disadvantaged communities. Few of the organisations had formalised programs in place, but many made efforts to share ‘success stories’ informally.

Mentoring programs were identified as empowering and strengthening practices that could help families navigate service systems, adjust to parenting a child with disability, and give young people with a parent in prison a reliable and committed adult to contact for support and advice.

One organisation had a formalised mentoring program with established mentoring relationships between trained adult mentors and children aged between eight and eighteen years who had a parent in prison. The program runs for a 12-month period and aims to give children and young people a buddy, role model and mentor to help them to overcome some of the challenges they face. The service provider was eager to emphasise the positive impact that the mentoring relationship had for many young people who might otherwise have struggled to overcome the adversity they faced as a consequence of having a parent in prison:

And there’s many examples of kids who have continued with school, got on with life, ended up in university, ended up getting full time jobs, even though mum or dad’s gone back to jail a few times. They’ve got on with life.

A service provider working in child disability support referred to the benefits that mentoring could bring to many of the families she worked with. She spoke of many families she had known over the years who had struggled to cope with their child's disability diagnosis initially, but were now coping well and their child was thriving. Despite not having a formalised mentoring program in place, this service provider explained that many of these parents were willing to speak to other parents who were dealing with similar issues. Yet, she was aware that individuals who offered to mentor would benefit from training, so that they did not present to struggling families as having all the answers:

Sharing of experience more like having them as a resource. Not having them in their ear all the time but it would be 'Would you mind if I have a question that I give you a call?' Having that as a resource would be really valuable.

This service provider thought that mentoring relationships were likely to evolve through the social activities her organisation offered for families in their local area. However, the interview prompted her to think about how mentoring could be offered to families in a more formalised way.

A service provider working in a child and family resource centre also described an informal mentoring system they facilitated. The centre offered advice and support concerning children's developmental needs and any other issues families might be struggling with, such as housing, enrolling their child into mainstream schooling, or connecting with other groups or services in the community. A large number of their client group consisted of refugee families. The informal mentoring program that they facilitated developed from observations staff had made about 'key welcomers' which they identified among the clients attending their service. Not only was this informal mentoring support regarded as beneficial for the mentee, but it helped build the confidence of the individual invited to become a mentor:

We look for the people in the group who are the key welcomers and who are the key people who have strengths and confidence that they can

share with other people... So then after groups we will talk with those people and say 'Look we saw this. That was fantastic today. Would you be able to share that with such and such next week, because they have a similar journey and we think that your story would help them?'... So it's just sort of upskilling them and building their capacity and helping them to develop those relationships and share their strengths and their successes.

Another service provider in a multicultural community centre noted the importance of sharing 'success stories' with families facing trying circumstances. The service did not have formalised programs in place, but staff were conscious of trying to share these success stories wherever possible. Sharing these success stories was not simply geared towards assisting people navigate service systems, but it was also an attempt to convey messages of hope in that some individuals' circumstances do improve:

There's definitely lessons about seeking support but there's also lessons about, 'It can get better'... Things being surmountable, things being, 'You can get past this' and breaking it down into a sense of '...and here are the steps to get there', so actually making it more practical and achievable.

Facilitating informal knowledge sharing between families was another intentional strategy employed by play group facilitators in another organisation. Their knowledge of the families who were doing well and those who were struggling enabled them to identify the parents that could support others:

Some families will be doing better than others, so you might then facilitate those informal discussions about, you know, 'How do you get through the week? What is it that you do differently that others don't do that's affordable? Is it about, you know, are we going to the park, are we using some of those free services that are out there?' So it's about really us as workers I think facilitating some of that.

7.3 Services' responses to family needs

More work is needed to allow communities to identify protective practices. We do not know to what extent the strengths of the communities can be attributed to the services in the area, and we did not evaluate the outcomes of services. Nevertheless, the views of practitioners on the challenges faced by families, and their responses to these challenges, provide insights on the resources available to families in these communities.

When asked to identify the key challenges facing the families in their community, the responses covered a range of socio-economic issues that are often a consequence of living in circumstances of poverty and disadvantage. These included the challenges of finding suitable employment and the resultant lack of income, housing insecurity and housing affordability, transport difficulties, drug and alcohol use, inadequate transport services, domestic violence, and poor mental health. Not all of these issues were identified as problematic in all communities, however, and individuals' responses often depended on the type of organisation in which they worked and the specific needs of their client group.

7.3.1 Ensuring accessibility of services

Awareness of services

All services explained that families needed to be aware of the existence of services in order to engage with them. Awareness of the different types of services and how to access them was reported to be particularly important for families from CALD backgrounds. One service participant explained that '[Families from CALD backgrounds have] been put out into the community with their young children and don't know how to access services'. A lack of knowledge about how the service system operates was noted as a challenge for many CALD families:

You've got to let them know to go to a local doctor to get that verified because if they're staying here and their kids are going to go to school we need some sort of verification from the right places that the kids have got some

immunisation status ... So that's an important thing that we're regulated by here as well.

The importance of providing service referral pathways, including raising families' awareness of available support services, was also reported by a childcare provider. In this service, the staff member explained that families of CALD backgrounds, particularly families who have recently arrived in Australia, are being referred to council playgroups and need support in registration processes, for example completing the correct forms and submitting these at the council chambers in time for enrolment the following year. The interviewee explained that these 'little things' can have a significant impact on the accessibility of the services as most newly migrated families are unaware of their existence and the processes involved.

Newly arrived migrants, particularly those who have recently left a detention centre, may experience precarious migration and residency which in turn can affect parents' ability to gain employment, secure housing, and gain access to health care. One interview participant explained that efforts to move families out of detention and into the community can result in families feeling unsupported.

You've got these families who aren't entitled to welfare benefits, who aren't entitled to Medicare, who are then living out in the community, not supported, separated from all the people they were living with, but their community within the detention centre is gone.

Within the alcohol and other drug (AOD) sector, English language comprehension and acknowledgement of drug-related issues were identified as specific challenges in engaging CALD families. A staff member explained that to overcome language barriers, services utilised interpreter services, or staff who spoke the language. Yet, an unwillingness to acknowledge drug-related issues in some CALD communities presented a bigger challenge in engaging some CALD groups.

For another service, moving into outreach models of service provision was also thought to be important. Being physically separated from the council building could increase awareness of the service's existence, and it could service other parts of the service catchment.

Acceptance, engagement and communication

Another challenge facing families was the ability of services to effectively communicate with parents. This was a particular challenge for child care services who often only saw parents very briefly during drop-off and pick-up times. Given the small window of opportunity to engage parents, communication was identified as vital because if families are 'willing to share their stories or their problems so that we are aware of it we can refer them to places'. In addition to language barriers impeding on communication, a staff member reported that for 'some of the cultures, they don't like to give too much away or actually if we're identifying things it's actually putting stress on them as far as things we've noticed with their children's behaviours'. Given the importance of engaging and communicating with families, the above service had extended their operating hours and ensured that staff who could speak languages other than English were available to families.

Wider societal issues, such as recent terrorism threats, law changes and negative media coverage of Arabic-speaking Australians, were seen to create service-level challenges, particularly in relation to engagement and community acceptance of services. In the following example, a practitioner describes how recent socio-political influences created specific and significant challenges for linking newly-arrived migrants with appropriate services. The staff member explained that CALD families, particularly those from the Middle East, were grateful for assistance, however, he also explained that many feel disconnected from mainstream Australian culture:

'I'm not understood. My value systems are not necessarily being accepted here... We work with a lot of Muslims and some of them really do feel that there's a real disconnect between 'Team Australia' and then the other populous critique of whether they are welcome or not'.

Trust

The level of trust that families had with services was also explained in terms of challenges that families face, particularly for those newly arrived CALD families who may have a different experience liaising with services in their

home countries. A practitioner explained that families from CALD backgrounds often come to their service for practical matters first. One family, for example, was confused because a 'government man in whatever agency is giving me a hard time, I don't understand why. You guys seem to have the expertise; can you give me a hand with this?'. Once the service has been able to assist with these practical matters, a relationship is built with the family and 'then there's a very strong sense of 'Okay, this is somewhere that I can come to when things get overtaking'. Building trust with families was also reported to be important in reducing any cultural misinterpretations. For example, newly arrived families often perceived encounters with officialdom as 'standoffish and unengaging', but improved communication could help these families understand that agency staff are not deliberately unfriendly, 'it's just that they have a million people to see and they're trying to make sure that they give a thorough job which can at times feel a little mechanical'.

7.3.2 Responding to the needs of families from CALD backgrounds

English as a second language

Overwhelmingly, a major challenge identified across all services was language barriers for families where English was a second language. Language skills were perceived to be vitally important for engaging families with services and subsequent family outcomes. One participant explained 'I think it's incredibly difficult to access social networks, services and to be able to speak with a service provider [when you do not have the language skills necessary]'. In another service, language barriers and culturally appropriate service provision were seen to be particularly important for engaging newly arrived fathers in appropriate services relevant to their needs. For one service, language was identified as a barrier that may prevent fathers with limited English in knowing about, accessing, or engaging with services. The staff member explained: 'we've had a couple of guys that have come along and sort of hung around for a day and then [we] realised that they're just not getting a conversation'. However, in this example, the service was a men's shed, which was initiated

to bring men together to talk about male issues, and engagement was also described in terms of cultural appropriateness. For example, one of the most common conversations in the men's shed was about prostate cancer, which the service provider also noted may not always be a culturally appropriate conversation for some men from CALD backgrounds.

Non-recognition of overseas qualifications

For a number of CALD families, university and other educational qualifications gained in home countries were not recognised in Australia, and many were required to undertake further training in order to use their qualifications. For one service, this delay or lack of recognition of international qualifications created challenges for newly arrived CALD families finding suitable employment. Lack of recognition of international qualifications was also identified by another service provider, who explained that the service intended to focus on employment pathways for newly arrived communities and asylum seekers in the coming year.

Support to overcome language barriers

Many services went to great lengths to assist families with limited English proficiency. These service-level strategies included: changing the operating hours of the service so that parents could attend language courses, assisting families when speaking with other services; employing a culturally appropriate workforce; using community members and parents for translation; and using external translators.

The most common strategy used by services for communicating with CALD families was the use of external, professional translator services. In one council service, a staff member explained that council interpreters or external interpreters were used to assist in communicating with CALD families.

Another service reported occasionally having to rely on other clients to assist in situations where they needed a translator. This was a strategy employed by services with limited funds for employing professional translators. Although cost-effective, drawing on community members to translate on behalf of other clients was not always ideal, particularly if the issues being discussed were of a sensitive nature. Occasionally, however, given that some of the issues facing families were

pressing, such as needing to pay a bill, drawing on community members to translate was utilised as a last resort:

We've had times when other people in the waiting room have volunteered to assist but that's obviously far from best practice. But when a bill needs to be paid that day, there are limits to what we can do.

Employing a CALD workforce was another strategy employed by services to accommodate their CALD client group. A childcare manager explained 'we have a lot of children who start here that they can't speak English. So a lot of the [staff] are able to talk to the children throughout the day in their home language'. Assisting families where English was a second language was also reported to be crucial when speaking with other agencies and services, and with assisting clients to complete government forms.

Another strategy employed by one service to accommodate their CALD client group was to change their hours of operation so that the parents of the children utilising their service could attend language classes. The staff member explained 'in our community, because it's very multicultural, a lot of them are trying to do English courses, so [we find we are] trying to find care for those shorter hours which they usually come across us with'.

7.3.3 Responding to social and economic exclusion

Inter-generational impacts and challenges

Some of the challenges facing families were described by service providers as being inter-generational. For example, a mainstream service provider on the NSW North Coast described how colonial history and generational loss negatively influenced the ability of this service to engage families of Aboriginal descent. The staff member explained that the location of their service 'was a penal colony in history ... so a lot of families in those days were dispersed out from [the local area] ... There is that generational loss and grief that is a challenge with Aboriginal families utilising non-Aboriginal services'.

A service provider who works with children and families where a parent had been incarcerated noted how the experience of incarceration was often inter-generational and that these children

were at greater risk of ending up in prison compared to other children. Indigenous children in these families face an even higher risk. The challenges faced by these children included stigma, shame, isolation, fear, confusion, grief, loss, and withdrawal from education.

Inter-generational influence was also identified as a challenge for families in AOD services. The use of drugs and alcohol as coping mechanisms serves to normalise their consumption:

People have been using a substance, that's what dad did, that's what grandpa did, so some of the things that they're doing are quite normalised within the family ... So it's about how do we break that cycle when it's so entrenched within the family.

Cultural norms and values

Another challenge identified by service providers was differences in cultural expectations, particularly with respect to the discipline and punishment of children. This was particularly challenging for staff working with CALD communities in which corporal punishment was acceptable. Overcoming the issue with these families was recognised as demanding a great deal of sensitivity:

So [you are] trying to actually build enough trust with someone that you will have an open and mutually respectful discussion ... So that does set a very high par in terms of building connection with families.

The same staff member also explained that at times their service may need to make a child protection report. Staff therefore needed to ensure that the family understood the service provider's statutory responsibility and that the service would seek to work with the family:

We give the family a rough idea of the level of risk that we perceive and what we're recommending the [statutory child protection agency] take action ... [So] you're actually creating a nurturing environment with your own children, where everyone wins and also where you're not feeling like you're being bossed around by busybody white folk.'

Differences in cultural expectations were also evident between families and services with respect to issues of domestic and family violence. A service provider explained how

difficult it is for services to be aware and respond to these issues in CALD communities, and recalled a particular instance where a newly arrived mother visited the service with a black eye, but was unwilling to disclose any details. Another example concerned a child who injured his toe by accident at a day care service and the parents' subsequent reaction to the incident. The family were enraged and accused staff of mistreating their child because he was black. The staff member felt that these parents' experience as refugees may have influenced their reaction:

But looking back where these families have come from if you realise they've come through the camps and things like that or – you can kind of relate to why their behaviour is so overprotective.

Social isolation and exclusion

Services working with newly-arrived migrant families or families that have moved inter-state identified social exclusion as a major issue for these families due to their lack of social networks and family support. Engaging families from cultures where families are expected to source support from within their extended family rather than from external formal support systems was identified as a challenge by some services. Many young CALD people were, for example, sometimes accused of betraying their families if they sought assistance outside of the family:

There's a lot of resistance from the family because 'Hold on, you're now not only attacking your cultural expectations, you're attacking us as individuals you're meant to value'.

Services working with families of children with a disability highlighted how a great number experienced exclusion and isolation from families with typically-developing children.

Homelessness, housing stability and overcrowding

Housing and homelessness were identified by many services as key challenges for many of the families they worked with. Keeping appointments for treatment was identified as a challenge for many homeless people in need of support for AOD use. Housing instability directly influenced care arrangements, and could also influence child protection decisions

about whether or not to remove children from families. Parental incarceration also resulted in housing instability and had a negative impact on the overall functioning of families, resulting in 'major upheaval' if children have to move house or school, and may result in loss of contact with friends and other family members. These issues also serve to create further social isolation and stigma. One staff member explained:

Families can be turned upside down when the primary carer ends up in jail. So who's going to look after the kids? What's the care plan arrangements? So sometimes kids have to live with another relative, they might have to move address, they might have to - they might lose their pets, they might lose their school they were attached to ... You know, more likely to be disengaged from school.

Racism, stigma, and shame

Across all services, racism, stigma, and shame were described as specific challenges that could lead to further social isolation or exclusion. For example, a family from a CALD background had a child with autism who had been excluded from another service-based childcare arrangement. Shame and exclusion in this incident were spoken of in terms of fear of rejection from the community. Within this service, support was offered so that the child could attend the centre and be 'genuinely included and actively participate. Not just attending and sitting on the side'. Stigma and shame were also identified as common among families experiencing problematic drug use.

Some services working with families from CALD backgrounds reported that most experienced racism at some stage, something that was deemed a 'familiar migrant experience'. Other service providers identified racism and its negative impact on families, particularly with respect to the current racial profiling of 'the war on terror'. As this profiling has identified Muslim people as a threat, the service provider explained how Muslim women 'are more reluctant to get on a tram and come and see us particularly if they don't know us. If they have already built a relationship then that is different'.

7.4 Conclusion

A family's access to basic resources – stable housing, income, and food – is a critical starting point. If a family is struggling to meet basic needs, it is almost impossible for them to cope when faced with additional adversity.

The importance of informal support from extended family and from individuals' social networks were also noted as critical for many families who were trying to cope with challenging life circumstances. When families could draw on these informal support systems, they were better able to cope with adversity and less likely to rely on formal support systems. At the same time, however, even with strong informal support networks, access to formal support that could provide specialised advice and expertise was critical for many families dealing with adversity.

Many service providers, however, worked with client groups that often lacked informal support systems as a consequence of migration and exclusion. CALD families, families of children with disability, families where a parent is in prison and families in which drug and alcohol use are problematic often lacked these informal support networks or were shunned by family and friends. For many of these families, the formal support system replaced the informal support that they traditionally might have relied on. For families struggling to cope with challenging life circumstances, engagement with the formal support system provided a range of benefits. These included improved parenting skills, improved life management skills, an improved ability to overcome problems, greater knowledge of the service system, greater opportunities for personal development, and the development of a wider social support network. Gaining access to formal support services was seen as particularly important for socially isolated families who were often subsequently linked in with other formal and informal support. For many socially isolated families, engaging with the formal support system was essential to unlocking opportunities for developing informal support networks. Although movement from formal to informal support networks operated in both directions, it was more commonly reported that formal support systems

were the springboard for developing informal support systems.

Service providers also identified a number of family practices and characteristics which contributed to families' wellbeing. These included: having family values, rituals, and routines; parents' relationships; and parents' attitude, mindset, and traits.

These findings support the importance of ongoing funding for identifying and measuring the effectiveness of community strengthening projects, and sufficient resourcing of those which are successful. Strong communities can struggle to emerge without social investment, particularly if communities experience population shifts into and out of the community.

From their experience of working with families dealing with challenging life circumstances, these discussions with service providers provide some insights into what factors, behaviour, and support help families cope with adversity. Nevertheless, all of the service providers recognised that there were many families in their LGA that managed to cope and thrive without the need to access formal support services. This study shows that there is scope for undertaking further research which adopts a positive deviance framework. Rather than exploring why families are struggling, it is important to explore what helps families thrive and do well when faced with challenging life circumstances and to translate the lessons learned into practical resources.



8. Findings: parents who use drugs and parents with mental illness

This section reports the findings from thirteen qualitative interviews conducted with two sets of parents who share characteristics associated with a high risk of child maltreatment (see Section 4.3). The two affinity communities selected for study were: parents with mental illness and parents who use drugs. Organisations working with parents with mental illness and parents who use drugs were asked to circulate a flyer about the research in which interested participants were asked to make direct contact with the researchers. This arm's length approach, in combination with snowball sampling, yielded 13 participants, comprising eight parents who use drugs and five with mental illness. The interviews were conducted by phone between April and June 2014. In the interviews, parents were asked about their experiences of raising children and family life. We included questions about sources of information and support, typical family routines and parenting practices, and routines and practices around managing drug use and mental illness.

8.1 Communication

Overwhelmingly, all parents described the importance of open lines of communication between themselves and their children about drug use or mental health issues. This open communication was perceived to be an effective practice that positively influenced the functioning of the family. As there were differences between the drug use and mental health cohorts with respect to the nature of the conversation and the age at which these issues were raised with their children, communication as a protective practice will be discussed separately for the two groups.

8.1.1 Communicating with children about mental health issues

All parents in the mental health cohort spoke of the importance of open communication about their illness with their children and for some, this communication was perceived to be the difference between their family and others in similar situations who may not be doing as well. For example, when Amy was asked why she thought that her family may be doing better than other families in similar situations, she

stressed that open lines of communication within the family unit was very important. This open communication was seen to create a shared understanding of Amy's illness within the family whilst also creating opportunities for the family to be involved in the management of Amy's illness:

I think the communication [is a strategy that we use in our family] that we talk a lot about what's happening [...] I try and let everyone know like what my psychiatrist has said and what the plans are and you know if there has been a change in my medication (Amy, 48 yrs, mental health cohort).

Kaden also highlighted how open lines of communication about his and his wife's mental health illness was a particularly important strategy used in their family. Like Amy, Kaden explained that open communication created a shared understanding of his illness. Interestingly, Kaden also identified that his communication was a response to the lack of communication he experienced from his parents as a child. Kaden explained:

We grew up in [an] era, where the parents are parents and the children are children, you are not as a unit. So we as a family now discuss everything as a family and encourage our children to understand and talk about mental illness [...] If you are trying to hide it away from the children, the children are like a piece of paper with nothing written on it, you've got every excuse to write on that piece of paper, it's how you write on that piece of paper (Kaden, 45 yrs, mental health cohort).

Caroline also spoke about the importance of communicating with her son, and gradually imparting more information as he grew older:

My oldest boy is extremely bright, he is really bright, he is very perceptive, he's very emotional, and he knows stuff going on. So I think gradually, up until just recently it's always just been daddy is sick, mommy is sick but I am very gradually changing the terminology and talking a little bit more about it [...] I need to kind of get my head around how to discuss that with him in a way that's appropriate. [A support service] have a DVD, which I have just got my hands on that I am going to watch to have a look at to see, like I am learning about these resources now (Caroline, 40 yrs, mental health cohort).

8.1.2 Communicating with children about drugs

Similar lines of open communication were highlighted as important strategies by parents who used drugs. Parents emphasised the need to be honest, and to increase the type and amount of information they shared with children as they grew older. For example, Kristen spoke about the importance of open communication about drugs with her daughter, and how she believed that this educated her daughter about drugs and the harm they can cause. She also felt that this communication was important for ensuring that her daughter and her friends would feel comfortable discussing these types of issues in the future. Kristen explained:

[My daughter] really understands that drug users are people but she also understands that drugs do ruin lives so you know, it's not that she's, me being open and honest with her doesn't at all mean or look like she's going to go and use drugs any time soon. (Kristen, 33 yrs, drug use cohort).

Kristen also explained that creating open lines of communication was not always easy, and that using communication as a strategy required some effort and took some time to develop. Kristen explained:

Yeah [it was] a very tricky conversation, it didn't happen just in one conversation though, she tested the waters a bit to see if I was going to be honest with her, I think, and so it happened over you know a couple of weeks.

Most parents in the drug use cohort also spoke of a lack of communication in relation to drugs with their own parents or family members, or for other families where there was no drug use. This absence of discussion was something they were consciously trying to change within their own family. Chris explained:

I think the only difference is usually you get a little bit more communication. I really believe that, I think there are some really uptight families out there that are very straight and narrow but they don't talk to their kids and their kids are prohibited from doing everything, even asking about everything (Chris, 43 yrs, drug use cohort).

8.2 Cohort specific practices and strategies: drug use

8.2.1 Parenting identity

All parents who used drugs described themselves as parents first, as opposed to identifying as a person who uses drugs and has children. For example, Chris explained that 'I am very much a person that believes that you know just because you are a user, doesn't mean that you are a bad person and it doesn't mean that you can't parent in a good and positive way'. For Phillip, parenting was described as a greater part of his life than drug use, but he was also aware that his drug use would become a sole identity for some people. Phillip explained:

I consider being a parent more a part of my life than drug use is. I get far more as a parent than as a drug user and if you are going to label myself as kind of one thing, but it's just one, just as parenting is just one aspect, I also think I am just an individual person. I mean there's so many identities there but unfortunately if you mention drugs, that becomes the sole identity in so many different situations (Phillip, M33, drug use cohort).

Kristen believed that there was no difference between herself and a mother who did not use drugs, and she also stressed that the love you have for your child was the most important factor. She did acknowledge, however, that societal constructions of people who use drugs had created a level of judgment that she believed was not imposed on other parents:

I understand that I am a person, I am not just a drug user, I am a mother and I am all these other things. I actually hate that I get put into the category of drug user and nobody ever talks about the other, bigger parts of my life ... I don't think there is a difference between me and the next mother. ... The only difference comes to how the rest of the world sees us, like if I was to come out that that's what I did in my spare time that's what the difference is. I would lose my kids or yeah they would look down on me and my children, my children would suffer as well so I have to hide what I do (Kristen, 33 yrs, drug use cohort).

8.2.2 Choosing when and what drugs to use

All parents in the drug use cohort were on opiate substitution treatment (OST) programs. The ability to use illicit drugs therefore involved significant planning and awareness. Alannah explained 'using heroin is something that needs to be quite planned you know, kind of starting the day or two before so you can have a shot and feel it'.

Phillip and Alannah also described the influence that the choice of drug could have on effective family functioning, especially the negative influence that the use of amphetamines would have on their stability and subsequent parenting capacity. One adopted strategy was the avoidance of amphetamines, because of their impact, in part due to the long duration of intoxication and hangover:

When we have been using say amphetamines, which we try and stay away from now because we just can't function as a parent as we would like if we've been up for two nights. The few times that it has happened where we've pretty much had to you know take like two or three hour slots of one of us sleeping and one of us with him and then swap over to try and get through that come-down (Alannah, 37yrs, drug use cohort).

8.2.3 Not using drugs in the presence of children

Although all parents in the drug use cohort spoke of age-appropriate communication with their children with respect to drugs and drug use, all of them also discussed strategies to minimise their children's awareness of specific injecting episodes, for example by not using or injecting drugs in front of their children. The practices used by parents when not using drugs in front of their children also changed as their children got older. For example, when the children were babies, parents explained that they were probably 'more relaxed about sort of using, only when he was a baby and wasn't sort of like, couldn't have been aware of anything' (Phillip, 33 years). As children grew from babies to toddlers, parents commonly spoke of using drugs in other rooms, such as the bathroom, so as to minimise any awareness of their drug use

by their children; and waiting until children were in bed or out of the house.

Sue and her husband John spoke of using another room when their daughter was young; however, this strategy had lost its effectiveness as their daughter grew older and this practice of concealment had created some stress. Therefore, Sue explained that the main strategy that she and her husband John used for minimising awareness of drug-use episodes was to distract their daughter when these episodes were taking place. Sue explained:

Look we've tried to normalize it really, as much as possible. We don't inject in front of her but we you know, I don't have any shame around it and one of the things we discovered was when we did things like lock ourselves in the bathroom that that actually created a lot more stress than you know a casual thing. But we kind of use a strategy of distracting her so one of us will do something and the other one distract her, yeah. So while [my partner] is fixing up I might go in and play a game with her, watch a movie with her (Sue, 49 yrs, drug use cohort).

For Kristen, identifying times when her children would not be home, such as when they were staying with friends, was an important practice that she used to minimise her children's awareness of her drug use. Kristen also explained that she thought this was appropriate because she was using drugs in her own time, which she equated as similar to those people who may go out on the weekend and have a social drink. Kristen explained:

I do it in my time so you know if they're at a friend's place for the night or yeah at their aunties families house or anything like that, that's my time and instead of going out nightclubbing I'll go out and you know take some drugs and sit at home and clean or watch a movie or do whatever so yeah (Kristen, 33 yrs, drug use cohort).

8.2.4 Storage of injecting equipment and drugs

Parents who used drugs also explained that it was common to be extremely careful about where they would store their injecting equipment and OST. They explained that drugs and equipment were kept in locked cupboards or

rooms, which were not accessible, or within reach of their children. This practice was explained in terms of ensuring the safety of their child, as well as minimising awareness of drug use within the family unit. For example, Kristen explained 'yeah I have got a place at, I've got like a kind of walk in robe and it's got a very high shelf that is really unreachable and I keep it in a box up there and that's under all of my bags'. Other parents talked about storing drugs and equipment in medicine cabinets and locked boxes which are stored out of reach.

8.2.5 Separating time with children from time with friends who use drugs

Parents who used drugs were particularly selective about who could come into the family home or what sorts of drug-related environments they would visit with their child. The practice of screening people who may have contact with their child appeared to be particularly relevant in relation to ensuring the child's safety and wellbeing. For example, Kristen explained that a rule she had was that she would never take her children with her 'to drug dealer's houses or anything like that' (Kristen, 33 years). Chris also described how he minimised contact between his children and the wider drug using scene by implementing strict rules about who could visit his house, and the times that people could visit. Chris explained:

I'd have like pretty strict rules about like who came to the house, times that it was ok for me to indulge in that sort of use and other times when it wasn't. I'd have like a fairly strict, like I just made rules for myself ... I had a couple of close friends that we'd use together sort of thing and I would just get them to run around for me so I wasn't running around with the kids. And not having like all-weekend parties at the house like I have seen, it didn't really happen for me that way you know (Chris, 43 yrs, drug use cohort).

8.2.6 Passing strategies, and strategic and selective disclosure

Parents who used drugs commonly reported the need to 'pass' as a non-user, or blend in, so as to not disclose their drug use to other people. This passing was spoken of in terms of a number of different environments where parents would consciously attempt to hide their

drug use. The importance of hiding drug use was particularly relevant for Liz who said, 'I still can [pass], nobody would know. If I had my sleeves down, nobody knows I am an injecting drug user, [and my children] weren't singled out as having that junkie mum' (Liz, 55 years). Chris also highlighted how no one at the school his children attended would be aware of his drug use:

I can tell you now that all the parents from the school, no idea, no idea whatsoever. And they just thought I was a lovely young man and you know I used to have mothers coming up to me and going ah you know we think you are doing a great job with your kids (Chris, 43 yrs, drug use cohort).

However, when Kristen was asked during the interview whether she would use passing as a strategy, she questioned how people would be able to discern between people who used drugs and those that did not:

I don't know, it's as if you are talking your stereotypical, how the media portrays users, I just think the majority of drug users look like everyday people (Kristen, 33 yrs, drug use cohort).

The ability to pass was not identified by parents in the mental health cohort; however, this did not mean that these parents felt comfortable disclosing their mental illness to anyone. Rather, within the mental health cohort, a type of passing could be seen whereby parents used selective and strategic disclosure. Kaden explained:

Because our family dynamics with mental illness is not publicized at the school, so the rest of the school don't know about it but if they do, I always said to them you just say there is nothing to hide (Kaden, 45 yrs, mental health cohort).

8.2.7 Access to take-away doses of opiate substitution treatment

All study participants in the drug use cohort were on an opiate substitution treatment (OST) program, and all parents explained that OST gave them the ability to stabilise their opiate addiction, and therefore not go through opiate withdrawal. As a result, OST was explained in terms of being able to be more effective and constant in the family

environment. More importantly, the provision of opiate substitution through take-aways, i.e., where participants would be able to collect a week or more of OST and therefore not be required to attend a dosing clinic daily, was identified as crucial in maintaining family and employment responsibilities. Phillip highlighted the importance of OST in terms of the parental responsibilities and creating a stable environment for their child:

It makes a HUGE difference ... Honestly you know, I sometimes think about single mothers and people that and actually not even single mothers, but single fathers as well but, yeah but parents that have kids, especially to be honest young kids, that have to dose daily and I just sort of think I don't know how they do it? (Phillip, M33, drug use cohort).

8.3 Cohort specific strategies: mental health

8.3.1 Acknowledging and accepting mental illness

Within the mental health cohort, all parents emphasised the importance of acknowledging and accepting mental illness, both for the individual and the family as a whole. This acknowledgement was perceived to create a better understanding of a person's illness. For example, Amy explained that it was her 'self-awareness that is important as well because I think people with mental illness they do try and ignore the symptoms as long as they can because they want to function as long as you can'. In describing how important acknowledging illness was in the effective functioning of her family, Amy highlighted how this acceptance had changed over time:

I suppose the recognition that I do have a mental illness, because like those first few years, particularly when the girls were young, I didn't want to acknowledge it so you know we quite often had quite severe mood swings but that doesn't really happen now (Amy, 48 yrs, mental health cohort).

Caroline also described how acknowledging her illness created awareness around her health issues and this awareness made it easier 'to cope'. Interestingly, Caroline also explained that

learning how to cope with the ups and downs of her mental illness was similar to parenting. Both involve learning through experience, accepting fluctuations and change, and knowing that there will be good times and difficult times:

Yes [acknowledging my health issues] made a huge difference... Well once you, it's the old saying that when you give the demon a name you have power over it, you have acknowledged it, you are aware of it and then you can do something with it or do something about it ... For you to cope with your mental health, your knowledge of it, your coping with it, it fluctuates, it fluctuates according to what's going on in your life, it fluctuates to your own health. Parenting is the same thing, you know you learn from experience, you know you have good days and you have good years, you have bad days and bad years and somehow you have to cobble it all together and then just survive and know that it's not necessarily never-ending or yes this is always going to be the case in some situations, but how you manage it and how many good days and bad days there are (Caroline, 40 yrs, mental health cohort).

The power of acknowledging mental health issues was also highlighted by Kaden, who identified that this acceptance helped in living with, and managing, mental illness. Furthermore, Kaden also highlighted how this acceptance was not an individual process but one that his whole family had acknowledged:

It comes down to the things that I found is acceptance and not discharging mental illness away from the family and accepting that it is a part of the family and learning how to live with it and manage it, not try to erase it (Kaden, 45 yrs, mental health cohort).

Kaden also described how the acknowledgement of his illness had led to practical strategies that he had developed through discussions with his family and his GP that helped him to manage his mental health episodes:

I have a threshold that I call it a silo effect – if my mental stress goes to a high percent I go and see a GP, so it doesn't escalate to out of control [...] when I start to get to my breaking point,

that's when I start like seeing professionals and that sort of thing but before I even get up to there I always talk to my family and my wife.

Like Kaden, Amy explained that when she had acknowledged and accepted her illness, the ability to identify and respond to symptoms and triggers was more easily managed. For example, Amy highlighted that when a child is born, most people focus on the child and therefore the needs of the mother may go unnoticed, or a mother may be unwilling to indicate occasions when she was not coping for fear of being judged:

The most important thing is that you know your triggers and you know the symptoms of your mood changing and get people who are around you to be alert to those things; like your partner and other people too that they are all in tune. Sometimes when you first have the baby it's, everyone is concentrating on the baby and they forget about mum and then you sort of add the mother, you need to be showing everyone you are coping even though in your inner world you are not coping because everyone thinks you should be coping because you have just had a new baby (Amy, 48 yrs, mental health cohort).

After having acknowledged and learned to manage her mental illness, Amy explained that she would be more likely to use strategies such as admitting herself to hospital earlier than she would have before, explaining:

I suppose I would probably go into hospital earlier than I needed to. When before I would probably wait until I was sort of in crisis but now I would go in earlier and I think, and we generally make that as a family decision that it's probably better to go in now (Amy, 48 yrs, mental health cohort).

8.4 Ability to draw on personal resources

The parents in this study were quite different from those often recruited to child protection, drug use, and mental health studies in that the majority were university educated and in full-time employment. These educational and financial resources were identified by all as a major influence and contributor to their capacity to parent well.

8.4.1 Education and knowledge

Most parents in this case study sample were university educated, and all described how this was an influential personal resource that could be drawn upon to increase effective family functioning. For example, Amy described how her education and employment as a nurse enabled her to navigate the health system, and made her aware that 'the family should be looked after and I didn't want there to be disruptions in their lives'. Caroline highlighted that she and her parents were university educated and this as well as Caroline's employment within a health care system were important resources that she utilised when navigating health systems in relation to her own mental health issues:

I have access to things that people don't ... Professionally I know where to go and how to do this stuff and it's easy for me because I've got professional skills to help me to do that and I've got links to go. But I think it could be quite difficult if you don't have those kinds of things (Caroline, 40 yrs, mental health cohort).

Liz also explained how she and her family were university educated resulting in her feeling included and able to participate in society. Liz explained:

Well look, I was brought up by two middle class, upper middle class parents who you know I had brothers and sisters, I went to school, I was educated. I felt I actually felt included in society but chose not to [conform to class norms] and I think that makes a huge difference (Liz, 55 yrs, drug use cohort).

8.4.2 Employment and financial capacity

The families all had at least one parent working full time, and all the participants identified this employment as important for enabling a positive and healthy environment for their children. For example, when Liz was asked about the main challenges parents who use drugs faced, she responded that structural barriers, such as poverty, were critical:

*'Money. Just money. A lot of this s**t wouldn't happen, it really wouldn't. A lot of it is about poverty.'*

The families in this study viewed themselves as mostly financially secure. They also explained that financial stress was an issue that many families need to manage, regardless of whether or not they use drugs or have a mental illness. Sue, for example, explained:

Money, issues with money, that's been the worst, the hardest thing... I kind of talked to some normal parents and kind of got a bit of relief in that way... being able to talk to other people who didn't have that same stretch on their income for them to say 'mate we've all got limits, we can't do everything' (Sue, 49 yrs, drug use cohort).

The importance of a family's financial capacity to meet the everyday cost of living, such as housing, food, and basic utilities, was identified as critical for managing what could otherwise be stressful life circumstances. Many recognised that financial insecurity was detrimental to individuals' mental health and were relieved that they did not have to deal with this additional stress:

I think the thing that you are looking at is striving, living and striving with mental illness, it's the lack of what they call a system in not just in day-to-day living but housing and food and utility... There's not much out there so you know I am lucky in the way that I have got a full time job and be able to support my family, but there'd be a lot more families out there that is in a situation that is not better than I am and how do they cope and you know, financial burden and the ability to support the family and the additional stress that contributes to the relapse or ongoing mental health (Kaden, 45 yrs, mental health cohort).

Amy also described how her capacity to pay for casual housekeeping duties, such as cooking and cleaning, were important for maintaining stability for her family and for allowing her time to recover:

If I have to go to hospital for a period of time, we do hire a cleaner... I just try and, what I try to put in place is things that won't, so that the children's lives won't be distracted or messed up because of my illness and I try and keep it like a neutral ground like everything's the same, like the housework is done, washing and ironing is done and the house cleaner will even cook the

meal at that time ... It just seems to take a lot of pressure off me that there is someone actually being able to help just keep the house running (Amy, 48 yrs, mental health cohort).

Alannah also recognised that having full-time employment and an income were critical for maintaining a positive home life and she felt that people on benefits were more likely to struggle. Yet, in spite of their relative financial security, both Alannah and her husband still had to juggle their finances in order to cover their rent and child-care costs:

That's the thing and it's like obviously here we both work but you know a lot of [my husband's] wages goes on, we pay a lot, you know like half a grand in rent a [...] week and then I pay all of the day-care which we don't get any assistance for and I think that's, sometimes I don't think people realize that like yeah we are not in a [public housing] we don't get any assistance ... I worry about [our son] getting ill and me or [my husband] not being able to work and not being paid (Alannah, 37 yrs, drug use cohort)

Sue described how her full-time work was the source of income for her family and how she tried to make her children financially aware. Additionally, Sue also described using practices such as lay-by facilities when buying gifts to avoid any financial pressures impacting on birthdays, Christmas, and other important events.

An added financial cost to most of these parents was the cost of pharmaceutical and illicit drugs. For example, Chris highlighted how his use of illicit drugs involved a direct and indirect cost:

'Financially, because obviously being illegal [drug use is] quite expensive you know and your earning capacity is already lowered when you have got kids to look after and child care to pay and all this type of stuff. (Chris, 43 yrs, drug use cohort)

Felicity reported that the cost of her mental health medications created a financial burden: 'Absolutely, medications are expensive and not being able to work full time. [My medications, even with a health care card, cost] about \$80 a month'.

However, one distinct difference between how parents described this financial cost in illicit

drugs and mental health medications was evident in the research interviews. Parents who used drugs reported a level of guilt associated with this spending, which was not as apparent in the mental health group. For example, Alannah describes the guilt she feels at times associated with the cost of her illicit drug use:

Don't get me wrong, I do feel guilt over some things and I kind of think you know I'd really like to be doing this differently. I mean for example the amount I spend on heroin a week, I kind of think oh God that could be going towards something else but that [...] but then I do kind of think no our son has a great life and you know he is really, really well loved and you know like I guess he's a lovely boy so sometimes I think the proof is in the pudding kind of thing (Alannah, 37 yrs, drug use cohort).

8.5 Daily structures and routines

Because research has found that child maltreatment occurs when parents who use drugs and parents with mental illness cannot establish or maintain routines, we asked about daily practices: bedtimes, mealtimes, taking children to childcare and school.

Mostly, parents described routines in terms of juggling family, work, and care responsibilities. Their responses indicate that the demands and rewards of parenting in vulnerable families are similar to those in other families. Employment is very valuable to all the parents who work, but this comes at the cost of time with their children. For example, Catherine works full time, and leaves for work early in the morning, returning home at 7pm or later. Therefore, her husband, who is the primary carer of their son because he is not in paid employment, would be responsible for their 10-year old son's day-time meals and school drop-offs and pick-ups. Although this works well for this family, Catherine's account also indicates the limits it places on her time with their son:

During the week I am gone before [our son] gets up, so I don't see him in the morning. His dad gets him ready for school and makes his breakfast and feeds him, makes his lunch, I might see him, occasionally I see him, but I am just going out the door. So this morning I just said 'see you sweetie, I love you, see you

tonight', when I left (Catherine, 50 yrs, drug use cohort).

A few parents with mental health problems said that fixed routines for themselves, such as sleep times and mealtimes, were helpful for managing their symptoms, or that routines were sometimes affected by symptoms and that plans were in place in these situations. For example, Amy's husband could take time off work when needed, and ensure that the children maintained their daily routines. Amy's mother also assisted the family as she 'would come in and bake with the kids. She'd come in and make sure they got off to school on time, have their lunches done, do some housework'.

8.6 Ability to draw on social support

8.6.1 Shared parenting and equality

The importance of having a supportive and active partner was emphasized by all parents in a relationship. The male partners of both Liz and Sue (in the drug use cohort and employed full-time) were both the primary carers. Alannah described the importance of equality with her partner in parenting roles, both in terms of effective family functioning and in the responsibilities she expected her partner to take for their son.

The capacity of both parents to take on daily household duties and ensure that children's routines were maintained was seen to be particularly important. Amy, for example, described how her partner ensured their children's daily routines were not impacted by her cyclical health issues; however, this was only made possible by her husband's flexible working arrangements, which may not be available to all families. Amy explained:

On a bad day I don't really get up. [My husband] will have time off work and he will get the girls off to whatever they need to be doing. Yeah and generally everyone has to step up that notch you know to help out with the cleaning and the cooking and that sort of stuff. Most of the time it works. (Amy, 48 yrs, mental health cohort).

The importance of maintaining a child's relationship and interactions with both parents in times of separation was also described by Kristen, who had separated from her oldest

daughter's father but where both parents were still present and active in their daughter's life. This co-parenting was seen to be particularly relevant for Kristen, who also explained that the support provided by her daughter's father were also there for her when needed:

[My eldest daughter's] father luckily is a fantastic guy and [our daughter] would go and spend regular time with him each week ... You know I suppose, well [my eldest daughter's] father, if I am having problems with [my eldest daughter] or she is having problems at school or something I can call him and we can talk about it and how best to approach it or you know just when me and [my eldest daughter] are having a bit of a bad time she can go and spend some time over there which, but that kind of support. (Kristen, 33 yrs, drug use cohort).

The parents also spoke of the challenges of isolation, both for the primary caregiver and the family as a whole. John and Sue reflected on how the situation, where Sue was working and John was not, had placed some stress on John. Sue also explained how their very strong family relationships, and John's role as carer and being out of the workforce had impacted John in terms of social isolation, which Sue explained in terms of an inability to trust:

He doesn't kind of make those kinds of connections so yeah so it's much more, yeah we are sort of and unfortunately well fortunately or unfortunately we are a pretty tight unit ... I think when you use, you do get isolated. I think [my husband] has particular trust issues; we both have particular trust issues (Sue, 49 yrs, drug use cohort).

One of the challenges identified by fathers whose role was primary caregiver was the inability to access services for their children as they were growing up, or feeling that their role was not acknowledged or accepted:

But there was, like there were so many supports out there for [my wife] as a mother and there was nothing for me. I didn't feel like I really had support or there was no options available if I needed support as a father (Phillip, 33 yrs, drug use cohort).

Chris, who was a single father, couldn't find a parents group with fathers when his son was an infant: 'I think it might have been a single parents

group, it wasn't called a mothers group, but there wasn't any blokes there'.

Despite the very active role taken by fathers in their children's lives many still felt excluded by service providers. Kaden, for example, described attending an antenatal class with his pregnant wife and asking questions about his mental health that he felt were important, but which were not taken seriously:

We'd gone to antenatal classes and I asked those questions and they weren't very helpful [...] I think that they didn't anticipate the question coming into an antenatal class and I think that because I was educated and I was trying to cover all bases, and it is one of those things that I don't think that they had anticipated. (Kaden, 45 yrs, mental health cohort).

Phillip also described how gendered expectations of parenthood meant that he had felt ignored or marginalised in the hospital both when his son was born and in later health care settings:

I got the impression that you know they didn't really understand why I was there full stop, it was an issue for [my wife] as you know the traditional caregiver to be addressing and not me. And, you know, it's always been something that I suppose I pride myself on is you know being a very active and involved parent (Phillip, 33 yrs, drug use cohort).

8.6.2 Support from extended family

The importance of social support from the extended family was highlighted by all parents as particularly influential in creating and maintaining positive family environments. The types of support that extended families could provide was extremely diverse, and commonly included basic household chores, assistance with children's daily routines, emotional support, positive relationships between children and extended family, financial support; and children's outings. The variety of social support received from family members was, for example, particularly relevant for Kaden (45yrs, mental health cohort), who spoke of the support he received from his brothers:

Well, my brothers, we are around the same age. We all grew up [in Australia] so we have a

better education and it's more open ... Yeah, if I am having, if I am a bit down or something I will ring up ... So all my brothers, I've got four, and they ask 'how's it going, how are you guys going' and we go 'ah we're alright'. [They also ask] how's it been, up and down, do you want me to take the kids off you for this, or why don't you bring the kids around for a few hours or something to get them out of your hands or I will give you guys a bit of a break (Kaden, 45 yrs, mental health cohort).

For other parents, the willingness of the extended family to take over household chores and ensure that the children's daily routines were maintained when required was identified as one of the more important types of support. For example, Caroline explained that social support, such as the child minding she received from her mum and dad, were an important practical strategy that not only provided her with time to manage herself and her illness and care for a two-year old toddler, but also gave her older son a positive and active relationship with his grandparents and the attention she believed he needed:

My mum and dad would have my older boy every two or three weeks for a day and maybe overnight once a month, which was really good for him because what that does is that gives him some very different role modelling – a good, close relationship with his grandparents and a bunch of other really good stuff, you know somewhere where he is the centre of attention (Caroline, 40 yrs, mental health cohort).

Other parents also described the importance of extended family support as a practical and important factor in the effective functioning of their family and the wellbeing of their children, and in terms of learning practical and vital parenting skills. For example, Kristen was from a large Aboriginal family and spoke of the interaction with her extended family as being the 'best times' and an important source of parenting and cultural knowledge:

We've got a bit of a big family as well ... [So it's] those times when everybody gets together, it's the best times you know, all the cousins are together, they are all happy, everybody is supporting each other and it's just you know a good month or so of just having a nice time and

sharing stories and you know and although it probably doesn't look like it to the outside world, you're just sharing parenting tips, you're sharing everything and that's exactly what you need (Kristen, 33 yrs, drug use cohort).

Financial support from extended family was also important for a number of parents. One parent commented on how her daughter's godfather is not only a source of emotional support, but that he also provides her daughter with various treats that the family would struggle to afford:

He provides a lot of those extra things that we don't provide for her [...] he takes her to see every movie, you know every kids movie and you know, buys her toys and magazines and takes her on outings and takes her to the zoo and on ferries and so he picks up a lot of that stuff yeah and that's enormously helpful for us. That is really, really great (Sue, 49 yrs, drug use cohort).

8.6.3 Support from friends and colleagues

Parents in the drug use cohort reported being able to call on close friends for childcare and for minimising their child's awareness of particular drug-use episodes. Liz explained how this role could extend beyond short support to providing overnight care for each other's children. She explained this in terms of gender, where 'women do that':

I needed child care like we used to watch each other's kids like if you wanted to go to school or you know someone would mind your kids while you went and had a shot – I mean you do look after each other in those, like we would look after each other and each other's children as much as they can, like the women do that ... You'd take each other's kids for the night, or if someone had no money on them, you'd just you know you actually develop a support network of other women in the same situation and you bail each other out whenever you have to (Liz, 55 yrs, drug use cohort).

Felicity described how building social connections at her local church provided her with strong friendships and support for herself and her son. Although Felicity had not explicitly disclosed her mental illness in this example, she explained that this social support was important in maintaining a healthy environment for herself and her son:

Over the years since I moved to this area I became a Christian at the church I attend and that's, you know they've always been very inclusive, never felt anything other than included in that respect and I have developed some very you know very strong friendships and they are generally really very supportive of [my son] and I as well. (Felicity, 48 yrs, mental health cohort).

Connections with employment also provided social support. Caroline described her workplace as open, supportive, and caring where everyone looked after one another and where health issues could be openly discussed:

What you find is that there is a lot more people out there who manage depression [...] and the advantage in my particular office is that we are quite open about things with each other and share things and have quite a caring environment in our office where we look after each other to an extent, we check on each other so we talk about family problems and keep an eye on each other and that's very useful. (Caroline, 40 yrs, mental health).

However, not all parents described an open and caring work environment. For example, Amy had disclosed her mental illness at work and reported that her manager discusses it too frequently and would question her inappropriately.

8.6.4 Challenge to social support: stigma and isolation

The biggest obstacles to seeking social support from friends and family were potential stigma and isolation for their children. All parents in this study were connected to some extended family in some sense, and these relationships provided support that helped create positive environments for their children. However, accessing this support still presented significant barriers. Caroline, for example, described the important influence of her mum and dad in her son's life. However, her reluctance to disclose her illness to her father, who is a psychologist, and use his knowledge as a resource to manage her own illness highlights a tension in disclosure of mental illness even within close and supportive family structures. Caroline explained:

I have never talked to my parents about my own depression because they have had history with

their own family that I just don't feel like putting that on my mum's shoulders (Caroline, 40 yrs, mental health cohort).

Stigma and a lack of understanding of mental health issues were also described as a barrier to seeking social support from extended family. For example, Kaden explained how his elderly parents were from an Asian background that did not accept mental illness as a legitimate health issue:

I am from an Asian background, that old style, where mental illness is still like a stigma and that's what I have been trying to break through these oriental senior people. So it's my aim to actually break that stigma ... The stigma of mental illness in the Asian community is more like a taboo. They think it is a psychological thing, that you think too much (Kaden, 45 yrs, mental health cohort).

For Felicity, judgement was felt at a number of different levels, for being a single parent and also as a consequence of exaggerated depictions of mental illness in the media. She also described feeling judged by people who would use unsubstantiated mental health diagnoses to discuss the behaviour of others. Felicity explained:

Once I went out to dinner and a few women were sitting and going 'you know my bloody ex-husband, he's got bipolar' and 'oh yeah, I reckon mine does too because nah, nah, nah'. Like just such a term of denigration ... they have got to sort of slander him by giving him a mental illness, (Felicity, 48 yrs, mental health cohort).

For parents who used drugs, stigma and discrimination were commonly identified as challenges they faced, especially the possibility of isolation or exclusion of their children as a consequence.

8.7 Use of support services

The nature and types of organisational support that parents who used drugs or who had a mental illness drew from were quite distinct and different, and also varied across distinct phases of their children's lives. They described support from mental health organisations, support during pregnancy, and services for children. Importantly, the availability of formal support

was reported to create 'options, that's what it is, to have options' (Felicity, 48 yrs, mental health cohort).

8.7.1 Mental health

The ability to navigate mental health systems and other organisations providing support was explained in terms of parents' education and employment contacts. Crucially, being 'connected to mental health services was important' (Amy, 48 yrs, mental health cohort) and the relationship between the parents' education and employment was also noted as being important. For example, Felicity reported that as a consequence of her education and employment, she had access to a network of supportive colleagues and could access private health care. As a result, she felt she could access a better quality of care and support than many others might receive:

There are these wonderful people that work with me and understand ... Whereas other people they don't have such a good GP or they have a public psychiatrist that doesn't even look them in the eye and it's only every three months or something (Felicity, 48 yrs, mental health cohort).

Caroline also reported how her education, professional skills, and contacts were vital in finding appropriate organisational support for her children because these skills and experiences made it easier for Caroline to know where to search for appropriate information and support.

8.7.2 Support during pregnancy

The organisational support provided, or accessed, by a number of different public health systems during pregnancy was diverse. Unsurprisingly, parents who experienced a supportive and nurturing experience during their pregnancy were more likely to report accessing and maintaining continuity in care. For example, Felicity highlighted how a trial mid-wives program implemented a care plan that is still benefiting her:

*I told them about my bipolar and they were just exceptionally attentive, they were just brilliant and you know it was really, I didn't plan to become a single parent, it was a s**t situation*

and they were really, really, really supportive [...] I was hooked up with my local early child care nurse who just turned out to be the most brilliant supportive woman and took extra time with me and I just felt so taken care of and she connected me with a local female GP [...] she's still our family GP to this day and she just spends so much time if I need it and all this sort of stuff, fits me in at any time and also the childhood nurse recommended me to go to a group, it's a unit for families . So I yeah it just all came together through this maternal healthcare thing, it was just amazing ... Oh I am so blessed! (Felicity, 48 yrs, mental health cohort)

The ability to disclose pharmacotherapy or illicit drug use to health services during pregnancy was explained as an important factor in whether organisational health support was accessed during pregnancy. Kristen, for example, reported that she had accessed a mid-wife during her pregnancy who was culturally appropriate and respectful, and due to this, Kristen trusted her, which in turn ensured adequate health screening during the pregnancy as well as after the birth. Kristen explained:

When I became pregnant I did have my first habit on heroin ... I had all pre-natal care and my midwife knew and I had a drug and alcohol counsellor that knew. I felt really supported through that 'cause of our Aboriginal heritage we are able to access Aboriginal [specific services] and the midwife and the drug and alcohol nurses were just fantastic through the whole process ... I just felt like I could trust them 100% over anybody else. I mean my grandmother; my mum and those three people are the only people that knew [about my drug use] (Kristen, 33 yrs, drug use cohort).

For Phillip and Alannah, a midwife who was aware of their pharmacotherapy use and who provided support and advocacy in an environment where they had experienced discrimination made the birth of their son 'less stressful' and more 'empowering' for them.

8.7.3 Support for children

Within the mental health cohort, parents commonly spoke of communicating with their children's school about the family's health issues. This open communication created

awareness around health issues, and also provided the child with support when required. For example, Caroline described open and regular communication with her child's school, which she believed was a beneficial strategy:

I made it very clear to the principal what the family situation was. We went up to talk to them anyway because [our eldest son] is quite bright. We went up to talk to the teacher about what our options were and what we needed to do before he started school and then I kept in contact with the principal to let her know what our family dynamics were about [...]. I book a meeting at least three times a year to sit down and talk to them. (Caroline, 40 yrs, mental health cohort).

Kaden also highlighted how discussions with his son's school principal, although initiated by him and not by the school, had been positive. One of the effects has been that the school now has resources for children of parents with mental illness:

Since I've spoken to the principal about it there's a bit more development and I push and I push more publications to go to the school, publications about children with parents with mental illness, go to the school and any other children that may be in the same situation as ours don't have to go through the same process what we did (Kaden, 45 yrs, mental health cohort).

Felicity also described how she was able to discuss her health issues as well as her son's learning disabilities with her son's school:

I told his primary school... I felt comfortable in telling them because they are a really compassionate school and people and [our son] has also got that learning disability, which they had to pay extra attention to. I just found, I just felt that they, look I think that they just looked after all the kids and I was just really happy with them and the support that they gave him (Felicity, 48 yrs, mental health cohort).

When her son transitioned to high school and was not receiving the support he needed, she chose to switch to an independent school and received fee relief because she disclosed her mental illness to the school.

While most of the parents with mental illness talked about the benefits of communicating

with their children's school, one parent who used drugs described the conversation with the school as very difficult. Chris, another parent, disclosed to his children's school that he was about to start a prison sentence, because he believed that open communication with school staff was important for giving them an understanding of his children's situation.

For a number of parents in this study, finding and using appropriate services for their children was also described as particularly beneficial. For Kaden, linking his children to the pre-natal mental health service that his wife used also ensured that his children received the emotional and psychological support they required. Felicity had found a young carers group:

There was a poster for young carers [at the dentist] and it said that young carers are also children that look after parents with a mental illness and it kind of clicked with me and I rang them and then I found out about these websites and everything and yeah, it was a whole new thing 'cos it never occurred to me. I always thought a carer was someone who looked their old, severely disabled member of the family or something. So I got connected and the coordinator there, she has just been brilliant. (Felicity, 48 yrs, mental health cohort).

However, although formal services were very important to parents, they also described barriers to receiving support. In findings consistent with the literature, parents described services that were inaccessible due to stigma and discrimination, restricted hours of operation, eligibility criteria, or services which had been discontinued.

8.8 Strategic avoidance of services

Most of the parents said that they avoided child protection services, an avoidance based on fear, which contrasted with their active engagement with other support services. For example, Liz explained that she actively tried to avoid all interactions with public services: 'didn't go anywhere near anyone, the government [...] you know you just won't touch them when you've got children because you are too frightened to'.

Other parents have knowledge and contact with the statutory child protection system because

they are mandatory reporters in the course of their employment. This knowledge did not reassure them or give them confidence in the system:

Well I have got the experience in working with these people personally and professionally but you know it's a hard world to work in when you do have a mental illness because sometimes you think everyone is watching to see if you are ok. And you think, am I just being paranoid but I don't think so, I think people are actually just really always got it on their mind, you think: would you think the same way if I had diabetes, would you be worried about my diabetes, no, I don't think so (Amy, 48 yrs, mental health cohort).

The fear of child protection and its impact on help seeking behaviour was also highlighted by Felicity in an instance where she had chosen not to go to hospital in case the admission triggered a child protection report. She explained:

I've got a background in working in welfare and [the statutory child protection agency] were involved in my work and things like that so I avoid them at all costs and that's why I will not go into hospital under any circumstances and even in the last couple of months I was just so not good that I nearly drove myself to the local hospital and I just went I just can't, do you know what I mean, because I can't risk it (Felicity, 48 yrs, mental health cohort).

Kristen believed the child protection system immediately categorised her as at-risk because she is an Aboriginal person on an opioid substitution program:

Yeah, well you know so it doesn't take much, if you are Aboriginal and in itself, you know systems seem to always look at you for being disadvantaged and kind of like there is something wrong with you (Kristen, 33 yrs, drug use cohort).

When she was pregnant, Sue described a negative experience of being effectively mandated onto a methadone program. Nonetheless, she used this experience to ensure she would be safe even under the scrutiny of child protection agencies:

He basically said you need to go on to methadone tomorrow. If you don't go onto

methadone tomorrow you won't be taking your baby home from the hospital. So I went on to methadone straightaway. It made me do everything really, really carefully [...] I was actually quite determined to do everything right, rather than the opposite, yeah. I was determined that they wouldn't have any cause [...] say that I hadn't done the right thing (Sue, 49 yrs, drug use cohort).

In contrast, Chris, who disclosed to his children's school that he was about to start a prison sentence, also sought out support from the child protection agency:

I approached [the agency] and said look this is what's going on, I was completely honest with them. I said I don't know how long I am going to be away for, I don't know what I am going to do with my kids but I need help.

His interactions with the agency were positive: one of Chris's friends became a foster carer for his children, with casework support from the child protection agency:

And because I approached them and they said you know you have been a single dad for all these years and we have never heard of you, that's a good thing. They said we will help you and they actually did (Chris, 43 yrs, drug use cohort).

Although avoiding interactions with child protection was a deliberate strategy pursued by most of the parents, they were also aware of the disadvantages of this. Liz was asked what impact avoiding child protection would have on parents and a child's interactions with important health services:

Oh well the problem is that they don't go to the doctors when they need to, sometimes they don't, they just don't go anywhere near child services, once their baby is born they don't go and get the immunizations, they don't go and you know they just try and stay away from anyone who can do them in (Liz, 55 yrs, drug use cohort).

While the parents in this study had resources to choose services that are useful for them, and to manage whether and how they disclose their circumstances to agencies, other parents with fewer resources may avoid all services and institutions.

8.9 Discussion

Some of the strongest themes to emerge from these data are in reference to communication with children, schools and services. Parents talked about normalising their lives—in terms of age appropriate conversations with children, and being honest. This finding contrasts with previous research which emphasises parents' strategies of concealing drug use from children in an effort to minimise harm (Rhodes et al., 2010; Richter & Bammer, 2000). However, this honesty was deliberate, planned, and selective: parents also talked about the importance of being able to choose whether or not disclose to other people, and ensuring that children were not exposed to their parents in a state of intoxication or mental distress. This finding was common both to parents who use drugs and those with mental health problems, and both groups also discussed the importance of informal support from friends and family. Importantly, although this project was not focused on specific services or support models, formal support services also emerged as very important.

All of the parents had significant personal resources on which to draw, and these contribute to their daily routines and assist at times of crisis. Most were educated to university level, had connections to paid employment, as well as friends and family. The benefits of these included emotional support and information, assistance with childcare and household chores, providing treats for children (trips to the movies, time away from younger siblings), connections to culture, and friendship and support for parents.

There were a number of connections between the findings of the Delphi study and those of the qualitative study. Both highlight the importance of support to parents from friends and extended family, and the availability and accessibility of formal services. They both identify knowledge about the demands and realities of parenting as being important.

The qualitative study also identified a number of strong themes that were not highlighted in the Delphi study. The qualitative study found that the capacity to ask for help, to use services strategically, and to persist with seeking help seems to be connected to a sense of self-

identity and acceptance, as well as a lack of shame about drugs and mental health problems by the parents. Although this is an unexpected finding, it makes intuitive sense. Parents who are confident and feel secure in their right to seek assistance are probably more likely to persist if initial attempts are not successful. Conversely, those with a less secure sense of self and entitlement may be easily discouraged and less confident in seeking assistance.

Connected with this, a number of parents in the qualitative study reported a strong commitment

to shared parenting and active involvement from fathers. Because services did not anticipate this (hardly revolutionary) disruption to gender norms, they did not address themselves to fathers until the parents asserted themselves. It seems that a slightly unorthodox attitude to parenting, and gender equality in the relationship, may be a factor in gaining the support that is needed from services rather than settling for what services initially want to provide. These parental characteristics are also protective factors for children's wellbeing.



9. Conclusion

A number of common themes recurred across the Delphi study and qualitative research with parents and service providers:

- formal support services are very important: services need to be available, accessible and trusted, and sufficiently flexible to respond to different needs at different times;
- the support provided to parents is beneficial if it improves their knowledge and resources around parenting, and if it builds their connections with peers and community; and
- social, cultural and recreational resources benefit parents and therefore children, again because they enable parents to broaden their social networks.

Although this was not mentioned specifically in the Delphi study or by services, parents' responses to questions indicate that considerable resources are required to be a competent and safe parent: material, social, and educational. Our interviews with parents who use drugs indicate that they are affected by the intensification of parenting, which increase parents' responsibilities to optimise their children's educational and other outcomes. Much of the research on parenting intensification focuses on 'mainstream' parents,

but these elevated responsibilities are also felt by parents from stigmatised and vulnerable groups.

We can also identify the need for further work in this area of understanding the conditions necessary to create child safe and child friendly communities. Research on risk and vulnerability is relatively well-established, and data sources such as the Australian Early Development Census provide valuable information on the characteristics of vulnerable communities, which enable careful targeting of services and support. However, conceptualisation and data on the characteristics of families and communities who do well in a context of low resources or high risks, especially at community level, are much less developed. We found little evidence that communities have been encouraged to track and monitor their successes in protecting children. Most experts in the Delphi study and practitioners and managers in the qualitative case studies focused on family characteristics, such as help-seeking behaviour. This is unsurprising as most research also emphasises family rather than community characteristics.

There are also challenges, as noted in Section 4.2, of defining communities, and these in turn present challenges in managing and analysing

data on communities. Families in many areas, especially cities, do not live their lives in one LGA or administrative area—they may live in one LGA, attend school in another, and use services in a third. This is not problematic for the AEDC and other large studies of child outcomes, such as the Longitudinal Study of Australian Children, but research on communities requires data to enable different kinds of analysis. At present, it is possible to identify communities with unexpectedly positive outcomes, but more data is needed to identify the characteristics and interactions in those communities which produce those outcomes. If services and communities were encouraged to measure outcomes at a community level, rather than only an individual or service level, and to collect and manage data on these outcomes, this gap could be

addressed. In order to facilitate this, improved data collection and availability on a number of measures would be beneficial, for example:

- parent's sources of social and service supports;
- perceptions and experiences of community safety for themselves and their children;
- their perceptions and experiences of the community resources available for their children; and
- parental stress.

Our analysis of community strengths/social character was based on Census data on volunteering, child care for other people, and domestic work, which is very limited.

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11. Appendix A: Data for LGAs

Table A1 Median values for LGAs

Variable	Median values for Victoria LGAs	Median values for NSW LGAs
AEDC 2009		10.53
AEDC 2012	9.25	9.3
Child abuse 2010-11	6.7	
Domestic violence 2009		335.4
Domestic violence 2012		345.8
Family incidents with children present 2010-11	326.6	n/a
Liquor offences 2009		256.2
Liquor offences 2012		174.2
IRSAD 2011	981 (1032.5)*	959.0
IRSD 2011	993 (1026.5)*	968.35
Alcohol use	5.1	n/a
Psychological stress		11.4
Social support	93.1	91.8
Lone parent families (children 0-6)	14.6	18.6
Lone parent families (children 0-17)	18.8	
Low income families (children 0-6)	33.5	36.05
Low income families (children 0-17)	32.7	
Low education families (children 0-6)	14.5	19.6
Low education families (children 0-17)	19.6	
Young mothers(children 0-6)	6.0	8.95
Young mothers(children 0-17)	3.2	
Jobless families (children 0-6)	13.6	19.05
Jobless families (children 0-17)	14.0	
Aboriginal and Torres Strait Islander parent (children 0-6)	1.2	5.2
Aboriginal and Torres Strait Islander parent (children 0-17)	1.1	

Notes * Figures in brackets indicate median values for metropolitan LGAs.

Table A2 Within-LGA data: Maribyrnong

Maribyrnong	% Children developmentally vulnerable on 2 or more AEDC domains 2012	IRSD score	Number of children
Braybrook/Tottenham	11.5	801.15	134
Footscray	5.5	939	101
Kingsville	7.5	1018.6	55
Maidstone	7.8	938.06	81
Maribyrnong	5.2	1051.7	101
Seddon	10.2	1031.72	50
West Footscray	6.3	967.14	116
Yarraville	7.9	1046.63	198

Source: AEDC Community results table Maribyrnong 2012 [excel table export]
<http://www.aedc.gov.au/data/data-explorer?id=42572>

See also Maribyrnong Community profile 2012;
http://www.aedc.gov.au/ClientData/CommunityProfiles/2012_24330.pdf

Table A2 Within-LGA data: Moreland

Moreland	% Children developmentally vulnerable on 2 or more AEDC domains 2012	IRSD score	Number of children
Brunswick	3.6	1035.88	177
Brunswick East	9.6	1052.18	77
Brunswick West	3.1	1023	102
Coburg	5.1	1006.27	305
Coburg North	7.4	969.8	77
Fawkner	15.3	901.68	182
Glenroy	11.5	932.95	249
Gowanbrae	12.3	1079.51	58
Hadfield	6.5	939.75	82
Oak Park	4.1	1043.1	50
Pascoe Vale	8.3	1011.4	142

Source: AEDC Community results table Moreland 2012 [excel table export]
<http://www.aedc.gov.au/data/data-explorer?id=42578>

See also Moreland Community profile 2012;
http://www.aedc.gov.au/ClientData/CommunityProfiles/2012_25250.pdf

Table A4 Within-LGA data: Hastings

Hastings	% Children developmentally vulnerable on 2 or more AEDC domains 2012	IRSD score	Number of children
Bonny Hills	5.1	1026	45
Kendall and surrounds	7.7	972	42
Kings Creek and surrounds	16.7	1042	45
Lake Cathie	14.3	992	50
Lakewood/West Haven	0	935	24
Laurieton	11.1	893	18
Port Macquarie/North Shore	5.2	975	537
Wauchope and surrounds	10.4	915	122

Source: AEDC Community Results Table Hastings 2012 [excel table export]
<http://www.aedc.gov.au/data/data-explorer?id=42474>

See also Hastings Community profile 2012:
http://www.aedc.gov.au/ClientData/CommunityProfiles/2012_13750.pdf

Table A4 Within-LGA data: Holroyd

Holroyd	% Children developmentally vulnerable on 2 or more AEDC domains 2012	IRSD score	Number of children
Girraween	7.8	997	93
Greystanes	7.1	1019	307
Guildford	9.8	879	213
Guildford West	14.5	933	84
Merrylands West	7.5	925	99
Merrylands/Mays Hill/Holroyd	9.7	921	368
Pemulwuy	1.3	1101	76
South Wentworthville	9.6	969	80
Wentworthville	10.3	996	179
Westmead	8.1	990	195
Woodpark	5	997	23

Source: AEDC Community results table Holroyd 2012 [excel table export]
<http://www.aedc.gov.au/data/data-explorer?id=42420>.

See also Holroyd Community profile 2012;
http://www.aedc.gov.au/ClientData/CommunityProfiles/2012_13950.pdf

12. Appendix B: Interview schedules and recruitment material

Families Thriving in Adversity Family Discussion Guide - Final

Discussion guide to be adapted as appropriate for geographic case studies and communities of affinity – parents who use drugs and parents with mental health issues.

Intro. Qs.

- Can you start off by telling me a bit about your family? (who lives with you, children, extended family close by?)
- What are the best things about living in this area? What are the bad things?
- How would you describe your child/ren's relationship with you?
- What do you feel are the main challenges facing families in this community?
- Compared to other families living in this community, how well do you feel your family is doing? Why? Prompts:
 - parents' social networks/connections;
 - intergenerational and extended family supports;
 - relationships between parents/caregivers;
 - formal and informal supports;
 - engagement in social, recreational and cultural events in the community.

Qs for parents who use drugs:

- Can you tell me about your children (age etc.) and who you live with?
- Tell me a little bit about your daily routines e.g., taking the children to school, work, shopping, sport, watching TV. What do you and your family [or you and your children] do to have fun together?
- Can you tell me about when you found out you were expecting your first child? Was it planned? How did you feel?
- Who (or what) helped you the most--when you were pregnant? –when the baby was born? In the first year of being a parent? Now?
- What have been the most important things you've learnt or discovered about looking after babies and children?
- What would you say are the main challenges that parents who use drugs face when raising children?

- Can you talk about how you use drugs now (how often, who with, where)
- Can you talk about how you manage your drug use as a parent? (e.g., plan to use when children are away/asleep/at school; conceal use from children; store drugs securely; only use at friends' places)
- Have there been any times when you felt you couldn't cope or didn't know what to do? (e.g., child behaviour, hanging out, financial emergency, health emergency) What did you do?

Qs for parents with mental health issues:

- Can you tell me about your children (age etc.) and who you live with?
- Tell me a little bit about your daily routines e.g., taking the children to school, work, shopping, sport, watching TV. What do you and your family [or you and your children] do to have fun together?
- Can you tell me about when you found out you were expecting your first child? Was it planned? How did you feel?
- Who (or what) helped you the most when you were pregnant? –when the baby was born? In the first year of being a parent? Now?
- What have been the most important things you've learnt or discovered about looking after babies and children?
- What would you say has been the most difficult thing about being a parent?
- Can you talk about how you manage [your mental health issues] as a parent?
- What are the things that you do to minimise the impact your mental health issues might have on your children?
- Have there been any times when you felt you couldn't cope or didn't know what to do? (e.g., child behaviour, financial emergency, health emergency for you, health emergency for your children). What did you do?

Invitation to participate in research about raising children

The Social Policy Research Centre is conducting a study about families who are doing well in circumstances that might be difficult for other families. The study is being done for the Department of Families, Housing, Community Services and Indigenous Affairs. We want to find out about what helps some families stay safe and well when other families in similar circumstances might not do as well.

We would like to talk to parents whose family is doing well about the things they do that help keep them and their children safe and well. If you decide to **take part in an interview**, we will speak with you about your experiences of raising children and about where you live.

During the interview we would like to take notes and will also ask you to agree to let us record the interview to make our notes better. You will not be identified in the report or any of the papers we write or publish. What you tell us will be **completely confidential** and will not be told to anyone other than the researchers involved in the study, except as required by law.

Interviews should take about 1 hour. We acknowledge that this is a significant amount of your time, and as a sign of appreciation, we will give you a store **voucher to the value of \$50**.

If you are **based in Sydney** and interested in being interviewed for this research project about raising children in challenging circumstances, please contact the Social Policy Research Centre on (02) 9385 7800 or email sprc@unsw.edu.au to arrange a suitable time for interview.

